



Understanding the Particularities of an Unconditional Prenatal Cash Benefit for Low-Income Women: A Case Study Approach

INQUIRY: The Journal of Health Care
Organization, Provision, and Financing
Volume 56: 1–12
© The Author(s) 2019
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/0046958019870967
journals.sagepub.com/home/inq



Ashley Struthers, MA, OT Reg (MB)¹ , Colleen Metge, PhD²,
Catherine Charette, PhD^{1,2}, Jennifer E. Enns, PhD³ ,
Nathan C. Nickel, PhD³, Dan Chateau, PhD³,
Marianne Chartier, PhD³, Elaine Burland, PhD³,
Alan Katz, MBChB, MSc, CCFP³, and Marni Brownell, PhD³

Abstract

We explored the particularities of the Healthy Baby Prenatal Benefit (HBPB), an unconditional cash transfer program for low-income pregnant women in Manitoba, Canada, which aims to connect recipients with prenatal care and community support programs, and help them access healthy foods during pregnancy. While previous studies have shown associations between HBPB and improved birth outcomes, here we focus on *how* the intervention contributed to positive outcomes. Using a case study design, we collected data from government and program documents and interviews with policy makers, academics, program staff, and recipients of HBPB. Key informants identified using evidence and aligning with government priorities as key facilitators to the implementation of HBPB. Program recipients described how HBPB helped them improve their nutrition, prepare for baby, and engage in self-care to moderate the effect of stressful life events. This study provides important contextualized evidence to support government decision making on healthy child development policies.

Keywords

social support, mothers, determinants of health, policy analysis, poverty

What do we already know about this topic?

Quantitative evaluations of the Healthy Baby Prenatal Benefit, an unconditional cash transfer available to low-income pregnant women living in Manitoba, Canada, have shown that recipients have better birth outcomes (decreased rates of low-birth-weight births and preterm births and increased rates of breastfeeding initiation) than non-recipients with similar family and socioeconomic characteristics.

How does your research contribute to the field?

There is a need for research that provides an understanding not only of the health outcomes associated with unconditional cash transfers, but of *how* interventions like the Healthy Baby Prenatal Benefit might contribute to these outcomes. We conducted a qualitative study that incorporated the views of multiple stakeholders (program recipients and decision makers) to gain new insights into the way the program was implemented and the mechanisms by which its effects came about.

What are your research's implications toward theory, practice, or policy?

Although the literature suggests that implementing unconditional cash transfers can be challenging, our study found that champions of the cause can overcome these challenges using evidence and building on previous policies and programs. As well, the unconditional aspect of the Healthy Baby Prenatal Benefit appeared to be key in its success—recipients were empowered to choose how to use the benefit to best meet their needs, and thereby were able to address a number of the social determinants of health they were experiencing, reduce stress in their daily lives, and prepare for baby.



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons

Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

Introduction

The prenatal period is a critical time of human development with long-term implications on a child's life course.¹⁻³ In industrialized countries like Canada and the United States, the risk of poor birth outcomes is higher among pregnant women living in poverty, as they are more likely than high-income women to have high levels of stress, smoke cigarettes, and/or drink alcohol during pregnancy, and have inadequate nutritional intake.^{4,5} In utero exposure to stress, harmful substances, and poor nutrition increases the risk of low-birth-weight and preterm births, which can impact a child's lifelong health and development.⁶⁻⁹ Thus, there has been considerable focus on improving birth outcomes for infants born to low-income women.

The importance of investing in prenatal health was recognized by the provincial government of Manitoba, Canada, in 2001, when it implemented an unconditional cash transfer program under the auspices of Healthy Child Manitoba, a multidepartment strategy to promote healthy child development and support families in Manitoba. The Healthy Baby Prenatal Benefit (HBPB) program connects low-income expectant mothers to early prenatal care and community resources, and sends monthly mailings of pamphlets on prenatal health (e.g., information on smoking, nutrition, and mental health).¹⁰ In the second and third trimesters, the program provides checks to a maximum of \$81.41 CAD/month to help women access healthy foods during pregnancy. To be eligible for the HBPB, applicants must be Manitoba residents, obtain a doctor's note confirming their pregnancy, and have an annual net family income of less than \$32,000 CAD. For context, the women in the study were living well below Manitoba's low-income cutoff – about one-third of women in the study had an annual income of less than \$32,000 and were eligible for the HBPB, and the average annual income of women who actually received the HBPB was less than \$22,000 CAD.

The HBPB has been the focus of two previous quantitative studies evaluating its effectiveness in improving birth outcomes and its role in reducing population-level inequities in health outcomes. In these studies, HBPB program data were linked to population-based administrative health data, and the benefit was found to be associated with decreased rates of low-birth-weight births, preterm births, and increases in breastfeeding initiation,¹¹ as well with a decrease in the gap between high- and low-income families in these same

birth outcomes.¹² The literature demonstrates similar positive associations for other cash transfer programs; however, most are conditional on the recipient fulfilling some type of desired behavior, for example, attendance at medical appointments.^{13,14} Evidence related to benefits like the HBPB, which does not attach conditions, is limited, and our understanding of how cash transfer programs contribute to narrowing the inequity gap in health outcomes in developed countries is almost nonexistent.

Thus, there is a need for research that provides an understanding not only of the positive health outcomes with which unconditional cash transfers are associated but also of *how* interventions like the HBPB might contribute to these outcomes. Although some quantitative studies on HBPB have been published, the meaning behind the outcomes and the context of their attainment can be more fully described using a qualitative approach. By incorporating multiple stakeholder perspectives, we gain new insights into how those involved with the program, such as recipients, decision makers and researchers, understand the implementation and effects of this early childhood intervention. This approach may help to identify key issues that will support government decision making on healthy child development policies.

The purpose of this study was to describe how an unconditional cash transfer program, the HBPB, improved the birth outcomes among low-income mothers and how it narrowed the equity gap in birth outcomes between high- and low-income families in Manitoba. We sought to answer the following questions: What policy and program decisions led to the design of the HBPB and how were these decisions made? Was the HBPB implemented as designed and what were the barriers and facilitators to implementation? What were the perceptions of the program stakeholders (including recipients of the benefit) on the mechanisms by which the program works and the successes and limitations of the HBPB?

