Inclusion Policy Lab: Evaluation Results

Extremadura – Social Inclusion Life Plan for vulnerable women

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This report has been prepared by the General Secretariat of Inclusion of the Ministry of Inclusion, Social Security, and Migration within the framework of the Inclusion Policy Lab, as part of the Recovery, Transformation and Resilience Plan (RTRP), with funding from the Next Generation EU funds. The Ministry of Health and Social Services of the Autonomous Region of Extremadura has collaborated in the preparation of this report, as the entity responsible for the execution of the project. This collaborating entity is one of those implementing the pilot projects and has collaborated with the General Secretariat of Inclusion in the design of the RCT methodology, actively participating in the provision of the necessary information for the design, monitoring, and evaluation of the social inclusion itinerary. Furthermore, their collaboration has been essential to gathering informed consents, ensuring that participants in the itinerary have been adequately informed and that their participation has been voluntary.

The partnership with J-PAL Europe has been a vital component in the efforts of the General Secretariat of Inclusion to improve social inclusion in Spain. Their team has provided technical support and shared international experience, assisting the General Secretariat in the comprehensive evaluation of pilot programs. Throughout this partnership, J-PAL Europe has consistently demonstrated a commitment to fostering evidence-based policy adoption, facilitating the integration of empirical data into strategies that seek to promote inclusion and progress within our society.

This evaluation report has been produced using the data available at the time of its writing and is based on the knowledge acquired about the project up to that date. The researchers reserve the right to clarify, modify, or delve into the results presented in this report in future publications. These potential variations could be based on the availability of additional data, advances in evaluation methodologies, or the emergence of new information related to the project that may influence the interpretation of the results. The researcher is committed to continue exploring and providing more accurate and updated results for the benefit of the scientific community and society in general.

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Executive Summary

- The **Minimum Income Scheme**, established in May 2020, is a minimum income policy that aims to guarantee a minimum income to vulnerable groups and provide ways to promote their social and labor integration.
- Within the framework of this policy, the Ministry of Inclusion, Social Security and Migration (MISSM) fosters a strategy to promote inclusion through pilot projects of social innovation, which is conducted in the **Inclusion Policy Lab**. These projects are evaluated according to the standards of scientific rigor and using the methodology of **Randomized Controlled Trials**.
- This document presents the evaluation results and main findings of the "Social Inclusion Life Plan" project, which has been conducted in **cooperation** between the **MISSM and the Ministry of Health and Social Services of the Autonomous Region of Extremadura**.
- This study evaluates an **intervention of personalized and comprehensive support in the socio-labor and health fields** aimed at women between 18 and 45 years of age, with children in their care, and beneficiaries of the Extremadura Guaranteed Income or the Minimum Income Scheme. **Treatment group 1** received interventions from the socio-occupational environment. **Treatment group 2** received interventions from the health care setting. **Treatment group 3** received interventions from the socio-occupational and health fields. The control group received the usual services offered by Social Services, Employment and Health from the Junta de Extremadura.
- The project took place in the Autonomous Region of Extremadura in the health areas of Cáceres, Badajoz, Zafra-Llerena, and Navalmoral de la Mata. A total of 851 people participated (209 in the control group and 214 in each of the treatment groups).
- 41% of the participants reside in the health area of Badajoz, 26% in Cáceres, 18% in Navalmoral de la Mata, and the remaining 16% in Zafra-Llerena. The average age of the sample is 36.5 years, with 80% of people between 30 and 45. 13% of the participants have no education, 38% have primary school and 24% have secondary school. Finally, 58% of the sample is unemployed and 16% working.
- 53% of the participants assigned to treatment group 1, 50% of those assigned to treatment group 2, and 50% of those assigned to treatment group 3 have participated in some activity.
- The main results of the evaluation are as follows:
    - **Quality of life**: a positive and significant impact of 4.75% is observed on the quality-of-life indicator for the socio-occupational Treatment group 1.
    - **Employability**: a positive and significant impact of 10.24% on employability in the healthcare Treatment group 2 is observed.
    - **Employment expectations**: a positive impact of 1.8% is observed if the three treatments are considered together compared to the control, which is not observed in a disaggregated manner by treatments.
    - **Job placement**: a positive and significant impact of 66% is observed for the three treatments together compared to the control in the self-reported number of hours worked in the previous week (1.5 hours worked more). This effect is not observed

with the indicator of days worked obtained from administrative records of working lives.

- **Quality of employment**: a positive and significant impact of 74% (€40.74) is observed for the three treatments together compared to the control in self-reported monthly wage income. If analyzed in each group separately, the indicator coefficient is in all cases positive and is significant for Treatment group 3.

1 Introduction

General Regulatory Framework

The Minimum Income Scheme (MIS), regulated by Law 19/2021[1], is an economic benefit whose main objective is to prevent the risk of poverty and social exclusion of people in situations of economic vulnerability. Thus, it is part of the protective action of the Social Security system in its non-contributory modality and responds to the recommendations of various international organizations to address the problem of inequality and poverty in Spain.

The provision of the MIS has a double objective: to provide economic support to those who need it most and to promote social inclusion and employability in the labor market. This is one of the social inclusion policies designed by the General State Administration, together with the support of the Autonomous Communities, the Third Sector of Social Action, and local corporations[2]. It is a central policy of the Welfare State that aims to provide minimum economic resources to all individuals in Spain, regardless of where they live.

Within the framework of the National Recovery, Transformation, and Resilience Plan (RTRP)[3], the General Secretariat of Inclusion (onwards, SGI by its acronyms in Spanish) of the Ministry of Inclusion, Social Security, and Migration (MISSM) participates significantly in Component 23 "New public policies for a dynamic, resilient and inclusive labor market", framed in Policy Area VIII: "New care economy and employment policies".

Investment 7: "Promotion of Inclusive Growth by linking socio-labor inclusion policies to the Minimum Income Scheme" is among the reforms and investments proposed in this Component 23. Investment 7 promotes the implementation of a new model of inclusion based on the MIS which reduces income inequality and poverty rates. Therefore, the MIS goes beyond being a mere economic benefit and supports the development of a series of complementary programs that promote socio-labor inclusion. However, the range of possible inclusion programs is very wide, and the government decides to pilot different programs and interventions to evaluate them and generate knowledge that allows prioritizing certain actions. With the support of investment 7 under component 23, the MISSM establishes a new framework for pilot inclusion projects constituted in two phases through two royal decrees covering a set of pilot projects based on experimentation and evaluation:

[1] Law 19/2021, of December 20, establishing the Minimum Income Scheme (BOE-A-2021-21007).

[2] Article 31.1 of Law 19/2021, of December 20, 2021, establishing the Minimum Income Scheme.

[3] The Recovery, Transformation and Resilience Plan refers to the Recovery Plan for Europe, which was designed by the European Union in response to the economic and social crisis triggered by the COVID-19 pandemic. This plan, also known as Next Generation EU, establishes a framework for the allocation of recovery funds and for boosting the transformation and resilience of member countries' economies.

- **Phase I: Royal Decree 938/2021**[4], through which the MISSM grants subsidies for the execution of 16 pilot projects of inclusion pathways corresponding to autonomous communities, local organizations, and the Third Sector of Social Action organizations. This royal decree contributed to the fulfillment of milestone number 350[5] and monitoring indicator 351.1[6] of the RTRP.
- **Phase II: Royal Decree 378/2022**[7], which grants subsidies for a total of 18 pilot projects of inclusion pathways executed by autonomous communities, local organizations, and the Third Sector of Social Action organizations. This Royal Decree contributed, together with the previous one, to the fulfillment of the monitoring indicator number 351.1 of the RPTR.

To support the implementation of evidence-based public and social policies, the Government of Spain decided to evaluate the social inclusion pilot projects using the Randomized Controlled Trial (RCT) methodology. This methodology, which has gained relevance in recent years, represents one of the most rigorous tools to measure the causal impact of a public policy intervention or a social program on indicators of interest, such as social and job placement or the well-being of beneficiaries.

Specifically, RCT is an experimental method of impact evaluation in which a representative sample of the population potentially benefiting from a public program or policy is randomly assigned either to a group receiving the intervention or to a comparison group that does not receive the intervention for the duration of the evaluation. Thanks to the randomization in the allocation of the program, this methodology can statistically identify the causal impact of an intervention on a series of variables of interest. This methodology enables us to analyze the effect of this measure, which helps determine whether the policy is adequate to achieve the planned public policy objectives. Experimental evaluations enable us to obtain rigorous results of the intervention effect, i.e., what changes the participants have experienced in their lives due to the intervention. Additionally, these evaluations provide an exhaustive analysis of the program and its effects, providing insights into why the program was effective, who has benefited most from the interventions, whether there were indirect or unexpected effects, and which components of the intervention worked, and which did not.

[4] Royal Decree 938/2021, of October 26, 2021, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2021-17464).

[5] Milestone 350 of the RTRP: "Improve the rate of access to the Minimum Income Scheme and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and social action entities of the third sector to conduct the itineraries. The objectives of these partnership agreements are: (i) to improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies."

[6] Monitoring indicator 351.1 of the RTRP: "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and social action entities of the third sector to conduct pilot projects to support the socio-economic inclusion of MIS beneficiaries through itineraries".

[7] Royal Decree 378/2022, of May 17, 2022, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of €102,036,066, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124).

These evaluations have focused on the promotion of social and labor inclusion among MIS beneficiaries, recipients of regional minimum incomes, and other vulnerable groups. In this way, the MISSM establishes a design and impact evaluation of results-oriented inclusion policies, which offers evidence for decision-making and its potential application in the rest of the territories. The promotion and coordination of 32 pilot projects by the Government of Spain has led to the establishment of a laboratory for innovation in public policies of global reference named as the Inclusion Policy Lab.

For the implementation and development of the Inclusion Policy Lab, the General Secretariat of Inclusion has established a governance framework that has made it possible to establish a clear and potentially scalable methodology for the design of future evaluations, and promoting decision-making based on empirical evidence. The General State Administration has had a triple role as promoter, evaluator, and executive of the different programs. Different regional and local administrations and the Third Sector of Social Action organizations have implemented the programs, collaborating closely in all their facets, including evaluation and monitoring. Additionally, the Ministry has had the academic and scientific support of the Abdul Latif Jameel Poverty Action Lab (J-PAL) Europe and the Centre for Monetary and Financial Studies (CEMFI), as strategic partners to ensure scientific rigor in the assessments. Likewise, the Inclusion Policy Lab has an Ethics Committee 8, which has ensured the strictest compliance with the protection of the rights of the people participating in the social inclusion itineraries.

This report refers to "Social Inclusion Life Plan", executed within the framework of Royal Decree 938/2021[9] by the Ministry of Health and Social Services of the Autonomous Region of Extremadura. This report contributes to the fulfillment of milestone 351 of the PRTR: "Following the completion of at least 18 pilot projects, publication of an evaluation on the coverage, effectiveness, and success of the MIS, including recommendations to increase the level of application and improve the effectiveness of social inclusion policies".

[8] Regulated by Order ISM/208/2022, of March 10, 2022, which creates the Ethics Committee linked to social inclusion itineraries, on 20/05/2022 it issued a favorable report for the realization of the project that is the subject of the report.

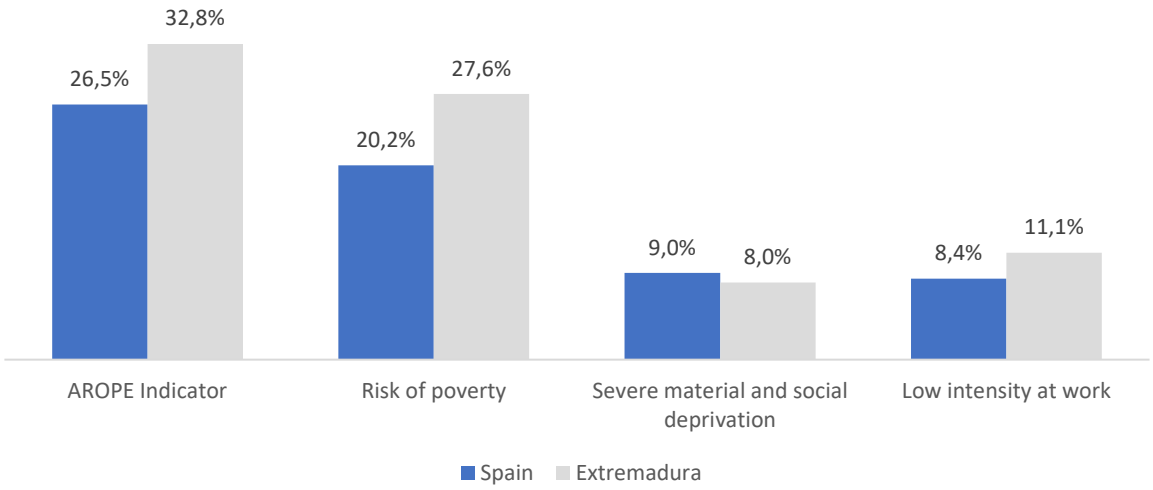
[9] On January 27, 2022, an Agreement was signed between the General State Administration, through the SGI, and the Administration of the Autonomous Region of Extremadura, through the Ministry of Health and Social Services, for the implementation of a project for social inclusion within the framework of the Recovery Plan. Transformation and Resilience, which was published in the "Boletín Oficial del Estado" on February 21, 2022 (BOE no. 44). Subsequently, on April 3, 2024, the Addendum to the Agreement with the Autonomous Region of Extremadura, for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, signed on March 25, 2024, was published in the "Boletín Oficial del Estado" (BOE no. 82).

Context of the project

Extremadura has one of the highest at-risk-of-poverty and social exclusion rates (AROPE)[10] in Spain, along with Andalusia, and after the autonomous city of Ceuta.

In particular, the AROPE rate in Extremadura is 6.3 percentage points higher than the national average, standing at 32.8% (National Institute of Statistics, 2023a). Indeed, analyzing the different components of this rate, the risk of poverty is 7.4 percentage points higher in Extremadura, and the proportion of people in households with low work intensity is 2.7 percentage points higher, compared with the national average.

