HIDDEN CORE VALUES LINKED TO DIACONAL SERVICES WITHIN LUTHERAN HEALTH CLINIC IN MAJUNGA, THE 'CAPITAL CITY OF MALAGASY MUSLIMS' IN THE NORTH-WEST PART OF MADAGASCAR

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Master's Thesis

Master's Degree in Diakonia and Christian Social Practice

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Number of words: 27 802

June 1st 2016

ABSTRACT

This master thesis is a qualitative case study aiming at revealing the hidden core values of a diaconal service within a Lutheran hospital based in Majunga; the capital town of Malagasy Muslim in the North West part of Madagascar. Although, life in this place as well as in many parts of the Island becomes more and more difficult due to political and economical crisis at highest and lowest levels, a good number of people from different classes, ethnic groups even Muslim remain loyal customers to this quite expensive hospital., Through the study of the choice of those customers, this paper has explored some of the main reasons behind this reality which are more or less related to the evidence-based of unknown values linked to diaconal healthcare. Interviews and focus group were boosted by Delphi method in order to collect in-depth explanatory data. Two hidden core values: respect and trust were consequently identified in the presentation of findings, and after gaining further insights from the analysis section using interpretive sensemaking and narrative analysis, three more values were uncovered: hope, hospitality and faith in action. As a result, central to this paper is making a case that for a powerful attractiveness of client in long term, this Lutheran hospital needs to maintain the expression of such values and in addition make use of the value justice for a real and full embodiment of its diaconal characteristics into action.

Key words: *Lutheran hospital, patients' choice, diaconal service, hidden core values*

ACKNOWLEDGEMENTS

First of all I would like to express my heartfelt thanks to The Lord God, The Lord Jesus Christ and The Holy Spirit for His blessing which has kept me in good health during these two years.

My warmest gratitude goes to Dr. Professor Kjell Nordstokke who is my supervisor, for esteemed scholarly guidance in the process of writing my research work, thank you very much for your tolerance and precious support.

Then, I would like also to offer exceeding appreciation to all my lecturers and staff at Diakonhjemmet University, for providing and sharing academic knowledge about this exciting science on Diakonia within an excellent international environment I have ever experienced.

Sincere thanks to Dr. Heuric and especially to Pastor Rova-Hegener (American Lutheran Church Oslo), for taking their precious time in proof-reading this paper and correcting my English. My appreciation goes to Pastor Arild and Pastor Per Ørjan with family, for their unwavering dedication in supporting my life in Norway.

My deepest gratitude is reserved for my loving wife, Felana, my three lovely daughters; Gratia, Tiantsoa and Fehizoro, my parents and my loved ones who encouraged me to never give up through their daily prayers.

To all my friends in Madagascar, Norway and everywhere; thank you for encouragement and help. You are really true friends.

Last but not least, my special thanks and gratitude are addressed first to the Malagasy Lutheran Church for giving me permission to join this study, secondly to Norwegian Government (Lånakassen) for grant, thirdly to the Director of Salfa Antanimalandy with his staff who have willingly sent me important information about the mainline context in Majunga and finally to the patients with their caretakers who accepted to share with me interviewing narratives. Without their agreement, the completion of this work would be unhauthentic. Thus, may The Triune God receive all the glory and may Jesus flood His blessings upon you all.

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ABREVIATIONS AND ACRONYMES

ARHAP	African Religious Health Assets
CSB1 or 2	«Centre de santé niveau 1 or 2» Health basic center level 1 or 2
ELCA	Evangelical Lutheran Church in America
GHM	Global Health Ministries
HIV/AIDS	Human Immunodeficiency virus and Acquired Immunodeficiency Syndrome
INSTAT	National Institute of Statistics in Madagascar
IRHAP	International Religious Assets Program
LWF	Lutheran World Federation
MLC	Malagasy Lutheran Church
NMS	Norway Mission Society
NSD	Norwegian Centre for Research Data
RCT	Rational Choice theory
RHAs	Religious Health Assets
SALFA	Sampan'Asa Loterana momba ny FAhasalamana or the Health Department of MLC
WHO	World Health Organization

CHAPTER ONE: INTRODUCTORY CHAPTER

1.0 General introduction

"And He (Jesus) sent them out to be preachers of the Kingdom of God, and to make well those who were ill" states the 'doctor' Luke (Colossians 4:14) about the two dominant roles intended for the first disciples of Jesus, according to the second verse of the chapter 9 of his Gospel (Luke 9:2). These preaching and healing ministry still remains the core task of the mission of most of today's Christians. Therefore, SALFA (Sampan'Asa Loterana momba ny FAhasalamana) or the Health Department within Malagasy Lutheran Church (MLC) in Madagascar, has developed its motto from this statement: "Izahay mitsabo, Jesosy manasitrana", which literally means "we treat, Jesus heals". Accordingly, wherever one goes all over Madagascar and a plate displaying this advertising slogan is hooked somewhere, one should know that a Lutheran clinic is established there. Even though─after long efforts of different and successive Malagasy Governments in the implementation of World Health Organization (WHO) program, public health centres that are supposed to be functional throughout Madagascar have not been succeeding in handling main public health issues. Therefore, apart from the generally precarious situation in terms of health in the country, the religious motivations of the leaders and partners of Salfa incite them to continue to extend its health activities over all Madagascar in parallel. For example, with regard to this 'holy concurrence'[1], one finds in its (Salfa's) current strategic plan 2011 to 2016 that Salfa Headoffice dares to express the following vision: Salfa clinic as a "model healthcare Ministry in medical care, training and research, operating an excellent and sustainable management system" (SALFA 2011).

Furthermore, the message published by the well-known international financial organizations such as the World Bank, and also bilateral donors, like USAID─ taking into account the findings of their analysis and observations about the performance of private health facilities, was a real encouragement for Lutheran medical staff on their purpose because it clearly says: "reduce the level of government involvement in health care and

[1] 'Holy concurrence' is the translation of famous Malagasy expression of useful competition for a very good purpose for all: "fifaninana masina".

promote the private sector" (Bennett et al 1997:2). And today, all development agencies and international institutions (World Bank, WHO, European Union…) consider that all health facilities, both private and public, must be constitutive of the entire national health systems. However this is not the case for us in Madagascar where only public structures receive subsidies from the state.

More than ever, Lutheran health centres which are a non-profit institutions and only counting on its own resources to ensure its sustainability, are somehow constrained to well manage all its assets in order to survive vis-à-vis this fierce competition not only with the public centres but with the private for-profit health facilities as well. This thesis will just try to explore one of the main reasons why those Lutherans facilities arrive anyway to grow all around Madagascar by attracting customers' attention and preference.

Accordingly, in this introductory chapter, I introduce my study to the reader. The central subjects addressed here include; background information and motivation for the thesis, goal of the research, relevance of the problematic, research question and hypothesis, limitation of proposed research, brief review on existing research, understanding of concepts, and the structures and organization of the thesis. To wrap up this part, a chapter conclusion is given.

1.1 Background information and motivation for the thesis

Before coming to study in Oslo, I, trained as medical doctor, was working for the MLC as a Technical Assistant first (2011 to 2012) and then Technical Director at Salfa Headoffice (2013 to 2014). Since the beginning of my mandate even along the way with this department, the new Managing Director (the one who was elected in 2010), the two other Directors (administrative and operations directors) and I have felt touched by the different problems in which many Lutheran clinics in remote areas suffered innocently because of three years (2008 to 2010) of crisis distressing the Headquarters (a more details will be given in the context chapter). For, throughout the course of that period the support namely the "poor fund" and all forms of cooperation were blocked by our usual donors. Then, we tried to do our best in implementing a change of leadership style, a new planning credible project documents in order to convince and regain the confidence of our potential partners such as Global Health

Ministries (GHM) and Evangelical Lutheran Church in America (ELCA), Norway Mission Society (NMS), Danish Mission and so on.

At that time our analysis was emphasized on what was not really working, which clinics or services or project were suffering, and how to rebuild what was ruined... In other words, our effort for seeking solution was started on identifying a 'tree problem' to developing a 'tree solutions'. Our focus was much more on problem.

However, after my study at diakonia where I have discovered advanced theories and new skills on making successful a diaconal activity, I realized that it is possible to find solving problem process by searching, developing and sharing what happens at successful diaconal services. Regarding the current case, carrying out an academic research within one of the strongest Malagasy Lutheran clinics might be interesting and supportive. For such study may offer insight into how the discovery on its success could be used to improve the lack encountered in the others (Salfa's clinics). I am strongly motivated to use the approach learnt from this master's on Diakonia to explore those new findings in order to be copied by the centers in a material and organizational struggle as a good model. Thus I wish my humble contributions through this thesis will be useful both for those in needs and for the Lutheran hospital in Mahajanga where the study has been carried out.

Eventually, as a Christian medical researcher, my long-standing desire is to be actively involved with a research capable to provide an evident resolution showing the possibilities of truthful approach at the service promoting health system especially in developing countries. And I am really keen on increasing my knowledge in both theoretical and practical way such as in science of diakonia.

1.2 The goal of this research

This paper generally envisages contributing in identifying the hidden core values associated with diaconal health services carried out in Madagascar, an example of tropical poor country. In order to reach this general aim, two specific purposes should be achieved:

First, explore the existence of these values of diakonia by analyzing the perceptions of people who have consulted at the Lutheran hospital in Mahajanga– the 'capital city of

Malagasy Muslims' in the North-West part of Madagascar, in regard with the payment after service, the quality of service, the impact of chaplain service for patients and the values of the medical personnel. Second, observe the values in practice during medical examinations both in the main hospital and in its annexes implanted in remotes areas. There is a strong connection between these objectives because, if the result of the first study seeks the answer from clients about the hospital values, the second findings will portray, during the diaconal practice, how genuine those values are.

1.3 The relevance of the problematic

My close attention has drawn by the noticeable threefold paradoxes observed in relation to the client attendance at the Lutheran health centre in Majunga[2]. Actually, the problematic my study is dealing with, takes an interest on the patient's choice that does not follow the logic of the calculations and the social reality in general.

First of all, this Christian facility, where all medical activities are paid services, is still preferred by a good number of patients (Table 1), and that certainty is experienced almost every day, even though the medical consultation is free in all public health centres. Normally, with the unfavourable economic circumstances in Madagascar, one would expect that people will normally go to public hospital in order to avoid unnecessary cost in the private hospitals. However, the basic fact portrays that some customers in Majunga are attracted to the Lutheran hospital in spite of the heavy financial cost in the Lutheran hospital (Figure 1).

Table 1: Number of patients received at external consultation services in Lutheran and public facilities in 2015 (Salfa Antanimalandy 2015, CSB2 Sotema Antanimalandy 2015)

Health Facility	SALFA Antanimalandy	CSB2 Sotema Antanimalandy
Number of consultants	11 736	13 958

[2] Majunga is the French appellation of Mahajanga; both are interchangeably used in all publications, book or articles reporting something about this town.

Then, it is important to notice here that, the medical staffs employed by the government periodically receive training and sustainable supports compared to those from private hospital. This means that the quality of the service there (in public sphere) is quite maintained. And due to the ”enough income” and ”good retired pay”─compared to what one has at private company─in public system, Lutheran medical personals really desire to work for public facility. For instance, according to the annual report 2014 of the whole department of health in Malagasy Lutheran Church, at least two physicians: one general practitioner and one surgeon have moved to the public structure (SALFA 2014). However, that doesn't a matter for many patients in this Muslim part of Madagascar, despite their poverty exacerbated by increasing inflation (causing low purchasing power), they continue to come seeking health in this Lutheran hospital and once more, prefer the payment of complete invoices for care received instead of getting gratis medical care in public hospitals.

Finally, in spite of the fact that, generally Muslim people do not trust Christians and vice versa, this clinic is also frequented not only by the poor and middle classes of the Muslim brothers and sisters but by the rich Sunni businessmen of Indo-Pakistani origin. By the way, one actually deals with a study of an interesting people's choice.

According to the unanimous response of most members of Lutheran medical staff, the patient's satisfaction was due to the 'grace of Jesus Christ'. They often prefer to found their reason for their success in this general religious conviction while other scientific factors of paramount importance can be involved in the choice of those people. Thus, one must formulate an *explicit statement* of research question (Bryman 2012:9).

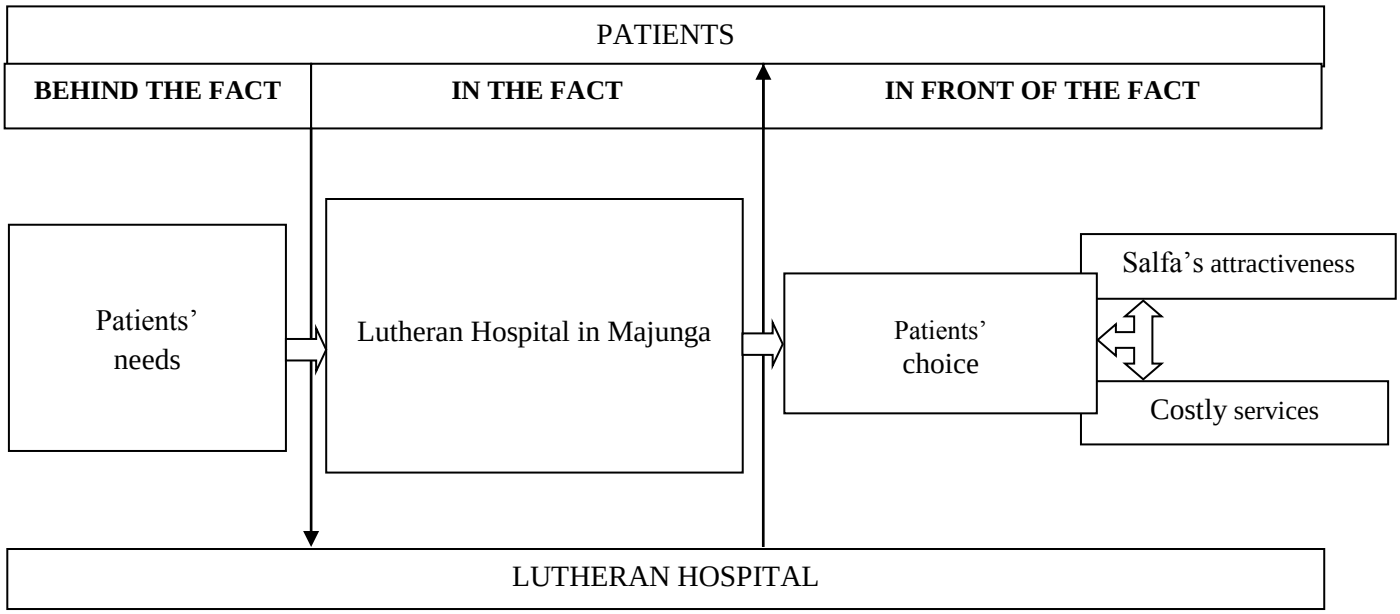

Figure 1: A helping representation of the reality between loyal customers of Salfa and its diaconal services

1.4 The research question and the hypothesis

In order to bring some efficient contributions on resolving the previous problematic, I propose the following research question: Why do the diaconal services in the Lutheran health institution in Majunga, in terms of seeking health, attract the choice of native inhabitants and foreigners. The relevant approaches in social research will be applied to seek the elements of answer of this central question. In any event, the researcher presumes as a general hypothesis that the core values of diakonia within and around the health services offered by this Lutheran clinic in Mahajanga make it preferable. Yet, those values are either under communicated or completely unknown by the staff, it is for this reason why I mentioned in the title of this thesis: Hidden core values.

Moreover, formulating a question research is one of the very important steps in social research. For, if researcher is not aware enough, a small defect committed at the beginning could lead to a big mistake on findings later. In an attempt to prevent such eventuality, and to really aim at the achievement of the first specific objective of my paper, I have narrowed the question research on four (4) research subquestions (Creswell 2014:140):

a) How does the price of services affect the patient's choice?

b) How does the quality of service delivery have an effect on their choice?
c) How does the spiritual dimension have in impact on their choice?
d) And how do the values of medical personnel influence their choice?

1.5 Limitation of proposed research

As mentioned previously, firstly this study is done only on one of the ten big Lutheran Hospitals in Madagascar. And secondly, the medical personals under communicate the question of values, therefore I think it is wise to make the first specific purpose as a starting point of my research. And given to the time constraints and the delicacy of observation─at least a non-participating informed observations, done at a number of randomly chosen part of time during medical acts is needed for this section, the second specific objective is not addressed by this study. Thus, my master thesis, which is a qualitative research, intends then to play a role of an in-between footstep among diaconal further qualitative and quantitative studies namely another Master thesis or *Philosophiæ Doctor* (Phd) and the evidence-based of core values within a diaconal health services in poor country.

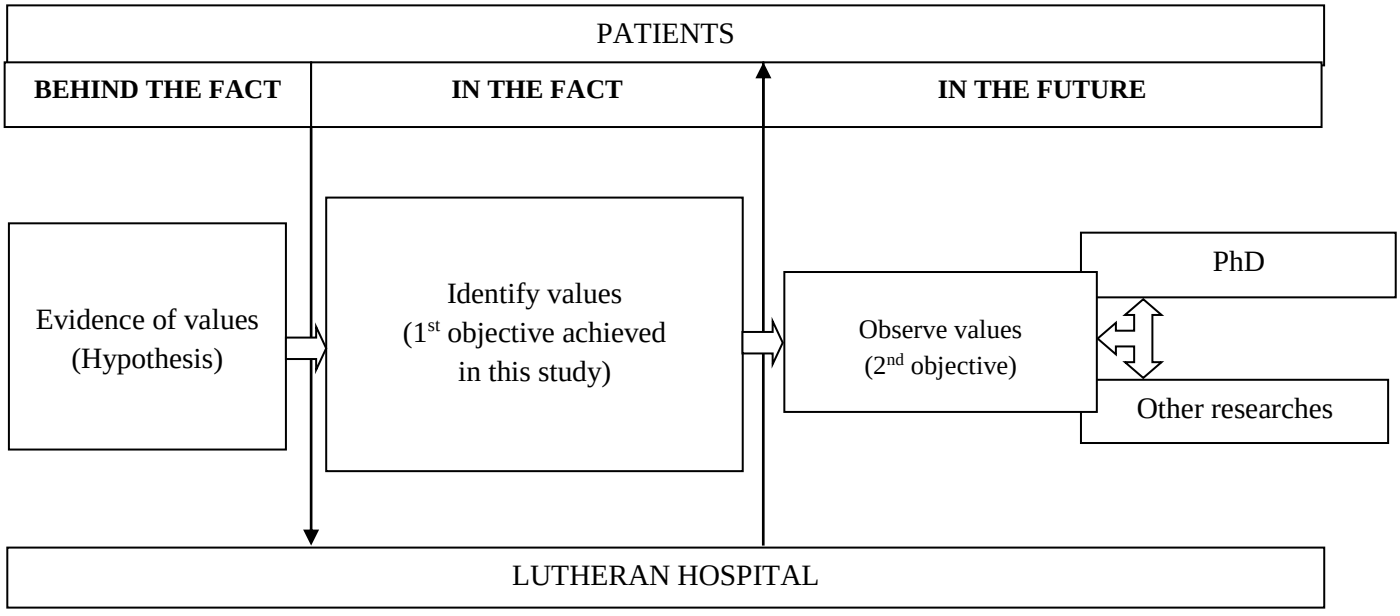

Figure 2: A helping representation of the tendency of this research

1.6 Brief review on existing research

The preliminary literature review done by the investigator triggered a critical reflection on three subheadings: patient choice and health facilities, professional values and health sector and values and diaconal services.

1.6.1 Patient choice and health facilities

The first writings that stimulated my enthusiasm for tackling the present topic was the one written by Dealey because after its reading my understanding started getting deeper into one aspect of English patients preferences in their selection not only of the hospital but the care that they need. This article is a literature review concerning indeed patients' choice and the issues showing how they will reach a decision about their surgical and medical care (2005:576-9). Then, the empirical findings of the study about patients' expectations and satisfactions in public and private Egyptian hospitals examined by Mohamed Mostapha will be used in this thesis as well (2005:516-532). And the third one for this subdivision is an article entitled "Factors affecting patient's choice of hospitals". It gives an access to factor analysis identifying "the underlying hospital-related and attitudinal dimensions that influence a patient's choice of hospital" through eight variables: cost of treatment, employment, quality of services, convenient administrative procedures, perceived state of health, health insurance coverage, age and sex. The study was carried out in Riyadh Saudi Arabia within four health centres: two public hospitals and two private hospitals (Saeed KS 1998:420-4).

1.6.2 Professional values and health sector

From the perspective of Kui-Son et al's research, an integrative model of health care attracting client attention is feasible by established relationships among service quality, value, patient satisfaction and behavioural intention in the context of South Korean health care market. Such findings have been consulted because of their appropriateness for some facets of the current topic (Kui-Son et al 2004:913–921). Among the results the researchers realized that both service quality and value have a significant direct impact on behavioral intention while value assessment was influenced by perceived service quality. In addition, a book edited by Pattison et al, explaining more or less how and why professional health care and values have changed over the last 40 years, was consulted too for this study. For its academic

analysis brings to my attention a general insight on the test of the different angles of my unconfirmed hypothesis (Pattison 2010:13-244).

