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[Qualitative Protocol]

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

Objectives

This is a protocol for a Cochrane Review (qualitative). The objectives are as follows:

The main aim of this review is to explore how conditional and unconditional cash transfers aimed at impacting on health behaviours are experienced and perceived by recipients. By health behaviours we mean health service use, health outcomes, or socioeconomic outcomes related to health (e.g. cash grants to address catastrophic healthcare costs). We will focus on the general experience, including acceptability and feasibility of these interventions.

The secondary objectives include:

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

BACKGROUND

Description of the topic

There is a strong link between poverty and ill health (Marmot 2005). There is also increasing evidence of the negative implications of out-of-pocket payments for health (Lönnroth 2014); and indirect costs associated with ill health such as lost income (Wingfield 2014). Cash transfers, both conditional and unconditional, have been highlighted as one possible way to counter these effects (Sidney 2016). Social protection, which includes cash transfers, can also contribute to achieving sustainable development goals: ending poverty; and better health for all (Carter 2018; Zembe-Mkabile 2015). Cash transfers can be part of formal social protection or social security approaches, or can be standalone interventions (e.g. Wingfield 2016).

Conditional cash transfers are payments given with a condition attached (e.g. school attendance; Marshall 2014). Unconditional cash transfers are payments given without conditions or required action (e.g. the universal child grant; Handa 2015). 'Cash plus' interventions combine a cash intervention with another intervention, which can be information/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 services (Lutge 2015), or a supplement to help address the direct or indirect costs of treatment (Wingfield 2017). The use and study of cash transfers is increasing. It is an important complement to Universal Health Coverage and financial risk protection, a concept which conventionally covers only essential medical costs (Lönnroth 2014). There has also been increased interest relating to cash transfers in tuberculosis (TB) care in order to meet the World Health Organization (WHO) End TB Strategy goal of "zero TB-affected families incurring catastrophic costs by 2020" (Uplekar 2015). More recently, acknowledging the benefits of cash transfers, 'cash plus' approaches have been developed, which combine cash with another health intervention, for example integrated HIV care and maternal health care (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, but the effect on health is not as large as desired, even in the case of conditional cash transfers (Adato 2011). 'Cash plus' strategies have been suggested as one possible way to amplify programme effects to impact on health (Harris-Fry 2018).

In this review, we will include both conditional and unconditional cash transfers. We define unconditional cash transfers as non-contributory monetary payments to individuals by governmental, international or non-governmental organisations to help them meet minimum consumption needs (Garcia 2012). We define conditional cash transfers as similar non-contributory monetary payments to individuals subject to a condition that they fulfil behaviour requirements, for example that children attend school, or parents make use of basic preventive nutrition and healthcare services (Alcobia 2014). We define 'cash plus' interventions as interventions which provide cash in combination with an additional form of intervention, for example education (Roelen 2017). 'Non-contributory' in this instance refers to cash payments which are not a form of insurance, and which do not require a partial payment or deposit by an individual to receive them. While we recognise the larger effects that cash transfer programmes can have on sustainable development goals, economies at large and general

well-being, our review will be limited to examining the impact of cash transfers on the health and well-being of individuals.

Cash transfers and health

TB and HIV are two examples of diseases for which cash transfers have been used, but their applicability goes beyond these examples. Many diseases, both infectious (Govender 2015) and non-infectious (Engelgau 2012), can push patients (further) into poverty. Cash transfers may prevent this, but they also have other important effects on patients. Large international projects, such as the Transfer Project, showcase the positive impacts of unconditional cash grants in Africa on a range of outcomes including health (UNICEF Innocenti 2018). Lagarde 2009 and Pega 2015, two Cochrane Reviews on the health impacts of (respectively) conditional and unconditional cash transfers found moderately weak evidence to suggest that unconditional grants might not impact on health service access and use, but may increase food security, diet variety, and money spent on healthcare, and reduce the likelihood of having had any illness in the three weeks prior to the measurement point. In contrast, conditional grants are reported to lead to increased use of health services, better nutritional status and health outcomes, and increased uptake of preventive services for children and pregnant women (Lagarde 2009). Other reviews on conditional cash transfers suggest beneficial health effects among children in low- and middle-income settings and an impact on proximal and intermediate social determinants of health, for example nutrition and teen pregnancy (Owusu-Addo 2018). There is, however, a dearth of information on the unintended consequences, perceptions and experiences from the perspective of the recipients of cash transfers, including their acceptability. There is little analysis on how context-specific issues affect cash transfer implementation. There is also a need to analyse how recipient-specific factors influence the ways that cash transfers impact health behaviours. For example, existing systematic reviews have not been able to definitely answer the question as to whether it is more beneficial to give cash transfers to women instead of men (Yoong 2012).

