Inclusion Policy Lab: Evaluation Results

Fundación "la Caixa" – Children's Spaces: 0-3. An early childhood support program for vulnerable families at risk of poverty or social exclusion

April 2024

Financiado por la Unión Europea NextGenerationEU

MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES

Plan de Recuperación, Transformación y Resiliencia

Fundación "la Caixa"

cemfi

J-PAL

Catalogue of publications of the General State Administration

https://cpage.mpr.gob.es

© Ministry for Inclusion, Social Security and Migration

Madrid, 2025

Author:

General Secretariat for Inclusion

Edited and distributed by:

General Secretariat for Inclusion

Calle Agustín de Betancourt, 19. 28003 Madrid

E-mail: sg.inclusion@inclusion.gob.es

Web: https://www.inclusion.gob.es/web/inclusion

NIPO PDF 121-25-004-1

Quotation:

General Secretariat for Inclusion, Ministry for Inclusion, Social Security and Migration (2025). Inclusion Policy Lab: Evaluation Results. Fundación "la Caixa" – Children's Spaces: 0-3. An early childhood support program for vulnerable families at risk of poverty or social exclusion.

This report has been prepared by the General Secretariat for Inclusion of the Ministry of Inclusion, Social Security, and Migration within the framework of the Inclusion Policy Lab, as part of the Recovery, Transformation, and Resilience Plan (RTRP), with funding from the Next Generation EU funds. As the agency in charge of carrying out the project, La Caixa Foundation has collaborated in the preparation of this report. This collaborating organization is one of the implementers of the pilot projects and has collaborated with the SGI for 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. Likewise, their collaboration has been essential to gathering informed consent, ensuring that the 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, Ana García-Hernández (J-PAL Europa) e Inés Torres Rojas /J-PAL Europa-CEMFI), have participated under the coordination of Mónica Martínez-Bravo (until January 8, 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 evaluation needs 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 component in the efforts of the General Secretariat of Inclusion to improve social inclusion in Spain. Their team has provided technical support and shared international experience, assisting the General Secretariat in the comprehensive evaluation of pilot programs. Throughout this partnership, J-PAL Europe has consistently demonstrated a commitment to fostering evidence-based policy adoption and facilitating the integration of empirical data into strategies that seek to promote inclusion and progress within our society.

This evaluation report has been produced using the data available at the time of its writing and 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.

Financiado por la Unión Europea NextGenerationEU | MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES | Plan de Recuperación, Transformación y Resiliencia | Fundación "la Caixa" | cemfi | J-PAL

Index

EXECUTIVE SUMMARY 1

1 INTRODUCTION 3

2 DESCRIPTION OF THE PROGRAM AND ITS CONTEXT 11

2.1 INTRODUCTION 11

2.2 TARGET POPULATION AND TERRITORIAL SCOPE 13

2.3. DESCRIPTION OF INTERVENTIONS 13

3 EVALUATION DESIGN 15

3.1 THEORY OF CHANGE 16

3.2 HYPOTHESIS 18

3.3 SOURCES OF INFORMATION 19

3.4 INDICATORS 20

3.5 DESIGN OF THE EXPERIMENT 21

4 DESCRIPTION OF THE IMPLEMENTATION OF THE INTERVENTION 24

4.1 SAMPLE DESCRIPTION 24

4.2 RANDOM ASSIGNMENT RESULTS 29

4.3 DEGREE OF PARTICIPATION AND ATTRITION BY GROUPS 34

5 RESULTS OF THE EVALUATION 37

5.1 DESCRIPTION OF THE ECONOMETRIC ANALYSIS: ESTIMATED REGRESSIONS 37

5.2 ANALYSIS OF THE RESULTS 38

6 CONCLUSIONS OF THE EVALUATION 42

BIBLIOGRAPHY 46

APPENDIX 48

ECONOMIC AND REGULATORY MANAGEMENT 48

SAMPLE BALANCE 52

RESULTS ON THE USE AND ASSESSMENT OF THE KNOWLEDGE AND RESOURCES ACQUIRED 57

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 Control Trials.
- This document presents the evaluation results and main findings of the project "Children's Spaces: 0-3. An early childhood support program for vulnerable families at risk of poverty or social exclusion", which has been conducted by **"la Caixa" Foundation and different third sector organizations**, in cooperation with the **MISSM**.
- This study evaluates a **specific training program that targets the empowerment of families in parenthood competencies and skills given a set of workshops developed in the "Children's Spaces: 0-3"** of each participating entity. Thus, while the **treatment group** receives the training and a cross-cutting intervention structured in a model of social accompaniment and support (support for labor inclusion, goods for basic needs, etc.), the **control group** receives only the model of social accompaniment and support.
- The project took place in **nine autonomous communities** (Andalusia, Aragon, Canary Islands, Castilla y León, Catalonia, Valencia, Basque Country, Community of Madrid, and Region of Murcia). The initial sample consisted of 944 titular families (non-reserve) (473 in the treatment group and 471 in the control group) and 65 reserve families (to replace possible withdrawals).
- On average, participating families have a child on the itinerary (0-3) with an average age of two years, and almost half of them are girls (46%). In addition, 32% of families have at least one breastfeeding child, and only 5% of children between 0 and 3 years old go to school. 46% of families have 3 or more children under the age of 18, while 29% of them have two and 25% have one. More than half of the families are two-parent families (65%), while 35% are single-parent families.
- In addition, the main caring responsibilities fall on women, as 84% of primary tutors are female. The tutors are, on average, between 34 and 37 years old and 38-45% have Spanish nationality. On average, the maximum number of years of tutors' education is 7, and only 38% of families have at least one tutor employed. 74% of primary tutors are unemployed, and of those employed, only 8% have a permanent job. In the case of the child's second tutor, the proportion of unemployed is lower, 59%, but an equally low percentage (9%) has a permanent job.
- The degree of follow-up of the participants in the treatment group in the family workshops was high, with 79% attending at least three-quarters of the activities.
- The main results of the evaluation are as follows:

- **Improvement of parenthood competencies** observed and reported by **social service professionals:** the intervention increases objective competency indicators (responsiveness, affection, encouragement, and education) by about half a standard deviation.
- **Improvement of self-reported parenthood competencies:** The encouragement index indicates that families in the treatment group report 0.15 standard deviations higher than families in the control group. Likewise, families in the treatment group report an affection index 0.13 standard deviations higher than families in the control group.
- **Improvement of economic, intra-family and educational vulnerability: economic** vulnerability decreases by 1.4% in treated families, vulnerability in intra-family relations by 1.2% and vulnerability in education by 1.3%.
- The results indicate an improvement in the vulnerability indicators of the treatment group in terms of housing, health and sociocultural capital that is not statistically significant.

1 Introduction

General Regulatory Framework

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

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

Within the framework of the National Recovery, Transformation, and Resilience Plan (RTRP),[3] the General Secretariat of Inclusion (onwards, SGI by its acronym 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 randomization in the allocation of the program, this methodology can statistically identify the causal impact of an intervention on a series of variables of interest. This methodology enables us to analyze the effect of this measure, which helps determine if 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

[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 euros, within the framework of the Recovery, Transformation, and Resilience Plan (BOE-A-2021-17464).

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

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

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

has benefited most from the interventions, whether there were indirect or unexpected effects, and which components of the intervention worked, and which did not.

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 pathways.

This report refers to the pilot project: "Children's Spaces: 0-3. An early childhood support program for vulnerable families at risk of poverty or social exclusion", implemented within the framework of Royal Decree 378/2022[9] by "la Caixa" Foundation. 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

Parenthood competencies entail the set of skills that allow parents to face the vital task of being parents in a flexible and adaptive way, in accordance with the developmental and educational needs of their children (Rodrigo et al., 2009). Thus, parenthood competencies refer to the array of skills that parents possess and use to shape their relationships with their children.

[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 September 8, 2022, an agreement was signed between the General State Administration, through the SGI and the La Caixa Foundation 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 September 17, 2022 (BOE no. 224).

In this context, positive parenting is a specific approach to structuring and modeling parent-child relationships. Positive parenting refers to the behavior of parents based on the best interests of the child. That is, parents take an active caring role, develop their capacities, and offer recognition and guidance to their children. In addition, positive parenting entails the establishment of limits that allow the full development of the child (Recommendation Committee of Ministers of the Council of Europe, 2006). In this regard, positive parenting implies that parents must offer their children structure, care, guidance, recognition, empowerment, education without violence, while respecting the best interests of the child and his/her rights (Council of Europe, n.d.). In this context, this project focuses on evaluating the continuous and constant exercise of skills and competencies related to affection, encouragement, responsiveness, and education.

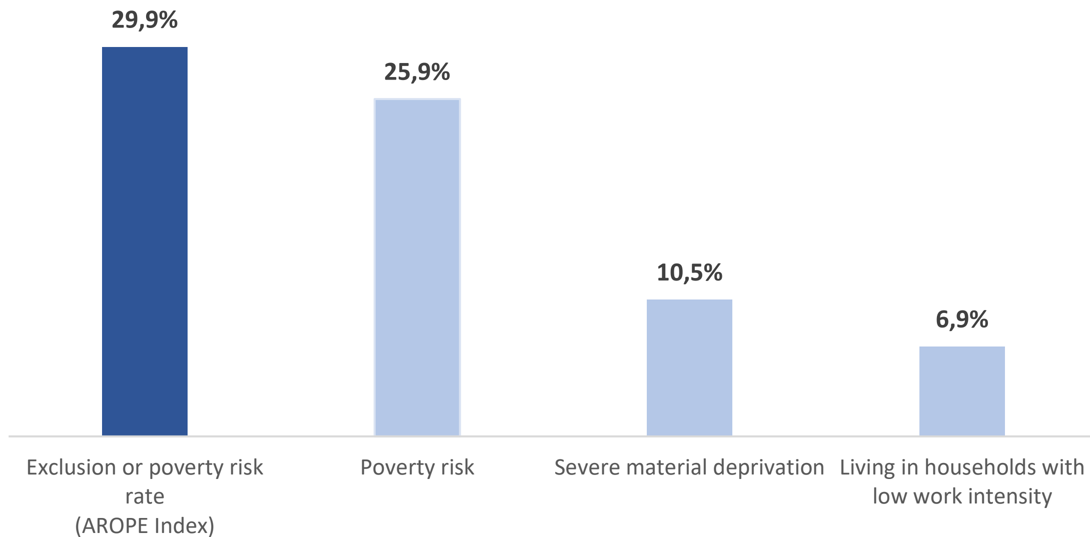
Likewise, in addition to parenting skills and competencies, the psychosocial environment also has a direct impact on the development of positive parenting. Specifically, poverty and social exclusion, when combined with a lack of parenting skills from a positive parenting perspective, can generate a negative feedback loop. That is, on the one hand, social exclusion and poverty can cause or aggravate the lack of parental skills and, on the other hand, the lack of parental skills can reflect the lack of personal skills in other areas of daily life (work, family, social, etc.). In this way, families in situations of socioeconomic vulnerability often face challenges in the development and implementation of parenting skills from the paradigm of positive parenting, due to the lack of material resources to complement the education of children (psychologists, social counselors, etc.), time constraints or lack of awareness about these crucial skills. As a result, these facts highlight the need for support and intervention targeting these vulnerable communities.

