# Inclusion Policy Lab: Evaluation results

## Galicia: Comprehensive Support Project for the Reduction of Child Poverty

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MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES
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XUNTA DE GALICIA
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The General Secretariat of Inclusion of the Ministry of Inclusion, Social Security, and Migration has prepared this report within the framework of the Inclusion Policy Lab, as part of the Recovery, Transformation and Resilience Plan (RTRP). It has been funded by the Next Generation EU funds. As the agency in charge of carrying out the project, the Department of Social Policy and Youth of the Regional Government of Galicia has collaborated in the elaboration of this report. This collaborating entity is one of the implementers of 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 were adequately informed and that their participation was voluntary.

A research team coordinated by CEMFI (Center for Monetary and Financial Studies) has substantially contributed to this study. Specifically, Laura Hospido, senior economist of the Bank of Spain, has participated under the coordination of Mónica Martínez-Bravo (until January 8th, 2024) and Samuel Bentolila, professors at CEMFI. The researchers have actively participated in all phases of the project, including the adaptation of the initial proposal to the needs of the evaluation through randomized experiments, the evaluation design, the definition of measurement instruments, data processing, and the performance of econometric estimations that lead to quantitative results.

The partnership with J-PAL Europe has been a vital role 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 and integrating empirical data into strategies that promote inclusion and progress within our society.

This evaluation report has been produced using the data available at the time of its writing and it 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 affect the interpretation of the results. The researcher is committed to continuing 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 "Comprehensive Support Project for the Reduction of Child Poverty," which has been performed in **cooperation between the Ministry of Inclusion, Social Security and Migration (MISSM) and the Department of Social Policy and Youth of the Regional Government of Galicia.**
- This study evaluates a comprehensive and personalized intervention based on the needs of participating families, compared to a standard intervention model. Participants in the **treatment group** received an individualized plan through intensive support and assistance services. These services and aids are grouped into three packages: social, educational, and active inclusion, comprising a total portfolio of 22 interventions. The **control group** did not receive any services from the project.
- The project took place in the following locations in the Autonomous Community of Galicia: A Coruña, Ferrol, Lugo, Ourense, Pontevedra, Santiago de Compostela, and Vigo. A total of 2,038 individuals participated (910 in the treatment group and 1,128 in the control group).
- On average, 54% of project participants reside in single-parent households, and nearly 90% receive the Minimum Income Scheme (MIS). Regarding locations, 27% live in Vigo followed by A Coruña, where 23% of participating families inhabit.
- The degree of participation of the treatment group in training ranged from 9% to 23%, while participation in individual orientations ranged from 23% to 40%. Regarding economic assistance, 50% of participants in the treatment group received assistance in health and care.
- The new model of personalized support, adapted to the specific needs of each family member, provides:
    - **Improvement in child material deprivation**: the comprehensive and personalized treatment has a positive and significant effect with an average improvement of 0.13 to 0.17 standard deviations compared to the traditional model.
    - **Improvement in social inclusion**: the effect of comprehensive treatment is positive and significant with an improvement in the social inclusion of participants of 0.20 to 0.29 standard deviations on average compared to the traditional model.

- Social inclusion is measured using an indicator calculated from seven dimensions. The results of these are as follows:
    - **Improvement in health habits and care**: the treatment has a positive and significant effect on the emotional health level of treatment group participants, and their ability to bear the burden of dental care expenses.
    - **Reduction in the risk of housing loss and improvement in housing conditions**: the treatment has a positive and significant effect with an improvement of 0.13 to 0.17 standard deviations. Additionally, participants in the treatment group have greater knowledge of assistance and energy-saving mechanisms, and better identification of delays in payment of expenses.
    - **Improvement in digital skills**: the effect on the digital skills of the treatment group results in an average improvement of 0.11 standard deviations, although it is only significant at 10%.
    - **Assumption of parental responsibilities**: the impact of treatment is positive and significant at the 1% level, ranging from 0.12 to 0.15 standard deviations, compared to the control group. There is a positive effect in both, the development of parental skills and in the degree of family satisfaction.
    - **Greater integration into the community and relationships with the environment**: individuals in the treatment group show a positive and significant effect at 1%, ranging from 0.37 to 0.40 standard deviations, compared to the control group. This impact is due to greater satisfaction in personal relationships and greater trust in others.
    - **Greater integration and educational success**: personalized treatment shows a positive and significant effect at the 1% level ranging from 0.14 to 0.18 standard deviations, compared to the control group. This is essentially based on greater coverage of school material needs and increased school attendance.
    - **Improvement in employability**: treatment shows no significant effect, although there is an improvement in household members' activation for job seeking.

# 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 (onward 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, sets out 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. Along with the preceding Royal Decree, this one helped the RTRP's monitoring indicator number 351.1 to be fulfilled.

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 labor insertion 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 random 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. In addition, 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 MVI access rate; ii) increase the effectiveness of the MVI 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 MVI 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 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. In addition, 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 "Comprehensive Support Project for the Reduction of Child Poverty", executed within the framework of Royal Decree 938/2021 [9] by the Department of Social Policy and Youth of the Regional Government of Galicia. This report contributes to the fulfillment of milestone 351 of the RTRP: "Following the completion of at least 18 pilot projects, the 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".

**Context of the project**

Child poverty stems from diverse causes and manifests in different dimensions. Factors associated with poverty include the employment status of adult household members, especially in single-parent and large families, as well as age, nationality, and level of education completed by parents, or the environments in which they live and the availability of resources.

There is a direct relationship between child poverty and educational success. Children living in households at risk of poverty and social exclusion tend to have parents with lower education levels. Among other effects of poverty is healthcare, including the emotional well-being and mental health

[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 the 28th of December 2021, an agreement was signed between the General State Administration, through the SGOPIPS, and the Department of Social Policy of the Regional Government of Galicia for the implementation of a project for social inclusion within the framework of the Recovery, Transformation, and Resilience Plan, which was published in the "Official State Gazette" on the 31st of January 2022 (BOE no. 26).

of minors, which also influences academic success. Similarly, inadequate housing conditions may affect educational outcomes.

One of the fundamental problems associated with low incomes and lack of employment is the intergenerational transmission of poverty. Children in poverty are less likely to succeed academically and, consequently, have fewer opportunities for decent jobs in the future.

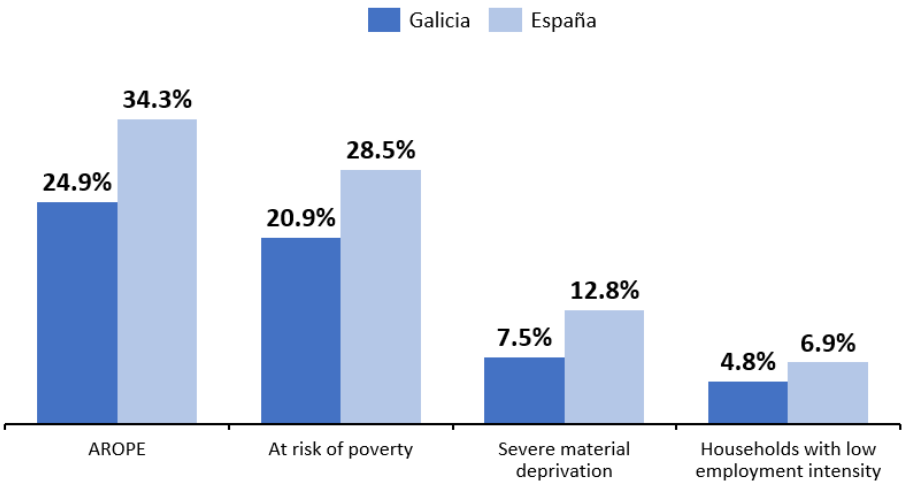
According to the Living Conditions Survey conducted by the INE, child poverty affected 34.3% of children and adolescents in Spain in 2023, equivalent to 2.4 million individuals. Furthermore, poverty manifests more intensely in the younger population (under 16 years old) than in other age groups. In 2023, the gap was 7.8 percentage points higher compared to the age group ranged from16 to 64 years and more than 13 percentage points compared to those over 65 years old.

Addressing child poverty has significant consequences for society in two main areas. On the one hand, the major public investment that needs to be made in this population over its lifetime. On the other hand, the opportunity cost that society must bear because of the child's poverty situation. Child poverty is generally associated with poorer academic development and early school dropout —due to household economic needs, disadvantage in terms of health, material goods, inability to dedicate to school activities, among others—. This implies lower chances of having decent jobs in the future and, therefore, a loss of potential resources in terms of generating knowledge for society. This generates an intergenerational transmission of poverty, where, according to EAPN's report data, four out of five people (83.3%) in poverty remain in poverty for many years. For these reasons, child poverty is one of the main focuses of analysis for national and European social policies.

According to the latest data presented by EAPN - Spain, Galicia, the autonomous region targeted by this project, recorded a child poverty rate of 24.9% in 2022, equivalent to approximately 92,000 children and adolescents. This region has poverty levels 9.4 percentage points lower than the national average in 2023 (34.3%), and in line with the child poverty rate reached by the European Union (EU-27) [10] in 2022 (24.7%). Among the components that make up the AROPE indicator, which is the most used index in the EU-27 for poverty comparatives, the situation of the risk of poverty stands out, affecting 20.9% of minors in Galicia, followed by severe material deprivation (7.5%), and low intensity of employment in the household (4.8%).

[10] The latest data regarding the AROPE rate in the EU-27 corresponds to 2022.

**Figure 1: Children poverty rate (AROPE) and its components[11]**




Note: data relative to Spain corresponds to 2023 while data relative to Galicia corresponds to 2022.

Source: Living Conditions Survey, INE; The State of the Poverty, EAPN - SPAIN

While poverty measurement is primarily conducted from a socio-economic perspective, it is a complex issue with several causes and strong intergenerational transmission, needing the creation of comprehensive and personalized programs that address multiple dimensions. To ensure optimal monitoring and support, having adequate personnel resources is also important.

**Regulatory framework associated with the project and governance structure**

Principle 11, which aims to advocate for children's rights, stands out within the scope of the European Union, the European Pillar of Social Rights (EPSR)[12]. Additionally, the European Child Guarantee (ECG), Council Recommendation (EU) 2021/1004, approved in June 2021, with the purpose of breaking the cycle of child poverty and ensuring access to six basic rights or services for all children and adolescents at risk of poverty or vulnerability[13].

At national level, the **National Strategy for the Prevention and Fight against Poverty and Social Exclusion 2019-2023** establishes a benchmark framework for poverty reduction in Spain. Likewise, the State Action Plan for the Implementation of the European Child Guarantee (2022-2030) is a report

[11] Analysis of the Child-focused 2022 Living Conditions Survey in Galicia, as the latest data regarding the AROPE rate disaggregated by autonomous community and age group corresponds to 2022 (report conducted by EAPN – Spain).

[12] The Action Plan of the European Pillar of Social Rights establishes twenty principles of social rights, through specific initiatives achievable by 2030.

[13] Basic rights included in the ECG: education and childcare; healthcare; education and extracurricular activities; adequate housing; at least one healthy meal per school day and healthy nutrition.

prepared by research personnel and coordinated by UNICEF ECARO and UNICEF Spain, in collaboration with the Ministry of Social Rights and Agenda 2030 and the High Commissioner against Child Poverty. This report analyzes children's access to the six basic rights outlined in the ECG and provides a subsequent diagnosis. This Action Plan is implemented in accordance with current public policies such as Law 26/2015, of July 28, amending the child and adolescent protection system; Organic Law 1/1996, of January 15, on the Legal Protection of Minors, partially amending the Civil Code; and Organic Law 8/2021, of June 4, on comprehensive protection of childhood and adolescence against violence (LOPIVI by its acronyms in Spanish).

In that way, all European and national regulations are aligned with the framework established in the 2030 Agenda and with the Sustainable Development Goals (SDGs).

This pilot project aligns with European and national strategies to combat child poverty and social exclusion, as well as with the 2030 Agenda for Sustainable Development, specifically contributing to SDGs numbered 1, 3, 4, 5, 8, 10, and 11.

Considering the direct relationship between child poverty, educational success, and intergenerational poverty transmission, the Department of Social Policy, and Youth of the Regional Government of Galicia, proposes a project based on designing a treatment tailored to the specific needs of each family and its members, integrating multiple dimensions grouped into three packages of measures: social, educational, and labor-related.

The scientific objective of the project is to evaluate the results and impact of this extensive and personalized model according to the specific needs of each family member. Furthermore, it aims to promote knowledge transfer to the policymaking process and obtain lessons and recommendations for the beneficiaries' inclusion policies.

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

- The **Department of Social Policy and Youth of the Regional Government of Galicia**, as the entity responsible for project management and execution, budgetary control and monitoring of various actions, and coordination among stakeholders.
- The implementation of social inclusion itineraries is performed by third-sector organizations in social action, which with specific teams address the various particularities of social exclusion situations in the region. The list of entities is as follows:
    - Fundación Juan Soñador (coordination, management support, evaluation, and implementation)
    - Fundación Meniños (implementation)
    - Cáritas Diocesana de Mondoñedo-Ferrol (implementation)
    - Asociación Arela (implementation)
    - Cáritas Diocesana de Lugo (implementation)
    - Centro de Desarrollo Rural O Viso (implementation)
    - Centro de Desarrollo Rural Portas Abertas (implementation)

- The **Ministry of Inclusion, Social Security, and Migration** (MISSM) as the project funder, and the main responsible for the RCT evaluation process. Thus, the **General Secretariat of Inclusion** (SGI) assumes the following commitments:
    - Providing support to the beneficiary organization for the design of actions to be conducted for the execution and monitoring of the grant object, as well as profiling potential participants in the pilot project.
    - Designing the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary organization and scientific collaborators. Additionally, conducting the project evaluation.
    - Ensuring strict compliance with ethical considerations by obtaining approval from the Ethics Committee.
- **CEMFI and J-PAL Europe**, as scientific and academic institutions supporting MISSM in the design and RCT evaluation of the project.