1.6.3 Values and diaconal services

Scarce research has been performed shedding light on the two constructs constituting the core elements of the topic of my master thesis: diaconal health services and values. And the authors that I have found belong to Diakonhjemmet UC. For example, Askeland emphasized the values in practice in the management of one diaconal hospital based in Oslo: Diakonhjemmet hospital (2011:169). And currently, another research on the same framework but rather oriented to value-based leadership is also under way within diaconal hospital Lovisenberg in Oslo (Espedal 2015). If there is an obvious limitations and scarcity over the existing researches for developed countries like Norway, how about the poor and developing countries which are the real ground target of diakonia. This fact further confirms the essence of conducting this research in Madagascar classified among the poor countries in the world with low human development index─at 155th on Human Development Ranking (UNDP 2014).

However, in order to understand the 'ins and outs' of the theme, some of unpublished articles or reports produced by Salfa and professionals at MLC with a number of relevant literatures not only on the specific issues of the professional and diaconal services but rather general on values have been consulted as supplementary. Let us mention just some of them, firstly the only one article tackling methodically, beside its main purpose─ how values and behaviour may be approached and researched in professional practice─the issue of hidden values: "Values in Professional Practice: Towards a Critical Reflective Methodology" (Aadland 2010). After that, the book written by the same author, which contains an added explanation of those hidden values, caught my attention too: Ethical Reflexion in The Helping Professions (Aadland and Matulayova 2011). And the last one is the recent welcomed book for academicians, Christian professionals… entitled: "Diakonia as Christian Social Practice: An introduction" (Dietrich et al 2014) where the most university professors and researchers at Diakonhjemmet University College such as Nordstokke, Stifoss-Hanssen, Haugen… highlight in a very scientific way the dimension in and around the science of diakonia and the importance of the values within the diakonia study (namely PhD research) among

professional diaconal workers or institutions and their (the values) asset-based approaches in general.

1.7 Understanding of concepts

1.7.1 The term “values”

The word value─basically: a Middle English term: from Latin *valere*, then the feminine past participle of old French word *valoir* equivalent to 'be worth' (Oxford dictionary)─integrates our daily conversation either at home or in the workplace or everywhere. On one hand, in my personal view, values are communally considered as a sort of official power given by authorities to something (a certificate has a value if signed by the Mayor for example) or someone (missionary, representative…). In other hand, through a more scholastic manner, the scholar Banks defines values as a general ethical principles that explain the way how look like firstly the professionals’ treatment towards customers and then the quality─bad or good─of their actions. These are: *principles of autonomy, non-maleficence, justice, beneficence, respect for and promotion of individuals’ rights to make choices and to self-determination, equality, promotion of well-being…* (Banks 2004:79-80). Furthermore, the concept values is pointed "as a major component of organizational culture and are often described as principles responsible for the successful management of a number of companies" (Meglino 1998:351). In this respect, theorists label it *professional values*. Given to Haugen, values may have two varieties either “values that influence the working of the organization and the actual conduct of its employees” or an ‘expressed values’ (cited by Dietrich et al 2014:125). Eventually, in a very simplistic style, Ravlin defines it ”as desirable behaviour” (cited by Meglino 1998:351). In sum, values are usually a good thing─with the exception of certain values violating law (Corey 2011:76).Therefore everyone has to maintain, protect, communicate and promote them─ Jekins states that among ordinary beings who/which value themselves “humans only recognize and respect this self-valuing” (2008:43). Even The Bible authenticates this values’ goodness. One has already known that Jesus’ followers deserve many good things such as grace, blessing, eternal life… but also values according to the Apostle Peter: “the value is for you who have faith” (1 Peter 2:7).

Additionally, based on Pattison et al’s findings values essentially accomplish certain functions called *value-talk*: first, *values legitimize action and organizational arrangements*,

second, *values help coordinate action*, third, *values can be used to discipline*, fourth, *values justify change* first then *resistance to change* and fifth *values help create and consolidate identity* (Pattison et al 2010:13-14). As a result, the professional's values might affect and influence his or her work and his or her client.

And the last but not least, leading information that needs to be introduced here is the categorization of values evoked by Aadland: According to his analysis, values are expressed within language through the use of verbs such as 'want', 'prefer', 'hate' and 'despise' (Aadland 2010). As values are mainly expressions of ideals, preferences of worth and intentionality─extracted from previous actions through processes of interpretive sensemaking─they shape the directions of daily action of an actor whether he or she is in society or at workplace. Then values could be, firstly personal or social or professional. Afterwards, the context profiles them, then one may have economic, ecological, political… and moral values. And given to the results of research values applying *value hierarchy* or reflective sensemaking process, Aadland has explored the two big groups of values: the open values and the hidden ones (Aadland and Matulayova 2011). We will come back to a further explanation on that in the theory chapter and discussion chapter when examining values encountered at my research site.

1.7.2 The concept diaconal institution

Diakonal institution is simply an Institution or organization or agency performing *diakonia* which is a "caring ministry of the Church […] Gospel in action" (Dietrich 2014:4). Such Christian institution which is basically led by local congregation and usually founded by biblical inspiration called *mythos.* For instance Diakonhjemmet Hospital in Oslo is inspired by the history of Good Samaritain (Leis-Peters cited by Bäckström 2011:138). Such institution is supposed to meet the four (4) qualities developed Kramer in his theory: *the vanguard* or pioneer function, the *improver* functions, the *regular provider* and the *value guardian* (Dietrich et al 2014:157).

Furthermore, a diaconal organization is all the time aware to be mindful of its values. As mentioned earlier they (the values) are expressed and should be functional according to the circumstances experienced by the professionals and the whole institution vis-à-vis their clients. All its activities with its tangible and intangible assets must contribute as much as

possible to a holistic care. The overall aim is to treat all clients as a human being created in likeness of God with taking into consideration their physical, psychological, physiological, social and spiritual dimensions. This human dignity is so important because it is ”an incomparable and inalienable dignity” (Bäckström 2011:111).

1.8 Structures and organizations of the thesis

The first chapter of this paper starts with a general introduction of the scope of the research. Then consecutively; background information and motivation for the thesis, goal of the research, relevance of the problematic, research question and hypothesis, limitation of proposed research, brief review on existing research, understanding of concepts, and the structures and organization of the thesis.

The chapter 2 provides the contextual information in regard with Madagascar, Mahajanga the research site, Salfa’s history and the Malagasy health system.

The chapter 3 deals with methodology: here one addresses some basic questions: why have I preferred qualitative method? Where the research area and what is are the reasons of its choice? When did the fieldwork take place? Who are my informants and interviewees? How did I carry out the interviews? How many obstacles and challenges have I met? Are validity and reliability respected?

The chapter 4 gives an outline of the my theoretical framework that I will use to interpret data: the Rational Choice theory, the IRHAP (International Religious Health Assets Programme) theory and Aadaland’s concept about values.

The Chapter 5 presents all my findings: the data that has been responded in advance the research question.

The chapter 6 is the analysis and critical discussion of data.

The chapter 7 consists of the final resume of my master thesis.

It is essential to notice also that each chapter has a succinct introduction and is ending by short conclusion.

1.9 Chapter conclusion

The understanding of people's reason motivating their strong preference for Lutheran diakonal hospital in Mahajanga is the central target of this study. Many informations in front, in and behind this situation are needed before going through the body of the investigation. So let us have a look at its context.

CHAPTER TWO: CONTEXT

2.0 Introduction

In this section I examine the context at national, regional and local levels. This will help the investigator in interpreting and discussing the data of the study later in chapter six. Thus this chapter is organized under the following headings; an overview of Madagascar, Lutheran Church and health department, local context of the Lutheran Hospital in Majunga and the usual summary chapter.

2.1 An overview of Madagascar

2.1.1 Geographical context of Madagascar

Madagascar is a tropical Island of multiple singularities. This world's fourth largest island, called also the red island because of the red laterite within its soil, holds almost the double of Norway's superficies (not including the marine area) with 592 029 square kilometres in the Ocean Indian. About 400 km─the Mozambique Channel─separate this country from African continent in which it takes part.

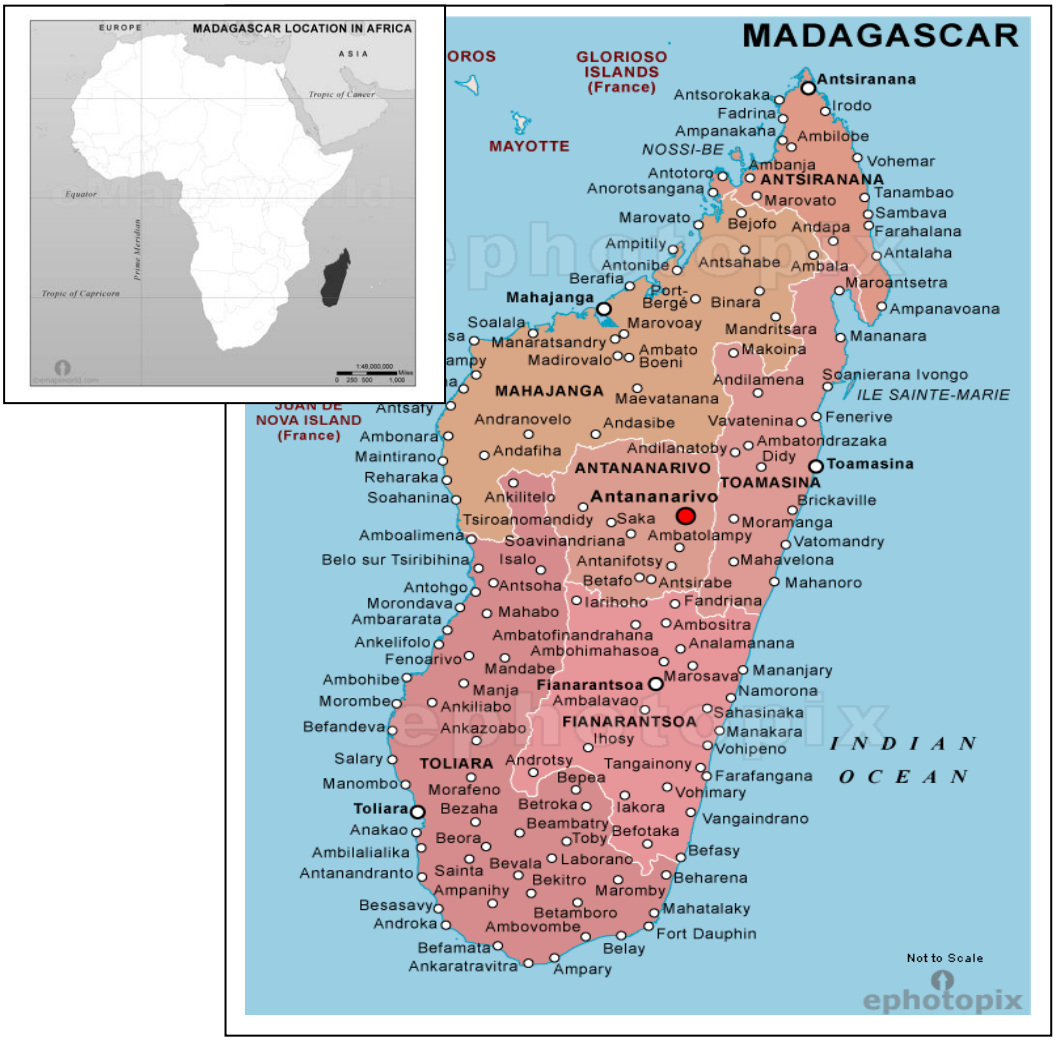

Figure 3: Geographical location of Madagascar (source: http://www.ephotopix.com/)

The biogeographic isolation of Madagascar, the variety of its relief and climate favoured the special biodiversity of malagasy flora and fauna. They are particularly characterized by a high rate endemism that means unique in the world. In addition of the primary forest, there is a range of landscapes of enormous diversity. Besides sandy beaches, aquatic jungle the northwest coast is in many cases protected by a singular coral reef called “tsingy”. The east coast is a string of cliffs crowned by giant trees and 'Ravinala' or the traveller’s tree. Farther south, the scenery gives the thorny bush, semi-desert terrain and savannah with sometimes walkways baobab trees. Inside, the land bares gradually; in the

north, fertile basins and in the centre some plateaus, rice field and predominantly chain of the mountains.

A Norwegian researcher states that Madagascar is a 'paradise of ecologies' (Dahl 1999:2). Because in addition to what is mentioned above, this land is “full of marvels” (Oberlé cited by Dahl 1999:2). For example this nation is the unique place in the world where one can find in primitive forest the free lemurs (most of their species exist only there)─small primates have evolved separately from African monkeys.

However, this natural richness is, generally threatened by political problems worsened by poverty and more specifically destroyed by deforestation led by businessmen loggers, miners of gold and precious stones and the development of the traditional agriculture based on slash and burn.

Madagascar owns an international valuable patrimony that Malagasy people must protect.

2.1.3 Malagasy social context

The red Island hosts a mosaic of 23,812,681 Malagasy people[3] from migration. Those inhabitants still cultivate the customs of their ancestors. They can be seen as the product of mixing between the first occupants Austronesian (Vazimba…) and those who came later (Hova neo-Austronesian from Indonesia, Arabs, Africans ...), who emigrated to the island to build a 18 ethnic groups whose traditions fascinate anthropologists (Dahl 1999:2). Here are some proofs confirming that the Malagasy cultural background has cultural traits upon culture of Austronesians, Pacific Islands, Indonesia, Borneo via New Zealand and the Philippines: ancient agriculture (the rice cultivation, sugar cane…), music (instruments such as the flute or valiha in Malagasy…), dance, traditional architecture for house, iron extraction and so on (Dahl 1999:2-3). Besides the 18 ethnic groups, some communities from a recent immigration are considered; these include: the Indo-Pakistani community ("Karana") owners of private commercial companies and jewellers, Comorians living mainly in the North and Nord-

[3] Central Intelligence Agency (CIA): https://www.cia.gov/library/publications/the-world-factbook/geos/ma.html (date of visit 07/03/2016).

western part of the country (Majunga and Diégo) and the Chinese community for wholesalers & retailers and food.

Despite the diversity of the population that is at the origin of different dialects throughout the island, and according to the new Constitution (2010) the Malagasy language is the national language of Madagascar, and French is the second official language. Linguistically, the Malagasy belongs to the Maritime Southern Austronesian family (Dahl 1999:2). In 1835, the publication of the Malagasy Bible had improved the model of a written language of Malagasy Latin alphabet[4].

Eventually, if the Malagasy society includes mostly the "merina"; the majority of Austronesian ethnic group, in the centre, the coast parts are a little bit cosmopolite. Also it is essential to discern that in the far northwest, in Majunga, a cosmopolitan region, specially displays its Muslim influence and the North keeps track of the last outpost of French colonization.

2.1.4 Political context

The Malagasy socio-political structure generally inherits secular system subsequent to the colonization epoch. This period led by France (1895-1960) ended the monarchy regime. And in 1960, like with other African colonized countries, the declaration of independence was 'artificial'. Because some colonisers still impose indirectly their system. As result since the first Malagasy Republic till now, many political crises plunge number people into poorer situation. The recent one took place on 2009 and lasted five years. We are now at the 4th Republic which is 'République multipartite' French designing a semi-presidential regime where the head of state is an elected president and the chief of Government is a designed Prime Minister. Executive power is handled by the Government team while legislative power is shared between the Government and both the National Assembly and the Senate. And theoretically the high judiciary does not dependent to the first two (Malagasy Costitution). The main goal of the constitutional change aims to improve the value laden practice, the economy and all other resources, however the current official President of Madagascar

[4] Archive MLC.

(elected in 2013) and his team are still very far from the effective problem solving process of poverty. The obvious change concerns the political position, the Constitution and law, the territorial delimitation (the former 6 provinces has changed into 22 regions)…but not the Malagasy wealth.

2.1.5 Economic context

The Malagasy economy depends essentially upon the external funds. In other words, if the international community endorses the political leaders in some way forced to accept structural adjustment policies such as liberalization of the economy, the economic downturns are enhanced. According to US Department of State, the only patent economic growth for Madagascar was known in 2005 when the effort of the President at that time Ravalomanana met the criteria requested for benefiting the Millennium Challenge Account[5].

In regards to the actual trends in Malagasy Human Development Index between 2009 and 2014, UNDP gives minus 4. This depicts clearly that at least the population of Madagascar is fourfold impoverished[6]. The reality of this national poverty goes contrary to the certainty of the values of Madagascar's sources of growth such as on international trade we have export revenue from textiles industry, cacao, vanilla, cloves, ..., in national income, the tourism linked to the rich biodiversity of the land, agriculture, onshore heavy oil and the extractive industries. Before such unfair situation─After the crisis in 2009, 69 % of the Malagasy people receives less than the line threshold 1 dollar per day (World Bank 2009), one has been wondering for long time, is the Malagasy economic healthiness really beyond the reach of our political leaders.

2.1.6 Health situation

Similarly to other developing countries, the health system in Madagascar espouses WHO's Constitution. One of its basic principles states: "The achievement of any State in the

[5] U.S. Department of State: http://www.state.gov/r/pa/ei/bgn/5460.htm (visited on 07/03/2016)

[6] UNDP: http://hdr.undp.org/en/composite/trends (visited on 07/03/2016)

promotion and protection of health is of value to all"[7]. In a quick interpretation, a health services run with good quality only provide a valuable treatmnent for all.

According to WHO again, many dimensions are involved in terms of quality within healthcare:

> these dimensions require that health care be: effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need; efficient, delivering health care in a manner which maximizes resource use and avoids waste; accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need; acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities; equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status; safe, delivering health care which minimizes risks and harm to service users. (WHO 2006:9-10)

Thus the different successive Malagasy Governments focus their effort on implementing an health policy encompassing the basis of the pyramid territorial administration (see below) up to the top which is the Ministry of health.

[7] WHO Constitution: http://www.who.int/governance/eb/who_constitution_en.pdf (visited on 07/03/2016)

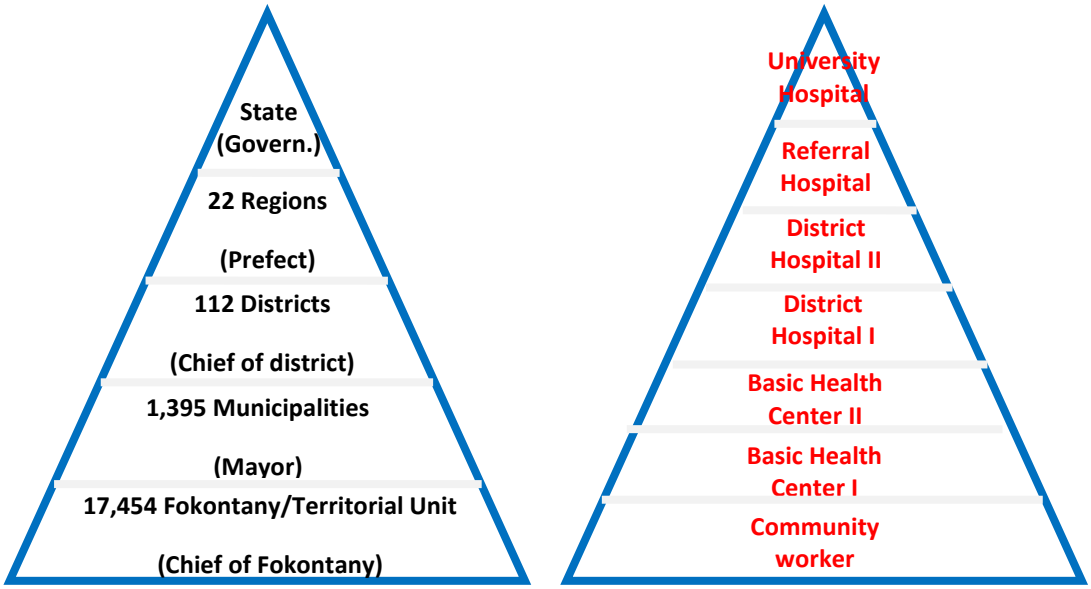

Figure 4: Comparison of the pyramid of territorial administration with that of health facilities

As mentioned above the state wanted to establish a closer health system to all people. On account of this, to all administrative levels are given well-defined health facilities. At the pyramid basis, the community workers trained in community approach, sensitize and guide patients to appropriate facilities. They are well known in the projects against malaria and HIV/AIDS. Thereafter, the basic health centre I (CSB I in French) led by a certified nurse. He or she can give consultation and treatment following the eight recommendations from WHO regarding the primary healthcare. The most populated municipalities have CSB II (basic health center II) where a medical doctor is responsible. In the capitals town sparsely populated, one has district hospitals I (CHD I), led by chief medical (there are more medical doctor). In addition of capacity of hospitalization, there are maternity and laboratory.

Moreover, CHD II or district hospitals II are located in the capitals of great importance characterized by the presence of an operating theatre, held by one or more surgeons. One can also meet some specialists such as ophthalmologist or radiologists with ultrasound equipment. In the main town of the region, one finds CHR, referral hospitals. These facilities have many beds and many specialists. And in larger cities, university hospitals (CHU) that are more developed than the CHR, participate in the training of medical students. The Minister of the

health is represented by Regional director for the Region and Inspector Medical Doctor for the district.

