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CCTs through a wellbeing lens: The importance of the relationship between front-line officers and participants in the Oportunidades/Prospera programme in Mexico

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This article explores the social relationships created in the delivery of conditional cash transfer (CCT) programmes using a wellbeing lens. Most CCTs influence people's lives in overarching terms, including income, health and education. Their implementation process, however, also places policy participants in new and constant interactions with the front-line officers that implement the programmes. Wellbeing scholarship brings to our attention the centrality of social relationships in people's lives. This literature widely agrees that the quality of our relationships with others is possibly the most essential element of a good life. Therefore, given the recent entrance of wellbeing to the realm of policy, an exploration of the relationships created in policy contexts using a wellbeing lens is a necessary next step. This article examines this in the context of the Oportunidades/Prospera programme in Mexico, one of the most successfully regarded CCTs in Latin America. It presents primary qualitative data about the officer–recipient relationship during the delivery of the health conditionalities and explores its implications on the wellbeing of recipients. The article concludes that the relationships created during policy implementation have far-reaching effects on wellbeing and need to be better acknowledged in policy design and evaluation.

Key words: CCTs, Oportunidades, Prospera, wellbeing, mixed-methods, social relationships, officer–recipient interactions, client-provider, policy delivery.

Introduction

Over the past twenty years a wave of conditional cash transfer (CCT) programmes have proliferated across the world with the motivation of reaching the first Millennium Development Goal of eradicating extreme poverty and hunger. The Prospera[1] social programme in Mexico has been key in this endeavour as it has been considered one of the most successful CCTs in Latin America and the biggest social programme in the history of the country, reaching 6.1 million families in 2015. Like most CCTs, it seeks to improve the life of the poorest families in terms of income, health and education, which are the most discussed aspects in internal and external evaluations (IFPRI, 2002; Campos, 2012). In its implementation process, however, Prospera also influences the relational experiences of the participant families[2] by placing them in new and constant interactions with front-line officers, especially with the officers that provide and regulate the health

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conditionalities. This article argues that the continual interactions between officers and recipients during programme delivery build a relationship that is potentially vital for the success of the programme's aims but, more importantly, for the wellbeing of recipients.

Indeed, wellbeing scholarship has consistently underlined the integral role of social relationships in people's lives (e.g. Haller and Hadler, 2006; Ryan and Deci, 2001; La Guardia and Patrick, 2008; Rojas, 2007a; Camfield *et al*., 2009). No matter what approach is used, all agree that having positive relationships with others is possibly the most essential aspect of living a good life. Despite this overarching significance, neither wellbeing scholarship nor public policy have explored the relationship between officers and policy recipients in depth. Therefore, the entrance of wellbeing into policy makes an exploration of the role of relationships created in policy contexts a necessary next step. This article seeks to address this gap by scrutinising the influence of the relationship with health officers on the wellbeing of the families within Prospera. To do so, mixed-methods research was conducted in two localities of the state of Puebla investigating the experiences of recipients during programme delivery, their perceptions of the quality of their relationship with health officers and the relevance of this relationship for wellbeing.

The article starts by presenting the case of Prospera, the processes of implementation, and what is currently known about the relationship between officers and recipients in the context of public policy. This same section also stresses the value of a wellbeing lens in policy evaluation, discusses the significance of relationships to wellbeing and justifies the exploration of policy relationships through a wellbeing lens. In the second section, the methodology and research settings are described before moving on to the findings. Due to space constraints, this article will only present findings from the qualitative interviews with the programme's recipients. The article will end with a brief discussion of the urgency of evaluating the impact of the officer–recipient relationships and the benefits of taking a wellbeing approach for this task is offered as a conclusion.

Wellbeing, Prospera, and the officer–recipient relationship

The primary aims of Prospera are to improve the wellbeing of the poorest families and reduce the intergenerational transmission of poverty by incentivising the investment in 'basic capabilities'. These are sought by combining short- and long-term strategies together with a rigorous principle of co-responsibility between the state and its citizens. In practice, this principle entails that the programme commits to provide quarterly income transfers directly to mothers, with the condition that they send their children to school and attend regular health check-ups (Skoufias, 2005). Through this principle, Prospera also seeks to promote the agency and empowerment of its participants by transforming their role from clients of the state to active citizens that take part in their own development and in the investment of their own capabilities (Molyneux, 2006).