In view of the above, this report follows the following structure. **Section 2** provides a project description, detailing the issues to be addressed, the target audience for the intervention, and the specific interventions associated with improving levels of social inclusion. Next, **Section 3** contains information related to the evaluation design, defining the theory of change linked to the project, hypotheses, sources of information, and indicators used. **Section 4** describes the implementation of the intervention, analyzing the sample, the results of random allocation, and the level of participation and attrition in the intervention. This section is followed by **Section 5**, which presents the evaluation results, with a detailed analysis of the econometric analysis carried out and the results for each of the indicators used. Finally, the general conclusions of the project evaluation are described in **Section 6**. Besides in the **Economic Management and Regulatory** appendix, additional information is provided on management tools and project governance.

**Ethics Committee linked to the Social Inclusion Itineraries**

During research involving human individuals, 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 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 March 23, 2023.

# 2 Description of the program and its context

This section describes the program that the Department of Social Policy and Youth of the Regional Government of Galicia implemented in the framework of the pilot project. Furthermore, it defines the target population, the territorial scope, and provides a detailed description of the intervention.

## 2.1 Introduction

This project aims primarily to enhance social inclusion among families with children and adolescents who are beneficiaries of the Minimum Income Scheme (MIS) and/or the Galician Social Inclusion Income (onward RISGA by its acronyms in Spanish[14]), as well as other vulnerable families, to alleviate

[14] The Social Inclusion Income of Galicia is a public benefit aimed at ensuring economic subsistence resources for those who lack them, as well as progressively achieving their autonomy and social and labor integration, through the right and duty to participate in personalized integration processes.

child poverty. Additionally, the project seeks to evaluate the **outcomes achieved** and draw conclusions regarding a series of learnings and recommendations for inclusion policies aimed at MIS and RISGA beneficiaries.

To this end, this project proposes the following:

- Provide **adapted support and services** to the targeted family units, enabling their access to services by removing existing obstacles, promoting the full exercise of their rights, and enhancing social inclusion.
- Offer specific **educational** support to minors within the family units to promote their continuity within the education system, enhance educational achievement and mitigate the intergenerational transmission of poverty.
- Provide training opportunities in **employable skills** to active or potentially active members of the family unit, facilitating employment itineraries, enhancing their skills, and supporting active job seeking.

This analysis evaluates this innovative program in comparison to the standard model of social service provision, offering a range of 22 personalized interventions tailored to the specific needs of each family member. The three principal areas of intervention within the program are: employment, education, and social, encompassing various dimensions such as health and care, housing, digital literacy, parental responsibility, and community action.

The conceptual framework for enhancing social inclusion among families with minors in situations of vulnerability is based in understanding social exclusion as a multidimensional phenomenon (Fundación Foessa, 2019; Alguacil Gómez, 2012). This needs the acknowledgment of several adverse circumstances, such as lack of economic access, education, healthcare, adequate housing, or community support resources, which are closely interrelated (Subirats, 2005). Therefore, addressing this issue calls for an approach that combines policies promoting integration with individualized and versatile assistance (Aguilar, Llobet, & Pérez Eransus, 2010).

Given the multitude of issues addressed regarding child poverty and social inclusion, empirical evidence using RCT extends from purely economic interventions to those targeting labor and social integration of families. Economically, interventions providing unconditional financial support to families with children have shown significant benefits to the physical and mental health of children in Canada (Milligan & Stabile, 2011) and Finland (Määttä et al., 2015). Other interventions associated with the provision of school lunches have not only reduced food insecurity but also improved the emotional well-being of children from low-income families (Feely et al., 2020).

From a labor perspective, notable RCTs conducted in Colombia (Attanasio et al., 2008) and the Dominican Republic (Ibarraran et al., 2014; Card et al., 2007) demonstrate the importance of vocational training in enhancing employment, income, and job stability, especially among families with limited educational achievement. Socially, the study by Negrão et al. (2014) in Portugal focused on teaching parenting skills to families living in poverty, obtaining highly positive outcomes on family well-being due to improvements in parental and communication skills between parents and children. Noble et al. (2021) evaluated the effects of an intervention encompassing not only economic transfers

but also parenting support services and access to community resources, also obtaining highly positive outcomes in reducing poverty and improving financial stability, child development, and family well-being.

Despite the multitude of studies addressing specific issues associated with child poverty and social exclusion, few interventions comprehensively analyze the array of dimensions linked to child poverty and social exclusion. The program implemented by the Regional Government of Galicia, as part of the pilot project, aligns with this innovative and multifactorial vision of the issue. It constitutes one of the first empirical evidence in Spain using RCTs to comprehensively evaluate different actions aimed at combating child poverty and social exclusion.

## 2.2 Target population and territorial scope

The target population for the intervention comprises those family units with dependent minors who are beneficiaries of the Minimum Income Scheme (MIS) and/or the Galician Social Inclusion Income (RISGA) in the following localities: A Coruña, Ferrol, Lugo, Ourense, Pontevedra, Santiago de Compostela, and Vigo.

This is the selection criteria for participating families, with the family as the unit of analysis:

- Families with children residing in the selected localities who are beneficiaries of MIS and/or RISGA.
- Families in situations of social exclusion or at risk in rural areas identified as territorially excluded.

Further details regarding the recruitment process are provided in **section 3.5** within the framework of the evaluation design.

Additionally, the project encompasses three additional areas of rural intervention, located in the provinces of Lugo and Ourense. The project also targets families with children in situations of vulnerability, poverty, or social exclusion, whether they are beneficiaries of MIS/RISGA or not. Specifically, the intervention involved families residing in the following municipalities:

- Municipalities of Bóveda, Monforte de Lemos, Pantón, Pobra de Brollón, Saviñao, and Sober (defined in Royal Decree 99/2012, of March 16, on Community Social Services of Galicia as area 22)
- Municipalities of Baltar, Calvos de Randín, Os Blancos, A Porqueira, Rairiz de Veiga, Sandiás, Sarreaus, Trasmirás, Vilar de Barrio, Vilar de Santos, Xinzo de Limia (defined in Royal Decree 99/2012, of March 16, on Community Social Services of Galicia as area 29)
- Municipalities of Castrelo do Val, Cualedro, Laza, Monterrei, Oímbra, Riós, Verín, Vilardevós (defined in Royal Decree 99/2012, of March 16, on Community Social Services of Galicia as area 30).

Subsequent sections present information relative to the evaluation of the intervention in urban areas, using RCT. Information about rural areas which are evaluated using different methodologies, is in the **Summary of the FAIN Project performed in rural areas** appendix of this document.

## 2.3 Description of the intervention

Social exclusion and poverty are multidimensional, dynamic, and cumulative phenomena, where contributing factors intersect and exacerbate each other. To address this complex situation, the objective is to provide an extensive range of aids for personalized intervention tailored to the specific needs of each family in the treatment group. The multidimensional nature of social exclusion involves not only insufficient economic outcomes but also access to services, social and community participation, and employment opportunities.

In this way, this study designs a series of individualized intervention plans for the treatment group participants, through intensive aid and support services. These resources are adjustable to the individual needs of each family member.

During an initial phase, the professional team of the project's executing entities undertake a diagnosis of the family's situation. Based on this diagnosis, the professional from the executing entity develops an Action Plan, selecting the services and assistance that best fit the family's situation. This Plan may include interventions affecting the entire family unit, as well as interventions targeting specific members or subsets. Each Action Plan is designed according to a portfolio of predefined services in relevant areas for social inclusion, structured into three service packages.

The following table outlines the services included within the three packages considered in the treatment group:

**Table 1: Supply of Services and Assistance of the FAIN Project [15]**

| Package | Field | N | Type | Name |
|---|---|---|---|---|
| **Social support** | ***Health and care*** | 1 | Group | Training groups in health and caregiving |
| | | 2 | Individual | Individualized guidance in health and caregiving |
| | | 3 | Support | Financial assistance for healthcare expenses |
| | ***Housing*** | 4 | Group | Sessions for improving housing quality |
| | | 5 | Individual | Individualized housing guidance and support |

[15] For further information, please refer to the appendix**: "Supply of Services and Assistance of the FAIN Project."**

| Package | Field | N | Type | Name |
|---|---|---|---|---|
| | | 6 | Support | Rental assistance for housing |
| | | 7 | Support | Assistance for housing repairs |
| | | 8 | Support | Utility payment assistance |
| | ***Digital skills and connectivity*** | 9 | Group | Basic digital skills workshops |
| | | 10 | Support | Connectivity assistance |
| | | 11 | Support | Assistance for acquiring computer equipment |
| | ***Parental responsibility*** | 12 | Group | Training sessions in parental responsibility |
| | ***Community action*** | 13 | Group | Community participation activities |
| **Educational support** | ***Educational sphere*** | 14 | Group | Educational reinforcement groups |
| | | 15 | Individual | Individualized support sessions |
| | | 16 | Group | Informal education groups |
| | | 17 | Support | Assistance for school supplies |
| | | 18 | Support | Assistance for non-formal educational activities |
| **Active inclusion support** | ***Laboral sphere*** | 19 | Group | Training courses in basic skills |
| | | 20 | Group | Training courses in professional skills |
| | | 21 | Individual | Individualized orientation sessions |
| | | 22 | Support | Assistance for reconciliation |

For each intervention, the program specifies the duration of support and services offered, the targeted age groups, the type of activity proposed, and provides a brief description of the contents.

On the other hand, the control group does not receive any type of services from the project. As an incentive for their participation and to prevent sample loss, families participating in the control group receive a €25.5 gift card for each interview conducted at each measurement point, before the intervention (baseline survey) and another €25.5 after the intervention (endline survey). Additionally, these families in the control group continue to receive the usual supports provided by social services and the Third Sector of Social Action throughout the program.

# 3 Evaluation design

This section describes the design of the impact assessment of the projects outlined in the preceding 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 schematizes 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. It explains the relationships between these elements, the assumptions underlying them, and outlines 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, this theory identifies the expected effects 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 final 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 Department of Social Policy and Youth of the Regional Government of Galicia identified the need to diminish child poverty in Galicia, which involves diverse causes and is manifested across multiple dimensions. The origin of this phenomenon is closely correlated with the educational success of children and the poverty level of their parents (intergenerational transmission of poverty).

Additionally, in most cases, health problems, emotional and physical well-being issues, along with housing conditions aggravate the situation.

This need or issue delineates the areas of action within the project and the associated activities. Specifically, this study defines three major areas of intervention: social support, educational support, and employment activation. The intervention is adapted to the needs of families and their members to address participants' social needs through training groups, guidance sessions, group workshops, and financial support aimed at covering participants' basic needs (healthcare, housing, utilities, and computer equipment). Additionally, the intervention provided reinforcement groups, individuals support sessions, and assistance in the school environment (school materials and non-formal educational activities) to enhance the educational success of children.

Regarding actions more focused on employment, training courses (covering basic and professional skills) and guidance sessions are implemented to enhance the employability and occupation of participating families. It is also important to highlight the support that enables adults responsible for children to balance their responsibilities, thereby promoting and facilitating their attendance at courses.

All these resources and activities yield a set of outputs. By measuring the outputs obtained, it is possible to determine whether and to what extend beneficiaries have received the activities or inputs. Proper reception of the resources and activities performed is essential for the program to achieve the expected intermediate and final results. If beneficiaries do not effectively receive the program, it is difficult to observe improvements in the indicators of employment, housing situation or quality of life.

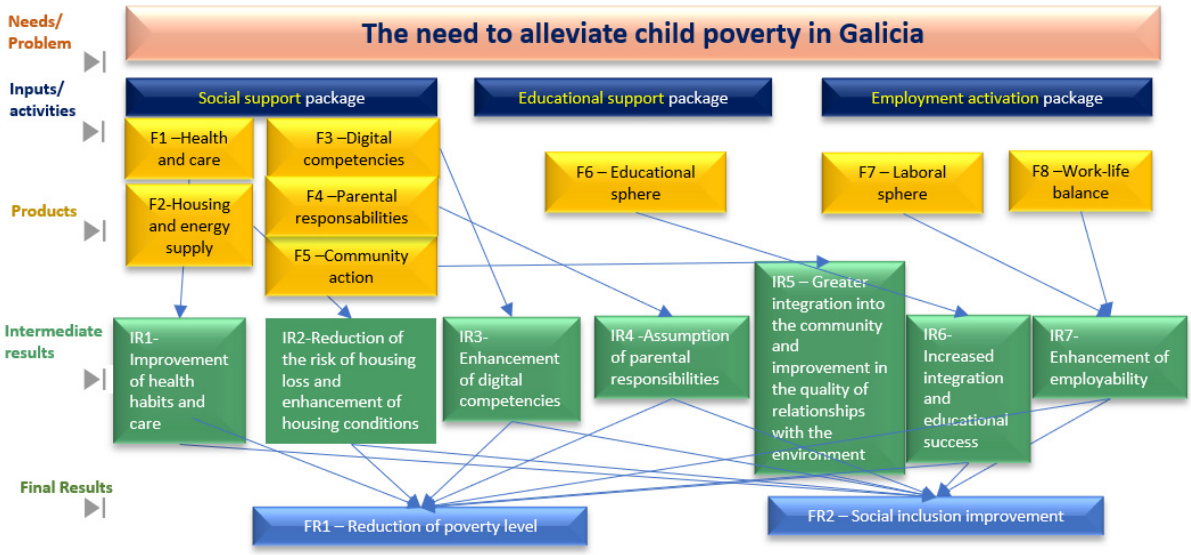
In this project, outputs are defined as the number of people receiving the services or aid provided. For instance, social support aims to increase the number of beneficiary families receiving support in areas such as healthcare and caregiving; housing and energy supply; digital skills; and parental responsibilities and community action. Educational support aims to enhance the educational success of minors in the short term and their employability in the medium and long term. Activities focused on employment aim to develop employability skills and facilitate work-life balance. Without the receipt of these outputs or provisions, improvements in poverty levels and social inclusion of families cannot be expected.