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 tuberculosis treatment completion and cure (Torrens 2015). Universal health coverage will contribute toward eliminating 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 occur 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 vaccinations. These two intervention types—unconditional cash transfers and conditional cash transfers—have different pathways to an outcome. One of the areas in which this review will contribute is examining these pathways and attempting to conceptualise the way the interventions work. Important to

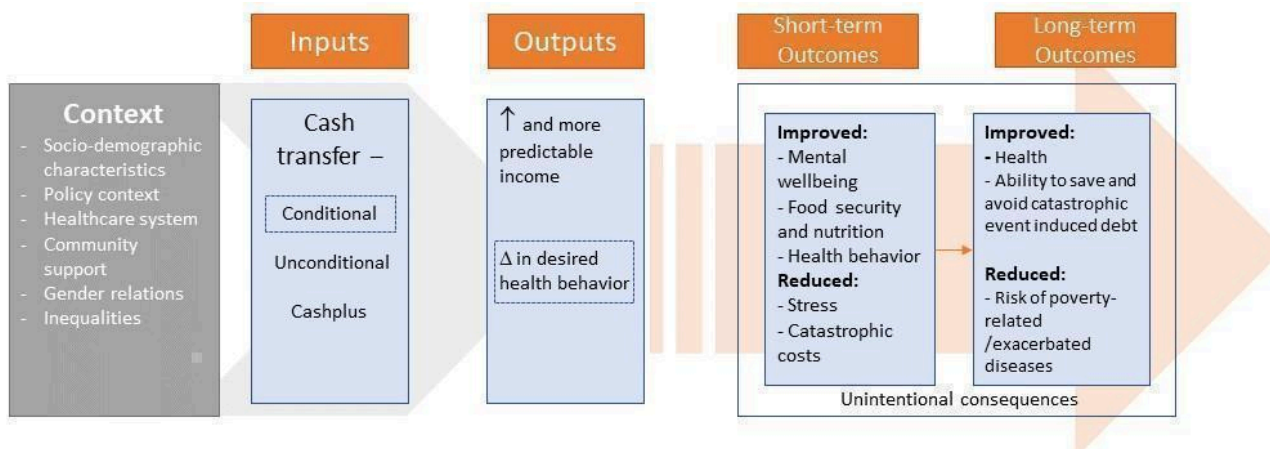
consider in this is how the programme conceptualisation may affect recipient experience. For conditional cash transfers, the pathway to impact could be conceptualised, for example, using the 'nudge' theory (Thaler 2009), which posits that individuals sometimes make bad choices, and should be 'nudged' towards better ones. The approach has been adopted in many settings as a public health approach, and has been evaluated for, for example, diabetes (Möllenkamp 2019), and for 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 between different programmes within the category of conditional cash transfer programmes, for example.

Partly because of these nuances, the logic model below represents only the general features of cash transfer programmes; it is not possible to comprehensively present the intervention workings in a logic model. Conditional and unconditional and 'cash plus' strategies have different pathways to impact. Conditional grants have a potentially stronger impact on health and health behaviour, as receiving the grant can be tied to these outcomes. The pathway of unconditional grants 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, where the other component can be, for example, education (Pettifor 2019), with differing impacts on health behaviours. Our interest is in the unintended and intended effects of these interventions and how recipients—both at household and individual level—experience and perceive the intervention, including whether it is acceptable to them, and what unintended outcomes may have emerged.