Theoretically, this organizational structure reinforced by the facilities belonged to private health sector seems competent. However, the reality displays the inverse, for Unicef recently reports that Madagascar's health system is poor, especially after the long political crisis following the coup d'Etat in 2009. Rural remote areas face a major problem of access to health centre, many people are living without basic social services. In 2012 alone, more than 200 basic health centres have closed due to lack of medical staff. Every year, 3,000 Malagasy women die, or 8 each day die from causes related to pregnancy and about 44,000 children, or 120 a day, die before reaching their fifth birthday. Unfortunately, those kids die of preventable causes: pneumonia (21 %), malaria (20%) and diarrhea (17 %) (Unicef 2014). And because of poverty exacerbated by inflation and increasing insecurity, there are also those who die by self-medication or having had recourse to charlatans. Adequate medical practices are as important as the health educations which also play a major role in health for all in Madagascar. National and international NGOs have already been contributing on that purpose with other potential members of Civil Society namely churches but health statistics are still alarming.

2.2 Lutheran Church and health department

The Malagasy Lutheran Church contributes sincerely to the healthcare system in Madagascar through Salfa group. I must introduce here "group" to Salfa appellation because the Lutheran health department coordinates besides the health centres many projects involving to the health such as: Eye program, Mahefa project (community-based approach of health), clinical audio project, project against malaria and so on. Most of those activities are diaconal and done on behalf of the Malagasy Lutheran Church the third biggest Church in Madagascar after the Roman Catholic and Presbyterian Church. Those three Churches with the Anglican form the Malagasy Council of Christian Churches which is an organizational umbrella playing a pivotal leadership role in different socio-political issues for the country. Hence, health activities performed on Church's sake are always valuable both for the state and the inhabitants who are mainly Christians─if one refers of people baptized, the following

figure 74.5% of Malagasy Christians, given by Pew Research Center (2014) from US is quite obvious.

Furthermore, the history of MLC and the beginning of Salfa's activities are intertwined. The history of the SALFA can be divided into three main periods according to the summaries that I took from the archive[8] written by two of leading staff at this department: Mr. Andreas Richard (Advisor at SALFA Headoffice) and Mr. Lanto Rabenasolo (Director of operations). For each period one will mention dates, milestones and the development of Salfa thanks to the beneficial intervention of the Lord Jesus leading our slogan: "We treat, Jesus heals".

Firstly, late nineteenth century to the independence year 1960: Around the period from 1850 to the beginning of colonization, Norwegian missionaries sent by the NMS (Norwegian Mission Society) settled in the current Vakinankaratra region, specifically Betafo. Later, they moved to Antsirabe town with one main objective: to evangelize the Malagasy folks. Evangelization was held in parallel with social, charitable and health activities, in other words the 'Gospel in action' or *diakonia*. Consequently, there was an opening for Leprosy at Mangarano. Norwegian missionaries, who brought the Gospel in Madagascar, were therefore the pioneer of Malagasy Lutheran healthcare. Thus, the writer thinks that the translation in Norwegian of Malagasy Lutheran Church is kept on its all official letterhead as a reminder of a great job of them (see an example on the geographical representation of Lutheran health centres below).

Due to not having an approved diploma by the French colonizers, those missionaries were not allowed to develop the health training and activities. The doctors had to go back to the Faculty of medicine in France. And after graduation from French government, they returned to open the Andranomadio hospital (CHR level) in 1901, the one of today's famous Lutheran Hospital.

During the same period, the American missionaries settled in the South of Madagascar, Fort Dauphin Bezaha on the banks of river Onilahy. In 1940 Dr. John Dyrnes

[8] Salfa Archive.

and his wife both preached the Gospel and provided medical service. Another Lutheran hospital was then opened in Manambaro by Americans in 1950. This included the first center for nurses training (the precursor of the SEFAM: Sekoly Fanomanana Mpitsabo mpanampy or Lutheran Paramedical Institute currently based in Antsirabe).

Secondly, from 1960 to 2000: After the Independence of Madagascar, while the diaconal services led by Norway were expanding to the Southeast Vangaindrano, and South west Bekoaka Morondava the Americans missionaries went to the South part of the Island. The settlement of Lutheran missionaries─ALC (American Lutheran Church) for the US, the NMS (Norwegian Mission Society) for the Norwegians and DMS (Danish Mission Society) for the Danish─were based on three key points: local requirements, general agreement between Lutheran Church (should evangelize the southern part of the country) and Presbyterian Church (in charge of northern part) and the authorization from state.

In 1963, another Lutheran hospital was opened by Dr. Stanley Quanbeck (son and grand-son of American missionaries) in rural village called Ejeda. In the beginning the plan was to build a hospital in the main town of South which is Toliary but the Ministry of health willing a good health for all sent them to this remote areas. The Lutheran heal organization has fulfilled here the *Improver function* of diakonia for this hospital has improved the local healthcare by creation of surgery, X-ray… services met at public hospital CHD II level.

The colonizers, followed later by the Malagasy themselves centralized the administration and decisions in centre, precisely in Antananarivo the capital town of Madagascar. Thus, in 1979 that the National Preparatory Committee of MLC Grand Synod (KMSL Komity Mpanomana ny Synode Lehibe) met in Fianarantsoa decided to create a real health department for health: SALFA. The aim of its tasks are firstly to coordinate the general administration of all Lutherans health centers, to ensure drug supply system, to administer the containers of the medical stuffs and equipment sent by overseas partners and to study feasibility of new health activities in different areas, even abroad. Via South South Program within MLC, Salfa has sent Malagasy physician, Dentist to the southern part of the planet, such as Cameroon, Tanzania, Bangladesh… Dr. Quanbeck was elected to be the first Managing Director of Salfa. During his period 1979 to 2000, many ‘collaborations-bridge’ were established with individuals or organizations both local and foreign. Thanks to him

many students in Malagasy medicine recruited by SALFA have benefited training abroad (Africa, Europe and even in the USA). From 11 in 1979, the number of health SALFA centres increased to 30. Moreover, He took into consideration the importance of the integration of the health Community in Salfa action. Therefore, during his presidency, many community activities have emerged by: the fight against tuberculosis mostly funded by NMS in close cooperation with Raoul Follereau Foundation, the implementation of psycho-social support for the people suffering from mental diseases treated in special place created by MLC: Tobim-pifohazana (the holistic approach of diakonia is highlighted here because both medical and spiritual treatment are provided for free), the family planning with the United Nations system and the pre-impregnated mosquito net program with WHO in which Salfa was the initiator to Madagascar (pioneer function in diakonia)...

Thirdly, from 2000 to present: During this period, the SALFA has faced two major challenges: to support financially its organization and to cope with globalization which is required so much. Three Malagasy leaders have succeeded Dr. Quanbeck—He had definitely left Madagascar after a busy career and a successful mission in 2003. Akin to with any 'business', the SALFA Group has had its ups and downs status. The organization repeatedly had to adapt before becoming over time a multinational group—currently with more than fifty functional health facilities throughout Madagascar (look at figure 2). It also passed through various stages, including a financial and managerial crisis of 2008 in 2010 that I have already mentioned. It is very logic that the direction of a given Malagasy organization led by foreign missionaries is relayed to the local leaders. But in management and cooperation, donors' recommendations must be respected. The non respect of them were penalized by withholding of all ordinary supports (funds, containers...) which had reached a real crisis point for the whole group. And we know once the vital activity closes down debts are increasing... However the second Malagasy elected Director in 2010 did not want to blame anyone for this crisis which seemed to be enveloping the whole group (especially the Lutheran health facilities in rural areas were suffering and some were closed). Because first, of the respect of Christian values and second as a Group, and secondly there are many involved factors in this last failure. Until he passed away, he gave his best to rectify the situation by a participative leadership supported by a new strategic plan ensuring the maintaining of SALFA's role as a contributor to the promotion of health and complete well-being of the Malagasy.

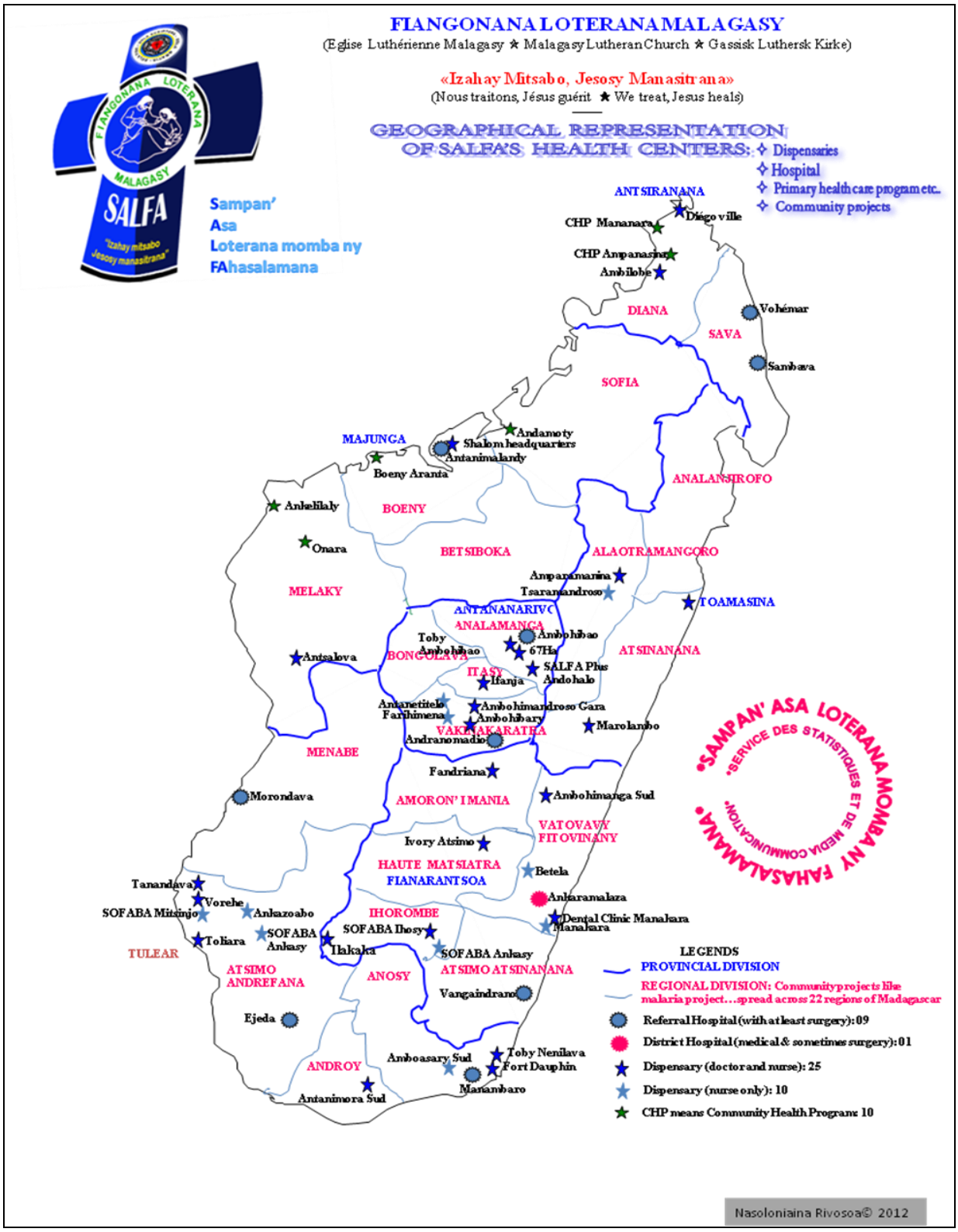

Figure 5: The 55 health centres within Salfa

Fortunately, this second Malagasy Director of Salfa group with his team was capable to regain the confidence of all former donors. Yet, the new grant must be not used to pay the debts, and then the reform has been working slowly but surely. The new opportunities of support have allowed Salfa to strengthen or to restart the rural clinic, to run new community-based project… Finally, in the end of 2014 all debts were paid off. Since then the members of Salfa group, the partners and the whole church have been waiting for positive results at central, and regional levels. But new challenges have been arisen and made complicated the redressing of the health department, one of them the sudden departure of this Director. Now Salfa is still in transition period till the upcoming election organized by the National Committee of MLC this year. As result only the projects receiving continual funds such as, Mahefa project, project fighting against HIV/AIDS, "prison ministry"… and the big hospital like Mahajanga hospital can continue to improve the quality and quantity of health services provided for their beneficiaries or clients.

2.3 Local context of the Lutheran Hospital in Majunga

The Lutheran hospital in Majunga, one of the reputed private health center in Madagascar, serves not only people from its region, called Boeny region but those from surrounding regions (Regions Melaky, Betsiboka…). The health services there started in 1988[9] with a basic dispensary type II and become a Referral Hospital after three years later. It has services of surgery, X-ray, ultrasound, laboratory, internal medicine, maternity… and two operating theatres. Now, a hundred personals led by chief surgeon ensure the running of the centre. In addition, three annex clinics join to this facility.

An apparent advantage of this hospital is its location on a spacious, quiet and fenced place on 8km from the main town of the municipality of Majunga. The name of its precised locality is Antanimalandy.

Regarding the contextual information about the region where this hospital is esthablished, two points merit clarification for they are more or less related to the participants of the research: the inhabitant and the economy. As we already know, some people use the

[9] Archive of the Lutheran hospital Antanimalandy Majunga

French name Majunga, other prefer the Malagasy term: Mahajanga meaning literally "*helping to recover from sickness*". One categorizes this municipality as a cosmopolitan town, for the populations come from diverse origins but cohabit in harmony. Besides, the few Sakalava (the original inhabitants of Mahajanga) and the other 17 Malagasy ethnic groups, there are "Karana" or a Malagasy appellation of India-Pakistan people who hold an economic role quite important, Comorian and some families of Franco-Malagasy origin. The number of mosque in this city confirms the predominance of Islam there.

Economically, Mahajanga is the second biggest seaport in Madagascar. And it is the first attractive place to be for most Malagasy and foreigners too during Holydays because of its touristic potential principally constituted by sandy beaches, natural park with unique white lemurs and its tropical heat more or less invariable throughout the year. Even so, the higher unemployment rate given by National Institute (INSTAT 2012), the direct observation of what really happens at daily life of people, the increasing insecurity since 2009, the monopolization of fructifying micro and macro business by foreigners… illustrate the causes of poverty over there. For instance, seafood is available in this northwest coast of Madagascar, but the fierce competition among big companies having sophisticated boat let a very little chance of success for the fishermen using pirogue and traditional fishing. The population turns around the vicious circle of poverty. And the jeopardy comes when one or more of their family members get sick.

2.4 Summary chapter

This chapter has revealed that the general and local circumstances within and around the setting of my topic: health and diakonia in Majunga can be fully understood and assessed now. Then let us move on the system of methods used for this particular research.

CHAPTER THREE: Methodology

3.0 Introduction

The chapter examines different major steps in regard to the method applied in gathering information for this research study. I shall bring out coherent answers of significant questions under different headings met in social research methods. Most of them are worthy of attention such as the subjects of research site, research design, fieldwork, target population, research implementation and its data, ethical considerations, challenges encountered and the issues of validity and reliability. After the descriptive explanation, the chapter shuts down with a short conclusion.

3.1 Where the research area is

My background as a medical doctor working on behalf of MLC led me to carry out my research at Lutheran health department. And Majunga, is selected by the fact that I had lived over there for five years up to 2011 (working as National coordinator of primary health program at Shalom Project), which means during and just after the period of financial crisis of Salfa Group (described earlier). Thus I am having more general knowledge about the impact of that trouble on the management, the eventual institutional values, and major issues in this chosen hospital. In this Muslim town, the Lutheran diaconal hospital is not solitary besides the government health centres for people there have a broad range of choice in terms of seeking health: Many “médecins libres” (private medical consulting place run by a Medical Doctor), Private lucrative clinics, other faith-based clinics from different church denominations and traditional healers. Such actuality makes interesting the implementation of my research there, in which illogicality (research problem on heading 1.3.1) of customers’ choice can be studied. Additionally, my selection was also confirmed by the absence of powerful history (no reputation or infrastructures or supports from former missionaries like the others Lutheran hospital because it was created by Malagasy Medical Doctor’s initiative) for this Lutheran Hospital. One can therefore deeply scrutinize with more obviousness the research question dealing with client’s attractiveness, through an appropriate outline of investigation design.

3.2 Why I have chosen the following research design

Generally, the social research comes down in the first step to a choice among the following three methods: *qualitative method,* a method based on the assessment without systematic concern of measure, is appropriate if one deals with non-manipulated data. But when desires to measure phenomenon is present in the research *quantitative method* is needed. And the third one called *mixed method*, which is more and more frequent, likely involves the use of both quantitative and qualitative approaches (Bryman 2012:35-38). According to my understanding improved by the knowledge acquired from my study on science of diakonia and Christian social practice, the choice of methodology depends on the nature of the research problem described above (Rubric 1.3) and the guidelines from the research question taking into consideration the context and not the inverse. As one has seen on rubric 1.4, my choice was the qualitative method because I wanted to identify no statistical or no numeral answers but the perceptions verbally expressed by customer having consulted in the Lutheran Hospital in Majunga. Creswell corroborates such fact, by stating that the qualitative research looks forward to "exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (2014:4). Moreover, qualitative methods are mostly characterized by inductive tendency seeking to seize one individualized phenomena, with the intention to formulate models for many (Ritzer and Ryan 2011:481). Regarding the application of this theory, we see in my case that the interpretations of the customers' perspectives after their experienced passage in that one Lutheran hospital (one phenomena) could possibly provide from new data (my findings), better future measures and strategies for the continuous success within the hospital in question and for all members of Salfa (models for many), even for those outside its own group.

In other words, my research work (hidden core values in diaconal hospital) which is quite new in developing country starts with analysis from one situation to gradually formalize and progress the data obtained to new useful theory or outcome (opened values) for all Malagasy Lutheran hospital. My research therefore seeks to build academic knowledge from the reality faced upon health diaconal services. Accordingly I have to transform the subjective perceptions and observations offered by the clients to an objective understanding.

Furthermore, among the five kinds of research designs cited by Bryman (2011:66): *Experimental design*: involving very often laboratory experiment, *survey design*: focussing on structured observation of one or more cases, *longitudinal design*: an iterative study on phenomena during a given period of people's course of life), *comparative design*: examining contrasting cases with more or less identical methods and the *case study design*: defined as a study on a detailed and intensive analysis of a single case, I chose the last one. The main rationales behind this choice were at least threefold. Firstly, the previous explanation about why qualitative research fits my research portrays more or less a concordance of the definition of case study, for it was a wish on *detailed analysis* on the clients' views about the healthcare offered by one of ten Malagasy Lutheran hospitals─a *single case*. Also, the constraint of time and resources on master thesis don't allow researcher to work on many complex cases. In addition, in my objective study I have already announced that this study is a precursor of a further research. Such fact supports Webster's commonsensical concept of case study quoting that this "detailed examination of a single example of a class of a phenomena […] may be useful in the preliminary stages of an investigation (cited by Flyvbjerg 2011:301). Secondly, the résumé of the discussions developed by Yin (1984) Eisenhardt (1989:532-550) and Smeltzer & Zener (1992:446-472) in regard with the advantages of qualitative case study was one of the influencing factors too. They agree if one uses this technique in a very methodical and rigorous way, it allows to approach both the fluidity and complexity of human, social and managerial situations with a credible findings. The case study is narrowly useful in situations where one wants to illuminate the 'why' (in this paper the research question starts with this, inquiring the cause of the clients' attraction) and 'how' of particular phenomena facing situations where researchers have little control over an interesting case (like the hidden core values here) in a given context of real life (Ibid). And thirdly, the results of case study can contribute to fulfil my final aim concerning the building of an inducting theory valuable for all Lutheran faith-based clinics in Madagascar (Eisenhardt 1989:532).

Basically, five types of case study are identified: The *critical case* (based on verification of the hypothesis of well-developed theory), the *extreme case* (such a clinical studies), *exemplifying case* (exploring conditions, key social process and links within a single case), *revelatory case* (opportunistic analysis of a case previously inaccessible to science) and *longitudinal case* (study of a case having two or more junctures and a longitudinal element that can be investigated over time) (Yin 2009 cited by Bryman 2011:70-1). It is obvious that,

when one looks at those brief definitions, exemplifying case study is very suitable to the present research. For I planned to grasp an in-depth concept of the further links between the patients' choice and diaconal services at hospital through the narrative of the history during their visit at the health centre. Consequently, the nature of my methodological approach for collecting data is partly a *historial-hermeneutic method* and mainly an *exemplifying qualitative case study*. Now the selection of research site needs to be highlighted.

3.3 When did the fieldwork take place

After more than one month of my application and report of my proposal research to NSD, I received an official feed-back and information giving me an authorization to do a research in accordance of Norwegian laws. My fieldwork was mostly conducted in Mahajanga town and in surrounding villages from 05th till 15th August 2015. I decided to do my fieldwork in the places mentioned above because in there people experiencing the issue under research could straightforwardly be located and provide pertinent information for the study (Bryman 2012). The most methodological tools used in this fieldwork have a qualitative grounding, for example interview, focus group, sampling method ... The following headings will consider every detail of that.