Figure 1: Risk of poverty and social exclusion and its components (2023)



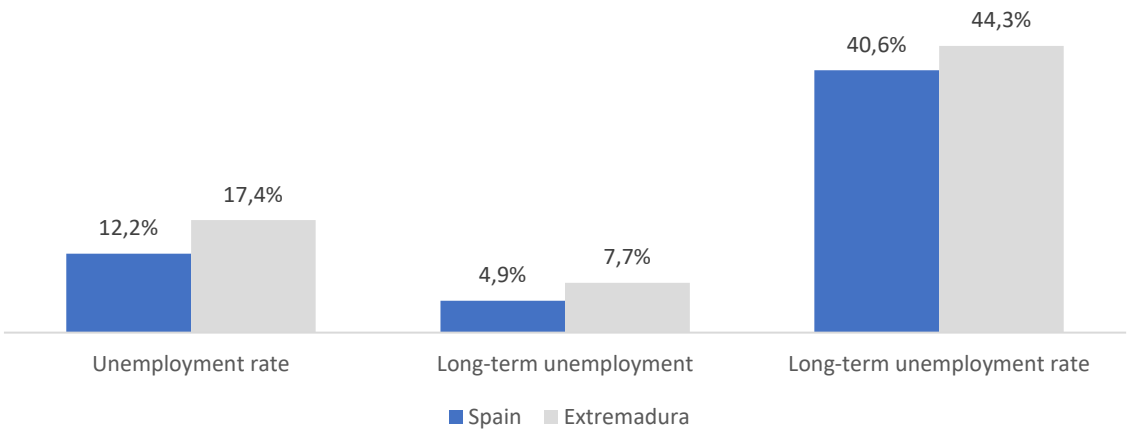
Source: INE (Living Conditions Survey)

Regarding the labor market, the results for the Autonomous Region of Extremadura present a relatively worse situation with respect to that of Spain as a whole (National Institute of Statistics, 2023b). **Figure 2** shows that the unemployment rate in 2023 in this Autonomous Region was 17.4% (5.2 percentage points above the national average), with a percentage of long-term unemployed out of 44.3% (3.8 percentage points higher than the Spanish average). Thus, the unemployment rate for

[10] The population at risk of poverty or social exclusion is defined according to criteria established by Eurostat. It includes individuals who are in at least one of the following three situations: (1) At risk of poverty (equivalent income below 60% of the median income per consumption unit). (2) Experiencing severe material and social deprivation (if they report lacking at least seven out of the 13 items on a list that includes, for example, not being able to afford a meal with meat, chicken, or fish at least every two days, maintaining the home at an adequate temperature, having two pairs of shoes in good condition, or replacing worn-out clothing with new ones). (3) Living in households with no employment or with low work intensity (households in which working-age members worked less than 20% of their total work potential during the year prior to the interview).

those who have been actively looking for work for more than a year stood at 7.7%, above the Spanish average (2.76 percentage points higher).

Figure 2: Employment situation (2023)



Source: INE (Active Population Survey)

Regulatory and strategic framework associated with the project

This pilot project is in line with the framework established in the 2030 Agenda and with the Sustainable Development Goals (SDGs). In particular, the pilot project is aligned with European and national strategies in the field of social activation of people in situations of social vulnerability, as well as with the 2030 Agenda for Sustainable Development, contributing specifically to SDGs 1, 3, 5, 8, and 10.

Additionally, at the European level, the fight against poverty and social exclusion has its legal basis in Articles 145 to 161 of the **Treaty on the Functioning of the European Union** (TFEU), relating to employment and social policy.

In particular, the fight against poverty and social exclusion is one of the specific objectives of the Union and its Member States in the field of social policy. To this end, there are various instruments relating to the social activation of people in situations of social vulnerability, including:

- **European Pillar of Social Rights (EPSR).** Additionally, the relevance of the rights included in Chapter I (relating to equal opportunities and access to the labor market), it highlights in Chapter III ("Protection and social inclusion"), the fact that "for people who are able to work, minimum income benefits must be combined with incentives for (re)integration into the labor market".
- **Council Recommendation on an adequate minimum income that seeks active inclusion.** Aims to combat poverty and social exclusion by promoting adequate income support, particularly through a minimum income; effective access for people lacking sufficient resources to essential services and training and promoting the employability of those who are able to work, in line with the active inclusion approach, with a view to guarantee a dignified life at all stages of life.

- **Council Recommendation on the integration of the long-term unemployed into the labor market**, recommends that member states support the registration of job seekers and a greater labor market orientation of integration measures, facilitate an individual assessment of long-term unemployed registered with employment services, and prepare a specific offer of a labor integration agreement at the latest before the long-term unemployed have been unemployed for eighteen months.

For its part, **Spain** has both regulatory and strategic documents and public policies related to the social activation of people in situations of social vulnerability. Specifically, they highlight:

- The **National Strategy for Preventing and Fighting Poverty and Social Exclusion 2019-2023**, which aims to combat poverty, especially child poverty, and reduce inequality and disparity in income levels. This Strategy is developed through annual Operational Plans.
- The **Social Inclusion Network**, a space financed and promoted by the European Social Fund to improve policies and practice for social inclusion. This network is the product of a joint initiative of the Administrative Unit of the European Social Fund, the Ministry of Labor and Social Economy, and the Directorate-General for Family Diversity and Social Services of the Ministry of Social Rights and Agenda 2030.

Additionally, in the specific field of mental health, the **Mental Health Strategy of the National Health System 2022-2026** includes, along 10 strategic lines, a series of objectives and recommendations aimed at improving the mental health of the population, early detection, and effective care for people with mental health problems. For its part, the **Mental Health Action Plan 2022-2024** is proposed as an instrument to facilitate the implementation of the objectives and recommendations contained in the Mental Health Strategy 2022-2026.

In the Autonomous Region of Extremadura, **Article 4 of Law 14/2015 of April 9, 2015 on Social Services in Extremadura** states that one of the purposes of the Public Social Services System is "to guarantee to every person, group or community the coverage of both basic personal needs and social needs, ensuring equal opportunities, access to resources, support to promote attitudes and capacities that facilitate autonomy and well-being, social inclusion and integration, prevention, adequate coexistence, social participation, equal promotion and the right to live with dignity during all stages of their lives". Finally, it is worth highlighting **Law 5/2019, of February 20, on Extremadura Guaranteed Income**, aimed at ensuring the minimum of a dignified life for individuals and family units and promoting the labor and social integration of those who are in a situation or at risk of social exclusion.

The scientific objective of the project is to evaluate the impact on people of receiving personalized and comprehensive support in the socio-labor and health fields compared to the usual treatments that are being offered by social, employment, and health services. Likewise, it is intended to evaluate the impact when both treatments (socio-occupational and health) personalized and comprehensive are applied together compared to when only one of the two is applied.

The governance framework established for the proper implementation and evaluation of the project includes the following actors:

- The **Autonomous Region of Extremadura**, beneficiary entity and coordinator of the project through the **Ministry of Health and Social Services**, currently the Ministry of Health and Social Services.

  Other relevant actors in the project are the three **Diocesan Caritas** based in Extremadura (Cáritas Diocesana Mérida-Badajoz, Cáritas Diocesana Plasencia and Cáritas Diocesana Coria-Cáceres), in charge of implementing the interventions, and the **University of Extremadura**, a collaborating entity in the design and methodological definition of the tools required for the evaluation of the project.

- The **Ministry of Inclusion, Social Security and Migration** (MISSM), as the funding source of the project and responsible for the RCT evaluation. For this reason, the General Secretariat of Inclusion and Social Welfare Objectives and Policies (SGOPIPS) assumes a series of commitments:
  - Provide the beneficiary entity with support for the design of the actions to be conducted for the execution and monitoring of the object of the subsidy, as well as for the profiling of the potential participants of the pilot project.
  - Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary organization and scientific collaborators.
  - Evaluate the pilot project in coordination with the beneficiary entity.
- **CEMFI and J-PAL Europe,** as scientific and academic institutions that support MISSM in the design and the RCT evaluation of the project.

Taking all the above into account, this report follows the following structure. **Section 2** provides a **description of the project**, detailing the problem to address, the specific intervention associated with adoption, and the target audience for the intervention. Next, **Section 3** contains information related to the **evaluation design**, defining the Theory of Change linked to the project and the hypotheses, information sources, and indicators used. **Section 4** describes the **implementation of the intervention**, analyzing the sample, randomization results, and the level of participation and attrition of the intervention. This section is followed by **Section 5**, which presents the **evaluation results**, with a detailed analysis of the econometric analysis performed and the results for each of the indicators used. **Section 6** describes the general **conclusions** of the project evaluation. Finally, the appendix on **Economic and Regulatory Management** provides additional information on project management instruments and governance of the pilot project.

Ethics Committee linked to the Social Inclusion Itineraries

During research involving human subjects, in the field of biology or the social sciences, researchers and workers associated with the program often face ethical or moral dilemmas in the development of the project or its implementation. For this reason, in many countries it is a common practice to create ethics committees that verify the ethical viability of a project, as well as its compliance with current legislation on research involving human beings. The Belmont Report (1979) and its three fundamental ethical principles – respect for individuals, profit, and justice – constitute the most common frame of reference in which ethics committees operate, in addition to the corresponding legislation in each country.

With the aim of protecting the rights of participants in the development of social inclusion itineraries and ensuring that their dignity and respect for their autonomy and privacy are guaranteed, Order ISM/208/2022 dated March 10 creates the Ethics Committee linked to the Social Inclusion Itineraries. The Ethics Committee, attached to the General Secretariat of Inclusion and Social Welfare Objectives and Policies, is composed of a president – with an outstanding professional career in defense of ethical values, a social scientific profile of recognized prestige and experience in evaluation processes – and two experts appointed as members.

The Ethics Committee has conducted analysis and advice on the ethical issues that have arisen in the execution, development, and evaluation of the itineraries, formulated proposals in those cases that present conflicts of values and approved the evaluation plans of all the itineraries. In particular, the Ethics Committee issued its approval for the development of this evaluation on June 7, 2023.

2 Description of the program and its context

This section describes the program that the Ministry of Health and Social Services of the Autonomous Region of Extremadura implemented in the framework of the pilot project. Furthermore, it describes the objective of the study, the target population and the territorial framework, and provides a detailed description of the intervention.

2.1 Introduction

This project aims to improve the quality of life of citizens, particularly of people receiving the Minimum Income Scheme (MIS) or Extremadura Guaranteed Income (RG by its acronyms in Spanish), through the design and development of comprehensive inclusion itineraries (Social Inclusion Life Plan). The intervention is based on a person-centered care model (individualized itinerary) and community health intervention strategies.

Among the studies that analyze interventions related to those evaluated in this report, the Jensen (2012) study stands out. It is an experimental study that explores the effect of greater availability of employment opportunities on the decisions and well-being of women between 15 and 21 years of age in rural areas of India. Visits by company recruiters for three consecutive years increased these women's knowledge of potential employment opportunities, leading some of them to invest more in learning job skills, have a greater likelihood of entering the labor market, and experience a substantial change in their career aspirations.

Behaghel, Crépon, and Gurgand (2014) analyzed the effects of a counseling program for job seekers at risk of long-term unemployment in France. Using the RCT methodology, the study evaluated the impact of this program when offered by the private sector or by public employment services, finding that counseling services were effective, especially in accelerated placement programs. Additionally, the provision of services by the public sector was more cost-effective than the private sector.

Osman and Speer (2022), through RCT, studied how complementarities in skills can affect vocational training outcomes for unemployed university graduates in Egypt. The authors worked with an NGO that offered four weeks of training programs in "soft" skills and other techniques and found that the types of skills taught in vocational programs mattered. Additionally, the results showed the importance of complementarity between skills programs. All programs increased the probability of finding a job, compared to the group that did not receive any program.

Also related to skills, Bandiera et al. (2017) evaluated a set of programs aimed at women in poverty in Bangladesh through the RCT methodology: an asset package and a support and training package where they were taught animal care skills. The combination of these activities allowed the beneficiaries to begin to become familiar with the care of farm animals, which increased the supply of work and income.

Finally, in relation to health interventions, Lim and Hyun (2021) investigated, experimentally, the impact of pilates and yoga sessions on volunteers aged from 30 to 49. The experiment lasted 8 weeks. One group of volunteers was assigned to do yoga on a regular basis, another did pilates on a regular basis, and the control group did none of these exercises. Those who did pilates or yoga were found to exhibit behaviors that promoted better health than those in the control group. Additionally, these people had a better perception of their own health.

For their part, Ridley et al. (2020) conducted a meta-analysis of the effect of mental health treatment on poverty reduction. The study focused on the evidence linking poverty with anxiety and depression disorders, trying to understand the bidirectional causality between mental health and poverty; that is, the fact that mental illness reduces employment, which, in turn, reduces income, and that, at the same time, negative economic shocks can cause mental illnesses such as depression and anxiety.

2.2 Target population and territorial scope

The target population of the project is women between 18 and 45 years of age with dependent children, who receive the Minimum Income Scheme or the Extremadura Guaranteed Income, or those who can receive both at the same time.

The project was implemented in four of the existing health areas in the Autonomous Region of Extremadura: Cáceres, Badajoz, Zafra-Llerena, and Navalmoral de la Mata.

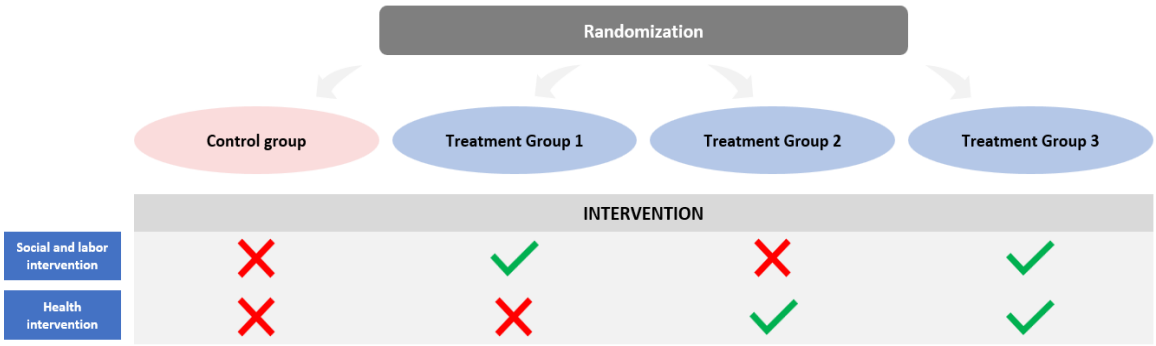
Section 3.5, as part of the evaluation design, provides further details on the recruitment process.

