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STAKEHOLDERS' ATTITUDES TO THE CONDITIONAL CASH TRANSFERS TO THE LOW INCOME FAMILIES IN LATVIA

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Abstract

This paper analyzes attitudes of the major stakeholders to the Conditional Cash Transfers programme adopted in Mexico, which sees building human capital as a main tool to fight poverty. The authors overview the poverty, health, nutrition and education challenges in Latvia, describe current solutions and identify stakeholders' attitudes to Conditional Cash Transfers as the possible tool addressing these challenges. Attitudes of parents, doctors, teachers and government representatives to different components of Conditional Cash Transfers programme were determined with a help of questionnaire and interviews. The model adapted to the country specific factors based on stakeholders' attitudes was developed, and the cost of such programme was estimated by the authors.

Keywords: conditional cash transfers, human capital, poverty.

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1 Abbreviations

CCT - Conditional Cash Transfer
CIA - Central Intelligence Agency
CSB - Central Statistical Bureau
ELA – State English Language Arts Test
EU – European Union
GMI - Guaranteed Minimum Income
WB – The World Bank
WHO – The World Health Organization

2 Introduction

In 2008 Latvia had one of the highest at-risk-of poverty rates in the EU with more than fourth of population not reaching satisfactory income threshold (Appendix A). Recent polls show vast majority of population (89.0%) believing that poverty is widespread (European Commission, 2009).

Poverty has negative impact on health: latest statistics¹ from WHO (2009b) and Eurostat (2009) on various health indicators display low life expectancy, high proportion of smokers and high probability of death before reaching fifth birthday. Poverty also has negative impact on education: more than a half of at-risk-of poverty people admit that the lack of funds has prevented their children from participating in school and class activities (Dedze, Kruzmetra, Lazdina, & Mikisko, 2007).

One of the responsibilities of the government is to take actions and procedures to promote the basic well-being of the individuals in need. These actions can take a variety of forms, such as monetary payments, health services, vouchers, discounts, and differ from country to country. One method to ensure the basic well being of the low income families is to employ welfare system which is known as Conditional Cash Transfers programme (CCT).

CCT are programmes that transfer cash to the low income households, provided that households make investments in the human capital. Programmes are targeted to the households living in poverty, and have a double effect: provide immediate help and modify one of the main causes of poverty - the lack of human capital. There are a number of countries which have already adopted the system of conditional cash transfers. Since 1997 programme "Oportunidades" is being implemented in Mexico, and it was the first programme of this kind. Similar programmes are accepted by many countries including Brazil, Argentina and USA. The extent of benefits received reaches up to 20.0% of the mean of household consumption, but in terms of budget, the costs of programmes range from about 0.08 to 0.5% of GDP (Fiszbein & Schady, 2009).

Programme in Mexico is particularly elaborated. Government created a system of CCT that have three different components: health, nutrition and education. The health component provides basic health care for all members of the family. The nutrition component includes a

¹ Statistics was gathered on November 30, 2009. Selected indicators on adults' health and education are presented in Appendix A and selected indicators on children's health are presented in Appendix B.

fixed monetary transfer for improved food consumption for small children, pregnant and lactating women, whose family members visit doctor regularly. The education component gives grants to the families whose children are attending school and doctor regularly (*Oportunidades program in Mexico*). Studies indicate the positive effect these programmes have: school attendance is increasing, health status is improving, country's poverty level is decreasing and poverty gap diminishing. As the result the improvement of learning outcomes is reached (Fiszbein & Schady, 2009).

The current economic situation in Latvia makes the idea of CCT to the low income families a dream at first glance. From the other side, worsening of the financial situation, raising unemployment rate and increasing social pressure require supportive interventions in this vulnerable sector.

Therefore, the research question of this thesis is: What are attitudes of major stakeholders towards the CCT to the low income families in Latvia? By major stakeholder authors mean parents, teachers, doctors and government representatives. Particularly, authors want to find out their opinion regarding the adoption of the benefit system, consisting of three components: health, education and nutrition, and conditional in compliance with certain rules. Also, the authors attempt to estimate the benefits of CCT system in comparison with the existing social support system and to specify the possible sources of funding. To answer the research question authors use two methodologies: survey and interviews.

The aim of the paper is to contribute to the understanding the benefits of the CCT and explore the attitudes in Latvia. Based on the Mexican model, the authors will provide the model of the CCT system suitable for Latvia based on the country specific data and the empirical results. Detailed economic evaluation of developed model and suggestions on implementation of the proposed model are beyond the scope of this research.

The paper consists of six parts. In the first, the authors explore the situation in Latvia regarding poverty, health and educational and determine how the government is addressing problems related to these issues. In this section the authors pay special attention to the existing benefit system to the low income families in Latvia. Next, in the literature review the authors focus on the literature explaining the reasons of poverty and ways of overcoming it. The authors also describe CCT in detail and provide the evidence on success of the programme, with a particular focus on the welfare system employed in Mexico. The third part is devoted to the methodology. In the fourth part the authors provide the results and in the fifth - develop and

adapt the version of Mexico's CCT to the local needs and estimate its cost. In the last part the authors conclude.

3 Background

Latvia is a place of birth of a number of exceptional people. For example, the world famous painter Mark Rothko, architect Michael Eisenstein, chess champion Michail Tal were born here. Outstanding minds continue to emerge. In 2009 in the International Mathematics Competition Latvia received the bronze medal (International Mathematical Olympiad, 2009), in the International Chemistry Olympiad it was the silver medal (International Chemistry Olympiad, 2009). Literacy rate in the country is high: more than 99.0 %, the number of students also is remarkable: six in ten young people in the age between 15 and 24 are attending the higher education institutions (Appendix A).

Regarding the health issues Latvia reveals good records on high rate of children vaccinations (Appendix B), relatively low number of diabetic diseases and low number of overweight person (Appendix A). Access to the improved drinking water resources and improved sanitation is high (WHO, 2009a). The recent statistical data demonstrate that one in two Latvian inhabitants assess their own health as good or very good (Svarckopfa, 2009).

All in all there is a potential for raising educated and healthy people in Latvia, but there is also a certain obstacle for this. The obstacle is poverty. During the last year the citizens experienced the increases of the income tax and the value added tax, as well as the cut in the system of the social protection, including cuts in pensions, parental allowances for working parents, cuts in non-taxable minimum income. Poverty is increasing rapidly and brings problems to health and education.

3.1 Poverty in Latvia

In 2008 about 20% of Latvians considered themselves near to poor and about 4% thought they were poor (CSB, 2009). About 89% of population believe that poverty in Latvia is widespread and 69.0% think that poverty level has considerably increased lately (European Commission, 2009). Four out of 10 Latvians admit that they do not have enough money for buying provisions and paying bills (Alberte, 2009).

During 2007 the level of the poverty line² in Latvia was 117.00 LVL per person per month for one-person's household (Ministry of Welfare, 2009), but in 2008 Latvia had the highest poverty rate in the EU with 26.0% of population not reaching the income threshold above the poverty line (Appendix A). In 2007 18.5% of households with children had the level of income at the risk of poverty (Baltic News Service, 2009).

In Latvia families are legally considered to be low income and eligible for benefits if their income per family member during last three months does not exceed half of the minimum wage of 180,00 LVL. Also the family members must not have the money deposits, bank loans, assets generating income, and must not be fully dependent on the government subsidies (The Cabinet of Ministers of the Republic of Latvia, 2009).

The government helps the low income families by providing GMI benefit and housing benefit.

GMI. GMI benefit is calculated as the difference between the household income per family member and GMI level.³ As of October 1, 2009, the Ministry of Welfare has set the GMI level of 45.00 LVL per child and 40.00 LVL for an adult. This benefit is paid monthly for three months. After three months has passed, the household can be applied for the benefit again, and if the person is still eligible, she will receive it again. The maximum duration of GMI benefit is nine months per year. The Ministry of Welfare forecasts that in 2009 GMI will be received by 2.5% of the population, but in 2010 - by 4.4% (Jursevskā, 2009). To receive the benefit, the eligible adults must sign an agreement, requiring them as a condition looking for an employment actively.

Housing- benefit. The aim of this benefit is to help families to pay their utility bills. The government is covering part of these bills. The rules regarding housing benefit vary across the local municipalities. For, instance, in Riga for a person living alone Riga City Council may cover 60 KW of the bill for electric energy, two m³ of the consumption of hot water, a part of the costs for the heating, but the total amount of the housing benefit must not exceed the amount equal to

² Poverty line is the minimum level of income needed to meet the basic needs. It varies across time and space and can be defined in different ways (WB, 2009). In the EU poverty line has been set at 60% of the national median equivalized income. National median equivalized income is value which splits the summary of the distribution of income in the country in two equal parts

³ Example: family with two adults and two children. Father is working and receives 120 LVL. Mother is a housewife and receives childcare benefit 8 LVL per child. GMI benefit= GMI (family) –Income (with benefits)= (40+ 40+ 45+ 45)- (120+ 8+ 8)= 34 LVL

the difference between the sum of the bill itself and the GMI level and the household's income with GMI benefit being included⁴ (Riga City Council, 2004).

3.2 Nutrition in Latvia

Nutrition is an input to and the foundation of health and development, and the better nutrition means stronger immune systems. Food consumed must contain all the nutrients in the correct proportions that are necessary for a human body (WHO, 2008). The Food Guide Pyramid advises to consume certain food groups in certain amounts⁵. (US Department of Agriculture)

In Latvia, on average, only one of four pupils eats at least one fruit/vegetable per day, but the consumption of sweets and lemonades is high (Gobina, Pudule, Grinberga, Velika, Tilgale, Villerusa, & Teibe, 2007). Half of Latvian parents admit their children nutrition is not healthy (Diezina, 2009). One third of the respondents report that lately they are choosing cheaper and lower quality food; 35.0% admit that they are eating less (Tite, 2009). About 37% of Latvian inhabitants are ready to consume outdated products after their expiration date. (Delfi, 2010)

The government has addressed the issue of children nutrition. Since November 1, 2006, it is not allowed to distribute beverages that have added dyestuffs, sweeteners, preservatives, caffeine, and amino acids in educational institutions. It also includes candies, caramel, and sweets containing certain dyestuffs and sweeteners that are not permitted for distribution in educational institutions.

3.3 Health in Latvia

Anca, G., Barisa, L., Cimdins, P., Djackova, S., Dmitrijeva, J., Doskina, I. (2002) explain that health is based on several factors, such as biological (gender, genetics), socio-economical (employment, poverty), environmental (quality of air, water, social environment, housing), connected to the lifestyle (physical load, right nutrition, abstinence from smoking and excessive alcohol consumption) and access to services (education, transport, free time spending possibilities).

⁴ Example: family with two adults and two children. Father is working and receives 120 LVL. Mother is a housewife and receives childcare benefit 8 LVL per child. Housing bill is 30 LVL. Housing Subsidy= GMI (family) + Bill-Income (including GMI benefit)= (40+ 40+ 45+ 45)+ 30- (120+ 34+ 8+ 8)= 30 LVL.

⁵ For instance, for a 4-8 years old child it is advised to consume 1.5 cup of vegetables and 1.5 cup of fruits and 3 ounces (about 85 grams) of meat per day. 1 cup of vegetables is counted as 2 medium carrots or 1 large pepper or one large tomato. 1 cup of fruits is counted as 1 large banana or 2 medium plums or 8 strawberries or one medium pear. 3 ounces of meat is counted as small steak.

Experts worldwide indicate that 20.0% of the health quality depends on the health care, but 80.0% are influenced by the socio-economic situation. The highest risk to the health quality is poverty, as it limits access to the healthy food and to the health promotion activities (Velmers, 2006).

In Latvia during 2007 about 1% of children died before reaching five years of age and infant death became third highest in the EU. Children deaths from injuries, suicide and poisoning are substantially higher than the EU average (Appendix B).

CIA (2009) estimates that in Latvia the life expectancy at birth in 2009 is going to be the lowest in the EU: Latvia has more than 30.0% of smokers, one of the largest indicators in the EU. Out of ten thousand people 16 die due to alcohol abuse and 50 - due to smoking related causes (Appendix A). 23.0% of boys and 8.0% of girls consume at least one bear per week. One in five girls is smoking at the age of 15 (Gobina, Pudule, Grinberga, Velika, Tilgale, Villerusa, & Teibe, 2008).