In the short term and as a direct result of the intervention, this project expects an improvement in health habits and care within families through aid and educational workshops. Additionally, a reduction in the risk of housing loss is expected, along with an improvement in housing conditions through defined financial aids. Furthermore, enhancements in digital skills and increased educational success are expected as a result of reinforcement groups and individual guidance. The social support package aims to enhance parental responsibilities and promote greater integration into the community and relationships with the environment. Ultimately, the goal is to improve employability within families through training courses and skills development, alongside support for family work-life balance.

In the medium to long term, the improvement of the mentioned intermediate indicators should culminate in enhanced social inclusion and a reduction in poverty levels among participating families.

The following figure illustrates this causal sequence of actions, beginning with identified needs or issues, and the necessary activities and resources required to achieve the anticipated changes in participants.

**Figure 2: Theory of Change**




## 3.2 Hypotheses

The primary goal of this pathway is to enhance the socio-economic inclusion of families with dependent children who receive the MIS and/or the RISGA. This translates into a reduction of child poverty and intergenerational transmission of poverty.

As detailed in the Theory of Change, this project encompasses multiple domains, ranging from educational success and improvement of physical and emotional health to the enhancement of families' employment situation. Consequently, in evaluating the model, several hypotheses compare the outcomes of the treatment group with those of the control group in each of the aforementioned areas, using specific indicators. This multidimensional approach enables a comprehensive assessment of the impact of the intervention on the lives of the beneficiaries and a more complete understanding of its effectiveness across different dimensions.

Below, this section proposes the hypotheses to test in each of the major areas, where the primary hypotheses are the expected final outcomes of the Theory of Change, and the secondary hypotheses are based on the defined intermediate results.

## *Main hypotheses*

### 1. Reduction of poverty level

This hypothesis postulates that the comprehensive and personalized treatment model leads to a reduction in poverty among participating families. Additionally, the program aims to reduce child material deprivation as a complementary outcome.

### 2. Social inclusion improvement

The second primary hypothesis suggests that social inclusion will improve compared to the conventional support model.

## *Secondary hypotheses*

### 2.1 Improvement of health habits and care

The personalized intervention proposes an improvement in the health habits and care of the participating families.

### 2.2 Reduction of the risk of housing loss and enhancement of housing conditions

This hypothesis considers that through improved housing conditions and quality facilitated by the treatment, the risk of housing loss is diminished, and the residential conditions of the participants are enhanced.

### 2.3 Enhancement of digital skills

The treatment postulates that greater digital literacy results from the guidance and tutoring provided.

### 2.4 Assumption of parental responsibilities

As the project targets families with minors in vulnerable situations, this hypothesis suggests that this innovative comprehensive and personalized model enhances parental responsibility.

### 2.5 Greater integration into the community and improvement in the quality of relationships with the environment

The treatment improves the integration of families within their community and facilitates the enhancement of the quality of their relationships within their environment according to this hypothesis.

### 2.6 Increased integration and educational success

The itinerary assumes an improvement in the integration of at-risk children and greater educational success.

### 2.7 Enhancement of employability

The final secondary hypothesis suggests that participants in the comprehensive and personalized treatment improve their employability compared to the traditional support model.

## 3.3 Sources of information

To gather the necessary information to construct the outcome indicators, the technical team conducted surveys targeting the participating families in the project. Specifically, they are requested to complete a survey before the intervention (baseline) and after the intervention (endline). The surveys were performed in person with the assistance of computer software (CAPI format) at premises provided by the entities, except when respondent needs required telephone administration (CATI format).

These surveys allow to understand certain aspects of the participants at the two points of analysis. The reference adult person of the household completed the questionnaire, responding about their own situation and on behalf of all household members. This person is the beneficiary of the assistance (MIS and/or RISGA). Household members are individuals who reside regularly in the dwelling (spending most of their daily rest there) and share household expenses (individuals benefiting from expenses (children, individuals with no income, etc.) and/or contributing to household income).

Thus, the surveys conducted prior to the intervention and upon its completion have been specifically designed to quantify the expected outcomes outlined in the Theory of Change.

The representative of the household unit completed the survey that comprises the following sections:

- **Sociodemographic characteristics**: the questions aim to analyze the generic situation of the household, its components, and the incomes and deficiencies of the families.
- **Housing**: this section focuses on the residential situation of households, quality, safety of housing, and potential economic problems related to housing. Also considers the degree of satisfaction of families with their housing.
- **Health**: this section raises questions related to the health status of household members, including children, needed medical care, and expenses on dental care and medications.
- **Education**: this section focuses on children and adolescents in the household of school age (6-16 years). The questions are focused on the educational needs of children, the number of subjects failed by each member, and levels of absenteeism.
- **Parenting**: this section includes issues related to satisfaction with family life and relationships among family members.
- **Community integration**: this section addresses aspects related to the household, studying personal and community relationships with the aim of measuring the degree of inclusion in the environment.
- **Digital skills**: this section studies the provision of resources in terms of digital skills and the level of skills and use of these. The main objective is to determine the knowledge of the

household members, possession of any digital signature certificate, and the level of knowledge of electronic administrative processes.

- **Employment**: this section analyzes the job search of household members, reasons for not seeking employment, actions taken to find a job, and whether income derived from work has increased in previous months.
- **Health, social, or economic context during the project**: this section seeks to assess whether there have been any external factors or events that have influenced the family or the environment and have impacted the intervention's effectiveness.

In addition to the questionnaires, and although they are not linked to any of the indicators used to measure the intervention hypotheses, this analysis uses the following complementary sources of information:

- Project intervention data registry: information relative to the type of intervention performed with each family and its components, as well as the intensity of the intervention.
- Administrative records of the MIS and the RISGA: information regarding the families belonging to the treatment and control groups concerning the receipt of benefits.

## 3.4 Indicators

This section describes the indicators that this study uses to evaluate the impact of the itinerary, divided by themes related to the hypotheses described above.

***Main hypotheses***

### 1. Reduction of poverty level

To assess the poverty of participating families, this analysis uses two indicators, the information for which is gathered through the surveys conducted on both, the treatment and control groups:

**Reduced AROPE**: a synthetic poverty indicator based on the following components:

- **Absence of relative monetary poverty**: the poverty threshold is set at 60% of the median household income distribution per consumption unit, with household net income (household disposable income) divided by the number of consumption units considered. The reference threshold is from Galicia, and a household is deemed to be in a situation of relative monetary poverty if its income per consumption unit falls below this threshold. This indicator is estimated both before and after the intervention and assumes a value of 0 (below the poverty threshold) and 1 (not below the poverty threshold).
- **Material and social deprivation**: measured by whether the household lacks at least three out of seven components of the material and social deprivation indicator. If the household lacks 3 out of the 7 components, it is determined to experience material and social deprivation. It is measured at the beginning and after the completion of the intervention, with a range between 0 (extreme risk of poverty) and 7 (no risk of poverty).

The values taken by this synthetic indicator are 0 when the household is considered poor and experiencing material and social deprivation, 1 when either of these conditions is positive, and 2 when neither condition occurs, representing the best possible situation. To facilitate interpretation across different indicators, this indicator is standardized in regressions.

**Child Material Deprivation**: it comprises eleven dichotomous variables (Yes/No), where the sum of all variables yields the indicator result with a range between 0 (maximum child material deprivation) and 11 (no child material deprivation). This indicator is only estimated upon completion of the intervention. To facilitate interpretation across different indicators, this indicator is standardized in regressions.

## 2. Social inclusion improvement

A single indicator measures social inclusion, based on questionnaire data collected before and after the intervention:

**Level of social inclusion**: measured through a synthetic indicator calculated in two ways. Firstly, as the average of the seven synthetic indicators that comprise the secondary hypotheses of the project. Normalized between 0 and 1, with 1 representing the best possible situation. Additionally, a weighted composite index by Anderson (2008) has been calculated from the same seven synthetic indicators representing each dimension. This method aggregates information from a set of variables that attempt to measure a common latent variable. The method computes a weighted average of all variables, where the weight assigned to each variable depends on its correlation with the others (lower correlation, higher weight).

Below, this report presents the synthetic indicators used to determine the level of social inclusion:

### *Secondary hypotheses*[16]

### 2.1 Improvement of health habits and care

**Synthetic Health Indicator**: estimated as the average of 8 indicators, with a value ranging from 0 (minimum level of health and care) to 1 (maximum level of health and care).

- Perceived health level by participants.
- Frequency of medical care.
- Frequency of illness.
- Level of quality of life related to health.
- Level of emotional health.
- Health literacy level.
- Expenses on dental care.

[16] All the indicators comprising the synthetic indicators of the secondary hypotheses take values between 0 and 1. To facilitate interpretation across different indicators, they are standardized in the regressions.

- Expenses on medications.

### 2.2 Reduction of the risk of housing loss and enhancement of housing conditions

**Synthetic Housing Indicator**: calculated as the average of the 5 indicators that comprise it. It takes values between 0 (maximum level of risk of housing loss and minimum level of housing conditions) and 1 (minimum level of risk of housing loss and maximum level of housing conditions).

- Synthetic indicator of residential deprivation due to overcrowding.
- Indicator of residential deprivation due to structural problems in housing.
- Level of awareness of assistance and mechanisms for energy savings.
- Identification of delays suffered by the household in paying expenses related to mortgage loans, rent, or utilities.
- Indicator of satisfaction level with housing.

### 2.3 Enhancement of digital skills

**Synthetic Digital Skills Indicator**: estimated as the average of the 5 indicators, with a value between 0 (absence of digital skills) and 1 (mastery of digital skills).

- Internet availability.
- Level of interest in developing digital skills.
- Level of confidence in handling digital tools (basic, basic work, and advanced) by different household members.
- Digital signature certificate: an indicator related to the availability of the digital certificate by any household member.
- Level of interaction with Government and Public Services: compound indicator measured through the dealings with the Public Administration by households and the skills of families in the past few months.

### 2.4 Assumption of parental responsibilities

**Synthetic Parental Responsibility Indicator**: calculated as the average of the 2 indicators that compose it, with a value between 0 (no parental responsibility) and 1 (maximum parental responsibility).

- Level of development of parental skills.
- Degree of family satisfaction.

### 2.5 Greater integration into the community and improvement in the quality of relationships with the environment

**Synthetic Community Integration Indicator**: estimated as the average of the 4 indicators that comprise it, with a value between 0 (no integration) and 1 (maximum integration).

- Degree of satisfaction in personal relationships.

- Level of trust in others.
- Degree of perceived social support.
- Degree of civic participation.

### 2.6 Increased integration and educational success

**Synthetic Education Indicator**: calculated as the average of the 4 indicators that compose it, ranging from 0 (minimum integration and educational success) to 1 (maximum integration and educational success).

- Degree of coverage of school material needs.
- Grade repetition of school-aged household members.
- Number of subjects failed in the previous school year by the children in the household.
- Level of school absenteeism.

### 2.7 Enhancement of employability

**Synthetic Employability Indicator**: it takes values ranging from 0 (minimum level of employability) to 1 (maximum level), and it is calculated as the average of the following indicators:

- Degree of job search.
- Degree of activation towards employment.
- Access to employment.
- Degree of income increase.

## 3.5 Design of the experiment

To assess the effect of the treatment on each of the previously mentioned indicators, this study uses an experimental evaluation (RCT), in which participants are randomly assigned to either the treatment or the control group. The recruitment and selection process of the beneficiary families for the intervention, as well as the random allocation and the temporal framework of the experiment, are detailed below.

**Recruitment of intervention beneficiaries**

The initial population are families residing in Galicia and beneficiaries of the MIS and/or the RISGA.

To identify potential beneficiaries, this report uses the records of recipient families and applies two selection criteria: families must have underage children at the time the pool of potential beneficiaries is obtained, and they must reside in the localities of A Coruña, Ferrol, Lugo, Ourense, Pontevedra, Santiago de Compostela, and Vigo. After applying these filters, the technical team contacted the potential beneficiaries through the dispatch of a letter. Consequently, implementing entities were tasked with contacting MIS recipient families, while for RISGA recipients, a collaboration was established between implementing entities and social services. The personnel from Third Sector Social Action organizations have conducted the family recruitment in each territory: Fundación Juan Soñador in A Coruña, Lugo, and Ourense; Asociación Arela in Vigo and Santiago de Compostela; Fundación

Meniños in Pontevedra, and Cáritas Mondoñedo – Ferrol in Ferrol. Subsequently, these implementing entities contacted families by phone and coordinated with municipal social services and other social organizations.

To obtain the informed consent, priority was given to individual-format sessions (one family), and group sessions with a maximum of 20 families were also conducted. During these sessions, the personnel informed families about the launch of the project and the services provided. Each family was informed that they could become participants in either the treatment group or the control group, in which case they would contact them later. The organization of the sessions considered several anticipated risks in the project, applying potential mitigation strategies (prioritizing individual recruitment of families and reinforcing initial communication, among others).