3.4 Who are the participants of the target group of this study

Two key informants; electrician and gardener of this Lutheran hospital─ who have been employed there since its opening and master very well the history of that Salfa hospital─helped me out to meet clients and translate some dialects during focus group. The process of getting appropriate participants espoused the "snowball way": it is a chain sampling and like in other sampling approaches in qualitative method, this technique is more flexible and less structured approach aiming at forming a group of participants from a key informant. My two key informants introduced me to my two patients of the hospital (one current and one former patient). Then after the meeting and interview done according to their schedule, they (the two first participants) gave me a name and address or phone number of my next participants and so on until I reached 25 participants. However, in order to avoid medical staff's influence that might lead to certain biases into the Customers' perceptions (for fear of them patients are tempted to give only positive viewpoint of the reality), very few in-patients during the fieldwork were interviewed, even if they were at this time experiencing the

phenomenon. Concerning the focus group, the caretakers accompanying patient and using the shared kitchen and dormitory for all of them were involved and gathered in the hospital chaplain. As result: Firstly, I have included: respondents who have experienced at least both Lutheran hospital and public hospital but decided to remain a regular customer to Salfa hospital. Secondly, I must have excluded: those who shared with me sensitive information. They were six (6) and three (3) of them knew who I am (a former Technical Director of Salfa). They were interviewed but their quotations are not presented among the findings. Also children under 14years old (not allowed according NSD) were not accepted. The investigator's target population therefore included nineteen (19) participants (see table 2).

Table 1: List of data collection methods and informants

Collecting data methods	Interviewees	Type of information	Total number of interviewees
Snowballing	Informants	Name, address and phone number of target people involved on non-probability sampling method	02
Individual interviewing narratives with Delphi method	Current patient (CP)	Perceptions	02
	Muslim people (MP)	idem	04
	Former Patient (FP)	idem	08
Focus group	Family Members (FM)	idem	05
Overall total			21

3.5 How I carried the research

3.5.1 Data collection instruments

The methodology as well as the data collection is closely interrelated to the research question. Here, as said before, the question expects to non-manipulable data such as perceptions expressed by words, narrated by customers having consulted in Lutheran diaconal Hospital in Majunga. Consequently, the clients included at the target population were asked to tell the story of their former and/or current consultation session there. For this purpose, an interview guide (Annex 1) was developed in order to discover eventual values **behind**, **in** and **in front of** their histories. I borrowed this insightful analysis from a hermeneutic approach (Bergant 1993:189). The values could be actual but not expressed and remain unknown *behind* the reality in the hospital. They might be experienced by the patients *in* the medical service offered for the sake of their health during their stay there. Yet, it is also possible that those values are well known and in connection to the environment of healthcare or more precisely *in front* of the current context of diaconal health services. The later analysis of collected data from my data collection instruments will tell more about this.

Before each session, self-presentation and explanation of the objectives, research question and the surrounding study were performed for all interviewees. A non-neutral and unclear terms engendering questions were removed (Creswell 2014:185-190).

The focus group which is an interactive session with five (5) family members of the patients supplemented the individual interviewing narratives. In one hand this small enough group gave to each of caretakers a chance to talk and in other hand it is large enough to them to give diversity of perceptions.

All conversations were done in Malagasy language. I used an audio recording to save them and preferred to not take notes except the initials of participants and dates, so that the respondents could continue to provide credible narratives with fluency. Also I emphasize that all interviews were done in respect of anonymity and ethics. I tried to put an academic rigor in collecting data because it is of central importance in research. However, despite my good will changes are possible due to unpredictable events during the research and each research step may be affected (Creswell 2014:186). Some challenges that I met during the field work will be reported later on.

3.5.2 Procedures of data compilation

Like in any study, nobody can predict if plans go forward or not in providing the data and expected results─'findings on unobtrusive values' but one tries to approach by the *natural setting* style" (Creswell 2014:185). Afterward, the researcher has six phases to follow:

First: Organizing and preparing raw data, second: Reading through all data, thirdly starting Tesch's Eight steps in coding process, fourth, using this coding to get an interrelation between themes and description, fifth, using narrative passage for themes/descriptions to covey findings and finally interpreting the meaning of themes/descriptions which constitute findings (Creswell 2014: 197-200).

For this step of compilation, once collected, data were carefully transcribed world by world (verbatim) and encoded : CP 1-2 for current patient, FP 1-8 for former patient, MP 1-4 people wearing like Muslim (they were former patient) and FM: 1-5 for Family members of the patients i.e. caretakers. Thereafter I translated the relevant transcripts and arranged them according to the 4 sub-questions of the research question. Before analyzing data, I transcribed world by world (verbatim) the sentences expressing key events linked to the perceived values (presented in the findings chapter) within participants' stories. I tried to reformulate key events within participants' stories in different contexts based on their different perceptions. The non-verbal expressions were not studied.

3.5.3 Process of data analysis

Concretely, the investigator tried to interpret by *sensemaking process* (Aadaland's concept in theory chapter) and by narrative analysis the feelings and action experienced by clients, by using theories and comparison to the academic definition and concepts of values found in the literature. For this intention, I employed the functionality of the software Microsoft Word (windows 8) "ctrl+F" to generate a word list comprising relevant word expressing *value* (reference to the rubric understanding of concept in the introduction chapter) and their location within the patients' quotations. By coding, I marked labels (textual and numeral codes) to sentences in the text containing a substantive words expressing *value*. For example HP1 for the first verb "to hope".

Concerning the narratives analysis, I applied the simple approach of Brinkmann and Kvale (2009:223): summarizing the narrative, orienting the listener to different focus point of

the narrative (when, where, who…), complicating action by identifying the central details of the narrative, evaluation of those details and the 'coda'. In addition I looked for patterns and explanations in the data which I grouped and organized according to a given thematic framework refuted or proved by the concepts elaborated by the theorists and literature. The theme like "The spiritual issue reflecting the Christian values" illustrates this fact. Subsequently related themes were identified and recurrent themes were mapped out into group (the chapter analysis will present all themes) aiming to develop and test my hypothesis emphasizing the evidence based of the values in the services offered by this diaconal hospital. This analysis through the process of interpretive sensemaking with narrative analysis, coding, indexing and categorizing the meanings within transcripts, actually helped me to grasp participants' idea that include direct and indirect answer to the research question. However to be honest, contextual and linguistic challenges may be source of error that I could not exclude (Brinkmann and Kvale 2015:64). Definitely, critical thinking had been needed during the data analysis.

After considering those points with respect of the pathway defined by the four sub-questions, I shall present:

a) The hidden core values within the diaconal service
b) The interesting values behind the phenomenon
c) The core values not confirmed by the clients but in front of the current reality

Eventually, I will exemplify the findings of my qualitative case study in this hospital as central scientific development worthy for generalization to all diaconal clinic in the Group Salfa as well as for other interested private hospitals in the developing countries.

3.6 How about research ethics

This section needs to attract researcher's attention, for the issue of ethics is threefold involved. First, the ethical consideration is an usual practice associated with all researches. Secondly, even though this study is a pure social research on science of diakonia, medical research ethics were considered, because of the implication of some health factors in the study. Thirdly the protection of Muslim and Christian interviewees throughout the research. A female Muslim should not be examined by male Doctor—Muslim culture does not allow

them [...]. In this hospital, however, they come to consult with the permission of their husbands. The staff in the hospital should not make public such particularity. For example, it is decidedly possible that during my focus group both Muslims (wearing normal clothes) and Christians attended. Then it is not appropriate talking about this in focus group.

In addition, due to the requirement for student in Norway, I first lined up to NSD guidelines, then to the Malagasy Authorities and to medical ethics committees in Madagascar. Creswell predicts that ethical concerns can occur firstly, in the beginning of the study, and the issue of religious difference might catch the researcher's attention too. One needs a mutual respect of the existing differences, claimed Creswell. Secondly, during collection data, once again, I was constantly aware on the risk of having problems when a Muslim woman is questioned about their examination by Christian man doctor or nurse (question 6 in the interview guide). Then, I followed the Creswell's advices, aiming to avoid collecting very sensitive information. Regarding the reporting, storing and sharing data, the observance of honesty was taken into my consideration. Also, I really consider Lissi Rasmussen's recommendations on publishable information linked to Christian-Muslim relation issue (Creswell 2014:92-101).

3.7 How many obstacles and challenges did I meet

A part from high rate of insecurity and weather (strong wind) preventing me to go to visit the annex of the hospital based in a area called Boeny Aranta that is 90% Muslim. Some of my participants reside there. The snow ball chain somehow forced me to meet the participants in this village. This could not possible because it is very risky to go there by pirogue. Then changes predicted by Creswell (2014:186) occurred here, the last patient was asked to provide another name and address outside of Boeny Aranta.

Additionally I was experienced the prohibition on interviewing people in the beginning of my fieldwork. Because the campaign intended for the election of Mayor at that time had not started yet. In this case my conversation to the participants was suspicious for the authorities as doing propaganda for a given candidate before the legal period. This constituted a real obstacle for my research for if I came one month before this election, I must have waited one month.

3.8 What do I think about validity and reliability

The notion of validity and reliability proves and values the scientificness of a my research. Validity connotes: "determining whether the findings are accurate from the standpoint of researcher, the participants or the reader of an account" (Creswell 2014:201). In this research, my hypothesis and the findings are well related. I have been aware of this all the way through the implementing of different its steps.19 interviewees are enough in my opinion to guarantee the quantity of participants in qualitative study. And it was I who did the fieldwork with audio recording and not an intermediary then the quality required for internal validity was respected and precise. On the other hand, the external validity of this research looks at the degree of the accuracy with which it is possible to extend the new knowledge in the findings towards other hospital Salfa. I believe that this external validity also is accurate in my case.

Singh indicates that reliability is an "issue of consistency of measures, that is, the ability of measurement instrument to measure the same thing each time it is used" (Singh 2007:77). Thus for my research, the variations of circumstances that I encountered (temporality, some changes or external influences from third person) did not affect my independence on my interpretations of the data. Consequently if other researcher wants to verify this, I am quite sure that by using the same instruments of data collection and through with respect to the similar conditions, his or her findings would allow to certify the reliability of both my data this independence between the data and me (the researcher).

3.9 Chapter summary

This chapter highlighted how data were to be collected, what and how instruments were used and how about the intended ways for analyzing data collected. The next chapter is the theoretical framework, that represents another important component of data analysis.

4.0 Chapter introduction

A theory, understood as a testable and model-based ideas developed by scholars, remains one of the paramount tools used and chosen by researcher in accordance with the need of the analysis of his or her research (Ritzer and Ryan 201:646-8). As I have introduced, two basic themes will be under discussion later in my research; these are the patient's choice and the hidden core values in connection with diaconal healthcare. For this to happen, I shall use two main theories with one conceptual framework that globally address them (the themes studied): the Rational Choice Theories or RCT for the former and the International Religious Health Assets Program or IRHAP with Aadaland concept will be applied to identify the latter.

4.1 The theoretical framework for patient's choice: RCT

The advantages of RCT whose the pioneer was Georges Homans (1961 cited by Scott 1999:127) prevail over its limits in my construction of theoretical framework.

4.1.1 RCT and definitions

Some scientific definitions for the sake of RCT needing further explanation are developed by different theorists, however according to Maleseviæ its understanding "draws from the simple assumption that human beings are rational and self-interest motivated in their everyday actions" (2002:194). By all the odds, what happens in many areas of humankind's daily life is that individual acts rationally when he or she comes to making choices or decisions. And our life invariably based on the concept of choice influenced by our preferences. Depending upon situations, at some point, a decision must be made. We live all the time with an experience of a series of choices; simple, big, serious... Here are some concrete examples: concerning mundane activities; whether eating only vegetable (vegetarian) or meat. Concerning an investment, an investor has to make his or her choice, according to the utility that results and the benefit that can be obtained from the project. Concerning faith, people are free to become believer in Jesus Christ and inherit eternal life (Christian) or to remain unbeliever forever. And in our case, patient can seek health whether at public health

center or at private clinic such as a diaconal hospital. All we have and face in the past, now and in the future are mostly based on the notion of choice.

Then what does make a choice rational? The Scott's definition of RCT gives us a clear standpoint; he depicts that this theoretical framework is known as an "idea that all action─for instance choice or decision─is fundamentally 'rational' in character. People very often use their rational to calculate the likely costs and benefits of any action before deciding what to do" (in Browing et al 1999:126). That is to say that, one minimizes the disadvantage in order to maximize the benefits.

4.1.2 RCT and rationality

Through the rationality everyone evaluates the level of utility of the chosen activity. That might correspond to a level of benefit source of satisfaction, and which leads people to associate an acceptable level of risk. Because, obviously the available alternatives certainly encompass both costs and consequences─ and not only for better life but possibly for worse too. Therefore everybody's intelligence is naturally supposed to be able to master collecting, organizing and analysing some information about the alternatives actions and their environment in order to make a rational decision (Ritzer and Ryan 2011:494). The individual called also actor, needs a complete access to this analyzed information. It (information) always presents a set of values of a given act that motivates actor's choice after rational calculations aiming to maximize their desired ends (Ibid). As result RCT is a "means-end theories" (Ibid).

Besides, there is an original explanation of this rationality of RCT. This concept has been influenced by Weber's famous typology of action according to many researchers such as Norkus (2000:259-282). He has identified that people are acting rationally following four basic patterns: a human action such as choosing can be: traditional or affectual or instrumentally rational or, finally value rational (1978:24-25).

First, the *traditional action* corresponds to the types of actions, almost boosted by reflexes stimuli, by which actor's behaviour is the product of habit. Here the repetition seems covering the sense and the reasons of action. *Traditional action* is an action that individuals perform because the group (parents…) to which they belong have always run. In addition,

Weber portrays that for this traditional action the eternal yesterday is weighted. “We do without discussion because it has always been doing by many” (1978:25).

Second, the *'affectual'* is the pattern of action committed under the emotional influence. It is usually characterized by non-awareness and uncontrolled behaviour. The cause of this type of action, as its name suggests, relates to the existence of individual intrinsic affects and feelings. Consequently, affectual actor seeks immediately to satisfy his or her need for present enjoyment or tries to get rid of a current excitation (Ibid).

Third, *instrumentally rational* action that matches to the model of action for which the actor rationally scales both the means and goals of his chosen action. In this case individuals do not care about the moral consequences of their rational actions. The only thing that does matter is how effective and rationally determined are actions. Action is also rational, for the actor and the selected mean represent on one way or another the most efficient resources used to achieve the goals people have set up. These people have to make a rational choice between the conflicting and the alternative ends. And such rational assessment doesn’t take into consideration the external judgment from the observer. For Weber, this third type seems so understandable. Because, the recourse to rationality purpose will be characterized by a certain relative flexibility over the actor's choice of a given action. Through rational calculating vis-a-vis the evaluation of consequences of his or her act, he or she will be able to choose the most economical way but at the same time the most effective to accomplish his or her ends. It is this dimension of flexibility that distinguishes rationality purpose of rationality in value (Ibid).

Four, *rationality in value* which stimulates actors to attain a value by value-action. They act because of purely rational value with regardless of the foreseeable consequences of their actions (in contrary to what we have seen about instrumentally which assess the consequences). Actor’s service is controlled by the duty, dignity, religious guidance, piety... For example in the military and especially in religious call, the question of devotion remains the cause of concern. A careful and thoughtful pursuit of inflexible objective─wherefrom the action derived, is lifted up at the expense of individual interest. On the contrary to instrumentally rational, rationality in value refuses any flexibility and adaptability. In which case, the simple calculation of means and ends is not enough to define the goals that the actor

expects because the ends themselves are often chosen arbitrarily and previously by rationality in value, or extracted from the surrounding tradition. A woman, in pursuit of beauty (value), who doesn't care about how much does it cost, exemplifies this fact. In other words it is a fulfilment of unconditional demands. In many cases, the material interests, not the ideas, directly overlook the actions of humans. The specificity of this Weber's analysis depicts on one circle, that the purpose of such action (the value) is more arbitrary then irrational, and in other circles he explains that the means selected for this arbitrary aim are rational, so that why one calls it rationality in value. (Weber 1978:25-26).

4.1.3 RCT and its other properties

Generally within RCT one deals with the balance of the utility-optimizing between sellers and buyers, that takes aim to make money or profit. For this reason it has long been appeared as the predominant successful approach in economics. Moreover because of its explanatory and operational strength, RCT is used in a number of social science disciplines such as sociology, psychology, political science (Ritzer and Ryan 201:494).

Holton and Turner in their study about the tenets of Weber's thought on economy and society, corroborate the fact that RCT is applicable to explain both market and non-market phenomena as well (2010:22-23).

In addition, Kien-hong Yu, P. (2011) highlights that in RCT the basic premises are:

> All human beings base their behaviour on rational calculations, all human beings act with rationality when making any choices and all human choices are aimed at the optimization of their pleasure or profit (Kien-hong 2011)

And, eventually, thanks to the qualitative evidence and the formal conceptualization of RCT, we can more or less understand the mechanism of the transitive preferences of people seeking to optimize the utility of a particular action. Accordingly other scholars have discovered that, subject to a range of constraints, an informal choice may become rational when it is consistent, deliberative, and the decision makers have a logical justification for the choice. (Ulen, 1999; Scott, 2000). In this regard, my research seeks to identify which formal even informal, well-expressed or half-expressed components within the expression of

patients' perceptions are related to their conviction that maximizes their ideal personal benefits or profit. However, one of main RCT limits is that other aspects among those elements namely beliefs, spirituality and hidden values are beyond of calculations and rational thoughts. As consequence, I shall use two others analytical frameworks for that purpose: The International Religious Health Assets Program or IRHAP theory and Aadland's concept on discerning hidden values.

4.2 For approaching hidden values: IRHAP theory and Aadland's concept

4.2.1 IRHAP theory

If RCT was a toolset for explaining mostly the views about the health seekers the IRHAP theory is the one which examines their perceptions of things around the health providers. According to Nordstokke, due to its international stakes and global reflect, the term IRHAP has replaced the African Religious Health Assets Program (ARHAP) which refers to an interdisciplinary approach bringing "together social scientists, health experts, theologians and others with purpose of gaining a better understanding of the interface of religion and public health…" (Nordstokke 2014 in Dietrich et al 2014:215-6). Thus, in what follows, the terms ARHAP and IRHAP will be interchangeably used for they share the same theoretical framework.

4.2.1.1 The theoretical foundations of ARHAP

As its name indicates, ARHAP began in December 2002 in Africa (ARHAP report 2006:23). The objective aimed at addressing to the scarcity of systematic knowledge base of Faith-based institutions working in health. The choice for this part of the world was based on the fact that there─where one can find the mix of different religious traditions and varying contexts, African people as well as researchers, academicians, practitioners and donors are facing with the growing public health challenges (Ibid). Thereafter either small institutions or leading Universirties such as The University of Cape Town, Emory University, University of Witwatersrand and so on, have been interested to this theoretical approach. Hence, in 2006, even the world leader in health program: the World Health Organization (WHO) has approved it (ARHAP's theory) and accepted to support collaborative ARHAP's researches in Lesotho, Zambia and throughout southern Africa. These African countries have been particularly

victims of the 'major human tragedy' which is the HIV/AIDS (ARHAP 2006). The WHO recognizes that Religious entities are key collaborator for the public health agencies, in the implementation of the program emphasizing universal access to prevention, treatment and support services for patients living with HIV (Ibid). The studies using ARHAP's framework and carried out in these high priority African countries, have identified, mapped and assessed the religious health assets (RHAs) which can be effectively marshalled in the health program against the HIV/AIDS (Ibid).

The research done on this pandemic in African context is only one among of others examples illustrating the substantial contribution of ARHAP theory to the fight against today's challenges in public health. Usually ARHAP's researchers approach through studying RHAs engaged within the services performed by FBOs (including Muslim, Christian... faith-based organizations) on health issues. An in-depth understanding of this theory helps us to figure out its broad stakes as well as its particularities when fighting for the well-being of people. For this perspective let us consider the ideological connotations around ARHAP theory given to the account presented by some leading academicians and ARHAP's theorists. First of all the term "asset" which has caught recently the attention of stakeholders working for the development work in Southern of Africa. ARHAP theorists state that this concept, used mainly in its plural form "assets" refers to:

> a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation (ARHAP report 2006:39).

From this definition, one notices at first glance that there are two groups of assets: the set of empirical facts (concretes resources, organizations...) or 'tangible assets' and beyond them 'the intangible ones' (capabilities, skills...). These assets frequently listed in the economic narratives are indeed used 'in the realm of sociology' and known as a 'social capital' (Nordstokke in Dietrich et al 2014:215). And the value of such social assets is recognized by sociologists in the formation of society, for they are obviously connected not only to people's worldview but also with social values system and their spirituality (Ibid).

Second, in ARHAP's methodology, the understanding of health has improved by the introduction of a new technical word "healthword". Germund and Cochrane designate it as

“the complex web of elements that shape how health and well-being is understood, relationally rather than atomistically, ecologically rather than reductionistically” (Cochrane et al 2011:xx). From this perspective, the issues about health involve other settings beyond the medical evidence. Researcher should also grasp the meaning of the relationships and the environment around patients, health providers and health facilities. This surrounding space or healthword is particular because it is shaped by personal and contextual history of everyone. ARHAP researcher claim that healthword “expresses the perception of a person in relation to their interaction with the world around them” (Ibid). And such perception appear very manifest when religion and the mobilisation of health assets align (Ibid).