Government is helping the low income families to improve their health. Since October 1, 2009 the low income family members and all children under the age of 18 are free from paying the patient contribution in health care institutions. Before that date the low income people had to cover 50.0 % of the costs. In 2010 the government is planning to cover expenses on compensated medicaments after the household will spend on them 50.00 LVL (Ministry of Health, 2009).

3.4 Education in Latvia

Primary and secondary education in Latvia is free of charge. However, parents are frequently required to contribute money for the school needs, such as renovation of the classrooms, or making specific purchases. The parents estimated their average payments to school at about 12 LVL per month (Dedze & Strode, 2009). The parents also have to buy textbooks and stationery for their children. The amount necessary to spend on these things is estimated to be about 80 LVL per academic year per child in grade three (Zepa & Bebrisa, 2007).

A number of pupils discontinue their studies, repeat grade or receive report card only (Appendix C). Despite the fact that primary education is compulsory, some experts estimate that 15-25 thousands of children do not attend school. It is difficult to calculate the exact number of dropouts because of the inconsistency of the data. The financial situation of the family may be attributed as one of the reasons for dropping out from school. Most of the pupils, who dropped

out or are on the verge of dropping out, are coming from the families that “judging by the financial status, have to be characterized as needy or even poor” (Dedze et al., 2004).

The family benefit is given to the low income families to buy books and other things necessary for education and it varies between local municipalities. In Riga this benefit reaches up to 30.00 LVL per month and is paid in three months time since the need is identified. The low income families may also receive benefits to cover the public transportation costs. In Riga the amount of this benefit can not be more than 30.00 LVL per child per year (Bernu Tiesibu Aizsardzibas Centrs, 2000), and the free lunch in the school canteen is available for all children in grade one.

The government has also addressed the dropout problem by introducing pedagogical adjustments programmes for those with the low level of education, social adjustment programmes for those with behaviour challenges and staffing schools with professionals who provide assistance in working with children facing challenges (Dedze et al., 2007).

The government of Latvia is addressing the problem of poverty and poverty-related issues: it provides GMI benefit, housing benefit, some educational benefits. In most cases these benefits are of little help in fighting poverty in the long run. Providing GMI or any other benefit without asking for contributions from other side is inefficient. To tackle poverty the government must design welfare benefits in the manner that boosts productivity, catalyzes capabilities and potential and maximizes human capital. CCT are based on the building of human capital to fight poverty. In the next section authors review the literature about human capital, explain paths how it can help to fight poverty and explain CCT in detail.

4 Literature Review

4.1 Human Capital and the Cycle of Poverty

Human capital consists of all qualities of a people, such as knowledge, health, skills and experience that affect their possibilities of current and future money income, psychological income and income in kind (Kooreman, Wunderink 1997, p.180). Educational capital may take different forms: from formal schooling and French to the lectures on the virtue of punctuality and honesty. Components of health capital are also different: visits to doctor, annual dental checkups, and aerobics classes. Health capital is different from educational capital in several forms. While educational capital raises an individual’s work productivity, and thus, wage rate, health capital lowers the number of days in any period, when an individual is sick (Bryant, Zick, p. 216).

Poor families are likely to remain poor, and often across generations, because educational and health capital, which is necessary to get out of poverty, can be obtained if an individual has financial resources. This concept is known as a poverty cycle. The low income individuals do not have resources for building their human and physical capital - and with the low human and physical capital they remain poor (Business Dictionary).

In the US almost one half of the children born to the low income parents become the low income adults, but in the UK- this fraction is 40.0%. In both countries 40.0% of the children from wealthy families tend to become wealthy adults. In Canada one third of rich and one third of poor children remained rich and poor respectively (Corac, 2006).

4.1.1 Income → Education → Income

It was found that the importance of teachers and schools are less critical than student socioeconomic status as indicated by a number of family background characteristics, such as parental education, profession and income (Boissiere, 2004). The fact that family income has an impact on education cannot be neglected.

Poverty affects child development because it hampers parents' ability to purchase the materials, experiences and services that are conducive to the successful development. Children from wealthy families can obtain better cognitive stimulating materials (books, computers), more frequent stimulating parent behaviour (visits to a museum) and better home environment (clean and safe). They also can maximize their human capital, as they are not expected to participate in the labour market during their studies or immediately after the graduation.

The investment in education is very important and is "similar to the investment in equipment" (Becker, 1993). Becker's human capital theory was widely studied and tested by many researches (Bouaissa, 2009, Erosa, Koreshkova, & Restuccia, 2007, Barro, 1991, Olaniyan, & Okemakinde, 2008) especially in terms of income differential between countries. The empirical evidence suggests that 83.0-96.0% of the future income depend of the educational level of an individual and the return on education is calculated to be no less than 7.0% and it becomes larger with additional years of studying (Bouaissa, 2009). Total factor productivity of the countries is also found to be affected by the accumulation of human capital (Erosa et al., 2007). Poor countries with high human capital per person develop faster to catch up wealthier countries (Barro, 1991). Investment in human capital determines economic growth and development (Olaniyan & Okemakinde, 2008).

4.1.2 Income → Health → Education → Income

Individuals whose family income in 1980 was greater than USD 50,000, putting them in the top 5.0% of incomes, had a life-expectancy at all ages that was about 25% longer than those in the bottom 5.0%, whose family income was less than USD 5,000 (Deaton, 2003). One of the reasons is that wealthier families can purchase more and better quality health “inputs”.

Healthy people are likely to have better educational results (Behrman, 1996, Ding, Lehrer, & Audrain-McGovern, 2007). Improved health and nutrition positively affects grades of the low income people. Investment in the low income children improves school attendance (Behrman, 1996). Ding et al. (2007) studied the relationship between health and educational outcomes in the transition age between children and adults, and identified the large impact of the poor health on school achievement. The impact is also found to be different for girls and boys. Poor mental and physical health of the females affected their academic results much more, than males (Ding et al., 2007).

Healthy people are more likely to have higher income, be more productive and stimulate economic growth (Jackle & Himmler, 2007, Gambin, 2005, Knaul, 1999, Aguayo-Rico, Guerra-Turrubiatse, & Montes, 2005). The investment in health and nutrition in early childhood leads to higher wages and also higher productivity in the labour market (Knaul, 1999). The significant impact of health on economic growth was identified by Aguayo-Rico et al. (2005).

4.2 Conditional Cash Transfers (CCT)

The aim of CCT is to reduce poverty, by making welfare programmes conditional upon the receivers’ actions. Money is transferred only to the low income households, who meet certain criteria. These criteria may include enrolling children into public schools and maintaining adequate attendance levels, getting regular check-ups at the doctor's office, receiving vaccinations, getting prenatal and postnatal health care treatments (Fizbein, 2009).

Almost every country in Latin America has such a programme. There are large-scale programmes in Bangladesh, Indonesia, and Turkey. All countries participating in 2009 are presented in Figure 1. In some countries such as Brazil and Mexico, CCT have become the largest social assistance programme, covering millions of households.

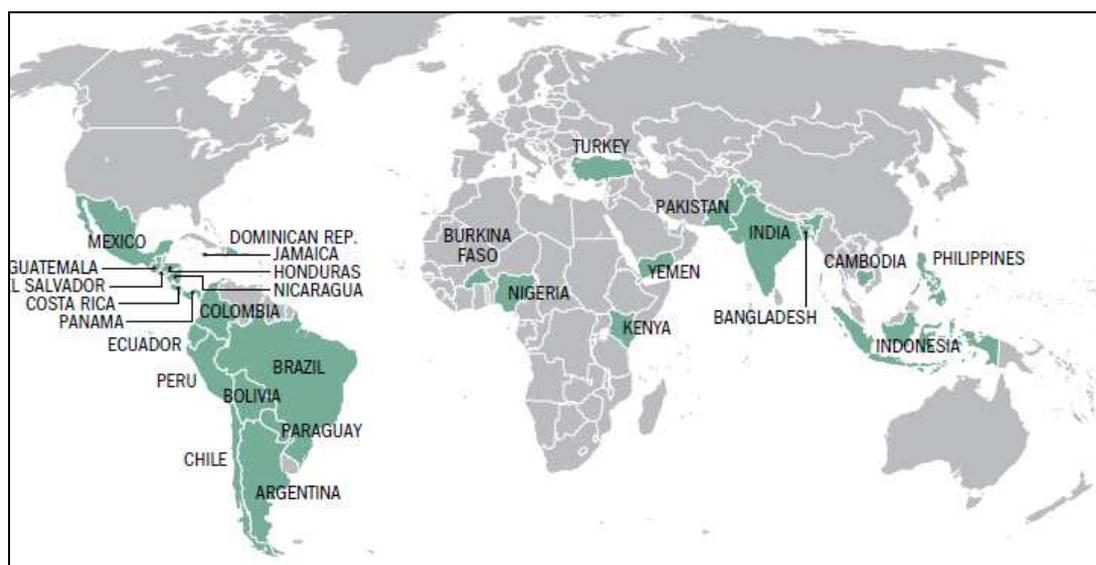


Figure 1. Countries participating in CCT in 2009. Source: Fisbein, 2009

CCT programmes vary. According to Fisbein (2009), in terms of absolute coverage, they range from pilot programmes with a few thousand families (Kenya, Nicaragua) to 11 million families (Brazil). In terms of relative coverage, the programmes cover a range from about 1.0% in Cambodia to 40.0% in Ecuador. In terms of the budget the programmes cost from 0.1 % of the gross domestic product (GDP) in Chile to about 0.5 % in countries such as Brazil, Ecuador, and Mexico. The generosity of benefits ranges up to 20.0% of average household consumption in Mexico. Recently similar programmes were adopted in USA, particularly in New York City and Washington, DC. In Europe the only country implementing CCT is Turkey.

4.2.1 CCT in Mexico

The first country to introduce CCT was Mexico. The motivation for the appearance of the programme was economic crisis (drop in GDP by 6% during 2005, but the new political administration created a political climate that facilitated the change. (Levy, 2006) The initial name of the programme was “PROGRESA”, and then the name was changed to “Oportunidades”. Oportunidades substituted ineffective subsidies and badly targeted cash transfers, and gave beneficiaries the freedom to choose how they used the transfers as long as they invested in human capital, committing to certain rules, namely education, health, and nutrition.

Beneficiary. In Mexico the eligibility for benefits is evaluated in three steps (geographical, socio-economic, and threshold). At first geographical targeting is used to determine which areas are mostly marginalized. Poorest geographical regions are identified on the basis of the community poverty index, which is constructed using such variables as proportion of the community supplied with electricity, proportion of the community with a drainage system, the availability of a public or private telephone. The availability of a preschool and the availability of a health center are also taken into account. Then, families applying for the benefits are asked to provide information on the specific socio-economic characteristics regarding living conditions, and the acquired information is used to calculate family's score (Martinelli & Parker, 2009).⁶ Families with score below certain threshold (0.69) are chosen and then visited to verify the information given. As information is verified, household is enrolled in the programme and eligible for the benefits. This process takes up to five months (Gertler et. al., 2006).

Benefits. Benefits in Mexico are non-conditional and conditional. Basic package of health services with a particular emphasis on preventive health care is free for all households, participating in the programme. It includes vaccinations, prevention and control of tuberculosis and prenatal care (Silva, 2009).

Other benefits are conditional on compliance with the certain requirements. All monetary cash transfers are given to the female head of the family.

1) Under the condition that all family members attend scheduled preventive visits to the health care clinic and at least one of them attends monthly seminars on health topics, family may receive benefits. Family receives an appointment booklet containing a schedule of visits for each household member. Visits are recorded in a form and used by the beneficiary as a proof of the fulfilment of the conditions. Bimonthly benefits that family can receive are as follows (Silva, 2009):

- cash transfer for food 210 MXP (8.00 LVL)⁷ per family per month;

⁶ Indices for calculation of the family score are negative and positive. Negative indices are as follows: constant - 1.579; region from 0 to - 0.657; female is a head of the family - 0.02. Positive indices: no gas stove 0.761, no refrigerator 0.507, unpaved floor 0.475, no toilet 0.415; no washing machine 0.127, no car 0.159. Poor of education of the head of the family, age of the head of the family, size of the family and number of children below 11 contribute to the larger index (Martinelli & Parker, 2009).