This CCT has been praised internationally for its effective design and implementation (e.g. Barber and Gertler, 2010). One of its virtues is that it is subject to regular evaluations that have widely confirmed its success in objective terms, such as increasing household income and consumption, raising children's school attendance and improving health and nutrition (IFPRI, 2002). However, the mechanisms through which Prospera has pursued its objectives have placed families in a new social scenario with the front-line officers that deliver the benefits and regulate the conditionalities. Arguably, the most complex and important of these interactions is that with the health staff in the local clinics.

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The function of the doctors and nurses is to provide and monitor the different activities in which the families are involved through the programme. Prospera's regulations officially require participants to attend health workshops every month and regular medical check-ups. The latter generally involve family appointments for preventive check-ups twice a year, but those who are pregnant or suffer from hypertension, diabetes, obesity or malnutrition meet the medical staff every two months. There seems to be, however, a few unofficial requirements in place, as found in the two localities studied and according to the experience of some research participants (recipients and officers) in other localities. These unofficial requirements involve, among other tasks, cleaning the clinic and the streets of the locality and participating in health campaigns. The sources and incentives behind these activities are unclear and seem to vary from clinic to clinic. The spread of these practices too are difficult to determine as no official source appears to discuss or regulate them, indicating they have become an informal practice within the architecture of the programme's implementation.[3] Despite these ambiguities, the evidence suggests that health officers regulate these activities as part of the requirements families have to comply with in order to receive their benefits. The official and unofficial health conditionalities create more recurrent and long-term interactions between officers and recipients in Prospera than might appear at first sight.

This is particularly relevant since these practices echo the broader literature on development studies where policy processes are understood as the result of the interaction between power relations (Wood, 1985), in which the access encounters of policy participants through front-line officers are central (Eyben, 2010; Schaffer, 1985). Moncrieffe and Eyben (2007) argue that the position in which front-line officers are located within the institution confer them a discretionary power that allows them to choose to some extent who deserves the assistance, the kind of assistance and how it will be delivered. Moreover, these relationships are also embedded in the politics of identity as people embody their social position not only within the hierarchies of the institution but also their position in the outer social world (Eyben and Moncrieffe, 2006). Hence, according to this discipline, policy-making and implementation cannot be detached from the relational structures in which they are embedded. The nature of this relationship could thus influence its quality and people's wellbeing in important ways.

A key characteristic of wellbeing scholarship is placing the person and her perspectives at centre-stage and demonstrating through extensive empirical work that the good life involves a multiplicity of aspects that undoubtedly lie beyond the material and economic. Despite being a nascent field, many academics and policy-makers advocate a wellbeing approach to guide policy decisions (Cummins *et al.*, 2009; nef, 2011; Rojas, 2007b; Rojas and Martinez, 2012; White, 2010; White, 2014). Wellbeing can indeed offer a more comprehensive view of human life and of the influence of policies and programmes in its betterment as it permits thinking about poverty and deprivation not only in terms of the resources that people lack, but also in terms of how they feel and think about what they are able to be and do (White, 2010; Gough *et al.*, 2006). This holistic approach is derived from various objective and subjective approaches to wellbeing, such as basic needs and the capabilities approach on the one hand, and happiness and psychosocial perspectives on the other.

This article is primarily concerned about the contribution of subjective approaches to public policy. The fundamental claim of subjective approaches is that how people think and feel about their lives is valuable, and is an important complement to the

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objective indicators traditionally employed (Stiglitz *et al*., 2009). Particularly relevant for the purposes of this work are the overarching findings within this scholarship about the integral role of social relationships in the experience of wellbeing. Though relationships are studied at different levels by the various subjective approaches to wellbeing that exist today, all agree that relationships are possibly the utmost essential aspect of the good life (for literature on subjective wellbeing, see Haller and Hadler, 2006; Diener and Seligman, 2002; for domain satisfaction, see Cummins, 1996; Rojas, 2007a; for psychological wellbeing, see Argyle, 2001; Ryff and Singer, 2000; Ryan and Deci, 2001; La Guardia and Patrick, 2008; for development, see Camfield *et al*., 2009).