After verifying participation criteria and explaining the project in detail, interested families sign the informed consent, thereby approving their participation in the program. Consequently, the signatory group defines the study sample.

**Informed consent**

One of the fundamental ethical principles of research involving human beings (respect for people) 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 person, and the request and registration of their consent to participate. Consent should begin with a comprehensible presentation of key information that will help the person 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

After signing the consent, participants in the experiment are randomly assigned to either the treatment group or the control group. Random assignment is the cornerstone of RCTs for identifying a causal relationship between treatment and outcomes. When executed properly, this process ensures that the treatment and control groups are statistically comparable, encompassing both observable and unobservable variables. This homogeneity provides the necessary framework for accurately measuring potential effects resulting from the intervention.

The unit of randomization is the household, i.e., families. The MISSM performed the random allocation based on the list provided by the Regional Government of Galicia of all families that had signed the informed consent. Household typology—whether they are single-parent or non-single-parent families—and locality—A Coruña, Lugo, Ourense, Pontevedra, Ferrol, Santiago de Compostela, and Vigo—are used as stratification variables to ensure balance between the treatment and control groups for each stratum formed by the combination of these variables.

**Figure 3: Sample design**

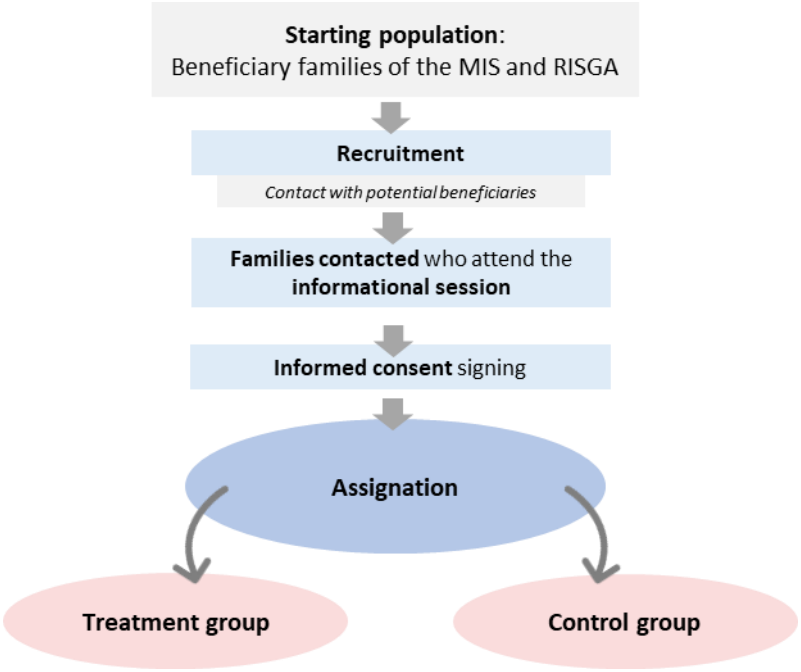
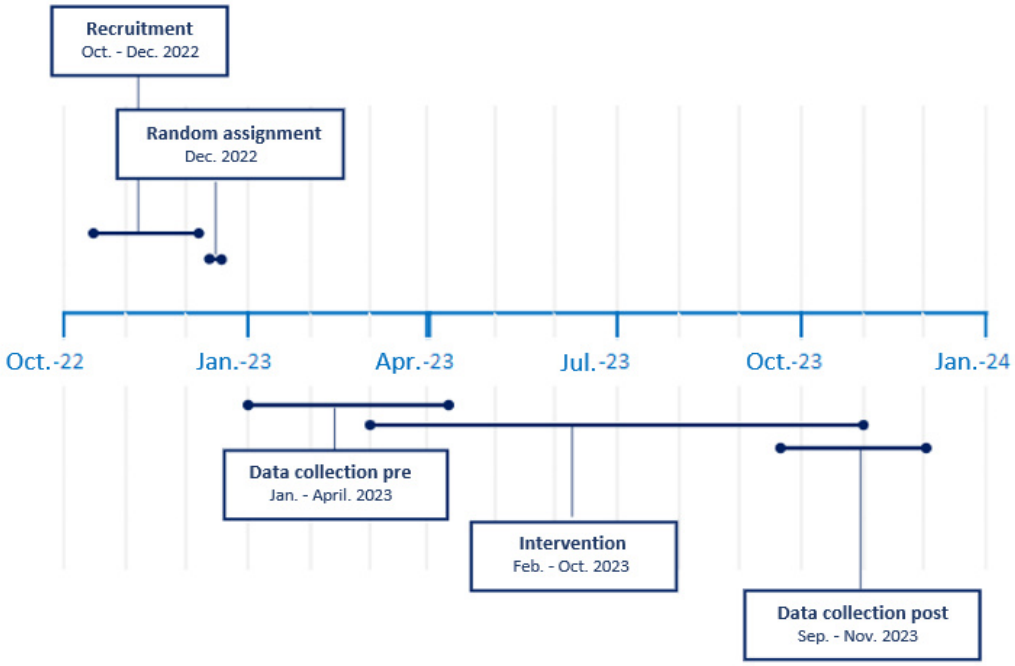



**Figure 4** illustrates the timeline for the implementation and evaluation of the itinerary. The participant recruitment process by the Regional Government of Galicia—where potential beneficiaries are enlisted and assessed against participation criteria—occurs between October 24 and December 7, 2022. As mentioned earlier, at the time of recruitment, the informed consent is also obtained, followed by the random assignment of participants who meet the criteria and express interest in participation. The baseline survey is typically conducted either at the time of recruitment or in the subsequent early sessions. The itinerary's or intervention's development occurs for each participant from the entry point in February 2023 until the execution deadline (October 31, 2023). Finally, the final survey for participants takes place between September and October for the control group families, and between October and November for the treatment group families, provided that the participant remains reachable.

**Figure 4: Evaluation timeline**




# 4 Description of the implementation of the intervention

This section describes the practical aspects of how the intervention was implemented as part of the evaluation design. It describes the results of the participant recruitment process and other relevant logistical aspects to contextualize the results of the evaluation.

## 4.1 Sample description

In the outreach's initial stage, 6,152 families potentially eligible for the project received letters. This contact aimed to extend the project opportunity to families receiving MIS and/or RISGA benefits with children in their household. In addition to the prior contact, telephone calls were made, reaching a total of 4,204 families through both recruitment channels.

Approximately, 74.3% of the contacts (3,176 households) agreed to participate in the project. **Table 2** shows the main recruitment data, ranging from the distribution of potential beneficiaries in each locality to concluding with the final sample of households that sign the informed consent (IC):

**Table 2: Recruitment record**

| | A Coruña | Ferrol | Lugo | Ourense | Pontevedra | Santiago | Vigo | TOTAL |
|---|---|---|---|---|---|---|---|---|
| **Potential beneficiaries** | 1,470 | 561 | 892 | 892 | 445 | 339 | 1,553 | **6,152** |
| *Potential beneficiaries that could not be contacted* | 425 | 184 | 209 | 177 | 119 | 39 | 325 | **1,478** |
| **Contacted** | 1,046 | 357 | 620 | 640 | 302 | 293 | 946 | **4,204** |
| *Do not want/Cannot participate* | 375 | 133 | 129 | 166 | 68 | 55 | 160 | **1,086** |
| **Want/can participate** | 671 | 223 | 491 | 474 | 234 | 238 | 786 | **3,117** |
| *Do not sign the IC* | 141 | 42 | 137 | 173 | 58 | 69 | 136 | **756** |
| **Sign the IC** | **530** | **181** | **354** | **301** | **176** | **169** | **650** | **2,361** |

Following these informational sessions, a total of 2,361 households signed the informed consent to participate in the project. However, after a process of refining the information about the families in the records, 2,359 families were ultimately randomly assigned. The remaining families - up to the 4,204 families that were contacted - either declined the possibility of participating after being informed or did not attend the informational sessions due to lack of interest or other personal reasons. Of these 2,359 participating families, 2,094 families are beneficiaries of the MIS and 265 of the RISGA.

**Table 3: Predicted units in each group**

| Participants | | | | |
|---|---|---|---|---|
| | **'Universe'** | **Selected sample** | **Treatment group** | **Control group** |
| **Expected families** | 6,152 | 3,433 | 1,700 | 1,733 |
| **Recruited families** | | **2,359** | **1,060** | **1,299** |

**Characteristics of the final sample of the evaluation**

Of the 2,359 families included in the sample, 321 did not initiate the project, primarily due to lack of interest, and therefore did not complete the survey at the beginning of the treatment. Consequently, a total of 2,038 families began the intervention, with 910 in the treatment group and 1,128 in the control group, all of whom completed the initial questionnaire.

During the itinerary, 235 families were withdrawn. 60% of them did not indicate a specific reason. Among the rest, the most common reasons provided by these families were lack of availability and self-perception of not needing the treatment.

Out of the total number of families that started the intervention (2,038 families), 1,862 (91%) also responded to the survey upon completion of the intervention. The attrition rate registered is very low, which is further analyzed in detail in **Section 4.3**.

**Table 4** shows the descriptive statistics of the variables related to the intervention, according to the information collected in the baseline survey. The table reports the characteristics of the families and the final and intermediate outcome indicators available before the intervention began. The table has six columns: the variable name, the number of observations, the mean, the standard deviation, and the minimum and maximum values.

**Table 4: Descriptive statistics of the sample**

| Variable | N | Mean | Standard deviation | Minimum | Maximum |
|---|---|---|---|---|---|
| Treatment | 2,038 | 0,45 | 0.50 | 0.00 | 1.00 |
| *Stratification variables* | | | | | |
| Single-parent household | 2,038 | 0.54 | 0.50 | 0.00 | 1.00 |
| A Coruña | 2,038 | 0.23 | 0.42 | 0.00 | 1.00 |
| Ferrol | 2,038 | 0.08 | 0.27 | 0.00 | 1.00 |
| Lugo | 2,038 | 0.15 | 0.36 | 0.00 | 1.00 |
| Ourense | 2,038 | 0.12 | 0.33 | 0.00 | 1.00 |
| Pontevedra | 2,038 | 0.07 | 0.26 | 0.00 | 1.00 |
| Santiago de Compostela | 2,038 | 0.07 | 0.26 | 0.00 | 1.00 |
| Vigo | 2,038 | 0.27 | 0.44 | 0.00 | 1.00 |
| *Family characteristics* | | | | | |
| MIS | 2,038 | 0.88 | 0.32 | 0.00 | 1.00 |
| RISGA | 2,038 | 0.12 | 0.32 | 0.00 | 1.00 |
| Household size | 2,038 | 3.34 | 1.19 | 1.00 | 9.00 |
| Number of minor household members | 2,038 | 1.65 | 0.85 | 0.00 | 6.00 |
| Number of employed household members | 2,038 | 0.55 | 0.66 | 0.00 | 3.00 |
| Age of the respondent | 2,038 | 40.93 | 8.33 | 20.00 | 75.00 |
| Gender of the respondent: female | 2,038 | 0.87 | 0.34 | 0.00 | 1.00 |
| Nationality of the respondent: Spanish | 2,038 | 0.70 | 0.46 | 0.00 | 1.00 |
| *Indicators* | | | | | |
| Reduced AROPE | 2,038 | 0.58 | 0.65 | 0.00 | 2.00 |
| - Relative monetary poverty absence | 2,038 | 0.11 | 0.31 | 0.00 | 1.00 |
| - Material and social deprivation | 2,038 | 2.48 | 1.55 | 0.00 | 7.00 |
| Synthetic social inclusion indicator | 2,038 | 0.72 | 0.09 | 0.31 | 0.95 |
| - Health indicator | 2,038 | 0.78 | 0.14 | 0.20 | 1.00 |
| - Housing indicator | 2,038 | 0.66 | 0.13 | 0.19 | 0.99 |

| Variable | N | Mean | Standard deviation | Minimum | Maximum |
|---|---|---|---|---|---|
| - Digital skills indicator | 2,038 | 0.62 | 0.16 | 0.00 | 1.00 |
| - Parental responsibility indicator | 2,038 | 0.69 | 0.24 | 0.00 | 1.00 |
| - Community integration indicator | 2,038 | 0.66 | 0.19 | 0.00 | 1.00 |
| - Education indicator | 2,038 | 0.90 | 0.12 | 0.29 | 1.00 |
| *Some intermediate variables* | | | | | |
| Health literacy level | 2,038 | 0.90 | 0.20 | 0.00 | 1.00 |
| Emotional health level | 2,038 | 0.62 | 0.21 | 0.00 | 1.00 |
| Knowledge of aids and energy-saving mechanisms | 2,038 | 0.50 | 0.27 | 0.00 | 1.00 |
| Identification of delays in expense payments | 2,038 | 0.70 | 0.30 | 0.00 | 1.00 |
| Interest in digital skills development | 2,038 | 0.79 | 0.27 | 0.00 | 1.00 |
| Family satisfaction level | 2,038 | 0.69 | 0.24 | 0.00 | 1.00 |
| Trust in others | 2,038 | 0.55 | 0.27 | 0.00 | 1.00 |

45% of the families belong to the treatment group. The sample reveals that over half of the families are single-parent households with a female reference person (87%). In terms of locations, the largest cities (A Coruña and Vigo) contribute the most families to the pilot. 88% receive the MIS, while the remainder receive the RISGA. The average age of the respondent is 41 years old, and 70% hold Spanish nationality.