2.3 Description of interventions

The project foresees the realization of an impact evaluation through RCT where the participants in the project are randomly assigned to one of the four experimental groups.

- **Control Group.** A group of participants who do not receive treatment or intervention within the Life Plan. They receive the usual services offered by Social Services, Employment and Health from the Junta de Extremadura.
- **Treatment Group 1: Social and Occupational Treatment.** A group of participants who receive interventions only from the socio-occupational environment.
- **Treatment Group 2: Health Treatment.** A group of participants who receive interventions only from the health field.
- **Treatment Group 3: Comprehensive Life Plan.** A group of participants who receive the necessary interventions derived from the preparation of the Life Plan for Social Inclusion, which include the socio-occupational and health spheres.

Figure 3: Intervention scheme



The actions, concentrated in the areas of socio-occupational and health intervention, are interventions and personalized treatments in addition to the usual ones already being offered by the social, employment, and health services.

Area of socio-occupational intervention

The intervention begins with a social triage, in coordination with the Basic Social Care Services, assessing individuals based on their degree or level of poverty and social exclusion. After this, a personalized social inclusion itinerary is designed, providing participants with guidance and follow-up. This itinerary includes the provision of the necessary services and aid to cover basic and essential needs that are not covered by the current aid system, which hinder the development of other competencies, skills, or abilities that could improve their personal situation regarding poverty and social exclusion.

In coordination with the Extremadura Public Employment Service (SEXPE), this project worked with participants to design a personalized employment integration plan. This plan provides information, guidance, support, and monitoring of services, and aid not covered by the current aid system. It aims to develop skills, abilities, and competencies that enhance employability for effective social inclusion.

The additional actions and services conducted by the intervention teams are as follows:

- Exhaustive and individualized social diagnosis.
- Design of the personalized and complete social inclusion itinerary.
- Personalized, intense, and continuous social support.
- Specific emotional care support and accompaniment.
- Individualized diagnosis and preparation of the professional profile.
- Design of the personalized inclusion itinerary for employment.
- Support in the active search for employment.
- Advice on self-employment and entrepreneurship.
- Intermediation actions.
- Conciliation measures.
- Another type of training.
- Other socio-labor actions.

These actions may be conducted if they are not covered by the resources that are set in the areas subject to intervention and financed with public funds in that area of intervention.

Health intervention area

The intervention begins with a triage of people in terms of their state of health, focusing especially on situations related to mental health and validated by a nursing service. After this triage, intervention is conducted through the provision of services, designed by a nursing professional, necessary to cover those needs derived from their state of health, mainly mental, and that hinder the development of other competencies, skills, or abilities that can improve their social and labor positioning for effective social inclusion.

The actions in this area are as follows:

- Individualized medical diagnosis/report.

- Personalized care in the field of mental health with specialized sessions of psychological therapies.
- Physical therapy if required by a physiotherapist.
- Personalized attention to nutrition and healthy lifestyle habits adapted to their needs.

3 Evaluation design

This section describes the design of the impact assessment of the projects described in the previous section. The section describes the Theory of Change, which identifies the mechanisms and aspects to measure, the hypotheses to test in the evaluation, the sources of information to build the indicators, the indicators, and the design of the experiment.

3.1 Theory of Change

This report, with the aim to design an evaluation that enables us to understand the causal relationship between the intervention and its final objective, develops a Theory of Change. The Theory of Change makes it possible to schematize the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long-term results sought by the intervention, understanding the relationships between them, the assumptions on which they rest, and outlining measures or outcome indicators.

Theory of Change

A Theory of Change begins with the correct identification of the needs or problems to be addressed and their underlying causes. This situational analysis should guide the design of the intervention, i.e., the activities or products that are provided to alleviate or resolve the needs, as well as the processes necessary to properly implement the treatment. Next, we identify the expected effect(s) based on the initial hypothesis, i.e., what changes – in behavior, expectations, or knowledge – are expected to be obtained in the short term with the actions conducted. Finally, the process concludes with the definition of the medium- to long-term results that the intervention aims to achieve. Sometimes, the effects directly obtained with the actions are identified as intermediate results, and one identifies the indirect effects in the results.

The development of a Theory of Change is a fundamental element of impact evaluation. At the design stage, the Theory of Change helps to formulate hypotheses and identify the indicators needed for the measurement of results. Once the results are achieved, the Theory of Change makes it easier, if results are not as expected, to detect which part of the hypothetical causal chain failed, as well as to identify, in case of positive results, the mechanisms through which the program works. Likewise, the identification of the mechanisms that made the expected change possible allows a greater understanding of the possible generalization or not of the results to different contexts.

The theory of change for this project is based on the identification of the obstacles and difficulties for the social and labor inclusion of women beneficiaries of the Extremadura Guaranteed Income or the Minimum Income Scheme.

To address this situation, a series of actions (inputs or activities) are proposed, which constitute the resources and actions required to generate the program's outputs[11]. Personalized social and emotion-support, a personalized job placement itinerary (with accompaniment, guidance, training, and intermediation actions), personalized mental health services (psychological care, addictions, and anxiety control), personalized physical therapy services (postural hygiene, pilates, and yoga) and nutrition and healthy habits (oral hygiene and hiking).

As a result of the actions described above, and under certain assumptions (in particular, that people have sufficient time and attend the sessions and that they are motivated to conduct the proposed activities), it is expected that a series of products will be obtained. In other words, as a direct result of the programmed activities, it is expected that women will see their social and emotional needs met, that they will improve their work skills, and that their mental and physical health needs will be met.

The development of the project, under certain assumptions (that the training sessions are effective, that the training is adapted to the needs of the participants, and that the health interventions are appropriate to the needs and are effective), makes it possible to achieve intermediate results in the short term. Particularly, improved quality of life and life satisfaction, a better labor market situation and increased motivation, improved women's mental health (reduced anxiety and addictions and improved life satisfaction), better physical health and better lifestyle habits and more training, with more work experience and economic improvements.

Finally, a series of long-term final results are expected to be obtained, such as an improvement in the social inclusion of women and their families; an improvement in employability; an improvement in the quality of life, better self-esteem, and better attitudes towards life; and greater job placement.

The following figure illustrates this causal sequence of actions, initiated by the activities and resources necessary to obtain the expected changes in the participants. To this end, each phase encompasses a series of components that make these changes possible and that are determined by the actions conducted in the previous phase.

[11] The Theory of Change described in this section refers to the so-called "Comprehensive Life Plan", which includes interventions in both the socio-occupational and health spheres. In relation to treatment groups 1 and 2, the inputs/activities, outputs, intermediate results, and final results will be, respectively, those corresponding to each of the areas of intervention.

Figure 4: Theory of Change

3.2 Hypothesis

The hypotheses to test for each of the different axes of analysis are the following.

Improvement in social inclusion

Based on the intervention, this study intends to test whether there is an improvement in the social inclusion of women and their families.

Improved quality of life, self-esteem, and attitudes towards life

In relation to this aspect, the main hypothesis is that there is an improvement in quality of life. As a secondary hypothesis, this report expects to test whether there is a reduction in anxiety and depression and an improvement in physical activity.

Improving employability

In relation to employability, this study tests as a main hypothesis whether employability improves. Likewise, this evaluation also tests two secondary hypotheses: whether there is an improvement in the self-perception of barriers to employment and whether employment expectations improve.

Improving job placement

Finally, in this area, the main hypothesis is that there is an improvement in labor market insertion. As a secondary hypothesis, this study tests whether there is an improvement in job satisfaction and whether there is an improvement in the quality of employment.

3.3 Sources of information

To collect the information necessary to construct the result indicators, surveys aimed at the participants of the itinerary are mainly used, as well as data from administrative records.

The questionnaires are provided by the territorial intervention teams through an encrypted web application designed for this purpose by the team of the University of Extremadura (UEX). This report uses two measurements: one before starting the interventions (**baseline survey**) and one at the end (**endline survey**).

In particular, the study performs the following questionnaires:

- **Questionnaire of sociodemographic variables:** This questionnaire collects personal, academic, and employment information along with data from the cohabitation unit.
- **Residential exclusion scale:** This questionnaire captures the degree to which certain statements are perceived as a problem in relation to the housing situation in the last six months.
- **Self-perception scale of barriers to employment:** It includes the degree to which certain statements are perceived as a barrier to accessing employment.
- **Scale of employability factors:** This questionnaire includes the degree of agreement with certain statements about employability factors. Particularly, it asks about social circumstances, personal circumstances, basic training, professional experience, technical skills, and job search.
- **Perceived Control of Job Search Expectations Scale (PCS-JE):** It includes the degree of agreement or disagreement with certain statements relating to self-efficacy in job search, job search success, internal locus of control, and professional experience.
- **Job placement questionnaire:** Information is collected on the number of hours worked in the last month, the degree of quality in employment, and the degree of satisfaction with the job[12].
- **SF-36 Quality of Life Questionnaire:** It collects information on physical function, physical role, body pain, general health, vitality, social function, emotional role, mental health, stated health evolution, and general health assessment.
- **Hamilton's Hospital Anxiety and Depression Scale (HADS-A and HADS-D):** Through this questionnaire, this study collected information on certain statements related to anxiety and depression.
- **International Physical Activity Questionnaire (IPAQ):** This evaluation collected quantitative information (in days or minutes) on vigorous, moderate, and mild physical activity.

[12] The questions related to the first two indicators take the Labor Force Survey as a reference (see https://www.ine.es/daco/daco42/daco4211/epacues05.pdf). The questions used to measure the degree of satisfaction with employment have been adapted from different sources: surveys from other pilot projects, the Labor Force Survey and Eurostat (2017) "Final report of the expert group on quality-of-life indicator" (available at: https://ec.europa.eu/eurostat/documents/7870049/7960327/KS-FT-17-004-EN-N.pdf/f29171db-e1a9-4af6-9e96-730e7e11e02f?t=1490716665000).

- **Suicide Risk Scale (Plutchik Suicide Risk Scale):** It collects information on certain issues related to suicide risk.

For their part, the Social Security administrative records of working lives offer information on the number of days worked and the intensity of employment. This project uses administrative data on working lives, obtained by the SGI based on the agreement[13] signed for this purpose.

3.4 Indicators

This section describes the indicators used for the impact evaluation of the intervention, divided by themes related to the hypotheses described above.

Social inclusion

To test the main hypothesis regarding the improvement in the social inclusion of women and their families, this report uses the following indicator:

Residential exclusion indicator: Indicator constructed from the eight questions of the residential exclusion scale. The composite indicator is constructed using the method proposed by Anderson (2008), which aggregates the information from a set of variables that attempt to measure a common latent variable. Intuitively, the method calculates a weighted average of all the variables, where the weight assigned to each of them depends on how correlated it is with the others (the lower the correlation, the greater the weight). The final value of the indicator is standardized to ensure it has a mean of 0 and a standard deviation of 1.

Quality of life, self-esteem, and attitudes towards life

The testing of the main hypothesis regarding the improvement in quality of life is based on an indicator:

Quality of life indicator: Indicator constructed from the SF-36 quality of life questionnaire[14], which contains questions whose answers take values between 0 (worse quality of life) and 100 (best quality of life). The construction of the general health assessment indicator is performed as the average of all the questions.

On the other hand, this report evaluates the secondary hypothesis related to the reduction of anxiety and depression through two indicators:

[13] Agreement between the Secretary of State for Social Security and Pensions, the National Social Security Institute, the Social Institute of the Navy, the General Treasury of the Social Security, the Social Security IT Management and the General Secretariat for Inclusion and Social Welfare Objectives and Policies, for the provision of data necessary for the evaluation of inclusion strategies, https://www.boe.es/diario_boe/txt.php?id=BOE-A-2023-25107.

[14] Ware JE Jr, Snow KK, Kosinski M, Gandek B, SF-36 Health Survey: manual and interpretation guide. Boston: New England Medical Center; 1993.

Indicator of anxiety and depression: Indicator constructed from the Hamilton scale[15] as the sum of the values (between 0 and 3) of the answers to the 14 questions of the Hospital Scale of Anxiety and Depression, which takes values between 0 and 42. Depending on the questions added, two subscales ("anxiety" and "depression") can be constructed, which measure the absence (0-7 points), consideration (8-10 points), or presence of relevant symptomatology (more than 11 points), i.e., the possible presence of anxiety and/or depression. A global indicator can also be constructed by considering all responses.

Suicide risk indicator: Indicator constructed from the Plutchik Suicide Risk Scale[16] as the sum of the values (0 or 1) of the answers to the 15 questions of the suicide risk questionnaire, which takes values between 0 and 15. The cut-off point for suicide risk is a score of 6 or higher, so a higher score corresponds to a higher risk.

Finally, this report uses the following indicator to test the secondary hypothesis:

Physical activity indicator: Indicator constructed from the International Physical Activity Questionnaire (IPAQ)[17], as the sum of all weekly activities. The unit of measurement of the questionnaire is the MET, which is calculated from physical activity (light, moderate, or vigorous). From the results, in days or in MET, the level of physical activity can be interpreted[18].

Employability

To assess the improvement in employability, this project uses the following indicator:

Employability indicator: Indicator constructed from the questions of the Employability Factors Scale[19], which takes values between -33 (very low employability) and 99 (very high employability). Although in all items the evaluator has to choose, on a scale of 1 ("not at all agree") to 4 ("strongly agree"), the option that best reflects the person's situation, for the purposes of scoring the scale, questions relating

[15] Lobo A, Chamorro L, Luque A, Dal-Ré R, Badia X, Baró E; Validation Group in Spanish of Psychometric Scales (GVEEP). Validation of the Spanish versions of the Montgomery-Asberg depression and Hamilton anxiety rating scales. Med Clin (Barc). 2002 Apr 13; 118(13):493-9. Spanish. DOI: 10.1016/S0025-7753(02)72429-9. PMID: 11975886.

[16] Guirao Goris J, Gallud J. Plutchik Suicide Risk Scale. In: Guirao Goris J, Gallud J, editors Scales and instruments for assessment in home care. Valencia: Generalitat Valenciana. Ministry of Health; 2006. p. 113-5

[17] Craig CL, Marshall AL, Sjöström M, Bauman AE, Booth ML, Ainsworth BE, Pratt M, Ekelund U, Yngve A, Sallis JF, Oja P. International physical activity questionnaire: 12-country reliability and validity. Med Sci Sports Exerc. 2003 Aug; 35(8):1381-95. doi: 10.1249/01.MSS.0000078924.61453.FB. PMID: 12900694.