Therefore, in this context, it is essential to highlight the degree of social and economic exclusion of the group covered by this report: families with children between the ages of 0 and 3.

As shown by **figure 1**, in 2022, 29.9% of children between 0 and 3 years of age lived in households considered at risk of poverty or social exclusion (AROPE indicator[10]). Likewise, in relation to the components of the AROPE indicator for the year 2022, the component linked to household income (risk of poverty) stands out, affecting 25.9% of children between 0 and 3 years of age, followed by children population (0-3) with severe material deprivation (10.5%) and children population living in households with low work intensity (6.9%).

[10] The population at risk of poverty or social exclusion is defined according to criteria established by Eurostat. It refers to the population that is in at least one of these three situations: (1) At risk of poverty (equivalent income below 60% of the median income per unit of consumption). (2) Severe material and social deprivation (if you declare a deficiency in at least seven items out of the 13 on a list that includes, for example, not being able to afford a meal of meat, poultry, or fish at least every other day, keeping the house at an adequate temperature, having two pairs of shoes in good condition, or replacing damaged clothes with new ones). (3) In households with no employment or low employment intensity (households in which less than 20% of their total work potential worked in the year prior to the year of the interview).

Figure 1: Risk of poverty or social exclusion (AROPE Indicator) of children between 0 and 3 years old (2022)



Source: Survey of living conditions in Spain in 2022 by the INE (National Institute of Statistics). Data produced by the Children's Platform[11].

Consequently, given the socio-economic situation of children between 0 and 3 years of age in Spain, the project described in this report addresses a key problem for the educational future of these children. Education and training in parenting skills, from the perspective of positive parenting, has the potential to improve in a multidimensional way the quality of life of fathers, mothers, and children in the most vulnerable socioeconomic environments in Spain.

Regulatory framework associated with the project and the governance structure

The following is a summary of the main regulations and strategic plans directly related to the regulatory development of the areas of poverty and socio-economic vulnerability of children and parenting skills.

On the one hand, at the state level it is possible to find the following regulatory and strategic framework:

- **Organic Law 8/2021**: focuses on the comprehensive protection of children and adolescents against violence. In this context, this law makes explicit mention of positive parenting as a fundamental element of good care of the child. Likewise, this law also makes a specific definition of positive parenting, and regulatory aspects related to it as well as its promotion in society.

[11] https://www.plataformadeinfancia.org/wp-content/uploads/2023/07/INFORME-PLATAFORMA-INFANCIA-ECV-2023_ed03-1.pdf

- **Organic Law 8/2015**: modifies the legislative body dedicated to the protection of children and adolescents. In this sense, the objective of this law is to reform the regulatory framework that refers to the multidimensional protection of children (economic, legal, etc.) To adapt and update it to their needs.
- **State Action Plan for the Implementation of the European Child Guarantee** (2022-2030): aims at the adoption and implementation of the European Child Guarantee (recommendation of the Council of the European Union) to break the cycle of child poverty by ensuring access to six basic rights or services: education and children care; health care; education and extracurricular activities; adequate housing; at least one healthy meal per school day; healthy eating.

On the other hand, at the European level, the following stand out:

- **Recommendation (2006) 19 of the Committee of Ministers to Member States on Policies to Support Positive Parenting:** aimed at the recognition by States of the importance of parental responsibility. In this sense, the recommendation aims to improve the quality and conditions of parenting in European societies.
- **Council Recommendation (EU) 2021/1004**: with the objective of the establishment of a European Child Guarantee that ensures the well-being of children in different regulatory areas (economic, educational, health, etc.).
- **European Commission Recommendation 2013: Investing in children. Breaking the cycle of disadvantage**: with the objective to address child poverty from a multidimensional perspective (access to services, education, etc.) in the member states of the European Union.
- **2023 European Parliament resolution on reducing inequalities and promoting social inclusion in times of crisis for children and their families:** with the objective to reduce social exclusion and increase the protection of children and families in vulnerable socio-economic situations.
- **European Pillar of Social Rights:** with the objective to support and guarantee the right of children to enjoy affordable and good quality education and children care, as well as comprehensive protection against poverty.

Finally, at the international level, the **Convention on the Rights of the Child** adopted by the United Nations General Assembly in 1989 stands out. This convention addresses children's socio-economic vulnerability and parental competencies, by recognizing various fundamental rights related to a holistic vision of childhood (living standards, economic exploitation, and children's rights in cases of parental separation, etc.).

In short, addressing child poverty and improving parenting skills for better and more adequate care of children presents different levels of regulatory structures at the national, European, and international level. In this sense, the recent **State Action Plan for the Implementation of the European Child Guarantee** constitutes the cornerstone of spending and regulation with an impact on children until 2030.