Methods

Study Design

We used a case study design in seeking to understand the HBPB within its real-life context.¹⁵ Case studies can help researchers gain an in-depth understanding of contemporary phenomena including how and why policy decisions are made, how they are implemented, and the results they yield.¹⁶

¹George and Fay Yee Centre for Healthcare Innovation, University of Manitoba, Winnipeg, Canada

²Department of Community Health Sciences, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Canada

³Manitoba Centre for Health Policy, Department of Community Health Sciences, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Canada

Received 27 May 2019; revised 14 June 2019; revised manuscript accepted 17 June 2019

Corresponding Author:

Ashley Struthers, George and Fay Yee Centre for Healthcare Innovation, University of Manitoba, Third Floor, 753 McDermot Avenue, Winnipeg, MB R3E 0T6, Canada.

Email: astruthers@wrha.mb.ca

Our case study approach was situated in postpositivist critical realism. Critical realism—a form of postpositivism—is critical of our ability to know reality with certainty. Therefore, in this study, we have recognized the importance of multiple measures and observations and the need to use triangulation to evaluate the particularities of the HBPB. This involved developing a clear case study protocol with careful consideration of validity and potential bias, which in turn ensured that all elements of the case were measured and adequately described.^{16,17}

Data Collection

Case study research collects data from multiple sources, triangulating these data to understand the phenomenon.¹⁶ For this research, we collected data through the public records, program documents, and interviews with policy makers, academics, program staff, and beneficiaries of the HBPB program. We reviewed documents from Healthy Child Manitoba (including annual reports and web site pages), transcripts of the proceedings of the Manitoba government's legislature (known as Hansard documents) that mentioned the HBPB, and other key documents identified by the study participants.

Participants and Recruitment

We interviewed two groups of HBPB stakeholders: (1) a purposive sample of key informants whose role related to some aspect of the HBPB, including policy makers, academics, and program staff and (2) a convenience sample of HBPB recipients. Participation in the interviews was informed and voluntary; all participants provided informed consent. Recipients of the HBPB were each paid \$25 for participating; key informants were not paid.

Key informants were identified through discussion with the research team and/or document review, and all who participated were asked to suggest other potential participants. Interviews with key informants were completed between September 2015 and April 2016 either by telephone ($n = 1$) or in person ($n = 8$). The small number of key informants we interviewed reflects the small total number of HBPB employees and individuals involved in program operations; turnover of program staff over the last 15 years was minimal. There were some challenges to recruiting key informants involved in the initial development of the program, likely because of the time (15+ years) that had passed since the HBPB was launched.

Recipients of the HBPB were recruited with support from HBPB staff, who included an invitation to participate in the study in information letters sent out to approximately 375 recipients (age 16+) between mid-October 2015 and January 31, 2016. Participants either responded to the invitation or heard about the research from a friend or family member who had received the invitation. The invitation asked potential participants to contact the interviewer directly; therefore, HBPB staff were not aware of which recipients chose to participate. Recipient interviews were conducted between

November 2015 and May 2016 in person ($n = 17$), or by telephone ($n = 3$) for rural participants. In-person interviews were conducted at a location convenient to the participant, including private residences, the researcher's office, health offices or other community locations. The interviewer had no prior relationship with recipients.

Interviews

The lead author of this study interviewed key informants and recipients using semistructured interview guides. We developed separate interview guides for each of the two groups. The key informant interview guide was informed through the Precede-Proceed model of health promotion program planning and evaluation by Green and Kreuter,¹⁸ which guides planners to set priorities and develop objectives based on factors that influence a population's health status and identify barriers and enablers to successful implementation. The guide asked participants to describe their role as it related to the HBPB, and to describe the HBPB in their own words. We also asked key informants about how the decision was made to implement the HBPB, what evidence was used to develop the HBPB, what implementation barriers and facilitators they encountered, and how the benefit was intended to improve outcomes.

The recipient interview guide was informed by the literature and early key informant interviews. The interviewer asked recipients what they thought the purpose of the HBPB was, what worked well, how the HBPB could be improved, how receiving the HBPB helped them, and how they found out about and applied for the HBPB. We concluded the interview with a few demographic questions. The interview guide was modified slightly during the data-collection process to reflect insights gained through some of the initial interviews. Most interviews were audio-recorded and transcribed verbatim by a professional transcriptionist ($n = 7/9$ key informants, 15/20 recipients); the interviewer also took notes during interviews. In cases where the participant did not consent to audio recording ($n = 7$), the interviewer took handwritten notes and transcribed the notes as soon after the interview as possible.

The authors are aware of the power differential that was likely perceived between the researcher/interviewer and study participants, particularly recipients of the HBPB, and took steps to reduce this disparity by conducting the interviews in a location of the participant's choosing, dressing in a casual manner, attempting to build rapport with participants before beginning the interviews, and conducting interviews in a relaxed and conversational manner.

Data Analysis

The transcripts were anonymized and all case study data were imported into qualitative analysis software (NVivo 11). We used a general inductive approach¹⁹ for the qualitative analyses. First, transcripts and documents were read closely,

often more than once. This step was done concurrently with data collection. Next, we coded the text line-by-line, creating a preliminary coding framework. As codes emerged, subsequent segments of text were compared to existing codes and coded into one, if appropriate. If not appropriate, a new code was created. Once we had coded all transcripts and documents, we compared text within each emerging code to ensure consistency, and compared codes to identify overlap and relationships, thereby creating broader categories. Once this process was complete, we reviewed the categories and grouped them together into larger categories. In addition, the lead author kept a research journal to keep track of the research process, reflect on data, and record emerging insights. The credibility of the findings was augmented by features of our study design. We collected data from a range of participants, and triangulated data from a variety of data sources. In addition, the lead author frequently reflected on how her personal and professional beliefs and experiences could be influencing the analyses and emerging findings. Multiple drafts of the article were shared and discussed with the research team.

Ethics

The study received approval from the University of Manitoba's Human Research Ethics Board and the Government of Manitoba's Health Information Privacy Committee.