[18] Vigorous physical activity corresponds to vigorous physical activity at least 3 days per week achieving a total of at least 1500 METs or 7 days of any combination of walking, with moderate physical activity and/or vigorous physical activity, achieving a total of at least 3000 METs. Moderate physical activity corresponds to 3 or more days of vigorous physical activity at least 20 minutes per day, 5 or more days of moderate physical activity and/or walking at least 30 minutes per day, or 5 or more days of any of the combinations of walking, moderate or vigorous physical activity achieving a minimum total of 600 METs. Mild physical activity corresponds to non-compliance with the above criteria.

[19] Martínez-Rueda, N., & Galarreta, J. (2021). The Evaluation of Employability in Insertion Companies. Gizatea Employability Factors Scale (EFE). Professional Manual. Gizatea.

to social circumstances and personal circumstances are scored from -3 to 0, understanding that having high scores does not add to employability, but having low scores does reduce them. In the rest of the sections, the scale 1 to 4 translates into scores from 0 to 3, understanding that the minimum score does not add up and that, from there, the successive scores do add elements of employability.

For its part, this report uses the following indicator to test the secondary hypothesis related to the improvement in the self-perception of barriers to employment:

Indicator of barriers to employment: Indicator constructed from the 16 questions of the self-perception scale of barriers to employment, each of which is scored between 1 ("not at all agree") and 5 ("strongly agree"), indicating higher values and greater self-perception of these. The indicator is constructed with the Anderson method described above and standardized with a mean of 0 and a standard deviation of 1.

Finally, the secondary hypothesis on improvement in employment expectations is evaluated using an indicator:

Employment expectations indicator: Indicator constructed as the sum of the values, between 1 ("not at all agree") and 5 ("strongly agree") of the responses to the 12 statements of the Perceived Control of Job Search Expectations Scale (PCS-JE)[20] which takes values between 12 and 60.

Job placement

To test the main hypothesis relating to the improvement of job placement, this project employs two indicators:

Self-reported hours worked in the last week: Number of hours worked in the last week (constructed according to the response to the job placement questionnaire).

Days worked equivalent to full-time in the reference month: Number of days of registration with Social Security transforming part-time working days into full-time equivalent. This indicator is constructed with data from administrative records of working lives of the social security. November 2023 is considered the reference month for the endline data.

Finally, the secondary hypothesis on improvement in the quality of employment is evaluated using an indicator:

Self-reported wage income: Indicator of the monthly salary, in euros, in the last week (constructed according to the response to the job placement questionnaire).

For these three indicators, this project has considered that, for all those participants who have not worked in the reference week or month of reference, the value is 0.

[20] Gómez, R. P., Morejón, A. R., & Palenzuela, D. L. (2016). Validation of a personal control scale: a specific measure of expectations of perceived control of job search. Journal of Work and Organizational Psychology, 32(3), 153–161.

3.5 Design of the experiment

To assess the effect of treatments versus the control group on the above indicators, this study has used an experimental evaluation (RCT) in which participants are randomly assigned to the treatment and control groups.

The process of recruiting and selecting the beneficiaries of the intervention is detailed below, as well as the random assignment and timeline of the experiment.

Recruitment of the beneficiaries of the intervention

The potential participants are women between 18 and 45 years of age, with children in their care, and beneficiaries of the Extremadura Guaranteed Income or the Minimum Income Scheme. Their contact details are obtained from the databases of both benefits: in the case of the Extremadura Guaranteed Income (RG) and in the case of the Minimum Income Scheme by the MISSM.

The process of recruiting participants is conducted in collaboration with the Basic Social Care Services of each of the localities belonging to the areas in which the Life Plan for Social Inclusion will be executed. The Basic Social Care Services, based on the database of potential participants, contact them, mainly through telephone calls, which can be complemented and supported by holding information sessions where documentation of adhesion to the pilot project is delivered. These information sessions can be group, individual, or combined, when deemed necessary, by appointment in person.

The recruitment process for people participating in the Life Plan for Social Inclusion consists of the following actions:

- Action I. Availability of the database of potential participants by the Basic Social Care Services.
- Action II. Direct contact with potential participants.
- Action III. Signing of the informed consent by the participants who will be part of the evaluation sample.

Informed consent

One of the fundamental ethical principles of research involving human beings (respect for persons) requires study participants to be informed about the research and consent to be included in the study. Informed consent is usually part of the initial interview and has two essential parts: the explanation of the experiment to the subject, and the request and registration of their consent to participate. Consent should begin with a comprehensible presentation of key information that will help the subject make an informed decision, i.e., understand the research, what is expected of it, and the potential risks and benefits. Documentation is required as a record that the process has taken place and as proof of informed consent, if so.

Informed consent is required in most research and may be oral or written, depending on different factors such as the literacy of the population or the risks posed by consent. Only under very specific circumstances, such as when the potential risks to the participants are minimal and the informed consent is very complex to obtain or would harm the validity of the experiment, informed consent may be avoided, or partial information may be given to participants with the approval of the ethics committee.

Random assignment of participants

The project foresees the performance of an impact assessment by RCT in which the participants in the project are randomly assigned to 4 groups, as described in **section 2.3**. The initially planned sample was 2,000 people, so it was planned to assign 350 people to the control group and treatment groups 1 and 2, and 950 to treatment group 3 (Life Plan).

The MISSM randomly assigned the study sample to each of the four groups. To guarantee equivalence between the groups, the allocation procedure considers the health area as a stratification variable. In this sense, the assignment to the four-intervention group is proportional in each of the four health areas.

Figure 5: Sample design

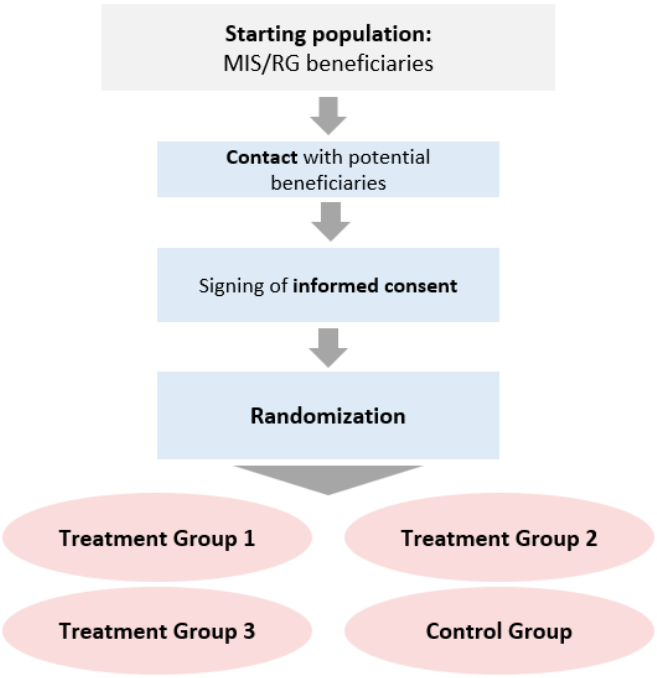
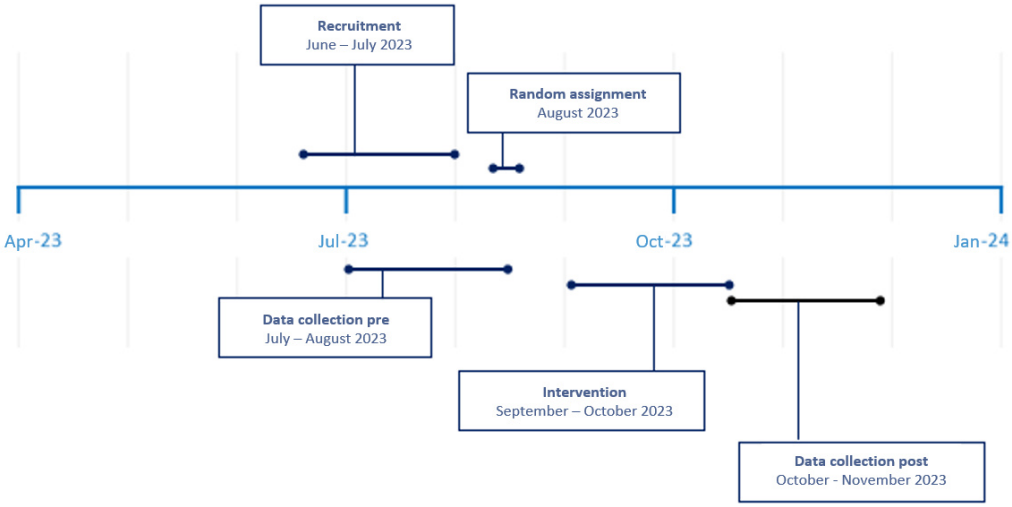


Figure 6 shows the timeline in which implementation and evaluation took place. The recruitment takes place between the months of June and July 2023. Participants complete the baseline survey between July and August 2023. In August 2023, the random assignment of participants who meet the criteria and who have signed the informed consent and are interested in participating is conducted. The development of the itinerary or intervention extends from September to October 2023. Finally, the collection of post data (endline survey) took place between October and November 2023.

Figure 6: Evaluation timeline



4 Description of the implementation of the intervention

This section describes the practical aspects of how the intervention was implemented, within the framework of the evaluation design. Describe the results of the participant recruitment process and other relevant logistical aspects to contextualize the results of the evaluation.

4.1 Sample Description

Based on the data provided by the MISSM and the Regional Government of Extremadura on beneficiaries of the MIS or the RG, results show that there are 2,752 individuals likely to be part of this project with the previously mentioned characteristics and in the territorial areas mentioned in section 3.5.

Table 1 shows the figures related to the recruitment process, starting from the population of potential beneficiaries up to the signing of the informed consent. Of a total of 2,752 potential beneficiaries, 1,603 are contacted, 58%. Of these, a total of 884 (32%) agreed to participate and 851 (31%) signed the informed consent, becoming part of the sample that would be randomly assigned to the treatment and control groups. The final number of participants who respond to the baseline survey and initiate the intervention is 707 individuals (26% of potential participants).

Table 1: Recruitment process

		Total	Province of Cáceres	Province of Badajoz
Population of potential beneficiaries		2,752	941	1,811
Non-contacted potential beneficiaries		2,742	931	1,811
Total number of potential participants who have been tried to contact but have not been able to	No telephone number in the listings provided	567	18	549
	Not located after making the 3 calls	269	104	165
	Restricted calls	19	7	12
	Phone not available/no phone exists	284	178	106
The number of potential participants contacted		1,603	624	979
Rejected for non-compliance		141	19	122
Unwilling/unable to participate		743	232	511
Reasons for refusing participation	Employed	101	33	68
	Forming	15	3	12
	Resides in another health area	46	38	8
	Homeless	1	0	1
	Do not attend the interview	173	44	129
	No reason	109	0	109
	Resides in another country	6	0	6
	Resides in another province	7	0	7
	Other miscellaneous reasons	120	114	6
Total number of potential participants who have agreed to participate		884	373	511
	Do not sign the IC	33	0	33
	Sign the IC	851	373	478
	After signing an IC, refuse to participate or do not attend appointments	143	37	106
	The final number of participants	707	336	371

Characteristics of the final evaluation sample

As noted, a total of 851 individuals participated in the randomization, of which 209 were assigned to the control group and 214 to each of the three treatment groups. Of these, 707 responded to the baseline survey.

Table 2 shows the descriptive statistics of the different variables measured at baseline. It shows the sociodemographic variables (including the stratification variable, and the health area) and the outcome indicators. For each of the variables, the mean, standard deviation, minimum and maximum values, and the number of observations is shown.

Table 2 shows that 41% of individuals reside in the health area of Badajoz, 26% in Cáceres, 18% in Navalmoral de la Mata, and the remaining 16% in Zafra-Llerena. The average age of the sample is 36.5 years, with 80% of individuals between 30 and 45. 13% of the participants have no formal education, 38% have a primary school and 24% have a secondary school. Finally, 58% of the sample is unemployed and 16% are employed.

In relation to the outcome indicators, the average score on the anxiety and depression scale is 12.72 points[21]. On the suicide risk scale, 3.8 points, below the cut-off point (6 points). The average physical activity is 1,933.18[22]. On the other hand, the indicators of residential exclusion and barriers to employment, constructed using Anderson's method (2008), have zero as the average. The average self-reported hours worked and monthly self-reported wage income among working participants is €21.8 and €558.71, respectively, while, in estimated values (i.e., considering a value of 0 for non-working participants), it is €4.01 and €102.73; on the other hand, the average number of FTE days worked in July 2023 is 1.87[23]. Finally, the average score on the quality of life, employability and employment expectations scales is, respectively, 73.51, 61.73 and 45.21.

Table 2: Descriptive statistics of the sample

Variable	Mean	Standard deviation	Minimum	Maximum	N
Badajoz	0.41	0.49	0	1	851
Cáceres	0.26	0.44	0	1	851
Navalmoral de la Mata	0.18	0.39	0	1	851
Zafra-Llerena	0.16	0.36	0	1	851
Age	36.49	6.62	18	53	704
Between 18 and 29 years old	0.17	0.37	0	1	704
Between 30 and 45 years old	0.8	0.4	0	1	704
Over 45 years	0.03	0.18	0	1	704
No education	0.13	0.33	0	1	707
Primary school	0.38	0.49	0	1	707

[21] The cut-off points refer to the subscales, with values below 7 being considered the absence of anxiety and depression.

[22] See footnote 13.

[23] It should be remembered that both indicators of job placement (self-reported hours worked and full-time equivalent days worked) differ both in the reference period and in the definition, as well as in the source of data. This gives rise to differences between them, which can be explained by the possible inclusion of informal employment in the self-reported indicator, the different employment situation depending on the reference period, or the lack of precision in the self-reported data.