Wellbeing scholarship often discusses 'social relationships' in terms of familial and community interactions, possibly as a consequence of its roots in psychology. 'Social relationships' (including family, friends, co-workers and the community) have been found to be central for wellbeing as they provide a sense of belongingness, support, care, trust and security (Baumeister and Leary, 1995; Reis and Patrick, 1996; Reis *et al*., 2000; Ryff and Singer, 2000). It is also commonly agreed that relationships can be of instrumental value to wellbeing as they help people cope with economic crises, find employment and access resources or services. They can also be intrinsically good, since having social contact and enjoying quality relationships throughout life are essential to living well.

This study relies on the inner wellbeing (IWB) approach proposed by the Wellbeing Pathways Project (WPP), particularly because it infers that relationships have a prominent role in the construction of wellbeing, being detached from the bounded conception of relationships as close and intimate. Wellbeing, it is proposed, is created from the interrelation between three dimensions: the material, the relational and the subjective (White, 2010; Gough and McGregor, 2007). The relational dimension recognises that notions of wellbeing are construed in a given time and space (context and culture are important) and constantly renegotiated in our interactions with others (people and institutions) through the creation and reproduction of identity, social structures and power (White, 2010; White and Blackmore, 2015). This broader understanding of the relational aspect of wellbeing better reflects the political nature of officer–recipient relationships described by the development literature above, and also sheds light on the different and far-reaching ways in which relationships (of any kind) can influence people's lives.

Notwithstanding the significance of relationships for wellbeing, the literature that has examined the implementation of Prospera's health conditionalities has primarily centred on the consequences for the programme's outcomes, rather than on the impacts of interactions with health staff for the recipients themselves (see Sánchez, 2008; Bautista *et al*., 2008). For instance, procedural issues such as lack of medicines, untimely medical attention, and the type of healthcare provider (institution), have been found to increase the dropout rates of recipients (Álvarez *et al*., 2007), as well as promoting a constant reliance on private medical attention that charges higher fees to patients, reducing the intended income effect of the cash transfer (Escobar Latapí, 2000).

From the perspective of recipients, however, the quality of their relationship with officers appears to be a significant aspect of the process of programme implementation. Saucedo (2013) found that while families shared the view that clinicians offered poor health services, most of their concerns were directed to the lack of courtesy received during check-ups. The quality of the treatment seems to be particularly critical for indigenous participants. They have reported less access to health centres, not because

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their localities do not have a health clinic, but mainly as a result of the attitudes and treatment received from health officials, including lower quality of medical attention, mistreatment, abuse and discrimination (Campos, 2012).

This process of programme implementation dangerously translates the discourse of co-responsibility into one of obligation (Molyneux, 2006), and possibly lends the bureaucratic procedures to be misused reinforcing wider patterns of discrimination and inequality. A small number of studies have observed that the officer–recipient relationship takes place in problematic conditions of asymmetric reciprocity and hierarchy. For instance, Smith-Oka (2013) argues that this relationship is highly mediated by the marked ethnic, class, skin colour and sometimes gender differences between them. These conflicting identities permit officers to exercise what Smith-Oka (2015) described as 'microaggressions', which include hostility, subtle insults, impatience, inappropriate teasing and attitudes of moral superiority towards recipients.

As this review exposes, most studies observe that officer–recipient relationships can affect the effective delivery of services and distort the aims of the programme (Agudo-Sanchíz, 2012). A few also problematise the nature and quality of the relationship by emphasising the influence of identity, power, discrimination and aggression that can be executed by officers during programme delivery, especially so in a health context where the social division between the poor policy recipient and the officer is exacerbated by their identities as patients and clinicians (Smith-Oka, 2015). An empirical question that remains, however, is whether this particular policy relationship is significant for people's wellbeing. To the author's knowledge, this has not been studied in the policy sphere or in the case of Prospera using a wellbeing lens. The only study found to tangentially discuss this is the large qualitative research conducted by Molyneux and Thomson (2011) on CCTs in Peru, Ecuador and Bolivia, where part of their findings suggested that female recipients expressed a lower sense of self-image, agency and empowerment when the interactions with health staff involved labelling, discrimination and violence. Therefore, what makes the evaluation of the quality of officer–recipient relationships crucial is the possible unintended effects on the wellbeing of the participant families.