Findings

In total, 29 individuals participated in interviews for this study: 9 key informants and 20 recipients. In addition, 66 documents that referenced the HBPB were reviewed, including Healthy Child Manitoba Annual Reports (n=13), Hansard documents from 2001 to 2016 (n=40), web sites (n=1), newspaper articles (n=8), and reports (n=4). The key informants we interviewed were academics, policy makers, and HBPB program staff. Most had been involved with the program before or soon after implementation. The recipients (aged 18-40) we interviewed were all currently receiving the HBPB. Most (n=12) had received the HBPB during a previous pregnancy, and most were receiving the full \$81.41/month benefit (n=17). The current pregnancy was the first pregnancy for four recipients; several (n=5) had children who were not living with them. Most lived in centrally located urban neighborhoods (n=15). During the interviews, recipients talked about their current experience receiving the HBPB and about their experiences in previous pregnancies.

What Policy and Program Decisions Led to the Design of the HBPB and How Were These Decisions Made?

The Design of the Benefit. The foundation for the HBPB can be found in the work of Dr Fraser Mustard, whose work

explicitated the connection between health and the social determinants of health.²⁰ Both key informants and Hansard documents acknowledge the role that Dr Mustard played. In reference to the Healthy Baby Program, Education Minister Nancy Allen said, "The incredible programming that we have done [is] because all of the research that has been done by Fraser Mustard in regards to early intervention," and another key informant articulated a similar message saying,

It was really Fraser Mustard's research and sort of really an explosion of early childhood brain development research that was showing now you know all the various things that are developing in prenatal period and which ones skyrocket in the first six months. (Key Informant)

During the 1980s and 1990s, there was also growing acknowledgment of the importance of early childhood development and the social determinants of health within the Manitoba government and civil society. In 1981 and 1982, the Community Task Force on Maternal and Child Health, led by the Social Planning Council of Winnipeg, issued a series of reports related to early childhood development and the social determinants of health, including "A Plan for Maternal & Child Health Care in Manitoba."²¹ This report identified the need for a more comprehensive approach to maternal and child health and emphasized targeting prevention services to high-risk groups. It recommended a prenatal family allowance be paid to pregnant women, contingent on visiting a physician or public health nurse, "in order that the woman have the financial resources to feed and care for herself properly during the pregnancy." It also underscored the role that prenatal benefits can play in encouraging women to seek prenatal care early. In 1995, a report commissioned by the Government of Manitoba called "The Health of Manitoba's Children"²² lent further impetus to early intervention strategies.

Creating the HBPB. In 1999, the incoming provincial government maintained the focus on the early years. Considered to be the first cross-sector council of its kind in Canada,²³ the new government established Healthy Child Manitoba to develop and take leadership of policies related to children across government departments comprising health, social services, justice, Aboriginal and northern affairs, education, culture, and status of women. Key informants thought this approach ensured cooperation and collaboration between all departments that dealt with children. One key informant stated: "That changed a lot of things because you had almost half of the cabinet sitting in a room monthly talking about what to do for kids" (Key Informant).

The new government described the HBPB as the first prenatal benefit in Canada,²⁴ although it resembled a program implemented by the previous government. Prior to the implementation of HBPB in 2001, the Women and Infant Nutrition (WIN) program had operated under the previous Manitoba government since 1998. Similar to the Healthy Baby Program, the WIN program included community support programs and

a financial benefit, but receipt of the benefit was contingent on community support program participation and was only available to women on income assistance. Recipients were eligible to receive a “nutrition supplement” of \$31.50/month (or \$65.00/month for women attending community programming) during the first and second trimesters.²⁵

Policy Shifts. While there were similarities between the HBPB and the WIN program, the creation of the HBPB involved two significant policy shifts. First, the new government desired to make the benefit available to more women because “there are many, many, many poor families who are essentially earning or receiving very similar to welfare levels of income working in our society who were not benefiting from that program”,²⁶ and so the HBPB was made available to *all* low-income women, not only those on income assistance, and but also to First Nations women living on reserves.

It was thought at the time that there was no other provincial program in Canada that extended this type of benefit to women living on reserve. The Premier said, “Aboriginal children and children in non-Aboriginal communities are treated equally under this program.”²³ The reason for extending the HBPB was given by the Premier as follows, “this benefit is extended to all families, including First Nations families, because a baby is a baby, is a baby”,²⁷ and this line was quoted many times thereafter.

The second policy shift was that the HBPB would have no strings attached (i.e., be unconditional). To receive the full benefit under the WIN program, women had to attend community programming, which limited access to women who were willing and able to attend programs; however, not all communities had programs available. Manitoba’s Minister of Family Services and Housing explained “We also know that compelling people usually just means they do not either get the allowance or take part in the program, so we think that those are important changes”²⁶ and “We believe in Manitoba women. We do not think you have to take a stick and beat them like the opposition does.”²⁸ They also chose to provide cash as opposed to food vouchers as “an important indicator of our respect for women’s right to choose for their family how best to use the money” (Key Informant).

Was the HBPB Implemented as Designed and What Were the Barriers and Facilitators to Implementation?

HBPB Implementation. According to key informants, the HBPB was implemented in 2001 as planned with one exception. The initial intention was for the HBPB application form to trigger a referral to public health, thus connecting women with additional services and supports. However, according to annual reports, it was not until April 2008 that a revised application form was implemented that facilitated the sharing of applicants’ contact information with Healthy Baby

Community Support Programs. This lag was the result of privacy concerns and the need to create a very simple consent statement for the application form. As one informant said, “I don’t think we ran into anything other than the privacy issue that I just had no anticipation . . . none of us did, we just didn’t see that one coming at all” (Key Informant).

Barriers and Facilitators to Implementation. Key informants identified several facilitators to implementation, including using evidence on the importance of early childhood development, the fact that child and adolescent development were key government priorities, and having champions advocating for the HBPB. They described using evidence of local needs and reviewing similar programs implemented elsewhere. Key informants involved in program development and implementation could not recall any significant opposition to the HBPB and attributed this to their use of evidence to gain support for the initiative. A key stakeholder explained, “We did a lot of work to kind of inoculate all of our initiatives against the kind of narrow Conservative/NDP political; if we say it’s good they say it’s bad, that sort of thing” (Key Informant). However, newspaper and Hansard documents indicate that there was at least some concern regarding how recipients would spend the money and the “no strings attached” approach was perceived by some to lack accountability. A family physician was “concerned that it could only be providing extra funding for cigarettes or alcohol.”²⁹ An opposition MLA was quoted in the Winnipeg Free Press saying,

The bottom line, I believe, is that there should still be some requirement for people to participate in educational programs so you have a little higher level of confidence that the money will actually go to improve the prenatal health of the child.³⁰

Key informants also thought the priority given to early childhood development facilitated implementation. The 2001/2002 Healthy Child Manitoba Annual Report described “healthy child and adolescent development as a top-level policy priority of government.”²³ It was also noted that early childhood development was a priority at the federal level because federal money was used to start the HBPB. There were also several champions (or advocates) for creating the HBPB, in particular, the Minister of Family Services and Housing, who was described as “a real advocate for kids” (Key Informant). Aside from the challenges related to triggering a referral to public health described above, no other barriers were identified.