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 have shown below how the broader sociodemographic, policy context and healthcare system, as well as community support, gender relations and inequalities, work 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 grant. The model shows that all three interventions can produce an increase in (and more predictable) income. Conditional grants, then, can impact in a change in a 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, however, a number of unintended consequences that we cannot 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?

The current 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 2015), or to engage in health behaviours. At the same time, cash transfers are increasingly used in development aid and emergency aid; and they 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).

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

transfers or the unintended consequences that these interventions may have. While it seems acknowledged that cash transfers can be beneficial for health outcomes, there are several important issues to investigate and discuss before implementing such programmes. For one, the ethics of conditional cash transfers and how to best design them require attention (Krubiner 2017). For another, the experiences of persons or patients receiving conditional or unconditional cash transfers have not been sufficiently documented in academic literature. The latter is linked to ongoing discussions about to whom this cash should be provided—a particular household member, or to men, or to women (Yoong 2012)—and what effects and uses the cash might have when provided to different genders.

To highlight these process-related issues, 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. Some exploration of these factors already exists: for example in Nigeria, a social protection intervention increased patients' appointment attendance through countering transport costs and reduced the stigma associated with the disease (Ukwaja 2017). 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 such as Australia, there is also evidence that cash transfers are acceptable in relation to incentivising chlamydia screening (Parker 2015). 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 what forms of cash transfers are seen as most convenient; what the barriers and facilitators to receiving cash transfers are in different settings; and whether they are acceptable in comparison to other approaches of health improvement, including in-kind transfers such as food parcels (Grobler 2011).

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 them. As these programmes are rolled out, it is vital to document and evaluate the contextual and recipient-specific issues that impact on the perceptions and outcomes of cash transfers, and their unintended or intended effects. This information will help us to understand the recipient-specific factors that affect the way interventions achieve their impacts. This review seeks to understand cash transfer recipients' perceptions of these interventions, including acceptability, feasibility, and unintended consequences.

OBJECTIVES

The main aim of this review is to explore how conditional and unconditional cash transfers aimed at impacting on health behaviours are experienced and perceived by recipients. By health behaviours we mean health service use, health outcomes, or socioeconomic outcomes related to health (e.g. cash grants to address catastrophic healthcare costs). We will focus on the general experience, including acceptability and feasibility of these interventions.

The secondary objectives include:

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

METHODS

Criteria for considering studies for this review

Types of studies

We will include primary studies that use qualitative or mixed-methods study designs. We will not limit the publications included by date.

The qualitative study designs may include different qualitative study approaches including ethnography, phenomenology, case studies, grounded theory studies and qualitative process evaluations, among others. We will include studies that use both qualitative methods for data collection (for example, but not limited to, focus group discussions, individual interviews, observation, visual or textual diaries, document analysis, or open-ended survey questions) and qualitative methods for data analysis (for example, but not limited to, thematic analysis, framework analysis, phenomenography, grounded theory). We will exclude studies that collect data using qualitative methods but do not use qualitative data analysis methods (for example open-ended survey questions where the response data are analysed using descriptive statistics only).

We will include both published and unpublished studies; and studies published in any language.

We will include those mixed-methods studies where it is possible to extract the data that were collected and analysed using qualitative methods. We will include studies regardless of whether they were conducted alongside studies of effectiveness related to cash transfers (Pega 2015).

We will not exclude studies based on our assessment of methodological limitations, but will use this information to assess our confidence in the review findings, and report quality explicitly within the review.

Topic of interest

We will include studies that report on experiences of cash transfer interventions provided by governmental, non-governmental or international agencies, or private for-profit agencies to:

- adult patients 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
- adult patients where the cash transfer is intended to benefit their children.

We will include studies reporting on the perspective of parents receiving the grant for their child, or adult patients receiving the grant in low-, middle- and high-income countries. Our interest lies in how recipients of grants for a health-related goal experience and perceive these grants. We will include studies focusing on any health condition and any social protection or other cash transfer mechanism. We will exclude in-kind transfers (e.g. housing, food parcels etc.). We will include studies where participants are currently receiving a grant, or that have recently (within 6 months) received a grant.