This section provides two main arguments. Firstly, it claims that wellbeing is a valuable lens through which public policies should be evaluated as it gives primary attention to people's perspectives of their lives. In addition to being a direct route towards finding out people's priorities and experiences, subjective wellbeing evaluations can provide direct guidance on the quality of service delivery (Cummins, 2005; Renwick *et al*., 1994) and on the quality of the relationships generated in the process. Secondly, given the prominence of relationships for wellbeing, this section provides evidence of important challenges involved in the encounters between policy officers and recipients. Thus, this article wishes to analyse, using the case of Prospera, whether the significance of relationships in wellbeing transcends the borders of close relationships to include the relationships created during policy implementation.

Methodology and research setting

The qualitative data presented here are drawn from a larger mixed-methods research exploring the roles of relationships in wellbeing. The fieldwork took place between January and September 2013 in two localities of the State of Puebla, Nexpan and

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Cualcan.[4] Nexpan is a semi-rural locality in the outskirts of the city of Puebla. The population is mainly *mestiza* (94.7 per cent reported not speaking an indigenous language). Cualcan, in contrast, is a rural and indigenous locality with a 97.9 per cent of the population speaking Nahuatl. It is located four hours away from the city. On average, participants had spent four or seven years as part of Prospera in Nexpan and Cualcan, respectively. The choice of case study sites was led by an interest in examining whether identity and location influenced officer–recipient interactions, given previous findings about increased discrimination towards indigenous and rural communities from health officers in Prospera (Campos, 2012; Smith-Oka, 2015).

The qualitative study consisted of a period of participant observation in each health clinic, as well as focus groups (2) and in-depth interviews (30) with recipients. The focus groups and interviews scrutinised how participants experienced their encounters with the officers delivering the health conditions, and explored the pathways in which the quality of these interactions[5] influenced wellbeing. No wellbeing approach was used to frame the interviews. Therefore, participants were free to talk about the relationship and their wellbeing in whatever manner chosen. In the analysis of the findings, however, the psychosocial approach of IWB was employed as it gives emphasis to subjective perceptions of wellbeing through a social perspective.

The IWB approach defines wellbeing as 'how people feel and think about what they can do and be' (White *et al*., 2013: 723). This is a multidimensional model composed of seven distinct but interrelated domains that have been found to constitute wellbeing, both theoretically and empirically (see White, 2010; White *et al*., 2013). The domains are economic confidence, agency and participation, social connections, close relationships, physical and mental health, competence and self-worth and values and meanings. This model thus evaluates how people perceive that their lives are going in personal, social and economic aspects.

Findings: relationships with officers and the wellbeing of policy participants

This section first presents a general picture of the quality of the relationship between officers and recipients in both localities and then focuses on the wellbeing effects from the recipients' perspectives. However, as will be noted, the narratives of participants occasionally overlap the quality of the relationship with their implications for wellbeing.

The first salient finding of this research is that recipients' accounts evoked an evaluation of their interactions with health officers beyond the quality of the medical attention received, emphasising instead the perceived attitudes and behaviours of the officers towards them. Naturally, the quality of the interactions varied between officers, with their position in the clinic as a salient distinguishing factor.[6] The relationship with temporary staff such as medical interns was usually perceived more positively than that with permanent staff. The directors of the clinics or chief doctors often featured in the interviews as the most important figures of authority, holding power over the procedures in the clinic and the conditionalities of Prospera.

Notwithstanding variations among staff, the two localities of this study generally experienced contrasting officer–recipient relationships. In Cualcan (rural), participants tended to describe their interactions in more positive terms, emphasising aspects such as communication, trust, kindness, dedication and empathy.

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> The doctor we have now is very kind. She treats you very well, listens and is approachable. Besides, if you ask her something she gives good explanations ... Yes, because the previous doctor was very rude, if you asked him anything he yelled at you from the start. Cualcan (1)

Participants also recalled negative experiences with former officers, particularly in relation to rudeness or disrespect as the previous quote shows, as well as to a lack of empathy towards those who did not speak Spanish.