What Were Key Informants’ and Recipients’ Perceptions on the Mechanisms by Which the HBPB Works and Its Successes and Limitations?

Mechanisms by which the HBPB works. In documents reviewed, the most common description of the HBPB’s purpose related

to helping women obtain nutritious foods during pregnancy. However, the government also indicated that the HBPB was intended to connect women to community supports, including health and parenting education and prenatal care.

In responding to the question “how does the Healthy Baby Prenatal Benefit help you?” recipients described how they spent the money. Most (but not all) recipients described using the money for food, and many indicated they used the money to buy baby items like diapers, formula, blankets and clothes, personal items like maternity clothes or prenatal vitamins, in addition to paying bills, acquiring identification, and transportation. Some used the money to compensate for lost income or to contribute to the costs of housing. Five mechanisms by which recipients and key informants thought the HBPB worked emerged:

- a. *Improved Health and Nutrition.* Recipients described how the money enabled them to buy healthy food, such as fruit and vegetables, meat, milk, or food to address cravings. They also used the money to purchase prenatal vitamins or address medical concerns, such as diabetes and iron deficiencies, through healthy eating. For example, “It just helps me by like healthy food is expensive, more expensive than junk food amazingly enough, so it just helps with getting fresh fruit and vegetables and stuff into my fridge” (Recipient).

Key informants also thought it was likely that women used the HBPB to buy healthy food, although some thought this alone could not account for the positive outcomes. As one informant explained, “Eighty dollars is helpful . . . but it’s not going to turn your life around, or necessarily turn your pregnancy around, but if it can connect you to other things, that’s part of the magic” (Key Informant).

- b. *Preparing for Baby.* This theme was identified by recipients only. Many recipients used the money to buy things for baby like diapers and bottles. Others said they were saving the money so they would be able to buy things once the baby arrived. In this way, they were able to prepare for baby. One recipient said,

Well like, you know like it helps me prepare, you know like I have like a few bucks actually in my pocket too, but you know like it helps me like start like buying my baby things you know and stuff like that so. (Recipient)

This money might enable women to not only consider the present, but to think ahead to the future and what the baby will need, including not only items, but also considering some parenting decisions like whether they want to breastfeed. For example, one recipient said, “Maybe start stocking up on bottles, I’m not sure if I want to breastfeed or bottle, last time it [breastfeeding] didn’t work” (Recipient) and another said,

Basically money-wise, that’s gonna help a lot with little stuff you need, help you think about it while you’re pregnant. Lets me think and process for what you’re gonna need, little things, helps you think clearly, I have this extra money, helps you think about what you’re gonna need. I’m really grateful for that. (Recipient)

- c. *Stress Reduction.* Low-income families experience money-related stresses. Key informants identified stress reduction as a potential mechanism, and recipients described ways they used the money to address pressing issues in their lives. In this way, the HBPB can be seen to moderate stressful life events. Some saw the money as a security net, for example, to make up for lost income if they were unable to work. Others used it for emergency situations, or to pay the rent or other bills, for example, “I would just save it in my bank account and it would be used for emergency situations like if I had to get to the hospital through the middle of the night” (Recipient), and,

. . . before I stopped working I had to reduce my shifts, yes because I was going through so much pain and everything like that, so I had to reduce it and I’m like okay no matter what is coming in, it’s going to, even if it’s going to just buy me groceries, milk and bread and something, at least it will get me that. (Recipient)

. . . like the one time the last time I received the benefit, like a roommate bailed on me, so I needed to help pay rent, so I used all my, my money plus when I got the benefit I used that as well to pay my rent kind of thing. (Recipient)

- d. *Self-care.* Many recipients described the HBPB in ways that highlighted how this money was for them, to engage in self-care and to care for their unborn baby. At the time of implementation, the Minister of Family Services and Housing said, “All women who apply for the benefit will have the check in their name to them because they are the recipients. They will use the money for the best interests of themselves and their children”.²⁸ Recipients described using the money to buy maternity clothes, and a few described how the money allowed them to enjoy some luxuries they would not otherwise have been able to afford, for example, diapers and Christmas gifts. One recipient said, “But the Healthy Baby Benefit is for me, like it benefits me and like my baby because then I already spend like all this money on food for my girls and like they’re already all taken care of” (Recipient) and another said, “Just, I spend that \$80 on myself so . . . And then usually my EIA [Employment and Income Assistance] check I help out with my mom so.” (Recipient).

Some recipients described feeling proud at being able to contribute to their family, as opposed to guilty for using the family's money. For example, "So it can be an addition or a contribution for my part to at least help me take care of this . . . it's really relieving" (Recipient) and "It's nice to know that we can use that luxury without feeling, having feeling guilty" (Recipient), where the luxury she is referring to is disposable diapers.

- e. Connection to Services and Health Education.* Connecting women to resources and supports, including primary care, was the most commonly cited mechanism by which key informants thought the HBPB worked. The HBPB provides health education directly through information pamphlets included with the monthly checks, and indirectly by connecting recipients to community resources. Key informants described the important role they thought the health information pamphlets played, but these were not top-of-mind for recipients who were much more likely to describe their participation in Healthy Baby Community Support Programs.

However, some key informants also acknowledged the possibility that the improved outcomes came about because women who applied for the HBPB already had better social support systems, and therefore, it would be expected that their outcomes would be better than nonrecipients.

What Works Well. In addition to the positive outcomes of the HBPB identified through earlier quantitative studies,^{11,12} key informants and recipients thought that the unconditional nature of the cash benefit was part of its success, and key informants thought relationship building contributed to the program's success.