## 4.2 Random assignment results

Once the sample is defined, participants are randomly assigned to either the treatment group or the control group, as explained in **Section 3.5**, and a balance test is conducted to ensure that, on average, the observable characteristics of the participants in both groups are equal. Balance between experimental groups is crucial for inferring the causal effect of the program by comparing their outcomes.

The following table shows the result of the random assignment, where 45% of the participants (1,060 participants) are assigned to the treatment group and 55% to the control group (1,299 participants). The stratification variables used are the locations where the project is implemented (A Coruña, Ferrol, Lugo, Ourense, Pontevedra, Santiago, and Vigo) and the household type (single-parent and others).

**Table 5: Results of the random assignment**

| Household type | Group | 1 | 2 | TOTAL |
|---|---|---|---|---|
| A Coruña | CG | 154 | 138 | **292** |
| | TG | 125 | 113 | **238** |
| Ferrol | CG | 42 | 57 | **99** |

| | | | | |
|---|---|---|---|---|
| | TG | 34 | 47 | **81** |
| Lugo | CG | 90 | 105 | **195** |
| | TG | 74 | 85 | **159** |
| Ourense | CG | 84 | 81 | **165** |
| | TG | 69 | 66 | **135** |
| Pontevedra | CG | 46 | 51 | **97** |
| | TG | 38 | 41 | **79** |
| Santiago | CG | 38 | 55 | **93** |
| | TG | 31 | 45 | **76** |
| Vigo | CG | 205 | 153 | **358** |
| | TG | 167 | 125 | **292** |
| **TOTAL** | | **1,197** | **1,162** | **2,359** |

Note: the variable "Household Type" takes values 1 (single-parent family) and 2 (others).

**Figure 5** [17] shows the balance tests results between the control group and the treatment group. All data presented in this figure refer to the survey conducted prior to the intervention (baseline)[18]. For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a dot and focused on it, the 95% confidence interval of that difference. A confidence interval containing zero, i.e., the vertical axis, will indicate that the mean difference between groups is not statistically significant or, in other words, is not statistically different from zero, meaning that the intervention groups are balanced. In case the confidence interval of the mean difference does not contain zero, the difference is statistically significant meaning the groups are unbalanced in this characteristic.

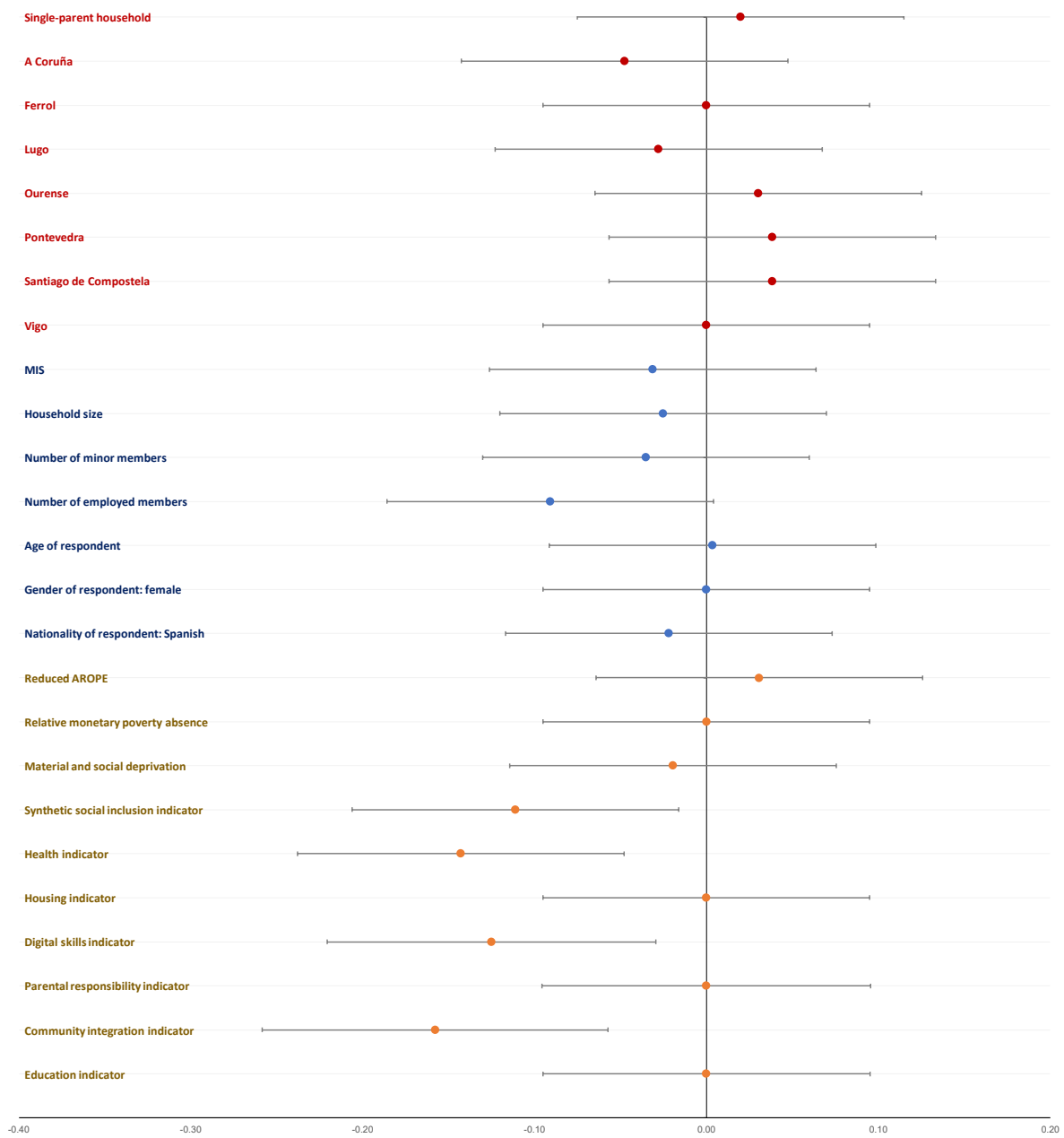
**Figure 5** presents that the treatment and control groups are not statistically different in most variables. However, there are some exceptions. In the case of sociodemographic variables, the average number of employed household members is 58% in the control group compared to 52% in the treatment group. This difference is significant at 10% level. This variable will be used as a control in models where controls are included.

While the main indicators generally do not exhibit differences between the treatment and control groups, the synthetic indicator of social inclusion shows a significant difference at 5% level. Upon examining its individual components, this analysis observes that initially unbalanced dimensions include health, digital skills, and community integration, with a significant difference at the 1% level. This indicator will be used as a control in models where controls are included.

[17] Please refer to **Table 21** in the appendix concerning the "**Balance between experimental groups"**.

[18] Random allocation was performed on 462 participants, while equilibrium analysis was performed on the 344 participants who started the intervention, which may impact the exceptions found.

**Figure 5: Difference between standardized means between treatment and control group (confidence interval at 95%)**




Note: in red, the variables used for sample stratification are displayed; in blue, the remaining sociodemographic variables, and in orange, the specific indicators used for project evaluation.

## 4.3 Degree of participation and attrition by groups

The group that signs the informed consent group constitutes the experimental sample randomly assigned to the control and treatment groups. However, both participation in the program and 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 effects on average of offering it, given the degree of participation. For example, if participation in treatment activities is low, the treatment and control groups will be very similar, and it will be more difficult to find an effect. On the other hand, this section tests 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**

The random allocation process involved 2,359 families, with 1,060 families allocated to the treatment group and 1,299 to the control group. During the itinerary, 235 families dropped out, with nearly half of them citing "Other" as the reason for discontinuation. The most common reasons include lack of availability and self-perception of not needing the treatment. Regarding the 235 discontinued families, it should be noted that the majority occurred before February 1, 2023, the start date of the intervention period, with very few occurring after the beginning of this phase.

Only the treatment group received the services (trainings and orientations) and assistance offered in the intervention. There was a significant difference between the diagnosis conducted on families and what could ultimately be implemented, mainly due to a lack of intervention time and the families' inability to participate in multiple services simultaneously. Thus, **Table 6** shows the percentage of participants who received training and guidance in the various areas considered.

**Table 6: Percentage of participants who received training**

| | Treatment group |
|---|---|
| ***Training*** | |
| Health and care | 9% |
| Housing | 4% |
| Digital skills | 11% |
| Parental responsibility | 11% |
| Community participation (group activities) | 21% |
| Education | |
| *Educative reinforcement in groups* | 15% |
| *Individual educative reinforcement* | 6% |
| *Non-formal education* | 23% |
| Laboral | |
| *Basic* skills | 15% |
| *Professional* skills | 11% |
| ***Orientations (individual)*** | |
| Health and care | 24% |
| Housing | 23% |
| Labor market | 40% |

Note: percentages calculated on the sample of 1,060 families initially randomly assigned to the treatment group.

On the other hand, **Table 7** captures the percentage of participants who received financial assistance, with half of them receiving some form of financial aid related to health and care. Overall, 82% of households participating in the treatment group received some form of intervention (training, counseling, or aid).

**Table 7: Percentage of participants who received economic aid**

| Trainings | Treatment groups |
|---|---|
| Health and care | 50% |
| Housing | |
| *Housing payments* | 27% |
| *Reparation* | 12% |
| *Utilities payments* | 31% |
| Digital skills | |
| *Connectivity support* | 28% |
| *Informatic equipment* | 0% |
| Education | |
| *Scholar material* | 44% |
| *Non-formal education activities* | 34% |
| Work-life balance | 10% |

Note: Percentages calculated based on the sample of 1,060 families from the treatment group initially assigned randomly.

**Attrition by groups**

**Table 8** displays the total number of participants registered in the evaluation. Out of the 2,359 who responded to the initial survey, 1,862 (79%) completed the final survey. The percentage is similar between the 1,060 assigned to treatment (78% of them completed the final survey) and those assigned to control (80%). Therefore, of the total families assigned to treatment or control, 79% provided post-intervention data, 80% in the control group, and 78% in the treatment group.

58 families that participated in the intervention did not provide data for the final survey, while 13 families non-participating households completed it.

**Table 8: Participation record and surveys performed**

| Group | Total | Completed final interview |
|---|---|---|
| **Total** | 2,359 | 1,862 (79%) |
| **Treatment** | 1,060 | 826 (78%) |
| **Control** | 1,299 | 1,036 (80%) |

To assess the statistical difference in attrition rates between the experimental groups is statistically significant, a simple regression is estimated. This regression uses the binary variable of non-completion of the final survey as the dependent variable and includes treatment assignment and some additional variables as regressors.

**Table 9** displays the results of these regressions. Column 1 shows estimations from the simple regression, without including any additional variables. The coefficient associated with the treatment

variable is 0.011 and is not statistically significant, indicating that the treatment group has an attrition rate 1.1 percentage points higher than the control group, and that this difference is not significant.

Additionally, to check for selective sample attrition, the analysis includes regressions with family characteristics and their interactions with the treatment variable. Columns 2 and 3 display the estimated coefficients for the interactions. We observe that the non-completion of the final survey is only significantly different in Pontevedra, where the treated completed 5 percentage points fewer final surveys than the controls (significant difference at 5%).

**Table 9: Regressions of the probability of not answering to the final interview**

| *Not completed final interview* | **(1)** | **(2)** | **(3)** |
|---|---|---|---|
| Treatment | 0.011 | 0.012 | 0.011 |
| | (0.013) | (0.089) | (0.089) |
| Treatment and Ferrol | | -0.024 | -0.025 |
| | | (0.068) | (0.068) |
| Treatment and Lugo | | -0.010 | -0.006 |
| | | (0.054) | (0.053) |
| Treatment and Ourense | | -0.002 | 0.002 |
| | | (0.054) | (0.053) |
| Treatment and Pontevedra | | 0.052** | 0.051** |
| | | (0.022) | (0.020) |
| Treatment and Santiago de Compostela | | 0.024 | 0.022 |
| | | (0.070) | (0.071) |
| Treatment and Vigo | | 0.013 | 0.018 |
| | | (0.014) | (0.017) |
| Treatment and Single-parent household | | 0.019 | 0.025 |
| | | (0.027) | (0.031) |
| Treatment and MIS | | -0.011 | -0.003 |
| | | (0.042) | (0.044) |
| Treatment and Age of the respondent | | -0.002 | -0.002 |
| | | (0.002) | (0.002) |
| Treatment and Female | | 0.001 | 0.000 |
| | | (0.025) | (0.025) |
| Treatment and Spanish nationality | | 0.031 | 0.032 |
| | | (0.022) | (0.024) |
| Treatment and Household size | | 0.017 | 0.035 |
| | | (0.012) | (0.027) |
| Treatment and Number of minor household members | | | -0.030 |
| | | | (0.038) |
| Treatment and Number of employed household members | | | -0.015 |
| | | | (0.018) |

| *Not completed final interview* | **(1)** | **(2)** | **(3)** |
|---|---|---|---|
| Observations | 2,038 | 2,038 | 2,038 |

Note: standard errors, clustered by randomization strata, in parentheses. * p<0.1; **p<0.05; ***p<0.01. All columns include randomization strata as controls. Columns 2 and 3 also include non-interacted variables as additional controls.

# 5 Results of the evaluation and data sources

The random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable, and therefore any difference observed after the intervention can be causally associated with the treatment. Econometric analysis essentially provides this comparison. However, it has the advantages of allowing the inclusion of other variables to gain precision in the estimates and of providing confidence intervals for the estimates. This section presents the econometric analysis conducted, the estimated regressions, and 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 typically just the difference in the variable of interest between the treatment group and the control group, since these groups are statistically comparable thanks to randomization. However, this is conditional on considering stratification and variables unbalanced at baseline (ensuring that existing differences between the treatment and control groups before the intervention are considered in the analysis). Additionally, in the following analysis, regressions in which the initial value of the dependent variable is controlled for whenever possible, i.e., the value before the intervention, are presented, improving the precision of the estimates.

