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Experiences of conditional and unconditional cash transfers intended for improving health outcomes and health service use: a qualitative evidence synthesis (Review)

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[Qualitative Review]

Experiences of conditional and unconditional cash transfers intended for improving health outcomes and health service use: a qualitative evidence synthesis

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ABSTRACT

Background

It is well known that poverty is associated with ill health and that ill health can result in direct and indirect costs that can perpetuate poverty. Social protection, which includes policies and programmes intended to prevent and reduce poverty in times of ill health, could be one way to break this vicious cycle. Social protection, particularly cash transfers, also has the potential to promote healthier behaviours, including healthcare seeking. Although social protection, particularly conditional and unconditional cash transfers, has been widely studied, it is not well known how recipients experience social protection interventions, and what unintended effects such interventions can cause.

Objectives

The aim of this review was to explore how conditional and unconditional cash transfer social protection interventions with a health outcome are experienced and perceived by their recipients.

Search methods

We searched Epistemonikos, MEDLINE, CINAHL, Social Services Abstracts, Global Index Medicus, Scopus, AnthroSource and EconLit from the start of the database to 5 June 2020. We combined this with reference checking, citation searching, grey literature and contact with authors to identify additional studies. We reran all strategies in July 2022, and the new studies are awaiting classification.

Selection criteria

We included primary studies, using qualitative methods or mixed-methods studies with qualitative research reporting on recipients' experiences of cash transfer interventions where health outcomes were evaluated. Recipients could be adult patients of healthcare services, the general adult population as recipients of cash targeted at themselves or directed at children. Studies could be evaluated on any mental or physical health condition or cash transfer mechanism. Studies could come from any country and be in any language. Two authors independently selected studies.

Data collection and analysis

We used a multistep purposive sampling framework for selecting studies, starting with geographical representation, followed by health condition, and richness of data. Key data were extracted by the authors into Excel. Methodological limitations were assessed independently using the Critical Appraisal Skills Programme (CASP) criteria by two authors. Data were synthesised using meta-ethnography, and confidence in findings was assessed using the Confidence in the Evidence from Reviews of Qualitative research (GRADE-CERQual) approach.

Main results

We included 127 studies in the review and sampled 41 of these studies for our analysis. Thirty-two further studies were found after the updated search on 5 July 2022 and are awaiting classification. The sampled studies were from 24 different countries: 17 studies were from the African region, seven were from the region of the Americas, seven were from the European region, six were from the South-East Asian region, three from the Western Pacific region and one study was multiregional, covering both the African and the Eastern Mediterranean regions. These studies primarily explored the views and experiences of cash transfer recipients with different health conditions, such as infectious diseases, disabilities and long-term illnesses, sexual and reproductive health, and maternal and child health. Our GRADE-CERQual assessment indicated we had mainly moderate- and high-confidence findings. We found that recipients perceived the cash transfers as necessary and helpful for immediate needs and, in some cases, helpful for longer-term benefits. However, across conditional and unconditional programmes, recipients often felt that the amount given was too little in relation to their total needs. They also felt that the cash alone was not enough to change their behaviour and, to change behaviour, additional types of support would be required. The cash transfer was reported to have important effects on empowerment, autonomy and agency, but also in some settings, recipients experienced pressure from family or programme staff on cash usage. The cash transfer was reported to improve social cohesion and reduce intrahousehold tension. However, in settings where some received the cash and others did not, the lack of an equal approach caused tension, suspicion and conflict. Recipients also reported stigma in terms of cash transfer programme assessment processes and eligibility, as well as inappropriate eligibility processes. Across settings, recipients experienced barriers in accessing the cash transfer programme, and some refused or were hesitant to receive the cash. Some recipients found cash transfer programmes more acceptable when they agreed with the programme's goals and processes.

Authors' conclusions

Our findings highlight the impact of the sociocultural context on the functioning and interaction between the individual, family and cash transfer programmes. Even where the goals of a cash transfer programme are explicitly health-related, the outcomes may be far broader than health alone and may include, for example, reduced stigma, empowerment and increased agency of the individual. When measuring programme outcomes, therefore, these broader impacts could be considered for understanding the health and well-being benefits of cash transfers.

PLAIN LANGUAGE SUMMARY

Experiences and perceptions of cash transfers for health

What is the aim of this synthesis?

The aim of this Cochrane qualitative evidence synthesis was to explore how people receiving health-related conditional or unconditional cash transfers experienced them. We analysed 41 qualitative studies to answer this question.

Key messages

People appreciate cash transfers and see them as necessary for their basic needs. However, cash transfers can influence people's relationships in positive and negative ways. Not all people want to receive cash and some recipients do not perceive that cash alone will be enough to change their health behaviour.

What was studied in this synthesis?

Conditional and unconditional cash transfer programmes are found across the world. A conditional cash transfer is money (cash) that is given to people if they behave in a certain way. For example, parents could receive cash if they take their children to a health centre. An unconditional cash transfer is money that is given without any conditions or rules about its use. In some settings, people receive cash transfers through government programmes. In other settings, cash transfers are mainly given through non-governmental organisations or

research projects. Many of these programmes aim to improve people's health, but research measuring the effect of these programmes on health shows mixed results. We, therefore, wanted to explore how people experienced these programmes.

What are the main findings?

We included 127 studies in the review and sampled 41 of these studies for our analysis. Thirty-two further studies were found after the updated search on 5 July 2022 and are awaiting classification. The sampled studies were from 24 different countries, across all World Health Organization regions. These studies primarily explored the views and experiences of cash transfer recipients with different health conditions, such as infectious diseases, disabilities and long-term illnesses, sexual and reproductive health, and maternal and child health. We had mainly moderate-to-high confidence in our findings. We found that people receiving the cash transfers saw them as necessary. They described the cash as helpful in the short term, and sometimes in the long term. However, people often felt that the amount given was too little to meet their needs. They also felt that the cash alone was not enough to change their behaviour and that they also needed other types of support, such as social or psychological support or training and opportunities for employment. People described how the cash empowered them and made them more independent, especially women and people with disabilities. In some settings, people experienced pressure from family or programme staff on how to use cash. People described how the cash had improved their relationships with their families and the community. However, in communities where some received the cash and others did not, this could also cause tension, suspicion and conflict. Some people also described being stigmatised for receiving cash transfers. While people often experienced barriers to accessing cash, some refused or were hesitant to receive the cash. Some recipients found cash transfer programmes more acceptable when they agreed with programme goals and processes.

How up-to-date is this synthesis?

We searched for studies published before 5 June 2020. The search was rerun in July 2022 and an additional 32 studies are awaiting classification.

SUMMARY OF FINDINGS

Summary of findings 1. Summary of review findings

Review finding	Studies contributing to the review finding	GRADE-CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
Theme 1. Perceptions of the cash transfer itself			
1. Recipients perceived the cash transfer as necessary and helpful for the immediate needs of the household, across all types of cash transfer programmes. They reported sharing their cash with their household out of duty, necessity or solidarity. Recipients were able to subsist on the cash transfer and provide for their families by purchasing day-to-day items and paying for living costs, meeting their immediate needs	Adato 2000a; Baba-Ari 2018; Balen 2018; Banda 2019; Baral 2014; Gewurtz 2019; Holler 2020; Khoza 2018; Miller 2012; Owusu-Addo 2020; Samuels 2016; Shefer 2016; Struthers 2019; Wamoyi 2020; Wei 2009; Woolgar 2014; Yeboah 2016; Yildirim 2014	High confidence	Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
2. Recipients across all types of programmes thought the cash amount was insufficient, as it only covered immediate but not all basic needs. In some cases, it was insufficient to cover the intended purposes of the programme	Adato 2000a; Baba-Ari 2018; Balen 2018; Baral 2014; Gram 2019; Holler 2020; Kelly 2019; Khoza 2018; Miller 2012; Nirgude 2019; Owusu-Addo 2020; Samuels 2016; Shefer 2016; Skovdal 2014; Stoner 2020; Struthers 2019; Tolley 2018; Wei 2009	High confidence	Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
3. Recipients, primarily participating in CCT programmes, felt that the cash transfer was not enough to change their behaviour. However, perceptions differed amongst recipients from 3 CCT studies, who considered cash as the main driver or a mediator for changing health behaviours	Baba-Ari 2018; Hikuroa 2017; Kelly 2019; Sidney 2016; Tolley 2018; Wei 2009; Woolgar 2014; Yeboah 2016; Yin 2018	Moderate confidence	Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Minor concerns regarding adequacy, and Minor concerns regarding relevance
Theme 2: Perceptions of the personal and social outcomes of the cash transfer			
4. Recipients thought that the cash transfer resulted in positive short- and long-term outcomes for them and their families in terms of better health, well-being and education. Some also thought that the programme provided the possibility to save or invest in productive activities	Adato 2000a; Balen 2018; Banda 2019; Baral 2014; Beskin 2019; Cooper 2017; Czaicki 2017; Hikuroa 2017; Khoza 2018; MacPhail 2013; Miller 2012; Owusu-Addo 2020; Samuels 2016; Stoner 2020; Struthers 2019; Tolley 2018; Thomson 2014; Wamoyi 2020; Woolgar 2014; Yeboah 2016; Yildirim 2014	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance

5. Across all types of programmes, the cash transfer was perceived to enhance the empowerment, autonomy and/or agency of recipients. Especially amongst women, empowerment and agency were reported through a feeling of security, better social relationships and enhanced decision-making power in households or with sexual partners. Women, adolescents, and people with disabilities felt that the cash gave them more autonomy, as it allowed them to become more independent and contribute to the household	Adato 2000a; Banda 2019; Cooper 2017; Garthwaite 2015; Gram 2019; Kelly 2019; Khoza 2018; MacPhail 2013; Plagerson 2011; Samuels 2016; Skovdal 2014; Stoner 2020; Struthers 2019; Thomson 2014; Ukwaja 2017; Yildirim 2014	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
6. Increased feelings of hope and resilience to overcome adverse life situations were observed especially within vulnerable groups and among people with HIV, tuberculosis or a long-term illness. Recipients' feelings of hope for a better life and the future motivated some of them to change their health behaviours. These feelings of hope came from the security, improved self-esteem and social status given by the cash	Baral 2014; Owusu-Addo 2020; Samuels 2016; Shefer 2016; Woolgar 2014	Moderate confidence	Moderate concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance
7. The cash transfer enhanced social cohesion and social capital building. Recipients reported feeling more connected to their community and uncomfortable about the exclusion of others from the programme. The cash transfer was also seen to lead to better family relationships and decreased levels of violence and stress in the household	Adato 2000a; Banda 2019; Khoza 2018; Miller 2012; Owusu-Addo 2020; Samuels 2016; Thomson 2014; Wamoyi 2020; Yildirim 2014	Moderate confidence	Minor concerns regarding methodological limitations, Minor concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance
8. Stigma was reported by recipients across all types of programmes, especially by people with a disability, mental disorders or long-term illnesses. Perceived stigma was often related to feelings of embarrassment and shame from being a cash transfer claimant or recipient. They also reported these feelings in relation to their illness and poor treatment by programme or medical assessors. Some recipients internalised the stigmatised identity imposed on them	Balen 2018; Banda 2019; De Wolfe 2012; Garthwaite 2015; Holler 2020; Jongbloed 1998; MacPhail 2013; Miller 2012; Plagerson 2011; Ploetner 2020; Samuels 2016; Shefer 2016; Thomson 2014; Woolgar 2014; Yin 2018	High confidence	No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
Theme 3: Perceptions of interaction with the cash transfer programme			
9. Recipients, mainly those with disabilities, long-term illnesses or mental disorders, reported that the eligibility process was inappropriate due to restricted or incongruous criteria. They also reported that assessment processes were not suitable for people with disability and mental disorders. The method for choosing the recipients was also considered unfair	Adato 2000a; Balen 2018; Banks 2019a; Beskin 2019; Garthwaite 2015; Holler 2020; Jongbloed 1998; Khoza 2018; MacPhail 2013; Ploetner 2020; Shefer 2016; Thomson 2014; Wei 2009; Yeboah 2016	High confidence	Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
10. Pressure, control, monitoring or restriction of the cash transfer used by those close to the recipients was observed across all types of programmes, especially among female recipients, who reported feelings of powerlessness. Pressure from the programme staff was also reported,	Balen 2018; Gram 2019; Kelly 2019; Khoza 2018; MacPhail 2013; Samuels 2016; Sidney 2016; Wamoyi 2020	Moderate confidence	Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding ade-

either as corruption or "enforced recommendation"			quacy, and Minor concerns regarding relevance
11. Social division, exclusion and isolation were commonly seen between recipients and non-recipients, sometimes associated with jealousy, envy and resentment	Adato 2000a; MacPhail 2013; Miller 2012; Owusu-Addo 2020; Samuels 2016; Thomson 2014	High confidence	Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
12. Recipients, especially people with disabilities, reported facing different types of barriers in receiving or accessing the cash transfer, including financial, knowledge, material and physical barriers. They reported complicated and cumbersome application or appeal processes and delays in receiving the cash, which led to stress	Arkorful 2020; Baba-Ari 2018; Balen 2018; Banks 2019a; Banks 2019b; De Wolfe 2012; Gewurtz 2019; Holler 2020; Kelly 2019; Nirgude 2019; Owusu-Addo 2020; Plagerson 2011; Ploetner 2020; Shefer 2016; Sidney 2016; Struthers 2019; Ukwaja 2017; Wei 2009; Yeboah 2016; Yildirim 2014	Moderate confidence	Minor concerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance
13. Recipients' participation in and perspectives of the programme were perceived by the studies' authors as necessary for its acceptability and effectiveness. CCT programmes that were sensitive to recipients' needs and had easy-to-understand, non-punitive and fair conditions were reported by recipients as more acceptable	Hikuroa 2017; Holler 2020; MacPhail 2013; Owusu-Addo 2020; Ploetner 2020; Skovdal 2014; Yin 2018	Low confidence	Minor concerns regarding methodological limitations, Serious concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance
14. Refusal or hesitancy in relation to receiving or applying for the cash transfer was seen in some cases to be motivated by distrust in the government or the programme and negative interactions with the programme staff. Personal circumstances relating to hesitance in applying for cash transfers included lack of motivation, competing demands and internalisation of the stigmatised identity of being 'lazy', mostly by people with mental illnesses	Baba-Ari 2018; Gewurtz 2019; Nirgude 2019; Plagerson 2011; Struthers 2019	Moderate confidence	Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance
15. Recipients found the programme more acceptable when they agreed with its goals and processes and also perceived advantages in being enrolled. They accepted the programme more readily when it was easily accessed and clear information was provided. This positive perception also contributed to recipients feeling satisfied and appreciative, which further enhanced acceptance of the programmes	Banda 2019; Khoza 2018; MacPhail 2013; Nirgude 2019; Samuels 2016; Skovdal 2014; Struthers 2019	Moderate confidence	No/Very minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance

CCT: conditional cash transfers
GRADE-CERQual: Confidence in the Evidence from Reviews of Qualitative Research

BACKGROUND

There is strong evidence that poverty is a key determinant of ill health (Marmot 2005). Moreover, both ill health and healthcare seeking are associated with negative socioeconomic consequences, such as direct out-of-pocket payments, and indirect costs, such as income and productivity losses (Lönnroth 2014; Wingfield 2014). This cyclical relationship can perpetuate or deepen situations of poverty and cause further adverse health events (Braveman 2003).

Social protection, understood as a set of policies and programmes aiming to prevent and reduce poverty and vulnerability throughout the life course (ILO 2021) is a way to counter this. Social protection can contribute to achieving the Sustainable Development Goals including ending poverty and striving for better health for all (Carter 2018; Zembe-Mkabile 2015).

Cash transfers are a form of social protection and have been highlighted as one possible way to counter the negative socioeconomic implications of ill health and healthcare seeking (Sidney 2016). Cash transfers can be part of formal social protection or social assistance approaches, or can be standalone interventions, through conditional or unconditional schemes (Wingfield 2016). Conditional cash transfers are payments given with a condition attached, for example, school attendance (Marshall 2014). Unconditional cash transfers are payments given without conditions or required action, such as the universal child grant (Handa 2015). 'Cash-plus' interventions combine a cash transfer with another intervention, which can be information or education, access to services or case management (Roelen 2017).

When employed for improving health service use or health outcomes, cash transfers can provide an economic incentive or enabler to attend healthcare services (Lutge 2015), or a supplement to help address the direct or indirect costs of treatment (Wingfield 2017). There has been increased attention to the complementary role that cash transfers could play to Universal Health Coverage (UHC) and financial risk protection, where only essential medical costs are usually covered (Lönnroth 2014). Cash transfers have also shown positive effects on poverty-driven diseases, such as tuberculosis (TB). Cash transfer programmes have been associated with contributing to reduced TB incidence (Nery 2017) and mitigating the catastrophic costs of TB in line with the World Health Organization's (WHO) End TB Strategy goal of “zero TB-affected families incurring catastrophic costs by 2035” (Uplekar 2015).

More recently, with the acknowledgement of the benefits of cash transfers combined with other interventions, such as psychosocial support or educational sessions, there has been an increasing development of cash-plus approaches, such as integrated human immunodeficiency virus (HIV) care and maternal healthcare with cash transfers (Cluver 2014 and Harris-Fry 2018, respectively). This has become a key discussion point, as cash transfers reportedly have an effect on other non-health-related outcomes (Austrian 2021) and the effect of even conditional cash transfers has been reported to be modest (Adato 2011). Cash-plus strategies have been suggested as one possible way to amplify the positive impacts of cash transfer programmes on health (Harris-Fry 2018).

Description of the topic

In this review, we included both conditional and unconditional cash transfers as well as cash-plus interventions that could include either a conditional or unconditional cash transfer. We defined unconditional cash transfers (UCT) as non-contributory monetary payments to individuals by governmental, international or non-governmental organisations to help them meet minimum consumption needs (Garcia 2012). We defined conditional cash transfers (CCT) as similar non-contributory monetary payments to individuals subject to the condition that they comply with specific requirements, e.g. payment dependent on children attending school or attendance for health care (Shibuya 2008). 'Non-contributory' in this instance refers to cash payments, which are not a form of insurance and do not require a partial payment or deposit by an individual to receive them now or in the future. We defined cash-plus interventions as interventions in which cash is provided in combination with an additional form of intervention, for example, education (Roelen 2017) or health services.

We included cash transfers targeted for improving health or health behaviours or that were assessed for health outcomes. While we recognise the larger effects that cash transfer programmes can have on the Sustainable Development Goals, economies at large and general well-being, our review was limited to examining the impact of cash transfers on the health and well-being of individuals.

How the intervention might work

There is evidence that cash transfers can improve adherence to treatment, health-seeking behaviour (Chaturvedi 2015), vaccination rates (Carvalho 2014), and health outcomes including TB treatment completion and cure (Torrens 2015). UHC will contribute towards eliminating the direct costs of medical care (UHC 2030 International Health Partnership 2017), but more than that is needed to cover non-medical direct costs (e.g. food and transport) and indirect costs such as income loss due to illness, disability and healthcare use (Lönnroth 2014). Without such supplements to household income, long-term diseases requiring frequent clinic attendance can push low-income patients into further poverty (Munro 2007).

Non-attendance at clinic appointments occurs for many reasons, for example, not being able to afford time off work or lack of affordable transportation to the clinic. On the other hand, individuals may lack the incentive to attend clinic appointments or preventive care, such as antenatal visits or vaccination appointments. In this sense, UCT and CCT intervention types have different pathways to achieve outcomes.

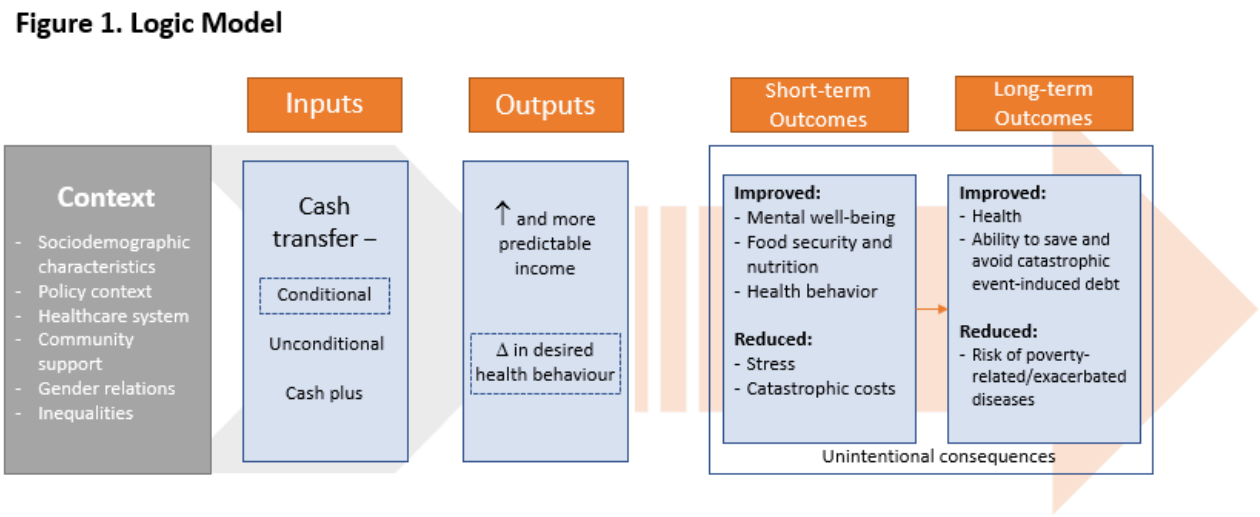
This review aims to contribute to the literature on cash transfers by examining the pathways and conceptualisation of how the interventions work. Important to consider here is how the programme conceptualisation may affect recipients' experience. For conditional cash transfers, the pathway to impact could be conceptualised, for example, using the 'nudge' theory (Thaler 2009), which posits that individuals sometimes make bad choices, and should be 'nudged' towards better ones. The approach has been adopted in many settings as a public health approach, and has been evaluated in, for example, diabetes care (Möllenkamp 2019), and curbing obesity through healthy eating (Arno 2016). The experience of a recipient of such a programme may be completely different from that of a recipient of a programme that

is defined using an egalitarian, supportive approach. Differences in such attitudes may be across conditional and unconditional cash transfer programmes, but also, for example, between different programmes within the category of CCT programmes.

Conditional, unconditional and cash-plus strategies have different pathways to impact. Conditional transfers have a potentially stronger impact on health and health behaviour, as receiving the transfer can be tied to these outcomes. The pathway of unconditional transfers could be seen as less direct, and more complex in the way that they affect health behaviours, potentially through availing funding to cover direct or indirect costs of treatment, or through reducing household stress. Cash-plus strategies, in turn, include cash as an intervention component, whereas the other component can be, for example, education (Pettifor 2019), with various impacts on health behaviours. This study aims to examine both the intended and unintended effects of these interventions and how recipients — both at a household and an individual level — experience and perceive the intervention, including whether it is acceptable to them, and what unintended outcomes may emerge.

The logic model presented in Figure 1 presents how the interventions — conditional, unconditional and cash-plus — could result in different short- and long-term outcomes. We also show below how the broader sociodemographic, policy context and healthcare system, as well as community support, gender relations and inequalities, function in the background of these interventions. The broader societal impact of the interventions is, however, beyond the remit of this review: our focus is on the short- and long-term impact as reported by individuals who receive the cash transfer. The model shows that all three interventions can produce an increase in (and more predictable) income. Conditional transfers can also result in a change in the desired health behaviour. The outcomes can be numerous, from improved mental well-being and reduced stress, and long-term outcomes that include improved health and reduced risk of poverty-related diseases. There are likely, however, several unintended consequences that we could not capture in the logic model.