- a. The 'Unconditional' Nature of the HBPB.* Recipients were asked whether they thought the HBPB should be tied to support program attendance or not. Initially, many thought it would be okay for them either way, based on their own circumstances. However, as they thought about it, most preferred that the HBPB not be tied to the support program, and gave reasons such as accessibility of locations, schedules (for example, if the mom is working or a student), caring for other children, discomfort in groups, or already knowing the information. One recipient said, "Because like why do you have to go to a program to get the check? . . . Like it's being forced, like what if you don't want to go there . . . 'Cause I don't want to go there," (Recipient) and another said,

Well I think you could go ahead and give more money to people that go to the groups, but what you're doing possibly is alienating a whole group of people that maybe

they can't make it to the group or they had a fight with someone in the group. (Recipient)

Recipients were also asked about their perspective on the HBPB being a check as opposed to food vouchers. Many recipients were indifferent to this. Others supported the check, usually citing the flexibility of buying whatever you really want or need at a convenient location. One recipient said "I think the check is more flexible, I think the money is better" (Recipient). Similar to the conversation about tying the HBPB to group attendance, even if participants did start out in favor of vouchers, they sometimes talked themselves out of it. However, several thought vouchers would be better. During these discussions, participants commented on "other women" who might be making unhealthy choices about how to use the money. For example, spending the money on addictions, "Some women that are pregnant don't really think about the baby, some just think about themselves and like their addictions and like, 'cause there are women out there that would just use their money to feed their addiction" (Recipient), and "Well either way's okay, yeah but like I know some girls that are on it don't spend their money very wisely" (Recipient).

- b. Relationship Building.* Key informants identified relationship building as a major success of the program. HBPB staff were described as very invested, and most had been with the program almost since implementation. From the perspective of key informants, the relationship between recipients and staff members was important and staff worked hard to cultivate a relationship that was respectful, welcoming, and different from recipients' relationships with other systems like Child and Family Services or Employment and Income Assistance (EIA).

So that's an unusual arrangement for how we're set up but at the time it was felt that that would be a good cost-effective community friendly approach that wasn't associated with existing systems that at the time were seen as potential barriers, like you know there's, for example, stigma in having to go to EIA or whatever for some families. (Key Informant)

Recipients did not describe relationship building with HBPB staff. However, key informants descriptions suggest that relationships were often initiated when staff provided assistance with the application process—and none of the recipients we interviewed said they had received assistance from HBPB staff to complete the application form. Therefore, this opportunity for relationship building was not a part of their experiences, but may have been for other recipients.

What Does Not Work Well. Key informants and recipients identified some limitations or opportunities for improvement

related to HBPB's reach, the application process, and the money provided.

- a. *Reach.* Approximately 26% of women who received income assistance, and were therefore eligible for the HBPB, did not receive the benefit.³¹ Key informants identified challenges related to reaching people in rural communities and individuals who might not want to apply for the HBPB because of distrust in the health care and welfare systems (e.g., "because they don't want to be on the radar when they're pregnant, so they are reluctant to sign anything," Key Informant). Starting in 2011/12, additional activities were undertaken to improve reach, such as consultations with income assistance offices and newcomer services, and public media and door-to-door campaigns.

Potential recipients' ability to access the HBPB depends on hearing about the HBPB. Most recipients said they found out about the HBPB from a health care provider, friends or family. Recipients thought some women might be unaware of the HBPB. For example, one recipient said, "I didn't know about the benefit in previous pregnancies. I was in-between doctors and back and forth to the reserve" (Recipient). Recipients suggested ways to improve the reach of the HBPB; including focusing on in-person connections, and advertising within adult education facilities, shopping centers and in drug stores close to the pregnancy tests.

Some participants were aware of the HBPB in previous pregnancies, but did not apply. For several participants, age appeared to play a role in not applying for the HBPB. One recipient described why she did not apply in a previous pregnancy despite knowing about it, "I'm not even sure, too young, I'm not even sure, I didn't even bother with it . . . People told me but I was busy with going to school" (Recipient). Some of the younger participants in this study were hesitant to apply, for example, "I just didn't really bother with doing it I guess 'cause like I didn't really like care at the time I guess when she told me" (Recipient). One recipient identified another group who might be hesitant to apply. She had lived on reserve during previous pregnancies and thought that although women on reserve might be aware of the HBPB, they were reluctant to get "city folk" involved in their pregnancy by applying.

Each recipient who participated in the study was asked if they knew of friends or family who they thought were eligible for the HBPB but did not apply, and some did. When asked if they knew why they did not apply, many described a lack of motivation (e.g., "Hmm, I think they just don't want to do the paperwork," Recipient), but also some of the competing demands these women were facing. For example, one participant said, "she just needs to fill it out, she's just being lazy," but then went on to say "well she has three kids of her

own, so she's busy because all her kids are young, all under four" (Recipient).

- b. *Application Process.* The application process might also be a barrier to accessing the HBPB. To apply for the HBPB, the applicant must complete a 4-page form and provide confirmation of pregnancy from a medical practitioner. Key informants described barriers to applying such as not having money to pay for proof of identification, a health care provider to write the note, or transportation to the medical appointment. Key informants recognized that for some women, language and literacy may be barriers to completing the form.

The application process was described as straightforward and easy by many recipients, but almost half had help to fill out the form, usually from family, but also physicians or other clinic staff (none described receiving help from HBPB staff). Some were hesitant to apply because of personal circumstances. For example, one recipient with an unplanned pregnancy was not planning to apply because she was concerned about the possibility of a miscarriage, but was encouraged to apply by her physician,

I figured like the amount of time it would take to do the application and get approved for it and all that, I figured out well there's no time because then what if I end up going in [to labor] and but then I just, my doctor just told me just to do it. (Recipient)

- c. *The Amount of the Benefit.* The amount of the benefit, which has not changed since implementation in 2001, was also a concern to key informants. Most recipients received the maximum amount, which represented almost a 10% increase in their income.¹¹ Although some key informants agreed that this was likely enough to make a difference, there was also a sense that the amount was not enough, and some questioned whether it was still enough to attract people to seek prenatal care and apply. One key informant said, "It's probably not generous enough now, the cost of food and cost of things that are needed for babies, I suspect it really should be updated, this is, this rate is now 15 years old really" (Key Informant).