The participants in the studies may be adults, male or female, from the age of 18 upwards, while the target groups could be any age, including children.

Search methods for identification of studies

Electronic searches

The Cochrane Effective Practice and Organisation of Care (EPOC) Information Specialist will develop the search strategies in consultation with the review authors. We will search the Epistemonikos database for related reviews in order to identify eligible studies for inclusion, as well as the following electronic databases.

- MEDLINE, Ovid
- CINAHL, EBSCOhost
- Social Services Abstracts, ProQuest
- Global Index Medicus, WHO
- Anthropology plus, EBSCOhost
- EconLit, ProQuest
- Scopus, Elsevier

We will develop search strategies for each database. We will not apply any limits on language or publication date. We will search all databases from the beginning of each database to the date of search. We will include a methodological filter for qualitative and mixed-methods studies as available from the EPOC group. See [Appendix 1](#) for the MEDLINE search strategy, which we will adapt for other databases. We will provide appendices for all the strategies we use to allow replicability.

Searching other resources

We will review the reference lists of all the included studies and key references (i.e. relevant systematic reviews). We will conduct a cited reference search for all included studies in Web of Science Core Collection (Clarivate Analytics). We will also check the bibliography of studies that were included in the intervention reviews in order to identify any qualitative studies that were associated with the intervention study. We will contact authors of included studies to clarify published information and to seek unpublished data. We will contact researchers with expertise relevant to the review topic to request studies that might meet our inclusion criteria.

Grey literature

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

- OpenGrey: www.opengrey.eu
- Agency for Healthcare Research and Quality (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

We will complement this search through examining reference lists of the grey literature reports identified, and expert referral through our networks.

Selection of studies

Two review authors (SA and KSA or SA and KV) will independently assess the titles and abstracts of the identified records to evaluate eligibility. We will retrieve the full text of all the papers identified as potentially relevant by two review authors. When only one author suggests a study might be relevant, the whole team will discuss whether to retrieve the full text. Two review authors will then assess these papers independently. We will resolve disagreements by discussion or, when required, by involving another author (TW). When appropriate, we will contact the study authors for more information.

We will include a table listing excluded studies and reasons for their exclusion. When the same study has been presented in different reports or articles, we will collate these so that each study (rather than each report) is the unit of interest in our review. We will also include a PRISMA flow diagram to show our search results and the process of screening and selecting studies for inclusion.

Language translation

When titles or abstracts are published in a language in which none of the review team are fluent (i.e. languages other than English, Swedish, Finnish, Italian, French, German), we will carry out an initial translation through open source software (Google Translate). If this translation indicates inclusion, or if the translation is inadequate to make a decision, we will retrieve the full text of the paper. We will then ask members of Cochrane, or of other networks, who are fluent in that language to assist us in assessing the full text of the paper for inclusion. If this cannot be done for a paper in a particular language, the paper will be listed in the 'Studies awaiting classification' section of the review to ensure transparency in the review process.

If we decide to include studies published in languages in which the review team are not fluent, we will translate the whole paper using translation facilities available at our respective institutes, or private contractors able to translate academic texts.

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. As the topic includes both conditional and unconditional grants within the global context including both mixed-methods and qualitative research, we assume that the number of papers matching our inclusion criteria can exceed that which is possible for us to practically manage within the review. Large numbers of studies can threaten the quality of analysis ([Downe 2019](#)). Our sampling will be guided by a purposive sampling and data saturation approach ([Fusch 2015](#)).