Figure 1.



Why is it important to do this review and how will this review supplement what is already known in this area?

To date, no review has examined health-related cash transfer programme designs, delivery and outcomes from a recipient perspective, including their perceptions and experiences of the cash transfers or the unintended consequences that these interventions may have. While cash transfers may be beneficial for health outcomes, there are several important issues to investigate and discuss before designing (Krubiner 2017) and implementing such programmes on a larger scale. Another important issue is that the experiences of persons or patients receiving conditional or unconditional cash transfers are not frequently discussed. The latter is linked to ongoing discussions concerning to whom this cash should be provided — a particular household member, or to men, or women (Yoong 2012) — and what effects and uses the cash might have when provided to different recipients. To investigate these process-related issues and understand recipient perspectives, qualitative evidence is needed (Lewin 2015). Qualitative research can help to investigate the pathways from cash transfers to health, and to identify context-appropriate interventions.

While it is reasonable to expect that people are generally happy to receive cash, whether in return for attending a clinic or in general, implementing these programmes in new settings needs information about which forms of cash transfers are seen as most convenient; which barriers and facilitators to receiving cash transfers exist in different settings; and whether they are acceptable in comparison to other approaches of health improvement, including in-kind transfers, such as nutritional supplements or food parcels (Grobler 2011).

Existing Cochrane Reviews focusing on conditional and unconditional cash transfers give indications that cash transfers are a promising way of both supporting patients and incentivising them to attend health services (Lagarde 2009; Pega 2022) or to engage in health behaviours. Concurrently, cash transfers are increasingly used in developmental or emergency aid and humanitarian settings with reported positive health outcomes and

service use (Van Daalen 2022). As a social protection measure, cash transfers are included in country policies and key international policies, such as the United Nations' Sustainable Development Goals (UN 2015) and the WHO's End TB Strategy (Uplekar 2015).

Some studies have explored the perceptions of cash transfer recipients in specific contexts: for example, in Nigeria, a conditional cash transfer programme increased facility attendance and uptake of maternal and child health services by reducing the costs of transport to access the service for pregnant women (Ezenwaka 2021a). In South Africa, experiences of the government child grant have been assessed (Zembe-Mkabile 2015), as have experiences of conditional cash transfers to improve safe sexual practices among sex workers (Cooper 2017) and to incentivise adherence to HIV treatment and care (Czaicki 2017). In a high-income country, there is also evidence that cash transfers are acceptable to incentivise recipients to do chlamydia screening (Parker 2015). Through a qualitative approach, the current review contributes to this body of literature with global evidence on the perspectives and experiences of cash transfer recipients and proposes areas to address when developing cash transfer policies intended for better health outcomes and health service uptake.

In summary, consolidated evidence concerning how these interventions are perceived by recipients is needed, as is a description of the possible unintended outcomes described by the recipients. This review seeks to understand cash transfer recipients' experiences and perceptions of these interventions, including acceptability, feasibility, and unintended consequences.

OBJECTIVES

The main aim of this review was to explore how conditional and unconditional cash transfers with a health outcome are experienced and perceived by their recipients. Health can include health service use, health outcomes, or socioeconomic outcomes related to health (e.g. cash transfers to address catastrophic healthcare costs). We focused on the general experience, including the acceptability and feasibility of these interventions from a recipient perspective.

The secondary objectives include:

- understanding how differences in context and recipient backgrounds influence experiences and perceptions of conditional and unconditional cash transfer interventions; and
- describing the unintended consequences of conditional and unconditional cash transfers in different settings from recipients' perspectives.

METHODS

This is a meta-ethnography following the original seven steps outlined by Noblit and Hare (Noblit 1988) and guided by Sattar and colleagues (Sattar 2021).

Criteria for considering studies for this review

Types of studies

We included primary studies that used qualitative or mixed-methods study designs. The qualitative designs in this study included different qualitative study approaches, including ethnography, phenomenology, case studies, generic descriptive qualitative studies and qualitative process evaluations. We included studies that used qualitative methods for data collection (including focus group discussions, semistructured and in-depth individual interviews, observation and open-ended web surveys) and that used qualitative methods for data analysis (including thematic analysis, grounded theory, framework analysis, and content analysis). We excluded studies that collected data qualitatively but analysed them using quantitative methods (e.g. open-ended survey questions where the response data are analysed using descriptive statistics only), as qualitative approaches are considered the most appropriate to understand the perceptions and experiences of recipients. We included mixed-methods studies, where it was possible to extract the data that were collected and analysed using qualitative methods, and we used only the qualitative component of the study for analysis. We included studies published in any language.

We included studies regardless of whether or not they were conducted alongside studies of the effectiveness of cash transfers included in Lagarde 2009 and Pega 2022.

We did not use a quality threshold and we did not exclude studies based on our assessment of methodological limitations. We used the information about methodological limitations to assess our confidence in the review findings, using the GRADE-CERQual approach (GRADE-CERQual 2022).

We searched databases from their inception to 5 June 2020 and the search was updated in July 2022. The new studies found are awaiting classification.

Topic of interest

We included studies that reported on experiences or perceptions from recipients of cash transfer interventions provided by governmental, non-governmental or international agencies, or private non- or for-profit agencies targeted for improving health or health behaviours or that were assessed for health outcomes. We included different types of cash transfer interventions, which we categorised as unconditional cash transfers (UCT), conditional cash transfers (CCT), or cash-plus interventions that could include either a conditional or unconditional cash transfer component. We defined a UCT programme as non-contributory monetary payments to individuals by governmental, international or non-governmental organisations to help them meet minimum consumption needs (Garcia 2012). A CCT programme is defined as similar non-contributory monetary payments to individuals if a condition, typically a behaviour requirement, is fulfilled. We defined cash-plus interventions as programmes where either unconditional or conditional cash was given together with additional services, such as health checks, training or education sessions, psychosocial support or referrals to social services

Types of participants

The types of participants in the studies included recipients or carers of recipients of conditional or unconditional cash transfers or cash-plus interventions. We defined the recipients or carers as people who received a cash transfer as part of a government, non-government or project-based initiative. Participants could be:

- adult patients of healthcare services;
- the general adult population where the programme was assessed in terms of health impact or provided for purposes

of initiating, maintaining or increasing preventive or curative health behaviours (e.g. vaccination, treatment adherence, contraceptive use or testing or screening for diseases) or the avoidance of unhealthy behaviours (e.g. smoking cessation);
- adult caregiver recipients where the cash transfers were intended to benefit those receiving care, including but not limited to, children.

Types of settings

We conducted a global review, which was not limited to any particular setting or geographic location. Participants in the studies could come from any healthcare setting, primary, secondary and tertiary, or they could be outside the formal healthcare setting.

Types of health issues

We included any physical or mental health condition of participants.

Types of interventions

We included studies focused on conditional cash transfers, unconditional cash transfers, or cash-plus interventions, where cash was paid to individuals by governmental, international or non-governmental organisations in connection to national or local social protection programmes or research studies.

Search methods for identification of studies

Electronic searches

The Cochrane Effective Practice and Organisation of Care (EPOC) information specialist developed search strategies together with the research team. We searched the following electronic databases for eligible studies from the start of the database up to 5 June 2020. We reran the search between July and August 2022 and found 32 further studies which are awaiting classification. We searched the following databases:

- Epistemonikos, Epistemonikos Foundation (www.epistemonikos.org/) (searched 4 July 2022)
- Ovid MEDLINE(R) ALL <1946 to July 01, 2022> (searched 4 July 2022)
- CINAHL 1980 to present, EbscoHost (searched 4 July 2022)
- Social Services Abstracts 1979 - current, ProQuest (searched 4 July 2022)
- Global Index Medicus, WHO (searched 4 July 2022)
- Scopus, Elsevier (searched 4 July 2022)
- AnthroSource, American Anthropological Association (searched 3 August 2022)
- EconLit with Full Text, EBSCOhost (search 8 August 2022).

We chose these databases as they were likely to contain both social science and health-oriented literature on cash transfers. The search strategies conducted in July 2022 can be found in Appendix 1.

The Cochrane EPOC information specialist adapted and used guidelines developed by the Cochrane Qualitative Research Methods Group and searched most databases. A Tampere University librarian searched EconLit in 2020 and 2022, and Social Services Abstracts in 2022, while a Karolinska Institutet librarian/researcher searched AnthroSource. The searches included filters for qualitative or mixed-methods studies developed by the EPOC group.

Searching other resources

We complemented the database search by searching for studies that cited relevant studies already located for the review and searching the reference lists of all the included studies. We also searched the reference lists of included studies in effectiveness reviews of cash transfers for any linked qualitative studies.

For the search of qualitative studies linked to the effectiveness review, we examined the reference lists of Lagarde 2009 and Pega 2022 and located the articles reporting included interventions. We reviewed the reference lists of these intervention articles for cited qualitative studies.

Grey literature search

As many cash transfer interventions can be implemented by non-governmental organisations and development organisations (e.g. GiveDirectly), we also conducted a grey literature search in the following sources:

- OpenGrey: www.opengrey.eu
- C (AHRQ): www.ahrq.gov
- National Institute for Health and Clinical Excellence (NICE): www.nice.org.uk
- Eldis: www.eldis.org
- OAISTER: www.oclc.org/en/oaister.html
- GiveDirectly: www.GiveDirectly.org

The grey literature search strategies conducted in July 2022 can be found in Appendix 1.

We complemented this search by examining reference lists of the grey literature reports identified, and expert referrals through our networks. We ran the grey literature search in February and March 2021 and repeated it in July 2022, except for OpenGrey, which had been discontinued.

Selection of studies

We collated the records identified from databases, removed duplicates and uploaded them into Covidence. Four review authors (SA, KSA, KV and TW) then independently assessed the titles and abstracts of each record to identify relevant studies. We retrieved the full texts of all abstracts identified as potentially relevant and two independent review authors assessed each full-text article for inclusion according to the criteria below. For both the title/abstract and full-text screening, review authors resolved disagreements through discussion or, when required, by seeking a third review author's opinion. For articles not identified through databases, two authors screened titles and abstracts and conducted full-text assessment independently.

Our inclusion criteria were:

- primary studies;
- studies using mixed methods with qualitative data or qualitative studies;
- studies that report on experiences of cash transfer interventions provided by governmental, non-governmental or international agencies, or private for-profit agencies.

We included studies where the recipients could be:

- adult patients (male or female, over 18 years of age) of healthcare services (primary, secondary or tertiary); or
- the general adult population for the purpose of increasing, initiating or maintaining preventive or curative health behaviours (e.g. vaccinations, treatment adherence, or testing or screening for disease); or
- adults where the cash transfer is intended to benefit their children;
- studies reporting on the perspective of parents receiving the cash transfer for their child, or adult patients receiving the cash transfer in low-, middle- and high-income countries;
- studies focusing on any mental or physical health condition and any social protection or other cash transfer mechanism.

We included studies where participants were currently receiving a cash transfer or had recently (within six months) received a cash transfer.

We excluded papers that focused on in-kind transfers only, systematic reviews or literature reviews, quantitative studies, studies on cash transfers not examined for health outcomes (e.g. those focusing explicitly on poverty relief only), pay for performance for health workers, loan and savings groups, microfinance initiatives, and health insurance. We also excluded papers that did not include actual recipients or carers of recipients, but rather discussed potential interventions.

We retrieved the full text of papers that we considered relevant for independent assessment. Two review authors (from a combination of SA, KSA, KV, BK and TW) assessed the articles based on the review's inclusion criteria. Where there were disagreements, we discussed these with a third author's help.

We initially ran the searches in June 2020 and reran them in July 2022, when we found further 32 studies, which are now classified as awaiting classification. We will incorporate these studies in a future review update.

Language translation

We assessed titles that were available in English. Where the titles were translations of other languages, we sourced the abstract and asked colleagues for help in assessing their inclusion. The full text of studies that were in other languages than English was assessed by colleagues using a grid of assessment criteria. The languages included Spanish, Portuguese, Chinese and Russian. Only one study in Spanish that met the criteria for inclusion was identified during the update of the search. The full text in Spanish was assessed by four reviewers, two authors (CAY and TW) and two native Spanish-speaking colleagues.

Sampling of studies

Qualitative evidence synthesis aims for variation in concepts rather than an exhaustive sample, and large amounts of study data can impair the quality of the analysis. We used a multistep framework for sampling from the list of 127 studies eligible for inclusion. The steps included:

- start with maximum variation sampling using WHO regions: inclusion of all studies from under-represented regions with the least articles e.g. Eastern Mediterranean Region (EMR), South-East Asia Region (SEAR) and Western Pacific Region (WPR);
- review of studies by type of health condition involved (preventive interventions, infectious diseases, non-communicable diseases/chronic illnesses, reproductive and maternal health and child health): inclusion of all studies from conditions under-represented, e.g. mental health;
- review of studies by the richness of data, as defined by Ames 2019, through a combination of intensity sampling and criterion selection (type of study, amount of data, journal, coherence with objective).

We first used a maximum variation sampling strategy (Ames 2019) to allow a global perspective and understanding of the cash transfer experience. The sampling frame took into consideration the intervention country and its corresponding WHO region (WHO 2022), the health conditions for which the social protection was targeted, the type of cash transfer, and the sample population for the study.

We then employed criterion sampling and classified the study articles by the level of data richness using the Ames 2019 data richness score, and the degree to which the study focused on health.

First, studies that had a marginal focus on health were removed from the sampling frame (n = 16). Next, we classified the data richness based on a scale of 1 to 5, where 5 was the highest score (Ames 2019). We then selected and included for sampling all studies with a data richness score of 3 and above (n = 112) as per the Ames method (Ames 2019). These studies were then sorted by country and health condition. For the countries that were heavily represented in the final count, a selection for sampling was done to ensure that no health condition was over-represented in the sampled articles. For example, out of eight studies with social protection interventions for non-communicable diseases (NCDs) in the UK, we selected four studies. We then checked to ensure that under-represented health conditions such as mental health (n = 1) were among the sampled studies. The final list of studies sampled for analysis consisted of 41 papers.

Data extraction

We extracted data using a specially developed form that extracted information about the characteristics of included studies, including first author, date of publication, country and WHO region of the study, the context of the study, participant group, research methods used, the intervention studied and the health outcome linked to the study, as well as the sociopolitical context related to the intervention, if described in the article. We also extracted key results, themes and participant quotations that illustrated the themes from the articles.

We used Dedoose, a qualitative data analysis package, to extract the main concepts and ideas from the included articles, using the categorisation of first, second and third-order constructs (Atkins 2008). We listed these and checked for duplications.

We then categorised each paper according to the type of transfer (UCT, CCT, cash-plus) and looked at the relation of these concepts within each category. We started with the paper that scored higher on the richness scale that was considered to have a thick description.

Assessing the methodological limitations of included studies

We assessed the quality of individual studies using the CASP quality criteria (Critical Appraisal Skills Programme 2018). Three review authors (SA, KSA and BK) independently assessed each study using the CASP form. Where there was a disagreement, a third review author was involved in the discussion. Three domains were included in the quality assessment: validity of the results, author reflexivity and ethical considerations. We excluded the CASP section seeking to establish the value of the research locally as we do not have the capacity to evaluate this domain for the various study contexts. The results of the quality assessment are shown in the Methodological Limitations.

Data management, analysis and synthesis

We used a cloud-based server with specifically developed forms on Microsoft Excel for managing the data from different sources. For the searches of academic databases, we imported search findings into Covidence and removed duplicates. The Covidence database and the cloud server were accessible to all review authors. Included papers, searches of grey literature, citation searches, and reference searches were kept on the cloud-based server.

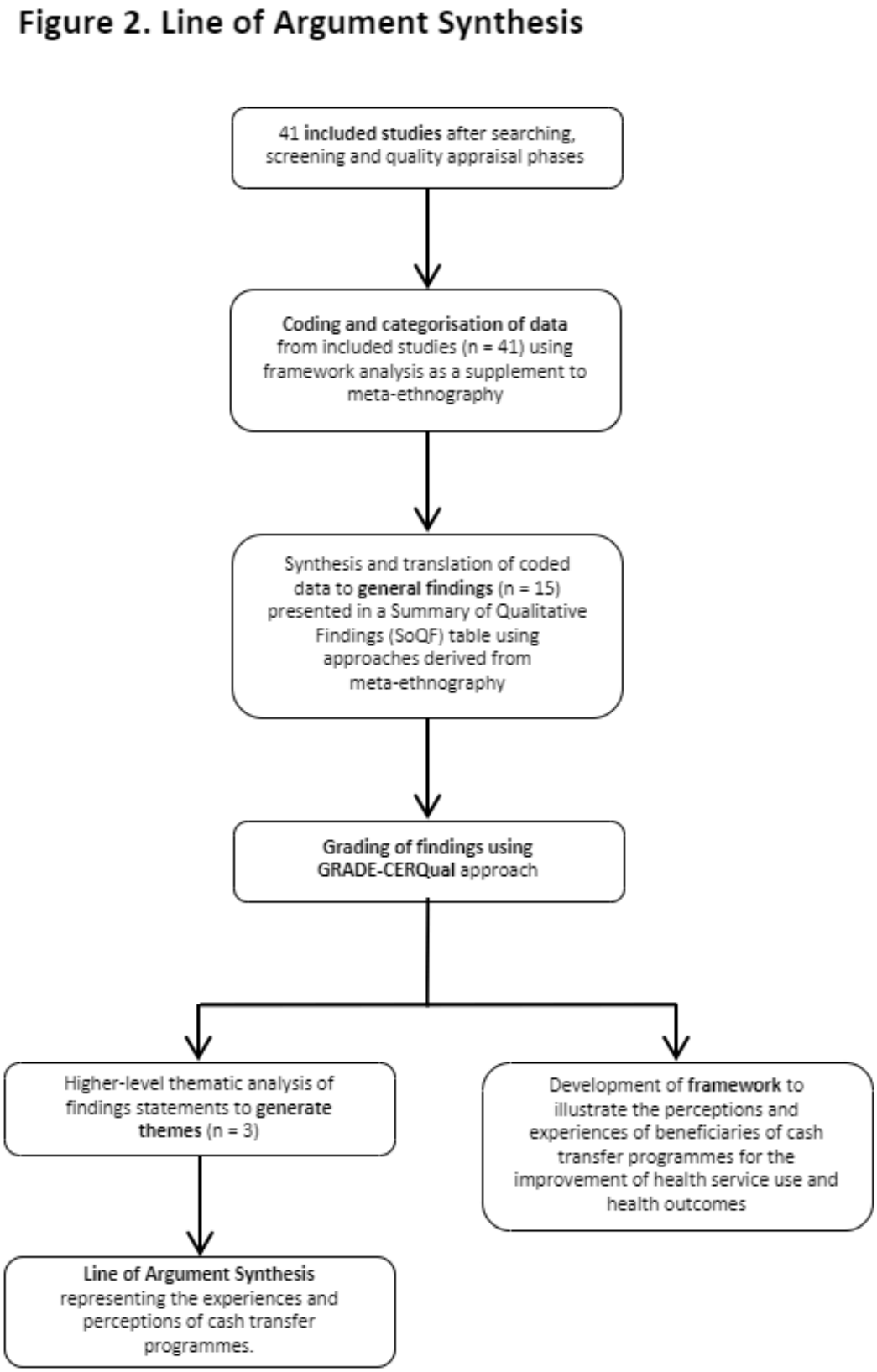
Initially, we extracted the meaning units from the papers, following first and second-order constructs (second-order constructs being what the author interprets the participants are saying) (Atkins 2008). We coded these using an inductive coding framework and through a thematic analysis approach. We then extracted these codes from the Dedoose system into Excel, and CAY, SA, and KSA, as the author team, discussed the structure of the coding framework, reorganising and renaming it. Using the Dedoose system, we then coded articles using this coding framework, adapting the framework as we went on to consider emerging issues. Two authors then verified the coding process and added data that should have been included.

We categorised each paper according to the type of cash transfer programme described (UCT, CCT or cash-plus). We then conducted the process of comparison by using an information-rich index paper, identified during the data extraction phase. We started from the richest paper, in our assessment of data richness as per the Ames method, and proceeded to translate each study into the previous one. We proceeded from paper to paper and compared themes across each other. During this process, we examined the studies in terms of their focus and content to determine whether we could conduct a reciprocal and/or refutational translation.

For the synthesis of the data, we did a reciprocal translation (Noblit 1988), linking similar findings between the studies according to each theme. We compared findings across different interventions, settings, and health conditions to detect response patterns. We paid attention to the patterns emerging in terms of the country setting, sex, sociopolitical setting, and programmatic setting, as well as the impact of other contextual factors, particularly poverty rates in the setting, and how they might affect analysis findings. We noted carefully where there were contradictory results and conducted a refutational translation analysis. We looked at the context, the design of each study, and how they impacted the differences in the findings. The incongruencies and disparities were described within the themes.

We then transformed the thematic description into review findings. We conducted a constant comparison of review findings, descriptive text and the original articles throughout the analysis process. We examined this to determine whether a line of argument synthesis, as described by Noblit and Hare, was possible (Noblit 1988). A flowchart illustrating the stages of the analytic process is shown in Figure 2.

Figure 2.



Assessing our confidence in the review findings

The review authors (CAY, SA and KSA) used the Confidence in the Evidence from Reviews of Qualitative Research (GRADE-CERQual 2022) approach to assess our confidence in each finding (Lewin 2018), using the iSoQ (Interactive Summary of Qualitative Findings 2022) Beta programme for the assessment. GRADE-CERQual assesses confidence in the evidence, based on the following four key components.

1. Methodological limitations of included studies: the extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
2. Coherence of the review finding: an assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesises those data. By cogent, we mean all supported or compelling.
3. Adequacy of the data contributing to a review finding: an overall determination of the degree of richness and quantity of data supporting a review finding.
4. Relevance of the included studies to the review question: the extent to which the body of evidence from the primary studies supporting a review finding applies to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

After assessing each of the four components, the three review authors (CAY, KSA, SA) made a judgement about the overall confidence in the evidence supporting the review finding. The team judged confidence as high, moderate, low or very low. The final assessment was based on a consensus among the review authors. All findings started as high confidence and were graded down if there were important concerns regarding any of the GRADE-CERQual components.

Summary of qualitative findings table and evidence profile

Summaries of the findings and our assessments of confidence in these findings are presented in the Summary of findings 1. Detailed descriptions of our confidence assessment are presented in Table 1.

Integrating our findings with Cochrane Intervention Reviews

We identified reviews related to this qualitative evidence synthesis by Lagarde and colleagues (Lagarde 2009) on conditional cash transfers and Pega and colleagues (Pega 2022) on unconditional cash transfers. Our initial plan was to juxtapose findings from our review with theirs in a matrix following the method used by others (Harden 2018). As we completed the process with the studies included in the Lagarde review, we understood that the process was not yielding sufficient meaningful data to understand how the interventions or programmes took into account the factors that emerged from our findings.

Our findings of experiences and perceptions of cash transfers were at different levels, from the practical barriers to access to the unintended outcomes of hope and empowerment. These unintentional outcomes are not easily described in intervention trials and are difficult to account for in intervention design. Instead of comparing these reviews directly, we, therefore, suggest questions guiding the development and implementation of cash transfer programmes or interventions.