> The doctor's treatment affected me because you couldn't even talk to him, ask him a question or any information because he would yell at you or say things to you. A lot of people were afraid of him ... Sometimes I thought about those that don't speak Spanish, especially the elderly, like my mother. Imagine if my mom went (to the clinic) by herself? How would he treat her? He would probably send her off without healing her. Cualcan (2)

In contrast, in Nexpan (semi-rural) negative experiences were the norm, whereas positive interactions were rarely mentioned. When the relationship was perceived as negative, participants in both localities expressed being mistreated, yelled at, and publicly shamed. In Nexpan, however, they tended to describe the relationship in stronger hierarchical terms, and experiencing threats or abuse of power were particularly common.[7] This was primarily discussed in relation to the chief doctor, but the participant observation quoted below suggests that the dynamics within the clinic as a whole seemed to follow a similar approach.

> Sometimes [the doctor] explodes with the first who crosses her way. That time when she yelled at me, I felt very embarrassed because the clinic was full. I would have expected her to understand and to listen to the reasons why my daughter missed the (compulsory) appointment [she had a school exam] ... She has yelled at many beneficiaries! Many! ... I didn't receive the cash transfer this time, so I will just wait and if I do not receive it again, well. The *vocal* told me to talk to the doctor about it and to bring her a form, but no way! If I go to the clinic, she will yell at me! [*Researcher*: But not going could mean that you would be taken out of the programme, wouldn't it?] Well, I tell my husband, I'd rather wait and see, if I do not get it again I might bring the forms or I (might) just stay like this. Nexpan (3)

> Maybe it is wrong for me to say this, but, the doctor abuses her position a lot. She puts conditions to signing the attendance record depending on whether she likes you or not, or sometimes she might simply find an excuse not to sign it. And she forces us to do things! Nexpan (4)

Overall, the data from this research confirmed the influence of the quality of officer relationships on the attitudes of recipients towards the clinic and the programme (e.g. Álvarez *et al.*, 2008). Positive relationships were often narrated as improving their trust in the clinic, increasing their willingness to attend and the perceived quality of the medical attention received. Negative relationships, on the other hand, compelled recipients to avoid interacting with certain staff or to avoid going to the clinic altogether, which entailed needing to resort to other sources of health care (including private care and traditional healers that are potentially harmful for their economic security and health, given the costs of treatment and the difficulty of identifying legitimate physicians) and the risk of losing the programme.

For participants, having a good relationship with officers was deemed important in order to receive appropriate and timely medical attention for themselves and their families,

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but also because officers were perceived to have significant power over their stay in the programme. Very few described the health services received as part of Prospera as a right or an entitlement (mostly *vocales*[8]). More often, they felt that they should negotiate receiving the service with the officers by having a positive relationship with them.

> It is important to have a good relationship with the medical staff because the clinic is the first place we would go if we have an ill (family member). Especially families like us who have scarce resources, and if we don't have a good relationship with them they will not treat us. Cualcan (5)

> because the doctor is the only one who signs (the attendance record of Prospera), the only one who authorises anything. Nexpan (6)

In addition to the effect that this relationship could have on their health and economic circumstances, previous quotes start to indicate other ways in which the quality of this relationship affected inner wellbeing. Indeed, for many women, being mistreated by officers entailed general discomfort, distress and negative feelings.

> If I go to the clinic in pain, and they do not assist me, they tell me off or yell at me, well, if I am already feeling bad, then I feel worse. That is why some people look for other options . . . But people do not say anything because of fear . . . yes is mainly fear that if I say something the doctor will not take my attendance (of Prospera). Cualcan (7)

Following the IWB model, one could argue that the mistreatment and threats involved in the interactions with doctors influenced their sense of economic security (economic confidence) as is evident in the recurrent expressions of fear of losing the programme. The cash transfer was described as essential by all participants, as it allowed them to have food and clothing for their families, buy school materials for their children and occasionally save to start building brick rooms in their houses. Nonetheless, participants perceived that remaining in the programme was not only determined by their own behaviours (complying with the conditions) but by the discretion of the officers who decided when to sign their attendance record or to accept proofs of absence. This could imply that even if the policing role of the health staff is important for the regulation of the programme, it also lends itself to arbitrary decisions, creating a hierarchical relationship between officers and participant families.

> [*Researcher*: Do you feel that your relationship with the staff in the clinic can affect you and your life?]

> Yes it can, because she can decide not to sign [my attendance record] even though I am complying. So just like that I lose the programme and I can no longer go to my workshops nor receive my support [cash transfer]. Cualcan (8)

This hierarchical relationship also affected how much recipients felt they could use their agency to change the situation. As the next quote shows (see also quotes 2, 3, 7), officers' expressions of power discouraged participants from approaching them to discuss a problem regarding their attendance record, to raise their voices when they disagreed

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about how they were being treated or about decisions made in the clinic, or even get organised to collectively follow a complaint.