The pilot project that is the subject of this report is aligned with European and national strategies in the field of child poverty and the promotion of parenting skills, as well as with the 2030 Agenda for Sustainable Development, specifically contributing to SDGs 1, 4, 5 and 10.

Considering the context of child vulnerability in Spain and the importance of early education for children, “la Caixa" Foundation proposes a project to promote parenting skills from the paradigm of positive parenting in environments of socioeconomic vulnerability in families with children between 0 and 3 years old. Thus, this project constitutes a unique opportunity to understand the impact of interventions aimed at the development of parenting skills in combination with material aid, such as the monthly Child Support Supplement (CAPI) designed to complement the MIS in those families with children under 3 years of age.

The scientific objective of the project is to evaluate the effectiveness and efficiency of different workshops to improve initial care (0-3), offering support for the development of care and positive parenting skills, as well as for the reduction of family social vulnerability. In addition, this project aims to promote the transfer of knowledge to the process of public policy development and to be accountable for its results.

In this context, the governance framework constituted for the correct execution and evaluation of the project includes the following actors:

- **"La Caixa" Foundation**, as the entity responsible for the implementation of the project**.** This entity is one of the main banking foundations in Spain with various lines of work in the fields of research and health, culture and science, education, and social action. The project presented in this report is part of the social programs area of the CaixaProinfancia program, focusing on the fight against child poverty and promoting social and educational development of children and adolescents aged 0 to 18 from families at risk of social exclusion.

  It should be noted that **CaixaProinfancia program** is developed through various social entities in different cities in Spain. It is currently present in 145 municipalities with the support of more than 400 social service providers, organized in 194 networks, supporting more than 65,000 children and adolescents in Spain and Portugal in 2023. Consequently, the outstanding experience of "la Caixa" Foundation in the development and execution of social programs and childcare and its extensive collaboration with public institutions, private companies and third sector entities, endorse its suitability as a partner for the implementation of this project. Thus, within the framework of this program, "la Caixa" Foundation is the entity responsible for the design and structuring of the project. At the same time, third sector organizations selected through an open call in ten autonomous communities are responsible for the execution of the project.

  The **participating entities** and **members of CaixaProinfancia program** are non-profit organizations. They can take various legal forms: associations, foundations, cooperatives, etc. They are all participants in the CaixaProinfancia program and are, therefore, legally bound, within the framework of this program, to "la Caixa" Foundation. The main role of these entities is the execution of different interventions carried out in this project. They are also responsible

for the implementation of different workshops "Children's Spaces: 0-3" in charge of improving the parental skills of the participating families.

In addition to "la Caixa" Foundation and the participating non-profit entities that are members of CaixaProinfancia program, **other actors are involved**, such as territorial children's committees, social services, and educational centers. All of them contribute to the recruitment process of the participating families.

- The **Ministry of Inclusion, Social Security and Migration** (MISSM) is the main funding source of the project and the responsible entity for the RCT evaluation. Therefore, the General Secretariat for Inclusion assumes a series of commitments towards "la Caixa" Foundation:
    - To assist the beneficiary entity in the design of the actions to be carried out for the implementation and monitoring of the object of the subsidy, as well as for the profiling of the potential participants of the pilot project.
    - To design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary entity and scientific collaborators. Also, the MISSM conducts the evaluation of the project.
    - To ensure strict compliance with ethical considerations by obtaining the approval of the Ethics Committee.
- **CEMFI and J-PAL Europe** are scientific and academic institutions that support MISSM in the design and RCT evaluation of the project.

In view of the above, the current report follows the following structure. **Section 2** provides a description of the project, detailing the issue to be addressed, the specific interventions analyzed, and the target audience to which the intervention is directed. The objective is to present a diagnosis of the problems associated with the lack of parenthood competencies to justify the necessary implementation and evaluation of this intervention. Next, **section 3** contains information relating to the **evaluation design**, defining the Theory of Change linked to the project and the hypotheses, sources of information, and indicators used for the analysis. **Section 4** analyzes the **implementation of the intervention**, the sample, the results of the randomization performed, and the degree of participation and attrition of the intervention. This section is followed by **section 5** where this report presents **the results of the evaluation**, with a detailed analysis of the econometric analysis conducted and the results for each of the indicators used. Finally, the **conclusions** of the project evaluation are described in **section 6**. Adding to this, in the **economic and regulatory management** appendix additional information is provided regarding the management instruments and governance of the pilot project.

Ethics Committee linked to the Social Inclusion Itineraries

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

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

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

2 Description of the program and its context

This section describes the program that "la Caixa" Foundation implemented within the framework of the pilot project. This section describes the target population and territorial framework, as well as the main intervention of this itinerary.

2.1 Introduction

This report evaluates a model of family workshops developed in the "Children's Spaces: 0-3" that seek to improve parenting skills from a positive parenting approach in socioeconomically vulnerable families. In this way, through the transfer of knowledge from a positive parenting paradigm, this project aims to help legal tutors to acquire parenting skills. In addition, it also aims to reduce the vulnerability of the participating families in different aspects related to education, housing, economic issues, or sociocultural capital.

Positive parenting involves, among other things, the continuous and constant exercise of skills and competencies related to affection, encouragement, responsiveness, and teaching or education; and it is intimately related to family socioeconomic status. Specifically, those families with greater socioeconomic vulnerability have greater difficulties in developing and implementing parenting skills that favor the early development of children (Ayoub & Bachir, 2023; Hoff & Laursen, 2019).