⁷ Exchange rate 0.0378LVL/MXP

- food aid for better living 120 MXP (4.50 LVL) per family per month;
- cash transfer for energy expenses 52 MXP (2.00 LVL) per family per month;
- cash transfer for elders over 70 in amount of 295 MXP (11.20 LVL) per elder per month;
- nutrition supplements⁸ for pregnant or lactating woman and/or child under two years or malnourished children under five.

If a single visit to health institution is missed, the household is not eligible for benefits that month.

2) Under the condition that a child's absence at school does not exceed three days per month, child does not repeat any grade more than two times, attends regular health check ups and monthly seminars about health (at higher grades), family can receive educational scholarship. Scholarships are available for children from grade three to grade 12 and increase as children progress to higher grades and from grade seven are higher for girls than for boys. Beneficiaries can spend scholarships in the way that they think is the most appropriate: buying food, clothes or paying bills. The reasoning behind the higher transfers for girls lies in the fact that they show higher tendency to drop out from school. The amount of scholarship is listed in Appendix D. There is an upper limit in the total transfer received per household. Beneficiary children also receive funds for the school supplies. This benefit in contrast with educational scholarship is targeted exactly at purchasing books, and stationery. Elementary school pupils receive them at the beginning of each semester, middle and high school pupils - once per year. The size of the school supplies stipend in 2009 could be estimated as follows (Gertler, Martinez, & Rubino-Codina, 2006):

- grades from three to six: first semester - 187 MXP (7.10 LVL) , second semester - 93 MXP (3.50 LVL) per child per semester;
- grades from seven to nine: 350 MXP (13.20 LVL) per child per year;
- grades from 10 to 12: 560 MXP (21.20 LVL)⁹ per child per year.

⁸ Under this benefit children and pregnant woman obtain nutrition supplements worth 100.0% of daily recommended micronutrients and 20.0% of protein.

⁹ These amounts are calculated under the assumption that school supply stipend is adjusted to the inflation in the same manner as educational benefit. Educational benefits increased by 233.0% since 1997. The same increase is applied for school supply stipend.

3) Under the condition that child finishes the secondary school before the age of 22, family can receive one time transfer which depends on the success at school and is reaching 3318 MXP (125.00 LVL). This transfer (with accumulated interest) is available after two years from graduation or immediately if funds are used for going to college, purchasing health insurance, getting a loan to start business or applying for public housing (Conditional Cash Transfers, 2007).

Families are assured of having benefits for six years, afterwards a new measurement is taken using the same targeting instrument in order to determine whether they will continue to receive benefits or if their conditions have improved sufficiently, would be eligible for a narrower set of transfers or dropped out of the programme (Coady & Parker, 2009).

4.2.2 Impact of CCT in Mexico

There is a remarkable evidence of the positive effect of CCT on education, health and economic conditions.

There are positive significant relationships between cash transfers and cognitive and language assessment scores and children behaviour. Improved test scores and less behavioural problems of the children aged from six to eight years are explained by the improvement of the living conditions at home (Fernald, Gertler, and Neufeld, 2009). The result of the positive effect of the cash transfer system on the cognitive and language acquisition test scores were also supported (Fernald, Gertler, & Neufeld, 2008).

Additional educational factors such as school enrolment and transition rates from primary to secondary school have substantially increased with the establishment of the cash transfer programme in Mexico (Handa & Davis, 2006, Fiszbein & Schady, 2009). It was found that the effect for girls is larger than for boys and especially for elder children, because the difference between the amounts of transfers increases with age (Handa & Davis, 2006). The reasons for the increased school enrolment were also found to be different for boys and girls. The boys had begun attending school more frequently as the Oportunidades significantly decreased the amount of child work, but for girls the reasons was the considerable reduction in domestic work and the decreased amount of leisure time (Handa & Davis, 2006, Fiszbein & Schady, 2009). As a result the positive effects on education from Oportunidades reduced the education gap between rich and poor by 12.0% (Janvry & Sadoulet, 2004).

Mexican CCT programme includes the health component, thus the effect of the impact on the children's health was also studied by several researchers (Fiszbein & Schady, 2009, Fernald, Gertler, & Neufeld, 2009, Hoddinott & Bassett, 2009, Fernald et al., 2008). Already after two

years they could observe the positive effect from the programme, because the likelihood of newborn and young children of getting ill had reduced by 0.2 % or more (Fiszbein & Schady, 2009).

The nutrition component of the programme had a significant positive effect on the children growth (Fernald et al., 2009, Hoddinott & Bassett, 2009, Fernald et al., 2008). The largest effect on the stature for age change was observed for less educated women (Fernald et al., 2009). The CCT programme also decreased the amount of socio-emotional problems of children especially at the age of 8-10 (Fernald et al., 2009).

The CCT have a very tight relationship with several economic factors (such as consumption, investment, saving and others) thus both direct and indirect effects on the economy were observed. As CCT in Mexico showed the significant effect on the increase of consumption (Hoddinott & Wiesmann, 2008, Handa & Davis, 2006, Fiszbein & Schady, 2009), the largest increase took place for the poorest households and especially for the products of nutrition (Hoddinott & Wiesmann, 2008), and the increase in the consumption of the services was experienced (Fiszbein and Schady, 2009). The investment in productive assets and agriculture was increased and about 12% of the received money was invested. (Handa & Davis, 2006, Fiszbein & Schady, 2009). Oportunidades had quite large income inequality reducing affect amounted approximately 21.0% decrease in the appropriate figures (Soares, Osorio, Soares, Medeiros, & Zepeda, 2007). The CCT programme had no indirect negative effect on wages, prices or other governmental transfers, but the real income was affected positively (Fiszbein & Schady, 2009). Another indirect factor in Mexico was the decreased migration abroad and it changed people's attitude to the decision making of spending their income in the households (Handa & Davis, 2006).

5 Methodology

5.1 Research Strategy

The authors have identified five types of stakeholders: government representatives, teachers and doctors, parents and children. Government is responsible for the decision making and funding and managing of CCT, teachers and doctors represent education and health component of the programme, low income parents and low income children are direct beneficiaries, wealthier parents and wealthier children are potential beneficiaries and potential payers for the programme (if some resources are devoted to the CCT these resources are not

devoted to the wealthier parents) However, in this paper the authors obtain the opinion of government, doctors, teachers and parents only and the opinions of children are excluded from the attention.

To find out attitudes of the stakeholders authors used the qualitative and quantitative research methods. The doctors, teachers and government representatives were interviewed. As authors were interested in the opinion of the experts and the direct conversation was the best way to understand their view about the reasoning behind attitude to the particular benefit component. This part of research is purely qualitative. Attitudes of the parents were obtained through the surveys. Survey is a quantitative research method: authors have constructed the questions in a manner that made it possible to analyze answers statistically (Strauss & Corbin, 1998).

There was a reason for doing both qualitative and quantitative approach.

The nature of research question made the authors choosing qualitative technique. According to Strauss and Corbin (1998), “qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods.” The qualitative method has been criticized for being too subjective, as it relies on the researcher’s view what is important and what is not. Also it is difficult to replicate research and to generalize results to the other settings (Bryman & Bell, 2003). To the authors’ mind these drawbacks were fully compensated by acquiring rich and reflective data from the professionals in the field studied. Such data were necessary for deep, extended, grounded and thus, good and clear answer to the research question.

One of the aims of the quantitative survey is examining attitudes, which is the subject of the present paper. Another advantage of the survey method is that larger sample could be researched, which allowed us to achieve higher level or reliability and the subjectivity of the authors was reduced (Thomas, 2006). The main disadvantages of the quantitative survey method are that the outcome and results are limited because of the closed type questions, the context of the situation could not be known as well as the authors did not have any control of the environment (Matveev, 2002). These disadvantages were reduced by having “other” option in many questions, where respondents could write their thoughts.

By combining qualitative and quantitative methods the authors made methodological triangulation. The rationale of triangulation is that flaws of one method are often strengths of another. By combining methods, observers can achieve best of each (Mathison, 1988)

5.2 Surveys

Attitudes of parents were determined through the questionnaire. This is a good tool to study attitudes (Kilis, personal communication, November 23, 2009). Main disadvantage of mailed questionnaires was the low response rate, but it was the least expensive of all data gathering processes. Typical return rate is 25.0-40.0%. (McNabb, 2004, p.152)

Inability of the researcher to assist the respondent with explanations during self administered surveying is known as one of the drawbacks of this methodology. Therefore, the authors were paying special attention to the process of piloting the survey.

To access the parents, the authors used internet social network www.draugiem.lv. Internet is widely used in Latvia¹⁰ and draugiem.lv in 2009 was the third most popular website in Latvia for the internet users aged 15-74 (Brica, 2009). Authors were hoping to access also low income parents, as internet is freely available at public places. For instance in Latgale (the poorest region in Latvia) there are at least 212 free internet access points. (Vucins, 2008)

Authors wanted the responses to be representative. To achieve that, the authors used proportional to the size sampling methodology. The authors identified 28 largest cities with their districts in Latvia and calculated the percentage of the total Latvian adult population living in that district.

Through the search function in the website “draugiem.lv” authors identified all the people living in the city of interest. Then between all the profiles of the people from this city authors randomly chose an adult above 22, investigated the profile with a particular attention paid to the photos in the album. If the person did not have the album or there were no photos with children in the album, the authors did not ask this individual to fill in the survey. Even if there were photos with the children, the authors analyzed the context of photos to be sure that the children were related to the person the authors were interested in. Also the authors did not send invitation to fill the survey if a person’s last visit to the website was more than one week ago or if two places of living were indicated: for instance, “Riga, Yelgava”.

Questionnaire and the results are presented in the Appendix E (The questionnaire is presented in English, but originally it was distributed to people in Latvian and Russian), population coverage in the Appendix F. The questionnaire was anonym and voluntary. In total

¹⁰ in 2009 56% of respondents in age 15-74 have been using internet during last seven days

the authors have distributed 600 questionnaires and received 173 responses. The low response rate can be explained by the channel of distribution and big number of questions in the survey. The data from the survey was analysed with a help of statistical program SPSS. All the illogical responses were deleted and only answers from those respondents who spent more than 20 minutes on filling in the survey were considered as reliable.

5.3 Interviews

The interviews took semi-structured form and were conducted in February-March 2010. Questions were divided in three parts. Part one was an introductory part with discussion of poverty and the current benefit system to the low income families. Part two was the discussion of different elements of CCT, which were designed taken into account the expertise of the respondent. If the respondent was a doctor, the attention was paid to the discussion of the health components. If she was a teacher, authors focused on the discussion of the education component. With the government representatives authors touched both the education and health topics, but not so deeply. The third part of the interview was focused on the discussion on the possible funding of the new benefit system.

Interviews were held with four doctors, one primary school teacher and four social teachers and five government representatives. The full list of persons interviewed is presented in the Appendix G. The choice of the doctors was based on the desire to obtain views of the doctors dealing with children of different age and also the family doctors. As the authors assumed that most of the low income families do not live in the centre of Riga, the school representatives for the interviews were chosen to be from the suburb schools with the amount of pupils not less than 400 and with grades from one to 12. Mainly social teachers were interviewed, because they are the main experts in the topic studied. From the state representatives, the authors have interviewed representatives from the Ministry of Health, the Ministry of Welfare, the Ministry of Education and Science and the Ministry of Finance. The choice of these persons was made with the aim to obtain the opinion from all the ministries, which would be involved if CCT were implemented in Latvia. Before the interviews all the interviewees agreed not to remain anonym and be cited in the thesis.

6 Results

This part presents attitudes of the stakeholders. First section is devoted to attitudes to the existing system of benefits. Next three sections explore attitudes to three different elements of

CCT: nutrition benefit, health benefit, education benefit. Then the opinions about possible sources of CCT funding are presented. Each section includes the summary of attitudes and their analysis.