Some recipients also commented on the amount being low, and thought it could be increased, but the increases they suggested were quite small (between \$5 and \$20 monthly). Others experienced challenges related to cashing checks. For example, some used nontraditional banking services (e.g., "most people have like that hookup where they can go and cash it like at a pawn shop or something or Money Mart," Recipient). Others would prefer direct deposit so they did not have to go to a bank to cash the check.

Discussion

Research on the HBPB and other similar programs indicates that cash transfer initiatives are successful at improving maternal and newborn outcomes. This case study builds on this body of evidence by seeking to understand how the HBPB is able to improve outcomes, both by examining how the HBPB came to be (decisions made regarding implementing the HBPB, and identifying barriers and facilitators to implementation) and how the HBPB helps recipients (mechanisms of action, what works well, and what does not work well). In particular, the setting of this case study in the context of a high-income country adds novel findings to the literature, which to date mostly addresses cash benefits in low-income countries.

This study confirms what is suggested in the literature about how prenatal benefits improve outcomes. Increasing food quantity and/or quality was a mechanism identified by both key informants and the literature,^{13,32,33} and almost all recipients in this study described using the HBPB to buy food. In many cases, they talked about using it to buy healthier food than they would otherwise have been able to afford. Stress has been linked to poor maternal and newborn outcomes, including low birth weight,³⁴ and the literature and key informants identified reducing maternal stress as a mechanism through which cash transfers might work.³⁵ Recipients described using the HBPB in ways that would likely reduce financial stress, for example, using it to pay bills, to maintain housing, or as a security net.

Several authors have identified empowerment as a mechanism or an outcome of participation in cash transfer programs,³⁵⁻³⁷ though our key informants did not. Kabeer defines empowerment as “the expansion in people’s ability to make strategic life choices in a context where this ability was previously denied to them.”³⁸ The findings of several studies indicate that cash transfer programs increase women’s empowerment by increasing self-esteem, control of resources, participation in decision making, and health education.³⁹⁻⁴² However, there is also some evidence that participation in conditional cash transfer programs might in fact increase the burden on women who do the work to fulfill the conditions.^{41,42} In our study, some recipients saw the HBPB as a way to engage in self-care; they chose to use the money for medication, clothing, or luxury items, or used it to contribute to their family’s well-being, and there was some indication they experienced feelings of pride associated with this. Being able to make choices and contribute to their family’s income likely played a role in empowering the women who received the HBPB.

One of our key findings, that most recipients also used the money to prepare for baby, was not identified by key informants or in the literature we reviewed. This is an important finding and suggests the HBPB encouraged recipients to think ahead, thus also helping them to become mentally prepared for having a baby.

The literature suggests that implementing unconditional cash benefits can be challenging for governments because of public perceptions that they promote dependency,⁴³ bring up questions about who deserves benefits and who does not, and raise the issue of accountability between governments and citizens.⁴⁴ The HBPB was a response to growing awareness about the importance of early childhood development and the social determinants of health. According to key informants, its development was facilitated by several strategies and factors, including using a growing body of evidence about the importance of early childhood development and local needs to advocate for the implementation of a prenatal benefit, having strong champions, government prioritization of early childhood development, and building on a program initiated by a previous government. In other words, the environment in Manitoba had been primed for the HBPB and there were strong advocates. These factors likely helped HBPB decision makers overcome any potential opposition to an unconditional benefit for low-income pregnant women.

Findings from this study support the value of providing the HBPB as cash. Recipients described using the HBPB to help them meet basic needs and prepare for baby. They appreciated the flexibility provided by checks rather than food vouchers. Providing food vouchers instead of checks would eliminate the other useful and healthy ways recipients used this additional income. Junior et al also found study participants preferred cash because “they could decide how to use [unconditional cash transfers] to meet their unique needs.”⁴³

Key informants questioned whether the amount of the HBPB, which had not increased since its inception, was enough. In other words, would outcomes be even better if the amount was higher, and for the women who do not apply, would a higher amount be a better enticement? Some recipients also raised this as a concern, and thought that even small increases (\$5-\$20/month) would make a difference. Although there is limited evidence related to the amount of money provided to recipients through unconditional cash transfers, a study in Kenya compared the perspectives of women receiving an unconditional cash transfer of \$1000 with those receiving \$500, and found those who received less money “were more likely to say nothing good had happened in their life.”⁴³

Although the HBPB program reaches about 75% of intended beneficiaries, this means a large number of eligible women (25%) are not receiving the benefit. The barriers described to accessing the HBPB included literacy and language challenges, lack of awareness of the HBPB and the eligibility criteria, getting a doctor’s note to confirm pregnancy, mistrust of health care and social services systems, lack of motivation, and competing demands in women’s daily lives. Many of the recipients interviewed received assistance to fill out the forms, indicating that those with more limited social support networks might not have the needed support to complete the application process. In a case study of the implementation of unconditional cash transfers in three countries, Jones et al found that poor communication

and misperceptions regarding eligibility criteria reduced program uptake.⁴⁴ There is also a body of literature describing mistrust of low-income populations for health care providers and how it contributes to underutilization of health services.^{45,46} These are important barriers to program participation that should be taken into consideration by program planners and administrators.

Finally, our case study design offered us a flexible research approach that enabled a holistic, in-depth, multiple perspective examination of an unconditional cash transfer program for low-income pregnant women within real-life contexts.⁴⁷ The design of the case study using the case study approach of Yin,¹⁷ with the Precede-Proceed model of planning for key informant questions by Green and Kreuter,¹⁸ allowed for a form of analytical induction when the data were analyzed and interpreted around mechanisms, successes, and limitations.

Limitations of This Study

The amount of time that had passed since the program was implemented was a limitation of this study because it meant that several potential key informants had moved on to new roles or retired and thus were difficult to contact. However, we triangulated documentary sources to get a fuller understanding of how the HBPB emerged and was implemented. Caution should be used in generalizing the findings to the larger population regarding how women use the HBPB because the women who participated self-selected and so may not be representative of all recipients. Although steps were taken to reduce social desirability bias through the informed consent process and building rapport, this self-selection might have been a factor in the study findings. The authors were concerned about whether the women interviewed would feel comfortable enough to reveal using the HBPB for anything other than food; however, interviewees appeared to be sincere and were willing to describe other ways they used the HBPB. Although people may participate in health research for altruistic or therapeutic reasons,⁴⁸ HBPB recipients live on a low income, and some may have been primarily motivated to participate by the \$25. Cook and Nunkoosing⁴⁹ suggest that paying interview participants can negatively affect the conversation during the interview, for example, by limiting the amount that participants are willing to share. Finally, we did not interview any non-recipients to get their perceptions on the barriers to accessing the HBPB, which might have added to the richness of the narrative.