While the area of child poverty and socioeconomic vulnerability corresponds to a topic widely addressed by public policies and evaluated through RCT, parenthood competencies, as well as the relationship of these skills with precarious socioeconomic levels, have not benefited from similar public and academic attention.

The empirical evidence on the use of RCT in relation to child poverty and social inclusion ranges from purely economic interventions to those aimed at the labor and social insertion of families. For example, from an economic point of view, interventions that provide unconditional economic support to families with children stand out, obtaining significant benefits on children's physical and mental health in Canada (Milligan, K., & Stabile, M., 2011), and Finland (Määttä et al., 2015).

Additionally, the meta-analysis carried out by Morrison et al., (2014), presents the results of different programs aimed at improving the parenting skills of families in European countries. For example, the Family Nurse Partnership (Scotland), the Positive Parenting Program (Scotland) and the Preparing for Life intervention (Ireland) have promoted visits by qualified nurses and social workers to mothers of children aged 0-2/3 in socio-economically vulnerable areas. The objective of these visits was the transfer of health knowledge and the development of workshops to improve parenting skills. Thus, with regards to the evaluation and RCT design of the programs, it is worth highlighting the positive impact of the interventions on parental behavior and indicators related to the health of children (for example: levels of immunization).

Other advocacy programs published after the mentioned meta-analysis demonstrate similar results. Weisleder et al., (2016) evaluate an early intervention program in the United States led by pediatricians and addressed to mothers in vulnerable socioeconomic situations. The RCT evaluation shows that the transmission of knowledge from the paradigm of positive parenting has positive effects on the early socio-emotional development of the child. Likewise, Leijten et al., (2017) evaluate the "Incredible Years Parenting" program in the Netherlands, which mainly consists of workshops on the transmission of parenting skills in those families with special ethnic and socioeconomic vulnerability. In this sense, the results of the evaluation indicate that these workshops have had a positive effect on the behavior of the children through an improvement in parenting skills.

In summary, RCT evidence for interventions that improve parenthood competencies from a positive parenting perspective is relatively scarce when compared to the existing evidence for interventions directly aimed at improving children's socioeconomic vulnerability. In this sense, the interventions that have been evaluated show that workshops based on the transmission of knowledge and the implementation of parenting skills can improve the skills of parents in precarious socioeconomic situations and have an impact on the emotional well-being of children.

The "Children's Spaces: 0-3" program emerges as a pioneering and seminal opportunity to evaluate the impact of workshops aimed at the development of parenting skills. Contrary to what is indicated in the literature, this evaluation not only covers these skills, but also analyzes the impact of the mentioned workshops on other socioeconomic and relational indicators.

2.2 Target population and territorial scope

The target population are families in a situation of socioeconomic vulnerability with dependent children between the ages of 0 and 3 years. In particular, the access profile included families with a high degree of social vulnerability, low level of employment, lack of parenting skills, and no or few specific skills for child-rearing, and difficulties in schooling children. In this way, the main units of analysis of the project are made up of families with an income below the Public Indicator of Income of Multiple Effects (IPREM)[12].

Specifically, this project has given priority to the recruitment of families with the following socio-demographic characteristics:

- New mothers and often very young mothers.
- Single-parent families (mainly single-parent families constituted by a mother and their children).
- Families with a high number of children in which there are limitations in care.
- Immigrant families including those without sufficient knowledge of the language of the territory in which they inhabit.
- Families (mainly formed by women) without access to labor insertion or with truncated processes due to the birth and upbringing of the child.

Finally, it is important to mention that this pilot project has been carried out in the following 9 Autonomous Communities: Andalusia, Aragon, the Canary Islands, Castilla y León, Catalonia, the Valencian Community, the Basque Country, the Community of Madrid, and the Region of Murcia.

More details on the recruitment process and actors involved in this process are provided in **section 3.5** as part of the evaluation design.

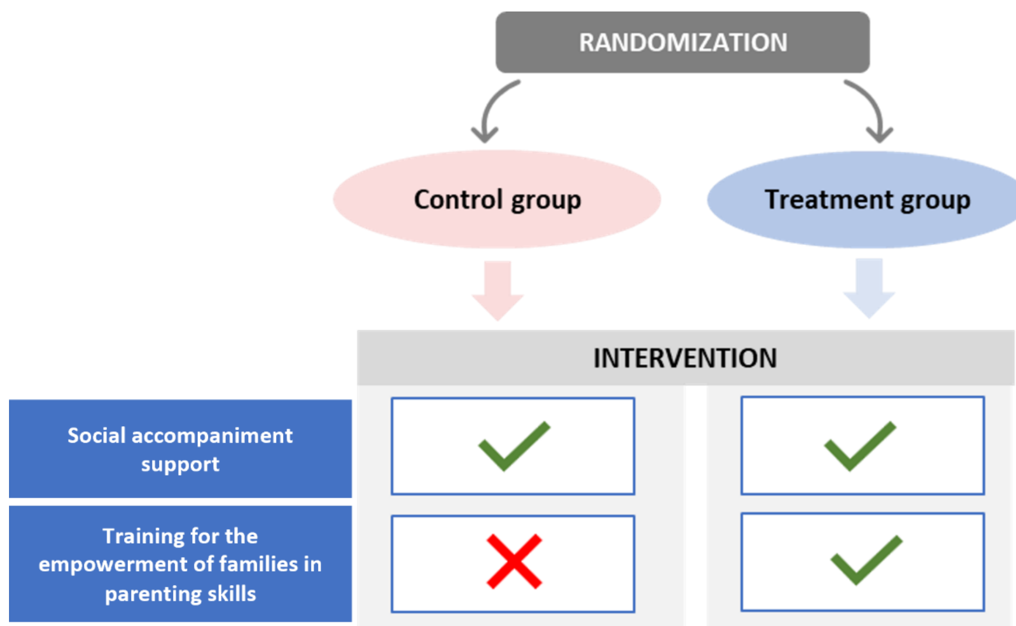
2.3. Description of interventions

The interventions in this itinerary are framed within a global model of socio-economic, labor, and educational support implemented by the participating entities and members of the CaixaProinfancia program mentioned in the previous section. The activities of this project are supported by two different lines of actions: (i) activities related to social accompaniment and support; and (ii) training