In particular, the specification of the regressions presented below is 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 the family *i*, $T_i$ indicates whether the family has been assigned to treatment (=1) or control (=0), $Y_{i,t=0}$ is the initial value of the dependent variable (i.e., before the intervention), $X_{i,t=0}$ is a vector of controls (number of household members who work and synthetic indicator of social inclusion) and $\varepsilon_i$ is the error term.

The standard errors are always clustered at the level of the randomization stratum. As explained earlier, the variables used in stratification are family type (single-parent or not) and location (7 cities), resulting in a total of 14 randomization strata.

## 5.2 Analysis of the results

### 5.2.1 Main and secondary results

This section exhibits the results of the evaluation on primary and secondary indicators, following the structure of the evaluation framework. All outcome variables have been standardized to have a mean of zero and a standard deviation of one. This allows interpreting all regression coefficients in terms of standard deviations, which is useful for comparing the size of effects across different domains.

***Main hypotheses***

**1. Reduction of poverty level**

**Table 10** presents the intervention results on poverty. For each indicator, two specifications are provided: one without controls and another with additional controls not balanced in **Table 21**.

The first two columns present the impact on poverty using the reduced AROPE index. The coefficient of the treatment variable is -0.03 standard deviations without controls and 0.006 standard deviations with controls. Neither is statistically significant. Similarly, the coefficients corresponding to the relative monetary poverty indicator in columns (3) and (4) or those of material and social deprivation in columns (5) and (6) are also not significant.

Columns (7) and (8) display the results for the child material deprivation index, with a positive effect of 0.13 standard deviations without controls (statistically significant at 5%) and 0.17 standard deviations with controls (significant at 1%). This indicates that the comprehensive and personalized treatment resulted in an improvement, on average, of 0.13-0.17 standard deviations compared to the traditional model.

**Table 10: Effects on poverty**

| | Reduced AROPE | | Relative monetary poverty absence | | Material and social deprivation | | Child material deprivation | |
|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Treatment | -0.031 | -0.006 | -0.025 | -0.005 | -0.027 | -0.012 | 0.131** | 0.175*** |
| | (0.045) | (0.048) | (0.031) | (0.031) | (0.047) | (0.050) | (0.060) | (0.054) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.28 | 0.31 | 0.18 | 0.21 | 0.47 | 0.48 | 0.03 | 0.16 |
| Dependent variable control mean | 0.011 | 0.011 | 0.011 | 0.011 | 0.015 | 0.015 | -0.057 | -0.057 |
| Dependent variable initial value | Yes | Yes | Yes | Yes | Yes | Yes | No | No |
| Additional controls | No | Yes | No | Yes | No | Yes | No | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; *** p< 0.01.

In summary, the treatment has a positive effect on the child material deprivation index compared to the control group. These results seem to suggest that the additional services received with comprehensive and personalized treatment are primarily dedicated to children. For this indicator, baseline information is not available, so it could not be included as an additional control variable. The estimated effects for personalized support might have been larger with a pure control group, which received no assistance.

## 2. Social inclusion improvement

**Table 11** reports the results of the intervention on the synthetic indicator of social inclusion. In columns (1)-(4), the analysis presents the index where all variables receive the same weight (unweighted), while columns (5)-(8) expose the weighted Anderson index (2008).

**Table 11** follows the same structure as the previous one, although in this case, specifications with and without their baseline value are compared for the same indicator, as its construction is not exactly comparable in both periods. In all specifications considered, regardless of the type of indicator and the regressors included, the effect of comprehensive and personalized treatment compared to the traditional model is positive and significant at 1%. The average improvement is 0.20-0.29 standard deviations.

**Table 11: Effects on social inclusion**

| | Non-weighted | | | | Weighted | | | |
|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Treatment | 0.196*** | 0.261*** | 0.259*** | 0.261*** | 0.239*** | 0.295*** | 0.285*** | 0.288*** |
| | (0.041) | (0.038) | (0.039) | (0.038) | (0.039) | (0.038) | (0.039) | (0.039) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.05 | 0.38 | 0.38 | 0.38 | 0.05 | 0.29 | 0.31 | 0.31 |
| Dependent variable control mean | -0.085 | -0.085 | -0.085 | -0.085 | -0.103 | -0.103 | -0.103 | -0.103 |
| Dependent variable initial value | No | No | Yes | Yes | No | No | Yes | Yes |
| Additional controls | No | Yes | No | Yes | No | Yes | No | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; *** p< 0.01.

The synthetic indicator of social inclusion consists of 7 dimensions referring to the secondary hypotheses analyzed below: health, housing, digital skills, parental responsibility, community integration, education, and employability. **Table 12** shows the impact of the treatment on each of these dimensions. In these regressions, the initial indicator value has not been included as a control

because, depending on the indicator, it is not always available, or if available, it is not always fully comparable to the final measurement.

**Table 12: Effects on the components of the indicator of social inclusion**

| | Health | Housing | Digital skills | Parental responsibilities | Community integration | Education | Employability |
|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Treatment | 0.018 | 0.167*** | 0.073 | 0.150*** | 0.367*** | 0.179*** | 0.017 |
| | (0.048) | (0.040) | (0.056) | (0.032) | (0.052) | (0.030) | (0.047) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.15 | 0.22 | 0.12 | 0.23 | 0.23 | 0.14 | 0.03 |
| Dependent variable control mean | 0.007 | -0.051 | -0.013 | -0.051 | -0.14 | -0.061 | -0.009 |
| Dependent variable initial value | No | No | No | No | No | No | No |
| Additional controls | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

The results suggest that the treatment has had a greater impact on the dimensions of housing, parental responsibility, community integration, and education. This evaluation does not detect significant effect on the indicators of health, digital skills, or employability.

## *Secondary hypotheses*

### 2.1 Improvement of health habits and care

**Table 13** presents the results related to the effects on health. The synthetic index reveals that the impact of personalized treatment is small and not significant. However, when analyzing each of the variables included in the indicator separately, two of them have a significant impact: the intervention improves the level of emotional health (column 3) and the ability of the treated individuals to bear the burden of dental care expenses (column 4). Overall, the treatment has not had a significant impact on the other health-related variables.

**Table 13: Effects on health**

| | Health indicator | | Emotional health level | Ability to assume the burden of dental care expenses. |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 0.018 | 0.037 | 0.099*** | 0.094* |
| | (0.048) | (0.051) | (0.025) | (0.049) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.15 | 0.22 | 0.42 | 0.07 |
| Dependent variable control mean | 0.007 | 0.007 | -0.028 | -0.045 |
| Dependent variable initial value | No | Yes | Yes | No |
| Additional controls | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.2 Reduction of the risk of housing loss and enhancement of housing conditions

**Table 14** shows the results of the intervention on the housing indicator. The treatment impact is positive and significant at 1%, with the synthetic index showing an average improvement of 0.13-0.17 standard deviations. This evaluation detects significant impacts in better knowledge of aid and energy-saving mechanisms (column 3) and improved identification of delays in paying housing-related expenses (column 4).

**Table 14: Effects on housing conditions**

| | Housing indicator | | Knowledge of assistance and mechanisms for energy-saving | Identification of delays in expense payments |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 0.167*** | 0.133*** | 0.079* | 0.164*** |
| | (0.040) | (0.034) | (0.042) | (0.044) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.22 | 0.39 | 0.16 | 0.3 |
| Dependent variable control mean | -0.051 | -0.051 | -0.03 | -0.058 |
| Dependent variable initial value | No | Yes | Yes | Yes |
| Additional controls | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.3 Enhancement of digital skills

**Table 15** reports the results of the intervention on digital skills. Without considering the initial value (column 1), the personalized treatment impact is not significant. However, including the baseline value in the regression (column 2) increases precision, making the impact significant. Among the significant components, the treatment positively affects interest in digital skills compared to the control group (column 3). The average improvement is 0.11 standard deviations, although it is only significant at the 10% level.

**Table 15: Effects on digital skills**

| | Digital skills indicator | | Interest in digital skills |
|---|---|---|---|
| | (1) | (2) | (3) |
| Treatment | 0.073 | 0.112* | 0.105* |
| | (0.056) | (0.059) | (0.050) |
| Observations | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.12 | 0.34 | 0.17 |
| Dependent variable control mean | -0.013 | -0.013 | -0.029 |
| Controls | No | Yes | Yes |
| Dependent variable Pre | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.4 Assumption of parental responsibilities

**Table 16** reports the results of the intervention on the assumption of parental responsibilities. The impact is positive and significant at the 1% level, ranging between 0.12-0.15 standard deviations. Considering each component of the index with a significant impact, we observe that the impact is positive both in the measure of parental skills development (column 3) and in the degree of family satisfaction (column 4).

**Table 16: Effects on parental responsibility**

| | Parental responsibility indicator | | Parental responsibilities development | Family satisfaction level |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 0.150*** | 0.124*** | 0.103** | 0.113*** |
| | (0.032) | (0.029) | (0.045) | (0.036) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.23 | 0.27 | 0.14 | 0.26 |
| Dependent variable control mean | -0.051 | -0.051 | -0.038 | -0.046 |
| Dependent variable initial value | No | Yes | Yes | No |
| Additional controls | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.5 Greater integration into the community and improvement in the quality of relationships with the environment

**Table 17** presents the results of the intervention on community integration. Once again, the impact is positive and significant at the 1% level, ranging from 0.37 to 0.40 standard deviations, the highest of all estimated effects. Considering each component of the index with a significant impact, this impact is attributed to both the improvement in the degree of satisfaction in personal relationships (column 3) and in trust in others (column 4).

**Table 17: Effects on community integration**

| | Community integration indicator | | Personal relations satisfaction | Trust in others |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 0.367*** | 0.398*** | 0.076* | 0.115*** |
| | (0.052) | (0.047) | (0.042) | (0.035) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.23 | 0.28 | 0.23 | 0.26 |
| Dependent variable control mean | -0.14 | -0.14 | -0.019 | -0.018 |
| Dependent variable initial value | No | Yes | Yes | Yes |
| Additional controls | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.6 Increased integration and educational success

**Table 18** presents the results of the intervention on educational integration and success. Both concepts are measured with a synthetic indicator that captures the coverage of school material needs, academic performance, and the degree of school attendance. The personalized treatment shows a positive and significant effect at the 1% level ranging from 0.14 to 0.18 standard deviations. This is supported by improvements primarily in the coverage of needs, but also in school attendance.

**Table 18: Effects on educative integration**

| | Education indicator | | Material needs covered | School attendance |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 0.179*** | 0.142*** | 0.283*** | 0.090*** |
| | (0.030) | (0.031) | (0.045) | (0.035) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.14 | 0.38 | 0.21 | 0.14 |
| Dependent variable control mean | -0.061 | -0.061 | -0.118 | -0.03 |
| Dependent variable initial value | No | Yes | Yes | Yes |
| Additional controls | Yes | Yes | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

## 2.7 Enhancement of employability

**Table 19** reports the results of the intervention on the employability of participants. This report measures employability with a synthetic indicator based on a set of questionnaire items that capture objective factors, including the proportion of household members seeking employment, potential improvement in income from work, and specific job-seeking activities (activations). In this case, personalized treatment does not significantly improve employability, despite an increase in job-seeking activations by household members.

**Table 19: Effects on employability**

| | Employability indicator | Activations for employment |
|---|---|---|
| | (1) | (2) |
| Treatment | 0.017 | 0.127* |
| | (0.047) | (0.065) |
| Observations | 1,862 | 1,862 |
| $R^2$ | 0.03 | 0.06 |
| Dependent variable control mean | -0.009 | -0.062 |
| Dependent variable initial value | No | No |
| Additional controls | Yes | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

### 5.2.2 Heterogeneity analysis.

This section analyzes the variation in effects based on participant characteristics. The section includes regressions like those in the previous section but adds variables for estimating different effects and their interaction with the treatment.

**Table 20** reports the heterogeneous results by family type (single-parent or not). The table consists of 6 columns, corresponding to the three main hypotheses indicated in the evaluation framework: poverty reduction, using the AROPE rate (columns 1 and 2), child material deprivation indicator (columns 3 and 4), and social inclusion (columns 5 and 6).

**Table 20: Heterogenous effects by family type**

| | Reduced AROPE | | Child material deprivation | | Synthetic indicator of social inclusion | |
|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| Treatment | -0.028 | -0.002 | 0.101 | 0.133* | 0.163*** | 0.166*** |
| | (0.059) | (0.068) | (0.076) | (0.068) | (0.030) | (0.031) |
| Single-parent household | -0.065 | -0.059 | 0.470*** | 0.486*** | -0.011 | -0.001 |
| | (0.041) | (0.048) | (0.052) | (0.046) | (0.020) | (0.027) |
| Treatment and single parent | -0.006 | -0.008 | 0.057 | 0.080 | 0.179*** | 0.177*** |
| | (0.088) | (0.094) | (0.115) | (0.098) | (0.046) | (0.047) |
| Observations | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 | 1,862 |
| $R^2$ | 0.28 | 0.31 | 0.03 | 0.16 | 0.38 | 0.38 |
| Dependent variable control mean | 0.011 | 0.011 | -0.057 | -0.057 | -0.085 | -0.085 |

| | Reduced AROPE | | Child material deprivation | | Synthetic indicator of social inclusion | |
|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| Dependent variable initial value | Yes | Yes | No | No | Yes | Yes |
| Additional controls | No | Yes | No | Yes | No | Yes |

Note: the added controls include the number of household members who work and the synthetic indicator of social inclusion. Robust/clustered standard errors have been used at the stratum level.
Significance levels: * p < 0.1; ** p < 0.05; ***p < 0.01.