Study Implications and Future Research

Although the literature suggests that implementing unconditional cash transfers can be challenging, our study found that champions of the cause can overcome these challenges using evidence and building on previous policies and programs. The unconditional aspect of the HBPB also appeared to be

key in its success—recipients were empowered to choose how to use the benefit to best meet their needs, and thereby addressed a number of the social determinants of health they were experiencing, reduced stress in their daily lives, and prepared for baby. The implications of this study's findings, taken together with our previous examination of the ability of the HBPB to improve birth outcomes and reduce population-level inequities, are that the HBPB is a powerful and cost-effective intervention associated with many beneficial outcomes for low-income mothers and their families. Decision makers in the Manitoba provincial government have recognized the value of the HBPB through their continued support of the program (albeit at the same level of funding as in 2001, a maximum of CAD \$81.41/month). A series of ongoing and future studies will further enhance our understanding of the HBPB by examining whether the benefit is associated with improved outcomes specifically for Indigenous women in Manitoba.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Canadian Institutes of Health Research (grant no.: ROH-115206) and the Heart & Stroke Foundation of Canada (grant no.: PG-12-0534) under the program of research entitled "PATHS Equity for Children: A Program of Research into What Works to Reduce the Gap for Manitoba's Children."

Ethical Approval

The study received approval from the University's Health Research Ethics Board (#H2015:111) and the province's Health Information Privacy Committee (HIPC #2011/2012 – 24B).

ORCID iDs

Ashley Struthers  <https://orcid.org/0000-0002-3153-7295>

Jennifer E. Enns  <https://orcid.org/0000-0001-7805-7582>

Supplemental Material

Supplemental material for this article is available online.

References

1. Barker DJP. The origins of the developmental origins theory. *J Intern Med.* 2007;261(5):412-417. doi:10.1111/j.1365-2796.2007.01809.x.
2. Jefferis BJ, Power C, Hertzman C. Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study. *BMJ.* 2002;325(7359):305. doi:10.1136/bmj.325.7359.305.
3. Wadhwa PD, Sandman CA, Porto M, Dunkel-Schetter C, Garite TJ. The association between prenatal stress and infant birth weight and gestational age at birth: a prospective

- investigation. *Am J Obstet Gynecol*. 1993;169(4):858-865. doi:10.1016/0002-9378(93)90016-c.
4. Blumenshine P, Egerter S, Barclay CJ, Cubbin C, Braveman PA. Socioeconomic disparities in adverse birth outcomes: a systematic review. *Am J Prev Med*. 2010;39(3):263-272. doi:10.1016/j.amepre.2010.05.012.
 5. Lu MC, Kotelchuck M, Hogan V, Jones L, Wright K, Halfon N. Closing the black-white gap in birth outcomes: a life-course approach. *Ethn Dis*. 2010;20(1)(suppl 2):S2-S62.
 6. Hack M, Klein NK, Taylor HG. Long-term developmental outcomes of low birth weight infants. *Future Child*. 1995;5(1):176-196. doi:10.2307/1602514.
 7. Stein REK, Siegel MJ, Bauman LJ. Are children of moderately low birth weight at increased risk for poor health? a new look at an old question. *Pediatrics*. 2006;118(1):217-223. doi:10.1542/peds.2005-2836.
 8. Ramsay MC, Reynolds CR. Does smoking by pregnant women influence IQ, birth weight, and developmental disabilities in their infants? a methodological review and multivariate analysis. *Neuropsychol Rev*. 2000;10(1):1-40.
 9. Nigg JT, Breslau N. Prenatal smoking exposure, low birth weight, and disruptive behavior disorders. *J Am Acad Child Adolesc Psychiatry*. 2007;46(3):362-369. doi:10.1097/01.chi.0000246054.76167.44.
 10. Healthy Child Manitoba. Healthy baby. <https://www.gov.mb.ca/healthychild/healthybaby/index.html>. Published 2018. Accessed January 5, 2018.
 11. Brownell M, Chartier M, Nickel N, et al. Unconditional prenatal income supplement and birth outcomes. *Pediatrics*. 2016;137(6):e20152992.
 12. Brownell M, Nickel N, Chartier M, et al. An unconditional prenatal income supplement reduces population inequities in birth outcomes. *Health Aff (Millwood)*. 2018;37(3):447-455. doi:10.1377/hlthaff.2017.1290.
 13. Fernald LC, Gertler PJ, Neufeld LM. Role of cash in conditional cash transfer programmes for child health, growth, and development: an analysis of Mexico's Oportunidades. *Lancet*. 2008;371(9615):828-837. doi:10.1016/S0140-6736(08)60382-7.
 14. Fiszbein A, Schady NR. *Conditional Cash Transfers: Reducing Present and Future Poverty*. Vol. 1. Washington, DC: The World Bank; 2009.
 15. Carolan CM, Forbat L, Smith A. Developing the DESCARTE model: the design of case study research in health care. *Qual Health Res*. 2016;26(5):626-639. doi:10.1177/1049732315602488.
 16. Yin RK. *Case Study Research: Design and Methods*. 4th ed. Thousand Oaks, CA: Sage; 2009.
 17. Yin RK. *Applications of Case Study Research*. Thousand Oaks, CA: Sage; 2012.
 18. Green LW, Kreuter M. *Health Program Planning: An Educational and Ecological Approach*. Boston, MA: McGraw-Hill Education; 2004.
 19. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. *Am J Eval*. 2006;27(2):237-246. doi:10.1177/1098214005283748.
 20. Norrie McCain M, Mustard F. *Reversing the Real Brain Drain, Early Years Study: Final Report*. Toronto, ON: Children's Secretariat; 1999. <http://govdocs.ourontario.ca/node/15136>. Accessed August 5, 2019.
 21. The Community Task Force on Maternal and Child Health. *A Plan for Maternal and Child Health Care in Manitoba*. Winnipeg, MB: The Community Task Force on Maternal and Child Health; 1982.
 22. Postl B, Martin G, Boulanger M. *The Health of Manitoba's Children*. Winnipeg, MB: Healthy Child Manitoba; 1995.
 23. Healthy Child Manitoba. 2001-2002 annual report 2001-2002. <https://www.gov.mb.ca/healthychild/about/annual.html>. Published 2002. Accessed August 5, 2019.
 24. Legislative Assembly of Manitoba. *Hansard, 37th Leg, 3rd Sess, No 6*. November 20, 2001. https://www.gov.mb.ca/legislature/hansard/37th_3rd/hansardpdf/6.pdf
 25. Province of Manitoba. Provincial assistance recipients to benefit directly from \$2 million for prenatal and infant nutrition [press release] <http://news.gov.mb.ca/news/index.html?d=comments&item=23496>. Published 1998. Accessed August 5, 2019.
 26. Legislative Assembly of Manitoba. *Hansard, 37th Leg, 2nd Sess, No 58A*. July 5, 2001. https://www.gov.mb.ca/legislature/hansard/37th_2nd/hansardpdf/58a.pdf
 27. Legislative Assembly of Manitoba. *Hansard, 37th Leg, 2nd Sess, No 18*. April 24, 2001. https://www.gov.mb.ca/legislature/hansard/37th_2nd/hansardpdf/18.pdf
 28. Legislative Assembly of Manitoba. *Hansard, 37th Leg, 2nd Sess, No 14*. April 18, 2001. https://www.gov.mb.ca/legislature/hansard/37th_2nd/hansardpdf/14.pdf
 29. Rabson M. Cash-during-pregnancy plan begins. *Winnipeg Free Press*. July 2, 2001:3.
 30. Kuxhaus D. Prenatal bonus a first. *Winnipeg Free Press*. April 18, 2001:1-2.
 31. Brownell MD, Chartier M, Au W, Schultz J. Program for expectant and new mothers: a population-based study of participation. *BMC Public Health*. 2011;11:691. doi:10.1186/1471-2458-11-691.
 32. Adato M, Roopnaraine T, Becker E. Understanding use of health services in conditional cash transfer programs: insights from qualitative research in Latin America and Turkey. *Soc Sci Med*. 2011;72(12):1921-1929. doi:10.1016/j.socscimed.2010.09.032.
 33. Owusu-Addo E, Cross R. The impact of conditional cash transfers on child health in low- and middle-income countries: a systematic review. *Int J Public Health*. 2014;59(4):609-618. doi:10.1007/s00038-014-0570-x.
 34. Brown SJ, Yelland JS, Sutherland GA, Baghurst PA, Robinson JS. Stressful life events, social health issues and low birth-weight in an Australian population-based birth cohort: challenges and opportunities in antenatal care. *BMC Public Health*. 2011;11:196. doi:10.1186/1471-2458-11-196.
 35. DFID and UK AID. *DFID Cash Transfers Evidence Paper. Policy Division Papers*. 2011. <https://socialprotection.org/discover/publications/dfid-cash-transfers-evidence-paper>. Accessed August 5, 2019.
 36. Feldman BS, Zaslavsky AM, Ezzati M, Peterson KE, Mitchell M. Contraceptive use, birth spacing, and autonomy: an analysis of the Oportunidades program in rural Mexico. *Stud Fam Plann*. 2009;40(1):51-62.
 37. Handa S, Peterman A, Seidenfeld D, Tembo G. Income transfers and maternal health: evidence from a national random-