6.1 Attitudes towards the Existing System of Benefits to the Low Income People

Attitudes of the stakeholders towards the existing system of help to the low income people are mainly negative (see Table 1). More than a half of the parents believe that the system is poor and must be changed. The teachers point that in their practice the lack of clothes is preventing children from attending the school in winter, the lack of money is preventing children from attending the school on the day when the money for excursion is collected, and psychological and health problems of the low income children are badly affecting their results at school. The doctors mainly criticize the health system, but not the benefit system. They admit the positive change in the availability of the free medical services for the low income families. They also mention that in Latvia the classification of the low income people does not work properly, and they frequently see the people who have the low income status and want to receive medical services free of charge, but in reality they are not the low income because of the illegal income or wealthy relatives. The government representatives demonstrate the awareness about such drawbacks of the existing system as the low threshold for the low income status, insufficient support to educate the children from the low income families, but in general they believe that the government does its best. All government representatives think that the support for the low income families falls under the responsibilities of both: the families themselves and the government.

Table 1

The Summary of Attitudes towards the Existing System of Benefits to the Low Income People

Teachers'	Doctors'	Government representatives'	Parents'	
			Low income ¹¹	Wealthier
Safronova- negative. Reasoning: children benefits are too small, no free health insurance.	Kreichberga- sees positive trends. Reasoning: free medicine for the low income people, social workers at hospitals. Criticized government for little promotion of breastfeeding.	Zvirgzdina- positive. Reasoning: increase in GMI level, larger share of government support in municipalities' expenditure on GMI benefits.	57.6% think that the existing system is bad and requires changes.	55.7% think that the existing system is bad and requires changes.
Shlika- negative. Reasoning: children benefits are too small, system of identification of the low income people is not proper.	Lacis- cannot say. Sees positive current free medical services. Criticized big number of doubtful clinics, not enough technological improvements, big amount of infant's deaths.	Gravitis- sees positive and negative trends. Positive: introducing free health care to the low income people. Negative: system of identification of the low income people is not proper.	27.3% think that the existing system could be improved.	17.1% think that the existing system could be improved.
Kornilova- negative. Reasoning: no free lunches for children, not enough financing for children.	Zvaigzne- negative. Reasoning: the system of identification of the low income people is not proper.	Grinis- sees positive and negative trends. Positive: free education, free health care to the low income people. Negative: no free books, no free transportation.	15.2%- difficult to say.	23.6%- difficult to say.
Pesika- negative. Reasoning: no free books and other necessary things for children.	Meiksane- cannot say. Criticized government for little promotion of illness prevention.	Shints- slightly negative. The current system could be restructured to be more efficient.	0.0% think that the existing system is good.	3.6% think that the existing system is good.
Manakova- negative. Reasoning: children benefits are too small.		Matskevichs – positive. Education is free for all people.		
Conclusion: attitudes are negative.	Conclusion: attitudes are controversial.	Conclusion: attitudes have positive inclination.	Conclusion: attitudes are negative.	Conclusion: attitudes are negative.

¹¹ Authors divide parents to low income and wealthier according to their response to the first question of the questionnaire.

In sum, there is a ground for introducing new benefit system: doctors, teachers, and parents are ready for changes and want them, but government representatives realize that the current system could be improved.

6.2 Attitudes towards the Health Component of CCT

6.2.1 Attitudes towards Giving Money for Regular Health Visits

Table 2 is presenting attitudes towards providing the money for regular doctor visits and these attitudes are controversial. The most frequent argument against was fear that the money received for the health visits will be spent on unhealthy goods as alcohol and cigarettes. Some doctors and most of the government representatives were commonly offering to replace money with some other form of benefit. However, it should be noted that if doctors frequently offered to replace the money with the food, clothes or other real goods, the government representatives proposed to substitute money with such type of benefit so that people would not have immediate consumption possibilities, for example “virtual point” system for regular visits that later might be exchanged to other healthcare services.

The parents demonstrate their readiness to do regular health visits, but want the amount of benefit to be more than 15.60 LVL per month. Despite the fact that the government representatives like the idea that families must do something in order to receive benefits, they do not support the building of the health capital through the direct distribution of financial resources. The government representatives are more inclined to give the opportunity to obtain health capital through the extra health services for those who undergo the necessary health procedures. Unfortunately, with this approach the improvement of the health is likely to affect only those people who do care about their health from the very beginning. For those who are not interested in their health issues, little changes are expected.

Regarding the administration of the health component, the doctors admit that they are very busy to do it themselves, but they also think that the residents¹² can administer this as they are not busy, but clever, educated and are able to detect illnesses. Kreicberga from “Riga Maternity Hospital” admitted that they can report all the information about the visits related to pregnancy, but not the visits of the children health checkups. Also from the doctors point of view

¹² Resident is a doctor who received doctor’s diploma but does not have signature rights yet. This period usually lasts for six years after receiving a diploma.

the family members will follow the doctor visits if these visits are well planned: if people are given a particular time when to come so they do not have to wait in the queue.

Table 2

The Summary of Attitudes towards the Health Component of CCT

Doctors'	Government representatives'	Parents'	
		Low income	Wealthier
Zvaigzne- negative. Money cannot force to care about health. Money can be spent on unhealthy goods.	Zvirgzdina- negative. Money is a bad form of benefit. Providing free health insurance is better.	50.0%- think that 15.60 LVL per month is a sufficient amount to attract majority to do regular health procedures.	43.9% - think that cash not needed, free medical services are enough.
Meksane- negative. Money is a bad form of benefit. Providing goods is better.	Grinis- negative. Money is a bad form of benefit. Providing free health insurance is better.	32.1%- think that 15.60 LVL per month is not needed, free medical services are enough.	39.8%- think that 15.60 LVL per month is a sufficient amount to attract majority to do necessary health procedures.
Lacis- positive and negative. Positive: good tool to prevent illnesses because of early identification and treatment. Negative: the lack of doctors to organize this procedure.	Gravitis- positive and negative. Positive: good stimulator to care about health and prevent illnesses. Negative: waste of government resources on health checks of healthy people.	17.9% think that 15.60 LVL per month is not enough to make the majority of the low income families visiting doctor (sufficient amount of benefit on average: 35.00 LVL)	16.3% think that 15.60 LVL per month is not enough to make the majority of the low income families visiting doctor (sufficient amount of benefit on average: 51.00 LVL).
Kreicberga- positive. Good tool to detect illnesses and protect people around sick.	Shints- negative. Money is a bad form of benefit. Providing free health services is better.		
	Matskevichs- negative. Money is a bad form of benefit. Money can be spent on unhealthy goods.		
Conclusion: attitudes are controversial.	Conclusion: attitudes are mainly negative.	Conclusion: attitudes are controversial with a tendency to positive if the amount of benefit is increased.	Conclusion: attitudes are controversial, with a tendency to positive if the amount of benefit is increased.

In sum, there is a support from parents, government representatives and doctors for building human capital through regular health visits, but there is not clear consensus about the best form of encouraging regular doctors' attendance.

6.2.2 Attitudes towards the Necessity of the Educational Seminars on Health

The doctors admit that in some periods of a person's life the health seminars are necessary (pregnancy, teenage years) and also if movies are shown during the seminars, they could have a bigger effect on people.

Parents' attitudes are negative and from the survey the reasoning behind this opinion is not clear. Several hypotheses can be put forward. Firstly, the low income parents might believe that the organization of seminars will not be proper; secondly, the wealthier parents might believe that the behaviour of the low income people during the seminars will be apathetic. But it is also likely that such polar attitudes are reasoned by the doctor-patient behaviour model, when one party tends to instruct, but other party frequently wants to avoid instruction.

If we assume that the organization of the seminars is accurate, people responsible for the organization are able to lead the discussion in interesting manner then the seminars are likely to be effective tool to build human capital (see Table 3).

Table 3

The Summary of Attitudes towards the Necessity of Educational Seminars on Health

Doctors'	Parents'	
	Low income	Wealthier
Zvaigzne- positive. Supports educational seminars not only for the low income people.	42.9% see seminars pointless, not adding value.	48.0% see seminars pointless, not adding value.
Meksane- positive. Insisted that it is a brilliant initiative.	32.1% think that government should give money without any requirements.	35.8% see seminars useful and likely to improve health of people.
Kreichberga- positive, if topics cover wider specter of issues (not health only), topics are personalized according to needs of people and frequency of seminars is well reasoned.	25.0% see seminars useful and likely to improve health of people.	16.3% think that government should give money without any requirements.
Lacis- positive. Considered seminars realistic, emphasized necessity for additional remuneration for doctors and need for good organization to avoid situations when the people come just to sit and not listen.		
Conclusion: attitudes are positive	Conclusion: attitudes are negative	Conclusion: attitudes are negative

6.3 Attitudes towards the Nutrition Component of CCT

Doctors' attitudes towards nutritional component are mainly positive (see Table 4). Two doctors doubted the necessity to give the nutrition supplements to children, as children must be breastfeed and may have allergy to these supplements. Therefore, they advised to supplement the nutrition of the mother only. The doctors also advice personalizing the list of supplements, which would help to avoid possible bad consequences from the each individual's organism reactions to the certain elements of the supplements.

Government representatives' attitudes towards the nutritional component are mainly negative. They frequently emphasized that vitamins in food are better than vitamins in chemical powders and offered to replace this part of benefit with food. It is necessary to admit that some doctors were mentioning that the supplements are not the best source of vitamins, but in general accepted them.

Parents were not asked about attitudes to the supplements, but about their thoughts regarding fulfilling the conditions necessary to receive these supplements. It turned out that if both: attending seminars and doctors – are necessary requirements in order to receive the benefits, only about 40% of respondents expect that the families will fulfil them.

Table 4

The Summary of Attitudes towards the Nutrition Component of CCT

Doctors'	Government representatives'	Parents'	
		Low income	Wealthier
Zvaigzne- negative. Sees natural food as a better source of vitamins.	Zvirgzdina- negative. Sees natural food as a better source of vitamins.	42.9% think that parents will follow scheduled doctor visits and educational health seminars	44.7% think that parents will follow scheduled doctor visits and educational health seminars
Meksane- positive if given to mothers, accepts supplements to children under certain conditions.	Matskevich- negative. Warns that people can sell nutritional supplements.	28.6% think that parents will follow scheduled doctor visits, but will miss educational health seminars.	30.9% think that parents will follow scheduled doctor visits, but miss educational health seminars
Kreicberga- positive if supplements are given to mothers.	Gravitis- negative. Sees natural food as a better source of vitamins. Warns that standard package of vitamins cannot be applied to all people.	25.0% think that parents will miss both scheduled doctor visits and educational seminars on health issues.	19.5% think that parents will miss both scheduled doctor visits and educational seminars on health issues.

Doctors'	Government representatives'	Parents'	
		Low income	Wealthier
Lacis- positive. Offered distribution by pharmacies, not hospitals and adoption of electronic system for controlling the distribution.	Grinis and Shints- positive.	3.6% think that parents will attend educational seminars on health issues, but miss scheduled doctor visits.	4.9% think that parents will attend educational seminars on health issues, but will miss scheduled doctor visits.
Conclusion: attitudes towards supplements to mother are positive; necessity of supplements to children is questioned frequently.	Conclusion: attitudes are mainly negative.	Conclusion: greater part of parents expects regular attendance of doctor, but doubts regular attendance of educational seminars.	Conclusion: greater part of parents expects regular attendance of doctor, but doubts regular attendance of educational seminars.

In sum, attitudes towards additional supplementing the nutrition of the low income people with vitamins are mainly positive, but the doctors and the government representatives have the disagreement about the source of these vitamins: chemical or natural. The parents are unconvinced about the high rate of beneficiaries fulfilling necessary conditions in order to receive supplements.

6.4 Attitudes towards the Education Component of CCT

Attitudes towards the various components of education benefit vary (see Table 5). The low income parents want money as the form of benefit, are ready to report the spending, and are prepared to take on the responsibility to achieve a certain level of knowledge by their children, but want the amount of benefit to be higher. The government representatives and teachers generally are against giving the money as commonly are suspicious that money will not be spent on children and provision of goods will be more effective tool in the process of building children's educational capital.