RESULTS

Results of the search

We found 127 studies eligible for inclusion and we sampled 41 of these studies for inclusion in the analysis (Figure 3). For the 86 studies that were included but not sampled, the reasons for not sampling included insufficient data quality (n = 44), over representations of country, health condition, or programme (n = 26), only focused on well-being and/or nutrition (n = 10), and minimal focus on health (n = 6).

Figure 3. PRISMA flow diagram.

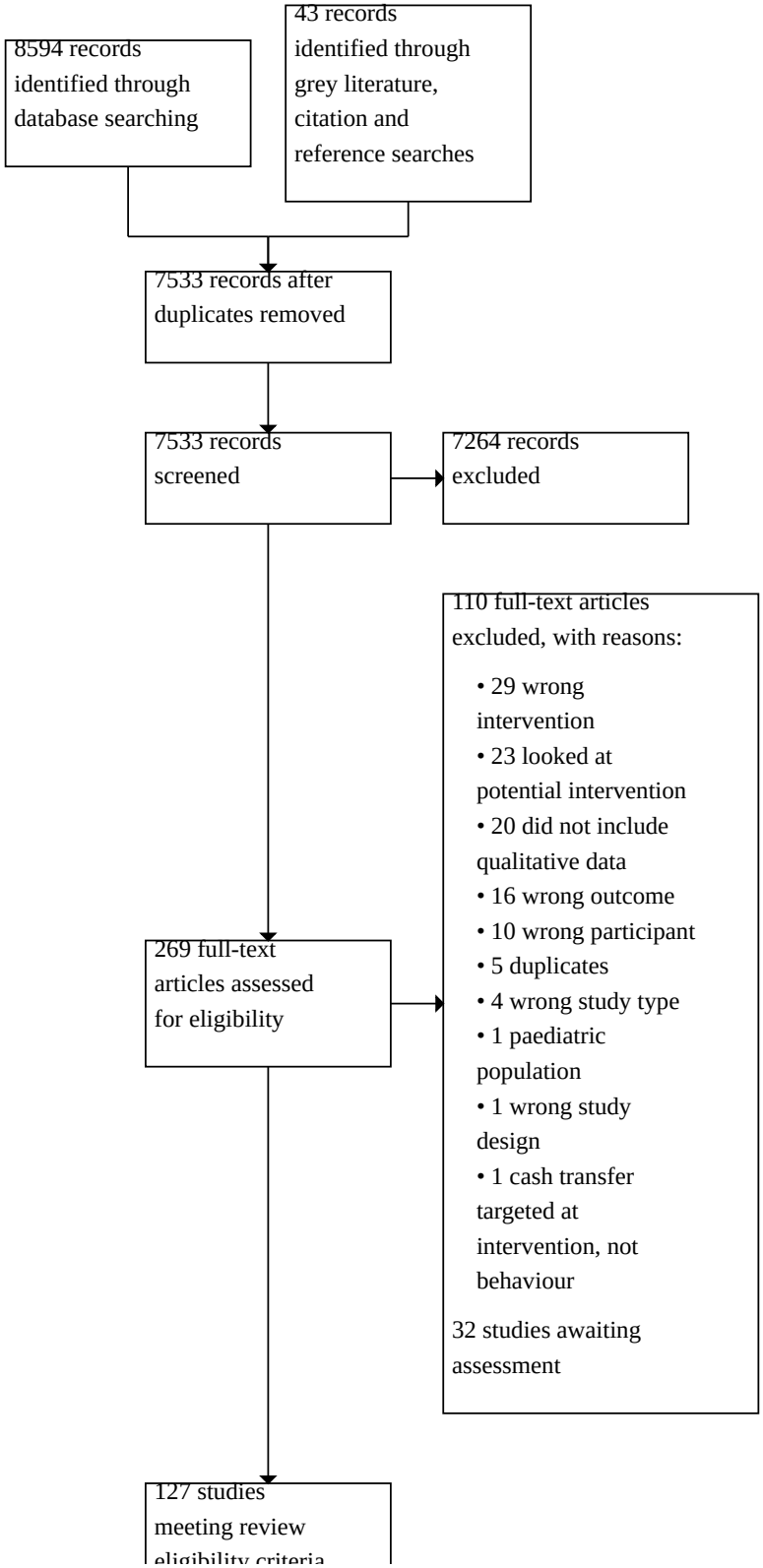
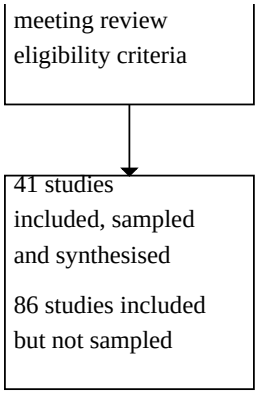


Figure 3. (Continued)



We excluded 110 full-text studies. Their reasons for exclusion are listed in Characteristics of excluded studies.

Additionally, after rerunning the search, we found 32 further studies that are awaiting classification (Afroz 2021; Alam 2020; Atkins 2021; Barrington 2022; Camlin 2022; Cena 2020; Cheetham 2019; Clifton 2022; Dave 2022; Ehlers 2022; Ezenwaka 2021; Galarraga 2020; Gangaramany 2021; Ghose 2021; Gong 2020; Iguna 2022; Kangwana 2022; Karakara 2022; Kenyon 2020; Krukowski 2022; Lees 2021a; Paajanen 2021; Packel 2021; Perez 2020; Reid 2022; Shay 2021; Spencer 2022; Stein 2022; Swartz 2022; Voils 2021; Wamoyi 2021; Zhang 2021). All studies sampled for analysis were published between 1998 and 2020.

Description of the studies

In this section, we describe the studies that we included and sampled. For a more detailed description of studies that were included and sampled as well as studies that were included but not sampled, see Characteristics of included studies. For a detailed description of studies awaiting classification, see Characteristics of studies awaiting classification.

Setting

The sampled studies comprised countries from all six World Health Organization (WHO) regions: African region (n = 17), region of the Americas (n = 7), European region (n = 7), South-East Asian region (n = 6), Western Pacific region (n = 3); and one multiregional study covering countries from the African and the Eastern Mediterranean regions (n = 1).

Twenty-nine studies were based in low- and middle-income countries (LMICs): South Africa (n = 6) (Kelly 2019; Khoza 2018; MacPhail 2013; Plagerson 2011; Stoner 2020; Woolgar 2014); Ghana (n = 3) (Arkorful 2020; Owusu-Addo 2020; Yeboah 2016); Nepal (n = 3) (Banks 2019b; Baral 2014; Gram 2019); Tanzania (n = 3) (Cooper 2017; Czaicki 2017; Wamoyi 2020); China (n = 2) (Wei 2009; Yin 2018); India (n = 2) (Nirgude 2019; Sidney 2016); Nigeria (n = 2) (Baba-Ari 2018; Ukwaja 2017); Colombia (n = 1) (Balen 2018); Malawi (n = 1) (Miller 2012); Mexico (n = 1) (Adato 2000a); Turkey (n = 1) (Yildirim 2014); Viet Nam (n = 1) (Banks 2019a); Zambia (n = 1) (Banda 2019); Zimbabwe (n = 1) (Skovdal 2014) and one multiregional study including Kenya, Mozambique, Uganda, Yemen and the Occupied Palestinian Territory (n = 1) (Samuels 2016).

Twelve studies were based in high-income countries (HICs): UK (n = 5) (De Wolfe 2012; Garthwaite 2015; Ploetner 2020; Shefer 2016; Thomson 2014); Canada (n = 3) (Gewurtz 2019; Jongbloed 1998; Struthers 2019); USA (n = 2) (Beskin 2019; Tolley 2018); Israel (n = 1) (Holler 2020); and New Zealand (n = 1) (Hikuroa 2017).

Type of programme

We included studies on unconditional cash transfer programmes (UCT), conditional cash transfer programmes (CCT) and cash-plus programmes, as previously defined. Nineteen studies focused on UCT programmes (Arkorful 2020; Banks 2019a; Banks 2019b; Baral 2014; De Wolfe 2012; Garthwaite 2015; Gewurtz 2019; Holler 2020; Jongbloed 1998; Kelly 2019; Miller 2012; Nirgude 2019; Plagerson 2011; Samuels 2016; Shefer 2016; Struthers 2019; Ukwaja 2017; Wamoyi 2020); 13 studies corresponded to CCT programmes (Adato 2000a; Baba-Ari 2018; Balen 2018; Beskin 2019; Czaicki 2017; MacPhail 2013; Sidney 2016; Stoner 2020; Thomson 2014; Wei 2009; Woolgar 2014; Yildirim 2014; Yin 2018); five studies were on cash-plus programmes, out of which three were cash-plus CCT (Cooper 2017; Hikuroa 2017; Tolley 2018) and two were on cash-plus UCT (Banda 2019; Gram 2019). There were also studies with mixed types of programmes with different cash transfer branches: three studies were on UCT and CCT (Owusu-Addo 2020; Skovdal 2014; Yeboah 2016); and one study was on UCT and cash-plus CCT (Khoza 2018).

Health conditions

Thirteen studies covered infectious diseases, seven of which were related to HIV (Czaicki 2017; Khoza 2018; MacPhail 2013; Miller 2012; Tolley 2018; Wamoyi 2020; Woolgar 2014), five were about tuberculosis (Baral 2014; Nirgude 2019; Ukwaja 2017; Wei 2009; Yin 2018) and one was on human papillomavirus (HPV) (Beskin 2019). Ten studies corresponded to maternal and child health and sexual and reproductive health (Baba-Ari 2018; Balen 2018; Banda 2019; Cooper 2017; Gram 2019; Sidney 2016; Skovdal 2014; Stoner 2020; Yildirim 2014). Six studies were related to programmes for people with disabilities (Arkorful 2020; Banks 2019a; Banks 2019b; Holler 2020; Kelly 2019; Samuels 2016); one study covered mental health (Plagerson 2011); five studies were related to health prevention or did not have a specified health condition, such as sickness

and incapacity benefits, pension plan and smoking cessation (De Wolfe 2012; Garthwaite 2015; Hikuroa 2017; Jongbloed 1998; Thomson 2014); three studies focused on programmes for mental health (Gewurtz 2019; Plagerson 2011; Ploetner 2020); three studies focused on programmes targeted for improving maternal and child health and nutrition (Adato 2000a; Owusu-Addo 2020; Yeboah 2016); and, one study was focused on disability and mental health (Shefer 2016).

Participants

As part of our selection criteria, all studies reported perceptions and experiences of cash transfer recipients, collected through qualitative methods. In some studies, beyond the recipient, participants included staff from the programme, health professionals, members of the family of the recipient or other non-recipient members of the community. For the purpose of this review, only the data from recipient participants were selected for analysis. Nine studies presented the experiences and perceptions of adult patients of healthcare services (Czaicki 2017; Khoza 2018; Miller 2012; Nirgude 2019; Tolley 2018; Ukwaja 2017; Wei 2009; Woolgar 2014; Yin 2018). Thirty-two studies explored the perspectives of the general adult population where the programme was assessed in terms of health impact or provided for purposes of increasing, initiating or maintaining preventive or curative health behaviours, or the cessation of unhealthy behaviours (Adato 2000a; Arkorful 2020; Baba-Ari 2018; Balen 2018; Banda 2019; Banks 2019a; Banks 2019b; Baral 2014; Beskin 2019; Cooper 2017; De Wolfe 2012; Garthwaite 2015; Gewurtz 2019; Gram 2019; Hikuroa 2017; Holler 2020; Jongbloed 1998; Kelly 2019; MacPhail 2013; Owusu-Addo 2020; Plagerson 2011; Ploetner 2020; Samuels 2016; Shefer 2016; Sidney 2016; Skovdal 2014; Stoner 2020; Struthers 2019; Thomson 2014; Wamoyi 2020; Yeboah 2016; Yildirim 2014). Six studies explored the perspectives of recipient women only, which included adolescent girls and young women (Baba-Ari 2018; Banda 2019; Gram 2019; Jongbloed 1998; MacPhail 2013; Stoner 2020; Thomson 2014). Three studies included the perceptions of adult caregiver recipients where the cash transfers are intended to benefit those receiving care, including but not limited to, children (Banks 2019a; Banks 2019b; Owusu-Addo 2020). One study did not present clear sample criteria but included recipients of the cash transfer programme (Balen 2018).

Methodological limitations of the studies

In some of the included studies, there was a lack of adequate consideration of the relationship between the researcher and participants. We also found poor reporting of ethical issues across many of the studies. All studies gave some description, even if very brief, of the context, participants, sampling strategy, methods and analysis. Details of the assessments of methodological limitations for individual studies can be found in Table 2.

Confidence in the review findings

Using the GRADE-CERQual approach and the iSoQ (GRADE-CERQual 2022) Beta programme, we assessed seven findings as high confidence, seven findings as moderate confidence and one finding as low confidence.

Our main concerns were related to the methodological limitations of the studies and the adequacy of the data. Common methodological limitations included a lack of adequate consideration of the relationship between the researcher and participants as well as poor reporting of ethical considerations. Additionally, in some studies, the appropriateness of the recruitment strategy to the aims of the research was unclear. The data were often assessed as being only partially adequate, mainly because some findings were supported by a small number of studies, some of which were more descriptive and rated 3 out of 5 on the richness scale. Some review findings presented concerns regarding coherence due to exceptions to the phenomenon synthesised in the finding or heterogenous explanations used to summarise the data.

Our explanation of the GRADE-CERQual assessment for each review finding is shown in the evidence profiles table (Table 1).

Review findings

We developed a set of individual findings organised into themes. In the themes described below, we synthesised the perceptions and experiences of cash transfer recipients in relation to the usage and the role of the cash transfer, the positive and negative impacts of the cash given its intended purpose, and also unintended consequences of the cash transfer, and the effects and outcomes of the cash within the household and the community. We used direct quotes from study participants to illustrate and contextualise the meaning.

We presented the summary of findings and our assessment of confidence in the summary of qualitative findings table (Summary of findings 1). Details and explanations of the confidence assessment are presented in the evidence profiles table (Table 1).

Theme 1: Perceptions of the cash transfer itself

The first theme corresponds to recipients' experiences of the cash transfer as a monetary payment, based on its primary purpose of being an economic enabler for coping with situations of shock or a financial supplement to their livelihoods. Participants' perceptions, in terms of their experiences of the usage of the benefit and the role of the cash (given its intended purposes), varied according to context and the goals of the programme. However, perspectives from recipients were based on similar practical and concrete actions related to the purchasing power of the cash transfer.

Three first-order construct findings were generated within this theme: 1) use of the cash transfer; 2) amount of the cash transfer; and 3) potential of the cash transfer to change behaviour.

Finding 1 (high confidence): Recipients perceived the cash transfer as necessary and helpful for the immediate needs of the household, across all types of cash transfer programmes. They reported sharing their cash with their household out of duty, necessity or solidarity. Recipients were able to subsist on the cash transfer and provide for their families by purchasing day-to-day items and paying for living costs, meeting their immediate needs

Recipients perceived the cash transfer as necessary and helpful for the immediate needs of their household, regardless of the type of cash transfer programme they were enrolled on and across all geographical regions (Arkorful 2020; Baba-Ari 2018; Balen 2018; Banda 2019; Baral 2014; Gewurtz 2019; Holler 2020; Khoza 2018; Miller 2012; Owusu-Addo 2020; Samuels 2016; Shefer 2016; Struthers 2019; Wamoyi 2020; Wei 2009; Woolgar 2014; Yeboah 2016; Yildirim 2014). They shared their cash with their household,

even though it was given individually. Parents, especially women, who were recipients shared the cash with their families and children willingly but also out of duty or necessity (Kelly 2019; Plagerson 2011; Wamoyi 2020). Adolescents shared it with their parents, caregivers or siblings out of necessity but also as a show of solidarity with the other members of the family. Cash granted to caregivers for orphan and vulnerable children in Ghana was indirectly shared with non-recipient children as "they all ate from the same pot" (Owusu-Addo 2020).

The cash transfer contributed to recipients' subsistence, and they were able to provide for their families (Holler 2020; Shefer 2016) by purchasing day-to-day items and paying for living costs (Wamoyi 2020; Woolgar 2014). This helped to meet their immediate needs in terms of food, rental, utility and medical bills, transport, clothes and school materials, thus addressing pressing issues in their lives (Holler 2020; Samuels 2016; Struthers 2019). Families from households in extreme poverty who experienced food insecurity appear to value the cash transfer more than those without food insecurity and some of the recipients who were entirely dependent on the cash transfer, considered it essential for their survival (Banda 2019; Baral 2014; Gewurtz 2019; Miller 2012; Wei 2009). Some perceived all the positive benefits from the cash transfer as crucial for their survival, with one recipient even suggesting that the discontinuation of the cash transfer would lead to suicide: "*If the programme stops, I have no reason to live anymore and I keep a bottle of poison on the top of my closet and I think of drinking it if things get worse*" (80-year-old recipient, Jenin, West Bank) (Samuels 2016, p. 1109). However, financially solvent recipients or those who underwent TB treatment in the private sector refused or did not value the cash transfer in the same way (Baral 2014).

Although uncommon, misuse of cash transfers was reported by some recipients. A minority of recipients reported spending the cash on alcohol, drugs, gambling or entertainment (Balen 2018; Khoza 2018; Plagerson 2011; Tolley 2018). In Colombia, some recipients reported that some women enrolled on a conditional cash transfer programme to increase their children's school attendance and medical check-ups instead took the cash themselves and abandoned their children (Balen 2018).

Finding 2 (high confidence): Recipients across all types of programmes thought the cash amount was insufficient, as it only covered immediate, but not all, basic needs. In some cases, it was insufficient to cover the intended purposes of the programme

Recipients across all types of programmes and in all geographical regions reported that the cash transfer amount was insufficient for their needs (Adato 2000a; Baba-Ari 2018; Balen 2018; Baral 2014; Gram 2019; Holler 2020; Kelly 2019; Khoza 2018; Miller 2012; Nirgude 2019; Owusu-Addo 2020; Samuels 2016; Shefer 2016; Skovdal 2014; Stoner 2020; Struthers 2019; Tolley 2018; Wei 2009; Yeboah 2016; Yildirim 2014). Recipients reported that the amount was not sufficient to cover all the needs of their children (Kelly 2019); others mentioned it was not enough to cover all their basic needs, but only immediate survival needs (Yildirim 2014); while people living with HIV reported that the cash transfer was not sufficient to help them overcome all the barriers to the treatment they faced (Tolley 2018). Some, however, said that the cash transfer was not enough to cover all their needs, but only helped to cope with daily challenges (Samuels 2016); others reported that it was inadequate to meet its intended purpose of nutritional support for their children (Nirgude 2019); and some said it was too low to live a life of dignity (Holler 2020).

While some recipients felt the cash transfer helped reduce poverty and inequality, others believed that it was insufficient to go beyond their immediate needs. This was because they could only afford food and medical expenses with cash, but not invest in the children's education or economically productive ventures (Owusu-Addo 2020).

Finding 3 (moderate confidence): Recipients, primarily participating in conditional cash transfer programmes, felt that the cash transfer was not enough to change their behaviour. However, perceptions differed amongst recipients from three CCT studies, who considered cash as the main driver or a mediator for changing health behaviours

Some recipients felt that the cash transfer alone was not enough to change their behaviour. Instead, drivers for change included the desire to be healthy or to survive (Baba-Ari 2018; Hikuroa 2017; Kelly 2019; Sidney 2016; Tolley 2018; Wei 2009) and the motivation to change to provide a better life for their family (Wei 2009; Woolgar 2014). They believed that the amount should be higher or that it should be combined with other interventions, such as social or psychological support or training and opportunities for employment (Yeboah 2016), as expressed by a recipient: "*The people here are not lazy. Given the opportunity, they will work but the jobs are not available and the money to begin their personal businesses is hard to get. That is why they are suffering.*" (B4, Ghana) (Yeboah 2016).

However, there were some exceptions and different perceptions amongst recipients from three CCT studies, in which cash was the main driver or a mediator for better health behaviour, such as maternal and health service visits in Nigeria (Baba-Ari 2018), institutional delivery in India (Sidney 2016) and adherence to treatment in China (Yin 2018).

Theme 2: Perceptions of the personal and social outcomes of the cash transfer

Recipients reported both positive and negative experiences and perceptions related to the cash transfer impacts. These included concrete immediate and long-term outcomes experienced by the individual, the household and the community, as well as individual feelings and impacts on social relationships. Findings within this theme had different nuances especially according to gender and type of targeted population.

Five findings were constructed related to positive and negative outcomes and impacts of the cash transfer: 1) short- and long-term outcomes; 2) empowerment; 3) hope and resilience; 4) social cohesion; and 5) stigma.

Finding 4 (high confidence): Recipients thought that the cash transfer resulted in positive short- and long-term outcomes for them and their families in terms of better health, well-being and education. Some also thought that the programme provided the possibility to save or invest in productive activities

Recipients reported positive short- and long-term outcomes and impacts of cash transfer programmes for them and their families in terms of better health, well-being and education (Adato 2000a; Banda 2019; Baral 2014; Beskin 2019; Cooper 2017; Czaicki 2017;

Hikuroa 2017; Khoza 2018; MacPhail 2013; Miller 2012; Owusu-Addo 2020; Samuels 2016; Stoner 2020; Struthers 2019; Tolley 2018; Thomson 2014; Wamoyi 2020; Woolgar 2014; Yeboah 2016; Yildirim 2014). In different types of programmes and target groups, better health was reported due to higher clinic attendance (Khoza 2018; Stoner 2020), better treatment adherence, improved nutritional intake (Adato 2000a; Miller 2012; Woolgar 2014), better hygiene, less risky health behaviour (Cooper 2017; Stoner 2020) and better knowledge about a particular health issue (Baral 2014; MacPhail 2013; Stoner 2020). Improved psychological well-being was described in relation to better mental health (Czaicki 2017; Khoza 2018; Miller 2012; Owusu-Addo 2020; Thomson 2014), reduced tension in the household (Samuels 2016) and decreased stress due to the security of receiving financial support (Czaicki 2017). Better education was perceived to result from knowledge obtained in information and education sessions from the programme, by increasing the duration of school attendance or from being able to purchase school materials (Balen 2018; Banda 2019; Khoza 2018; MacPhail 2013; Yildirim 2014). Recipients enrolled on cash-plus programmes also had a positive perception of the additional intervention, e.g. education sessions (Baral 2014) and support groups (Hikuroa 2017). Some believed that the additional intervention was even more beneficial to them in their current situation than the cash itself (Tolley 2018).

Some recipients believed that taking part in the programme yielded positive long-term effects. In some cases, for example in Canada (Struthers 2019) and Tanzania (Wamoyi 2020), the cash transfer was used for savings. In Colombia, Tanzania and Ghana, the cash transfer allowed for taking risks or investing in productive activities (Balen 2018; Cooper 2017; Yeboah 2016). In South Africa, cash improved resilience from external shocks, such as sudden death and funeral costs (Woolgar 2014), improving the family's life in the long run.