Third, the expression “religious entity” which captures the broad range of religious institutions, Faith-based Organizations, Community Support Group, Church, congregation, as well as self-standing individual practitioners. In ARHAP's field we take into consideration only the people’s engagement in health work. The diaconal hospitals, as one has described earlier (see rubric 1.5.2) is then one good example of religious entity. They may be seen as tangible religious health assets (ARHAP Report 2006:38-39).

And four, the fundamental notion in ARHAP’s approach: ‘religious health assets’ (RHAs): this term indicates the assets “located in or held by a religious entity that can be leveraged for the purposes of development or public health” (ARHAP Report 2006:39). In respect with this line, ARHAP’s reseachers and scholars agree that health and religion are intertwined. As result the mobilisation of RHAs leads to an effective transformation since it has been engageed and has an influence on all who and what are a part of it (ARHAP theorists 2006, Cochrane et al 2011 and Nordstokke 2014). Every health facility needs to be transformed to a real agentive actor of health capable to address the expectations of every patient preferring to be totally healed and empowered not only with physical, psychological treatment. Their basic needs expect moral, psychological, spiritual…healing or basically a holistic healing. As such, a better understanding, a methodological mapping and an analysis of tangible and intangible RHAs are really needed in matters of illness, healing and health in general.

4.2.1.2 ARHAP’s or IRHAP’s theory and hidden core values within diaconal health center

Mapping out and assessing diaconal assets through IRHAP's theoretical approach can contribute to identify some hidden core values. The concept of diaconal assets here is limited only to the assets linked to health issues. In contrary to the affirmation the World Church Council or WCC Busan assembly (WCC 2013 cited in Dietrich et al 2014) that it is broader. In this paper, I mean thereafter by diaconal assets, all RHAs encountered in Diaconal health center which is, according to the explanation in heading 1.5.2, a hospital run on behalf of the church. Moreover, it is worth to notice that not all Religious Entities are taken as Religious Health Assets (RHAs), and not all RHAs are seen as Religious Entities. Only those which are engaged in health work, are considered to be RHAs (ARHAP Report 2006:40). Such hospital influenced by Christian Religion faithfully presents the *healthword* of assets described above, in between patients and health providers. Nevertheless there is a very few published studies on that topic. That why, IRHAP theory wants to be an asset-based approach aiming at probing a 'bounded field of unknowing' by mobilising existing assets, rather than needs-based approach in which researchers seek to identify what is found to be lacking (ARHAP Report 2006, Cochrane et al 2011 and Nordstokke 2014). Accordingly, IRHAP may discover under communicated assets, like the hidden core values linked to diaconal services for instance. For in addition, ARHAP's or actually, IRHAP's academicians dare to conclude that "Assets carry value and may be leveraged to create greater value" (ARHAP Report 2006:39).

Besides, inspired by IRHAP's methodology, Nordstokke, in global view, succeeded to enumerate and develop further clarification of some relevant tangible and intangible diaconal assets (Nordstokke in Dietrich et al 2014:217-220).

Firstly, the tangible assets, understood as the more concrete resources, are:

a) *Practical and technical resources*: referring to diaconal involvement in caring or supporting curative interventions for the patients for example,

b) *Material and structural resources*: in relation to the diaconal facilities like hospitals…

c) *Human resources*: are constituted by professional workers having a behaviour influenced and strongly motivated by their Christian faith in their profession.

d) *Economic resources*: in regard with financial issues of diaconal activities evaluated according to its different sources.

e) *Communication resources*: in accordance with sharing the success stories through publications

According to Nordstokke, because of the dependence and the imitation of Western arrangement, the diaconal tangible assets seem like "*diakonia from above*" (Nordstokke in Dietrich et al 2014:217-8).

Secondly, the intangible diaconal assets are invisible and analyzed in the beginning from ordinary people point of view, whence the concept "*diakonia from below*" (Ibid) has been arisen, they are:

a) *The collective memory of the past*: a variety of real stories, namely Jesus' stories of healing…, that helps people to be optimistic of the possibility of what happened before in today's situation.

b) *Rites and rituals*: Strengthening services such as Sacrement, blessing … that can encourage people to serve each other in difficult times of life.

c) *Ethos*: Workers are called to spread values systems with high opinion of human dignity and great respect of human life.

d) *Relationships*: the fact that someone belongs to a given system, will motivate his or her participation at the practice of hospitality and mutual care.

e) *Trust*: the confidence that leads people like patients, Muslim… for example, to believe in the capacity of diaconal services.

f) *Moral authority*: a special quality of diaconal services that addresses sensitive topic by taking a pivotal role of good change

g) *Pioneering practice*: The unusual ability of diaconal initiatives in introducing a new practical approach so that the former practices may be improved (Nordstokke in Dietrich et al 2014:217-8). On the basis of the nonexistence of formal and strict distinction between tangible and intangible assets, because they are so interwoven and fostering each other, such practice can be seen in both sides (Ibid).

All these assets are diaconal because they are able to mobilize, motivate and empower people working in diaconal agencies. Also, they "form and sustain diaconal practice"

(Nordstokke in Dietrich et al 2014:216). And finally thanks to them diaconal agents are oriented, guided and corrected in the alignment of the health and religion upholded by IRHAP's study (Nordstokke in Dietrich et al 2014:217).

4.2.2 Aadland's concept on exploring hidden values

Aadaland' concept acts as a go-between (see Figure 6 below) between RCT and IRHAP's theory on exploring all potential hidden values in this research. Because this conceptual framework directly investigates the perception and the expressions about making choice, the action with its assets and the nature of the *value-in-use*. In regard to this Aadland underscores that when people have to make a choice, the two following questions always arise: How is the situation? And What we should do? He states that the first one necessitates *observation and interpretation* while the second one requires *prioritization of values* (Aadland and Matulayova 2011:10). The people's preconceptions and perceptions of values influence their grasp of an observed facts. After comprehension, and before making choice, they try to prioritize the involved values with *value hierarchy* which ranks the significant and the insignificant opinion (Aadland and Matulayova 2011:17). His definition of values mostly corroborates the researchers' accounts described in rubric 1.6.1 Understanding of terms.

Yet, in addition of the main categories of values explained previously: personal or professional or social, the reflection about values in everyday life engrosses the following assets: quality, activities, people and things (Aadland and Matulayova 2011:11). Actually, people interpret, prioritize differently, based on the differences acquired from family environment, political setting, religious and faith issues, professional background… Accordingly, the universal and open values that are stable like 'love' and 'joy' could be assessed easily. But how about the hidden values? According to Aadland, hidden values are "postulates or assertions about nobody can see" (Aadland and Matulayova 2011:29) and they might be totally hidden or half-hidden, negative or positive (Aadland and Matulayova 2011:33-7). Basically, our mind has an inaccessible area by *lucid consciousness*, which Freud calls 'subconscious' and 'unconscious'. Our striking old experiences (good or bad values) happening in the past are memorized inside the *subconscious.* Hereafter, from where, at a given moment, they must influence the actor's behaviour and action (Aadland and Matulayova 2011:29).And generally hidden values function in adopting such way. For values

could be “expressed as reflected in written or spoken statements and through action patterns” (Aadland and Matulayova 2011:34), a theoretical approach emphasizing observation of behaviour, interpretation and discussion implicating language framework namely hermeneutic, sensemaking process… could be useful for revealing those hidden values (Aadland 2010).

In organizational level, Aadland suggests a more developed value research approach, compared to what I have just presented above. This model demands a basic understanding and relevant value research process.

A minimum basis of understanding on organizational values seen as “the products of relational interplay […] of individual values” is needed as a point of departure of any process (Aadland 2010). Those values are socially constructions of worth, being expressed by practitioners in an open or hidden way, through their language, behaviour and actions. They shape the general courses of actions within the organization (Ibid).

Two alternatives may help to identify such values: the first one is the classical Subject/Object interpretive Model or SO-Model (Scherer 2003:316). It requires four steps: first; establishing as ‘right value’ a moral principle of preference, second; intending to act according to the value, third; an action performed according to the intention informed by value, and fourth; an interpretation of the action by *others* who are inflicted to it by employing, corresponding or deviating value standards (Aadland 2010).

The second one is the sensemaking process of values which first of all, involves also other persons constituting the sources of self-awarness because, they experience the organization from close range and use its services (Aadland and Matulayova 2011:34). This perfectly matches up my present research in which *others* are the former and the current patients with their family (CP, FP and MP). Next, the other feature of this model is that it intervenes in retrospect following action. After that, the application of the concepts from theories of tacit knowledge that generally supposes that values may be inferred from actions. Individuals exposed to similar situations repeat a coherent evaluating reaction, hence one comes to the notion of stable values (Aadland 2010). "Values demonstrated through behaviour may be partially or wholly preconscious to the actor, and as such tacit and hidden to his or her mind" affirms again Aadland. Also, his inspiration from the famous *Johari*

window leads the reader to get an insight of hidden values through own's analysis and that of others who have observed us (Aadland and Matulayova 2011:34). For that reason, he concludes that

> The naming of the value-in-use is for an observer to extract after an action is performed. This aspect expresses value systems as stable patterns of behaviour inferred from action and inform action too (Aadland 2010).

And at last, if necessary the examination of sensitivity and consciousness, between the concept of value and the concept of virtue ethics, is recommended, in order to discern how they both are developed in professional practice at the organizations.

Ultimately, Aadland values the use of hermeneutical understanding of social knowledge on his concept. In this line researcher has to collect "narratives, stories, rituals, habits, valuations, metaphors, and routines in search for profound meanings and hidden values". (Aadland 2010).

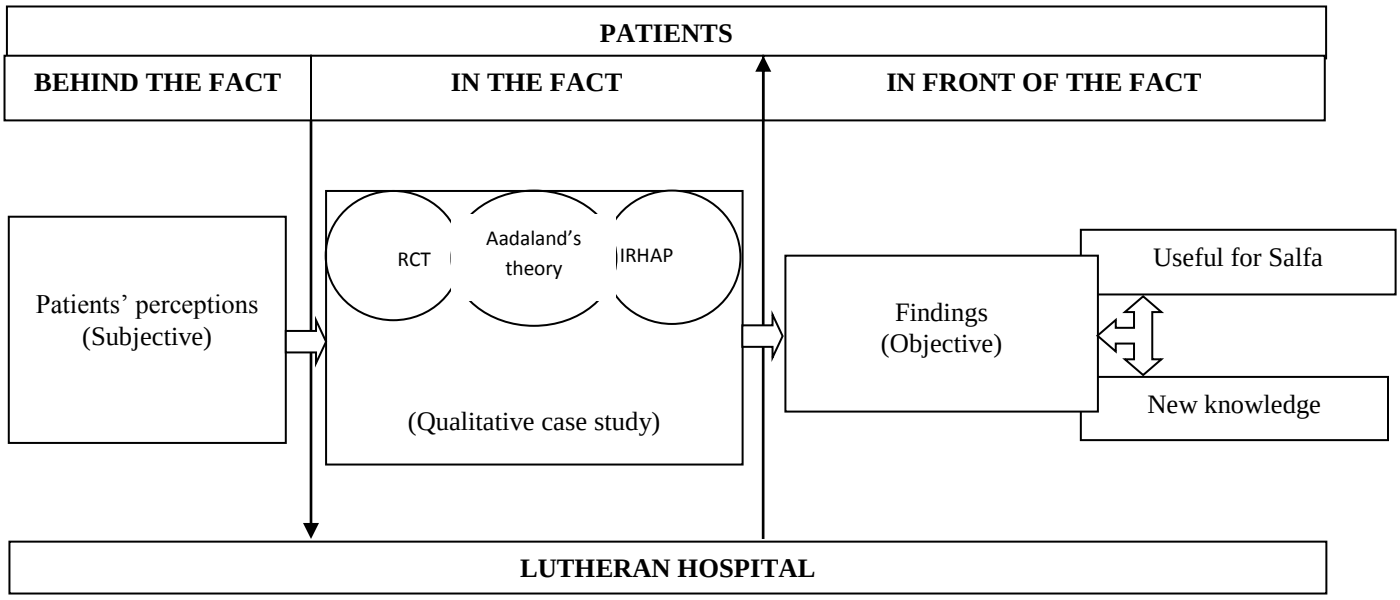

Figure 6: A helping representation my research

4.3 Chapter summary

The mainstream trends on RCT and IRHAP's theories have been discussed in this chapter. The efficiency of RCT has been proved in assessing the reasonable aspect of client's choice but this approach is feeble when the exploring of the abstract issues of beliefs, values, … arises. Then I shall use IRHAP's approach accompanied of Aadland's concept which seeks both to identify hidden assets and to assess the contribution of religious entities to health and well-being. According to me, the theories above are appropriate to discuss my findings which go after.

5.0 Chapter introduction

The researcher in this chapter shows the findings extracted from the histories narrated by the interviewed participants. Those findings emerged from the answers to the ten questions of my semi-structured interviews and focus group. However, in this section they are grouped and organized in line with the four sub-questions that led the data collection process. They thus try together to give a first impression of the responses to the main research question raised previously in my introductory chapter. Accordingly, before a brief chapter summary will be drawn, the chapter will present the direct perceptions of the patients about how: the price of services affects the patients' choice, the quality of service realizes an effect on their choice, the spiritual dimension induces an impact on their choice and the values of medical staff/the whole hospital influence their choice

5.1 How the price of services affects the patient's choice

Malagasy people love to talk about what happened in normal daily life. Meanwhile in the very first part of my interview, the answers that I was looking for about price influences were too simplified as pointed up by these quotes:

> *I am Lutheran, then my thought is […] we don't just think what is convenient for us like searching cheaper hospital; we have to consider what is best for the organizations which belong to our Congregation as well. I feel like […] if I should give money, I must give it, and it is my duty to give it to my brothers and sisters in faith… (CP1).*

> *It is true that one doesn't pay the consultation but they (the employees at Public hospital) charge you the fee related to some medical acts like biological analysis and so on. Anyway public dispensaries are way cheaper […] But it is hard for me to break habit, even though I pay more at my Hospital Salfa (Sometimes for many customers a Lutheran hospital is directly called Salfa) . The cost doesn't matter despite the poverty, because what matters is being treated within a shorter time. And I am hoping that this is still possible there (at Salfa) like my last case (FP1).*

You are right, life is extremely expensive [...] and I honestly have a meagre salary but my family and I, even most of our neighbours, remain among the faithful clients of Salfa. For we think, if we pay, health providers would care of us with more serious attention (FP2).

Consequently, I had to apply the Delphi approach (see 3.5.1 Data collection instruments) to help the next participants to answer more informatively. Generally, the perceptions in these finding are expressed by individuals in their own cultural and social understanding shaped by previous experiences. One female respondent, 24 years old, had this to say about her choice, in relation to the costs of medical services at Salfa Majunga and vis-à-vis her family's incomes:

All people in Majunga know that it is not easy, paying consultation fees, and especially hospitalization fees at Salfa, for people have a lower purchasing power during and after the crisis (the political crisis after coup d'etat in 2009). They (fees) are increased every year. Then our choice depends on our current resources. If we have insufficient money, we go to the public Hospital. But, amazingly, if we have enough and available money, like for the actual case, we are in habit of coming and seeking health at Salfa. We are not Lutheran, neither Christian, but […] after all we attend services in Christmas Eve, Easter… (laughs), this (choosing Salfa) happens to us like that [...] I think our habit is one reason behind this but there are also our hope, belief and trust which are inspiring us to prefer this hospital. Actually, we always wish that my current treatment will be good even as it was last time when we brought my mother here (CP2).

Another lady who is beyond the age of sixty, from a household in Majunga town raised a different concern about her preference for Salfa despite the high cost of medical charges there, in the following words:

Before doing a given act or in other words, making any decision, people may evaluate and predict the consequences of it. However, in case of paying medical fee, when we are facing a serious case of illness, I don't care how much will be the expenses. I always choose the costly Hospital wherever we are in Tana (the acronyme of the capital town of Madagascar)or here in Majunga...mmh [...] This way of thinking is automatic for me. Why because health as well life has a great value for mankind. Every sick person can die either at private hospitals or public ones. But I think it is better to go to the one where you feel reassured. Here is a concrete example, my son who died at Salfa in 2013 after five days of hospitalization […] (letting out two

long sighs) […] it was tough because he was my only son […] but I feel better consoled after having paid a big amount of money for trying to give him the best treatment as "ala-nenina" (malagasy term meaning last resort, term used mainly after death and when all other attempts a healing have failed). During his hospitalization (in special rooms for the patient who has possibility to rent them), paying such amount was not painful for us… I was very hopeful about the outcome of the medical intervention…whereas my family told me don't raise your hope too high or you may be disappointed [...] but no, I am not disappointed at all, I did best I could, then I am comforted [...] (FP3).

Furthermore, a man, 45 years old, stressed the worthiness of the cost of services restoring life and its values namely, the health services. According to him, Salfa is aware of that situation and the resolution taken by the leaders of the hospital regarding this is very welcomed by clients. He is quoted expressing:

Of course, consultation in public facilities is free of charge. I have been there before. But, I prefer paying more at the Lutheran hospital, where you are surrounded; first of all by people who cannot insult each other or exchange strong words, and then of Christian medical staff. This clinic really keeps in mind the real importance of life values. We are mere local farmers with limited incomes, and the price of medical treatment here is higher. But you know, life is very important for me, like for you I guess. I am willing to pay [...] for saving my life and for the services providing respect of its values… I dare to proudly repeat that at Salfa there is no problem for me to pay much money for my healing or for those of my lovely family members. And listen [...] the following explanation is among the very important facts why my neighbours and I prefer to consult doctors here, at Salfa only, here in Majunga, there is a method of payment with ease financial difficulties. For example, serious illness suddenly occurs at any time, and then you have to reach the hospital. Let us say your bill is about 1 000 000 Fmg (former Malagasy franc equivalent to 200 000 Ar in current Malagasy money) for three days of hospitalization and you cannot afford to provide the entire amount on the first day. The accountant and the cashier, surely, will give you time to look for the rest. And after recovering from your disease, beyond the payment deadline, you can wait in the common place for patients' followers until your family has completely paid. That is very very helpful for a countryman like me (FP7).

Similarly, during my focus group, one participant, a man who is a Driver (job) of 68 years old living at Ambalanjanakomby (235km from Majunga), sensitive of the latest answers (result of Delphi method on collecting data) said this:

> *Mister! Don't forget that there is a Malagasy idiom saying that: "ny tsara tsy mba mora na oviana na oviana" (the best is never cheaper). If you want to have a good thing, you logically must pay more. In the beginning, I didn't know how good the services provided by this Hospital (Salfa) we are talking about were, we only heard that the price is very expensive. Moreover, we saw, as you mentioned (referring to question number 3 of the interview guide) people are queuing there, then we realized that this hospital is really better than the others [...]. We decided to bring our brother to Salfa, who needed surgery (an in-patient at Salfa Majunga during the interview), even though, we know very well that firstly the admission fee is not charged in public hospital and secondly, there are a lot of specialists there. However, I don't share the same reasonability with the one (CP2) of your latest interviewees about that point. For my family, even if we don't have enough money, because as you see most of us, present here are from the countryside in the brush, I am telling you, I don't hesitate to borrow money or sell a big part of our goods in order to be able to pay his surgery fees (FM4).*

A number of my interviewees agree that the most important thing in choosing Salfa lays in the fact that paying more doesn't matter, for it satisfies a higher expectation that "*treatment will be better there*".

5.2 How the quality of service realizes an effect on patients' choice

Besides the price, checking the quality of services has an influential effect in making a choice. The findings of this research both from the interviews and focus group revealed some factors linked to the perceived quality from the patients. As I cited above, those participants were invited and guided to narrate the history, relating such quality, of their hospitalization or their visit for different services in this Lutheran hospital. However, due to restricted space I have selected only some relevant sentences, having picked them out from the stories, and grouped them under the following headings: availability of material resources, good organization of time resources, competence of human resources, international standard of technical resources and relevance concerning informational resources.

5.2.1 Availability of material resources (infrastructures in general)

Almost all participants I met in this Lutheran hospital (all CP and FM) have remarked on the improvement of its material resources (medical equipments etc.). This makes them reassured of their choice. They expressed this in different ways:

[…] two years ago (2013), I came here with my mom and there was only one functional operating theatre, now there are two. Look, they have a new ambulance too (pointing a forefinger to the car). This is just some of what I can perceive visually, but I think, they might have introduced new machines or equipment inside the different medical units […] They have made a difference and such tangible effort increases the quality of their services, and attracts clients for sure (CP1).

…this hospital is definitely distinct […] it is a Christian company, the leader and the employees here do not cease to try their best to show the beauty of God in many ways. I refer for instance to the new paint for the main buildings, new fence, those beautiful gardens, oh, I forgot this new "bloc" (the new house for the second operating theatre). We arrived here last night and I didn't pay attention to them. But since this morning my colleagues and I have been pleased by them. And I said to myself, watching every day, those flowering plants, even in bloom, transforms my sickness half-healed if I were sick [...] You rarely find the same, a well-maintained physical environment, in the public sphere (FM2).

For me, besides what others (in focus group) have said, one important detail that differentiates this hospital is the existence of the special dormitory (an extensive floor area with common kitchen) for patients' caretakers. Those from rural regions without relatives or friends in Majunga town have no need to worry about accommodation and preparing meals (In Madagascar, the family of the patients are always in charge of patients' food, not the hospital like in developed countries). One old man said to me, he does not feel like a stranger in this hospital and he is right (FM5).