Table 5

The Summary of Attitudes towards the Elements of the Education Component of CCT

<i>Attitudes towards different amount of benefit to the children of different gender</i>			
Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Strongly negative.	Unclear. Zvirgzdina supports individual approach. Others: dislike cash as the form of benefit.	Strongly negative (88.5% against).	Strongly negative (94.5% against).
Conclusion: attitudes towards different amount of benefit to the children of different gender are mainly negative.			
<i>Attitudes towards higher benefit to the children in higher grades.</i>			
Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Strongly negative.	Unclear, as government representatives dislike cash as the form of benefit.	Unclear (53.8% support, 38.5% say it must be equal).	Unclear (40.9% support, 54.5% say it must be equal).
Conclusion: attitudes towards giving higher benefit for children in higher grades are unclear.			
<i>Attitudes towards the amount of monthly benefit</i>			
Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Minimum 30.00 LVL. Pesika, Mankova- 30.00 - 40.00 LVL; Kornilova- 50.00 LVL, Safronova and Shlika -subsistence minimum, which was 163.34 LVL in February 2010. (CSB, 2010)	Unclear. Zvirgzdina cannot say the amount of benefit must be personalized. Others- do not want cash as the form of benefit.	Mean 58.58 LVL. Minimum 12.00 LVL.	Mean 45.27 LVL, Minimum 5.00 LVL.
Conclusion: the average amount of monthly education benefit agreed by parents and teachers varies between 51.93LVL - 89.34 LVL.			

Attitudes towards graduation benefit.

Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Mainly positive. Kornilova: motivating factor to study further. Social teachers: want the amount to be higher. Manakova: suggests providing children with free health diagnostics or health insurance instead.	Mainly negative. Matskevich- offers state budget slots in universities instead. Grinis- partly positive: support benefits to children with good marks.	Mainly positive (65.4% support graduation benefit).	Unclear (56.4% support graduation benefit).
Conclusion: attitudes are controversial with main support coming from teachers and the low income parents.			

Attitudes towards cash as the form of benefit.

Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Mainly negative. Pesika, Manakova, Kornilova, Safronova support coupons. Manakova offers to restrict the number of places where people can spend money and things which can be bought.	Mainly negative. Zvirgzdina: social worker must make decision regarding each family individually. Gravitis, Grinis, Matskevich and Shints: offer giving clothes, food and transportation cards instead.	Mainly positive (42.3% prefer money, but the low income family must report the spending details, 26.9% prefer money, 19.2% prefer vouchers and money together, 11.5% prefer vouchers). Other choices: free lunches, learning materials stationary, extracurricular activities; free higher education; covering all education related costs.	Mainly positive (36.8% prefer money, but the low income family must report the spending details, 33.0% prefer vouchers and money together, 20.8% prefer money, 9.4% prefer vouchers).
Conclusion: attitudes are controversial. Government representatives and teachers dislike cash as the form of benefit.			

Attitudes towards benefit linked to school attendance

Teachers'	Government representatives'	Parents'	
		Low income	Wealthier
Strongly positive. Pesika accepts some part of the benefit to be linked to school marks.	Mainly positive. Zvirgzdina supports individual approach.	Mainly negative (40.0% - linked to performance at school, 32.0% - prefer benefit without any condition, 28.0% - linked to regular attendance).	Mainly positive (57.8% - linked to regular attendance, 27.5% - linked to performance at school, 14.7% -prefer benefit without any condition).
Conclusion: the low income parents are the only stakeholders who want the benefit to be linked to school success. Others – mainly support linking benefit to the school attendance.			

6.5 Possible Sources of Funding of CCT

All stakeholders are against increasing of personal income tax and value added tax as they think that these taxes are already high enough. The teachers and parents are encouraging increasing the personal income tax for people with higher income. The donations as the possible source of funding are accepted only by parents and wealthier people demonstrate greater support. From all the stakeholders only the parents are ready to donate money to CCT themselves, but the average amount they could donate is not very high. The main proposals for the CCT financing sources are the WB financing, excise tax and real estate tax increase and the restructuring of the benefit system and healthcare system (see Table 6).

Table 6

The Summary of Attitudes towards the Possible Sources of Funding of CCT

Possible source of funding	Doctors'	Teachers'	Government representatives'	Parents'	
				Low income	Wealthier
Increased income tax	Negative.	Negative, but positive about the increased income tax for people with higher income.	Negative.	84.5% - negative. 50.0% positive about increased income tax for people with higher income.	82.7% - negative. 55.8% positive about increased income tax for people with higher income.
Increased VAT	Negative.	Negative.	Negative. Gravitis accepts increase to 25.0%	84.6% - negative.	83.7% - negative.

Possible source of funding	Doctors'	Teachers'	Government representatives'	Parents'	
				Low income	Wealthier
Donations	Negative.	Negative.	Negative.	Private donations: 50.0% - see as probable. Public donations: 53.9% - positive.	Private donations: 53.8% - positive. Public donations: 66.4% - positive.
Readiness to donate and the amount	Not ready to donate.	Not ready to donate as their wages are too low. Maximum amount – few LVL per month.	Not ready to donate.	34.6% are ready to donate. The average amount is 36.40 LVL per year.	45.2% are ready to donate. The average amount is 33.80 LVL per year.
Other offered sources of funding	Structural reforms – decrease number of small clinics; WB financing.	Equalizing wages in different professions; decreasing wages of the government representatives.	Stop giving benefits to all, who comply, WB or other financing from abroad; decreasing the expenses on country protection; increasing of the excise tax; imposing “Health Tax” – 2.0% from minimum wage; restructuring of the current system of cash transfer.	The charity concerts; reduction of the number of employees in the ministries; increase of the excise tax; EU funds; proceeds from millionaires; setting the limit amount, which could be spent on the promotional campaigns of the political parties; optimization of the government work; increasing of the real estate tax starting from the certain value of the property.	

7 Proposed CCT in Latvia

7.1 The Proposed Model

From the interviews and survey it is clear that the CCT existing in Mexico if implemented in Latvia should be adapted to the local needs. Thus drawing from the result of the survey and the interviews authors developed the optimal CCT system for Latvia (Appendix H).

Beneficiary. The idea of targeting the poorest people in the most marginalized communities can be modified. To avoid the situation of “providing benefits to all who comply,

but do not need benefits”, criticized by Zvirgzdina, the authors offered to start the choice of the beneficiaries with self-selection. Thus the authors suggest to skip the first step of indentifying the most marginalized communities, and move to the second step of the identification of the beneficiaries. All the people, who apply would need to fill in the questionnaire on their living conditions in the same manner as it is done in Mexico. The idea of evaluating the living conditions and personal characteristics of an applicant to CCT did not find a strong support neither during the interviews, nor during the survey (26.0% and 30.1% respectively). Therefore, it is recommended to take the living conditions into account, but keep the income of the family as the dominant index during the selection. As it was recommended by teachers and parents, the larger number of the children in the family must increase the chances to become a beneficiary. It is difficult to estimate the number of beneficiaries, therefore for the purpose of the further calculations we assume that most likely all the people currently are at risk of poverty (about 26% of the population) will apply.

Health component. The idea of providing the money for attending the doctors can be discarded: both the low income and wealthier parents to a certain extent expressed satisfaction with the possibility to enjoy just the medical service free of charge. The doctors offer to cover the extra costs if needed, provide the free health insurance or preventive diagnostics, but not the money. The government representatives dislike the idea of providing money; they offer the system of virtual health points and free health insurance instead. Therefore, it is advisable to proceed with the initiated free medical services for the low income people and to seek other ways on how to stimulate the building of health capital of the inhabitants instead of providing them with the cash transfers. The authors suggest the attendance to the doctor regularly as the necessary condition for maintaining the low-income status and receiving other benefits. As the general practioners are overloaded with the work, the residents must be involved in the organization, processing and reporting health visits.

Seminars. The idea of using cash transfers for regular attendance of the health seminars can be modified. The doctors demonstrate support for organizing such seminars not only for the low income people. Some parents also support this idea. However, a lot of effort must be put into the organization of the seminars in order to be effective. The topics must be adjusted to the age, gender, and other interests of the people. The doctors demonstrate readiness to lead these seminars for the additional compensation and assure that the seminars can be organized in hospitals and clinics. One seminar per month was mentioned as a good frequency/reoccurrence.

The authors suggest that the attendance of the health seminars as the necessary condition for maintaining the low-income status and receiving other benefits.

Nutrition. The idea of giving nutritional supplements for pregnant women and small children also can be developed further. The doctors emphasize the need to reconsider the elements of the “package” and personalize the list of supplements, but in general they demonstrate support in this activity. The government representatives partly dislike it, but the authors relay here on the opinion of the doctors and the representative from the Ministry of Health. The nutrition component must be modified. During the interviews it became clear that the supplements must not be limited to the artificial vitamins for small children, but it should be extended with the possibility to receive natural food both for children and older people. Pregnant women and children under two years must receive the recipe for the personalized “package” during the regular doctor check-ups and the “package” could be received in every pharmacy. Children of two to six years from the low income families must receive free food in the kindergartens and pupils must receive the free lunches at schools. The low income adults could receive a package of a certain food for better living once per month at the supermarket¹³. The condition for the recipient of these supplements must be the regular attendance of the doctors and the health seminars.

Education. The idea of giving the money for the regular school attendance can be developed further. The low income parents prefer linking the education benefit to the grades, but the other stakeholders prefer to provide the benefit for the regular school attendance, and, thus, there is no consensus. Taking into account both views, the authors offer to link the larger part of the education benefit to the attendance of the school, and to permit some fraction of the education benefit to be linked with the school success also. Similarly in New York, the family can receive a benefit if the child passes ELA¹⁴ and Math standardized test¹⁵ (Opportunity NYC). The idea of different benefits to the children of different age and gender should be neglected as the parents and teachers reported that it is not necessary. If, due to the scarce resources, the benefit is not possible to grant to all pupils, the respondents suggest that it must be given to the children in grades from one to five. After the interviews with the government representatives and

¹³ This system worked in Mexico before the introduction of CCT.

¹⁴ Students in grades three through eight take the State English Language Arts (ELA) Test.

¹⁵ In grades from three to five if child meets standard score family receive 300.00USD per passed ELA and 300.00USD per passed Math Test. In grades from six to eight if a child meets the standard score family receive 350.00USD per passed ELA and 350.00USD per passed Math Test.

the teachers the idea of making cash transfers as the form of education benefit should be reconsidered. It is proposed that the clothes, shoes, transportation cards, and basic package of school supplies or coupons for receiving / buying these things in a particular place and for a particular sum must be provided instead of the cash transfer. Necessity of the cash transfer at the graduation is also under the question. More than a half of parents (58.1%) prefer the graduation benefit over higher benefits during school years. The teachers do not oppose to the graduation benefit, but they do not like that it is offered as a cash transfer. The authors suggest following the system in Mexico: meaning that a graduate can receive the graduation benefit as the cash transfer only up to two years after the graduation or use it immediately for paying study fee or buying books.

The authors model system of benefit in Latvia on the basis of interviews and survey, but it does not mean that modeled system does not have the limitations. Most of the interviewees do not see the cash transfers as the form of conditional benefit and are suggesting to replace the cash transfers with the in kind contributions of good. However, the authors are drawing the attention that prior CCT in Mexico existed the programmes¹⁶, which provided the food, not money to the families and these programmes were criticized for their ineffectiveness. Levy (2006) points at the costly channeling of the food subsidies to the rural areas, high administrative expenses, corruption, duplication of efforts due to the little coordination, large share of subsidies not being captured by the poorest (Levy, 2006). It must be noticed that the government in Mexico prior to the introduction of CCT also had concerns about the potential use of the transferred income on inappropriate goods, e.g. alcohol, tobacco, therefore, before the introduction, the system was piloted.

If the conditional benefit system is ought to be implemented in Latvia, it is advisable to find the compromise between the concerns about possible ineffectiveness of transfers of items and the negative attitude of the majority of the stakeholders to the transfers of cash. Special individual bar coded cards for the school supplies and clothes for children in close cooperation with the selected store chains may be a good solution to this dilemma.

¹⁶ FIDELIST (1 kilodrama of free tortillas per household per day), DICONSA (sugar, rice, flour, corn, beans at 13.0-19.0% discount), and LICONSA (25.0% discount for four-eight liters of milk per week per each child under 12), DIF (School Breakfasts, community kitchens).