Finding 5 (high confidence): Across all types of programmes, the cash transfer was perceived to enhance the empowerment, autonomy and/or agency of recipients. Especially amongst women, empowerment and agency were reported through a feeling of security, better social relationships and enhanced decision-making power in households or with sexual partners. Women, adolescents, and people with disabilities felt that the cash gave them more autonomy, as it allowed them to become more independent and contribute to the household

Across all types of programmes, the cash transfer enhanced the empowerment, autonomy and/or agency of recipients. Empowerment and agency were reported especially amongst recipients who were adolescent girls, young women (Khoza 2018; MacPhail 2013; Yildirim 2014) or female sex workers (Cooper 2017). These recipients reported that the cash transfer gave them a feeling of security, enhanced decision-making power in their households or with sexual partners, and better social relationships due to the social capital building (Adato 2000a; Samuels 2016; Skovdal 2014). The cash transfer also allowed recipients to negotiate condom use and the number of sexual partners, as well as to refuse transactional sex, which they thought decreased adolescent pregnancy and marriage, reduced the risk of sexually transmitted infections and increased higher school attendance (Banda 2019; Stoner 2020). A sex worker reported the impact of training in negotiation power with clients: "*At the beginning, I didn't know anything about this, but after the training and being tested I start to change … I lecture (clients)about the advantage of using a condom and disadvantages of not using condoms. This technique helps me.*" (Respondent 08, Tanzania) (Cooper 2017). Women, adolescents, and people with disabilities felt that the cash gave them more autonomy (Garthwaite 2015; Thomson 2014), as it allowed them to become more independent from their partners or parents, and allowed them to contribute to the household and help alleviate their families or caregivers' financial burden (Kelly 2019; Khoza 2018; Plagerson 2011; Struthers 2019; Ukwaja 2017).

However, there was one exception where the cash transfer did not lead to women's empowerment (Gram 2019). In this study of a UCT programme in Nepal, women reported that the cash transfer was too low to increase their decision-making power in the household. Furthermore, they felt pressured or controlled by programme facilitators, who recommended and monitored the cash usage, or by their family members, given the household authority of the husband or mother-in-law in the Nepalese context (Gram 2019).

Finding 6 (moderate confidence): Increased feelings of hope and resilience to overcome adverse life situations were observed especially within vulnerable groups and among people with HIV, tuberculosis or a long-term illness. Recipients' feelings of hope for a better life and the future motivated some of them to change their health behaviours. These feelings of hope came from the security, improved self-esteem and social status given by the cash

Increased feelings of hope and resilience to overcome adverse life situations were observed in some studies, especially among vulnerable groups and/or people with HIV, tuberculosis or a long-term illness. They reported that the cash transfer gave them a feeling of hope for a better life (Owusu-Addo 2020; Samuels 2016; Woolgar 2014), of being cured of TB (Baral 2014) and of being able to go back to work in the future (Shefer 2016). This ultimately motivated them to engage in healthier behaviours (Baral 2014; Owusu-Addo 2020; Shefer 2016). This sense of hope resulted from the security of receiving regular payments, which led to decreased levels of stress and anxiety (Owusu-Addo 2020; Samuels 2016).

In a study that focused on the effects of a cash transfer on psychological well-being, recipients with a disability reported that the cash transfer increased their social status, restored their dignity and improved their self-esteem (Samuels 2016). The cash transfer also allowed them to "breathe again" and made them feel like they regained control over their lives. This increased self-confidence and self-worth helped them aspire for the future (Samuels 2016).

Finding 7 (moderate confidence): The cash transfer enhanced social cohesion and social capital building. Recipients reported feeling more connected to their community and uncomfortable about the exclusion of others from the programme. The cash transfer was also seen to lead to better family relationships and decreased levels of violence and stress in the household

Increased social cohesion and social capital building was a positive outcome of cash transfer programmes, as perceived by recipients. Social cohesion and social capital building were reported due to increased social interactions, feeling more included in and connected with their community (Miller 2012); feeling like an active member of the household and their community (Samuels 2016); contributing to their community (Miller 2012); no longer being alone (Samuels 2016); and being integrated and "being part of something" and thus, less vulnerable (Owusu-Addo 2020; Thomson 2014). Elderly recipients also reported having more

friends and more social encounters (Samuels 2016). These feelings of belonging resulted not only from being part of the programme and the recipients' community, but also from being able to contribute to the household with the cash. Solidarity was an expressed form of social cohesion and capital building in UCT and CCT programmes. Some recipients reported feeling sad due to the exclusion of other members of their community who did not receive the cash transfer; other recipients felt guilt or discomfort for being lucky and receiving the cash while others did not (Adato 2000a). In some cases, solidarity was expressed in a wish to share the cash with non-recipients in their community (Adato 2000a), in a feeling of being able to help others (Thomson 2014), or in actual sharing with the household, as reported by a recipient in Mexico: "*Well, I feel bad because sometimes there are times that some person that I know, she tells me 'oh sister I don't have anything to give to my children, and then I think and I say, I was thinking that in this way, also people who are in PROGRESA's program, the day they pay us, why don't we cooperate between all of us, some with some soup, others with soup, and we make bags and we give them to the ones who are not in PROGRESA. That was my way of thinking.*" (BM1-12, Mexico) (Adato 2000a).

Social cohesion and social capital building were both direct and indirect effects of the cash transfer. As a direct effect, some recipients spent the cash on contributions to religious ceremonies, which gave them a feeling of "personal fulfilment" (Samuels 2016); some elderly felt part of the community when socialising on payment days, as they could share similar experiences and challenges (Samuels 2016). Payment of school fees for recipient girls was also seen to benefit the entire community (Banda 2019). As an indirect effect, recipients reported that the increased security and stability provided by the cash allowed them to participate in social gatherings (Khoza 2018). Similarly, the cash enhanced women's financial stability allowing them to join savings groups, which in turn gave them social support and worked as a safety net for emergencies (Wamoyi 2020).

Recipients also reported a decrease in domestic violence and tension in the household, as most disagreements had resulted from poverty (Yildirim 2014) and stress levels were lower after the cash transfer (Samuels 2016). Family relationships were also affected positively due to increased collaboration (Samuels 2016). Better relationships between spouses and between parents and children were reported as a result of parents being able to support their children. Being able to support their children, in turn, made them feel that they were fulfilling their role as parents, becoming better role models for them (Samuels 2016).

Finding 8 (high confidence): Stigma was reported by recipients across all types of programmes, especially by people with a disability, mental disorders or long-term illnesses. Perceived stigma was often related to feelings of embarrassment and shame from being a cash transfer claimant or recipient. They also reported these feelings in relation to their illness and poor treatment by programme or medical assessors. Some recipients internalised the stigmatised identity imposed on them

Stigma was reported by recipients across all types of programmes, but especially by people with disability, mental disorders or long-term illnesses. Recipients perceived stigma in many forms: receiving or claiming a social benefit (De Wolfe 2012; Garthwaite 2015; Jongbloed 1998); having a disability or a mental disorder and not working (Garthwaite 2015; Ploetner 2020); or being seen as "undeserving", a "beggar" or receiving money for free (Plagerson 2011; Samuels 2016; Thomson 2014). They also reported feeling stigmatised in specific contexts: during the medical assessment to prove eligibility, where they were mistreated (Holler 2020); at banks to receive a cash payment, where they were seen as a second-class citizen (Balen 2018); and, in schools, where their children were stigmatised for having parents on a social benefit (Samuels 2016).

Stigma also led to low uptake of the cash transfer and people abandoning the process to claim the cash (Holler 2020). In Colombia, stigma was perceived by female recipients as humiliation and mistreatment when they had to stand in a queue for long hours to obtain their cash payment (Balen 2018). Women, including those who were pregnant, reported being submitted to situations that hurt their dignity, having to stand for hours in a queue, and being yelled at and treated with disdain by a municipality functionary. As a consequence, some of them gave up queueing and did not collect their cash (Balen 2018).

Recipients with mental disorders in the UK thought that they had a stigmatised identity that was imposed on them, mostly by media and public opinion, based on a small number of dishonest claimants (Ploetner 2020). This imposed identity made recipients feel as if they were not contributing to, or part of, society (Ploetner 2020). They reported feeling rejected by society, at work and by their own families, which led to social isolation, as reported by a recipient: "*They don't actually specify on your worst day who you are or how, how basically the media, in general, perceive benefit claimants… but I think there is a kinda perceived bias, not perceived bias, but it's a perceived notion that if you aren't working or if you aren't looking for a job and you are on benefits you are some kind, some kind of less of a person.*" (Ash, Focus Group 1, UK) (Ploetner 2020, p. 683)

Stigma was often associated with a feeling of embarrassment, shame and fear, and this was especially reported by people with disability or those receiving a cash transfer because of a long-term illness. Embarrassment was demonstrated in not disclosing their eligibility status to families and friends for a programme in the UK (Garthwaite 2015) or not complying with the condition of visiting health clinics to avoid disclosing their illness in China (Yin 2018). Furthermore, embarrassment and shame were enhanced by reported external views from the media, political leaders and programme and medical staff, of recipients as lazy, irresponsible, inferior, incapable, undeserving, dishonest or untrustworthy (Holler 2020; Plagerson 2011; Ploetner 2020). This identity constructed by external views often led to negative effects on recipients' mental health and psychological well-being (Plagerson 2011; Samuels 2016). It further led to the internalisation of such identity (Plagerson 2011) and self-stigmatisation (Shefer 2016).

Several recipients of a social cash transfer, mostly from the UK or South Africa, reported that if they could they would prefer to work instead of getting a cash transfer, as they thought work would give them dignity, self-worth and a sense of usefulness (De Wolfe 2012; Plagerson 2011; Ploetner 2020; Samuels 2016; Shefer 2016; Woolgar 2014).

Stigma around the programme and the recipients also resulted from 'rumours' or common beliefs in the community, as reported by three studies from the African continent. In two South African studies, recipients were stigmatised due to the belief that girls

were getting pregnant on purpose to be eligible (Plagerson 2011) or that the cash transfer intervention was infecting girls with HIV or teaching them to be sex workers (MacPhail 2013). Similarly, in one study in Zambia, a religious belief that those accepting the cash transfer would join Satanism also led to stigma against some recipients (Banda 2019).

However, in one study in Malawi, recipients who were stigmatised due to their health condition perceived a decrease in stigmatisation after the cash transfer as they felt more connected with the community, as reported by a recipient woman: "*Before the scheme, I could sometimes fail to collect my medicine because of lack of transport. I could not even borrow from anybody because they knew that I did not have any source of money. Now I am glad that I have easy access to healthcare because even if I don't have money people are always willing to lend me some*." (Female, 37 years old, Malawi) (Miller 2012, p. 207).

Theme 3: Perceptions of interaction with the cash transfer programme

Recipients reported different experiences when interacting with the programme, which included the application, assessment and appeal processes, the receipt of the cash payment and interaction with programme staff. Findings in this theme corresponded to aspects mostly related to the design and the implementation of the programme. Given the complexity and number of different programmes, this theme had more heterogeneous findings, as recipients reported different perceptions according to intervention type and intervention context.

Eight findings were constructed within this theme: 1) eligibility for the cash transfer; 2) pressure/control over the use of cash; 3) social division; 4) barriers to access; 5) acceptability of the cash transfer; 6) participation in the programme's process; 7) refusal to participate in the programme; and 8) conditionality of the cash transfer.

Finding 9 (high confidence): Recipients, mainly those with disabilities, long-term illnesses or mental disorders, reported that the eligibility process was inappropriate due to restricted or incongruous criteria. They also reported that assessment processes were not suitable for people with disability and mental disorders. The method for choosing the recipients was also considered unfair

Cash transfer recipients with disabilities, long-term illnesses or mental disorders reported that the eligibility process was inappropriate (Holler 2020; Jongbloed 1998; Ploetner 2020; Shefer 2016). People with disabilities believed that the criteria used to determine eligibility were too restrictive. For example, a core eligibility component was typically based on impairment to perform basic daily activities, such as getting dressed or showering; while cash transfer claimants felt they needed the support as, even though they were able to perform such activities, they were not able to work (Holler 2020). Women with long-term illnesses also perceived the eligibility criteria as inappropriate, since some women wanted or had part-time jobs, but unemployability was a requirement (Jongbloed 1998). They also reported that the financial needs assessment was intrusive (Jongbloed 1998).

People with an intellectual disability or a mental disorder believed that the assessment procedures were more suitable to assess people with physical disabilities (Shefer 2016). Some claimants with mental disorders faced difficulties in proving their inability to work since their disability was not visible (Shefer 2016), as reported by a claimant: "*My doctor called me a liar, my sister, my mum called me a liar. So you are writing down this form and they have read that form but why are they saying no, you must come to an assessment, we don't believe you. It's like saying we don't believe you, you are calling me a liar. That's what I've been called by kids at school, you know don't call me a liar, I am not a liar, why would I lie? So that is what is hard, straight away people sit there judging you and why are you judging me? Don't call me a liar, this is difficult enough without that." (*Ashley, UK) (Shefer 2016). Similarly, they reported a lack of knowledge and training from the programme assessors in the medical assessment (Ploetner 2020). These cash transfer claimants described how they could appear "fine" to the programme assessors but that their broader life context was not taken into consideration in the assessment (Ploetner 2020). They reported being spoken to by the programme assessors as if they were unreliable and untrustworthy, which made them see the process as degrading and dehumanising (Ploetner 2020). Some recipients reported being forced to exaggerate their illness or pain severity during the assessment process to ensure they were assessed "fairly" (Garthwaite 2015). Other recipients with a disability or long-term illness reported "cheating" to bypass the difficulties in the assessment process, such as reporting lower or no income (Holler 2020; Jongbloed 1998), "performing" to doctors, and submitting false claims (Shefer 2016) to "skew" their records (Thomson 2014).

Recipients also believed that the method for choosing the recipients was inappropriate. They reported a lack of accuracy and fairness in using the census as an assessment method based on poverty (Adato 2000a); assessment decisions made based on political connections (Balen 2018; Banks 2019b); misleading questions within the assessment process (Shefer 2016); and inconsistent criteria for assessing poverty (Wei 2009). Some recipients also believed that the selection of recipients was not appropriate or fair. Some recipients, especially those enrolled on poverty-based programmes, believed that "*everyone should get it*" in the community or the intervention, as everyone was equally poor or deserving (Adato 2000a; Khoza 2018; MacPhail 2013; Yeboah 2016). Some recipients thought that the selection of certain recipients was unfair or random and based on lottery and luck (Adato 2000a; Holler 2020; MacPhail 2013; Thomson 2014; Yeboah 2016). In one study, parents' views of adolescents as recipients diverged (Beskin 2019). Some believed that the cash should be provided to the adolescents' parents due to adolescents lacking the maturity to receive cash; others thought it should be split between adolescents and their parents since both should be involved; and a third group believed the adolescents should receive the cash transfer as a motivation for healthy behaviour (Beskin 2019).

Finding 10 (moderate confidence): Pressure, control, monitoring or restriction of the cash transfer used by those close to the recipients was observed across all types of programmes, especially among female recipients, who reported feelings of powerlessness. Pressure from the programme staff was also reported, either as corruption or "enforced recommendation"

Pressure, control, constraint or monitoring of the use of the cash transfer was observed across all types of programmes. This was more evident among female recipients, where family members, including male partners and sons (Gram 2019; Samuels 2016), exerted control or pressured recipients on how the cash was utilised (MacPhail 2013). In a multi-regional study, male partners or sons

demanded cash from the recipient women to spend on alcohol and drugs, creating tension in the household and leading to verbal and physical altercations (Samuels 2016). In another study, unmarried female recipients did not disclose the receipt of the cash to casual partners, due to a fear of them trying to control how the cash was spent. Instead, they consulted their mothers, who advised them on how to spend the money in an effective manner (Wamoyi 2020). However, married female recipients disclosed the cash receipt to their male partners to receive advice on its use, reporting that their partners were supportive but also controlling in how the cash should be spent (Wamoyi 2020). Married female recipients from a study in Nepal gave the cash transfer to their mother-in-law (Gram 2019); since recipients lived in their mother-in-law's house, these mothers-in-law were the authority and their guardians. However, in most cases, the mother-in-law refused or returned the cash (Gram 2019). Female adolescent recipients sought advice from their parents on spending the cash. In some cases, mothers exerted control over the cash, but the adolescent recipient made the final decision on its use (Khoza 2018). Male adolescent recipients, on the other hand, were reported to make independent decisions on cash use (Khoza 2018). In one study in South Africa, recipients reported being threatened, extorted or even robbed by household members or members of the community, who wanted to use the cash transfer for their own purposes (Kelly 2019).

In some studies, the pressure came from the programme staff or staff incentivised by the programme, either as a form of corruption (Sidney 2016), or “enforced recommendation” (Balen 2018; Gram 2019). In India, a trained female community health volunteer who assisted women pressured the recipients to pay for their services (Sidney 2016). Female recipients reported feeling powerless and afraid of not receiving proper care if they refused to pay, even though they knew there was no hospital policy enforcing such payments (Sidney 2016). In a study in Colombia, parents and children were pressured to purchase materials and uniforms by school employees, who constrained children or threatened to deny them entrance (Balen 2018). In another study in Nepal, programme facilitators gave recommendations to female recipients on the use of the cash transfer that women felt forced to take (Gram 2019). Recipients reported being constantly asked by facilitators to show the fruits they had purchased with the cash, even though they were enrolled on an unconditional cash transfer programme, in which they were free to choose how to spend the cash (Gram 2019). They reported not being able to save or spend the cash on other items, as they were told to spend this on specific fruits. They denied making their own decisions on the cash, stating that the programme’s NGO decided for them, as observed in this interview passage: "[Interviewer:] *Who took decisions regarding the use of the cash transfer in the household?* [Recipient woman:] *The women's group facilitator took decisions about this*. [Interviewer:] *Okay. But when you received the cash transfers then who took decisions regarding the use of that money?* [Recipient woman:] *That decision was done by that Sir who had asked me whether we spend that money on food for ourselves or whether we give it to our family members*." (Recipient 9, Sahku, Nepal) (Gram 2019, p. 14) The study author posited that this enforced recommendation could be seen as a “soft conditioning” on cash transfer, understood as an implicit constraint on the cash usage from others’ interpretation of the programme. “Soft conditioning”, according to the study author, is both inefficient, as recipients better know their own needs, and paternalistic, as it deprives the recipient of their freedom of choice (Gram 2019).

Finding 11 (high confidence): Social division, exclusion and isolation were commonly seen between recipients and non-recipients, sometimes associated with jealousy, envy and resentment

Social division, exclusion and isolation were commonly seen between recipients and non-recipients. Within an intervention study, discussions in the communities arose between families selected and not selected for the cash transfer (MacPhail 2013). Some participants who did not receive cash also thought that those receiving the cash transfer started isolating themselves (MacPhail 2013). Social division was also reported to arise from non-recipients feeling excluded from the programme and not joining social activities from the programme because they were not invited or did not feel welcome (Adato 2000a). The cash transfer could also lead to increased intra-household and community tension between recipients and non-recipients (Samuels 2016). Recipients from one study on smoking cessation felt that quitting smoking could lead to social isolation, as everyone in their social circle was a smoker; others felt that the cash transfer could lead to polarisation and stigmatisation as it targeted smokers as recipients, whom they considered as undeserving of the cash transfer (Thomson 2014).

Jealousy, envy and resentment were sometimes associated with social exclusion, division or isolation: neighbours were jealous of recipient families and had negative attitudes towards them (Miller 2012); non-recipients started rumours out of jealousy that recipient girls were HIV-positive, sex workers or pregnant (MacPhail 2013); widows were resented by the community for receiving the cash transfer (Samuels 2016); and recipients were jealous and resentful of other recipients who received higher transfers (Owusu-Addo 2020).

Finding 12 (moderate confidence): Recipients, especially people with disabilities, reported facing different types of barriers in receiving or accessing the cash transfer, including financial, knowledge, material and physical barriers. They reported complicated and cumbersome application or appeal processes and delays in receiving the cash, which led to stress

Recipients reported facing different types of barriers in receiving cash transfers. Barriers related to the banking system were frequently cited, including a lack of a bank account or a lack of essential documents and proof of residence to open one (Nirgude 2019); difficulties in opening an account (Sidney 2016); problems with the electronic fund transfer at rural and co-operative banks (Nirgude 2019); lack of understanding of the banking system due to illiteracy (Yeboah 2016); difficulties in cashing the check when using non-traditional banking services (Struthers 2019); failure of information systems (Balen 2018); and unsuccessful bank transfers due to mismatching personal and bank information (Nirgude 2019). Financial barriers were also commonly reported, as recipients faced unexpected costs related to receiving the cash transfer: such as transport costs to go to the bank (Balen 2018; Yeboah 2016); needing to deposit money to open a bank account (Nirgude 2019; Sidney 2016); and transport costs to meet the programme condition of going to the health facility before receiving the cash transfer (Baba-Ari 2018). These issues led to difficulties and delays in receiving the cash and, in case of lack of documentation, recipients were not even able to open a bank account and, therefore, were not able to enrol on the programme (Nirgude 2019).

Physical and geographical barriers were also experienced by recipients, such as difficulty in arranging transport to go to the health facility as required by the programme (Sidney 2016); long queues and waiting times at the payment point (Balen 2018); the need to travel from rural to urban areas and wait for days until the payment, leaving children alone at home (Balen 2018); and long distances and transport difficulties faced by people with limited mobility or living in remote areas (Banks 2019a). These physical and geographic barriers were particularly challenging for people with a disability, who encountered obstacles not only in reaching the location but also with the lack of accessible transportation and lack of accessibility at the facilities (Banks 2019a). In some cases, lack of accessibility hindered the uptake of services (Owusu-Addo 2020) or led to the exclusion of claimants with limited mobility and means (Kelly 2019). In one study from Colombia, due to the long waiting time at the payment point, recipient women paid others, including staff members, to stand in the queue for them or to skip the queue to have faster access to the cash transfer and be able to return to their children who were left unattended (Balen 2018).

Lack of information and knowledge about the programme was also frequently reported by recipients (Gewurtz 2019; Holler 2020; Nirgude 2019; Struthers 2019; Yildirim 2014). Some recipients thought that information should be given more effectively, especially in poorer areas, suggesting television advertisements as an option (Yildirim 2014). In another case, recipients became aware of the programme through friends or healthcare providers but believed that there were eligible women who were unaware of the programme, as it was not thoroughly publicised (Struthers 2019). People with a disability faced greater obstacles: for example, a recipient reported needing written information for people with a disability to refer to (Gewurtz 2019). Similarly, some recipients reported difficulties in filling in application forms because they did not understand the questions and received inadequate support or advice from the programme staff (Gewurtz 2019; Struthers 2019; Yildirim 2014).

Complicated and cumbersome application or appeal processes were reported in several studies, including both UCT and CCT programmes. Recipients reported waiting for long hours to receive the cash transfer (Balen 2018; Yeboah 2016); going through several steps of document preparation and approval (Nirgude 2019); repeated encounters with doctors and lawyers (Holler 2020); and lacking skills to fill in the application form or facing difficulties in understanding it and requiring assistance from family or programme workers (Ploetner 2020; Shefer 2016; Yildirim 2014). Several recipients reported negative effects on their mental health and well-being from these processes, such as stress, anxiety, fear, negative emotions, pain and insecurity (De Wolfe 2012; Gewurtz 2019; Plagerson 2011; Ploetner 2020; Shefer 2016).

Frequent delays in receiving the cash were also reported in some cases (Arkorful 2020; Balen 2018; Sidney 2016; Ukwaja 2017; Wei 2009; Yeboah 2016) and that cash transfers were given sporadically in others (Nirgude 2019; Yildirim 2014). In some cases of delay, the recipients did not receive the cash transfer at all (Yeboah 2016).

In two studies with programmes targeting women, recipients faced specific barriers due to reasons outside of their control (Sidney 2016; Struthers 2019). Some women were not able to enrol on the programme due to competing demands from families and their households, as the application process was cumbersome and they had to cater for the children (Struthers 2019). In the other study, despite their intentions, some women were not able to meet the condition of institutional delivery and, thus, did not receive the cash due to reasons outside of their control, such as not having a companion to go to the health facility or their delivery being too fast to reach the health facility (Sidney 2016).