[12] The Public Indicator of Income of Multiple Effects (IPREM) is an index used in Spain as a reference for the granting of aid, subsidies, or unemployment benefits. It was created in 2004 to replace the Minimum Interprofessional Wage as a reference for these aids.

for the empowerment of families in relation to emotional and educational competencies and skills for the multidimensional care of young children. The intervention has been designed following the RCT methodology, with a control group and a treatment group. Activities related to social accompaniment are aimed at both the control group and the treatment group. In contrast, family empowerment training is aimed only at the families in the treatment group. **Figure 2** summarizes the intervention scheme:

Figure 2: Intervention scheme



The following are the two lines of services provided to families:

Social accompaniment and support

The social accompaniment of the families, aimed at both the control and treatment groups, was carried out by a tandem of specially trained professionals (social worker and initial educator) through a 15-hour allocation of time per family during the intervention. In addition, this accompaniment was made up of the following tools or resources. In particular:

- **Passport 0-3**: all families who access the program have a passport used as an “instrument” aimed at the provision of incentives for better parental behavior. Specifically, this “instrument” acts as a "pedagogical contract" by showing behavioral achievements and visually explaining the route to follow during the project. This instrument managed by social work professionals seeks to support the trajectories of "good care" and "good education" of children, especially encouraging the commitment and empowerment of mothers and fathers.
- **Goods for basic needs**: associated with the 0-3 Passport; families have monetary aid in the form of a rechargeable wallet card with a benefit of up to 900 euros for the purchase of necessities (food, hygiene, clothing, etc.). This amount is distributed in three tranches of 300

euros per family and aims to strengthen the commitment of families and the support to the social action of the itinerary.

- **Support for integration**: support and assistance for integration is offered through "la Caixa" Foundation's Incorpora Program as well as other services specific to the territory (integration programs of social entities, local employment services, employment offices, etc.). Thus, the objective framed in this resource seeks to promote the inclusion of young people who are beginning their parental responsibility and have a long time of active parenthood ahead of them.
- **Voucher 0-3**: this resource facilitates ad-hoc non regular hourly assistance for parents, by providing a “babysitting service” within the "Children's Spaces 0-3". In turn, this may allow parents to solve family conciliation issues. This resource forms part of the package delivered by the social accompaniment of families, by facilitating attendance on intensive training programs. Hence, this resource grants three vouchers of 5 sessions each (2 hours per day). These vouchers are renewable according to the needs of the family and the degree of participation in the program.
- **Encounters 0-3**: consists of the organization of "0-3 snacks" (or equivalent meeting spaces) between peers to meet other families, share concerns, and facilitate the planned assessment of parenthood competencies and child development. Each “Children's Space 0-3” organizes 12 groups of families (6 with the treatment group and 6 with the control group), who participate in six meetings.

Training for the empowerment of families in parenting skills

The training for the empowerment of families in parenting skills materialized in the realization of family workshops developed in the **"Children's Spaces: 0-3"** addressed to the treatment group. Specifically, subgroups are formed within the treatment group made up of approximately 6 to 8 families who attend a training workshop. This workshop lasts 80 hours for each subgroup of families, distributed in 2 weekly sessions for 16 weeks. The activities of the workshop are developed based on practical training applied from the joint stay of parents and children with the professional of the "Children's Space: 0-3" and other families. Thus, the training focuses specifically on the knowledge of the child, the development of the affective bond, strategies for the care and the regulation of the child’s behavior. Specifically, the content of the workshops was structured in the following thematic lines: 1) woman mother; 2) immediate postpartum; 3) respectful parenting; 4) food and sleep; 5) integral development and 6) games.

3 Evaluation design

This section describes the design of the impact assessment. As a result, this section focuses on the theory of change. Specifically, this theory of change identifies the mechanisms and aspects to be measured, the hypotheses to be tested in the evaluation, the sources of information to construct the indicators, and the design of the experiment.

3.1 Theory of Change

To design an evaluation that allows us to understand the causal relationship between the intervention and its final objective, we begin by developing a theory of change. The theory of change makes it possible to schematize the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long term results sought by the intervention, to understand the relationships between them, the assumptions on which they are based, and to outline measures or outcome indicators.

Theory of Change

A Theory of Change begins with the correct identification of the needs or problems to be addressed and their underlying causes. This situational analysis should guide the design of the intervention, i.e., the activities or products that are provided to alleviate or resolve the needs, as well as the processes necessary to properly implement the treatment. Next, we identify the expected 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 carried out. 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 in the final results, the indirect effects.