7.2 Cost

The costs of the programme consist of the cost of the benefits and the administrative costs.

The health component should envisage the additional costs related to the regular health check ups. Despite the fact that the medical services are free for the low income people, it is not yet compulsory. After the introduction of the CCT in Latvia the additional resources will be necessary. It is difficult to estimate the cost of human resources needed to administer the regular health visits. The seminars should cause additional costs related to the organization of education seminars (films, presentations), leading of seminars (salaries to lectors). Development of the bar-coded cards that permits people to receive the items in the stores also requires additional funds. The authors estimate the administrative costs of these to be at the level of 6.0% from the cost of benefits as it is in Mexico (Fiszbein, 2009).

The cost of the nutritional supplements is estimated as follows: for the young mothers, pregnant and lactating women, the vitamin package per month costs 2.70 LVL.¹⁷ For small children the monthly dose of vitamins costs about 1.40 LVL¹⁸ and according to the advice of the doctors, the authors supplements it with the baby food and baby milk, so in total the nutritional supplement per child per month costs 20.00 LVL. For the children in age from two to six years, the cost of the food at kindergartens and schools is on average 1.40 LVL per day (Leta, 2007), thus it adds to 30.80 LVL per month, assuming 22 working days. For an adult we estimate the cost to be 45.51 LVL per month, which is the cost of the complete minimum consumer food basket in January 2010, according to the CSB (2010). The last estimation is very rough, as it is commonly known that the methodology behind the estimating price of complete minimum consumer basket is outdated and requires changes. However, the authors do not find any better measure for the cost of the food subsidy than the cost of the minimum food basket.

State budget for year 2010 has total expenditures in the amount of 3045.089 mLVL of which 197.491 mLVL (6.5%) are the expenditures of the Ministry of Welfare, 432.780 mLVL (14.2%) are the expenditures of the Ministry of Health and 194.203 mLVL (6.4%) are the expenditures of the Ministry of Education (6.38%) (Ministry of Finance).

¹⁷ Bio-Multi N90 vitamins for pregnant women for 90 days costs 8.00 LVL at Pils Aptieka on March 14, 2010

¹⁸ „Brinumberns” vitamins for children for 60 days costs 3.79 LVL at Pils Aptieka on March 27, 2010

We offer a programme which costs 360.089 mLVL, or 2.7% of 2009 GDP or 11.83% of all State Budget 2010 expenses (see the Appendix I for detailed calculations). We stress that despite the fact that programme from the first glance seems very costly, before abandoning the idea of implementing this programme, one should evaluate also the cost of non-implementation. Being poor is costly. Poverty causes lower productivity, poorer health, and higher likelihood of crime which in turn generates additional expenditures or decrease potential revenues.

Keeping in mind the attractiveness of the idea to fight poverty through building the human capital and the cost of implementing CCT in Latvia, we offer to substitute the existing system of social help to low income people with CCT. We emphasize choosing substitution, not supplementing, as supplementing is costly and its effectiveness is doubtful.

8 Conclusion

Overall the paper is addressing the issues about the health, nutritional and educational problems in Latvia and, proposing the Mexican Conditional Cash Transfer system as a solution, evaluates attitudes of the major stakeholders to CCT system in Latvia.

The authors found that in general it would be possible and advisable to introduce CCT in Latvia as the respondents were positive to some of the components of the programme, although they did not agree with some details, they did not object to the idea of CCT in general.

The authors found that doctors' attitudes to the regular doctor visits are controversial, because on one hand doctors do not want people to receive money as it is enough with the free medical services, but on the other hand the preventive method to build health capital could be effective. Health seminars, however, are supported by the doctors, but only if they are well organized. Attitudes of the government representatives to the health component on CCT are mainly negative as they think that monetary stimulation will not help to improve the health of the people. Parents would prefer the amount of the transfer for this component to be larger than 15.60 LVL per month, but general attitudes are negative both to the doctor visits and health seminars.

The doctors strongly support the nutrition component of CCT, but they also suggest personalizing the list of nutritional supplement and vitamins and reconsidering adding natural products. Most of the parents also support the system and only some government representatives do not like it.

Attitudes to the education component are mainly positive, but all the teachers and government representatives are against giving the money and rather prefer supporting children with the food, clothes and transportation. Most of the stakeholders except the low income people like the idea of linking CCT to the school attendance of the child. The opinion about the graduation benefit is controversial.

The proposed CCT system in Latvia is as follows: beneficiary is evaluated primarily based on the income and additionally on living conditions, personal characteristics and the amount of the children in the family; health component consists of regular doctor and health seminar visits as a necessary condition for maintaining the low-income status and receiving other benefits; nutritional component includes specially developed and personalized nutritional packages for pregnant woman and children under year two, free food for children in the kindergartens, free lunch for children at school and food packages for low income adults; education benefit is linked mostly to the regular school attendance and partly to the results at school in a form of bar-coded cards giving right to receive children clothes and shoes, school supplies and transportation cards in the amount of 80.00 LVL every second month; graduation transfer received immediately if used for payment for the university or buying books or received two years after graduation. The cost of such programme is estimated to be about 356,326 mLVL per year or 2.7% of Latvia's GDP in 2009, however, this estimation is not very precise due to the unavailability of the data and clear components of the system.

Suggestions for the further research

In depth estimation of costs of the CCT in Latvia with the particular attention paid to the administration of the costs and determination the poorest households outlook via observable household characteristics (estimation of the weights of specific socio-economic family characteristics through the poverty regression) are the fields for further research. The cost benefit analysis of the implementation of the programme could be also done by other researchers. There are methodologies for estimating the impact of CCT ex-ante, on the basis of microeconomically estimated models of the household behavior. The authors see ex-ante evaluation of CCT in Latvia as another interesting area of further investigation. The alternative policies to build human capital other than CCT can be researched.

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Appendix A. Statistics on Adults' Health and Education in 2006, 2007 and 2008.

Countries	At risk of poverty after transfers, % of total population year 2008	Female life expectancy at birth, in years, year 2007	Deaths due to alcohol related causes, per100000, year 2006	Deaths due to smoking related causes, per 100000, year 2006	Deaths in car accidents, per100000 year 2006	Suicide self-inflicted injury, per100000, year 2006	% of daily smokers	Abortions per 1000 live births	Students 15-24 years as % of corresponding age population	Literacy rate (%) in population aged 15+
Latvia	26 (1)	76.46 (1*)	159.08 (2)	511.09 (2)	16.45 (2)	17.94 (4)	32.7 (5)	530.27 (3)	62.5 (12)	99.7
Austria	12 (12)	83.1 (22*)	64.37 (12)	207.77 (13)	7.22 (12)	11.49 (9)	36.3 (1)	-	53.8 (22)	-
Belgium	-	82.6 (18*)	-	-	-	-	24.1 (20)	-	68.6 (5)	-
Bulgaria	22 (3)	-	67.68 (11)	405.36 (4)	7.97 (10)	8.34 (17)	32.3 (6)	503.83 (4)	52.4 (25)	98.2
Cyprus	16 (8)	82.22 (15*)	41.48 (20)	162.49 (21)	8.84 (8)	2.42 (23)	23.9 (21)	-	41.2 (29)	96.8
Czech Republic	9 (14)	80.22 (8*)	74.53 (7)	337.21 (5)	7.9 (11)	11.2 (10)	24.9 (18)	239.55 (11)	62.1 (14)	-
Denmark	-	80.59 (9*)	73.45 (9)	225.02 (10)	5.06 (18)	8.8 (15)	34.1 (3)	231.64 (12)	66.9 (7)	-
Estonia	19 (5)	78.84 (6*)	-	-	-	-	33.3 (4)	631.44 (2)	62.1(13)	99.8
Finland	14 (10)	83.12 (23*)	92.81 (5)	234.76 (8)	5.45 (15)	18.48 (3)	18.1 (25)	181.66 (13)	70.9 (1)	-
France	-	84.78 (25*)	68.29 (10)	123.81 (23)	7.04 (13)	13.86 (6)	26.1 (16)	-	58.6 (16)	-
Germany	15 (9)	82.67 (19*)	54.69 (13)	204.05 (14)	5.39 (16)	8.42 (16)	26.3 (16)	177.95 (14)	65.4 (10)	-
Greece	20 (4)	81.83 (10*)	39.38 (22)	223.23 (12)	13.96 (3)	2.83 (22)	27.6 (13)	-	60.1 (15)	96
Hungary	12 (12)	77.76 (4*)	-	-	-	-	30.5 (7)	463.84 (5)	63.7 (11)	-
Ireland	-	82.07 (12*)	46.32 (18)	223.7 (11)	5.79 (14)	9.44 (14)	26.1 (17)	-	58.1 (18)	-
Italy	-	-	43.48 (19)	170.83 (20)	9.03 (7)	4.47 (21)	24.5 (19)	-	56.3 (20)	98.4
Lithuania	20 (4)	77.23 (3*)	194.71 (1)	548.78 (1)	23.49 (1)	27.35 (1)	27.3 (14)	305.01 (8)	68.7 (4)	99.6
Luxembourg	13 (11)	82.21 (14*)	73.8 (8)	193.03 (15)	8.56 (9)	12.78 (7)	23.4 (22)	-	41.8 (28)	-
Malta	15 (9)	82.19 (13*)	35.92 (23)	263.67 (7)	2.27 (23)	5.46 (20)	28.2 (10)	0	44.5 (27)	-
Netherlands	-	82.54 (17*)	40.35 (21)	178.13 (19)	3.52 (22)	8.29 (18)	27.8 (12)	153.85 (15)	67.5 (6)	-
Norway	11 (13)	82.87 (20*)	51.53 (16)	183.14 (18)	4.33 (20)	11.09 (13)	29.9 (8)	241.39 (10)	66.1 (9)	-
Poland	17 (7)	79.78 (7*)	89.2 (6)	275.22 (6)	11.39 (6)	13.91 (5)	16.4 (27)	0.91 (16)	70.3 (2)	-
Portugal	18 (6)	82.23 (16*)	-	-	-	-	20.8 (23)	-	53 (24)	-
Romania	23 (2)	76.86 (2*)	105.58 (3)	493.6 (3)	11.77 (5)	11.15 (11)	19.2 (24)	684.55 (1)	53.6 (23)	97.3
Slovakia	11 (13)	78.44 (5*)	-	-	-	-	34.6 (2)	353.48 (6)	56.3 (19)	99.6
Slovenia	12 (12)	82.04 (11*)	99.15 (4)	189.38 (17)	12.65 (4)	19.62 (2)	28.1 (11)	297.25 (9)	70.1 (3)	-
Spain	20 (4)	84.33 (24*)	-	-	-	-	17.5 (26)	-	55.4 (21)	-
Sweden	12 (12)	83.09 (21*)	49.36 (17)	189.7 (16)	4.6 (19)	11.12 (12)	28.3 (9)	340.33 (7)	66.6 (8)	-
Switzerland	-	-	51.98 (14)	149.8 (22)	4 (21)	12.54 (8)	26.7 (15)	-	58.2 (17)	-
UK	-	-	51.82 (15)	231.47 (9)	5.22 (17)	6.61 (19)	-	-	47.3 (26)	-

Source: Created by authors on the basis of data from WHO, 2009b, and Eurostat, 2009. Number in parenthesis shows ranking if data is sorter in descending order. Number in parenthesis with star shows ranking if data is sorted in ascending order.