Finding 13 (low confidence): Recipients' participation in and perspectives of the programme were perceived by the studies' authors as necessary for its acceptability and effectiveness. CCT programmes that were sensitive to recipients' needs and had easy-to-understand, non-punitive and fair conditions were reported by recipients as more acceptable

The participation and perspectives of recipients in the programmes were described in some articles, mostly based on the interpretation of the studies' authors (second-order constructs). Some recipients reported feeling that they were "clients" in the programme or that the cash transfer was a favour (Owusu-Addo 2020). They felt they had no power in the programme and were not seen as equal partners, as they were not involved in the programme design. They also reported concerns about the lack of channels to make their voice heard and present their needs (Owusu-Addo 2020). Other studies showed that some recipients had to make themselves heard as self-advocates to guarantee their rights (Holler 2020; Ploetner 2020). In these cases, recipients had to tackle negative public attitudes and opinions themselves (Ploetner 2020) or deal with bureaucratic difficulties and appeal to higher instances themselves to guarantee their rights (Holler 2020).

In terms of the programme design, the studies' authors expressed some aspects that can affect the acceptability and effectiveness of the cash transfer, such as the importance of cash transfers being sensitive to patients' needs (Yin 2018). For conditional cash transfer programmes, for example, more compassionate and non-punitive schemes that take into account the context and the social determinants of recipients' behaviours were seen to be more effective (Hikuroa 2017). Recipients also accepted the conditions more readily when the monitoring was perceived as fair and accurate (MacPhail 2013).

A study from Zimbabwe focused on the acceptability of the conditions related to transfers intended to support children (Skovdal 2014). When recipients were held accountable for the cash through the conditions monitoring, they reported that it was easier to justify and accept the selection of certain recipients (Skovdal 2014). Recipients reported that, since they considered the condition to be fair, they accepted it and thought it was necessary. Conditions were, therefore, perceived to encourage recipients to change their behaviour and spend wisely, prioritising their children and incentivising good parenting (Skovdal 2014). The study's author emphasised that this perception was due to the community-led design of the programme, in which recipients participated in the monitoring process in a "social control of fair conditions" (Skovdal 2014). According to the study's author, the acceptability of conditions is high when recipients see a relative advantage in being enrolled on the programme and when the cash transfers go beyond their immediate needs. The study's author also posited that the programme needs to be simple, easy to understand and adequate to the recipients' way of life (Skovdal 2014).

Finding 14 (moderate confidence): Refusal or hesitancy in relation to receiving or applying for the cash transfer was seen in some cases to be motivated by distrust in the government or

the programme and negative interactions with the programme staff. Personal circumstances relating to hesitance in applying for cash transfers included lack of motivation, competing demands and internalisation of the stigmatised identity of being 'lazy', mostly by people with mental illnesses

Refusal or hesitancy in relation to receiving or applying for a cash transfer was seen in a few studies. This was due to personal circumstances or the participant's own perception of the cash transfer and the programme. Some participants lacked the motivation to fill in the paperwork required or they "did not bother" to do so, because they were busy (Struthers 2019). Low uptake was also reported amongst recipients with mental illness who internalised others' views of them being lazy and the stigmatised identity of being a recipient (Plagerson 2011). Distrust and confidentiality concerns were also reasons for low uptake and hesitancy in receiving the cash transfer. Participants with TB were concerned to share their bank information and disclose their TB status (Nirgude 2019), linked closely to stigma. Lack of trust in the government was another reason for refusal or hesitancy in relation to receiving or applying for the cash transfer. The general government distrust seen in the Nigerian context was an obstacle to uptake, as recipients did not believe the information about the programme (Baba-Ari 2018). Distrust was also a consequence of perceived poor communication towards the recipients, complex and unclear systems, and lack of trust and relationship building between programme staff and recipients (Gewurtz 2019). Recipients who had experienced poor interactions with the programme reported feeling stressed and distrusted the programme, which led them to limit their interactions with the programme (Gewurtz 2019).

Finding 15 (moderate confidence): Recipients found the programme more acceptable when they agreed with its goals and processes and also perceived advantages in being enrolled. They accepted the programme more readily when it was easily accessed and clear information was provided. This positive perception also contributed to recipients feeling satisfied and appreciative, which further enhanced acceptance of the programmes

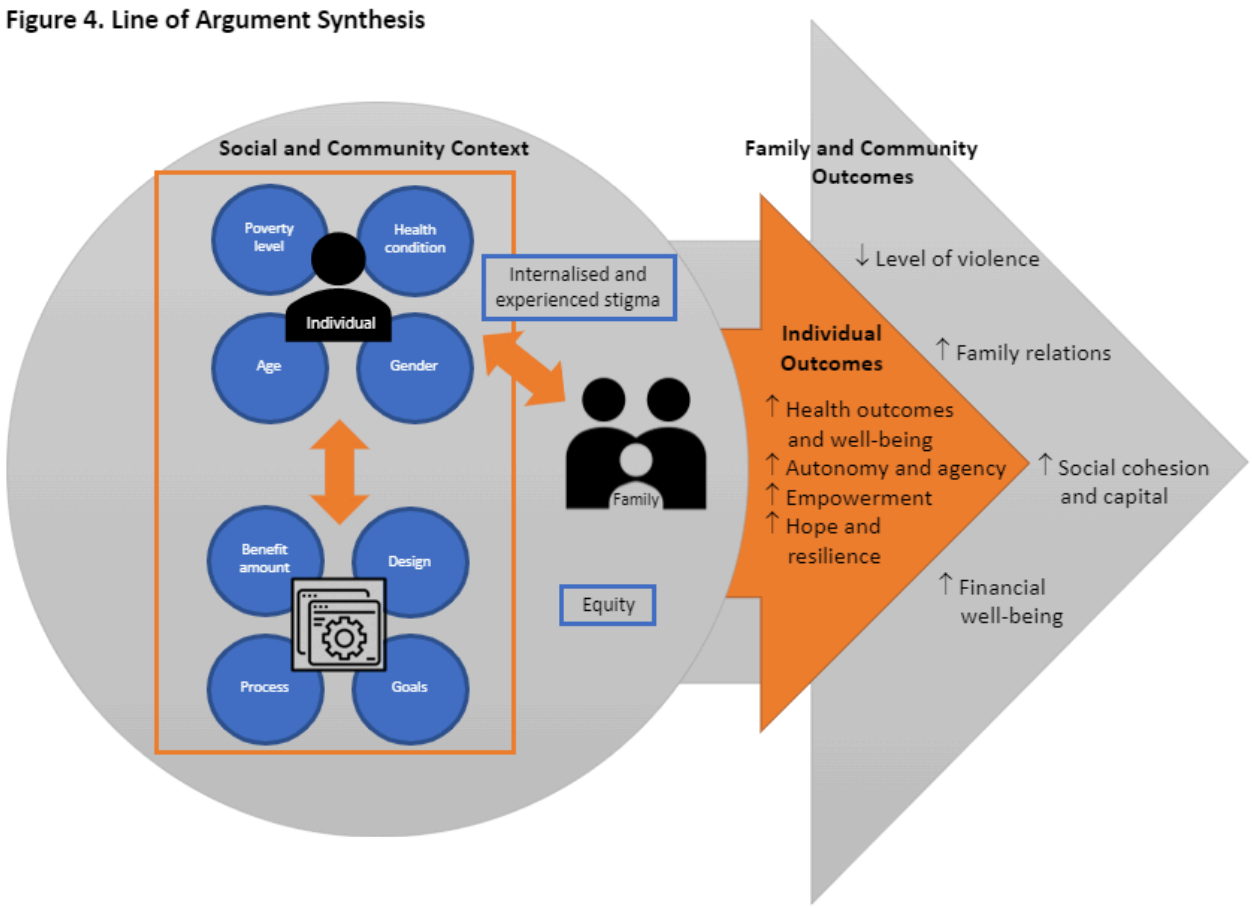
Recipients found the programme more acceptable when they agreed with its goals and processes. Examples are cases in which the cash transfer was easy to access and recipients had information about the programme (Banda 2019) and the perception of the programme as a "noble initiative", helping the poor and sick (Nirgude 2019). Similarly, caregivers were positive towards the programme as they saw its benefits for the adolescents in terms of becoming more knowledgeable about HIV and money administration (MacPhail 2013).

Recipients also appreciated and accepted the cash transfer better when they perceived advantages and positive outcomes, such as a positive impact on the whole family not only the recipient (Banda 2019); reduced adolescent pregnancy and marriage due to the cash transfer receipt (Banda 2019); and higher school attendance and lower engagement in crimes or transactional sex (Khoza 2018). In unconditional cash transfer programmes, some recipients were positive about the cash transfer due to its flexibility and freedom of use (Samuels 2016; Struthers 2019), and some believed it was "good to have free money" (Skovdal 2014).

The line of argument

We developed a framework integrating the findings from the qualitative synthesis into a line of argument synthesis or third-order interpretation. Figure 4 presents the synthesis framework, based on the original logic model from the protocol (Figure 1).

Figure 4.



In our framework, we see the individual, with their unique characteristics, including poverty level, health conditions, age and gender interacting with the programme. The interaction is then shaped by these background characteristics but also influenced by the programme's characteristics, including the amount of cash transfer, the processes of application, getting the cash transfer, and eligibility; the overall goals of the programme and the overall design of the programme (whether the programme is, for example, conditional cash transfer or unconditional); and what programme theory, implicit or explicit, informs these decisions. Both individual and programme factors are embedded in the social and local context that may shape them and influence the relationship between recipients and the programme.

The individual then interacts with family, and the broader societal and community context. They may have internalised or experienced stigma, or there may be questions of equity or unfair distribution of social benefits. How these different characteristics and background factors then interact leads to outcomes at individual, family and community levels. At the individual level, we may see improved health outcomes or increased well-being; increased autonomy or agency; empowerment; and increased feelings of hope and resilience. At the family and community level, we may see decreased levels of violence in the household due to reduced stress; better family and community relations; increased social cohesion and social capital; and financial well-being both in the short- and long-term.

Review author reflexivity

All the review authors are currently involved in, or have previously been involved in, research and policy-making on social protection and health, including those related to diverse health conditions. The team includes public health professionals/researchers, physicians, economists and social scientists. The team is active in the Health and Social Protection Action Knowledge Research Sharing Network (SPARKS Network 2022) and actively works toward promoting social protection for people with ill health. Given this background, the team members believe that social protection can help ill people and contribute towards reducing poverty among underprivileged populations, particularly in low- and middle-income settings. This could potentially have influenced the analysis toward focusing on positive influences, instead of neutral, conflicting, or negative experiences. Therefore, to minimise the risk of our perspectives influencing the analysis and interpretation of the data, we used refutational analysis techniques and explored and explained the contradictions in the findings of individual studies. The team also maintained a reflexive stance to enhance objectivity and reduce bias throughout the review process, from study selection to data synthesis.

Our initial stance on pro-social protection remained unchanged during the review. However, the analysis and the findings brought more nuance to this stance suggesting, for example, that for health outcomes, cash only is not enough to improve health - this

came out more strongly in the findings than we had discussed in our group to date. The data also brought across a stronger evidence base for cash-plus approaches and highlighted how cash transfer programmes' implementation, and the degree to which their recipients are considered in the design, can impact cash transfer acceptance as an intervention. To our surprise, we found that some recipients would rather work, even when they are unable to; and some actively refuse cash transfers. We also found a high degree of solidarity between recipients and non-recipients. As we expected, we found that cash transfers can bring conflict into a given area, when not equally distributed.

DISCUSSION

Summary of the main findings

For a summary of the main findings, see the Plain Language Summary.

Comparison with other reviews and implications for the field

Our findings make it clear that the pathway from a cash transfer, whether conditional or unconditional, to health outcomes or health behaviours is complex and the experiences of different individuals in different contexts can vary vastly. Many inter-related factors, related to the implementation of the programme, the sociocultural context of the programme, and individual views and experiences influence recipients' experiences and perceptions of cash transfer programmes and are therefore likely to impact their effects. We have tried to make these relationships clear in Figure 4, but recognise that some of the factors that may influence outcomes are beyond the reach of this review, such as the cash value of transfers given in the programmes.

The review contributes to existing debates on the need for cash-plus approaches to help improve impacts on health outcomes. Many recipients across different health issues and settings suggested that cash alone is not enough to impact behaviour and that additional interventions, such as education, health services, or other support, are necessary to impact health behaviour. This is less important where a cash transfer is explicitly geared towards changing behaviour through conditions but, even here, cash may not be sufficient for building motivation for change. At the same time, our review points out that while cash can cover basic needs in many settings, it is frequently seen by recipients as not being sufficient to meet needs or to change behaviour.

Another key area in which our review contributes is the importance of community buy-in, clear communication, and participatory approaches to building programmes. Another meta-ethnography, specifically examining the philosophical, ethical and political underpinnings of conditional cash transfers highlighted how decisions around conditional transfers are not apolitical, but relate to the particular context and should be decided upon transparently, considering ethical implications (Scheel 2020). One mechanism through which this could be achieved might be by using a participatory approach to programme design, including perspectives of recipients, and designing assessment, eligibility, and inclusion processes so that they seem fair and justifiable. Through this process, it may be possible to reduce the tensions sometimes created by these programmes.

Our review has some similarities with Owusu Addo and colleagues review on cash transfers and their impact on social determinants of health and health inequalities in low- and middle-income countries (Owusu-Addo 2020). They also found the reduction of stress and other pathways to health outcomes; our review also highlighted this in high-income settings. We did not find a clear pattern in differences in experiences and perceptions according to a country or regional context.

Our synthesis complements the findings of the effectiveness reviews conducted by Pega (Pega 2022) and Lagarde (Lagarde 2009). Pega and colleagues aimed at investigating whether receiving UCT would improve people's use of health services and their actual health, compared with not receiving a UCT, receiving a smaller amount or receiving a CCT. Additionally, it also aimed to assess the effects of UCTs on living conditions that influence health and healthcare spending. The findings of Pega's effectiveness review suggested that UCTs may not impact the use of health services among children and adults in LMICs. However, UCTs may improve health expenditure, some health outcomes, such as secure access to food, and some social determinants of health, such as school attendance and reduction of poverty (Pega 2022). On the other hand, Lagarde and colleagues aimed to assess the effectiveness of CCT in improving access to care and health outcomes, with a focus on poorer populations in LMICs. Their findings suggested that CCTs can be an effective way to increase the uptake of preventive services and encourage some preventive behaviours, with a noted improvement in health outcomes in some cases. However, it is still unclear which components lead to this positive effect (Lagarde 2009). Our findings contribute to the findings of the review effectiveness of Pega (Pega 2022) and Lagarde (Lagarde 2009), as we further examined the mechanisms through which cash transfer programmes can have positive and negative effects, based on the perspectives and experiences of recipients. To complement Lagarde's review, our findings suggest which components from the recipient's perspective, in relation to the programme's design and implementation, may increase programme impacts. Our findings highlight the impacts of the sociocultural context on the functioning of programmes and interactions between the individual, family and the programme. Our review also highlights that, even where the goals of a programme are explicitly health-related, the outcomes may be far broader than health only, and may include, for example, reduced stigma, empowerment and increased agency of the individual. When measuring programme outcomes, therefore, these broader impacts could be considered for understanding the health and well-being benefits of cash transfers.

Overall completeness and applicability of the evidence

Our sampling strategy was intended to be global in coverage. While we did search for relevant studies across all the WHO settings, and sampling ensured that all were reflected, we found that there were rather few studies from the Middle East and North Africa (MENA) regions in our global review. Our focus on rich data could be one reason for this gap, but the lack of social protection systems in MENA countries, or gaps in our search strategy, keywords used or language, could be other drivers for the lack of studies.

We did not exclude studies based on an assessment of their methodological limitations. We found several eligible studies in our search, but we could not analyse all of them, as the method of qualitative synthesis does not allow for analysing such a large body

of work. For that reason, our sampling strategy sought to sample for analysis the studies with higher data richness, seeking maximum variation in terms of health condition and country.

In our initial search, we found a large body of research specifically on disability benefits from the UK, which focused explicitly on stigma and shame. We also found a large number of studies on HIV from South Africa, which is also a well-studied area. This could also have influenced our findings, e.g. stigma was mostly perceived by people with a disability or long-term illness, and most studies with disabilities, mental disorders or long-term illnesses as health conditions came from the UK. We noted that certain health conditions were linked to specific geographic locations, as can be seen from the global burden of diseases. However, we tried to take this into account in our sampling strategy, where we sought to balance the health conditions and geographic locations of the studies, sampling for analysis the studies with richer data. Overall, we are fairly confident that we covered a wide range of settings and conditions in our review, although the review included only English-language texts.

When synthesising the findings, we sought to identify patterns across types of cash transfer programmes, target groups, health conditions and geographic locations. We first tried to organise the findings based on a division by type of cash transfer programme. We then identified similar themes across all types of programmes and decided to synthesise the findings based on broader thematic domains. Noting that the synthesis by type of programme resulted in only some patterns, we opted to present the findings based on overall themes, pointing at specificities (where relevant) for each type of programme or target group. This approach may have influenced the findings in the sense that most of them apply to all types of programmes. However, we sought to emphasise that some phenomena are more relevant to a specific type of programme (e.g. inappropriate eligibility criteria for UCT or non-punitive conditions for CCT).

The confidence assessment was also influenced by this approach, especially the assessment of the relevant domain. Since our sampling criteria sought to cover variation in terms of health conditions, geographic locations and types of programmes, most findings were supported by studies covering all types of programmes and different health conditions and, therefore, presented no or minor concerns regarding relevance. We did not downgrade our assessment based on this, since we considered our sample a subset with high-quality data of the total number of studies eligible globally.

A further limitation in our findings is our dependence on Samuels and colleagues *(*Samuels 2016), which described the findings from five different programmes in five different countries (Kenya, Mozambique, Uganda, Yemen and the Occupied Palestinian Territories of West Bank and Gaza). We chose to include Samuels and colleagues because they represented two countries from the WHO Eastern Mediterranean region (Palestine and Yemen), which were otherwise not represented in our sampled studies. There were three other studies from the EMR eligible for inclusion, but they were not sampled due to insufficient data quality or their focus only on nutrition and well-being. Since Samuels 2016 represents five different cases, it appears often in our findings, but the study's analysis in that respect is also fairly superficial *(*Samuels 2016). Unfortunately, the cases presented in Samuels 2016 were not published as separate papers.

Limitations of the review

We consider that our sample of studies gives a good overview of the global experiences of cash transfers. The experiences were surprisingly similar across high-, middle- and low-income settings. However, our study was limited by the need to sample from the 127 studies identified. A different sample may have yielded different results. However, we are confident that our findings reflect the key issues in the included papers, and represent global perspectives.

As part of our review process, we sampled those studies that where we considered that they had richer data. This could have affected the GRADE-CERQual assessments by increasing our confidence in the data. Previous meta-ethnographies have suggested that papers that provide more descriptive data may contribute less to the synthesis (Atkins 2008) and we, therefore, considered this sampling approach appropriate. We recognise that not sampling for analysis all the studies included can have an impact on the confidence assessment of our findings.

As our approach was global, we could not conduct an in-depth assessment of how the settings of each study impacted our findings. We did investigate the effect of different social protection mechanisms but are aware that the setting (e.g. the urban or rural nature of the programme implementation site) might impact the type of barriers experienced by some recipients. Another layer of analysis, focused on the rural/urban dimension, could lead to more nuanced findings. In addition, given a large number of studies from heterogeneous settings, some of our descriptions could be seen as superficial. For instance, we included a paper describing several cash transfer programmes (Samuels 2016) - this provided useful but not in-depth data.

We also combined papers that examined established government-provided social protection policies with intervention studies. In the latter, there was a division into intervention and control groups, which may have contributed to conflict, and suspicion within the setting. However, since we found the unfairness of distribution and suspicion created by cash transfers in both types of programmes, we think that these effects can be present wherever there is a division, and where programme goals are not communicated clearly.

Lastly, while reviewing the intervention effects studies included in Lagarde and colleagues (Lagarde 2009) and Pega and colleagues (Pega 2022), we could only identify sibling qualitative studies that were published before the intervention paper, and there is a possibility that other post-intervention sibling qualitative studies were not captured. Future updates of this review could include forward citation searching of relevant intervention effects studies.

AUTHORS' CONCLUSIONS

Implications for practice

From our review, we have the following implications for practice when designing and implementing cash transfer programmes. While many of these may seem generically relevant to all implementation programmes, there are specific considerations for cash transfer programmes.

To begin this process, we have included questions to consider when developing cash transfer interventions or programmes. These questions have been reviewed by five global members of

the SPARKS Network (SPARKS Network 2022), who are actively involved in developing, implementing and evaluating cash transfer programmes. The members were working in Argentina, Nepal, Sweden, Viet Nam, Uganda, and Zimbabwe.

1. Have you considered participatory methods in designing the programme?

a. Have you considered potential recipients' views of the intervention?

Our findings suggest that cash transfer programmes where recipients felt they could influence the programme and the eligibility criteria are clear, could be more acceptable. If time and funding allow, participatory approaches could further a feeling of ownership over the programme.

2. Have you designed a communication strategy for the programme that takes into account different target audiences?

a. Have you engaged the public in discussions about the programme?

b. Have you ensured the eligibility criteria are fair, appropriate and transparent?

c. Have you ensured the conditions, if any, of the programme, including duration, are clearly described?

d. Have you been transparent about the goals of the programme and its programme theory?

Also suggested by our findings, media has a role to play in how recipients are perceived in the community. Engaging in public discussion about the goals of the programme and its implementation could be useful. Knowing eligibility criteria, programme conditions and duration could help make the programme transparent, and help recipients in understanding goals. One of our findings suggests that people sometimes perceive eligibility criteria as unfair to others, and clear communication and working through a participatory approach may help to prevent this.

3. Have you surveyed the population, the setting and the context before implementation?

a. Have you conducted a needs assessment to establish the needs and acceptability of the programme?

b. Have you conducted a gender and intersectional analysis of your programme to inform your design?

c. Have you considered piloting and refining the intervention through process evaluation and feedback from people receiving/delivering it?

The needs assessment will inform your programme design in terms of acceptability, but also in terms of the amount and value of your cash transfer and possible additional interventions. If the area in which your programme is implemented does have job opportunities, consider giving additional services e.g. in a job application, training or entrepreneurship. In some areas, these are not realistic. Our findings also suggest that women and men and different target groups may have different experiences of the cash transfer programmes. As part of the needs assessment, gender and intersectional analyses would be important to understand the potential differences and for tailoring the intervention appropriately.

4. Have you fully considered the staff and the health system's readiness to implement the programme?

a. Are there mechanisms e.g. dedicated programme staff who can assist recipients with the registration process?

b. Have you trained staff e.g. on the use of non-stigmatising language, and recipient-centred behaviour to protect empowerment?

c. Have you set up accountability mechanisms where staff misconduct can be reported by recipients?

d. Have you set up monitoring mechanisms for the implementation process?

e. Have you established confidential communication channels for recipients in case of negative interactions with the staff?

Our findings suggest that staff may pressure recipients to use their cash transfers in certain ways. Staff may also strongly influence how recipients interact with the programme. There were also some hints of possible misconduct in distributing grants and incidents of negative behaviour among staff. Accountability mechanisms, such as anonymous "whistleblower" lines may help programme implementers to decrease the risk of misconduct and ensure that everyone is accountable.