Variable	Mean	Standard deviation	Minimum	Maximum	N
Secondary school	0.24	0.43	0	1	707
High school or equivalent	0.08	0.27	0	1	707
Intermediate vocational training	0.07	0.25	0	1	707
Higher Vocational Training	0.03	0.17	0	1	707
Higher education	0.07	0.25	0	1	707
Other	0.01	0.09	0	1	707
Higher to high school	0.25	0.43	0	1	707
Employed	0.16	0.37	0	1	707
Unemployed	0.58	0.49	0	1	707
Other employment situation	0.26	0.44	0	1	707
Anxiety and depression	12.72	9.04	0	42	706
Risk of suicide	3.80	3.43	0	15	705
Physical activity	1,933.18	3,053.06	0	32,880	704
Residential Exclusion	0.38	1	-1.08	2.13	707
Barriers to employment	0.53	1	-1.48	3.08	707
Self-reported hours worked in the last week	21.80	18.85	0	168	130
Self-reported wage income	558.71	332.21	0	1.300	130
Self-reported hours worked in the last week (imp)	4.01	11.68	0	168	707
Self-reported wage income (imp)	102.73	256.67	0	1.300	707
Quality of life	73.51	17.55	6.81	99.31	706
Employability	61.73	21.16	-23	99	707
Employment expectations	45.21	7.77	12	60	707
ETC days worked in July 2023	1.87	6.73	0	31	851

4.2 Random Assignment Results

The aim of the project was to reach 2,000 participants, women between 18 and 45 years old, recipients of the MIS or RG, with children at home, distributed in four health areas (Badajoz, Cáceres, Navalmoral de la Mata and Llerena-Zafra). Through recruitment, a total of 851 participants are reached. For logistical reasons and to draw conclusions about different types of territory (urban vs. rural), it was decided to randomize by health area, so that this is the only stratification variable. Although it was initially planned that treatment group 3 (which receives the complete Life Plan) would be larger, given that the sample size proved to be smaller than expected, it was decided that the four groups would have the same size to maximize statistical power and allow conclusions to be drawn.

After calculating the theoretical size of each group in each stratum, the participants were randomly assigned to the different treatment groups, until the theoretical group size in the stratum was reached, leaving the rest in the control group.

Table 3 shows the results of the random assignment, detailing the number of participants assigned to each group and breaking down this information according to the different health areas.

Table 3: Random assignment results

Health Area	CG	TG1	TG2	TG3	TOTAL
Badajoz	85	87	87	87	**346**
Caceres	53	55	55	55	**218**
Navalmoral de la Mata	38	39	39	39	**155**
Zafra-Llerena	33	33	33	33	**132**
TOTAL	**209**	**214**	**214**	**214**	**851**

To verify that the random assignment, explained in **section 3.5,** defines a control group and statistically comparable treatment groups, an equilibrium test is conducted to verify that, on average, the observable characteristics of the participants in both groups are similar. The balance between the experimental groups is key to be able to infer the causal effect of the program by comparing its results.

Figures 7 and **8**[24] show the results of the equilibrium contrasts between experimental groups. All data reflected in this figure refer to the survey conducted before the intervention (*baseline*). For each

[24] See **Table** in the Appendix relating to the **Among the relevant agents** for the implementation of the project are:

- **The Autonomous Region of Extremadura**, beneficiary entity and coordinator of the project through the Ministry of Health and Social Services, currently the Ministry of Health and Social Services.
- The three **Diocesan Caritas based in Extremadura**: Cáritas Diocesana Mérida-Badajoz, Cáritas Diocesana Plasencia, and Cáritas Diocesana Coria-Cáceres, in charge of the implementation of the interventions.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the project sponsor and the main responsible for the RCT evaluation process. For this purpose, the General Secretariat for Objectives and Policies of Inclusion and Social Provision (MISSM) undertakes the following commitments:
  a) Assist the beneficiary entity in the design of the activities to be conducted for the implementation and monitoring of the grant, as well as for the profiling of potential project participants in the pilot project.

observable variable, the difference between the mean of that variable in each treatment group and in the control group is represented by a dot and centered on it, the 95% confidence interval of this difference. A confidence interval containing zero (the vertical axis), will indicate that the mean difference between groups is not statistically significant, or in other words, it is not statistically different from zero. It will be concluded, therefore, that the intervention groups are balanced in this characteristic. In the case where the confidence interval of the mean difference does not contain zero, it can be concluded that the difference is statistically significant and, therefore, the groups are unbalanced in this characteristic.

Figure 7 and **Figure 8** show that the treatment and control groups are not statistically different in most variables. However, some imbalances were observed in the randomization, concerning the following sociodemographic variables:

- In terms of age, the control group has a higher proportion of women between 30 and 45 years old, while the three treatment groups have a higher proportion of women between 18 and 30 years old, with the significant difference being 10%.
- By educational level, treatment group 2 has a higher proportion of women with primary education than the control group and treatment group 1. Upon analyzing the comparison across all groups, an imbalance is observed for the group of people without education.
- Treatment groups 2 and 3 show a higher proportion of employed women than the control group while treatment group 2 exhibits a higher proportion of inactive women compared to the control group.

Regarding outcome indicators, this report observes imbalances in all indicators except for residential exclusion, self-reported wage income, employment expectations, and full-time equivalent days worked.

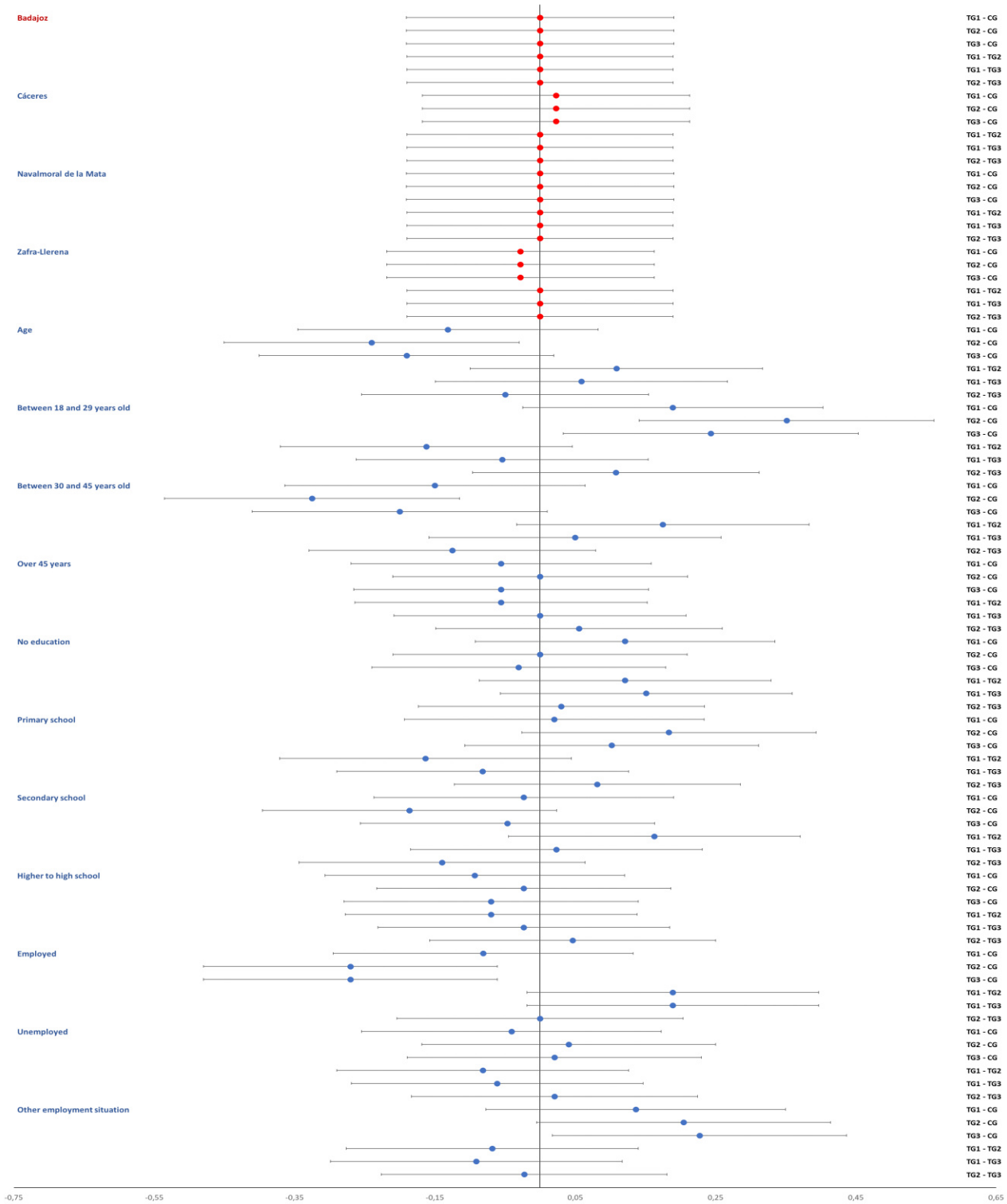
Therefore, in the regressions, this evaluation uses age, educational level, and occupation variables as controls, along with all but the three impact indicators for those without imbalance. Furthermore, this study includes the baseline indicator in the main specification.

b) Design the Randomized Controlled Trial (RCT) methodology of the pilot project in coordination with the beneficiary entity.
c) Evaluate the pilot project in coordination with the beneficiary entity.

- The **University of Extremadura** is a collaborating entity in the design and methodological definition of the tools required for the evaluation of the project.
- **CEMFI and J-PAL Europe**, as scientific and academic institutions supporting MISSM in the design and RCT evaluation of the project.

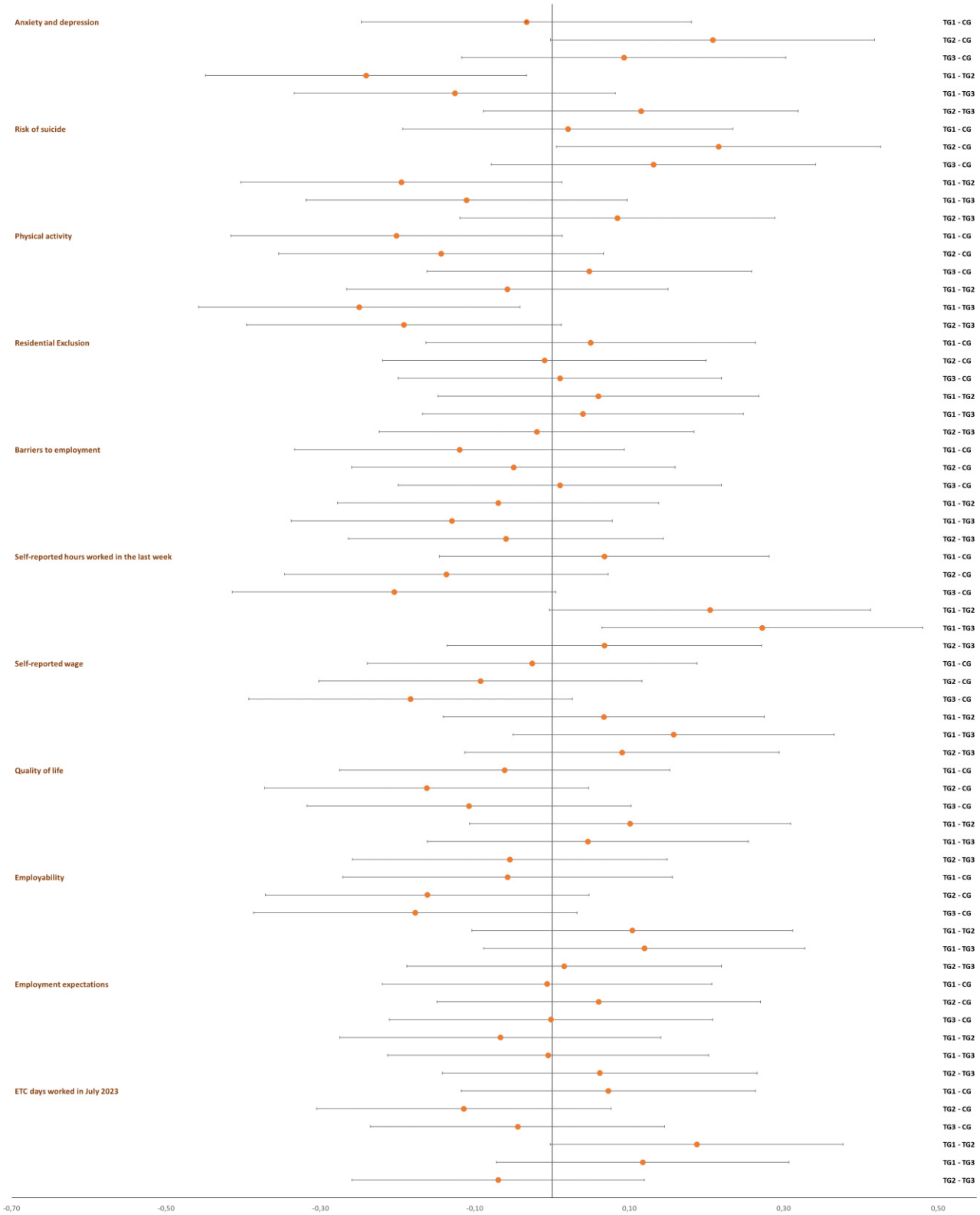
Balance between experimental groups**,** for the detail of the results of the balance tests.

Figure 7: Difference in standardized means between experimental groups – Sociodemographic variables (95% confidence interval)



Note: The stratification variables of the sample appear in red, while the other sociodemographic variables appear in blue.

Figure 8: Difference in standardized means between experimental groups – Outcome indicators (95% confidence interval)



4.3 Degree of participation and attrition by groups

The group signing the informed consent constitutes the experimental sample that was randomly assigned to the control and treatment groups. However, participation in the program and the response to the initial and final surveys are voluntary. On the one hand, it is convenient to analyze the degree of participation in the program, since the estimation of results will refer to the average effects of offering it, given the degree of participation. For example, if participation in treatment activities is low, the treatment and control groups will look very similar, and it will be harder to find an effect. On the other hand, this section checks whether the non-completion of the final survey by some of the participants reduces the comparability of the treatment and control groups after the intervention if the response rate is different between groups, or according to the demographic characteristics of the participants in each group.

Degree of participation

Firstly, all the women who have participated in the interventions have done so in the group that corresponded to them, except for one participant in treatment group 2 who has conducted activities in the socio-occupational field (reserved for participants in treatment groups 1 and 3).

Another important aspect to note is that, due to time constraints and the fact that the development of the itinerary was shorter than expected, the activities that were conducted in the health field in treatment group 3 (Comprehensive Life Plan) were not the same as those conducted in treatment group 2. Indeed, treatment group 2 received a series of actions with external professionals (psychologists, physiotherapists, among others) that were not available to the participants of group 3.

Table 4 shows that 53% of the participants assigned to treatment group 1, 50% of those assigned to treatment group 2, and 50% of those assigned to treatment group 3 participated in any of the activities.