We estimate that to meet data saturation we will have approximately 40 studies, which will ensure a coherent and rich analysis of qualitative findings ([Ames 2019](#)). Our sampling approach is to first select all eligible studies, following which we will purposively sample those that:

- are the closest match to our review aim (e.g. prioritising papers that fully focus on experiences of conditional cash transfers for health outcomes, or unconditional cash transfers where health outcomes are assessed, instead of those which focus on e.g. poverty and vulnerability without an explicit focus on health);

- have a rich description of findings as established from the rich description scale (Ames 2019). This criterion may risk excluding mixed-methods articles, and therefore we will ensure the first two criteria are satisfied and consider this only if there is a need to further filter the articles from step 1 and 2;
- represent a geographical spread from the regional groupings as established by the WHO from each region (African region, the Americas, South-East Asia Region, European Region, Eastern Mediterranean region and Western Pacific region) (World Health Organization 2019). We may adjust these based on country income grouping, in order to ensure that we have a balance of low-, middle- and high-income countries and one that represents different diseases (e.g. both infectious and non-infectious disease) to ensure representation from these different categories.

Data extraction

We will extract key information on each study including citation, descriptive information about year of publication, study objectives, participants, contexts, health issues and the interventions used (cash only; conditional or unconditional; health condition/effect aimed at). The contextual issues that we will extract include, for example, poverty and illiteracy rates where reported and average schooling available in the country. Extraction of further items will depend on the available contextual description within primary papers. Should we deem it necessary during the data extraction phase, we will extend the contextual description to additional searches on country setting (e.g. country inequality, social protection levels in general).

We will include WHO region and country income classification in this extraction. We will also extract the study design and study conduct, including sampling method, data collection method, theoretical orientation if any, sample size, and analysis method. Finally, we will extract study findings including qualitative themes, findings, and supporting quotations. We will also extract author interpretations/discussion of these findings, as well as paper conclusions.

Data management, analysis and synthesis

We will use Mendeley as the primary data management tool. We will create folders of search findings, and remove duplicates using the Mendeley tool. We will make the Mendeley database accessible to all review authors. In addition, we will keep included papers and references to them in a separate folder on a cloud-based server.

We will use meta-ethnography to conduct the analysis of the review (Atkins 2008; Noblit 1988). We will pay close attention to the differences in experience of cash transfers between different participant groups (gender, age, specific vulnerable groups, e.g. migrants or the extremely poor, as described in the papers) and settings (low-, middle- and high-income settings). We will also endeavour to highlight differences where they may be due to health conditions targeted by the grants/assessed by the study. We will take the final decision on the analysis when we have located study data, to assess whether the quality of the included studies can support a line-of-argument synthesis of existing qualitative studies (Noblit 1988).

Initially, we will extract the meaning units from the papers, following first and second order constructs (second order

constructs being what the author interprets the participants as saying) (Atkins 2008). We will examine the themes and extracts in one paper and compare them to themes and extracts in another. We will then begin to create overarching themes for each region. We will begin the process of comparison by using an information-rich index paper, identified during the data extraction phase.

In this process we will pay attention to the impact of context, particularly poverty rates in the setting, and how it might affect analysis findings. As our regional analysis is complete, we will compare the findings in each region in order to complete a reciprocal translation synthesis. We will then examine this to determine whether a line of argument synthesis, as described by Noblit and Hare is possible (Noblit 1988). We will use *Atlas.ti* as an analysis tool.

We will update the logic models presented earlier in this protocol during the review process. We will use relevant guidelines in reporting the findings (eMERGe France et al 2019).

Assessing the methodological limitations of included studies

Three review authors (SA, KSA, KV) will independently assess methodological limitations for each study using the CASP quality criteria (Critical Appraisal Skills Programme 2018). Where any of the team members are authors of included studies, they will not be involved in the assessment of quality of the study.

We will start assessing the methodological limitations of included studies by assessing a sample of two papers, in order to ensure that we understand the criteria similarly. We will resolve disagreements by discussion or, when required, by involving a fourth review author (TW). We will assess methodological limitations at least according to the following domains.

- Validity of results
- Inclusion of reflexivity (authors' explicit explanation of their position as to the research conducted) (Flick 2014)
- Ethical considerations

We will report our assessments in the Methodological Limitations table.