5.2.2 Good organization of time resources

Whatever the reason of admission to this hospital; either simple flu or acute illness needing immediate surgical care, everyone wants to be treated at once and to be healed as promptly as possible. The customers are very appreciative of the respect of their time. More than half of my participants have discerned a comparative advantage in this regard at Salfa. Some of them displayed this in the following quotes:

I told you earlier, we came to Salfa last night around 2a.m., and the security guard guided us up to the nurse's office. After this nurse had done our registration and checked the blood pressure, temperature […] he went to inform the physician (night guard) who arrived 15 or 20 minutes later. Then he examined my cousin and […] it was an acute appendicitis. Without delay, he prescribed some medicines and necessary medical analysis […]. And in the first hour in the morning, after prayer session (every day the employees must start their activities with worship of The Lord Jesus), the operation took place with success [...]. If this happened, in another hospital (Malagasy people are not direct on saying sensitive information), I am telling you, you would have to give tips (money) to the nurses first, then the Doctor in order to have medical care at night… even to the security agent. Afterwards, surely we would wait (in this other hospital) until the morning to start what they should do for him (the participant is still drawing the comparison in relation to his cousin). One recognizes that for patients requiring emergency care, even one hour seems an eternity… and in these conditions, any loss of time will be a lost chance to survive [...] (FM2).

What happened during my last visit at Loterana (non-Christian patients call the hospital "Loterana" or Lutheran in English) I was satisfied by my treatment, but the outstanding quality of this hospital is the organization of time […] employees always start working on time […] the receptionists move in order to properly refer clients to the correct service to which they need to go […] patients' family do not spend time going to town to buy medicines, they do it at the hospital's pharmacy (the big hospital in Madagascar sell medicines too). We have been in Androva (the place where the main public hospital in Majunga is) and after registration they give you orally some indications and you have to manage inside this big facilities […] we experienced an extravagant waste of time there (An adult man, 43 years old, MP3).

5.2.3 Competence of human resources

In regards to the competence and skill of Lutheran health workers, all my interviewees based their explanation on the quality of the result of their last visit to the hospital. Like this one young lady who highlighted this important part thus:

Yes, we have gone both to Androva and Loterana (Salfa) in the past… you are asking us (during focus group) the differences between them…quality, values…mmh… well, I am not a Doctor, so it is not easy to fairly compare the competence of this or that health agent. As you introduced, they have followed the same study, the same training… they should therefore provide the same degrees of competence either working for public facilities or on behalf of the church. But my

family likes to be treated at Salfa, and encourages our loved ones to consult here. I am here because of my sister in- law who is an in-patient at service of medicine (internal medicine unit) […]. But I have my own convictions too… the strong reason that pushes and pulls me to give my choice to Salfa is mostly based on what happened three years ago. I had a chronic angina. A free family doctor (in Madagascar there are many cases of physicians who alone run a small clinic or medical cabinet) treated me but the angina occurred again and again in intervals of 3 or 4 months, and I had to retake the same medicines…he told me that the cause of this was the poor status of some of my teeth… Meanwhile, last year my mother suggested I come here […] and I can remember…I received a strong "piqûre" (a French term for an intramuscular injection) and since that time till now, I have been totally released from this chronic illness […] I was wondering[…] it is true that some Doctors are doing business by 'half-treating' some patients[…]. But here at Salfa, you have God fearing personnel, who really apply the Gospel not only in their Church or at home but above all at their workplace […]. This Doctor (who treated her) didn't receive any gift (money) from me, I paid the fees at the cashier office and that was it… I believe the employees here, maybe not all of them but most of them, are afraid to do an evil thing because of their faith in Jesus…eventually, they are logically more competent compared to the others. Aren't they?(laughs) (FM1).

In addition, another explanation was given by a Muslim (as mentioned in the methodology chapter the participants are wearing their typical dress) guy on the same point, as follows:

At Salfa the same Dr does a regular postoperative follow-up on the patient they operated upon. The same surgeon who performed the surgery on the patient, will be responsible for the postoperative follow-up…that is great for me […] While In Androva (the name of the public hospital), the patient's follow-up is performed by different doctors who change every day. Also, what is worse is that there are too many students who check the patient too […] (MP4).

5.2.4 International standard on technical resources

One participant evoked one proof about the quality at Salfa hospital. In his own words:

Salfa's staff treat diseases with respect to standard norms in my point of view, for even white doctors (people from rural area call, both medical doctors and nurses "doctor". The foreigners are mostly nurses) from USA and Norway, work recurrently with them in this hospital (Salfa). It

is a bonus quality for this hospital and believe me Malagasy people take it into consideration in their decision-making- process concerning which hospital to choose (FM4).

5.2.5 Relevance of informational resources

Good and constant communication conveying clear information is recommended for the relationship between the healers and health seekers. That is what this loyal client of Salfa Majunga claimed in the following statement:

You have already got my first reason why we choose Loterana, right? (his response to the 2nd question of the interview was Salfa's reputation in his village)… Now let me give you another important motive showing Salfa's difference (compared to other hospitals) before I forget it. So, I am from Beloha Androy (in the South of Madagascar) but I have been here (in the Northwest part of Madagascar) since I was young…because of my business [...]. My wife too is Antandroy (the name of the dominant tribe from the South) […]. Formerly my wife and kids were used to go to Androva, but since 2000, we have moved to Loterana. The reason was maybe simple for others but very important for us. I was taken to this hospital at that time for a hernia[…]my big surprise was that the doctor (surely a nurse) who was supposed to examine me, called over his friend who had mastered our dialect, to do the examination […] and after my operation, this guy continued to transmit to me all recommandations in our language (the nurse is Antandroy too). And next to me (in the common room for in-patient) another doctor (another nurse) from the Southeast (another Malagasy tribe) took care of him because they spoke the same dialect. And I realized in this Lutheran hospital they are doing this by purpose. I label it as an exceptional quality that differentiates this hospital; this is because Salfa Majunga is the only hospital where you can find employees from the 4 corners of the Island (Madagascar). If you are Betsirebaka, a Betsirebaka doctor will come to examine you, if you are from Tana (Antananarivo), there is an Ambaniandro (Malagasy tribe from the capital town) among the staff here and so on, and so forth…(51 years old man, FP6)

Medical or administrative employees, like any other normal or typical patient, all need to be warned or updated instantly as well, of further information about what is happening in the current medical care. The information, which may come from the patients or the doctors remains essential. Such medical information has proved to be extremely important if expressed on one's tongue as illustrated by the next comment from the same participant above:

Mister, I really love Salfa's quality of communication between patients and doctors. It renders all technical and medical information understandable. You know, information is vital in terms of healing. Here again, a simple example, information about drugs comes from the pharmaceutical laboratory abroad and is transferred to the patient by the Doctor or pharmacist. So, if one does not pay careful attention on it (information), the medicine can become a poison […] for such information is very delicate. This covers all the administrative arrangements for the adequate intake of a given drug. This requires a clear expression. Especially when it deals with the tolerance of some active medicine (fear of allergy and contre-indications), gestures or behaviours to avoid during the period of treatment or hospitalization. To be honest with you, if the Doctor speaks my own language, I feel sweet sounds to my ears, which somehow "opiates" my pain and my mind with faith and hope. So, I have an untroubled decision to continue to choose Salfa as long as the people from my tribe work over there (FP6).

5.3 How the spiritual dimension induces an impact on their choice

All participants, mostly non-Christian, involved in this research found themselves in agreement that the spiritual issue should remain imperative in the healing process. Though, their responses did not give lengthy detail, they contain convincing ideas. The assertions were as follows:

We need a Christian practitioner, who surely cares and prays quietly for us and for the treatment. The pastor of the chaplaincy doesn't preach or counsel only, as you said, but he even shares Holy Communion here [...] He (the priest) visited us every day, and asked if we need special prayers without forcing us to become Christian. But why refuse? (it calls for accepting) The patient at his or her feeble status welcomes such action (FP4).

The presence of the chaplain is needed for the people following treatment and for those who are close to their last agony [...]. Moreover, for myself, when I am here (because she is ill and in the queue), I feel a certain degree of warmth in this hospital. Maybe it is a blind trust. I don't know. But really, this kind of warmth from their work of faith has been evident during my care. This is certainly not found in public facilities. For, the behaviour of staff in this Lutheran hospital has gospel roots (CP1).

As a faith-based institution, patients at Salfa acknowledge the great emphasis by its staff to carry out its slogan, "We treat, Jesus heals". This is done by daily preaching and occasional counselling for those (patients and caretaker) in need.

[…] based on the manner in which these personnel actively participate in religious services (most of the employees are deacons at the Lutheran Church in Antanimalandy) at church and even in their workplace (referring to the chaplain), we customers are inclined to hope uncritically that they have to treat people with dignity and personalized attention. Then Jesus helps them and us according to their famous motto (FP5).

Once again, my whole family chooses Salfa as being the most appropriate health center of the available hospitals around my village; this means that we are really satisfied by their health services […]. Concerning the chaplaincy service at Salfa, it is not a problem for us. Per contra, they achieve success (in terms of treating people) because they are not shy about the faith they profess, through their slogan you mentioned, and by the everyday preaching with "sacred song" that we could hear in the background from right here. (Salfa has its own radio programs for its patients and personnel that one can listen to from speakers in every room and along every corridor)[…] So I think, God bless their service for their fidelity. You (the researcher) know too that, FLM's reputation is not only from its health program but through projects with act alliance after cyclone, Shalom project etc. If my opinion could count, faith is a key factor for their road to success (MP4).

This former patient, who has been working for ADEFI company, has the right to choose among three big hospitals in Majunga according to the affiliation agreement in case of serious illness. In his words:

[…] when I am looking at the logo and the inscription "We treat, Jesus heals" at the reception, frankly I am at least 10% healed […]. Despite belonging to other denominations, we have chosen Salfa just only for that... The fact that the care is accompanied with prayers basically motivates us (FP8).

Gleaning from the above perceptions, Lutheran hospital is more useful than the church in terms of evangelization because of the healing activities. Church is open for believers only for few days (every Sunday or Saturday or maybe Wednesday) while the preaching in the hospital is performed day-by-day.

5.4 How the values of medical staff/the whole hospital influence their choice

All my interviewees used two terms when they refer to values: firstly, "lanja"─used frequently for indicating the values of a thing: its translation is weight, but its values meaning

indicates, according to most of them, *an imaginary heaviness or weight of thing which has a good influence*. Secondly: "valera", the "malagasization" (transliteration) of the French word "valeur" (values in English). This word describes *the high price of an essential character of a person or thing*. Both, of those meanings are interchangeably used in my participants' quotations. Once again, those who were interviewed in the beginning were struggling again, to identify what are the values of this Lutheran hospital if they are asked to discover them from the staff's practices. As usual, their answers were broader considering the general aspect of values and disregarding exceptions. The response from the Christian lady (CP1) can exemplify this: "*This hospital has Christian values [...] like love for neighbour [...]*" then when I asked, could she explain it in relation to her medical experience, then she had no clear answer [...]. I had to apply again the Delphi method. Finally, two former patients succeeded explaining two core values of the hospital. One revealed the respect, as she displayed in the following testimony:

> *Really, it is with great pleasure that I am participating in this meeting (focus group) to share with others how much I appreciate the services offered by the staff in this hospital: both medical and non-medical. Since my first contact with the Dr. Gustave (former Chief Doctor of the hospital) in October 2007 […] RIP (this Doctor has passed away)[…] since this day I never cease to be amazed at the consistency of the quality of services here [...] and that quality is mainly due to its value. This value is nothing but, its respect for us who are clients from rural area. I feel such value, not only during the Doctors' examination (reference to the question 5 of the interview guide) but through the services that they (Salfa's employees) referred to me […] (I was asking proof), wait, wait please […], I'll tell in detail what the history of my last visit here from what I experienced at the reception office till I got the hospital exit ticket. The motif was fibroma operation. At the reception, I received a warm welcome from the receptionist; this showed me respect* (FM3, a 64 years old women).

Then this lady listed for us (all participants of the focus group) all the different services she received, rather than expressing the special behaviour which showed her the value of respect. According to her, those normal steps in all normal hospital: clinical and paraclinical examinations, nursing assistance, cults, surgical procedures, postoperative care… and explanation about the bills at the end of her hospitalization, were done with respect, by saying:

All those (the above steps) are routines of hospital work but everything was accomplished with a real humane accompaniment of the sick. […]. Now, we continue to experience the same ascertainment during our actual visit here. I lie if I say, all services and staff at Loterana are the most perfect in the world, but I can say: At this hospital I always feel good humour and respect which I have never found elsewhere [...] I consider myself privileged to able to benefit from such respectful service. In other hospitals, only customers having a "4x4 car" (four wheel drive off road) receive such service. The reason behind this fact is their respect of God. I am atheist but I believe that this is the starting point of the rest […]. They (Salfa's staff) must respect each other and their clients. And the turn of patients with their family is coming, they have to respect Christian rules in the hospital […]. Here, there is neither use of swearwords nor insults nor unhealthy behaviours[…]. Respect is quite obvious: in doing, talking, approaching patient, in general (FM3).

What is meant by this is that her expectations about her rights and values have not been respected in other health centres she visited before. When she came to Salfa, the difference was palpable in her sight. Unfortunately, customers wearing colour-faded cloths and without shoes, seen by many as signs of people from countryside, have largely been stigmatized in Malagasy society because of their poor conditions. After that, she stressed again:

My needs and expectations are met here (at Salfa). Everyone wants to be respected, so if I have to choose I prefer realistically to make partnership with those who respect me (FM3).

In order to understand more fully her description about this values respect, I tried to acquaint her with the responses from the previous individual interviews (Delphi once more). She thus clarified as follows:

Well, before, during and after my examination, because of my lower education (she exaggerated a little bit), my old age […]. I repeatedly forgot or misunderstood technical information. So fearing that I might make a mistake, I had to ask them more questions than others patients […] but I always felt in their behaviour of answering me, a kind and respectful way of retrieving information, even to my lesser needs (FM3).

Two other aspects of showing the value of respect relative to the non-medical services within the hospital were evoked by this participant. She shared her sentiments by quoting:

If there is an appointed person like our roommate or even one of the staff who do not behave according to the main principles here, for example inequality, injustice and so on [...] we were told to report it by anonymous writings and put it in the box at the reception office (complaints and suggestions from patients, visitors are welcome). This is respect of our dignity (FM3).

I enjoyed their flexibility on payment of bills. It is still an expression of respect for poor people, isn't it?(FM3).

From the previous excerpt, my respondent emphasized that respect is another patient expectation besides the healing. She thinks that the employees play a leading role in living it as a value. This finding is directly in line with the hidden values that my research is looking for.

Still on the same concern, the second participant who was able to identify the second core values of this Lutheran hospital was a Muslim. He contributed by saying:

Not only me, but you can also ask some of my friends who are loyal client of Loterana, who, in a determined manner, confirm that its staff hold a higher position of trust compared to those of the public hospitals. And this level of trust concerns above all the case of our wives who need to be treated. We have, at many occasions, tested doctor's behaviour, when they (their wives) shared with us their experience during medical examination. We realize that this Salfa's service is more trustworthy. Trust really accounts for the values of this hospital. It is true that Androva hospital is neutral (or secular, independent of any faith because it belongs to the government), but more liberal… I mean…our conscience feels reassured at Salfa. Because the staff is ruled by Christian moral values which are stricter regarding behaviour in practice […] They treat our wives as their sisters […] However we must go to Androva if there is a need for a special medical care (MP1).

The two participants draw attention to the fact that if patients and their followers are to address the factors of choice of hospital, it will be through the values of respect and trust within and around its service.

Anyway a critical reader may wonder if all my participants are only the most satisfied patients who have no disapproving comments. In the methodology chapter, I have already indicated that the snowballing approach was used for choosing the participant. As a result, 25 respondents were recruited, however, due to the recommendation from NSD about sensitive

information; the critical perceptions from 6 participants were removed. The question 10 in my interview guide was stimulating such critical comments among the respondents. For, before proposing any suggestions they often wanted to start to share with the researcher their disagreements about some practices within Salfa. Here is one example of an incomplete expression of critique from one participant coded FP3. She introduced her lamentation as follows: ”*there was also an unpleasant experience related to some past injustices but… I am quite sure they have already checked my unsigned letter at the reception office*”. Indeed, the majority of such complaints are contained in the ideas box at the reception, which only the leaders of the hospital can see and examine.

5.5 Chapter summary

This chapter has reported that the narratives and stories from the patients can provide a most important finding for social research done in a given hospital. In this paper, they highlighted that the reasons for a patient's choice is generally, the result of the humane services provided by Christian staff. For, these workers perform their hardest and try their best in order to provide a valuable treatment for all. The researcher believes that the insight from these findings will lead, in the next chapter, to the application of theories to analyse and discuss the question about hidden values included in their daily practice.

6.0 Introduction

The researcher presents in this chapter the general interpretations and discussions of the data in order to answer the main research question inquiring of the reason for customers' attraction to Salfa hospital. The adopted themes directly discuss through theories and arguments from literature, the three main answers: the values that one can find "in", "behind" and "in front" of the diaconal practices within this institution.

6.1 The values "in" diaconal services provided by Salfa hospital

While, the *exemplifying qualitative case study* using *interviewing narrative* for data collection, facilitated the first understanding of patients' choices in the findings, as already introduced in previous section of methodology, in this analysis chapter, some *historial-hermeneutic method* that on synergy between *interpretive sensemaking* and *narrative analysis* recommended by Aadaland's (2010) were used for the recognition of the unknown values of this hospital (description in rubric 4.2.2). The synergistic effect of these different approaches and techniques helped me a lot first of all to test my hypothesis that my findings have already confirmed, and above all to comprehend in-depth knowledge of what my participants were meant by their own expression related to their perception. Let us subsequently interpret and discuss some of those meanings by rejoining the line that the four sub-questions have already traced in the presentation of the findings:

6.1.1 The high price seen as proof of values within the services

The costliness of price represents the evidence of the values in the services provided by the Lutheran hospital in Majunga. The data has reported that some respondents who have chosen Salfa Hospital argued that its (Salfa's) services are quite pricey, and one of them even mentioned *very expensive* (FM4). In our daily life, such a qualification is used all the time when customers and sellers debate about the price of jewellery studded with rubies and emeralds, or during a meeting concerning a particular business deal between a famous entrepreneur and a wealthy house owner. Looking at this every day trend, we may be tempted to draw a quick conclusion that rich people or those of a higher class in a society deserve

costly things or services. Paradoxically, some of my data in this paper also revealed that a number of my respondents belonging to the lower economic category are still capable to afford a high-priced hospital which they think can be most advantageous for their healing. Accordingly, this higher price in itself is defined as *valera* (rubric 5.4 in the findings chapter) or a value by them (my respondants). Although the words do not mean the same thing by Oxford's definition ─from a French root too, yet both meanings are very proximate and complementary. The translation of the entire idea of the term, "values" in my data means, "to be worth a high-price". In respect to this, they (participants) think the values of life merit an expensive fee. One should not forget that, according to the context chapter we have seen earlier, a majority of inhabitants residing around my research site live and cope with poverty linked to the local system (karana's stranglehold of the economy) and political situation (mismanagement at many levels). Nevertheless, Salfa's clients borrow money, sell goods… if need, in order to be treated at "their hospital"─I mean the hospital of their choice─in the case of illness. One may wonder how a farmer with low earnings can show a strong approval for spending more money, whereas the same services are partially free at Public facilities in Madagascar. Based on the finding of the study, the reason of this illogical choice is mostly the benefits they expected during and after receiving healing services. Here are some of them: community interest (CP1 from same denomination of the hospital), treatment with serious attention (FP2), health services revering life values (FP3, FP7)…

This illogicality in relation to the preference of Salfa's customers is however, rational according to the Rational Choice Theory (RCT). Because the beneficial outcomes above were rationally defined by them as needs through their own analysis from the information they heard or experienced, before choosing a hospital (Ritzer and Ryan 2011). Therefore, when the health services provided by Salfa are able to address those valuable needs, the patients and their families get satisfaction, which plays an important role in their rational choices in the future. Surely they will remain loyal customers of the hospital and invite friends and neighbours to come and seek health at Salfa (figure 7). They are accordingly, right in saying that *the price doesn't matter*, for the services are satisfactory and have value. Nevertheless, in my personal view, as a former inhabitant in this town, spending money is a real matter of concern to everyone rich or poor. That is why Malagasy created this very famous idiom "ny harena dia toy ny volon'orona ka na kely na be alainao dia maharary foana" literally, the money or the fortune bears a resemblance to hair nose, whatever quantity one or more you

take off with quick pull, it always painful". Then, in my conviction at Salfa they felt both the holistic healing with the pain I have explained after paying a quite big amount inherent to hospitalization fee, but the value of getting better prevails.

In addition, two of my participants CP2 and FP3─who scaled their incomes, calculated the likely costs and tried to find alternatives that could achieve similar benefits to the expected benefits, exposes in a very practical way the main basic premises of RCT presented by Kien-hong Yu (2011) and Browing et al (1999). As result, the rational thinking of my participant somehow pushed them to choose Salfa, in cases where similar services were offered by other hospitals in Majunga. That is why and how they determined to pay the expensive fee at this Lutheran hospital that they indirectly consider a great value. This first part of the analysis has rationally proven the evidence of the value within Salfa's health services but not identified its nature.