5. Have you evaluated your eligibility and assessment processes?

a. Have you ensured assessment processes are appropriate for the target group (e.g. people living with depression)?

b. Are assessment and eligibility processes as simple as possible and easy to navigate?

c. Are eligibility criteria fair, transparent and clearly communicated within the programme area?

Our findings suggested that some eligibility and application processes were considered by recipients to be too strenuous and difficult to navigate, especially among those who were unwell. Not understanding or being able to deal with application processes can create a barrier to access, and inequity within the programme, possibly excluding those who need support the most.

6. Have you sought to remove potential physical, institutional, or social barriers to receiving the cash transfer to increase equity?

a. Have you made sure distances to collection points are not insurmountable; that recipients can set up bank accounts close to their home if needed; etc.?

Our findings suggested that access barriers existed particularly in hard-to-reach places. The administration of the programme was also challenging, as people did not have the necessary documentation. Potential implementation issues should be identified during a context assessment and addressed during the implementation phase of the programme.

7. Have you carefully considered your support alternatives?

a. Have you considered what the cash transfer amount would translate into in the context of your programme (e.g. how much staples and other goods recipients can purchase)?

b. For CCTs: Is the amount of cash transfer sufficient to achieve programme goals?

c. Could you combine the cash transfer with other services (e.g. health communication, health services)?

Linking closely to implementation considerations, considering the different support alternatives, including the value of the grant, both in terms of absolute spending power and also achieving programme goals is important. In some settings, recipients stated a desire for opportunities to work in addition to cash. Findings support the use of "cash-plus" strategies for impacting health behaviour and health service use, as well as overall well-being.

8. Have you considered how the cash transfer will be used and shared in the household?

a. Have you considered that family or community members may pressure the recipient on how they spend the cash transfer?

b. Have you considered if and how the cash spending will be monitored or asked about during process evaluation?

Household members may interfere in how a recipient will spend the money. It is also possible that the cash transfer is shared within the household. These dynamics, as well as individuals' priorities, may influence the outcome of a programme.

9. Have you considered the long-term perspective of the programme?

a. Are you able to give the cash transfer consistently to foster a feeling of security?

b. Have you ensured that you communicated the amount, frequency and duration of support, at regular intervals?

c. Have you developed an exit strategy or transition programme for the cash transfer, if your programme is not indefinite in duration?

d. Have you considered mechanisms to be incorporated that would allow recipients to sustain themselves beyond the programme?

Our findings suggest that when cash transfers are provided regularly, they may support building a sense of security, especially in high-poverty settings. Evidence also suggested that the fear of payments ending and the actual ending of payments could negatively impact the recipient's mental health. It is important to consider the sustainability of your programme.

10. Have you included feedback mechanisms for recipients to report back on programme implementation and any concerns?

a. Can you create a user-friendly platform for recipients to provide feedback on their experiences with the programme (e.g. delays or non-payments, satisfaction)?

Linked closely with setting up feedback mechanisms for staff treatment of recipients, overall feedback mechanisms, whether through programme evaluation or as part of the programme implementation, would be useful.

Implications for future research

We did not identify sufficient data from the WHO region of the Middle East and North Africa. In contrast, we did have an over-representation of studies from South Africa and the UK. This could be due to the types of conditions included (disability and HIV), the language of the search being primarily English, and the advanced social protection settings in these countries. However, we would have expected more studies from Nordic countries, with expanded welfare states and social protection systems. Further research should therefore focus on bringing these perspectives into analysis, both Middle Eastern and North African region (MENA) countries, and Nordic countries.

Additionally, not all outcomes and impacts identified in this review have corresponding outcome measures. Our review has implications for intervention development, programme theory, and outcome measurement of interventions, as some of the key recipient perspectives, such as the sufficiency of the cash transfer that we identified are not measured routinely within effectiveness studies. Further methodological development is needed to assess how these dimensions could be integrated into future interventions and trials.

Our findings in this review were assessed to be of moderate or high confidence, and the findings were broad. We did find specific recommendations for conditional cash transfers more than other types of cash transfers. Further, perhaps separate reviews could be conducted for cash-plus approaches, and people's experiences of these. Detailed reviews on each of the three main forms of cash transfers may allow for a more detailed analysis of the issues that are specific to the different programme models.

Within our sample, most studies failed to report on the relationship between the researcher and the participant. Given that cash transfer programmes are closely linked with poverty and vulnerability, future studies should pay more attention to expanding on these issues. While this did not strongly affect our confidence in findings, where there is a power differential, participants may want to reflect on the interviewer's attitudes, whether expressed or implicit.

Our review focused on recipient perspectives of cash transfers, where they reported relations with programme staff and families. Future research could focus also on family dynamics and how decisions are made within the household on spending cash transfers. This would give a more rounded perspective to these issues and could help designers of cash transfer interventions.

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Atkins 2020

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CHARACTERISTICS OF STUDIES

Characteristics of included studies *[ordered by study ID]*

Abarbanell 2020

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Sexual and reproductive health
Sample population	30 women from Mayan community in Chiapa
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of cash transfer programme (PROSPERA)
Notes	

Abu-Hamad 2014

Study characteristics	
Country	Palestine
WHO Region	Eastern Mediterranean Region
Type of cash transfer programme	CCT
Health condition	Children's psychosocial well-being
Sample population	FGD with 71 children and 14 adults. IDI with 10 children and 5 caregivers
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality

Abu-Hamad 2014 *(Continued)*

Notes

Adato 2000a

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual reproductive health nutrition
Sample population	FGDs with 80 recipients
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Adato 2000b

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Nutrition
Sample population	80 recipients from 70 communities
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of cash transfer programme (PROGRESA)
Notes	

Adato 2011

Study characteristics	
Country	Nicaragua, El Salvador, Mexico and Turkey
WHO Region	Region of the Americas European region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Nutrition
Sample population	23 FGDs with 230 women in Mexico; 7 households in Turkey; 96 in El Salvador; 120 in Nicaragua within ethnographic community studies
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Allan 2012

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	Incentive
Health condition	Non-communicable diseases
Sample population	14 in-depth interviews with recipients
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of health condition (NCDs)
Notes	

Allen 2016

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Sexual and reproductive health
Sample population	60 IDI and 20 narrative timeline interviews with not in school - 15-to-23-year-old AGYWs
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (NCDs)
Notes	

Alves 2013

Study characteristics	
Country	Brazil
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Access to health service
Sample population	31 family beneficiaries and ex-beneficiaries of the programme
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Minimal focus on health
Notes	

Arkorful 2020

Study characteristics	
Country	Ghana

Arkorful 2020 *(Continued)*

WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	130 persons with disability
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Attah 2013

Study characteristics	
Country	Kenya
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Nutrition
Sample population	FDGs with recipients
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Attah 2016

Study characteristics	
Country	Kenya, Ghana, Zimbabwe, Lesotho
WHO Region	African region
Type of cash transfer programme	UCT

Attah 2016 *(Continued)*

Health condition	Nutrition
Sample population	FDGs and IDI with recipients
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Baba-Ari 2018

Study characteristics	
Country	Nigeria
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	12 interviews
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Balen 2018

Study characteristics	
Country	Colombia
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health

Balen 2018 *(Continued)*

Sample population	No information
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Banda 2019

Study characteristics	
Country	Zambia
WHO Region	African region
Type of cash transfer programme	UCT cash-plus
Health condition	Maternal and child health Sexual and reproductive health
Sample population	Total 46 participants of whom 33 were recipients (girls)
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Banks 2019a

Study characteristics	
Country	Nepal
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	35 people with disabilities; 9 caregivers of children, 14 adults with disabilities and the rest proxies of people with severe disability

Banks 2019a *(Continued)*

Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Banks 2019b

Study characteristics	
Country	Viet Nam
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	32 people with disabilities, out of which 24 were interviewed directly and, for 8 participants, information was gathered through their caregivers (for people with disabilities younger than age 18 and one adult with severe physical and communication impairments). 20 respondents were receiving the Disability Allowance.
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Baral 2014

Study characteristics	
Country	Nepal
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (TB)
Sample population	27 people receiving combined support and 22 counselling support
Richness scale	4

Baral 2014 *(Continued)*

Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Bernard 2000

Study characteristics	
Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	No information
Richness scale	1
Sampling status	Eligibile but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Beskin 2019

Study characteristics	
Country	United States of America
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HPV)
Sample population	Parents and their adolescents
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a

Beskin 2019 *(Continued)*

Notes

Breisinger 2018

Study characteristics	
Country	Egypt
WHO Region	Eastern Mediterranean region
Type of cash transfer programme	UCT
Health condition	Child and elderly
Sample population	In 6 communities, 12 semistructured interviews, 2 FDGs with men and women - FDGs mainly for recipients
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Chapple 2004

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Non-communicable diseases (lung cancer)
Sample population	Interviews with 45 people with lung cancer
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Chouinard 2005

Study characteristics	
Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	10 women
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Clarke 2019

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	49 individuals who had a chronic health concern or who were family carers for an adult or child with such concerns
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Minimal focus on health
Notes	

Coffey 2014

Study characteristics

Coffey 2014 *(Continued)*

Country	India
WHO Region	South-East Asian regio
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	Semi-structured interviews with 20 women who were pregnant or had recently delivered
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of programme (JSY)
Notes	

Cooper 2017

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT cash-plus
Health condition	Maternal and child health Sexual and reproductive health
Sample population	IDI with 20 sex workers
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Czaicki 2017

Study characteristics	
Country	Tanzania

Czaicki 2017 *(Continued)*

WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	IDI with 29 people living with HIV, out of which 16 were women and 13 men, and 17 were recipients of food incentives and 12 received cash
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

De Paoli 2012

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	29 people living with HIV
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of country (South Africa) and health condition (HIV)
Notes	

De Wolfe 2012

Study characteristics	
Country	K
WHO Region	European region

De Wolfe 2012 *(Continued)*

Type of cash transfer programme	UCT
Health condition	Long-term illnesses (myalgic encephalomyelitis)
Sample population	Participant observation; 18 people over email, 5 had a telephone interview. 23 in total. 21 were female
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Doshmangir 2015

Study characteristics	
Country	Iran
WHO Region	Eastern Mediterranean region
Type of cash transfer programme	UCT
Health condition	Well-being Nutrition
Sample population	Semistructured interviews with 14 fathers and 4 mothers, heads of household
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being and nutrition
Notes	

Ferreira 2009

Study characteristics	
Country	Brasil
WHO Region	Region of the Americas
Type of cash transfer programme	CCT

Ferreira 2009 *(Continued)*

Health condition	Healthcare seeking
Sample population	2 FGDs of 3 and 5 people each with recipient mothers
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Galárraga 2020

Study characteristics	
Country	Ghana
WHO Region	Africa region
Type of cash transfer programme	Incentive
Health condition	Infectious diseases (HIV)
Sample population	35 adolescents, with median age of 14 years old, 63% were male
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Garthwaite 2014a

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Non-communicable diseases
Sample population	25 recipients, out of which 15 were women and 10 were men

Garthwaite 2014a *(Continued)*

Richness scale	5
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (NCDs)
Notes	

Garthwaite 2014b

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Long-term illnesses
Sample population	25 recipients, out of which 15 were women and 10 were men
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (long-term illnesses)
Notes	

Garthwaite 2015

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Long-term illnesses (chronic condition)
Sample population	25 recipients, out of which 15 were women and 10 were men
Richness scale	5
Sampling status	Included for analysis

Garthwaite 2015 *(Continued)*

Reason for not sampling (if applicable)	N/a
Notes	

Gewurtz 2019

Study characteristics	
Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Mental health
Sample population	69 IDIs
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Ghose 2019

Study characteristics	
Country	United States of America
WHO Region	Region of the Americas
Type of cash transfer programme	Incentive
Health condition	Infectious diseases (HIV)
Sample population	30 participants
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of health condition (HIV)
Notes	

Gil-García 2016

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Nutrition
Sample population	30 heads of household and ethnographic participants
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Godfrey-Wood 2019

Study characteristics	
Country	Bolivia
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Healthcare seeking
Sample population	Ethnographic data collected through participant observation and semistructured interviews with 58 community members from 2 rural communities
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Goldblatt 2009

Study characteristics

Goldblatt 2009 *(Continued)*

Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	93 individuals including administrators and recipients
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Gopalan 2012

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	19 FDGs with 141 recipients
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of cash transfer programme (JSY)
Notes	

Goudge 2009

Study characteristics	
Country	South Africa
WHO Region	African region

Goudge 2009 *(Continued)*

Type of cash transfer programme	UCT
Health condition	Child health
Sample population	Case study with 15 households
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Govender 2015

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	1200 patient exit interviews and 17 IDI with patients
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of country (South Africa) and health condition (HIV)
Notes	

Gram 2019

Study characteristics	
Country	Nepal
WHO Region	South-East Asian region
Type of cash transfer programme	UCT cash-plus
Health condition	Maternal and child health

Gram 2019 *(Continued)*

	Sexual and reproductive health
Sample population	22 recipient women
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Greene 2017

Study characteristics	
Country	United States of America
WHO Region	Region of the Americas
Type of cash transfer programme	Incentive
Health condition	Infectious diseases (HIV)
Sample population	72 recipients
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of health condition (HIV)
Notes	

Harrington 2011

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Healthcare seeking
Sample population	30 recipient women and 1 participant from a rural village

Harrington 2011 *(Continued)*

Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of cash transfer programme (PROGRESA)
Notes	

Hikuroa 2017

Study characteristics	
Country	New Zealand
WHO Region	Western Pacific region
Type of cash transfer programme	CCT cash-plus
Health condition	Preventive health (smoking cessation)
Sample population	10 nursing students and their quit partner
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Holler 2020

Study characteristics	
Country	Israel
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	30 physically impaired men and women
Richness scale	4
Sampling status	Included for analysis

Holler 2020 *(Continued)*

Reason for not sampling (if applicable)	N/a
Notes	

Howel 2019

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Well-being
Sample population	50 individuals
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being
Notes	

Huda 2018

Study characteristics	
Country	Bangladesh
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Nutrition
Sample population	14 enrolled women, out of which 7 had delivered a baby and 7 were pregnant
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on nutrition
Notes	

Jongbloed 1998

Study characteristics	
Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Long-term illnesses (multiple sclerosis)
Sample population	23 women with MS
Richness scale	5
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Kelly 2019

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	32 people were formally involved in the study, but research activities centred on the stories and experiences of a group of 10 people accessing or seeking access to DGs in the community, who took part in 2 to 5 of the focus groups held (comprising 6-8 people) over the course of 3 months, as well as individual interviews and numerous informal engagements
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Khoza 2018

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT/CCT cash-plus
Health condition	Infectious diseases (HIV)
Sample population	49 IDIs between 16 and 18 year olds
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Knight 2013

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	10 households with an adult living with HIV or a person who had died from HIV
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Krishnan 2014

Study characteristics	
Country	India

Krishnan 2014 *(Continued)*

WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	IDI with 2 recipients
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Kuper 2016

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Disability
Sample population	33 semistructured interviews with people with disabilities and stakeholders, and 34 people in FGDs, out of which 19 were men and 15 were women
Richness scale	2
Sampling status	Eligible but not included
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Lahariya 2011

Study characteristics	
Country	India
WHO Region	South-East Asian region

Lahariya 2011 *(Continued)*

Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	IDI with 100 recipients
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Le Port 2019

Study characteristics	
Country	Mali
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Maternal and child health Sexual and reproductive health Nutrition
Sample population	Semistructured observation of cash distribution and semistructured interviews with 22 mothers selected from a survey
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Leclerc-Madlala 2006

Study characteristics	
Country	South Africa
WHO Region	African region

Leclerc-Madlala 2006 *(Continued)*

Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	33 support group members
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of country (South Africa) and health condition (HIV)
Notes	

Lees 2021

Study characteristics	
Country	Mali
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Well-being
Sample population	18 men, 18 first wives and 8 second wives
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being
Notes	

Leite 2011

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Non-communicable diseases (myalgic encephalomyelitis/chronic fatigue syndrome)

Leite 2011 *(Continued)*

Sample population	IDIs with 35 adults with ME/CFS and FGDs with 6 people
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (NCDs)
Notes	

Lloyd-Sherlock 2006

Study characteristics	
Country	Brazil
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Elderly
Sample population	20 IDIs in greater Rio de Janeiro
Richness scale	1
Sampling status	Eligible but not included
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

MacGregor 2006

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Mental health
Sample population	No information
Richness scale	2

MacGregor 2006 *(Continued)*

Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

MacPhail 2013

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	38 IDI with young women between 13 and 20 years old
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

MacPhail 2017

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	38 IDI with young women between 13 and 20 years old
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of country (South Africa) and health condition (HIV)

MacPhail 2017 *(Continued)*

Notes

Manji 2017

Study characteristics	
Country	United Kingdom
WHO Region	European region
Type of cash transfer programme	Multi-type
Health condition	Disability
Sample population	23 working-aged people with disability between 18 and 65 years old
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (disability)
Notes	

Miller 2012

Study characteristics	
Country	Malawi
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	24 semistructured interviews with PLWHA who were SCT recipients
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Molyneux 2011

Study characteristics	
Country	Peru, Ecuador and Bolivia
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	No information
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Nirgude 2019

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (TB)
Sample population	IDI with 10 people with TB, out of which 7 people received the cash transfer and 3 did not receive it
Richness scale	5
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Ong'olo 2009

Study characteristics	
Country	South Africa

Ong'olo 2009 *(Continued)*

WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	3 FGDs with 15 people from both sexes, and 3 individual interviews (2 women and 1 man)
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Opoku 2019

Study characteristics	
Country	Ghana
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	Semistructured interviews with 48 participants, out of which 20 were males and 28 were female
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Minimal focus on health
Notes	

Owusu-Addo 2016

Study characteristics	
Country	Ghana
WHO Region	African region
Type of cash transfer programme	CCT

Owusu-Addo 2016 *(Continued)*

Health condition	Well-being
Sample population	18 caregivers in semistructured interviews
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being
Notes	

Owusu-Addo 2020

Study characteristics	
Country	Ghana
WHO Region	African region
Type of cash transfer programme	UCT/CCT
Health condition	Maternal and child health Sexual and reproductive health Nutrition
Sample population	32 in-depth interviews and 12 focus groups with programme recipients, and observations
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Packel 2012

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)

Packel 2012 *(Continued)*

Sample population	66 transcripts of 80 interviews in the first round, 59 in the second round and then 49 more. Baseline 66 interviews and round 2 data for 95 interviews, 161 interviews in total representing 102 *(unclear sample)*
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of health condition (HIV) in the African region
Notes	

Palermo 2019

Study characteristics	
Country	Ghana
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Maternal and child health Sexual and reproductive health Nutrition
Sample population	IDIs with 20 recipient women at baseline, 12, and 24 months follow-up. Male partners of recipients at 12 and 24 months follow-up
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Parker 2015

Study characteristics	
Country	Australia
WHO Region	Western Pacific region
Type of cash transfer programme	Incentive
Health condition	Infectious diseases (chlamydia)

Parker 2015 *(Continued)*

Sample population	Semistructured telephone interviews with 18 young people
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Patel 2019

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (TB)
Sample population	11 in-depth interviews with patients
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Patel 2020

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Well-being
Sample population	Data collected for 131 families over the study period of 12 months
Richness scale	1

Patel 2020 *(Continued)*

Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Patrick 2014

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Welfare
Sample population	3 groups of out-of-work benefit claimants: young jobseekers (aged between 18 and 25); people with disability likely to be affected by the migration of Incapacity Benefit (IB) claimants onto Employment and Support Allowance (ESA); and single parents moving from Income Support (IS) onto Jobseeker's Allowance (JSA)
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Patrick 2016

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Welfare
Sample population	From the initial sample (22), 15 were selected to follow longitudinally, on the basis of those most likely to experience welfare reform during the period of the fieldwork. 9 women and 6 men from a range of age, with over-representation of women linked to the inclusion of single parents (disproportionately female) within the sample

Patrick 2016 *(Continued)*

Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Perry 2018

Study characteristics	
Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	Incentive
Health condition	Non-communicable diseases
Sample population	31 in-person focus groups with 212 programme participants, followed by a mail survey
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Pettifor 2019

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	60 IDIs and 20 narrative timeline interviews with AGYWs not in school between 15 and 23 years old
Richness scale	4
Sampling status	Eligible but not sampled

Pettifor 2019 *(Continued)*

Reason for not sampling (if applicable)	Over-representation of cash transfer programme (DREAMS)
Notes	

Peñalba 2019

Study characteristics	
Country	Philippines
WHO Region	Western Pacific region
Type of cash transfer programme	CCT
Health condition	Well-being
Sample population	5 recipient women, heads of household, between 33 and 56 years old
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being
Notes	

Plagerson 2011

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Mental health
Sample population	6 focus groups were conducted with grant recipients and non-recipients in the 3 survey communities included in the subsample; 52 semistructured interviews with a subsample of HEAD study participants in the same areas
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a

Plagerson 2011 *(Continued)*

Notes

Ploetner 2020

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Mental health
Sample population	23 participants, out of which 11 were women and 12 were men
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Price 2020

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Non-communicable diseases
Sample population	393 people in an online qualitative survey
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Puett 2018

Study characteristics	
Country	Burkina Faso
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Nutrition
Sample population	5 FGDs with 45 recipients
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on nutrition
Notes	

Rai 2011

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	Total 300 IDIs, out of which 24 IDIs each from mother given birth at home and institution, two IDIs each with members of Village Health and Sanitation Committees (VHSC)/Rogi Kalyan Samitis (RKS)
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Reisinger 2011

Study characteristics

Reisinger 2011 *(Continued)*

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	Incentive
Health condition	Non-communicable diseases (hypertension)
Sample population	Semistructured interviews with 54 veterans
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Robertson 2018

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	No information
Health condition	Non-communicable diseases
Sample population	393 people in an online qualitative survey
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (NCDs)
Notes	

Roelen 2017

Study characteristics	
Country	Ghana, Rwanda and South Africa
WHO Region	African region

Roelen 2017 *(Continued)*

Type of cash transfer programme	UCT
Health condition	Maternal and child health Sexual and reproductive health Nutrition
Sample population	Ghana: 101 adults and 98 children. Rwanda: 100 adults and 104 children. South Africa: 112 adults and 102 children
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Rossel 2019

Study characteristics	
Country	Uruguay
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Not health-related
Sample population	14 families who had been suspended from the programme for non-compliance with the education conditionality
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Minimal focus on health
Notes	

Rydell 2018

Study characteristics	
Country	USA
WHO Region	Region of the Americas

Rydell 2018 *(Continued)*

Type of cash transfer programme	Incentive
Health condition	Non-communicable diseases
Sample population	265 participants
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Saffer 2018

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	15 interviews with people with physical disabilities
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (disability)
Notes	

Samuels 2016

Study characteristics	
Country	Kenya, Mozambique, Occupied Palestinian Territories, Uganda, Yemen
WHO Region	African region and Middle East region
Type of cash transfer programme	UCT
Health condition	Disability

Samuels 2016 *(Continued)*

Sample population	In each country, 2 study sites were selected and in each site a set of qualitative and participatory data collection methods were applied. 38 structured observations
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Schnitzler 2020

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	4 ethnographic case studies
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Scott 2017

Study characteristics	
Country	Niger
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Nutrition
Sample population	124 women in focus groups or interviews
Richness scale	4

Scott 2017 *(Continued)*

Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on nutrition
Notes	

Shea 2017

Study characteristics	
Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	Incentive
Health condition	Non-communicable diseases
Sample population	30 semistructured telephone interviews with patients postintervention, 10 from each arm
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Shefer 2016

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability and mental health
Sample population	IDI with 17 disability grant recipients
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a