Table 4: Degree of participation in activities (percentage over randomization)

	Participate in socio-labor activities	Participate in health activities	Participate in any of the activities
CG	0%	0%	0%
TG1	53%	0%	53%
TG2	0%	50%	50%
TG3	48%	45%	50%
Total	26%	24%	38%

On the other hand, **Table 5** shows that among the participants who responded to the endline survey, 20% of treatment group 1, 24% of treatment group 2, and 29% of treatment group 3 did not participate in any activity.

Table 5: Participation in activities

	Participate in activities		Do not participate in activities			
	PRE survey answered	POST survey answered	PRE survey answered	POST survey answered	% ERP responses that do not participate	% POST responses that do not participate
CG	0	0	166	96	100%	100%
TG1	113	80	58	20	34%	20%
TG2	106	82	79	26	43%	24%
TG3	102	80	83	33	45%	29%

Attrition by groups

Throughout the intervention, there were 434 dropouts, of which 144 did not respond to the baseline survey. Out of the 851 participants who were initially randomly assigned, a total of 707 completed the baseline survey (83%), while 417 completed the endline survey (49%).

Table 6: Participants with data at baseline/at the endline

Experimental group	Number of people			% on randomization		% active participants who do not respond POST
	Random assignment	PRE survey responded to	POST survey answered	PRE survey responded to	POST survey answered	
CG	209	166	96	79%	46%	0%
TG1	214	171	100	80%	47%	30%
TG2	214	185	108	86%	50%	23%
TG3	214	185	113	86%	53%	25%
Total	851	707	417	83%	49%	26%

Note: "Active participants" are those who have participated in at least one activity.

The attrition in the response to the endline is not unbalanced by groups, the difference is not significant (see **Table 7**). Regarding different sociodemographic variables and outcome indicators at baseline, there are generally no significant differences in attrition between groups in relation to these variables and indicators. This study observes some differences in attrition in treatment group 2 for the 30-45 age group and for the quality-of-life indicator (both at 10% significance) and in treatment groups 2 and 3 for the suicide risk indicator (see **Tables 17** and **18** in the **Appendix**).

Table 7: Attrition by experimental groups (general)

	(1)	(2)
Treatment	-0.04	
	(0.04)	
Social and Labor Treatment		-0.01
		(0.05)
Health Treatment		-0.05
		(0.05)
Complete Life Plan		-0.07
		(0.05)
N	851	851
R^2	0.00	0.00

Note: Significance ***=.01, **=.05, *=.1. The analysis uses robust standard errors.

5 Results of the evaluation

Random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable. Therefore, any differences observed after the intervention can be causally associated with the treatment. Econometric analysis provides, in essence, this comparison. Nevertheless, this analysis has the advantages of allowing other variables to be included to increase accuracy in the estimates and provide confidence intervals for the estimates. In this section, the econometric analysis and the estimated regressions are presented, as well as the analysis of the results obtained.

5.1 Description of the econometric analysis: estimated regressions

The regression model specified to estimate the causal effect in a randomized experiment is usually simply the difference in the variable of interest between the treatment group and the control group since these groups are statistically comparable thanks to the randomization performed at baseline. Additionally to this analysis, the following results are presented: (i) regressions in which it is controlled for variables that may vary between the treatment group and the control group and may affect the impact of the treatment and (ii) regressions in which, in addition to including the previous controls, the initial value of the dependent variable is included, that is, the value before the intervention, which improves the accuracy of the estimates. This ensures that differences between the treatment group and the control group before the intervention is performed are considered in the analysis.

Regressions are estimated as follows:

$$Y_{i,t=1} = \alpha + \beta T_i + \gamma Y_{i,t=0} + \delta X_{i,t=0} + \varepsilon_i$$

Where $Y_{i,t=1}$ is the dependent variable of interest observed after the intervention for person i; T_i indicates whether the person has been assigned to any of the three treatment groups (=1) or to the control group (=0), $Y_{i,t=0}$ it is the initial value of the dependent variable (i.e., before the intervention), $X_{i,t=0}$ it is a vector of controls (sociodemographic variables) and ε_i it is the error term. In this case, the effect of participating in any of the three interventions versus control is being estimated.

Additionally, regressions are estimated as follows:

$$Y_{i,t=1} = \alpha + \beta_1 T_{1_i} + \beta_2 T_{2_i} + \beta_3 T_{3_i} + \gamma Y_{i,t=0} + \delta X_{i,t=0} + \varepsilon_i$$

Where $Y_{i,t=1}$ is the dependent variable of interest observed after the intervention for person i; T_{K_i} indicates that the person has been assigned to the treatment group K (=1) or not (=0), $Y_{i,t=0}$ is the baseline value of the dependent variable (i.e., before the intervention), $X_{i,t=0}$ is a vector of controls (sociodemographic variables), and ε_i is the error term. In this case, the effect of participating in each of the treatment groups separately is estimated.

Robust/clustered standard errors have been employed at the health area level. All specifications with controls include variables of age, education level, and occupation, as well as unbalanced impact indicators at baseline (excluding residential exclusion, wage income, employment expectations, and full-time equivalent days worked).

5.2 Analysis of the results

5.2.1 Primary and secondary outcomes

This section presents the results of the analysis of the contrast of the hypotheses presented above, following the structure of the evaluation scheme. As noted, this analysis presents three specifications for each variable: (i) without controls, (ii) with controls, and (iii) with controls and with the value of the variable of interest at baseline.

Social inclusion

Table 8 presents the results for the residential exclusion indicator. The first three columns show the results of the three treatment groups considered together versus the control, while the next three show the impact of each treatment group in a differentiated way. This report does not observe significant effects in any of the specifications.

Table 8: Effects on social inclusion

	(1)	(2)	(3)	(4)	(5)	(6)
Treatment (TG1+TG2+TG3)	0.04	0.02	0.04			
	(0.09)	(0.10)	(0.07)			
Social and Labor Treatment				-0.02	-0.02	-0.01
				(0.10)	(0.11)	(0.05)
Health Treatment				0.08	-0.00	0.07

				(0.13)	(0.10)	(0.07)
Complete Life Plan				0.04	-0.03	-0.06
				(0.10)	(0.05)	(0.11)
N	418	416	416	418	415	415
R^2	0.00	0.05	0.43	0.00	0.24	0.46
CG Dependent Variable Mean	1.11	1.11	1.11	1.11	1.11	1.11
Controls	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.65	0.87	0.74
Treatment Health = Life Plan				0.56	0.70	0.32
Treat. Socio-labor = Treat. Health				0.49	0.87	0.49

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Quality of life, self-esteem, and attitudes towards life

Table 9 displays the effects on the quality-of-life indicator. This study observes a positive and significant impact of 10% in this indicator of 4.75% for treatment group 1 (socio-occupational) compared to the control group. This impact is maintained across all specifications (no controls, with controls, and with controls and the indicator value at baseline). This study does not observe any impact in the other groups, in which the coefficients of the indicator are of lesser magnitude or of the opposite sign and statistically different from treatment group 1.

Table 9: Effects on quality of life

	(1)	(2)	(3)	(4)	(5)	(6)
Treatment (TG1+TG2+TG3)	-2.01	-1.88	0.41			
	(2.20)	(2.18)	(1.07)			
Social and Labor Treatment				3.16**	3.51**	3.51**
				(0.85)	(1.06)	(1.06)
Health Treatment				-4.87	0.42	0.42
				(2.91)	(0.58)	(0.58)
Complete Life Plan				-3.90	-0.91	-0.91
				(2.75)	(1.91)	(1.91)
N	418	416	416	418	415	415
R^2	0.00	0.04	0.65	0.03	0.67	0.67
CG Dependent Variable Mean	74.19	73.96	73.96	74.19	73.96	73.96
Controls	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.05	0.05	0.05
Treatment Health = Life Plan				0.55	0.44	0.44
Treat. Socio-labor = Treat. Health				0.03	0.07	0.07

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Table 10 shows the results on the indicators of anxiety and depression. No significant effects are observed in either of the specifications for either of the two indicators.

Table 10: Effects on anxiety and depression

	Anxiety and depression						Risk of suicide					
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Treatment (TG1+TG2+TG3)	1.35	1.30	0.72				0.87	0.89	0.05			
	(1.15)	(1.21)	(0.44)				(0.44)	(0.40)	(0.19)			
Social and Labor Treatment				-0.99	-0.72	-0.72				-0.01	-0.33	-0.33
				(0.70)	(0.61)	(0.61)				(0.03)	(0.32)	(0.32)
Health Treatment				3.04	0.58	0.58				1.32	0.06	0.06
				(1.61)	(0.41)	(0.41)				(0.62)	(0.11)	(0.11)
Complete Life Plan				1.82	0.71	0.71				1.21	0.29	0.29
				(1.16)	(0.54)	(0.54)				(0.60)	(0.30)	(0.30)
N	418	416	416	418	415	415	418	416	416	418	415	415
R^2	0.00	0.02	0.57	0.03	0.61	0.61	0.01	0.05	0.70	0.03	0.72	0.72
CG Dependent Variable Mean	12.49	12.62	12.62	12.49	12.62	12.62	3.18	3.19	3.19	3.18	3.19	3.19
Controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.04	0.02	0.02				0.12	0.11	0.11
Treatment Health = Life Plan				0.16	0.86	0.86				0.63	0.46	0.46
Treat. Socio-labor = Treat. Health				0.05	0.19	0.19				0.11	0.30	0.30

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Finally, **Table 11** shows the results of the physical activity indicator. In this case, the analysis does not show any significant effects in any of the specifications.

Table 11: Effects on physical activity

	(1)	(2)	(3)	(4)	(5)	(6)
Treatment (TG1+TG2+TG3)	-428.63	-436.41	-472.95			
	(621.22)	(584.18)	(513.29)			
Social and Labor Treatment				-560.72	-559.76	-559.76
				(312.90)	(332.33)	(332.33)
Health Treatment				-706.04	-556.23	-556.23
				(1.019.11)	(865.94)	(865.94)
Complete Life Plan				-45.43	-296.85	-296.85

				(559.33)	(519.15)	(519.15)
N	418	416	415	418	415	415
R^2	0.01	0.13	0.26	0.02	0.29	0.29
CG Dependent Variable Mean	2,054.27	1,982.16	1,982.16	2,054.27	1,982.16	1,982.16
Controls	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.22	0.35	0.35
Treatment Health = Life Plan				0.26	0.51	0.51
Treat. Socio-labor = Treat. Health				0.86	1.00	1.00

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Employability

Table 12 displays the effects on the employability indicator. A positive impact of 10.1%, significant at 5%, was observed on employability in treatment group 2 (health). This impact remains consistent in all three specifications, although it loses statistical significance when including baseline outcome indicators values as controls (column 4). Treatment group 1 has a positive but not significant coefficient in this indicator, although the Wald test shows that it cannot be said that the coefficients of treatment groups 1 and 2 are different.

Table 12: Effects on employability

	(1)	(2)	(3)	(4)	(5)	(6)
Treatment (TG1+TG2+TG3)	0.83	2.55	4.15			
	(2.42)	(2.11)	(2.72)			
Social and Labor Treatment				5.03	7.87	7.87
				(4.02)	(4.87)	(4.87)
Health Treatment				2.47*	6.85**	6.85**
				(1.02)	(1.72)	(1.72)
Complete Life Plan				-4.48	-0.16	-0.16
				(2.42)	(2.43)	(2.43)
N	418	416	416	418	415	415
R^2	0.00	0.14	0.34	0.03	0.38	0.38
CG Dependent Variable Mean	67.07	66.89	66.89	67.07	66.89	66.89
Controls	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.01	0.06	0.06

Treatment Health = Life Plan	0.03	0.10	0.10
Treat. Socio-labor = Treat. Health	0.51	0.84	0.84

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Table 13 presents the results on the secondary indicators of employability. A positive impact of 1.6%, significant at 10%, is observed on the employment expectations indicator when considering the three treatments together compared to the control. This impact loses its significance in the rest of the specifications and is not observed in a disaggregated manner by treatments.

Table 13: Effects on secondary employability hypotheses

	Self-perception of barriers to employment						Employment expectations					
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Treatment (TG1+TG2+TG3)	0.30	0.26	0.30				0.43	0.96	0.82*			
	(0.16)	(0.17)	(0.15)				(0.33)	(0.41)	(0.30)			
Social and Labor Treatment				0.22	0.29	0.29				1.75	2.50	2.50
				(0.15)	(0.15)	(0.15)				(0.91)	(1.44)	(1.44)
Health Treatment				0.26	0.14	0.14				0.29	1.25	0.72
				(0.13)	(0.10)	(0.10)				(0.70)	(1.05)	(0.95)
Complete Life Plan				0.42	0.35	0.35				-0.62	0.37	-0.20
				(0.21)	(0.15)	(0.15)				(0.78)	(0.65)	(0.48)
N	418	416	416	418	415	415	418	416	416	418	415	415
R^2	0.02	0.06	0.40	0.02	0.43	0.43	0.00	0.06	0.24	0.01	0.13	0.27
CG Dependent Variable Mean	1.34	1.34	1.34	1.34	1.34	1.34	45.48	45.36	45.36	45.48	45.36	45.36
Controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.30	0.71	0.71				0.19	0.34	0.21
Treatment Health = Life Plan				0.24	0.19	0.19				0.31	0.35	0.36
Treat. Socio-labor = Treat. Health				0.59	0.13	0.13				0.38	0.58	0.45

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Job placement

Table 14 presents the results on the indicators of job placement. The indicator of hours worked in the previous week shows a positive impact of 67.4% when considering the three treatments together compared to the control, significant at 10%. This impact loses significance when analyzed in each group separately and in the specification without controls. However, the coefficients of the indicator for the analysis by separate groups show the same sign and magnitude, and the Wald test shows that they are not different from each other, indicating that, although less significant, the impact is

maintained. On the other hand, the indicator of full-time equivalent days worked in November 2023 does not show any significant effect on any of the specifications or groups. It should be remembered that both indicators of job placement differ both in the reference period and in the definition, as well as in the source of data. This gives rise to differences between them, which can be explained by the possible inclusion of informal employment in the self-reported indicator, the different employment situation depending on the reference period, or the lack of precision in the self-reported data.

