

## Potential risks to SPs and participants and mitigation strategies

Risk to SPs	Mitigation strategy applied		Risk to Doctors	Mitigation strategy applied	
	During study design	During data collection		During study design	During data collection
Diagnosis of undetected disease by the study participants	<ul style="list-style-type: none"> <li>Screening and recruitment of healthy fieldworkers</li> </ul>	<ul style="list-style-type: none"> <li>Build a general environment on mutual trust, and reassure SPs regularly</li> <li>In case of diagnosis, supervisors and research team double-check the circumstances in which the diagnosis was told and get the SPs to be consulted by a second doctor</li> </ul>	Deception	<ul style="list-style-type: none"> <li>Ethical approval obtained</li> <li>government authorizations and local authorities' permission and support,</li> <li>participants Informed consent</li> </ul>	a. Verify all SP visits done to previously consenting providers
Exposure to injections, X-rays, or drugs ingestion	<ul style="list-style-type: none"> <li>Selection of case requiring low exposure</li> <li>As discussed with the local experts, no expectation of potentially harmful or invasive care such as hospitalisation with acute bronchitis. SPs might however in rare instances be offered a X-ray or an injection</li> <li>We identified facilities and GP clinics that have X-ray equipment and could potentially expose our SPs to X-rays. SPs were warned and reminded before visits with specific strategies to avoid such risk</li> </ul>	<ul style="list-style-type: none"> <li>As a last resort, reveal SP identity</li> </ul>	Data identification	<ul style="list-style-type: none"> <li>Obtain: National Instance for protection of private data INPDP permission</li> <li>Confidentiality agreements (to protect and never disclose any aspects of the research and providers information) signed by all the fieldwork team</li> <li>Anonymisation with ID codes for data management and analysis</li> </ul>	b. Paper questionnaires, prescriptions, sick notes, and any drugs given free of charge are collected within an hour by the supervisors and handed to the research team the same day

	<ul style="list-style-type: none"> <li>• Training to avoid them. To be assertive and yet remain realistic and not raise suspicion when rejecting, we designed several roleplays and mock consultations specifically to this goal during training</li> </ul>			<ul style="list-style-type: none"> <li>• Analysis at the aggregate level</li> </ul>	
Fatigue or anxiety	<ul style="list-style-type: none"> <li>• Selection of simple case not requiring difficult clinical signs to simulate or put systematically the SP in stressful situations</li> <li>• Recruitment and selection of appropriate SP profile, particularly able to manage unpredictability and motivated by the task</li> <li>• Extensive training to raise SP confidence and comfort with the case and the role</li> </ul>	<ul style="list-style-type: none"> <li>• Daily and rigorous monitoring and follow-up by supervisors and research team</li> <li>• Reassure, adjust with additional training and if needed terminate the SP job</li> </ul>	Increased risk to "real" patients consulting the doctor	<ul style="list-style-type: none"> <li>• Time and patient loads: Both public and private providers are paid for the SP consultation as any "real" consultation. In the pilot, average consultation time was XX in the public and YY in the private, which is overall a limited time.</li> </ul>	c. In case of serious emergency with real patients, SPs were instructed to step aside
Detection	<ul style="list-style-type: none"> <li>• Selection of the case with clinical signs easy to simulate</li> <li>• Extensive training with role plays and piloting to make SPs comfortable when simulating the case and familiar with their background story</li> <li>• Particular training sessions and role plays dedicated to the detection theme with various profiles of suspicious providers</li> </ul>	<ul style="list-style-type: none"> <li>• Fieldworkers have copies of ethical approvals and authorization letters in case of detection during visits</li> <li>• Supervisors keep copies of all the consents of the scheduled facilities and GP clinics to be visited on every particular day of data collection. Supervisors were geographically near the locations of facilities and GP clinics, so they can join rapidly the SPs if needed</li> </ul>	Unnecessary anxiety	<ul style="list-style-type: none"> <li>• The case chosen is mild</li> <li>• According to local experts, in the local context of care, the case does not trigger particular stress at the doctor level</li> </ul>	N/A

<p>Hostile behaviour (harassment or abuse) due to detection</p>	<ul style="list-style-type: none"> <li>• Ethical approvals obtained</li> <li>• Letters of authorization from MoH and regional health directorates obtained and sent to public facilities</li> <li>• Consent obtained from all the heads of the public facilities to be visited by SPs</li> <li>• Individual informed consent obtained from all private GPs to be visited by SPs and Information letter shared by the National medical council with GPs</li> </ul>	<ul style="list-style-type: none"> <li>• Fieldworkers have copies of ethical approvals and authorization letters if they are revealed and need to show them</li> <li>• Supervisors keep copies of all the consents of the scheduled facilities and GP clinics to be visited on every particular day of data collection. Supervisors were geographically near the locations of facilities and GP clinics, so they can join rapidly the SPs if needed</li> </ul>			
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