Shefer 2016 *(Continued)*

Notes

Sidney 2016

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	24 recipient women
Richness scale	5
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Skovdal 2014

Study characteristics	
Country	Zimbabwe
WHO Region	African region
Type of cash transfer programme	UCT/CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	35 IDIs and 3 focus groups with a total of 58 adults and 4 youths
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Smith-Oka 2009

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	Observations and IDIs with 58 recipients
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of cash transfer programme (Oportunidades)
Notes	

Soldatic 2018

Study characteristics	
Country	Australia
WHO Region	Western Pacific region
Type of cash transfer programme	CCT
Health condition	Disability
Sample population	3 in-depth interviews
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Sripad 2014

Study characteristics

Sripad 2014 *(Continued)*

Country	Ecuador
WHO Region	Region of the Americas
Type of cash transfer programme	No information
Health condition	Infectious diseases (TB)
Sample population	97 recipients
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Stainton 2004

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability
Sample population	25 recipients
Richness scale	5
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Minimal focus on health
Notes	

Stoner 2020

Study characteristics	
Country	South Africa
WHO Region	African region

Stoner 2020 *(Continued)*

Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	22 young women from intervention
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Struthers 2019

Study characteristics	
Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	UCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	20 interviews (17 in person and 3 over the phone) with recipients
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Syukri 2010

Study characteristics	
Country	Indonesia
WHO Region	South-East Asian region
Type of cash transfer programme	CCT

Syukri 2010 *(Continued)*

Health condition	Maternal and child health Sexual and reproductive health
Sample population	24 households of recipients in 4 villages
Richness scale	2
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Thomson 2014

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	CCT
Health condition	Preventive health (smoking cessation in pregnancy)
Sample population	88 pregnant women/recent mothers/partners/family members. 53 service providers, 24 experts and interactive discussions with 63 conference attendees
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Tolley 2018

Study characteristics	
Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT Cash-Plus
Health condition	Infectious diseases (HIV)

Tolley 2018 *(Continued)*

Sample population	76 interviews from 14 clinics
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Tonguet-Papucci 2017

Study characteristics	
Country	Burkina Faso
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Nutrition
Sample population	First year: 375 people that received cash transfers and 22 people from control group. Second year: 549 people that received cash transfers and 19 from control group
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on nutrition
Notes	

Turkey 2012

Study characteristics	
Country	Turkey
WHO Region	European region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	94 interviews with recipients

Turkey 2012 *(Continued)*

Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Similar to another sampled study (Yildirim 2014)
Notes	

Ukwaja 2017

Study characteristics	
Country	Nigeria
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (TB)
Sample population	103 in-depth interviews and 2 focus group discussions with patients who received the intervention
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

VanDevanter 2000

Study characteristics	
Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	20 women who participated in the intervention, divided between the sites
Richness scale	1
Sampling status	Eligible but not sampled

VanDevanter 2000 *(Continued)*

Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Vega 2017

Study characteristics	
Country	Mexico
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	2069 people interviewed (included mothers, partners, person that assisted in the birth and legislators)
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Vellakkal 2017

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	41 mothers who gave birth in the last year, 44 spouses and 11 residential mothers-in-law. Only 1 participant from each household
Richness scale	4
Sampling status	Eligible but not sampled

Vellakkal 2017 *(Continued)*

Reason for not sampling (if applicable)	Similar to a sampled study (Sidney 2016)
Notes	

Vlassoff 2017

Study characteristics	
Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual reproductive health
Sample population	5 recipients of the SHP (3 female and 2 male) interviews
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Wamoyi 2020

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	20 longitudinal in-depth interviews (IDIs) and 60 cross-sectional IDIs with AGYW in the cash transfer programme
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a

Wamoyi 2020 *(Continued)*

Notes

Wamoyi 2020a

Study characteristics	
Country	Tanzania
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (HIV)
Sample population	20 longitudinal in-depth interviews, 40 cross-sectional in-depth interviews, and 20 narrative timeline interviews with AGYW aged 15-23 participating in a cash transfer intervention
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Similar to a sampled study by same author
Notes	

Wei 2009

Study characteristics	
Country	China
WHO Region	Western Pacific region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (TB)
Sample population	IDI with 32 patients
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Wingfield 2015

Study characteristics	
Country	Peru
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Infectious diseases (TB)
Sample population	Unclear for the qualitative data, from 312 patients to 149 randomised to receive socioeconomic intervention
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Woolgar 2014

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Sample population	3 focus groups, 15 participants. 2 groups had experience with the cash transfer
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

World Bank 2012

Study characteristics

World Bank 2012 *(Continued)*

Country	Indonesia
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	No information
Sample population	No information
Richness scale	1
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Insufficient data quality
Notes	

Wright 2019

Study characteristics	
Country	UK
WHO Region	European region
Type of cash transfer programme	CCT
Health condition	Disability
Sample population	1082 interviews one study (welfare service users) and 59 interviews another study (single parents, disabled people and jobseekers)
Richness scale	3
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Over-representation of setting (UK) and health condition (disability)
Notes	

Yeboah 2016

Study characteristics	
Country	Ghana
WHO Region	African region

Yeboah 2016 *(Continued)*

Type of cash transfer programme	UCT/CCT
Health condition	Maternal and child health Sexual and reproductive health Nutrition
Sample population	22 individual interviews, 5 group interviews and 2 focus group discussions with beneficiaries and CLIC (community LEAP implementation committees) members
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Yildirim 2014

Study characteristics	
Country	Turkey
WHO Region	European region
Type of cash transfer programme	CCT
Health condition	Maternal and child health Sexual and reproductive health
Sample population	397 in-depth interviews with recipients (265 stated implicitly) and key informants
Richness scale	4
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Yin 2018

Study characteristics	
Country	China
WHO Region	Western Pacific region

Yin 2018 *(Continued)*

Type of cash transfer programme	CCT
Health condition	Infectious diseases (TB)
Sample population	In-depth interviews with 10 health workers and 10 patients. Retrospective cohort with 218 participants
Richness scale	3
Sampling status	Included for analysis
Reason for not sampling (if applicable)	N/a
Notes	

Zembe-Mkabile 2018

Study characteristics	
Country	South Africa
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Well-being Nutrition
Sample population	40 IDIs with mothers or primary caregivers of children under 5
Richness scale	4
Sampling status	Eligible but not sampled
Reason for not sampling (if applicable)	Focus only on well-being
Notes	

AGYW: adolescent girls and young women
CCT: conditional cash transfers
CFS: chronic fatigue syndrome
CLIC: community LEAP implementation committees
DG: disability grant
ESA: Employment and Support Allowance
FGD: focus-group discusssion
HEAD: Health, Environment and Development
HPV: human papillomavirus
IB: Incapacity Benefit
IDI: in-depth interview
IS: Income Support
JSA: Jobseeker's Allowance
JSY: Janani Suraksha Yojana

LEAP: Livelihood Empowerment Against Poverty
ME: myalgic encephalomyelitis
MS: multiple sclerosis
N/a: not applicable
NCD: non-communicable disease
PLWHA: people living with HIV/AIDS
RKS: Rogi Kalyan Samitis
SCT: social cash transfer
SHP: Second Honeymoon Package
TB: tuberculosis
UCT: unconditional cash transfers
VHSC: Village Health and Sanitation Committees

Characteristics of excluded studies *[ordered by study ID]*

Study	Reason for exclusion
Abbott 2000	No qualitative data
Abdul 2020	No qualitative data
Adams 2015	Examination of potential interventions
Adams 2016	Examination of potential interventions
Alves 2013b	Duplicate
Alves 2013c	Duplicate
Bermudez 2021	Wrong intervention (no cash transfer)
Blondon 2014	Examination of potential interventions
Bonevski 2011	Examination of potential interventions
Brasil 2005	No qualitative data
Brown 2019	Wrong intervention (no cash transfer)
Buller 2018	Wrong study type (no primary research)
Carrico 2016	Wrong study design
Choko 2017	Examination of potential intervention
Cluver 2013	No qualitative data
Costa 2020	Wrong recipient (no participant)
Courtin 2018	No qualitative data
Crewe 2016	Examination of potential intervention
Dadun 2016	Examination of potential intervention
Dar 2022	Wrong intervention (no cash transfer)

Study	Reason for exclusion
Davey 2021	No qualitative data
Dawar 2021	Wrong outcome (no focus on health and well-being)
De Milliano 2021	Wrong outcome (no focus on health and well-being)
De Savigny 2012	Wrong intervention (no cash transfer)
Easton 2018	Wrong outcome (no focus on health and well-being)
Evans 1987	No qualitative data
Falb 2021	Examination of potential intervention
Galarraga 2020a	Examination of potential intervention
Giles 2015a	Wrong participant (no recipient)
Giles 2015b	Examination of potential interventions
Gooding 2009	Wrong study type (no primary research)
Gopalan 2015	Wrong intervention (no cash transfer)
Gyan 2017	Wrong intervention (no cash transfer)
Hernández 2021	Wrong outcome (no focus on health and well-being)
Hjelm 2017	No qualitative data
Huang 2012	Wrong intervention (no cash transfer)
Huda 2018a	Duplicate
Hysong 2017	Wrong participant (no recipient)
Ir 2010	Wrong intervention (no cash transfer)
Jahangeer 2020	No qualitative data
Jones 2022	Wrong outcome (no focus on health and well-being)
Keigher 2011	Wrong outcome (no focus on health and well-being)
Kennedy 2014	Examination of potential interventions
Khoza 2018a	Wrong participant (no recipient)
Kullgren 2014	No qualitative data
Kumar 2020	No qualitative data
Lahariya 2011a	Duplicate
Lassa 2022	Wrong participant (no recipient)

Study	Reason for exclusion
Leng 2022	Wrong outcome (no focus on health and well-being)
Lewandowski 2009	No qualitative data
Lutge 2014	Wrong intervention (no cash transfer)
Luthuli 2022	Wrong outcome (no focus on health and well-being)
Malik 2020	Examination of potential interventions
Maluccio 2010	Wrong study type (no primary research)
Mantzari 2012	Wrong intervention (no cash transfer)
Mariano 2020	Wrong outcome (no focus on health and well-being)
McClinton 2021	Wrong intervention (no cash transfer)
McGill 2018	Examination of potential intervention
McKelvey 2018	Wrong outcome (focus on cash transfer for intervention not behaviour)
McNaughton 2016	Examination of potential intervention
Milimo 2021	Wrong outcome (no focus on health and well-being)
Miller 2010	Wrong outcome (no focus on health and well-being)
Mitchell 2014	Examination of potential intervention
Mitchell 2018	Wrong participant (no recipient)
Moffatt 2010	Wrong intervention (no cash transfer)
Molema 2019	Wrong participant (no recipient)
Moraes 2018	Wrong participant (no participant)
Moucheraud 2020	Wrong intervention (no cash transfer)
Mukhopadhyay 2013	Wrong intervention (no cash transfer)
Ndyabakira 2019	Wrong intervention (no cash transfer)
Ni 2012	Examination of potential intervention
Njuki 2013	Wrong intervention (no cash transfer)
Obare 2014	No qualitative data
Oduenyi 2019	No qualitative data
Ormston 2015	Wrong intervention (no cash transfer)
Owusu-Addo 2016a	Duplicate

Study	Reason for exclusion
Park 2012	Examination of potential intervention
Passey 2018	Wrong intervention (no cash transfer)
Phillips 2019	Examination of potential intervention
Plessis 2019	Wrong intervention (no cash transfer)
Priebe 2010	Examination of potential intervention
Pullen 2018	Wrong intervention (no cash transfer)
Ramírez 2021	Wrong participant (no recipient)
Ranganathan 2022	Wrong intervention (no cash transfer)
Ridde 2011	Wrong intervention (no cash transfer)
Rockliffe 2020	Paediatric population
Sacks 2015	Wrong intervention (no cash transfer)
Salinas-Rodríguez 2022	No qualitative data
Savin 2021	Wrong outcome (not focus on health and well-being)
Schoenberg 2015	Wrong intervention (no cash transfer)
Setiawan 2021	Wrong outcome (no focus on health and well-being)
Shah 2018	Wrong intervention (no cash transfer)
Shah 2020	Wrong intervention (no cash transfer)
Shei 2014	No qualitative data
Shelus 2018	Wrong intervention (no cash transfer)
Sherr 2020	No qualitative data
Sherr 2021	No qualitative data
Sidney 2012	No qualitative data
Skovdal 2008	Wrong outcome (no focus on health and well-being)
Taylor 2021	Wrong outcome (no focus on health and well-being)
Thrive 2019	Wrong study type (no primary research)
Topp 2013	No qualitative data
Vajravelu 2022	Examination of potential intervention
Virgona 2022	Wrong intervention (no cash transfer)

Study	Reason for exclusion
Warner 2020	Wrong participant (no recipient)
Weiser 2017	Wrong intervention (no cash transfer)
Whitford 2015	Examination of potential intervention
Wilding 2021	Examination of potential intervention
Ytrehus 2015	Wrong intervention (no cash transfer)
Zembe-Mkabile 2022	Wrong outcome (no focus on health and well-being)

Characteristics of studies awaiting classification *[ordered by study ID]*

Afroz 2021

Country	Bangladesh
WHO Region	South-East Asian region
Type of cash transfer programme	CCT cash-plus
Health condition	Infectious diseases (HIV)
Notes	

Alam 2020

Country	Bangladesh
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Nutrition
Notes	

Atkins 2021

Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Barrington 2022

Country	Ghana
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Sexual and reproductive health
Notes	

Camlin 2022

Country	Uganda
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Cena 2020

Country	Argentina
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Maternal and child health
Notes	

Cheetham 2019

Country	UK
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Disability
Notes	

Clifton 2022

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (colorectal cancer)
Notes	

Dave 2022

Country	India
WHO Region	South-East Asian region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (TB)
Notes	

Ehlers 2022

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (bariatric surgery)
Notes	

Ezenwaka 2021

Country	Nigeria
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Maternal and child health
Notes	

Galarraga 2020

Country	Ghana
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Gangaramany 2021

Country	Tanzania
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Sexual and reproductive health
Notes	

Ghose 2021

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Gong 2020

Country	Armenia
WHO Region	European region
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases
Notes	

Iguna 2022

Country	Kenya
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Kangwana 2022

Country	Kenya
WHO Region	African region
Type of cash transfer programme	Cash-plus
Health condition	Sexual and reproductive health
Notes	

Karakara 2022

Country	Ghana
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Access to health services
Notes	

Kenyon 2020

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (asthma)
Notes	

Krukowski 2022

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (obesity)
Notes	

Lees 2021a

Country	Mali
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Sexual and reproductive health
Notes	

Paajanen 2021

Country	Finland
WHO Region	European region
Type of cash transfer programme	UCT
Health condition	Non-communicable diseases
Notes	

Packel 2021

Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Perez 2020

Country	Philippines
WHO Region	Western Pacific region
Type of cash transfer programme	CCT
Health condition	Maternal and child health
Notes	

Reid 2022

Country	Canada
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Mental health
Notes	

Shay 2021

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (colorectal cancer)
Notes	

Spencer 2022

Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Sexual and reproductive health Well-being
Notes	

Stein 2022

Country	Uganda
WHO Region	African region
Type of cash transfer programme	UCT
Health condition	Infectious diseases (Covid-19) Healthcare seeking Well-being Nutrition
Notes	

Swartz 2022

Country	South Africa
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

Voils 2021

Country	USA
WHO Region	Region of the Americas
Type of cash transfer programme	CCT
Health condition	Non-communicable diseases (obesity)
Notes	

Wamoyi 2021

Country	Tanzania
WHO Region	African region
Type of cash transfer programme	CCT cash-plus
Health condition	Infectious diseases (HIV)
Notes	

Zhang 2021	
Country	Kenya
WHO Region	African region
Type of cash transfer programme	CCT
Health condition	Infectious diseases (HIV)
Notes	

CCT: conditional cash transfers
Covid-19: coronavirus disease-19
TB: tuberculosis
UCT: unconditional cash transfers

ADDITIONAL TABLES

Table 1. GRADE-CERQual qualitative evidence profiles

Review finding	Methodological limitations	Coherence	Adequacy	Relevance	GRADE-CERQual assessment of confidence	Number of studies supporting finding
1. Recipients perceived the cash transfer as necessary and helpful for the immediate needs of the household, across all types of cash transfer programmes. They reported sharing their cash with their household out of duty, necessity or solidarity. Recipients were able to subsist on the cash transfer and provide for their families by purchasing day-to-day items and paying for living costs, meeting their immediate needs	**No/Very minor concerns** Explanation: Minor concerns regarding methodological limitations because there were only 2 papers with concerns regarding data analysis. Additionally, there were concerns about ethics and the relationship between the researchers and the participants. Reporting of recruitment strategy has not been thoroughly developed. But all the studies have appropriate aim and methodology to answer the	**No/Very minor concerns** Explanation: No concerns about coherence, as the finding is supported by 18 articles with over 40 quotes, with the only exception from 1 participant	**No/Very minor concerns** Explanation: There were 18 studies supporting the finding, out of which only 4 studies were categorised as 3 out of 5 on the richness scale, and the remaining 14 studies were categorised 4 out of 5 on the richness scale	**No/Very minor concerns** Explanation: No concern, because the finding is supported by studies covering all types of programmes, all WHO regions and targeted to different population groups	**High confidence** Explanation: Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	18 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

	research question					
2. Recipients across all types of programmes thought the cash amount was insufficient, as it only covered immediate but not all basic needs. In some cases, it was insufficient to cover the intended purposes of the programme	**No/Very minor concerns** Explanation: Minor concerns regarding methodological limitations because there were some concerns regarding ethics and relationship between researchers and participants. There were concerns regarding data analysis on 2 articles, but all articles had appropriate aim and methodology to answer the research question	**No/Very minor concerns** Explanation: The studies had clear underlying data supporting the finding, with 37 quotes	**No/Very minor concerns** Explanation: There were 20 studies supporting the finding. 5 studies categorised as 3, 1 study categorised as 5 and 14 studies categorised as 4 out of 5 on the richness scale	**No/Very minor concerns** Explanation: No concern	**High confidence** Explanation: Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	20 references
3. Recipients, primarily participating in CCT programmes, felt that the cash transfer was not enough to change their behaviour. However, perceptions differed amongst recipients from 3 CCT studies, who considered cash as the main driver or a mediator for changing health behaviours	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because around a third of the studies were unclear regarding ethical considerations and relationship between researchers and participants	**Moderate concerns** Explanation: Moderate concerns regarding coherence because there were conflicting findings across the different programmes and according to the design of the study	**Minor concerns** Explanation: Minor concerns regarding adequacy because there were 9 studies out of 41 supporting the finding. 3 studies were categorised as 3, 1 study as 5 and five studies as 4 out of 5 on the richness scale	**No/Very minor concerns** Explanation: No concern regarding relevance. The studies covered different WHO regions, including HIC and LMIC and the finding corresponds to mainly CCTs	**Moderate confidence** Explanation: Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Minor concerns regarding adequacy, and Minor concerns regarding relevance	9 references
4. Recipients thought that the cash transfer resulted in positive short- and long-term outcomes for them and their families in terms of better health, well-being and education.	**No/Very minor concerns** Explanation: Very minor con-	**No/Very minor concerns**	**No/Very minor concerns** Explanation: There were 4	**No/Very minor concerns**	**High confidence** Explanation: No/Very mi-	19 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

Some also thought that the programme provided the possibility to save or invest in productive activities	cerns, because the relationship between researchers and participants and ethical issues were not adequately addressed, and some studies had unclear methods to recruit participants	Explanation: There are 19 studies supporting this finding, with over 80 quotes	studies categorised as 3 and 15 studies categorised as 4 on the richness scale; all of them had the main focus on health	Explanation: All 19 studies had a good coverage of WHO regions and cover all types of programmes	nor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	
5. Across all types of programmes, the cash transfer was perceived to enhance the empowerment, autonomy and/or agency of recipients. Especially amongst women, empowerment and agency were reported through a feeling of security, better social relationships and enhanced decision-making power in households or with sexual partners. Women, adolescents, and people with disabilities felt that the cash gave them more autonomy, as it allowed them to become more independent and contribute to the household	**No/Very minor concerns** Explanation: Minor concerns, as the relationship between participants and researchers was not adequately considered	**No/Very minor concerns** Explanation: The finding is supported by the data, with the use of the same terms. There was only 1 study contradicting the finding, which had an explanation for it	**No/Very minor concerns** Explanation: There are 16 studies supporting the finding. 5 studies were rated as 3 on the richness scale, 1 study as 5 and 10 studies as 4 out of 5	**No/Very minor concerns** Explanation: The studies covered different WHO regions, including HIC and LMIC, and all types of programmes	**High confidence** Explanation: No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	16 references
6. Increased feelings of hope and resilience to overcome adverse life situations were observed especially within vulnerable groups and among people with HIV, tuberculosis or a long-term illness. Recipients' feelings of hope for a better life and the future motivated some of them to change their health behaviours. These feelings of hope came from the security, improved self-esteem and social status given by the cash	**Moderate concerns** Explanation: Moderate concerns regarding methodological limitations because there were 3 studies with unclear statement of findings. Additionally, the studies did not address the relationship between researchers and participants	**No/Very minor concerns** Explanation: The data support the finding with direct quotes from the studies' participants and with focus on people with HIV, TB or long-term illness	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because there were only 5 studies out of 41 supporting the finding. However, 3 studies were categorised as 4 on the richness scale and 2 studies as 3	**No/Very minor concerns** Explanation: Very minor, because the studies covered different regions and different health conditions (infectious diseases and long-term illness)	**Moderate confidence** Explanation: Moderate concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	5 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