Table 14: Effects on labor market insertion

	Self-reported hours worked in the last week						ETC days worked in November 2023					
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Treatment (TG1+TG2+TG3)	0.96	1.51*	1.50*				0.05	-0.03	-0.03			
	(0.54)	(0.51)	(0.50)				(0.07)	(0.32)	(0.32)			
Social and Labor Treatment				1.87	1.13	1.13				0.52	-0.07	-0.07
				(0.98)	(0.71)	(0.71)				(0.60)	(0.70)	(0.70)
Health Treatment				0.48	1.29	1.29				-0.45	-0.04	-0.04
				(0.27)	(0.66)	(0.66)				(0.36)	(0.25)	(0.25)
Complete Life Plan				0.61	1.59	1.59				0.06	0.08	0.08
				(1.23)	(0.83)	(0.83)				(0.47)	(0.14)	(0.14)
N	418	416	416	418	415	415				851	700	700
R^2	0.00	0.25	0.25	0.01	0.28	0.28				0.00	0.55	0.55
CG Dependent Variable Mean	2.25	2.27	2.27	2.25	2.27	2.27				1.80	2.02	2.02
Controls	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Var. Baseline	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.45	0.59	0.59				0.68	0.85	0.85
Treatment Health = Life Plan				0.93	0.81	0.81				0.53	0.71	0.71
Treat. Socio-labor = Treat. Health				0.31	0.91	0.91				0.27	0.95	0.95

Note Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

Finally, **Table 15** presents the effects on job quality. The self-reported monthly wage income indicator shows a positive impact of 74.4% when considering the three treatments together compared to the control, significant at 1%. This impact is maintained across all specifications (with controls and delay, with controls and without controls). If analyzed in each group separately, the coefficient of the indicator is in all cases positive, although the impact is only significant for treatment group 3. The coefficients for treatment groups 1 and 2 are of lesser magnitude and not significant, although Wald's test does not allow a statistical distinction between the three.

Table 15: Effects on job quality

	(1)	(2)	(3)	(4)	(5)	(6)
Treatment (TG1+TG2+TG3)	26.87***	41.71***	40.74***			
	(4.32)	(4.84)	(3.33)			
Social and Labor Treatment				52.86	33.97*	33.93
				(23.90)	(13.27)	(15.42)
Health Treatment				8.10	27.57	22.86
				(17.01)	(23.61)	(26.28)
Complete Life Plan				21.59	46.85**	44.55**
				(18.10)	(13.10)	(12.43)
N	418	416	416	418	415	415
R^2	0.00	0.20	0.20	0.01	0.23	0.24
CG Dependent Variable Mean	54.46	55.03	55.03	54.46	55.03	55.03
Controls	No	Yes	Yes	No	Yes	Yes
Delay	No	No	Yes	No	No	Yes
Social and Labor Treatment = Life Plan				0.43	0.58	0.67
Treatment Health = Life Plan				0.69	0.50	0.50
Treat. Socio-labor = Treat. Health				0.31	0.87	0.80

Note: Significance: ***=0.01, **=0.05, *=0.1. The analysis uses robust/clustered standard errors at the health area level.

6 Conclusions of the evaluation

The purpose of this report is to evaluate the impact of the "Social Inclusion Life Plan" project, which offers personalized and comprehensive support in the socio-labor and health fields to women aged between 18 and 45, responsible for children and beneficiaries of the Extremadura Guaranteed Income or the Minimum Income Scheme. It should be noted that the intervention was shorter than initially

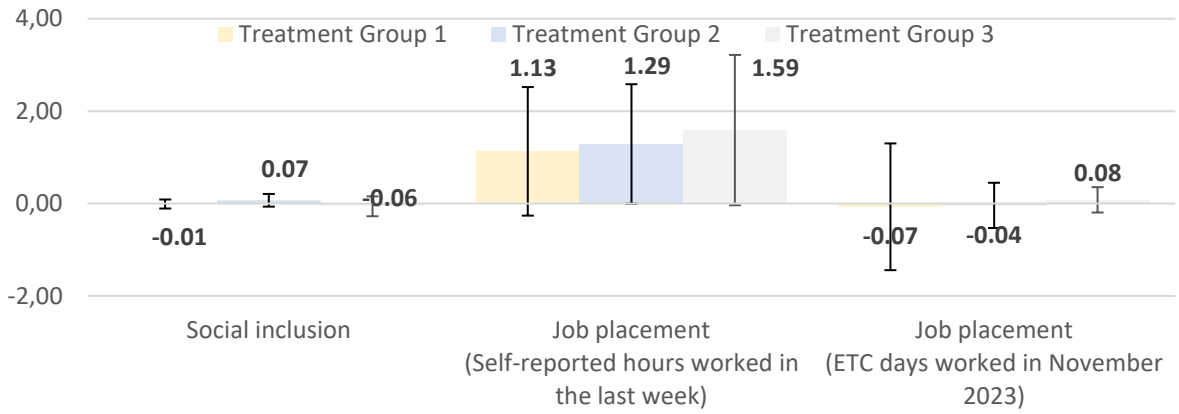
planned and that the activities conducted in each of the axes of action (socio-occupational and health) in the different treatment areas were not the same, contrary to what was planned in the original design.

The evaluation impact results indicate that the intervention has significant effects on quality of life, employability, employment expectations, job placement, and job quality.

Particularly, this study exhibits a positive and significant impact of 4.75% in the quality-of-life indicator for the socio-occupational treatment group. Regarding employability, the analysis exposes a positive and significant impact of 10.1% in the health treatment group. On the other hand, this evaluation also shows a positive impact of 2% on employment expectations if the three treatments were considered together compared to the control, which is not observed in a disaggregated manner by treatments. Regarding job placement, the report exposes a positive and significant impact of 67% for the three treatments together compared to control in the number of hours worked in the previous week (1.53 hours more). This evaluation does not exhibit a positive effect when analyzing data from administrative records of working lives. Lastly, this analysis displays a positive and significant impact across the three treatments together compared to the control in the monthly salary of 40.92 euros (74% increase). Specifically, if analyzed in each group separately, the indicator coefficient is in all cases positive and is significant for treatment group 3. rest of the indicators did not show any other significant impact.

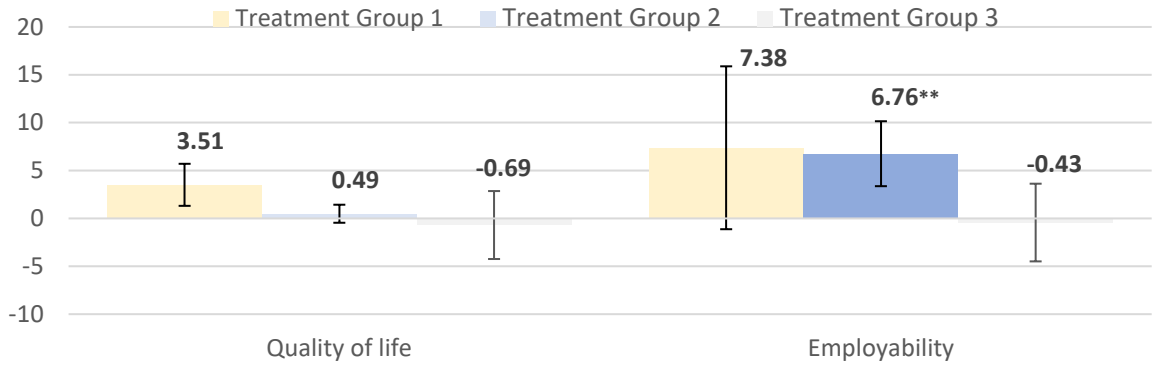
Figure 9 and **figure 10** present the intervention's effect on the primary outcome indicators across the four areas of analysis, presented in two different graphs for clarity.

Figure 9: Effect of the intervention on primary outcome indicators (social inclusion and job placement)



Note: In dark color are presented the indicators whose treatment effect is significant at 1%; in color of intermediate shade, indicators whose treatment effect is significant at 10%; and in light color those whose treatment effect is not significant. The effects included in the graphs refer to regressions with controls and with the initial value of the dependent variable.

Figure 10: Effect of the intervention on primary outcome indicators (quality of life and employability)



Note: In dark color are presented the indicators whose treatment effect is significant at 1%; in color of intermediate shade, indicators whose treatment effect is significant at 5%; and in light color those whose treatment effect is not significant. The effects included in the graphs refer to regressions with controls and with the initial value of the dependent variable.

Figure 11 shows the effect of the intervention on primary outcome indicators for the three treatment groups taken as a whole.

Figure 11: Effect of the intervention on primary outcome indicators for the three treatment groups taken together

Note: in dark color are presented the indicators whose treatment effect is significant at 1%; in color of intermediate shade, indicators whose treatment effect is significant at 10%; and in light color those whose treatment effect is not significant. The effects included in the graphs refer to regressions with controls and with the initial value of the dependent variable.

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Appendix

Economic and regulatory management

1. Introduction

Within the framework of the National Recovery, Transformation, and Resilience Plan, the General Secretariat of Inclusion (SGI) of the Ministry of Inclusion, Social Security and Migrations plays a relevant role in Component 23 "New public policies for a dynamic, resilient, and inclusive labor market," framed within Policy Area VIII "New care economy and employment policies".

Investment 7 "Promotion of Inclusive Growth by linking socio-labor inclusion policies to the Minimum Income Scheme" is one of the reforms and investments proposed in this Component 23. Investment 7 promotes the implementation of a new model of inclusion based on the Minimum Income Scheme (MIS), which reduces income inequality and poverty rates. To achieve this objective, the development of pilot projects has been proposed, among others, for the implementation of social inclusion pathways with the autonomous communities and cities, local entities, and Third Sector of Social Action entities, as well as with the different social agents.

Royal Decree 938/2021, of October 26, 2021, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of 109,787,404 euros, within the framework of the Recovery, Transformation and Resilience Plan[25] contributed to meeting milestone 350 for the first quarter of 2022 as outlined in the Council's Implementing Decision: "Improve the rate of access to the Minimum Income Scheme, and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to conduct the itineraries. The objectives of these partnership agreements are: (i) improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies". Likewise, along with Royal Decree 378/2022, of May 17[26], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and organizations of the Third Sector of Social Action to implement pilot projects to support the socio-economic inclusion of the beneficiaries of MIS through itineraries" contributed to compliance with

[25] https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-17464

[26] https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-8124

monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document.[27]

In addition, after the implementation and evaluation of each of the subsidized pilot projects, an evaluation will be conducted to assess the coverage, effectiveness, and success of the minimum income schemes. The publication of this evaluation, which will include specific recommendations to improve the rate of access to benefits and improve the effectiveness of social inclusion policies, contributes to the achievement of milestone 351 of the Recovery, Transformation and Resilience Plan scheduled for the first quarter of 2024.

In accordance with Article 3 of Royal Decree 938/2021, dated October 26, subsidies will be granted through a resolution accompanied by an agreement of the head of the Ministry of Inclusion, Social Security and Migration as the competent authority for granting them, without prejudice to the existing delegations of competence in the matter, upon request by the beneficiary organizations.

On **December 27, 2021**, the Autonomous Region of Extremadura was notified of the Resolution of the General Secretariat for Objectives and Policies of Inclusion and Social Security, granting a subsidy in the amount of **8,803,049.27 euros** to the Autonomous Region of Extremadura. On **January 27, 2022,** an Agreement was signed between the General State Administration, through the General Secretariat for Inclusion and Social Welfare Objectives and Policies and the Autonomous Region of Extremadura for the implementation of a social inclusion project within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Boletín Oficial del Estado" on February 21, 2022 (BOE no. 44)[28].

2. Timeline of the intervention

Article 16(1) of Royal Decree 938/2021 of October 26, 2021 established that the deadline for the implementation of the pilot projects of social inclusion itineraries subject to the subsidies provided for in this text shall not exceed the deadline of June 30, 2023, while the evaluation shall not extend beyond March 31, 2024, in order to comply with the milestones set by the Recovery, Transformation and Resilience Plan with regard to social inclusion polices.

However, in accordance with section 2 of the first final provision of Royal Decree 378/2022, of May 17, section 4 of article 6 and section 16 of article 16 are reworded, to extend the maximum period of the pilot projects of social inclusion itineraries subject to subsidies until **October 31, 2023,** maintaining the deadline **of March 31, 2024,** for its evaluation.

On **July 26, 2022,** the Autonomous Region of Extremadura requested an extension of the implementation period until **October 31, 2023**, authorizing it by resolution of the SGOPIPS dated

[27] Decision of the European Commission approving the document Operational Provisions of the Recovery, Transformation and Resilience Plan, which can be consulted at the following link: https://www.lamoncloa.gob.es/serviciosdeprensa/notasprensa/hacienda/Documents/2021/101121-CountersignedESFirstCopy.pdf

[28] https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-2776

August 15, 2022. Likewise, on March 31, 2023, it requested an extension of the execution period until **December 31, 2023**, which was denied by means of a resolution of the SGOPIPS dated April 19, 2023, as the requested deadline exceeded the established deadline.

Within this general timeframe, the implementation begins on **August 10, 2023**, with the start of the intervention itinerary, continuing the execution tasks until **October 31, 2023**, and then developing only dissemination and evaluation tasks of the project until **March 31, 2024**.

3. **Relevant Agents**

Among the relevant agents for the implementation of the project are:

- **The Autonomous Region of Extremadura**, beneficiary entity and coordinator of the project through the Ministry of Health and Social Services, currently the Ministry of Health and Social Services.
- The three **Diocesan Caritas based in Extremadura**: Cáritas Diocesana Mérida-Badajoz, Cáritas Diocesana Plasencia, and Cáritas Diocesana Coria-Cáceres, in charge of the implementation of the interventions.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the project sponsor and the main responsible for the RCT evaluation process. For this purpose, the General Secretariat for Objectives and Policies of Inclusion and Social Provision (MISSM) undertakes the following commitments:
  a) Assist the beneficiary entity in the design of the activities to be conducted for the implementation and monitoring of the grant, as well as for the profiling of potential project participants in the pilot project.
  b) Design the Randomized Controlled Trial (RCT) methodology of the pilot project in coordination with the beneficiary entity.
  c) Evaluate the pilot project in coordination with the beneficiary entity.
- The **University of Extremadura** is a collaborating entity in the design and methodological definition of the tools required for the evaluation of the project.
- **CEMFI and J-PAL Europe**, as scientific and academic institutions supporting MISSM in the design and RCT evaluation of the project.