For non-single-parent families, the treatment improved child material deprivation and social inclusion indicators, similar to the total sample. "Treatment and single parent" interaction shows positive impact on both indicators, though sometimes with low precision. For the synthetic of social inclusion indicator, the treatment effect for single-parent families is estimated to be twice that of non-single-parent families. However, this analysis shows no significant effects on reduced poverty indicators.

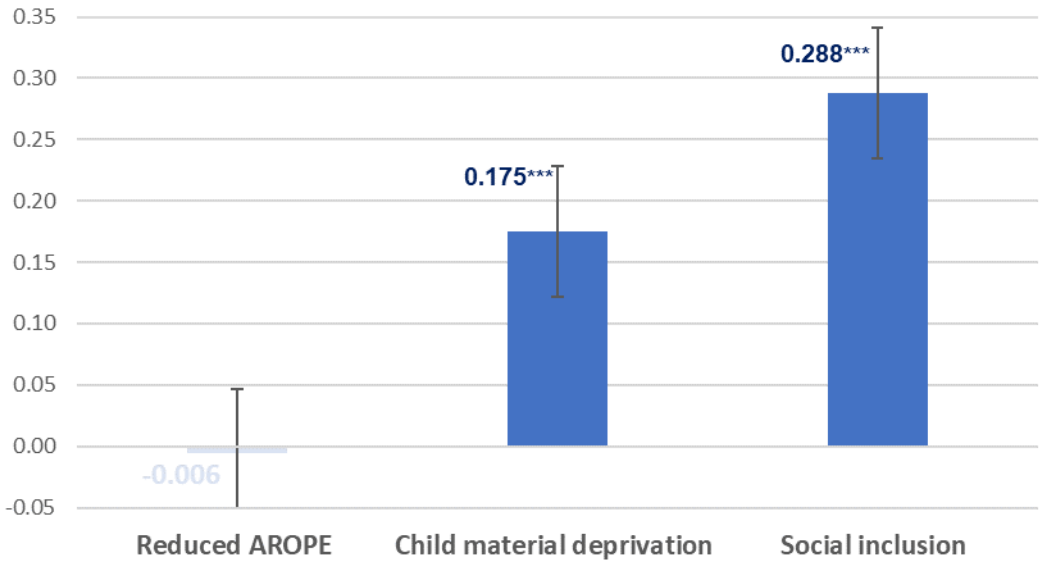
# 6 Conclusions of the evaluation

This pilot project evaluated the effects of a new comprehensive and personalized support model for families with children living in poverty, compared to the traditional model with standard assistance. The evaluation used an experimental design with stratified randomization (by family type and locality) to assign participants to the treatment or control group randomly. The initial sample includes 2,359 families in 7 localities in Galicia.

The personalized treatment has a positive and significant impact on the child material deprivation index. Positive effects are also found in the synthetic indicator of social inclusion, with the most significant improvements concentrated in measures of housing conditions, parental responsibilities, community integration, and education. However, despite an enhancement in household members' job search activities, the personalized treatment does not exhibit a positive effect on simplified poverty indicators, job success, or employability[19].

[19] Given the multifaceted nature of the intervention and the measurement of outcomes across a wide variety of indicators, it would be advisable, as an additional test of robustness, to adjust the standard errors for the presence of multiple hypotheses.

**Figure 5: Effect of the intervention in the main indicators (normalized indicators)**




Note: Dark blue indicates indicators for which the treatment effect is significant at the 1% level (Child Material Deprivation and Social Inclusion), while light blue represents non-significant indicators (Reduced AROPE). The effects depicted in the graphs refer to regressions with controls. The indicators are standardized.

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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 for Inclusion (SGI) of the Ministry of Inclusion, Social Security, and Migration is significantly involved 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 one of the reforms and investments proposed in this Component 23. Investment 7 promotes the implementation of a new inclusion model 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 autonomous communities, local entities, and Third Sector of Social Action organizations, as well as with the different social agents.

Royal Decree 938/2021, of October 26, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migrations in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation, and Resilience Plan[20], 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 pathways. 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[21], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and entities 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

[20]Royal Decree 938/2021, of October 26, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migrations in the field of social inclusion, for an amount of 109,787,404 euros, within the framework of the Recovery, Transformation, and Resilience Plan (BOE-A-2021-17464). It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-17464.

[21] 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 euros, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124). It can be consulted at the following link: 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[22].

Furthermore, following the execution and evaluation of each of the subsidized pilot projects, an assessment will be conducted to evaluate the coverage, effectiveness, and success of the minimum income schemes. The publication of this evaluation, which will include specific recommendations to improve the access rate to the benefit and enhance 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 of the beneficiary organizations.

On December 17, 2021, the Regional Government of Galicia was notified of the Resolution from the General Secretariat of Objectives and Policies for Inclusion and Social Welfare, granting a subsidy of €10,602,625.83. Subsequently, on December 28, 2021, a Convention was signed between the General Administration of the State, represented by the General Secretariat of Objectives and Policies for Inclusion and Social Welfare, and the Regional Government of Galicia, for the implementation of a social inclusion project within the framework of the Recovery, Transformation, and Resilience Plan. This Convention was published in the "Boletín Oficial del Estado" on January 31, 2022 (BOE No. 26)[23]

**2. Temporal framework of the intervention**

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

However, in accordance with Section 2 of the first final provision of Royal Decree 378/2022, of May 17, Article 6(4) and Article 6(1) are redrafted to extend the maximum term of the pilot projects of social inclusion itineraries subject to the subsidy until **October 31, 2023**, maintaining the deadline of **March 31, 2024,** for their evaluation.

[22] 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.

[23]Resolution of January 21, 2022, of the General Secretariat for Objectives and Policies of Inclusion and Social Provision, publishing the Agreement with the Regional Government of Galicia for the implementation of a project for social inclusion within the framework of the Recovery, Transformation, and Resilience Plan. It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-1528.

On June 15, 2022, the Regional Government of Galicia requested an extension of the implementation period until October 31, 2023. This extension was authorized by resolution of the General Secretariat of Objectives and Policies for Social Inclusion (SGOPIPS) dated August 4, 2022.

Within this general timeframe, the implementation begins on **February 1, 2023**, with the start of the intervention itinerary, continuing the execution tasks until **October 31, 2023**, and subsequently, only tasks related to project dissemination and evaluation are conducted until **March 31, 2024**.

### 3. Relevant agents

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

- The **Regional Government of Galicia**, as the beneficiary entity and responsible for the project implementation and coordination through the Department of Social Policy and Youth.
- The **Ministry of Inclusion, Social Security, and Migration (MISSM)** as the project sponsor and the main responsible entity for the RCT evaluation process. The General Secretariat of Inclusion (SGI) assumes the following commitments:
    a) Assist the beneficiary entity in the design of the activities to be carried out for the implementation and monitoring of the object of the grant, as well as for the profiling potential 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 **development of social inclusion itineraries has been conducted by Third Sector Organizations**, which addressed the diverse peculiarities of social exclusion situations in the region. The list of organizations is as follows:

| Name of the entity | Sector of activity |
|---|---|
| FUNDACIÓN JUAN SOÑADOR (coordination, support to the management and evaluation, implementation) | Social services |
| ASOCIACIÓN ARELA (implementation) | Family, childhood and minors |
| FUNDACIÓN MENIÑOS (implementation) | Social services |
| CENTRO DE DESARROLLO RURAL O VISO (implementation) | Social services |
| CENTRO DE DESARROLLO RURAL PORTAS ABERTAS (implementation) | Social service |
| CÁRITAS DIOCESANA DE LUGO (implementation) | Social services |
| CÁRITAS DIOCESANA DE MONDOÑEDO-FERROL (implementation) | Social services |

- **CEMFI and J-PAL Europe**, as scientific and academic institutions supporting MISSM in the design and RCT evaluation of the project.

## Supply of services and aids of the fain project

| | Services | Description / Duration |
|---|---|---|
| 1 | Health and Care Training Groups | Each workshop will last for 16 hours, conducted in 8 sessions of 2 hours each on a weekly basis. |
| 2 | Individualized Health and Care Guidance | Up to a maximum of 60 hours within 12 months (between 3 and 5 monthly sessions of one hour per person/family). |
| 3 | Assistance for Health Expenses | Financial assistance to facilitate access to medical, optical, pharmaceutical, or therapeutic consultations not covered by public resources according to family needs. Up to €200/year per person. |
| 4 | Group Workshop to Improve Housing Quality | Each training session will last for 8 hours and can be conducted in multiple sessions. |
| 5 | Individualized Housing Guidance and Support | Minimum of two interviews or home visits per year per family. |
| 6 | Housing Payment Assistance | Up to €150/month as required. |
| 7 | Housing Repair Assistance | Up to €1500/year as required. |
| 8 | Utility Payment Assistance | Up to €300/year as required. |
| 9 | Basic Digital Skills Workshop | Each training session will last for 12 hours, which can be conducted in 6 sessions of 2 hours or 4 sessions of 3 hours every two months. |
| 10 | Connectivity Assistance | Monthly payment for prepaid or contract internet connection supply as required, up to €50/month per family for a maximum of 12 months. |
| 11 | Equipment for Digital Access Assistance | Up to €150 per family per year. |
| 12 | Parental Responsibility Workshop | Each workshop will last for 16 hours in 8 sessions of 2 hours each on a weekly basis for two months. |
| 13 | Community Participation Activities | Each person will participate in a maximum of 24 hours of community participation activities per quarter. Activities may vary in duration from 2 to 4 hours. |
| 14 | Educational Reinforcement Groups | Aligned with the academic calendar set by the Department of Education and respecting non-school periods (37 weeks): Primary school: 1 hour / 4 days a week or concentrated in 2 hours / 2 days a week. Secondary school: 1.5 hours / 3 days a week. Post-compulsory education: 1.5 hours / 3 days a week. |
| 15 | Individualized School Support Sessions | Aligned with the academic calendar set by the Department of Education and respecting non-school periods (37 weeks): Primary school: 1 hour / 4 days a week. Secondary school: 1.5 hours / 3 days a week. Post-compulsory education: 1.5 hours / 3 days a week. |
| 16 | Non-Formal Education Groups | 4 hours/week per group during the school period (37 weeks). |
| 17 | School Supplies Assistance | Up to €150 per minor/year. |
| 18 | Assistance for Non-Formal Educational Activities | Up to €400 per minor/year. |

| | | |
|---|---|---|
| 19 | Basic Skills Training Courses | 12 hours per week, up to a maximum of 60 hours per training session. |
| 20 | Professional Skills Training Courses | Maximum of 250 hours per training session. |
| 21 | Individual Job Guidance Sessions | Up to 10 sessions of a maximum of 2 hours per session. |
| 22 | Financial Aid for Expenses Promoting Work-Life Balance | Up to €478/year. |

## Balance between experimental groups

**Table 21** reports balance tests between the control group and the treatment group. All data reflected in this table refer to the survey conducted before the intervention. The mean value of each variable is reported for both groups, as well as the number of observations in each group and the p-value resulting from a test of mean differences (using the t-Student statistic, not reported for space reasons) which includes random allocation strata as additional controls. The lower the p-value, the more confidently the hypothesis that the variable means in both groups are equal can be rejected. For example, if the p-value is less than 0.05, the hypothesis of equal means can be rejected with 95% confidence.

Panel A includes the stratification variables (single-parent and localities), which, if the initially randomized 321 families had not dropped out, would be balanced by design. We see that balance in these characteristics is kept despite those families that dropped out before starting. Panel B includes family characteristics and outcome indicators measured at baseline.