7. The cash transfer enhanced social cohesion and social capital building. Recipients reported feeling more connected to their community and uncomfortable about the exclusion of others from the programme. The cash transfer was also seen to lead to better family relationships and decreased levels of violence and stress in the household	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because only a few studies were unclear regarding ethical considerations and relationship between researchers and participants	**Minor concerns** Explanation: Minor concerns regarding coherence because they used second order-interpretation	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because there is only 1 study contributing to part of the finding, but the studies score high on the richness scale	**No/Very minor concerns** Explanation: Very minor, because the studies covered a wide range of regions and health conditions	**Moderate confidence** Explanation: Minor concerns regarding methodological limitations, Minor concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	9 references
8. Stigma was reported by recipients across all types of programmes, especially by people with a disability, mental disorders or long-term illnesses. Perceived stigma was often related to feelings of embarrassment and shame from being a cash transfer claimant or recipient. They also reported these feelings in relation to their illness and poor treatment by programme or medical assessors. Some recipients internalised the stigmatised identity imposed on them	**No/Very minor concerns** Explanation: Relationship between participant and researcher not addressed; 2 studies with no rigorous analysis	**No/Very minor concerns** Explanation: There is clear data supporting the finding	**No/Very minor concerns** Explanation: There are 15 studies supporting the finding, including 2 studies rated as 5 on the richness scale	**No/Very minor concerns**	**High confidence** Explanation: No/Very minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	15 references
9. Recipients, mainly those with disabilities, long-term illnesses or mental disorders, reported that the eligibility process was inappropriate due to restricted or incongruous criteria. They also reported that assessment processes were not suitable for people with disability and mental disorders. The method for choosing the recipients was also considered unfair	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because the studies did not address the relationship between researcher and participants and some studies did not have sufficient rigorous analysis	**No/Very minor concerns** Explanation: There is underlying data supporting the finding, with direct quotes from participants	**No/Very minor concerns** Explanation: There are 14 studies supporting the finding, 5 studies were rated 3, 7 studies were rated 4 and 2 studies were rated 5 out of 5 on the richness scale	**No/Very minor concerns** Explanation: Studies from HIC and LMIC, from different types of programme	**High confidence** Explanation: Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns	14 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

					regarding relevance	
10. Pressure, control, monitoring or restriction of the cash transfer used by those close to the recipients was observed across all types of programmes, especially among female recipients, who reported feelings of powerlessness. Pressure from the programme staff was also reported, either as corruption or "enforced recommendation"	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because studies did not consider the relationship between researcher and participant and did not address ethics considerations. Some studies had issues on clear statement of findings and rigorous analysis	**No/Very minor concerns** Explanation: There are around 18 quotes supporting the finding and the finding is very close to the underlying data	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because there are only 8 studies supporting the finding and 4 of them were more descriptive, rated 3 out of 5 on the richness scale	**Minor concerns** Explanation: Minor concerns regarding relevance because the finding is relevant for low- and middle-income settings	**Moderate confidence** Explanation: Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns regarding relevance	8 references
11. Social division, exclusion and isolation were commonly seen between recipients and non-recipients, sometimes associated with jealousy, envy and resentment	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because none of the studies addressed properly the relationship between researchers and participants and ethical issues were not clearly addressed	**No/Very minor concerns** Explanation: The finding is supported by clear data, with quotes from participants and clear description of the phenomena	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because the finding is supported by only 6 studies. However, 4 of them were rated 4 and 2 were rated as 3 out of 5 on the richness scale	**No/Very minor concerns** Explanation: The finding covered different geographical regions, including HIC and LMIC. It also referred to different types of health conditions and population groups and different types of programmes	**High confidence** Explanation: Minor concerns regarding methodological limitations, No/Very minor concerns regarding coherence, Minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	6 references
12. Recipients, especially people with disabilities, reported facing different types of barriers in receiving or accessing the cash transfer, including financial, knowledge, material	**Minor concerns** Explanation: Minor concerns regarding method-	**Minor concerns** Explanation: Mi-	**No/Very minor concerns** Explanation: The finding	**Minor concerns** Explanation: Minor	**Moderate confidence** Explanation: Minor con-	20 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

and physical barriers. They reported complicated and cumbersome application or appeal processes and delays in receiving the cash, which led to stress	ological limitations because some studies did not have rigorous analysis and some studies did not address the relationship between researcher and participants and ethical issues	nor concerns regarding coherence because not all studies contributed to all aspects of the findings, as there were different types of barriers according to context and target group	is supported by 20 out of 41 studies. 7 studies were rated 3 on the richness scale, 2 studies were rated 5 and 11 studies were rated 4 out of 5 on the richness scale	concerns regarding relevance because the finding was seen in different global regions, including HIC and LMIC, but only across 2 types of programmes (UCT and CCT)	cerns regarding methodological limitations, Minor concerns regarding coherence, No/Very minor concerns regarding adequacy, and No/Very minor concerns regarding relevance	
13. Recipients' participation in and perspectives of the programme were perceived by the studies' authors as necessary for its acceptability and effectiveness. CCT programmes that were sensitive to recipients' needs and had easy-to-understand, non-punitive and fair conditions were reported by recipients as more acceptable	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because the relationship between researchers and participants and ethical issues were not addressed in most studies. Additionally, some studies had unclear recruitment strategies	**Serious concerns** Explanation: Serious concerns regarding coherence because the finding is supported mostly by views from the authors	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because the finding is supported by 7 studies, out of which 5 were rated 3 out of 5 on the richness scale	**No/Very minor concerns** Explanation: The finding covered different regions, with both HIC and LMIC. It was also relevant to different health conditions and different programme types (UCT, CCT and cash-plus)	**Low confidence** Explanation: Minor concerns regarding methodological limitations, Serious concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	7 references
14. Refusal or hesitancy in relation to receiving or applying for the cash transfer was seen in some cases to be motivated by distrust in the government or the programme and negative interactions with the programme staff. Personal circumstances relating to hesitance in applying for cash transfers included lack of motivation, competing demands and internalisation of the stigmatised identity of being 'lazy', mostly by people with mental illnesses	**Minor concerns** Explanation: Minor concerns regarding methodological limitations because some articles had concerns regarding ethics and did not address the relationship between	**Moderate concerns** Explanation: Moderate concerns regarding coherence because the finding is based on around 10 quotes only and corre-	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because there are only 5 studies supporting the finding, out of which three were rated 3 out of 5 on the	**Minor concerns** Explanation: Minor concerns regarding relevance because the finding covered several global regions and differ-	**Moderate confidence** Explanation: Minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and Minor concerns	5 references

Table 1. GRADE-CERQual qualitative evidence profiles *(Continued)*

	researcher and participant	spond to a higher level of interpretation of the data	richness scale, as they were more descriptive	ent health conditions, but it was mostly focused on only UCT programmes	regarding relevance	
15. Recipients found the programme more acceptable when they agreed with its goals and processes and also perceived advantages in being enrolled. They accepted the programme more readily when it was easily accessed and clear information was provided. This positive perception also contributed to recipients feeling satisfied and appreciative, which further enhanced acceptance of the programmes	**No/Very minor concerns** Explanation: Very minor concerns due to unclear report on the relationship between researchers and participants and unclear consideration of ethical issues. A few articles had unclear recruitment strategy appropriate to the aims of the research	**Moderate concerns** Explanation: Moderate concerns regarding coherence because there are different nuances in the finding. The term "acceptability" was a second order construct, and the underlying data mentioned different terms, such as "like", "appreciate", "think it is good"	**Moderate concerns** Explanation: Moderate concerns regarding adequacy because there are only 7 studies supporting the data, out of which 3 were rated 3 and 3 were rated 4 out of 5 on the richness scale. But 1 article was rated 5	**No/Very minor concerns** Explanation: Minor concerns regarding relevance because the finding covered both HIC and LMIC and different types of programmes. It also corresponded to different target groups and different health conditions	**Moderate confidence** Explanation: No/Very minor concerns regarding methodological limitations, Moderate concerns regarding coherence, Moderate concerns regarding adequacy, and No/Very minor concerns regarding relevance	7 references

CCT: conditional cash transfers
GRADE-CERQual: Confidence in the Evidence from Reviews of Qualitative Research
HIC: high-income countries
LMIC: low- and middle-income countries
TB: tuberculosis
UCT: unconditional cash transfers
WHO: World Health Organization

Table 2. Methodological limitations of included studies[a,b]

Study ID	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?
Adato 2000a	Yes	Yes	Yes	Insufficient	Yes	No	Insufficient	No	NO
Arkorful 2020	Yes	No	Insufficient	Insufficient	Yes	No	Yes	No	YES
Baba-Ari 2018	Yes	Yes	Yes	Yes	Yes	No	Yes	Insufficient	YES
Balen 2018	No	Yes	Insufficient	Insufficient	Yes	Insufficient	No	Insufficient	YES
Banda 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	YES
Banks 2019a	Yes	Yes	Yes	Yes	Yes	No	Yes	No	YES
Banks 2019b	Yes	Yes	Yes	Yes	No	No	Yes	No	YES
Baral 2014	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	INS
Beskin 2019	Yes	Yes	Insufficient	Insufficient	Yes	No	Yes	Yes	YES
Cooper 2017	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
Czaicki 2017	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
De Wolfe 2012	No	Yes	Yes	Yes	Yes	Yes	No	No	YES
Garthwaite 2015	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	INS
Gewurtz 2019	Yes	Yes	Yes	Yes	Yes	No	No	Yes	YES

Table 2. Methodological limitations of included studies[a,b] *(Continued)*

Gram 2019	Yes	Yes	Yes	Yes	Yes	Insuffi-cient	Insufficient	Insuffi-cient	YES
Holler 2020	Yes	Yes	Yes	Insufficient	Yes	No	Yes	Yes	YES
Jongbloed 1998	Yes	Yes	Yes	Yes	Yes	No	No	Yes	YES
Kelly 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Insuffi-cient	YES
Khoza 2018	Yes	Yes	Yes	Insufficient	Yes	Insuffi-cient	Insufficient	Yes	YES
Hikuroa 2017	Yes	Yes	Yes	Yes	Yes	Insuffi-cient	Yes	Insuffi-cient	YES
MacPhail 2013	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
Miller 2012	Yes	Yes	Yes	Insufficient	Yes	No	Insufficient	Insuffi-cient	YES
Nirgude 2019	Yes	Yes	Yes	Yes	Insuffi-cient	Insuffi-cient	Yes	Yes	YES
Owusu-Addo 2020	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	YES
Plagerson 2011	Yes	Yes	Yes	Insufficient	Yes	No	No	Yes	YES
Ploetner 2020	Insuffi-cient	Yes	Yes	Yes	Insuffi-cient	No	Insufficient	Insuffi-cient	YES
Samuels 2016	Insuffi-cient	Yes	Yes	Insufficient	Yes	No	Insufficient	No	NO
Shefer 2016	Yes	Yes	Yes	Insufficient	Yes	No	Insufficient	Insuffi-cient	NO
Sidney 2016	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
Skovdal 2014	Yes	Yes	Yes	No	Yes	No	Insufficient	Yes	YES
Stoner 2020	Yes	Yes	Yes	Yes	Yes	No	No	Yes	YES

Table 2. Methodological limitations of included studies[a,b] *(Continued)*

Struthers 2019	Yes	Yes	Yes	Yes	Yes	Yes	Insufficient	Yes	INS
Thomson 2014	Yes	Yes	Yes	Yes	Yes	Insuffi-cient	Yes	Yes	YES
Tolley 2018	Yes	Yes	Yes	Yes	Insuffi-cient	No	Insufficient	Yes	YES
Ukwaja 2017	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	INS
Wamoyi 2020a	Yes	Yes	Yes	Insufficient	Yes	No	Insufficient	Insuffi-cient	YES
Wei 2009	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
Woolgar 2014	Yes	Yes	Yes	Insufficient	Yes	Insuffi-cient	Yes	Yes	YES
Yeboah 2016	Yes	Yes	Yes	Yes	Yes	No	No	Yes	YES
Yildirim 2014	Yes	Yes	Yes	Yes	Yes	No	Insufficient	Yes	YES
Yin 2018	Yes	Yes	Yes	Yes	No	No	Insufficient	Yes	YES

[a]Based on an application of a modified version of the Critical Appraisal Skills Programme (CASP) tool.
[b]We assessed each criterion using the following options:
YES: the criterion was sufficiently, clearly, and appropriately described in the study
INS(UFFICIENT): the study only offered a limited description of the criterion
NO: the criterion was not described in the study

APPENDICES

Appendix 1. Search strategies

Database search strategies:

Epistemonikos, Epistemonikos Foundation (www.epistemonikos.org/) (searched 4 July 2022).

Advanced search - Title/Abstract:

Search
(condition* OR uncondition*) AND ("cash transfer" OR "cash transfers" OR "economic transfer" OR "economic transfers" OR "monetary transfer" OR "monetary transfers" OR "financial transfer" OR "financial transfers" OR "cash incentive" OR "cash incentives" OR "economic incentive" OR "economic incentives" OR "monetary incentive" OR "monetary incentives" OR "financial incentive" OR "financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR "monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial interventions")
OR
(condition* OR uncondition*) AND reward* AND (cash OR economic* OR financial OR monetary OR money OR payment* OR paying)

Ovid MEDLINE(R) ALL <1946 to July 01, 2022> (searched 4 July 2022).

#	Search	Results
1	Financial Support/	3894
2	Financing, Government/	21315
3	Reward/	24515
4	Public Assistance/ec [Economics]	418
5	Social Welfare/ec [Economics]	1419
6	Social Security/ec [Economics]	1086
7	Token Economy/	950
8	((financial or economic or monetary) adj support*).ti,ab,kf.	6190
9	((condition* or contingent or uncondition*) adj3 (cash or grant* or reward* or payment* or benefits or money)).ti,ab,kf.	3715
10	((cash or economic or financial or monetary) adj (transfer* or grant* or award* or reward* or payment* or benefits or incentive* or intervention* or program* or scheme?)).ti,ab,kf.	17694
11	((social protection or social security or social welfare) adj6 (cash or economic or financial or monetary or money or payment*)).ti,ab,kf.	647

(Continued)

12	(cash plus or transfer* cash).ti,ab,kf.	32
13	((addition* or supplement*) adj3 income).ti,ab,kf.	1586
14	(support grant or support grants).ti,ab,kf.	123
15	or/1-14	77989
16	Qualitative Research/	75064
17	Interviews as Topic/	66801
18	qualitative.ti,ab,kf.	291624
19	interview*.ti,ab,kf.	420117
20	themes.ti,ab,kf.	94420
21	mixed method?.ti,ab,kf.	33743
22	or/16-21	666847
23	15 and 22	4745

CINAHL, EbscoHost <1980 to present> (searched 4 July 2022).

#	Query	Results
S18	S17 [Limiters - Exclude MEDLINE records]	2,481
S17	S11 AND S16	4,525
S16	S12 OR S13 OR S14 OR S15	459,91
S15	TI (qualitative or interview* or "thematic analysis" or themes or mixed W0 method*) OR AB (qualitative or interview* or "thematic analysis" or themes or mixed W0 method*)	361,779
S14	(MH "Thematic Analysis")	76,817
S13	(MH "Interviews")	160,812
S12	(MH "Qualitative Studies")	133,38

(Continued)

S11	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10	42,113
S10	TI ((addition* or supplement*) N3 income) OR AB ((addition* or supplement*) N3 income)	1,045
S9	TI ("cash plus" or "support grant" or "support grants" or transfer* W0 cash) OR AB ("cash plus" or "support grant" or "support grants" or transfer* W0 cash)	86
S8	TI (("social protection" or "social security" or "social welfare") N6 (cash or economic or financial or monetary or money or payment*)) OR AB (("social protection" or "social security" or "social welfare") N6 (cash or economic or financial or monetary or money or payment*))	291
S7	TI ((cash or economic or financial or monetary) W0 (transfer* or grant* or award* or reward* or payment* or benefits or incentive* or intervention* or program* or scheme*)) OR AB ((cash or economic or financial or monetary) W0 (transfer* or grant* or award* or reward* or payment* or benefits or incentive* or intervention* or program* or scheme*))S1	8,09
S6	TI ((condition* or contingent or uncondition*) N3 (cash or grant* or reward* or payment* or benefit* or money)) OR AB ((condition* or contingent or uncondition*) N3 (cash or grant* or reward* or payment* or benefit* or money))	2,058
S5	TI ((financial or economic or monetary) W0 support*) OR AB ((financial or economic or monetary) W0 support*)	2,715
S4	(MH "Social Welfare/EC")	404
S3	(MH "Public Assistance/EC")	146
S2	(MH "Economic and Social Security")	4,373
S1	(MH "Financial Support") or (MH "Financing, Government") or (MH Reward)	25,529

Social Services Abstracts, ProQuest <1979 to present> (searched 4 July 2022).

#	Search terms	Results
S1	SU("conditional cash" OR "unconditional cash")	26
S2	TI((condition* OR uncondition*) AND ("cash transfer" OR "cash transfers" OR "economic transfer" OR "economic transfers" OR "monetary transfer" OR "monetary transfers" OR "financial transfer" OR "financial transfers" OR "cash incentive" OR "cash incentives" OR "economic incentive" OR "economic incentives" OR "monetary incentive" OR "monetary incentives" OR "financial incentive" OR "financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR "monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial interventions"))	48
S3	AB((condition* OR uncondition*) AND ("cash transfer" OR "cash transfers" OR "economic transfer" OR "economic transfers" OR "monetary transfer" OR	179

(Continued)

	"monetary transfers" OR "financial transfer" OR "financial transfers" OR "cash incentive" OR "cash incentives" OR "economic incentive" OR "economic incentives" OR "monetary incentive" OR "monetary incentives" OR "financial incentive" OR "financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR "monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial interventions"))	
S4	S1 OR S2 OR S3	184

Global Index Medicus, WHO (searched 4 July 2022).

Advanced search - Title, Abstract, Subject descriptor.

Search
(condition* OR uncondition*) AND ("cash transfer" OR "cash transfers" OR "economic transfer" OR "economic transfers" OR "monetary transfer" OR "monetary transfers" OR "financial transfer" OR "financial transfers" OR "cash incentive" OR "cash incentives" OR "economic incentive" OR "economic incentives" OR "monetary incentive" OR "monetary incentives" OR "financial incentive" OR "financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR "monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial interventions")

Scopus, Elsevier (searched 4 July 2022).

Search
((KEY ("conditional cash" OR "unconditional cash")) OR (TITLE-ABS ((condition* OR uncondition*) W/3 ("cash transfer" OR "cash transfers" OR "economic transfer" OR "economic transfers" OR "monetary transfer" OR "monetary transfers" OR "financial transfer" OR "financial transfers" OR "cash incentive" OR "cash incentives" OR "economic incentive" OR "economic incentives" OR "monetary incentive" OR "monetary incentives" OR "financial incentive" OR "financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR "monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial interventions")))) AND ((KEY ("qualitative study" OR "qualitative research")) OR (TITLE-ABS (qualitative OR interview* OR "thematic analysis" OR themes OR "mixed method" OR "mixed methods"))) AND NOT INDEX (medline)

AnthroSource, American Anthropological Association (searched 3 August 2022).

Search

(Continued)

(condition* OR uncondition*) AND ("cash transfer" OR
"cash transfers" OR "economic transfer" OR
"economic transfers" OR "monetary transfer" OR
"monetary transfers" OR "financial transfer" OR
"financial transfers" OR "cash incentive" OR
"cash incentives" OR "economic incentive" OR
"economic incentives" OR "monetary incentive" OR
"monetary incentives" OR "financial incentive" OR
"financial incentives" OR "cash intervention" OR "cash interventions" OR "economic intervention" OR "economic interventions" OR
"monetary intervention" OR "monetary interventions" OR "financial intervention" OR "financial
interventions")

EconLit with Full Text, EBSCOhost (search updated 8 August 2022).

#	Query	Results
S18	S12 AND S17	113
S17	S13 OR S14 OR S15 OR S16	4,102
S16	TI mixed W0 method? OR AB mixed W0 method?	315
S15	TI themes OR AB themes	604
S14	TI interview* OR AB interview*	2,185
S13	TI qualitative OR AB qualitative	1,799
S12	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11	2,492
S11	TI (((addition* or supplement*) N3 income)) OR AB (((addition* or supplement*) N3 income))	163
S10	TI "cash plus" OR AB "cash plus"	5
S9	TI ((("social protection" or "social security" or "social welfare") N6 (cash or economic or financial or monetary or money or payment*))) OR AB ((("social protection" or "social security" or "social welfare") N6 (cash or economic or financial or monetary or money or payment*)))	90
S8	TI (((cash or economic or financial or monetary) W0 (transfer* or grant* or reward* or payment* or benefits or incentive* or program*))) OR AB (((cash or economic or financial or monetary) W0 (transfer* or grant* or reward* or payment* or benefits or incentive* or program*)))	1,048
S7	TI (((condition* or contingent or uncondition*) N3 (cash or grant* or reward* or payment* or benefits or money))) OR AB (((condition* or contingent or uncondition*) N3 (cash or grant* or reward* or payment* or benefits or money)))	202

(Continued)

S6	TI (((financial or economic or monetary) W0 support*)) OR AB (((financial or economic or monetary) W0 support*))	187
S5	TI "social security" OR AB "social security"	370
S4	TI "social welfare" OR AB "social welfare"	638
S3	TI "token economy" OR AB "token economy"	5
S2	TI "public assistance" OR AB "public assistance"	25
S1	TI "financial support" OR AB "financial support"	153

Grey literature search strategies:

National Institute for Health and Clinical Excellence (NICE) (searched updated 25 August 2022).

Advanced search - Type of evidence (primary research; practice-based information, Area of interest (public health; social care; clinical).

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

Open Grey (searched 23 March 2021).

Advanced search - Type of evidence (primary research; practice-based information, Area of interest (public health; social care; clinical).

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

Give Directly (www.givedirectly.org) (searched updated 25 August 2022).

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

Eldis (www.eldis.org) (searched updated 25 August 2022).

Advanced search - Type (document)

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

Agency for Healthcare Research and Quality (AHRQ) (searched updated 25 August 2022).

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

OAIster (searched updated 25 August 2022).

Advanced search - Format (Book; Article and chapters)

Search
(“cash transfer*” OR “incentive” OR “*grant”) AND health*

WHAT'S NEW

Date	Event	Description
28 June 2023	Amended	Minor text edit.

HISTORY

Protocol first published: Issue 6, 2020
Review first published: Issue 3, 2023

CONTRIBUTIONS OF AUTHORS

Clara Akie Yoshino: selecting studies, data extraction, analysing data, writing the first draft and editing

Kristi Sidney Annerstedt: conceptualising the study, writing the protocol, selecting studies, evaluating studies for quality and richness, contributing to data analysis, writing and editing

Beatrice Kirubi: contributing to searching for studies, evaluating included studies, data extraction, data analysis, contribution to writing

Tom Wingfield: contributing to the protocol, selecting studies, contributing to writing and editing

Kerri Viney: contributing to the protocol, selecting studies, contributing to writing and editing

Delia Boccia: contributing to the protocol, contributing to writing and editing

Salla Atkins: conceptualising the study, writing the protocol, selecting studies, evaluating studies for quality and richness, data analysis, writing, editing. Guarantor of the study

All authors approved the final version.

DECLARATIONS OF INTEREST

No authors have financial conflicts of interest. KSA was the first author of one of the included papers. This paper was assessed for inclusion and for quality and richness by the other team members. KSA was the second author and SA was the senior author of one of the studies awaiting classification. Our interest in terms of personal, political, academic and other interests are described in sections on reflexivity in the Methods and Results sections.

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Internal sources

- Salla Atkins, Finland

  Salary support for Tampere University.

  Information specialist support for the review.
- Delia Boccia, UK

  London School of Hygiene and Tropical Medicine.

External sources

- Clara Akie Yoshino, Sweden

  Clara Akie Yoshino was supported by the Swedish Institute and Swedish Research Council (Vetenskapsrådet), via Karolinska Institutet.
- Tom Wingfield, UK

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- Kristi Sidney-Annerstedt, Sweden

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- Kerri Viney, Australia

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DIFFERENCES BETWEEN PROTOCOL AND REVIEW

The authorship of the review changed from the original protocol. Beatrice Kirubi was added through her contribution to searching, study selection, analysis and writing. Clara Akie Yoshino was added through her contribution to analysis and overall writing. Knut Lönnroth was removed as he had not had the opportunity to substantially contribute to the review.

The original protocol aim did not sufficiently capture the issue that the cash transfer could be one that was for general poverty alleviation, but needed to be evaluated in terms of health outcomes. The previous aim was to explore how conditional and unconditional cash transfers that are aimed at impacting on health behaviours were experienced and perceived by recipients.

The current aim of this review was to explore how conditional and unconditional cash transfers with a health outcome are experienced and perceived by their recipients.

We deviated from the plan of developing a matrix to establish links between reviews of effectiveness and this qualitative synthesis.

We replaced the intervention review of effectiveness by Pega and colleagues from 2015 (Pega 2015) by an updated version from 2022 (Pega 2022).

We did not conduct a search on the database Anthropology Plus, but on AnthroSource. The name of the database was incorrect on the protocol and has been corrected.

INDEX TERMS

Medical Subject Headings (MeSH)

Americas; *Delivery of Health Care; *Health Services; Patient Acceptance of Health Care

MeSH check words

Adult; Child; Humans