Balance between experimental groups

The following table reports the balance contrasts between the control group and the treatment group. All the data reflected in this table refer to the survey conducted before the intervention. This table reports the mean value of each variable for both groups, as well as the number of observations in each group and the p-value resulting from a contrast of mean difference (using Student's t-statistic). The lower the p-value, the more confidently one can reject the hypothesis that the mean of the variable in both groups is equal. For example, if the p-value is less than 0.05, the hypothesis of equality of means at a confidence level of 5% can be rejected.

Table 16: Equilibrium tests between experimental groups

Variable	(1) GC Mean/(Var)	(2) GT1 Mean/(Var)	(3) GT2 Mean/(Var)	(4) GT3 Mean/(Var)	Balance between all groups F/p-value statistic	(1)-(2) P-Value	(1)-(3) P-Value	(1)-(4) P-Value	(2)-(3) P-Value	(2)-(4) P-Value	(3)-(4) P-Value
Badajoz	0.41	0.41	0.41	0.41	0.00	0.95	0.95	0.95	1.00	1.00	1.00
	(16.81)	(17.21)	(17.21)	(17.21)	0.95						
Cáceres	0.25	0.26	0.26	0.26	1.64	0.29	0.29	0.29	.	.	.
	(13.19)	(13.62)	(13.62)	(13.62)	0.29						
Navalmoral de la Mata	0.18	0.18	0.18	0.18	0.14	0.74	0.74	0.74	.	.	.
	(10.36)	(10.63)	(10.63)	(10.63)	0.74						
Zafra-Llerena	0.16	0.15	0.15	0.15	1.09	0.37	0.37	0.37	.	.	.
	(9.26)	(9.30)	(9.30)	(9.30)	0.37						
Age	37.45	36.58	35.86	36.19	35.87***	0.02**	0.26	0.15	0.54	0.54	0.57
	(1,907.60)	(2,331.89)	(3,157.87)	(2,800.78)	0.01						
Between 18 and 29 years old	0.09	0.16	0.22	0.18	3.88	0.07*	0.05*	0.05*	0.16	0.41	0.32
	(4.55)	(7.81)	(10.62)	(9.24)	0.15						
Between 30 and 45 years old	0.87	0.81	0.74	0.79	3.20	0.31	0.07*	0.15	0.19	0.36	0.23
	(6.36)	(8.88)	(11.83)	(10.24)	0.18						
Over 45 years	0.04	0.03	0.04	0.03	2.79	0.64	0.80	0.55	0.55	0.85	0.24
	(2.23)	(1.62)	(2.24)	(1.62)	0.21						
No education	0.12	0.16	0.12	0.11	35.89***	0.41	0.95	0.46	0.33	0.14	0.61
	(5.86)	(7.58)	(6.46)	(5.95)	0.01						
Primary school	0.34	0.35	0.43	0.39	33.54***	0.93	0.05**	0.26	0.06*	0.41	0.56
	(12.48)	(12.88)	(15.14)	(14.73)	0.01						
Secondary school	0.27	0.26	0.19	0.25	1.51	0.96	0.21	0.79	0.22	0.76	0.14
	(10.78)	(11.05)	(9.46)	(11.69)	0.37						
Higher to high school	0.27	0.23	0.26	0.24	0.89	0.45	0.74	0.69	0.69	0.88	0.75
	(10.93)	(10.21)	(11.85)	(11.35)	0.54						
Employed	0.22	0.19	0.12	0.12	131.51***	0.62	0.01**	0.02**	0.14	0.36	1.00
	(9.58)	(8.88)	(6.46)	(6.46)	0.00						
Unemployed	0.58	0.56	0.60	0.59	3.29	0.66	0.37	0.94	0.50	0.75	0.85
	(13.44)	(14.07)	(14.80)	(14.93)	0.18						
Other employment situation	0.19	0.25	0.28	0.29	14.92**	0.31	0.04**	0.18	0.48	0.28	0.76
	(8.61)	(10.73)	(12.46)	(12.75)	0.03						
Anxiety and depression	12.08	11.78	13.96	12.92	10.74**	0.68	0.32	0.58	0.14	0.22	0.21
	(4,398.27)	(4,523.00)	(5,362.55)	(4,736.31)	0.04						
Risk of suicide	3.47	3.54	4.21	3.92	6.48*	0.66	0.31	0.46	0.25	0.40	0.32
	(642.38)	(655.47)	(751.40)	(691.93)	0.08						
Physical activity	2,158.45	1,542.82	1,719.72	2,305.67	34.02***	0.05**	0.15	0.70	0.23	0.03**	0.05*
	(7.05e+08)	(3.72e+08)	(3.43e+08)	(7.42e+08)	0.01						

Residential Exclusion	0.37	0.42	0.36	0.38	0.14	0.71	0.90	0.95	0.64	0.79	0.92
	(56.33)	(60.29)	(59.68)	(58.93)	0.93						
Barriers to employment	0.57	0.45	0.52	0.58	22.32**	0.13	0.65	0.92	0.43	0.32	0.19
	(58.02)	(56.65)	(65.02)	(55.01)	0.01						
Self-reported hours worked in the last week	4.86	5.65	3.26	2.47	12.72**	0.48	0.07*	0.02**	0.07*	0.10	0.42
	(7,518.84)	(15,627.18)	(5,107.34)	(3,450.70)	0.03						
Self-reported wage	122.88	116.25	99.08	75.82	1.94	0.84	0.28	0.20	0.44	0.43	0.54
	(4.37e+06)	(4.00e+06)	(4.38e+06)	(2.68e+06)	0.30						
Quality of life	75.01	73.93	72.16	73.12	9.48**	0.52	0.42	0.53	0.54	0.72	0.14
	(16,512.25)	(20,058.37)	(18,648.48)	(16,932.72)	0.05						
Employability	63.90	62.68	60.48	60.15	17.69**	0.43	0.04**	0.14	0.30	0.19	0.91
	(25,040.15)	(23,088.98)	(30,161.39)	(26,479.02)	0.02						
Employment expectations	45.10	45.05	45.57	45.09	0.16	0.88	0.65	0.96	0.61	0.92	0.58
	(2,846.42)	(3,444.54)	(4,088.47)	(3,816.21)	0.92						
ETC days worked in July 2023	2.02	2.51	1.25	1.72	1.20	0.23	0.30	0.65	0.26	0.39	0.65
	(3,167.55)	(4,545.42)	(2,127.43)	(2,936.06)	0.44						

Attrition by groups

Table 17: Attrition by experimental groups (joint treatment)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
Treatment														0.01	0.07	0.01	-0.03
														(0.10)	(0.22)	(0.09)	(0.10)
Treatment*Anxiety and depression	-0.00																
	(0.00)																
Treatment*Risk of suicide		-0.03**															
		(0.01)															
Treatment*Physical activity			-0.00														
			(0.00)														
Treatment*Residential Exclusion				0.03													
				(0.04)													
Treatment*Barriers to Employment					-0.00												
					(0.04)												
Treatment*Hours worked in the last week						-0.00											
						(0.01)											
Treatment*Salary							-0.00										
							(0.00)										
Treatment*Hours worked in the last week (imp)								-0.00									
								(0.00)									
Treatment*Salary (imp)									-0.00								
									(0.00)								
Treatment*Quality of life										0.00							
										(0.00)							
Treatment*Employability											0.00						
											(0.00)						
Treatment*Employment Expectations												0.00					
												(0.01)					
Treatment*part_num													0.00				
													(.)				
Treatment*Badajoz														-0.06			

														(0.12)				
Treatment*Cáceres														-0.08				
														(0.13)				
Treatment*Navalmoral de la Mata														-0.05				
														(0.13)				
Treatment*Zafra-Llerena														0.00				
														(.)				
Treatment*Between 18 and 29 years old															-0.05			
															(0.26)			
Treatment*Between 30 and 45 years old															-0.12			
															(0.22)			
Treatment*Over 45 years old															0.00			
															(.)			
Treatment*No education																-0.01		
																(0.15)		
Treatment*Primary school																-0.03		
																(0.11)		
Treatment*Secondary school																0.00		
																(.)		
Treatment*High school																0.00		
																(.)		
Treatment*Employed																	-0.09	
																	(0.14)	
Title*Unemployed																	0.05	
																	(0.11)	
Title*Other employment status																	0.00	
																	(.)	
N	706	705	704	707	707	130	130	707	707	706	707	707	851	851	704	707	707	
R^2	0.02	0.03	0.02	0.02	0.01	0.01	0.01	0.00	0.00	0.00	0.02	0.00	0.18	0.04	0.04	0.01	0.01	

Note: Significance ***=.01, **=.05, *=.1. The analysis uses robust standard errors.

Table 18: Attrition by experimental groups (separate treatments)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
Social and Labor Treatment														-0.03	-0.29	0.02
														(0.12)	(0.28)	(0.11)
Social and Occupational Treatment*Anxiety and depression	0.00															
	(0.01)															
Health Treatment														-0.03	0.43*	-0.04
														(0.12)	(0.26)	(0.10)
Treatment Health*Anxiety and depression	-0.00															
	(0.01)															
Complete Life Plan														0.09	-0.09	0.04
														(0.12)	(0.28)	(0.10)
Complete Life Plan*Anxiety and depression	-0.00															
	(0.01)															
Social and Occupational Treatment*Risk of suicide		-0.01														
		(0.02)														
Treatment Health*Risk of suicide		-0.04***														
		(0.02)														
Complete Life Plan*Risk of suicide		-0.04**														
		(0.02)														
Social and Occupational Treatment*Physical Activity			-0.00													
			(0.00)													
Treatment Health*Physical Activity			-0.00													
			(0.00)													
Complete Life Plan*Physical Activity			-0.00													
			(0.00)													
Social and Labor Treatment*Residential Exclusion				0.05												
				(0.05)												

Treatment Health*Residential Exclusion	0.06								
	(0.05)								
Whole Life Plan*Residential Exclusion	-0.01								
	(0.05)								
Social and Labor Treatment*Barriers to employment		0.01							
		(0.05)							
Treatment Health*Barriers to Employment		-0.04							
		(0.05)							
Complete Life Plan*Barriers to employment		0.03							
		(0.05)							
Social and Labor Treatment*Hours worked in the last week			0.00						
			(0.01)						
Health Treatment*Hours worked in the last week			-0.00						
			(0.01)						
Complete Life Plan*Hours worked in the last week			-0.01						
			(0.01)						
Social and Labor Treatment*Salary				-0.00					
				(0.00)					
Treatment Health*Salary				-0.00					
				(0.00)					
Complete Life Plan*Salary				-0.00					
				(0.00)					
Social and Labor Treatment*Hours worked in the last week (imp)					-0.00				
					(0.00)				
Health Treatment*Hours worked in the last week (imp)					-0.00				
					(0.01)				
Complete Life Plan*Hours worked in the last week (imp)					-0.00				
					(0.01)				
Social and Labor Treatment*Salary (imp)						-0.00			
						(0.00)			
Treatment Health*Salary (imp)						-0.00			
						(0.00)			
Complete Life Plan*Salary (imp)						-0.00			
						(0.00)			
Social and Labor Treatment*Quality of Life							-0.00		
							(0.00)		
Treatment Health*Quality of life							0.01*		
							(0.00)		
Complete Life Plan*Quality of life							0.00		
							(0.00)		
Social and Labor Treatment*Employability								0.00	
								(0.00)	
Health Treatment*Employability								0.00	
								(0.00)	
Complete Life Plan*Employability								0.00	
								(0.00)	
Social and Labor Treatment*Employment Expectations									0.00
									(0.01)
Treatment Health*Employment Expectations									0.01
									(0.01)
Complete Life Plan*Employment Expectations									-0.00

						(0.01)
Social and Labor Treatment*part_num						-0.05
						(0.09)
Treatment Health*part_num						-0.07
						(0.09)
Complete Life Plan*part_num						0.00
						(.)
Social and Labor Treatment*Badajoz					0.08	
					(0.14)	
Social and Labor Treatment*Cáceres					-0.03	
					(0.15)	
Social and Labor Treatment*Navalmoral de la Mata					-0.01	
					(0.16)	
Social and Labor Treatment*Zafra-Llerena					0.00	
					(.)	
Health Treatment*Badajoz					-0.02	
					(0.14)	
Health Treatment*Cáceres					0.01	
					(0.15)	
Health Treatment*Navalmoral de la Mata					-0.06	
					(0.16)	
Health Treatment*Zafra-Llerena					0.00	
					(.)	
Complete Life Plan*Badajoz					-0.23	
					(0.14)	
Complete Life Plan*Cáceres					-0.20	
					(0.15)	
Complete Life Plan*Navalmoral de la Mata					-0.08	
					(0.16)	
Complete Life Plan*Zafra-Llerena					0.00	
					(.)	
Social and Occupational Treatment*Between 18 and 29 years old						0.36
						(0.32)
Social and Occupational Treatment*Between 30 and 45 years old						0.25
						(0.29)
Social and Labor Treatment*Over 45 years old						0.00
						(.)
Health Treatment*Between 18 and 29 years old						-0.44
						(0.30)
Health Treatment*Between 30 and 45 years old						-0.50*
						(0.26)
Treatment Health*Over 45 years old						0.00
						(.)
Complete Life Plan*Between 18 and 29 years old						0.10
						(0.32)
Complete Life Plan*Between 30 and 45 years old						0.02
						(0.29)
Complete Life Plan*Over 45 years old						0.00
						(.)
Social and Labor Treatment*No education						
Social and Labor Treatment*Primary school						
Social and Occupational Treatment*Secondary school						

						-0.19
						(0.18)
						0.01
						(0.14)
						-0.03
						(0.15)

Social and Labor																
Treatment*Higher education than secondary school																0.00
																(.)
Treatment Health*No education																0.18
																(0.18)
Treatment Health*Primary school																0.03
																(0.13)
Treatment Health*Secondary school																0.01
																(0.15)
Treatment Health*Higher education to secondary school																0.00
																(.)
Complete Life Plan*No education																0.01
																(0.19)
Complete Life Plan*Primary school																-0.14
																(0.14)
Complete Life Plan*Secondary school																-0.09
																(0.15)
Complete Life Plan*Higher to secondary education																0.00
																(.)
N	706	705	704	707	707	130	130	707	707	706	707	707	851	851	704	707
R^2	0.02	0.04	0.02	0.02	0.01	0.02	0.01	0.00	0.00	0.02	0.02	0.01	0.19	0.05	0.05	0.02

Note: Significance ***=.01, **=.05, *=.1. The analysis uses robust standard errors.