Appendix B. Statistics on Children Health in 2006

Countries	Probability of dying before age five per 1000 live births	Infant deaths per 1000 live births	% of live births weighing less than 2500 g	% of infants vaccinated against tuberculosis	Congenital anomalies per 100000 live births	Down's syndrome per 100000 live births	% of infants breastfed at three months of age	% of infants breastfed at six months of age	Deaths due to external causes of injury, poison, age 0-4 per 100000	Deaths due to external causes of injury, poison, age 5-19 per 100000
	9.32 (3)	7.62 (3)	4.6 (16)	99.9	502.24 (11)	103.14 (7)	72.6 (7*)	46.3 (5*)	23.01 (3)	22.63 (2)
	4.47 (11)	3.61 (14)	7.1 (7)	-	345.25 (12)	12.83 (15)	72 (6*)	65 (8*)	7.03 (8)	12.4 (10)
	-	-	-	-	2230.97 (9)	155.71 (4)	-	-	-	-
	11.73 (2)	9.73 (2)	9.3 (1)	97.7	721.84 (10)	32.44 (14)	-	-	12.81 (4)	17.58 (4)
	3.99 (18)	2.63 (22)	-	-	-	-	-	-	7.42 (6)	9.03 (16)
	4.12 (16)	3.33 (18)	7.1 (8)	99	3566.06 (5)	33.07 (13)	64.2 (3*)	40.9 (3*)	8.67 (5)	12.71 (9)
	4 (17)	3.4 (16)	6 (12)	-	7243.32 (1)	81.56 (10)	-	-	2.78 (22)	9.83 (13)
	-	-	4.4 (17)	98.6	3313.84 (6)	73.94 (11)	68.9 (5*)	49.8 (6*)	-	-
	3.33 (22)	2.86 (20)	4.3 (18)	98	3788.24 (3)	142.76 (5)	-	-	4.17 (18)	15.35 (5)
	4.36 (12)	3.57 (15)	-	-	-	-	-	-	6.67 (10)	9.74 (14)
	4.56 (10)	3.83 (9)	6.8 (9)	-	-	-	-	-	5.55 (12)	8.28 (20)
	4.27 (14)	3.69 (11)	9 (2)	-	-	-	-	-	5.09 (14)	11.62 (11)
	-	-	8.3 (3)	-	5777.45 (2)	164.21 (2)	95.2 (9*)	54.9 (7*)	-	-
	4.25 (15)	3.71 (10)	-	92.6	-	-	-	-	1.66 (23)	13.09 (8)
	4.33 (13)	3.65 (12)	-	-	-	-	-	-	3.48 (20)	8.79 (18)
	8.52 (4)	6.81 (4)	4.6 (15)	99.4	3751.8 (4)	115.14 (6)	52.7 (2*)	34.8 (2*)	24.98 (2)	32.19 (1)
	2.53 (23)	2.18 (23)	-	-	-	-	-	-	3.57 (19)	5.95 (23)
	4.62 (9)	3.61 (13)	6.45 (10)	80	2731.96 (7)	206.19 (1)	-	-	5.06 (15)	8.23 (21)
	5.28 (7)	4.43 (7)	-	-	-	-	48.2 (1*)	28.4 (1*)	4.77 (17)	6.23 (22)
	3.92 (20)	3.18 (19)	5.4 (14)	-	-	-	-	-	4.85 (16)	9.74 (15)
	7.07 (5)	5.98 (5)	6.04 (11)	93.7	-	-	-	-	7.16 (7)	14.82 (6)
	-	-	-	98.8	-	-	-	-	-	-
	16.48 (1)	13.91 (1)	8.04 (4)	99.2	-	96.14 (8)	-	-	29.56 (1)	20.24 (3)
	-	-	7.26 (6)	98	2714.08 (8)	53.8 (12)	65.79 (4*)	42.52 (4*)	-	-
	3.94 (19)	3.38 (17)	5.9 (13)	-	-	89.72 (9)	-	-	5.59 (11)	14.31 (7)
	-	-	7.5 (5)	-	-	-	-	-	-	-
	3.51 (21)	2.81 (21)	4.3 (19)	17	-	160.51 (3)	85.7 (8*)	69.2 (9*)	2.99 (21)	8.37 (19)
	5.14 (8)	4.43 (8)	-	-	-	-	-	-	6.84 (9)	10.16 (12)
	5.9 (6)	4.99 (6)	-	-	-	-	-	-	5.31 (13)	8.87 (17)

Source: Created by authors on the basis of data from WHO, 2009b. Number in parenthesis shows ranking if data is sorter in descending order. Number in parenthesis with star shows ranking if data is sorted in ascending order.

Appendix C. Report Cards, Repetition of Grade and Discontinue of Education

Number of report cards in grade nine (without special school)

Year	Girls	Boys	Report cards received by girls	Report cards received by boys	% girls received report cards	% boys received report cards	% of all pupils received report cards
2007/2008	13489	13516	376	615	2.79%	4.55%	3.67%
2006/2007	14322	14396	539	922	3.76%	6.40%	5.09%
2005/2006	15767	15260	469	892	2.97%	5.85%	4.39%
2004/2005	15962	16080	535	1148	3.35%	7.14%	5.25%
2003/2004	16145	15945	712	1581	4.41%	9.92%	7.15%

Number of report cards in grade 12 (without special school)

Year	Girls	Boys	Report cards received by girls	Report cards received by boys	% girls received report cards	% boys received report cards	% of all pupils received report cards
2007/2008	9855	7553	80	87	0,81%	1.15%	0.96%
2006/2007	10194	7413	97	98	0,95%	1.32%	1.11%
2005/2006	10472	7323	97	100	0,93%	1.37%	1.11%
2004/2005	9809	6855	68	72	0,69%	1.05%	0.84%
2003/2004	7939	5586	128	143	1,61%	2.56%	2.00%

Source: created by authors on the basis of data from Ministry of Education and Science.

Repetition of grade and discontinue of education, by year

Year	Percentage of pupils discontinuing studies after grade nine	Percentage of pupils discontinuing studies after grade 12	Pupils repeating the grade	Pupils total	Percentage of pupils repeating
2008/2009	4.60%	22.20%	7 390	249 446	2,96%
2007/2008	7.50%	22.80%	7 685	263 944	2,91%
2006/2007	5.10%	23.70%	8 834	279 872	3,16%
2005/2006	5.10%	21.50%	8 559	298 516	2,87%
2004/2005	4.70%	22.50%	10 305	315 633	3,26%
2003/2004	3.10%	21.50%	6 997	327 358	2,14%

Source: CSB, 2009

Appendix D. CCT Education Benefits in Mexico in the First Semester of 2009

Education benefits MXP (LVL)			
Grade	Boy	Girl	Max per family
3	140 (5.30)		
4	165 (6.20)		1455 (55.00)
5	210 (7.90)		
6	280 (10.60)		
7	410 (15.50)	430 (16.30)	
8	430 (16.30)	475 (18.00)	
9	455 (17.20)	525 (19.80)	2345 (88,60)
10	685 (25.90)	790 (29.90)	
11	735 (27.80)	840 (31.80)	
12	780 (29.50)	890 (33.60)	

Source: adopted by authors on the basis of research by Silva, 2009

Appendix E. Questionnaire and the Results of the Questionnaire for Parents.

Thank you for taking the time to complete this survey. It will take about 20-30 minutes of your time. Your participation is completely anonymous and voluntary. The data will be used for writing the Bachelor Thesis at the Stockholm School of Economics in Riga. If you have any questions about the survey, please contact us: vbabineca@sseriga.edu.lv or ialutina@sseriga.edu.lv. This survey will examine your beliefs, attitudes, and thoughts about a new benefit programme which could be implemented in Latvia.

(The response rate of the parents is indicated in the parentheses)

1. Do you consider your family as low income?
 - a. Yes (19.1%)
 - b. No (80.9%)

2. What kind of benefits do you receive at the moment (several choices possible)
 - a. No benefits (28.9%)
 - b. Children benefit (64.2%)
 - c. Unemployment benefit (5.8%)
 - d. Guaranteed minimum income benefit (1.2%)
 - e. Housing benefit (1.2%)
 - f. Other (please, specify) (5.2%)

3. Please, evaluate the government help to the low income people (one choice possible)
 - a. Government help to income people is good enough (2.9%)
 - b. Government help to the low income people could be improved (19.1%)
 - c. Government help to the low income people must be changed (56.1%)
 - d. Difficult to say (22.0%)

4. What must be taken into account when evaluating who is low income and eligible for benefits (several choices possible)
 - a. Income per family member (60.7%)
 - b. Ability to buy basic goods (45.1%)
 - c. Living conditions (does family have necessary furniture. what is the inner outlook of house) (26.0%)

d. Personal characteristics of the low income person (smoker, alcohol addictive, prisoner) (30.1%)

e. Other (please, specify) (2.3%)

5. Please, evaluate do the following conditions should decrease the chances of being eligible for benefits (one choice in each row possible)

	Definetly should decrease	Probably should decrease	Should have no effect
real estate property	7.5%	16.2%	76.3%
owning a car	9.3%	34.3%	56.4%
having a bank loan	10.4%	23.7%	65.9%

6. Please, evaluate do the following conditions should increase the chances of being eligible for benefits (one choice in each row possible)

	Definetly should increase	Probably should increase	Should have no effect
no refrigerator	19.1%	38.2%	42.8%
no washing machine	12.7%	27.7%	59.5%
no stove	35.8%	38.2%	26.0%
no WC	28.9%	38.7%	32.4%
no hot water	26.6%	30.1%	43.4%

7. Imagine that government decides to give the low income families 15.60 LVL per month if all family members visit doctor regularly and attend seminars on health organized by health institutions. What is your opinion about it? (one choice possible)

a. Cash of 15.60 LVL per month is not needed, as the low income families will be happy to enjoy free basic medicine (41.7%)

b. Cash of 15.60 LVL per month is sufficient amount to attract the majority of the low income families to do necessary health procedures. (41.7%)

c. Cash of 15.60 LVL is not enough to make the majority of the low income families visiting doctors. (16.6%)

8. If you chose “c” in question 7, please define the amount of money which should be enough to make the low income family to visit the doctors.

(average: 47.61 LVL)

9. What do you think about this benefit to the low income families: family each month receives additional money if one of family members each month attends one health discussion in the nearest hospital about some health topic: hygiene, harm of smoking e.t.c. (one choice possible)
- Such discussions are pointless: people will receive money, but not knowledge as they will not listen carefully (47.0%)
 - Such discussions are good: people will receive money and knowledge (33.8%)
 - Government should give money to the low income families without requirement to participate in such health discussions (19.2%)
10. What do you think about following benefit for the low income families: small children, pregnant and lactating woman in the nearest hospital each month can receive monthly dose of nutritional supplements and vitamins, but only if all family members visit doctor regularly and one of the family members attended monthly health discussion. What do you think about that? (one choice possible)
- Family members will visit doctor and health discussion in order to get nutritional supplements for small children, pregnant and lactating woman (44.4%)
 - Family members will visit doctor, but sometimes will miss health discussions therefore some families will lose their nutritional supplements for small children, pregnant and lactating woman (30.5%)
 - Family members will attend health discussions, but sometimes will miss doctor visits, therefore some families will lose the nutritional supplements for small children, pregnant and lactating woman (4.6%)
 - Family members will miss both health discussions and doctor visits, therefore frequently leaving small children, pregnant and lactating woman without nutritional supplements (20.5%)
11. Imagine that government also decides to stimulate education children from the low income families and is ready to give cash to families if they have children attending schools. What is the most efficient way to design this benefit? (one choice possible)

- a. The low income family with a child attending school receives cash each month without any condition (16.3%)
 - b. The low income family with a child attending school receives cash each month under the condition that child goes to school regularly (48.9%)
 - c. The low income family with child at school receives cash each month under the condition that child has good grades at school (28.4%)
 - d. Other, please, specify (6.4%)
12. If you chose “b” in question 11, please specify, what must be number of days per month a pupil can miss without reason in order to receive benefits.
- (average: 3)
13. If you chose “c” in question 11, please specify, what to must be pupil’s performance in order to receive benefits?
- a. 8-10 (6.4%)
 - b. 7-10 (31.9%)
 - c. 4-10 (38.3%)
 - d. Other (please, specify) (23.4%)
 (Mainly 6-10)
14. What do you think about amount of education benefit for children of different age? (one choice possible)
- a. It must be the same throughout the years (51.5%)
 - b. Children at higher grades should receive higher benefit (43.4%)
 - c. Children at higher grades should receive smaller benefit (5.1%)
15. How do you see education component of benefit to children of different gender? (one choice possible)
- a. Girls and boys should receive equal amount (93.4%)
 - b. Girls should receive more (1.5%)
 - c. Girls should start receiving more from grade 5 (2.9%)
 - d. Boys should receive more (0.7%)
 - e. Boys should start receiving more from grade 5 (1.5%)
 - f. Other (please, specify) (0.0%)

16. What must be a monthly benefit of education component for children in order to be able to purchase all necessary things for school? (specify amount in each row)

- a. Girl at grade 3 (average: 41.43 LVL)
- b. Boy at grade 3 (average: 39.68 LVL)
- c. Girl at grade 6 (average: 47.44 LVL)
- d. Boy at grade 6 (average: 46.81 LVL)
- e. Girl at grade 9 (average: 56.91 LVL)
- f. Boy at grade 9 (average: 54.87 LVL)

17. If government decides that the amount of education benefit for a boy from the low income family is 25.00 LVL per month, you think that

- a. It is too much and this amount should be decreased (5.9%)
- b. It is a lot, but could be left at this level (5.1%)
- c. It is good (36.8%)
- d. It is not enough, but little is better than nothing (37.5%)
- e. It is completely not enough and this amount should be increased (14.7%)

18. If it is said that education benefits at some grades cannot be financed, what is your choice of one grade without education benefits?

Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6
(9.6%)	(25.7%)	(10.3%)	(4.4%)	(6.6%)	(5.9%)
Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
(2.9%)	(2.2%)	(0.0%)	(5.1%)	(11.0%)	(16.2%)

19. If it is said that education benefits at some grades cannot be financed, what is your choice of one grade where education benefits must be paid for sure?

Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6
(55.9%)	(0.7%)	(2.2%)	(0.7%)	(2.9%)	(0.7%)
Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
(1.5%)	(1.5%)	(19.9%)	(1.5%)	(0.7%)	(11.8%)

20. Who should receive the education benefits?

- a. Child (7.1%)
- b. Mother (44.7%)
- c. Father (1.0%)
- d. Mother, but starting from grade ten children should receive it themselves (17.7%)
- e. Father, but starting from grade ten children should receive it themselves (0.0%)
- f. Other, please, specify (29.8%)

(Mainly: to the parent or guardian, who takes care of the child)

21. If you chose “d” or “e” in question 20, please specify, should child get a permission from parents in order to receive benefit?

- a. Yes (73.3%)
- b. No (26.7%)

22. If you chose “d” or “e” in question 20, please specify, should from which grade child can receive benefit herself?

(average: 9)

23. How do you think education benefit for the low income families should be administered:

- a. It must be given in the form of money (20.7%)
- b. It must be given in the form of money, but the low income family must report the spending details (35.7%)
- c. It is better to give vouchers for certain goods than give cash (10,7%)
- d. Vouchers and money must be combined (30.0%)
- e. Other (please, specify) (2.9%)

24. Do you think that one time benefit upon graduation is necessary?

- a. Yes (58.1%)
- b. No, it is better to pay higher benefits during studies at school (41.9%)

25. If you chose “a” in question 24, please specify, what should be the amount of graduation benefit in LVL.

(average: 109.80 LVL)

26. Please, evaluate do following sources of funding can be used for giving the low income families money for obtaining education and making regular visits to doctor.(1-

completely agree, 2- agree, 3- probably, 4- disagree, 5-completely disagree) (one choice in each row possible)

	1	2	3	4	5	Do not know
Loans from other countries	4.6%	2.3%	13.8%	20.0%	43.1%	16.2%
Increased income tax	5.4%	1.5%	8.5%	20.8%	62.3%	1.5%
Increased income tax for richer people	35.4%	19.2%	20.8%	6.2%	16.2%	2.3%
Increased VAT	4.6%	1.5%	6.9%	23.1%	60.8%	3.1%
Donations from private persons	30.0%	16.9%	33.1%	4.6%	12.3%	3.1%
Donations from corporates and funds	41.5%	22.3%	22.3%	2.3%	7.7%	3.8%

27. Do you have any other idea, where government could get money to fund this programme?

- a. Yes (15.7%)
- b. No (84.3%)

28. If you chose "a" in question 24, please specify, what are the sources of funding

(The complete list can be found in „Results” part)

29. Would you personally donate some money for helping the low income people by adopting new benefits?

- a. Yes (43.1%)
- b. No (56.9%)

30. If you chose "a" in question 29, please specify, how much you are ready to donate per year in LVL?

(average: 34.15 LVL)

31. What is your household's approximate total monthly income after taxes in LVL?

(average: 576.11 LVL)

32. How many persons live in your household?

(average rounded: 4)

33. How many children under 22 live in your household?

(average rounded: 2)

34. How many of them are girls?

(average rounded: 1)

35. How much pocket money do you give for one child per week? (LVL)

(average: 8.73 LVL)

36. How much money do you spend on one child per month on average? (LVL)

(average: 75.41 LVL)

37. Where do you currently live?

Selection (Cities or districts)

Riga 16.3%

Kurzeme 19.4%

Vidzeme 31%

Zemgale 22.5%

Latgale 10.9%

38. What is your e-mail address

(must remain anonym)

Thank you for participation!

Appendix F. Sample of the Study and Response Rate

	Number of adults in 2009	Adults living in area, % from total adult population	Number of questionnaires distributed	Number of answers expected
Riga and district	769 474	39.44%	237	59
Daugavpils and district	125 037	6.41%	38	10
Liepaja and district	108 676	5.57%	33	8
Jelgava and district	87 647	4.49%	27	7
Rezekne and district	64 598	3.31%	20	5
Ogres district	55 338	2.84%	17	4
Valmieras district	49 562	2.54%	15	4
Ventspils and district	48 745	2.50%	15	4
Jurmala	48 522	2.49%	15	4
Cesu district	48 128	2.47%	15	4
Tukuma district	45 960	2.36%	14	4
Jekabpils district	44 299	2.27%	14	3
Bauskas district	43 042	2.21%	13	3
Talsu district	39 197	2.01%	12	3
Madonas district	36 010	1.85%	11	3
Aizkraukles district	34 108	1.75%	10	3
Preiļu district	32 287	1.65%	10	2
Limbažu district	31 905	1.64%	10	2
Dobeles district	31 827	1.63%	10	2
Saldus district	30 484	1.56%	9	2
Kuldigas district	29 683	1.52%	9	2
Kraslavas district	27 998	1.44%	9	2
Valkas district	26 723	1.37%	8	2
Ludzas district	26 579	1.36%	8	2
Balvu district	22 845	1.16%	7	2
Gulbenes district	21 851	1.12%	7	2
Aluksnes district	20 458	1.04%	6	2
Total	1 950 983	100.00%	600	150

Source: created by authors on the basis of data from CSB, 2009

Appendix G. List of the Persons Interviewed

Name, Surname	Position	Working place
Teachers:		
Lubova Kornilova	Primary school teacher	Riga Zolitude Gymnasium
Zanna Manakova	Social teacher	Riga 16 th Secondary school
Svetlana Safronova	Social teacher	Riga Zolitude Gymnasium
Olga Shlika	Social teacher	Riga Zolitude Gymnasium
Rudite Pesika	Social teacher	Riga Jugla Secondary school
Doctors:		
Ilze Kreicberga	chief neonatologist	Riga Maternity Hospital
Andis Lacis	medical director	Children Clinical University Hospital
Vizma Meiksane	paediatric	Veselibas Centrs 4
Mudite Zvaigzne	family doctor	Veselibas Centrs 4
Government representatives:		
Arturs Gravitis	the head of Department of Health Organization	Ministry of Healthcare
Edgars Grinis	chief referent of the General Education department	Ministry of Education and Science
Aleksejs Matskevichs	chief referent of the General Education department	Ministry of Education and Science
Janis Shints	Senior expert in budgeting	Ministry of Finance
Dace Zvirgzdina	chief referent from Social Services and Social Help Department	Ministry of Welfare

Source: created by authors

Appendix H. The Model of the System of Benefits for Latvia

Beneficiary	Benefits	Conditions for receiving the benefits
pregnant and lactating woman	vitamins	Five visits to doctor during pregnancy, three visits after giving a birth, attending health seminar by any of woman's family members.
child four -12 months	vitamins, baby milk, baby food	Child regularly visits a doctor (three visits in a period). In the period from birth to three months three visits have been made.
child 13 -24 months	vitamins, baby food	Child regularly visits a doctor, (12 visits in period).
child two-six years	free dinner at kindergarten	Child regularly visits a doctor (two-four years: three visits per year, five-six years: two visits per year).
child seven-19 years	free dinner at school	Child regularly visits a doctor (two doctor visits per year) and regularly attends planned seminars on health issues.
child seven-19 years	Bar coded card, giving right to receive school supplies and clothes from shops for the amount of 40.00 LVL ¹⁹ per child per month in the period October-July and buy transportation ticket for child. Given to the woman, head of the family for all children.	Child has not more than three days per month at school missed, child regularly visits doctors (two doctor visits per year) and regularly attends to planned seminars on health issues.
child seven-19 years	Bar coded card, giving right to collect school supplies and clothes from shops in the amount of 40.00 LVL in August and September. Given to the woman, head of the family ²⁰ for all children.	No grade in report card is lower than six; regular visits to doctors and planned seminars on health issues.
child graduating grade 12	Cash transfer in the amount of 110.00 LVL after two years after the graduation or immediate cash to partly pay study fee in a highschool.	Child graduates from school.
adults 19-100+ years	Bar coded card, giving right to receive food items from shops for the amount of 45.16 LVL per each person in the household per month. Available food items are limited (no alcohol, cigarettes) Given to the beneficiary.	Yearly visits to doctors by each and attending planned monthly seminars on health issues. If any visit is missed, beneficiary loses the opportunity to bar-coded card for that month.

¹⁹ Mean for monthly educational benefit desired by parents is 47.88 LVL. After subtracting the cost of transportation ticket for pupil for one month at 7.80 LVL the remaining benefit is 40.08 LVL.

²⁰ If there is woman in the family, the benefit is received by the guardian of the child.

Appendix I. Cost of CCT in Latvia

Potential number of recipients of benefits in Latvia, persons	26% of population of respective age	Cost of benefit, per month, LVL	Cost of benefit, per person, per year, LVL	Cost of benefit, per population, per year, LVL
Number of children in age 4 months-12 months (applicants for nutrition benefit)	4047	20.00 ²¹	160.00 ²²	647520.00
Number of children in age 13 months-24 months (applicants for nutrition benefit)	6179	20.00 ²³	240.00	1482960.00
Number of children in age 2-6 (applicants for nutrition benefit in kindergarten)	27501	30.80 ²⁴	338.80	9317338.80
Number of children in age 7-19 (applicants for nutrition benefit at school) ²⁵	81555	30.80	246.40	20095152.00
Number of adults 19- 100+ (applicants for nutrition benefit)	475711	45.51 ²⁶	546.12	259795291.30
Number of pregnant and lactating woman (applicants for nutrition benefit) ²⁷	12141	2.70	32.40	393368.40
Number of children at age 7-19 (applicants for education benefit)	81555	48.00 ²⁸	576.00	46975680.00
Number of children at age 19 (applicants for graduation benefits in grade 12)	9081	110.00 ²⁹	110.00	998910.00
Subtotal				339706220.50
Administrative expenses (6%)				20382373.23
Total				360088593.80
GDP 2009				13244321000.00
% of GDP 2009				2.7%

Source: created by authors using data from CSB, 2009

²¹ Monthly vitamins at 1.40 LVL, one dose of baby milk at 5.00 LVL and baby food in the amount of 13.60 LVL.

²² To stimulate breastfeeding nutritional supplements are available from the age of four months.

²³ Monthly vitamins at 1.40 LVL, and baby food in the amount of 18.60 LVL.

²⁴ Assumed cost of food is 1.40 LVL per day, 22 working days per month

²⁵ We assume that all children go to school, do not repeat grades and start school at the age of seven. Number of recipients of all benefits is calculated on the basis of assumption that 26.0% of population at particular age will apply for benefits.

²⁶ In January 2010 subsistence minimum for food items according to the CSB, 2010

²⁷ We assume that number of pregnant women is the same as number of children at age up to 12 months, and 26.0% of these women apply for benefits. Number of lactating women is calculated on the assumption that all mothers breastfeed their children until age one, and 26.0% of women, who do breastfeeding apply for benefits.

²⁸ Mean for educational benefit obtained during survey is 47.88LVL

²⁹ Mean for graduation benefit obtained during survey is 109.80 LVL