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 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 lack of resources for access to initial child education for vulnerable families reinforces the need identified in this project concerning the lack of parental skills for the care and upbringing of dependent children between the ages of 0 and 3 years. In this way, this problem or need drives the starting point of the impact sequence of the theory of change of the intervention in the treatment group: **family workshops in the "Children's Spaces: 0-3"**.

The execution of these workshops promotes a series of actions embedded in a program for the development of emotional skills and educational strategies for the care of the child. In this way, this program is positioned as the main intervention to which the participants of the treatment group are exposed.

As a result, it is expected that this training program have a direct impact on the improvement of the parental skills of the participants, on the reduction of the social vulnerability of the families and on the use and appreciation of the knowledge and resources acquired during the development of the

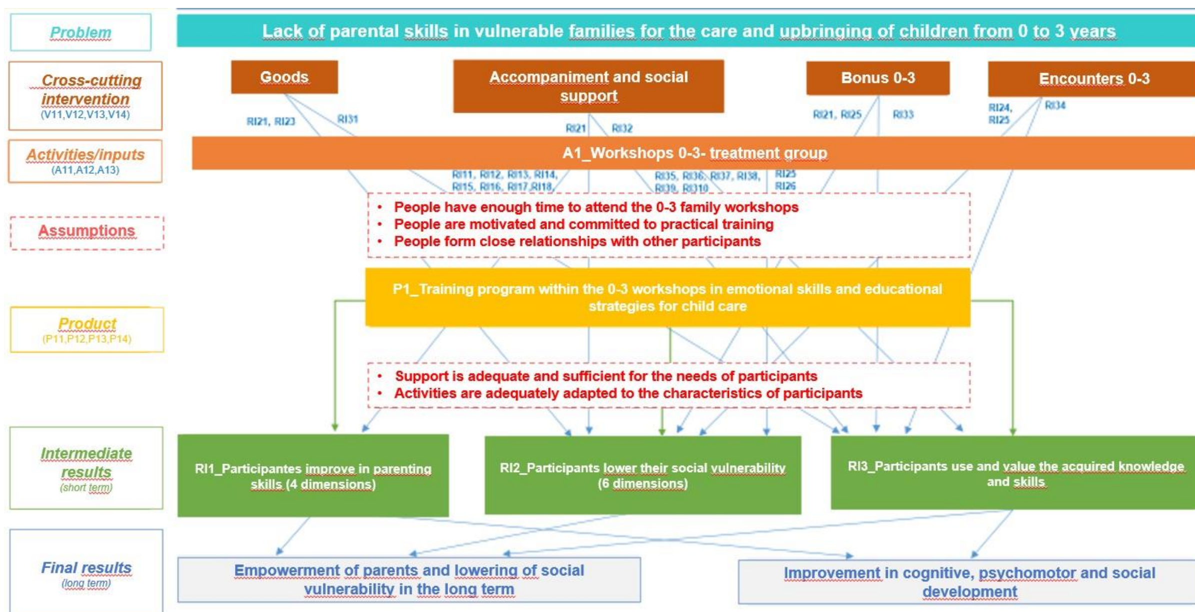
workshops. In this sense, these effects constitute the intermediate results of the sequence of impacts of the theory of change applied to this project. That is, it is expected that training in certain types of emotional and educational skills will end up generating, in the short term, a positive effect on the improvement of parental skills, as well as on the reduction of the precariousness and socioeconomic vulnerability of families. In addition, this analysis expects to observe a positive effect on the use and value of the knowledge and resources acquired during the training.

Finally, it is expected that this improvement in parenting skills, reduction of social vulnerability and promotion of the use and appreciation of the knowledge acquired during the training, will have a direct impact on final results defined in two aspects of the participants' lives: (i) empowerment of parents and reduction of social vulnerability in the long term, (ii) improvement in the psychomotor, cognitive, and social development of children.

Finally, it is important to mention that the chain of impacts reviewed in this section is subject to a series of assumptions that affect the causal capacity of the relationship between the product and the intermediate and final results of the project. By way of illustration, for training programs in emotional skills and educational strategies for the care of children to have an impact on improving parenting skills and reducing social vulnerability, the specific activities carried out in the development of these programs must be adapted to the characteristics and needs of the participants.

The following figure illustrates the causal sequence of actions just described, initiated by the problem, or need detected, and the activities and resources needed to achieve the expected changes in the participants.

Figure 3: Theory of Change



3.2 Hypothesis

As detailed in the previous section, this itinerary seeks to verify the differential impact of the pedagogical methodology applied through the family workshops in the "Children's Spaces: 0-3" in the following main dimensions:

- Increase of parenting skills from the paradigm of positive parenting.
- Reduction of the social vulnerability of families.
- Assessment and use of the knowledge acquired.

The scope of action of this project covers areas of incidence of different kinds. Hence, this multidimensional approach makes it possible to analyze the impact of the itinerary on work, educational and socio-economic aspects of the beneficiaries of the treatment, as well as the use and assessment of the knowledge acquired in it.

1. Improving parenting skills

The main hypothesis in this area of analysis postulates that the development of the training programs applied in the family workshops of the "Children's Spaces: 0-3" will improve the parenting skills of the participants in the treatment group. Parental competencies linked to positive behaviors and emotional skills are classified into four types: responsiveness, encouragement, affection, and education. The main hypothesis is based on observational measurements of these competencies by social service professionals.

Likewise, in a complementary way, the secondary hypothesis in this area of analysis postulates the improvement of self-perceived and self-reported parental competencies of those participants in the treatment group, compared with the self-perceived competencies of the control families.