> One has to agree with her [chief doctor] in everything, be condescending. Because, for example, if she were to find out [that she is complaining of the doctor in the interview] she would take it against me and she can even take me out of the programme ... We have tried to issue a complaint before, but we don't know how but she finds out and asks who was complaining and why. So you believe in her threats ... And we think, what can we do then? It is even worse when she threatens that she can sue us for defamation. How could we defend ourselves from that? Nexpan[9] (9)

In contrast to negative interactions, more positive relationships had the opposite effect. In Cualcan, where recipients perceived a better relationship with the staff, they felt more confident about approaching them to discuss issues about the programme or their own health (see quote 1). This was also mentioned by *vocales* since they are often the direct link between recipients and clinicians. Similarly, positive interactions with officers enhanced the women's self-confidence, not only during their encounters with officers but also their confidence to cope with other events in their lives. For example, some participants expressed that receiving good care from officers made them feel supported and confident when needing to make decisions with their husbands about family planning. The next excerpt is extracted from a conversation with a participant who recounts how she feels a stronger woman and more able to handle the bad relationship with her husband thanks to the support of a doctor.

> I told (my husband), 'if I had a place to live, you wouldn't enter my house again, because I am a woman and I respect and love myself.' [*Researcher*: What has helped you feel so confident?] Well, thanks to the workshops from Oportunidades, especially with Dr. Y [former doctor]. She gave us talks about self-esteem, female diseases and the like. But she talked to us openly. At the beginning we were shy because we weren't used to talk about those things. But when we started trusting her and talking to her constantly, we were more open. I don't know why they took her away from us. But yes, it was through her talks that I started saying, 'I will give it a try'. Nexpan (10)

The quote suggests that wellbeing could be promoted not only by the knowledge provided in the workshops of Prospera, but also by the way the doctor relates to recipients during the workshops. Yet, negative interactions that involved discrimination had a very strong effect on self-worth and competence. This is illustrated in the following excerpt from a focus group in Nexpan in which participants were asked to describe an experience during Prospera's compulsory medical visits.

> *G*: I'll tell you what I felt during an appointment. Imagine that as soon as the doctor arrives (at the room) she tells me not to get close to her. She tells me, 'Ma'am, move over there'.
> *E*: Yes, she doesn't want you to get close.
> *Researcher*: Why do you think she doesn't want you to get close?
> *G*: Well, because maybe she thinks that we have something [inherently] contagious. (Others agree)
> *Researcher*: And how does that make you feel? (Asks all)
> ***G***: We feel that she is undermining us ... as if I was worth nothing to her.
> *X*: One feels like ...

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> *L*: (Interrupts) Like you are worth nothing. (X – Yes)
> *A*: It affects your self-esteem!
> *P*: It's like if she feels very tall and we are very small.
> *G*: I thought so because that is how she said it, 'no, move, don't get close'. And I am sitting there thinking, 'The town worked for this? For [her] to be lazy and arrogant? (Many laugh) So [she] can talk to me any way [she] want[s] and treat us like that? No, that is not fair'. But I am not saying it aloud, only in my head.
> *Researcher*: Why don't you say it aloud?
> *E*: Because of fear. (Others agree)
> *L*: As I was saying, she (doctor) tells us, 'If I want I can erase you from here and you will be out (from Prospera) quickly!' And that's it. She might even say, 'I will not sign your attendance record'. (Many agree)
>
> Focus group, Nexpan.

This powerful quote illuminates a shared experience of a relationship of power, hierarchies and devaluation and its overarching influence on the wellbeing of policy participants by having control over their material wellbeing (the resources they can have) and their subjective wellbeing (how they feel about themselves and about what they can do). Overall, the results of this research suggest that the terms in which the relationship with health officers unfolds has the potential of improving or reducing the recipients' wellbeing in distinct domains, such as economic confidence, agency, competence and self-worth.

Conclusions

This article argues that while Prospera seeks to improve the life of poor families in overarching terms, the effectiveness of this goal is importantly mediated by their relationship with officers. However, the officer–recipient relationship is evaluated not in terms of its impact in the delivery of services or the functionality of the programme, but on its implications for the wellbeing of policy participants.