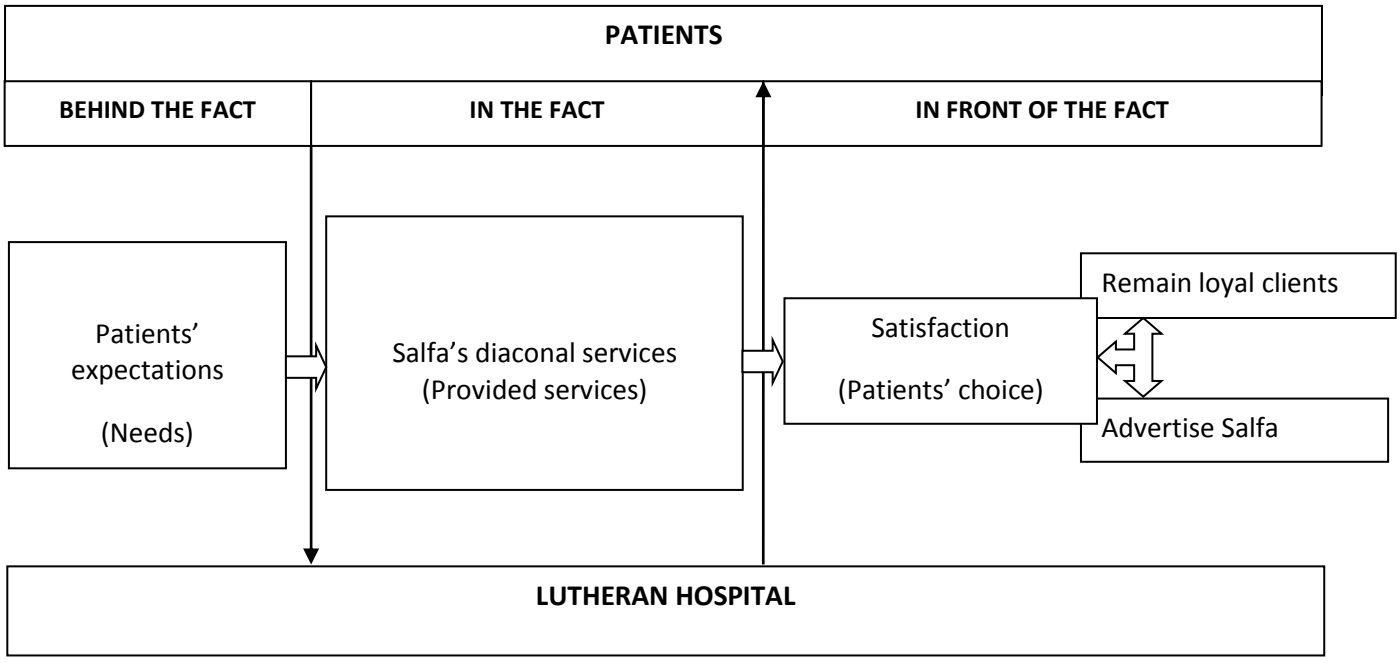

Figure 7: A helping representation of an imaginable scenario explaining approximately the first insight answering why customers come and remain loyal to the diaconal services at Salfa Majunga.

6.1.2 The quality of service expressing one of the main values in practice

Six distinctive attributes demonstrate the quality of the diaconal health services at Salfa: availability of material resources, good organization of time resources, competence of human resources, international standard of technical resources and relevance concerning informational resources. One has seen previously in chapter 4: theoretical framework, that according to the scholars Aadland and Matulayova (2011:11), the following assets activities, quality, people, and things which we see in everyday life, in the society, or at an organization are representing values. Once more this fact displays evidence of the values within the diaconal services at Salfa Majunga. Therefore those values are doubly confirmed now. Yet, are those 6 characteristics bonded to customers' choices enough to attribute the quality as its main values? Two possibilities for the answer might be found: yes and no. The IRHAP and RCT theories are being used in order to have an objective response.

In one circle, the "yes response" summarizes the expressions of the patients interviewed. According to the interviews, for them (patients) there is more to quality of service than to a diploma. Earlier in the general introduction, I have noticed that the health providers in the public facilities benefit more from the Government and international partners (unicef etc.) The incessant training may improve them both academically and in medical practice. The same happens in different sectors like in education for example. Even so, the most noteworthy insights that the patients illustrate in the interviews are the quality of the diaconal assets that involve the six preceding factors. The majority of them, based on the asset-based theory IRHAP, fulfil the particularities of the *diaconal tangible assets* described well by Nordstokke (Dietrich et al 2014). First of all, the availability of a dormitory for caretakers, new operation theatres, a new fence, a wonderful gardener, a new ambulance … reported in the data, fit into the group of *the material and structural resources* within a diaconal institution. Next, after the respondent FM1 lamented about one Physician who has used medical consultation as a fast and easy business of earning money, she portrayed the quality or value of her preferred doctor which corroborates rightly Nordstokke's description on human resources having a vocational practice led by Christian faith. Finally, if the good organization of resources and international standard on technical resources are a quality rejoining also this category of diaconal tangible assets, the ability to speak different Malagasy dialects, is another one. Though difficult to classify, for it is dealing with both

communication and relationships─between patients and health agents, it is part of the intangible diaconal assets of the chaplain service. One will come back to this later. The mistake on classifying assets doesn't really matter to our discussion, because IRHAP's theorists generalize that any kind of assets whether tangible or intangible are influential in the creation of values for a religious organization (ARHAP Report 2006:39). Customers are naturally attracted by the quality of great values, hence, my participants ended up choosing health diaconal services sustained by its religious assets (Nordstokke in Dietrich et al 2014). Over again, those customers needed rational thinking to evaluate such quality. For instance, the patient FP6 in choosing Salfa, who enjoyed so much the assurance from its staff of being able to have a conversation in his own language, acted rationally in order to satify his affectual enjoyment. This fact resonates with the *rational affectual* encountered in RCT (Norkus 2000).

In other circles, the answer may be no. The definition of quality in health care involves other dimension. From the working and universal definition given by World Health Organization that one has seen in Context chapter (rubric 2.1.6), there are a many other aspect to be considered before saying that a given Hospital is really of quality. Even if the 6 attributes we have seen above have been definitely taken into consideration by Salfa's staff (the qualification acceptable/patient-centered and equitable) , a good number of criteria (effective, accessible, safe and efficient) and areas need to be evaluated by a quantitative approach in order to determine the level of the quality of the health diaconal services within this Lutheran hospital. In this context the leaders should present a strategic plan, annual plan and daily logic framework that everyone (expert or patient) can have a look at. Because they show the required indicators related to quality of the accessibility and availability of health services (for example such hospital is supposed to have more than 100 beds, that is not the case there, there are less than 50 beds thre…), measurable quality of care to patients after their admission or their hospitalization ensuring continuity of care. To ensure the quality of health services one needs a monitoring system to measure the performance of the health system. Patient as well as staff need to know in which areas we achieve our goals and identify areas we need to improve.

The quality improvement is fully assessed if those patients perceptions in my findings would be completed by measures of standardized indicators which help to determine priorities

and measures which tracks the short, the mean and the long-term performance. Through collaboration and strong partners, with patients and MLC Headquartes

Therefore in my rational reasoning above, one does not have enough criteria to allow us in an objective way to say that the quality of services is a special value for this diaconal hospital. Further, in this context, it is expressing value only for the interviewed patients who cannot represent the whole client base.

6.1.3 The spiritual issue reflecting Christian values

The religious dimension enhances the image of the Lutheran Hospital in Majunga by expressing Christian faith in action. This aspect has arisen from the existence of the chaplain service in the hospital but a general picture given by the data depicts that many services there are imbued with Christian moral. And more than two thirds of my respondents mentioned they were influenced by this fact in their decision-making process when they chose a hospital. Considering the terms faith, belief, religion and the direct quotation from them (participants) such as "*blind trust*" (CP1) one wonders if all patients or their caretakers are actually applying rationality while making their choice. Certainly, there is a lack of objectivity in this section concerning the use of RCT. However, from IRHAP's perspective, chaplaincy activities and the religious practices inherent in it are comprised of intangible diaconal assets (Nordstokke cited in Dietrich et al 2014). Those patients are not erroneous in their perceptions about the diaconal services and the desirable behaviour of its staff, for the account raised from some IRHAP's studies has pointed out that such assets do not only mobilize, motivate and empower the employee working in diaconal agencies but also orients, guides and corrects them in the alignment of the needed health (Ibid). Moreover, if one refers to the simple definition of values cited earlier (rubric 1.8 Understanding of terms), those desirable behaviours in the midst of diaconal health caregivers are directly indicated as Christian values.

In addition, the Salfa's motto plays a powerful function in its reputation and image. Amazingly, my findings highlighted that Christian patients as well as non-Christians were impressed by it. The religious reasons that they could think of, are not so far from the following scholar's explanation. Generally, this slogan represents somehow the fourth of the four leading points (By grace alone, by faith alone, by Holy Scriptures alone) on Lutheran doctrine (McGrath 1999): By Jesus alone. This can be understood as only through His holistic

ministry namely preaching, healing, delivering and saving, individual sinner will be able to enter into fellowship with God (Ibid). Thus, if the choice of those patients in favour of Salfa is induced alike, this Christian approach is in line with Haugen's values description, emphasizing its influence in the workings of the organization (cited in Dietrich et al 2014).

However, Christian values are numerous (love, service, trust…), and one is looking for the specific ones attributed to Salfa's hospital. It is not worth it to select one or more on purpose without an unbiased approach. Then, up to this actual point of my discussion, still, the evidence of the existence of the values within Salfa's services is substantiated.

6.1.4 The two first identified values within the Lutheran diaconal services

Respect and trust are the two first values that have been identified by this research. The data collection method through interviews has displayed them more exclusively than the other preceding attributes like quality. Then the RCT and IRHAP's theories were used to objectively explain the phenomenon and to highlight the evidence-base of values within Salfa's services in Majunga. Yet, those theories did not sufficiently account for the identification and the disclosure of a particular value among others for this institution in question. Therefore, Aadaland's concept is called to play a role to mediate them. Accordingly, based on his model, respect and trust pertain to half-hidden values. First of all, they are unquestionably, values that are the patient's constructions of worth, being expressed by health care providers and services in an open or hidden way, through their language, behaviour and actions (Aadland and Matulayova 2011). Also those patients were using sources of self-awareness because they experienced the Salfa's hospital by using its services. Then, the understanding qualification hidden is thus both related to caregivers' sight and care receivers' perception. Aadland and Matulayova (Ibid) recommend the famous *Johari window* to lead us to get an insight of the categorization of hidden values through one's own analysis and that of others' need to observe us (Aadland and Matulayova 2011:34)

	Known internally	Unknown internally
Known externally	**Public**	**Blind**
Unknown externally	**Private**	**Unknown**

Figure 8: Johari window

According to this window the respect and trust are known by the clients─that is why they are attracted by them─but not the caregivers so they fit into the blind case and are truly half-hidden values.

6.1.4.1 The value respect:

The long narrative reported by the respondent the former patient, FM3, expresses the manifestation of the value respect by different employees. They are: receptionist with warm welcome, Doctors and nurses in *doing, talking, approaching patients, in general* show equal respect to everyone either rich people or those from rural area, convenient arrangement on paying hospitalization fee granted by accountant… Similarly, the Oxford dictionary defines respect as a real value encompassing in general the facts enumerated by this lady: "a feeling of admiration, polite behaviour towards or care for somebody/something that you think is important because of their good qualities or achievements". One of the qualities that patients have is his or her dignity. In this respect, Leape et al argue: "Honoring the patient's right and need to know everything that is relevant to his or her well-being is fundamental to doctoring and reflects respect for the doctored." (Leape et al 2012:848). Surely this lady was victim of disrespectful behaviour somewhere which would have been very harmful to her. Then at Salfa she felt the opposite, a respectful behaviour that lies at the basis of her hospital choice. Finally, for Salfa, the value respect should be fully expressed and maintained because it is highly essential for good patient care.

6.1.4.1 The value trust:

The value trust is the main reason behind the Muslim's preference for the Lutheran hospital in Majunga. This meaningful choice was the result of many tests checking the reliability of its status over time. With a careful and complete mapping of diaconal assets by

applying again IRHAP's concept, one would have discovered over time this second half-hidden core value of Salfa's services. For Nordstokke has found out that trust is part of intangible diaconal assets. His description resonates well the Muslim's case, as follows: trust is *the confidence […] leads […] patients, Muslim […], to believe in the capacity of diaconal services* (in Dietrich et al 2014:216).

Accordingly, in the literature another theorist proposes a relational explanation more rationally:

One party A trusts party B with respect to x (a specific domain of activity), when A believes that her interests are included in B's "utility function" such that B values what A desires because B wants to maintain a reputation for being trustworthy I the network of relations in which the A-B relation is embedded (Ritzer 2011:659).

The time is coming when the staff at Salfa will be aware of the existence and the importance of the value trust in luring customers. Then they should follow Ritzer's advice in order to keep it a reliable and stable value (Aadland 2011). He suggests that trust is a "belief that the trustee (to whom one trusts) will not take advantage of the vulnerability of the trustor (who trust)" (Ritzer 2011:659).

Health providers should not forget that the patients come bringing suffering, symptoms, the history of their illness linked to their personal life; this is already a sign of an incipient trust, looking forward to the kindness and competence of the caregiver. That necessitates a trustful staff.

6.2 The values "behind" the diaconal services provided by Salfa hospital

In this section the core values that we are going to identify are totally unknown, by both the patients and the staff at Lutheran Hospital in Majunga. Thus Aadaland's approach is the most suitable for their identification. According to Johari window, their whereabouts is in the case called "unknown". What Aadaland has advised us in the theory chapter as a solution to the exploration of those hidden values are SO-Model or the sense-making process. As I have announced, the second model will be profitable for my study, for it will extract them (hidden values) and their profound meanings from the patients' narratives or stories by a

hermeneutical study of expressions. For the basis I said formerly is that values; whether open or hidden, might be conveyed as derived from action patterns or as reflected in written or spoken expressions (Aadland and Matulayova 2011:34). As a result, I would say there are at least three expressions of values that could be revealed: hope, hospitality and Gospel in action.

6.2.1 The hidden value: hope

The hidden value hope can be revealed from patients' expressions. This term "hope" or its derivative "hopeful" are often times used by a number of my respondents: CP2, FP3, FP6 and FP5. In their narratives emphasizing that the Lutheran Hospital in Majunga remains their perfect choice, they expressed the verb hope in relation to an action showing an aspiration or feeling that the good outcomes of their last treatment would be at least the same for the next. Even though, nobody knows the way this coming or current treatment turns out, the feeling or the expectation is still subsisting. The FP5's saying: "customers… hope uncritically" assigns a confident responsibility for good humane patient care to Salfa's services. This explanation shows us clearly that hope is a desirable quality and behaviour─which is nothing but a value, expected with impatience by patients. In my point of view the trust at this point, concerns more or less organizational value rather than individual value. In this regard, Aadland (2010) views this value as "the products of relational interplay and as such more than the sum of individual values". All Salfa's staff must be conscious of this hidden value.

From another angle of view, here is an account from a Christian caregiver aware of the extent of the hope in healthcare, in her words:

Hope is defined as expectation, a feeling that what we want will happen, desire accompanied by expectation. It is opposite of hopeless, which is defined as impossible to solve, despair, detachment from the Holy Spirit (Claibourne 1997).

In her argument, hope guides us to a "light at the end of the tunnel" and induces belief in what can be…, helps us to reach for opportunity (Ibid). Following are Claiborne's suggestions for preserving this value hope:

- Forgiveness of self and others is a healthy step making room for future opportunites.

- Love! You can't give what you don't have;
- Laughter and a sense of humour are necessary skills to survive.
- Trust in God. Thy will be done! We cannot control the world, but we can control our reaction to it.
- Dreams are our visions of tomorrow and help keep us alive and filled with a joyful sense of mystery.
- Patience is a great teacher (Ibid).

The Salfa's staff, with the open value of hope, will then be the link to instilling hope in their patients who may be even hopeless. As a Christian, they could thus make place for a hopeful perspective in the mystery of what will happen about the coming outcome of the care. Concerning hope, the patient's choice depends mostly on what health providers are doing now, but even they attribute it to the future outcome of their treatment.

6.2.2 The hidden value hospitality

The recognition of the hidden value of hospitality is also made by sense-making of the framework of patients' expressions. Drawing on Oxford's definition, the concept hospitality which is a "friendly and generous behaviour or services that are provided by an organization for guests, customers, etc." is beyond doubt a value (Ravlin's definition of value cited by Meglino 1998:351). Again six of my participants have highlighted that at Salfa, even though they are customers they felt a "home-like" condition underlining good hospitality. First, CP1 believed that there is warmth in this Lutheran hospital and the personnel are "her brothers and sisters". Warmth is one main characteristic in a hospitable place. Then, FP1 and CP2 got into the habit of coming to seek health there. People are only in a habit in a place with which they are familiar. Habit and hospitality are "fellows". Finally, FM5 reported a countryman's feeling for this hospital, "they are treated like an owner and not stranger." Finally, FP6 insisted on the active role that the speaking of one's own language plays. This last expression is the most supportive of a hospitable hospital. These facts accurately confirm the truth of selecting hospitality as one of the Lutheran hospital' values.

In order to refute or prove what I have interpreted, let us consider the literature's version about hospitality. A term having its root from Latin *hospitalitas,*

hospitalis or'hospitable', *hospes*, *hospit* or 'host, guest' (Oxford dictionary). Hospes indicating thus one who receives the other, is a gesture of free hosting and welcome. The root word of hospital, hospitality and hotel is *hospes.* And for the hospital, it becomes a place for the care of the sick or places of healing. Healing aimed at the restoration of the body and the spirit (Jaynelle et al 2007). Florence Nightingale, is the pioneer on nursing and on revolutionizing the hospital's care for wounded soldiers in the Crimean War (Ibid). Hospitals propose to be safe places for care, so some changes are noticed now; consequently, hospitals seek to minimize the risk, make certain safety and encourage healing for care receivers and the care takers (Ibid). This hospitality concept is fundamental: Hospitality is an action of compensation for promoting equality, protection, in a world where the stranger does not have original place. One calls to fight against inequality of place and position between the two kinds of hosts: firstly the master is inside, he or she is the one who receives and secondly, the other comes from outside, it is passing and it is received (Jaynelle et al 2007). At Salfa, regardless of the customers' provenance, staffs perform patient-centred action. And the value hospitality was unconsciously part of them, but henceforth it must be become open for the two hosts who are partners forever. Initially (at the admission), there was a large gap between the caregiver and care receiver; but this gap can be bridged by a hospitable hospital whose staff gives a floor for equal treatment for all.

6.2.3 The hidden value faith in action

The patients' expressions provide a good number of clues to the detection of the hidden value faith in action. It is wise to usually start to have a look at definition of specific word and its meaning. In theological understanding (because we are talking about Christian faith-based hospital) the faith comes by hearing the Word of Christ (Romans 10:17) which is the Gospel. The Gospel designates the four books in the Bible explaining the life, teaching and mission of Jesus. Aiming to uncover the hidden value faith in action, the search of relevant expressions serving as clue remain crucial. If the term Gospel occurs two times the term faith six times. In view of that, let us consider some examples: FM2 pointed out that the external signs of the internal faith in God has been demonstrated by Salfa's staff in their work and environment. This relates the faith or the Gospel in practice. Maybe the clients are not

attracted by preaching but the outcome of the action of Christian worker led by faith. Second, FM1 put forward an idea confirming that the fear of God is manifested as the effect of the application of Gospel recommendation. This fear of God among Salfa's staff pleases God Himself but at the same time a desirable behaviour attracting customer's client too. Third, FP4 asserted that he needed a Christian Doctors and believer nurses for his eventual illness. Even this participant is not a believer, his clinic choice was caught by religious facilities, because in those centres health providers pray for the patient and the care, and this participant seems like believe in prayer fulfilment promised in the Gospel. Four, CP1, as a Lutheran Christian she may know more about faith and Gospel in action at a Lutheran organization then she was talking directly about Gospel root of health practice at Salfa. And five FP5, FP8 and MP4 were answering about the Salfa's slogan taken out from the Gospel of Luke. All those aspects with the chaplain service show us that this Lutheran hospital is formed, mobilized, motivated, empowered and sustained by the faith in Jesus which is the continuity of Jesus' action.

Actually what is Jesus' action? When Jesus journeys throughout of the cities of the Israel, He preached, taught and performed many healings. The healings among the signs performed by Him are in the Gospels. The Jesus' healings are numerous: the blind see, paralyzed rise,... yet, that's not all! Sinners are forgiven; men and women are restored to their dignity, like the Samaritan woman (John 4: 1-42). In Jesus, God comes to meet, heal and save mankind. The Church is pursuing His action by using its assets to heal bodies, hearts, relationships through the different organizations that belong to it. Salfa is an example for Malagasy Lutheran Church. Because He is always present: "And I am with you always until the end of the world" (Matthew 28, 20) all Christian are called to witness to Christ today by action (WCC and DIFAEM 2010). For Christian health services they are witnessing Jesus by their health care. In addition, from Christian understanding health is not only the absence of disease, it is this "fullness of life" which is a gift from God (Ibid).