**Table 21: Balance tests between experimental groups**

**Panel A: Stratification variables**

| Variable | Means | | | N | | |
|---|---|---|---|---|---|---|
| | Control | Treatment | P-value | Total | Control | Treatment |
| Single-parent household | 0.54 | 0.55 | 0.83 | 2,038 | 1,128 | 910 |
| | (21.54) | (17.35) | | 14 | 14 | 14 |
| A Coruña | 0.24 | 0.22 | 0.49 | 2,038 | 1,128 | 910 |
| | (15.72) | (12.17) | | 14 | 14 | 14 |
| Ferrol | 0.08 | 0.08 | 0.96 | 2,038 | 1,128 | 910 |
| | (6.44) | (5.16) | | 14 | 14 | 14 |
| Lugo | 0.16 | 0.15 | 0.23 | 2,038 | 1,128 | 910 |
| | (11.37) | (8.74) | | 14 | 14 | 14 |
| Ourense | 0.12 | 0.13 | 0.26 | 2,038 | 1,128 | 910 |
| | (9.02) | (7.73) | | 14 | 14 | 14 |
| Pontevedra | 0.07 | 0.08 | 0.35 | 2,038 | 1,128 | 910 |
| | (5.59) | (5.16) | | 14 | 14 | 14 |
| Santiago de Compostela | 0.07 | 0.08 | 0.36 | 2,038 | 1,128 | 910 |
| | (5.78) | (4.91) | | 14 | 14 | 14 |
| Vigo | 0.27 | 0.27 | 0.95 | 2,038 | 1,128 | 910 |
| | (17.01) | (13.70) | | 14 | 14 | 14 |

**Panel B: Family characteristics and results indicators**

| Variable | Means | | | N | | |
|---|---|---|---|---|---|---|
| | Control | Treatment | P-value | Total | Control | Treatment |
| MIS | 0.88 | 0.87 | 0.45 | 2,038 | 1,128 | 910 |
| | (8.85) | (7.67) | | 14 | 14 | 14 |
| Household size | 3.35 | 3.32 | 0.52 | 2,038 | 1,128 | 910 |
| | (128.17) | (94.25) | | 14 | 14 | 14 |
| Number of minor members | 1.66 | 1.63 | 0.47 | 2,038 | 1,128 | 910 |
| | (66.41) | (45.93) | | 14 | 14 | 14 |
| Number of employed members | 0.58 | 0.52 | 0.07* | 2,038 | 1,128 | 910 |
| | (39.77) | (28.09) | | 14 | 14 | 14 |
| Age of respondent | 40.92 | 40.95 | 0.98 | 2,038 | 1,128 | 910 |
| | (556.47) | (529.43) | | 14 | 14 | 14 |
| Gender of respondent: female | 0.87 | 0.87 | 0.87 | 2,038 | 1,128 | 910 |
| | (9.72) | (7.90) | | 14 | 14 | 14 |
| Nationality of respondent: Spanish | 0.71 | 0.70 | 0.70 | 2,038 | 1,128 | 910 |
| | (18.02) | (14.79) | | 14 | 14 | 14 |
| Reduced AROPE | 0.57 | 0.59 | 0.56 | 2,038 | 1,128 | 910 |
| | (36.16) | (30.06) | | 14 | 14 | 14 |
| - Relative monetary poverty absence | 0.11 | 0.11 | 0.82 | 2,038 | 1,128 | 910 |
| | (8.47) | (6.88) | | 14 | 14 | 14 |
| - Material and social deprivation | 2.49 | 2.46 | 0.76 | 2,038 | 1,128 | 910 |
| | (209.87) | (167.80) | | 14 | 14 | 14 |
| Synthetic indicator of social inclusion | 0.72 | 0.71 | 0.03** | 2,038 | 1,128 | 910 |
| | (0.77) | (0.61) | | 14 | 14 | 14 |
| - Health indicator | 0.79 | 0.77 | 0.04** | 2,038 | 1,128 | 910 |
| | (1.74) | (1.50) | | 14 | 14 | 14 |
| - Housing indicator | 0.66 | 0.66 | 0.80 | 2,038 | 1,128 | 910 |
| | (1.48) | (1.25) | | 14 | 14 | 14 |
| - Digital skills indicator | 0.63 | 0.61 | 0.04** | 2,038 | 1,128 | 910 |
| | (2.31) | (1.90) | | 14 | 14 | 14 |
| - Parental responsibility indicator | 0.69 | 0.69 | 0.93 | 2,038 | 1,128 | 910 |
| | (4.95) | (4.03) | | 14 | 14 | 14 |
| -Education indicator | 0.67 | 0.64 | 0.00*** | 2,038 | 1,128 | 910 |
| | (3.19) | (2.51) | | 14 | 14 | 14 |
| -Education indicator | 0.90 | 0.90 | 0.39 | 2,038 | 1,128 | 910 |
| | (1.33) | (0.97) | | 14 | 14 | 14 |

Note: standard errors, grouped by randomization strata, are shown in parentheses. * p<0.1; **p<0.05; ***p<0.01. Panel B includes randomization strata as additional controls.

## Summary of the FAIN Project performed in rural areas

The three major action blocks have been deployed across all Galician provinces, working with particular intensity in the seven major cities and in the rural areas corresponding to the municipalities included in rural areas 22, 29, and 30 according to Decree 99/2012, of March 16, on Galician community social services:

1. Rural 22 [24] (onward Monforte de Lemos)
2. Rural 29 [25] (onward Xinzo de Limia)
3. Rural 30 [26] (onward Verin)

In the three rural areas, 242 families with children and adolescents aged between 0 and 18 years, facing vulnerability or social exclusion, receiving non-contributory benefits, and/or using social services or NGO support services, participated. As in urban areas, the intervention includes three major action blocks: social support, educational support, and activation towards employment.

In rural areas, the evaluation relies on a longitudinal analysis of results, measuring participants before (pre-test) and after (post-test) receiving the intervention, using synthetic indicators for the two main intervention objectives: poverty reduction and enhanced social inclusion. The poverty indicator variation comprises monetary poverty and severe material deprivation components. Inclusion is defined across seven dimensions: health, housing, digital skills, parental responsibilities, community integration, education, and employability.

The project measures indicators through a survey containing 53 questions, mostly derived from internationally validated scales. The approximate duration of responding to the questionnaire is 45 minutes. We used the same pre-test survey as in urban areas for the post-test to ensure maximum comparability between pre and post measures. Since there was no control group, we kept the same version, which was slightly modified in urban areas.

**Sample characterization**

For evaluation purposes, this report only considers data from families that responded in both waves (pre-test and post-test) by the established cut-off date for statistical analysis (n=215), achieving a response rate of 89%.

[24] Encompasses the municipalities of Bóveda, Monforte de Lemos, Pantón, Pobra de Brollón, Saviñao, and Sober

[25] Includes the municipalities of Baltar, Calvos de Randín, Os Blancos, A Porqueira, Rairiz de Veiga, Sandias, Sarreaus, Trasmirás, Vilar de Barrio, Vilar de Santos, and Xinzo de Limia. Areas 29 and 30 of the project will function as a single entity for the purpose of intervention with families.

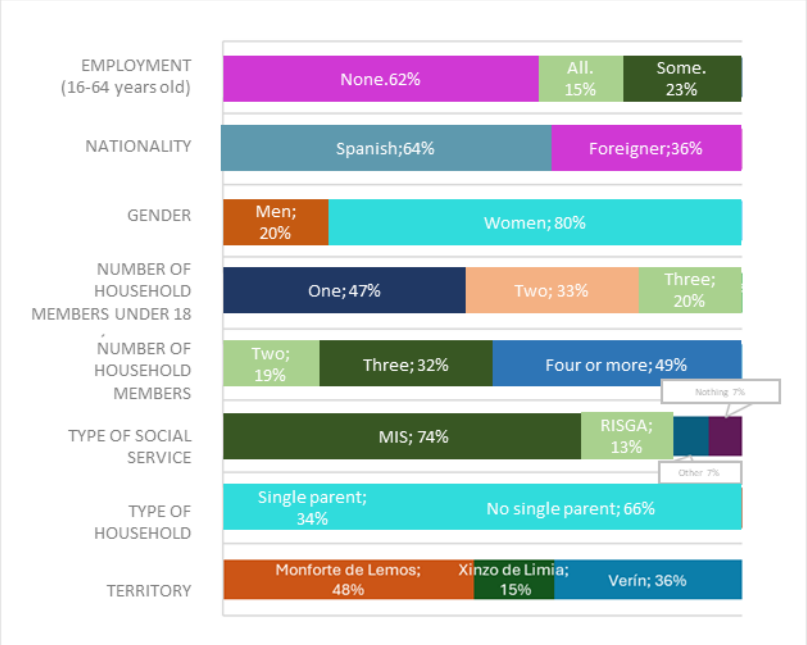
[26] Includes the municipalities of Castrelo do Val, Cualedro, Laza, Monterrei, Oimbra, Riós, Verín, and Vilardevós.

**Table 22: Number of families completing the pre-post survey by region**

| Territory | Families | Completed the survey | % |
|---|---|---|---|
| Monforte de Lemos | 121 | 104 | 86% |
| Xinzo de Limia | 36 | 33 | 92% |
| Verín | 85 | 78 | 92% |
| Total | 242 | 215 | 89% |

Households participating in the study have been classified by region (Monforte de Lemos, Xinzo de Limia, Verín); family structure (single-parent or not); type of benefit received (MIS, RISGA, other, none); number of members; number of minors; gender of the household's primary breadwinner; nationality; and the percentage of working-age individuals employed. **Figure 6** illustrates the distribution of households included in the analysis based on these variables.

**Figure 6: Sample characterization**




**Degree of participation**

On the other hand, **Table 23** characterizes households according to their participation in the project activities.

**Table 23: Households characterization based on participation in project activities**

| Field | Number and % of households, by activity type | | | | | |
|---|---|---|---|---|---|---|
| | Groups | | Individual | | Groups or individual | |
| Health | 28 | 13.0% | 156 | 72.6% | 162 | 75.3% |
| Housing | 23 | 10.7% | 145 | 67.4% | 150 | 69.8% |
| Digital skills | 36 | 16.7% | 82 | 38.1% | 96 | 44.7% |
| Parental responsibility | 42 | 19.5% | - | - | - | - |
| Community integration | 83 | 38.6% | - | - | - | - |
| Education | 77 | 35.8% | 150 | 69.8% | 161 | 74.9% |
| Employability | 83 | 38.6% | 90 | 41.9% | 125 | 58.1% |

Note: N=215. Source: activity registration application

Approximately three-quarters of households have participated in health or education activities. Between 60% and 70%, approximately, have been involved in housing or employability-related activities. Less than half have engaged in digital competence, parental responsibility, or community integration actions.

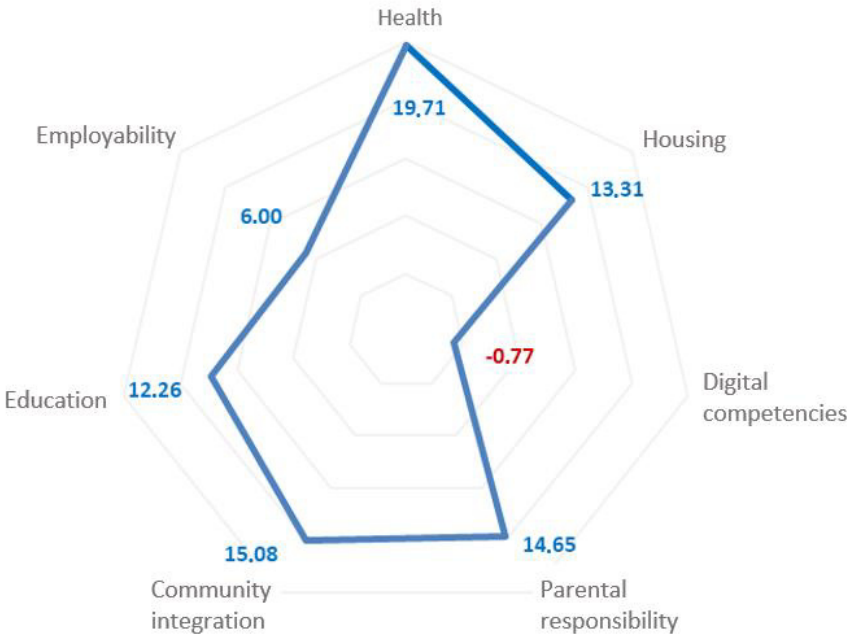
**Results**

This section presents the results of the evaluation on primary and secondary indicators, following the same structure of the evaluation framework previously presented for urban areas.

The comprehensive and personalized treatment tailored to the family's initial circumstances proves effective in promoting social inclusion. Moreover, over three-quarters (75.8%) of households experienced an enhancement in social inclusion following the intervention, with the synthetic indicator's rising by an average of 9.8% per household, representing a statistically significant increase with 95% confidence.

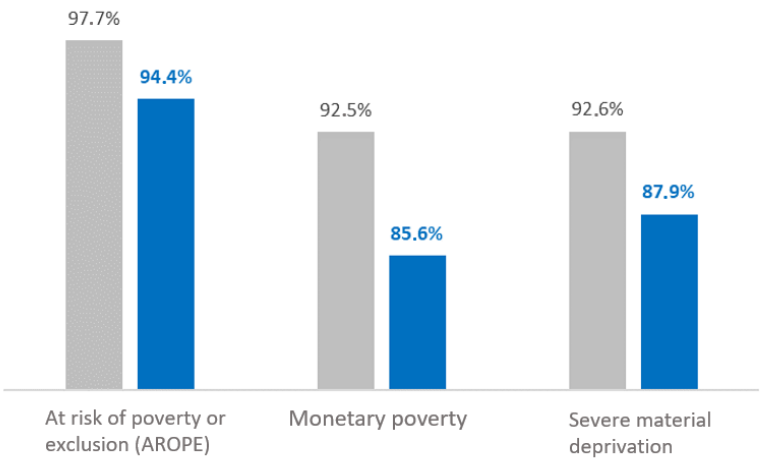
The multidimensional nature of inclusion and the interconnectedness among its dimensions, are reflected in the fact that all synthetic indicators composing inclusion (except digital skills) increase. The health indicator shows the highest growth (+19.7%), followed by community integration (+15.1%), parental responsibility (14.7%), housing (13.3%), education (12.3%), and, to a lesser extent, employability (+6.0%) (Figure 7). All increases are statistically significant at 95% confidence.

**Figure 7: Social inclusion. Variation (%) of Synthetic Indicator components**




Progress in inclusion coincides with a **reduction in poverty**. After the intervention, material deprivation and the percentage of households below the poverty threshold decrease. As a result, there is a decrease in the risk of poverty or social exclusion. The percentage of households at risk of poverty or social exclusion decreases by nearly 3% after the intervention (from 97.7% to 94.4%), a statistically significant change at 90% confidence.

**Figure 8: Poverty. Household percentage at risk of poverty or social exclusion (AROPE), with severe monetary poverty and material deprivation: before and after the intervention.**



This progress is the result of two phenomena: on one hand, the proportion of households experiencing monetary poverty decreases (-7.5%, a statistically significant decrease at 95% confidence) while on the other hand, the percentage of households experiencing severe material deprivation decreases (-5.0%, a statistically significant decline at 90% confidence) (**Figure 8**).