The findings give initial qualitative evidence of the far-reaching effects of this relationship on how policy participants feel and think about what they can do and be. In the two localities of this study, a negative relationship with health officers was associated with lower economic confidence due to the perceived power of officers over recipients' stay in the programme; lower sense of self-worth, competence, and social support because of experiences of mistreatment, discrimination and shaming; and reduced agency as this treatment promoted feelings of being incapable of transforming the terms of the relationship. Relationships characterised by shared authority and empathy, on the other hand, had opposite effects on wellbeing.

The qualitative data collected for this study is valuable for it directly includes the perspectives of policy participants about the quality of their relationship with officers and its implications for wellbeing. These results, though, are restricted to the experiences in the localities studied and do not test the statistical significance of this relationship for wellbeing. Nevertheless, one of the benefits of using a wellbeing lens is that it lends itself to explore this phenomena using well-studied subjective indicators in larger samples of recipients, localities, and programmes. Therefore, this article also seeks to open up space for further mixed-methods research on this topic.

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Ultimately, these initial findings attest that the relationships created through policy delivery should be incorporated into the design and evaluation of policies and programmes. An emphasis on relationships can uncover programme processes and unintended effects that are usually unaccounted for. Recognising the importance of these relationships also re-states the value of a wellbeing approach in the policy sphere as, it places the person and her perspectives at the centre-stage of policy design and delivery.

To conclude, the increasing interest of taking a human approach to policy-making emphasises that the concern about the implications of policy interactions should go past the simple delivery of a service to include a concern for the perspectives, experiences and wellbeing of the recipient families. In the words of one participant of this research: 'Oportunidades needs to pay attention to everything. It is not enough to send staff or to give money away, they need to look at the kind of treatment (provided) and the extortions that lie behind it.'

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Notes

1 The programme has had three re-formulations since first established in 1988 (see Gardner, 2008). Recently, in January 2015, it was reformed as Prospera to include actions that promote employment, labour inclusion and access to financial services; and extend scholarships from high school to higher education.

2 The author of this article prefers using the concepts of policy 'participant' or social programme 'recipient' over the value-laden concept of 'beneficiary'.

3 Smith-Oka (2013) found similar practices in surrounding states to Puebla. It is difficult to determine why these unofficial requirements are allowed. One possible explanation is that they serve as a tool for the national health office to achieve parallel goals like promoting health procedures and reaching quotas in their application (e.g. vaccinations); keeping clinics clean without hiring staff, and reducing workloads of current staff.

4 Participants were assured that the data, their names and their localities would remain anonymous. Therefore all names mentioned have been changed.

5 The qualitative data also served as a basis to design a scale evaluating the quality of the interactions with officers (QoR scale). This will be presented in a subsequent article.

6 This was corroborated in the interviews with clinicians, but these findings will be published elsewhere.

7 The literature suggested that the indigenous and rural identities could be important indicators of the terms of the relationship between officers and recipients, given the historical, cultural and political structures of Mexico against these groups. In the case studies presented here, however, the quality of the relationship was more adverse in Nexpan, the semi-rural and non-indigenous locality; although in Cualcan participants recalled past attitudes of discrimination and authoritative behaviour particularly against indigenous people who did not speak Spanish. Instead, in these localities, the nature and quality of the relationship seems to be influenced not only by their contrasting policy identities of 'recipients'

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and 'officers', but by their economic position and knowledge, with recipients generally being perceived as 'poor' 'patients' and officers as 'middle-class' 'clinicians'.

8 *Vocales* are recipients elected to represent their peers before the programme. For such a role, they receive training and thus have more information about Prospera's procedures. In the health clinic, they assist in the promotion and fulfilment of the health objectives by organising and incentivising participation, providing information, and being in direct communication with health staff (SEDESOL 2014).

9 It is important to restate that during data collection all necessary steps were carried out to protect the information and anonymity of participants. Notwithstanding, a possible limitation of the methodology of this research arises from the delicate nature of the data generated during the interviews and focus groups and the caution of some participants to express their experiences openly. This was minimised by gaining their trust, by clearly explaining the objectives of this research, the independence of the researcher from the clinic and from Prospera and their rights of anonymity and confidentiality.

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