Assessing our confidence in the review findings

We will assess if GRADE-CERQual is appropriate for assessing confidence in the review findings as the review progresses. Should we be able to use this system, three review authors (SA, KSA, KV) will use the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess our confidence in each finding. CERQual assesses confidence in the evidence, based on the following four key components.

- 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.
- 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 well supported or compelling.

- 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.
- 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 is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

After assessing each of the four components, we will make a judgement about the overall confidence in the evidence supporting the review finding. We will judge confidence as high, moderate, low, or very low. The final assessment will be based on consensus among the review authors. All findings start as high confidence and we will then downgrade if we have important concerns regarding any of the CERQual components.

Should we deem CERQual not to be appropriate for an interpretive review such as this one, we will endeavour to explain confidence in the review findings in the discussion.

Summary of Qualitative Findings table(s) and Evidence Profile(s)

We will present summaries of the findings and our assessments of confidence in these findings in the Summary of Qualitative Findings table(s). We will present detailed descriptions of our confidence assessment in an Evidence profile(s) (Lewin 2018).

Integrating our findings with Cochrane Intervention Reviews

At the end of our review, we will link our findings with the existing Cochrane Intervention reviews (Pega 2015; Lagarde 2009). The aim of our linked analysis will be to explore how the interventions assessed in the review might be better designed or implemented in future, given the contextual issues, experiences and perceptions highlighted in this review.

In order to synthesise findings from the qualitative review and existing intervention reviews, we will develop a matrix in which to juxtapose findings from the qualitative review and interventions following advice from Harden 2018. This will allow us to highlight contextual differences in their implementation. First, we will transform our review findings into recommendations

for interventions, to be used on one side of the matrix, as done in Thomas 2004. We will then map each included trial in the two reviews to these recommendations, assessing whether the recommendation matches with the intervention, or whether it does not. We will identify gaps through noting when a particular recommendation does not match any of the interventions included in the reviews.

Review author reflexivity

All reviewers are currently involved in, or have previously been involved in, research and policymaking on social protection and health, on different 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 network, and actively work 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 can potentially influence analysis toward focusing on positive influences, instead of negative experiences. The team will actively consider this in conducting the analysis, during coding, analysis and interpretation, ensuring that it does not constitute a bias.

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APPENDICES

Appendix 1. MEDLINE search strategy

MEDLINE and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions 1946 to March 24, 2020, Ovid

#	Searches	Results
1	Financial Support/	3726
2	Public Assistance/	2871

(Continued)

3	Token Economy/	929
4	Social Welfare/ec [Economics]	1390
5	Social Security/ec [Economics]	1069
6	((financial or economic or monetary) adj support*).ti,ab,kf.	4882
7	((condition* or contingent or uncondition*) adj3 (cash or grant* or reward* or payment* or benefits or money)).ti,ab,kf.	3114
8	((cash or economic or financial or monetary) adj (transfer* or grant* or reward* or payment* or benefits or incentive* or program*)).ti,ab,kf.	14091
9	((social protection or social security or social welfare) adj6 (cash or economic or financial or monetary or money or payment*)).ti,ab,kf.	531
10	cash plus.ti,ab,kf.	8
11	((addition* or supplement*) adj3 income).ti,ab,kf.	1325
12	or/1-11	32068
13	Qualitative Research/	52752
14	Interviews as Topic/	60853
15	qualitative.ti,ab,kf.	225364
16	interview*.ti,ab,kf.	349775
17	themes.ti,ab,kf.	67131
18	mixed method?.ti,ab,kf.	20372
19	or/13-18	548037
20	12 and 19	3081

HISTORY

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CONTRIBUTIONS OF AUTHORS

Salla Atkins: guarantor of the review. Wrote the draft of the protocol, and reviewed it for content following co-authors' inputs.

Kristi Sidney Annerstedt: contributed to review protocol content

Kerri Viney: reviewed and edited protocol

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DECLARATIONS OF INTEREST

Salla Atkins: none.

Kristi Sidney Annerstedt: none.

Kerri Viney: none.

Tom Wingfield: none.

Delia Boccia: none.

Knut Lönnroth: none.

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