Faith in action is simply Gospel in action which is diakonia (Dietrich 2014:4). What amazes me about this research is that more than 70% of the daily activity in this Lutheran Hospital is so clearly diaconal and neither employees nor customers have found this foundational value of it. They were talking only about some elements of Gospel in action but not the core value itself. Nevertheless, what is particularly striking and foremost concern in

diakonia is the action for poor and marginalized people. Thus, that is why diaconal service attaches more attention in such a circumstance. Its action deals with their needs according to the Christian concept stressing that all human beings were created in the image of God and are valued equally despite their societal class and race (Genesis 1:27; LWF 2013: 20). This explanation is suggestive to wonder if Salfa's patients who valued themselves as poor─they felt respected with the convenient way of paying fee, are really the poor in diaconal context. In accord to this, another fundamental core principle should be taken into consideration in diakonia, that is human dignity. Nordstokke, argues that the diaconal work from the local congregation should, in a flexible and open way, aim at lifting up this dignity (2011:44). Or in Salfa Majunga it seems that the household who can be able to afford the high price of hospitalization fee only are reported benefiting from its diaconal services. The patient victim of extreme poverty (World Bank definition) may be forgotten and openly excluded… In the past this lack which is an impediment in implementing the entire Gospel and faith in action might be due to the uncovered values. But timely now (core values are revealed) the Lutheran hospital is invited to be a real diaconal organization. Its leaders must think about this and propose a shorter, mean and long term plan for an action for the real poor patient even partially.

6.3 The values "in front of" the diaconal services provided by Salfa hospital

Such values are not identified from the findings. For the term in front is broader, the values I will analyse here are rather presented from the literature. However one powerful word revealed by two participants (FP3 and FM3) drew my attention. The term was injustices. By definition it refers to the fact of a situation being unfair and of people not being treated equally (Oxford dictionary). As I said there were no more details about what really happened but its meaning compared to the following more developed definition of diakonia warn all of us to take heed of the eventual risk, in other words, to prevent (an idiom says it is preferable to prevent than to treat). According to the Church of Norway diakonia is defined, as "the caring ministry of the Church. It is the Gospel in action and is expressed through loving your neighbor, creating inclusive communities, caring for creation and struggling for justice" (Church Council 2007: 5). Hence, the quality or value justice is of paramount importance for all diaconal Institutions. In my point of view this value endues the professional feature. And as such, if the leaders of the diaconal organization have adopted it as core value, it can

essentially operate certain functions called by Pattison et al *value-talk*: *legitimization action with organizational arrangements, coordination action, discipline action, justifying change in the* first time then *resistance to change* and finally *creation and consolidation identity* (2010:13-14).

In addition, here is an expression of one famous Diaconal hospital about its value justice:

Justice : We are to performed the services that the patients and their next to kin have the right to receive from us, and to speak out for the weak and vulnerable groups of society in order to assure that every individual receives what is their right to social and health services (Website of Diakonhjemmet Hospital Oslo).

Moreover LWF evokes awareness of all people involved to diaconal action, another link both to the current context (in front of the reality) and two values justice and hospitality. In its direct quotation: "it belongs to the mandate of prophetic diakonia to grant hospitality" (2009:33). What does prophetic diakonia mean, it is the a call inspired by Jesus and the prophets when they confronted those in power, for changes in unjust structures and practices (LWF 2009:81). The value justice is the of paramount importance for this hospital. Because if not the injustice could be itself a negative hidden value and especially if one cannot be able to discard it (Aadland and Matulayova 2011:39). However, transforming hidden positive value to open value can be achieved too (Ibid).

6.4 Chapter conclusion

This chapter highlighted the final result of my research. Six positive core values are now available for the Lutheran Hospital in Mahajanga: respect, trust, hope, hospitality, diakonia and justice. Salfa and even the Malagasy Lutheran Church Headquarters should pay close attention to their genuineness because they were extracted from the patients' witness. Such values have been shaped the direction of daily diaconal action of the hospital and could work better for the benefits of both its staff and its customers in the future. Some relevant idea for the future will be proposed in the final chapter.

CHAPTER SEVEN: FINAL CONCLUSION

7.0 Introduction

In this chapter, I present a summary of my findings from the research. Conclusions drawn from the data in regard to the advantage of values-in-use are also offered. At the end of the chapter, I will highlight suggestions for further research in this area for researchers who desire to improve skill, knowledge or to specialize in this particular subject.

7.1 Summary and findings

This master thesis has given an account of the exploration of the phenomena explaining the illogical choice, in opposition to the normal course in life, made by the patients who have consulted at the Lutheran hospital in Mahajanga─ the 'capital city of Malagasy Muslims' in the North-West part of Madagascar. The investigator was interested in finding out the identification of six hidden core values linked to the services there and associated with the main reasons of the phenomena. Twenty five respondents were interviewed, however nineteen were included in the exemplifying qualitative case study because of the NSD recommendation. The major data of the research were:

This study firstly revealed that the higher price of hospitalization fee doesn't matter for the customers. On the contrary, this fact constitutes one of the reasons why some are attracted to this preference, in spite of the poverty trap. It becomes clear that people put value in a high-priced service. In addition, five tangible assets related to the quality of services enhance the strengths and embellish the image of Salfa Majunga. They have been proved also as pull factors in patients' choices: accessibility of material resources, time well organized, competent human resources, international standards and relevant communication. The findings also supported the view that the spiritual dimension plays a leading role in a patient's choice.

This study points out that this Lutheran hospital has unknown potential besides Jesus' grace mentioned by the staff. The historial-hermeneutic qualitative study was very helpful in gaining an in-depth knowledge about this, as it may be behind, in, and in front of what was really occurring on the ground.

As a result, the specific factors that came up are two half-hidden core values: respect and trust, three hidden core values: hope, hospitality and diakonia and one more core value: justice, identified in front of the problematic.

Thus, if henceforth those values will be expressed and put as values-in-use for this hospital their functions will improve in the long-term. If the mobilisation of all resources, the empowerment, the coordination, the creation, the sustainability, are all consolidated within Salfa's identity it will be more attractive to customers. As the research shows, the attractiveness to these values was born from the patient's choice. If the diaconal hospital that has been running with hidden values caught patients' preferences, a diaconal hospital working with opened core values in use will even better catch patient's preferences.

Eventually this leads to dilemmas (Figure 9) and could be considered with close attention: firstly, should the Hospital Lutheran in Majunga continue to work with hidden core values or expressed values? For values which are expressed by customers (genuine) prevail more than formulated values. Secondly, should Salfa leave the standing high-priced hospital attracting many clients in order to reach the full status as diaconal health service providing free healthcare for the extremely poor people? Further study is needed for a rational choice for these dilemmas.

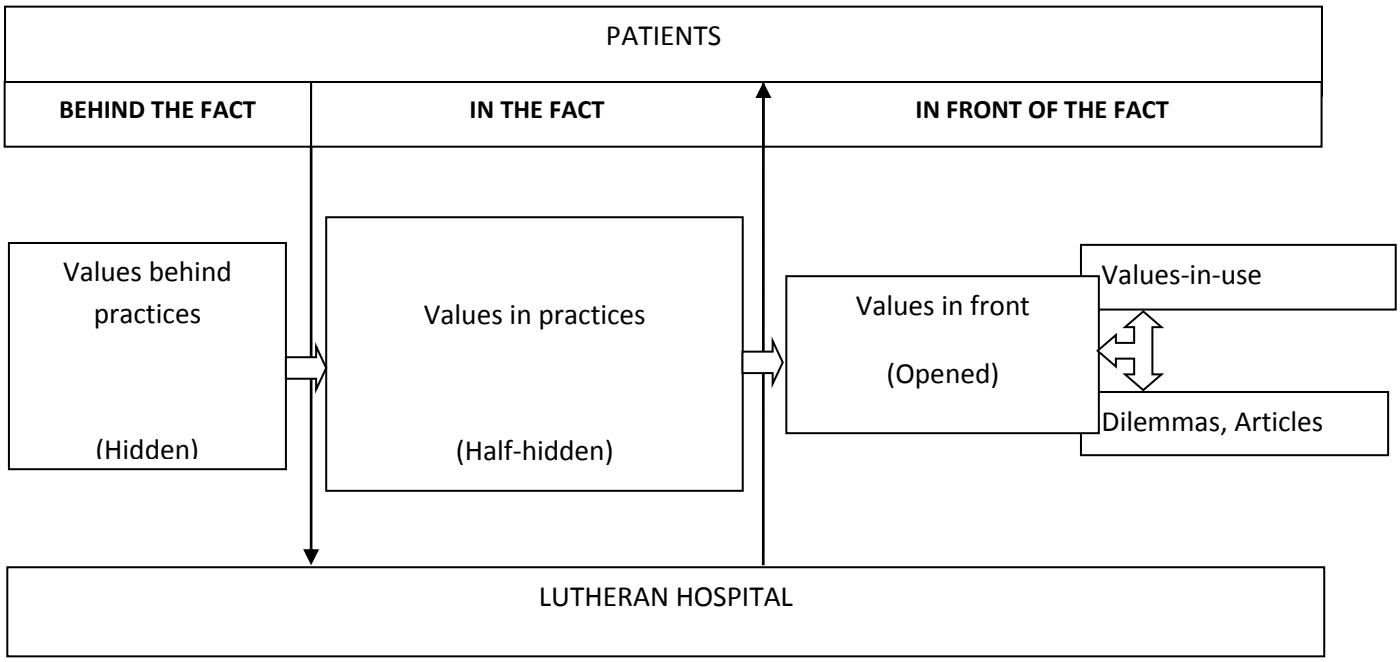

Figure 9: A helpful representation of the final tendency of this research

7.2 Further study

This area of study is really a specialty that requires development through a serious research project. A quantitative study with an observational method would be good to confirm the insights discovered by this qualitative approach. Another area of study could be to explore the evolution of the situation after putting to use these core values when the leaders of the hospital will choose to formulate them as expressed values.

BIBLIOGRAPHY AND WEBOGRAPHY

Aadland, E. (2010). Values in Professional Practice: Towards a Critical Reflective Methodology. *Journal of Business Ethics*. DOI 10.1007/s10551-010-0518-x. Diakonhjemmet UC.

Askeland, H. (2011). What do Diaconal Hospital Managers really do? *Diaconia*: Volume 2, Issue 2, pp. 145-169. DOI: 10.13109/diac.2011.2.2.145

ARHAP (2006). Appreciating Assets: The Contribution of Religion to Universal Access in Africa. *Report for the World Health Organization.* WHO HQ/05/148454, HQ/05/148467. Cape Town.

Bäckström, Anders, Grace Davie, Ninna Edgardh og Per Pettersson (red) (2011). *Welfare and religion in 21st century Europe, Volume 2, Gendered, religious and social change,* Ashgate, Farnham

Bennet S., Mc Pake B., Mills A. (1997), The Public/Private Mix Debate in Health Care?, in S. Bennett, B. Mc Pake, A. Mills (éd.), *Private Health Providers in Developing Sountries?: Serving the Public Interest?*, London & New Jersey, Zed Books.

Bergant, D. (1993). Biblical Hermeneutics of Liberation: Modes of Reading the Bible in the South African Context. *The Catholic Biblical Quarterly*, Vol.55(1)

Brinkmann, Svend et Steinar Kvale (2015). *InterViews. Learning the Craft of Qualitative Research Interviewing*. 3rd edition. Thousand Oaks, California. SAGE Publications.

Brinkmann, Svend et Steinar Kvale (2009). *InterViews. Learning the Craft of Qualitative Research Interviewing*. 2nd edition. Thousand Oaks, California. SAGE Publications.

Bryman, A. (2012), *Social Research Methods*, Fourth Edition. New York: Oxford University Press.

Claibourne, C. (1997). Hope in healthcare today. Creative Nursing. 10784535. Vol. 3, Issue 4. http://web.a.ebscohost.com/ehost/detail/detail?sid=d7e13e6c-f5ea-4c61-a596-21e6fb38f9d8%40sessionmgr4001&vid=1&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#AN=107261284&db=c8h (visited on 23/05/16)

Cochrane, J. R., Schmid, B., Cutts, T., (2011). *When Religion and Health Align*. Mobilising Religious Health Assets for Transformation. South Africa. Cluster Publications.

Coleman, J., S. (1990). *The Foundations of Social Theory*. UK. Cambridge

Creswell, J. W. (2014). *Research Design. Qualitative, Quantitative and Mixed Methods Approaches* (4th ed). London: Sage

CSB2 Sotema Antanimalandy (2015). Annual report

Dahl, Ø. (1999). *Meanings in Madagascar, Cases of Intercultural Communication* (1st ed). USA: Library of Congress Catalog

Dealey, C. (2005). Healthcare policy. The factors that influence patients' choice of hospital and treatment. British Journal of Nursing, 14(10)

Diakonhjemmet Sykehus. http://diakonhjemmetsykehus.no/#!/diakon/forside/om-sykehuset/brief-information-in-english/_1762 (visited on 24/05/16)

LWF (2009). Diakonia in context : transformation, reconciliation, empowerment. http://www.diakoni.nu/wp-content/uploads/2013/12/Diakonia-in-context-LWF-2009.pdf (visited 29/05/16)

Dietrich, S., Jørgensen, K., Korslien, K.K., Nordstokke, K. (2014). *Diakonia as Christian Social Practice: An Introduction*, Oxford: Regnum

Espedal, G. (2015) http://www.diakonhjemmet.no/DUC/Research/PhD-projects/Value-Based-Leadership-in-a-Diaconal-Health-Institution. (viewed 11th May 2015)

Eisenhardt K.M. (1989). Building Theories from Case Study Research. *Academy of Management Review*, vol. 14, (4).

Flyvbjerg. B., (2011). Ase study. The *Sage Handbook of Qualitative Research*. 4th Edition. Ch. 17

Holton, R. and Turner, B., S. (2010*). Max Weber on Economy and Society*. London. Routledge Revivals

INSTAT (2012) Institut National des statistiques Madagascar données: http://instat.mg/madagascar-en-chiffres-2016/ (visited on 09/03/2016)

Jaynelle F., Stichler, DNSc, RN, Fache. (2007). Is your Hospital Hospitable ? How physical environment influences patient safety. *Nursing for Women's Health*. AWHOON. http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=3271b75b-c92a-439b-a385-d42140558f5d%40sessionmgr4001&vid=1&hid=4212 (visited on 23/05/16)

Kien-hong Yu, P. (2011). *One-dot theory described, explained, inferred, justified, and applied.* New York: Springer

Kui-Son, C., (2004). The relationships among quality, value, satisfaction and behavioral intention in health care provider choice: A South Korean study. Journal of Business Research. Volume 57, Issue 8. Elsevier.

Leape, L. et al (2012). Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*. Vol. 87, No. 7

LWF (2013). https://www.lutheranworld.org/sites/default/files/LWF-Annual_Report-2013.pdf (visited on 23/05/16)

LWF (2009). Diakonia in context. Transformation, Reconciliation, Empowerment

McGrath, A., E., (1999). Christian theology. An introduction. 2nd edition. USA, Blackwell Publishers.

Malagasy Costitution. 4th Malagasy Republic: https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/87885/100324/F1780692018/Madagascar,%20Constitution%20de%20la%20IVe%20Republique%202010.pdf (visited on 07/03/2016)

Maleseviæ, S. (2002). *Rational choice theory and the sociology of ethnic relations: a critique. Ethnic & Racial Studies*. Mars, Vol. 25. Issue 2, 193-212. UK. Taylor & Francis

Meglino, B. M. and Ravlin, E. C. (1998). Individual Values in Organizations: Concepts, Controversies, and Research. Journal of Management, 24 (3):351-389. JAI Press.

Mohamed M. Mostafa, (2005). An empirical study of patients' expectations and satisfactions in Egyptian hospitals. International Journal of Health Care Quality Assurance, Vol. 18 Iss: 7,

Norkus, Z. (2000). *Max Weber Interpretive in Sociology and Rational Choice Approach. Rationality and Society.* Vol. 12 no 3.

NSD (2015). http://www.nsd.uib.no/personvern/en/notification_duty/meldeskjema?eng (Viewed 15 May 2015)

Pattison, S., Hannigan, B., Pill, R. and Thomas, H. (2010) *Emerging Values in Health Care*. The challenge for professionals. 1st Edition. London and Philadelphie: Jessica Kingsley Publishers

Pew Research Center (2014): Global Christianity: http://www.pewforum.org/interactives/global-christianity/#/Madagascar,ALL (visited 08/03/2016)

Rasmussen, Lissi (red.) (2007): Bridges Instead of Walls. Christian-Muslim Interaction in Denmark, Indonesia and Nigeria. Lutheran University press US and the Lutheran World Federation Geneva

Ritzer G., Ryan, J. M. (2011). *The Concise Encyclopedia of Sociology*. Chichester UK. Blackwell publishing.

Saeed KS, B., (1998), Factors affecting patient's choice of hospitals. Annals of Saudi Medicine, 18(5):420-424

SALFA (2011). Annual Report to Global Health Ministry USA.

SALFA (2014). Annual Report.

SALFA Antanimalandy (2015). Annual report

Scherer, A. G. (2003). Modes of Explanation in Organizational Theory, in H. Tsoukas and C. Knudsen (eds.). *The Oxford Handbook of Organizational Theory Oxford*. Oxford University Press,).

Scott, J. (1999) *Rational Choice Theory*. Browning, G., Halcli, A., Webster F. (1999). Understanding Contemporary Society: Theories of the Present.

Singh, K. (2007). *Quantitative Social Research Methods*. London: Sage. (pp. 62-75, 76-86, 122-125, 134-138, 142-147, 152-156, 338-340)

Smeltzer L.R., Zener M.F. (1992). Development of a Mode1 for Announcing Major Layoffs. *Croup and Organization Management*, Vol. 17, (4), Dec.

The Holy Bible.

The Oxford Dictionary

UNDP (2014). http://hdr.undp.org/fr/content/table-1-human-development-index-and-its-components (viewed 11th May 2015)

Unicef Madagascar (2014) : http://www.unicef.org/madagascar/fr/health.html (visited on 07/03/2016)

WCC. (2013) Report from WCC 10th Assembly in Busan, South Korea.

WCC, DIFAEM (2010). Witnessing to Christ today. Promoting health and wholeness for all. Germany. EKHN.

Weber, M. with Editors Roth, G. and Wittich C. (1978). *Economy and Society: An Outline of Interpretive Sociology.* Ed. Reprinted and revised. US. University of California press.

WHO (2006). Quality of care: a process for making strategic choices in health systems. http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf (viewed on 23/05/16)

Yin R.K. (1984). Case Study Research. Design and Methods. London, Sage Publications.

Annex 1

INTERVIEW GUIDE QUESTIONS FOR A RESEARCH ON MASTER PROGRAM "DIAKONIA AND CHRISTIAN SOCIAL PRACTICE" AT DIAKONHJEMMET UNIVERSITY COLLEGE NORWAY- OSLO

Supervisor : Professor Kjell NORDSTOKKE.

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The researcher's name : NASOLONIAINA Rivosoa

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Research site : Majunga (Madagascar)

Title of the research : "Hidden core values linked to diaconal services within lutheran health department in the North West part of Madagascar (Majunga)".

GENERAL OBJECTIVE:

To identify the evidence based of core values associated with diaconal health services in poor country.

OBJECTIVE OF THIS GUIDE:

To help the researcher in gathering the target people's opinions on the reasons of their choice for Lutheran clinic (as their favourite hospital when they get sick).

RESEARCH QUESTION:

Why do the diaconal services in the Lutheran health institution in Majunga, in terms of seeking health, attract the choice of native inhabitants and foreigners?

QUESTIONS:

1. **Generally, when you or a member of your closest relatives in your family or one of your best friends is sick, do you prefer to consult in Public or Lutheran clinic?**

2. **Could you give me any specific reason why you choose one of the hospitals to the other (Lutheran or public) and don't prefer the other?**

3. **You chose the Lutheran hospital, where people are queuing, and have to pay for consultation fee as well as medical bills. Knowing that life is expensive, how do you explain the reason for spending more on health services in the Lutheran Hospital, whereas the cost of consultation is free in public hospitals?**

4. **You have visited both the Lutheran and Public institutions; can you tell what happened during your hospitalization at the Lutheran hospital with respect to the qualities and values of health services provided that differentiate it from other facilities?**

5. **Services and personnel are connected, what are your impressions on the Lutheran medical staff and their values vis-à-vis equal treatment, rights, dignity and so on, during your medical examinations?**

6. **From your own view point as a Muslim, do you have different levels of trust in the staff of different hospitals? If so, why?**

7. **How can you scale the Lutheran clinic's approaches on health and healing?**

8. **Besides the healthcare services, as a faith-based institution, this hospital has a chaplain service that emphasizes its slogan "We treat, Jesus heals" by daily preaching and counseling for patients (and caretaker) in need. As one of the loyal customers of this Christian facility, what is your impression?**

9. **Values are of paramount importance both to the personnel and customers; to what extent can you assess the church's approach to health and the patients' choice based on their (patients) expression?**

10. **What are your suggestions about personal and institutional values that could make a Christian hospital working in a poor country like Madagascar better?**