- ized social cash transfer program in Zambia. *Health Econ.* 2016;25(2):225-236. doi:10.1002/hec.3136.
38. Kabeer N. Resources, agency, achievements: reflections on the measurement of women's empowerment. *Dev Change.* 1999;30(3):435-464. doi:10.1111/1467-7660.00125.
39. Adato M, de la Brière B, Mindek D, Quisumbing A. *The Impact of PROGRESA on Women's Status and Intra-household Relations: Final Report.* Washington, DC: International Food Policy Research Institute; 2000.
40. Bonilla J, Zarzur RC, Handa S, et al. Cash for women's empowerment? a mixed-methods evaluation of the Government of Zambia's Child Grant Program. *World Dev.* 2017;95:55-72. doi:10.1016/j.worlddev.2017.02.017.
41. Molyneux M, Thomson M. Cash transfers, gender equity and women's empowerment in Peru, Ecuador and Bolivia. *Gend Dev.* 2011;19(2):195-211. doi:10.1080/13552074.2011.592631.
42. van den Bold M, Quisumbing A, Gillispie S. Women's empowerment and nutrition: an evidence review. Washington, DC. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2343160. IFPRI discussion paper 01294. Published 2013. Accessed August 5, 2019.
43. Junior JA, Katz AM, Ahn R. The perspectives of young women in rural Western Kenya on unconditional cash transfers. *Poverty Public Policy.* 2016;8(1):72-94. doi:10.1002/pop4.127.
44. Jones N, Abu-Hamad B, Perezniето P, Sylvester K. Transforming cash transfers: citizens' perspectives on the politics of programme implementation. *J Dev Stud.* 2016;52(8):1207-1224. doi:10.1080/00220388.2015.1134772.
45. Duke CC, Stanik C. Overcoming lower-income patients' concerns about trust and respect from providers. *Health Affairs Blog.* <https://www.healthaffairs.org/doi/10.1377/hblog20160811.056138/full/>. Published 2016. Accessed August 5, 2019.
46. LaVeist TA, Isaac LA, Williams KP. Mistrust of health care organizations is associated with underutilization of health services. *Health Serv Res.* 2009;44(6):2093-2105. doi:10.1111/j.1475-6773.2009.01017.x.
47. Abma TA, Stake RE. Science of the particular: an advocacy of naturalistic case study in health research. *Qual Health Res.* 2014;24(8):1150-1161. doi:10.1177/1049732314543196.
48. Peel E, Parry O, Douglas M, Lawton J. "It's no skin off my nose": why people take part in qualitative research. *Qual Health Res.* 2006;16(10):1335-1349. doi:10.1177/1049732306294511.
49. Cook K, Nunkoosing K. Maintaining dignity and managing stigma in the interview encounter: the challenge of paid-for participation. *Qual Health Res.* 2008;18(3):418-427. doi:10.1177/1049732307311343.