2. Reduction of family social vulnerability

This hypothesis postulates that participation in the family workshops in the "Children's Spaces: 0-3" decreases the social vulnerability of the families benefiting from the training provided, compared to the control families. Family social vulnerability is measured in several dimensions of impact on family life, including economic vulnerability, housing vulnerability, educational vulnerability, health vulnerability, vulnerability in terms of intra-family relationships, and vulnerability in sociocultural capital.

3. Use and appreciation of the knowledge and resources acquired.

As a third area of analysis, this evaluation studies the assessment of the knowledge and resources acquired by the participants in each group, with the aim of assessing whether there are differences between them.

The results of this evaluation will be included in the appendix to the report, as it is considered a process analysis and not an impact analysis.

3.3 Sources of information

Researchers use the following sources of information to empirically evaluate and contrast the hypotheses described in the previous section.

Firstly, the basic identification, socio-demographic and economic data of the families are collected by an ordinary collection procedure in each of the entities. Furthermore, this information is introduced in a computer application for the management of the CaixaProinfancia program. This data is incorporated and updated by the social workers of the entities, who are also responsible for assessing the degree of social vulnerability. Specifically, the data necessary to assess the level of socioeconomic vulnerability in the dimensions indicated in the previous section (economy, housing, health, intra-family relations, sociocultural capital, and education), are collected through interviews **before** (baseline survey) **and at the end** (end-line survey) of the intervention concerning the family workshops in the "Children's Spaces: 0-3”.

Secondly, the evaluation of this project uses the internationally and academically validated PICCOLO tool, adapted to the Spanish context (Roggman et al., 2013; Vilaseca et al., 2019). Social workers and educators use PICCOLO, to evaluate and assess parental skills through observational techniques. Four dimensions are considered (affection, responsiveness, encouragement, education) with a total of 29 indicators. Adding to this, the process of data collection is carried out by each trained professional separately. Afterwards, these social workers create a unique assessment of each family through the triangulation of the information. Therefore, the second source of information corresponds to data sheets and technical assessments referring to parenthood competencies assessed by the specialists of each entity and is obtained both at the beginning and at the end of the intervention to assess progress in parenthood competencies.

Thirdly, to complement the assessment by the social technicians, surveys aimed at families are incorporated to determine their own self-assessment of parental skills and the degree of satisfaction and usefulness of the workshops. In particular:

- **Family questionnaire on parenthood competencies:** these technical sheets are completed **before** (baseline) and at the **end** (endline) of the intervention of the family workshops in the "Children's Spaces: 0-3". Specifically, these questionnaires incorporate self-assessments of the frequency by which certain types of positive behaviors are carried out. As an illustration, these questionnaires ask about the frequency (never, almost never, sometimes, almost always, always) by which parents speak to their children in an affectionate and caring manner.

- **Survey of satisfaction and usefulness of the workshops:** through a questionnaire, families assess the usefulness and satisfaction in relation to the experience and resources in which they have participated through a battery of questions received at the **end** of the interventions (endline) of this project. This survey is based on a qualitative scale (a lot, quite a lot, sufficient, a little, or not at all) aimed at understanding the level of satisfaction and self-perceived usefulness of families in relation to the experience and resources in which they have participated.

3.4 Indicators

This section describes the indicators used for the evaluation of the impact of the treatment studied in this project, classified by different topics related to the hypotheses described above.

Parenthood competencies

To evaluate the hypothesis concerning the improvement of parental skills of the treatment group through the training received in the family workshops developed in the "Children's Spaces: 0-3", this evaluation produces two groups of indicators:

Observational indices: Firstly, regarding the technical assessment conducted by professionals to analyze the parenting skills of the participating families, this evaluation constructs four quantitative indices measured at both the beginning and the end of the intervention: **responsiveness, affection, encouragement, and education.**

For instance, the emotional skill linked to affection is comprised of behaviors related to the affectionate tone by which the child is spoken to or the ability to smile and show affective warmth towards the latter.

Technicians quantify the frequency of these behaviors using a scale (absent=0; rarely=1; evident=2). The indices are the sum of the score given by the technicians for each specific behavior associated with a competency, taking values from 0 to 14 points for the competency dimensions related to affection, responsiveness, and encouragement, and from 0 to 16 for the dimension related to the ability of parents to educate and teach. Finally, these indices have been standardized for each dimension in such a way that they have a mean equal to 0 and variance equal to 1.

Self-perceived indices: the self-perceived indicators of parental competencies are constructed from the information provided by the parents of the children themselves. In addition, these indicators determine the frequency of positive behaviors (self-perceived) on the scale (Never (0); Almost never (1); Sometimes (2); Almost always (3); Always (4)) for the subsequent construction of the standardized index equivalent to the observable indices for behaviors related to **responsiveness, affection, encouragement, and education.**

Family social vulnerability

To measure family social vulnerability, several quantitative indicators are proposed for each dimension studied in this evaluation (**economic, educational, housing, health, intra-family relations, sociocultural capital**). The data to construct these indicators is collected at the beginning and at the end of the intervention.

Since June 2022, CaixaProinfancia program has had an instrument for measuring family social vulnerability that helps to diagnose the family situation, support within the planning of different social actions and procedures and allow the results of the program's interventions to be assessed more accurately. The instrument was developed and validated by the Consolidated Research Group in Pedagogy, Society and Innovation with the support of ICT (PSITIC) of the Faculty of Psychology,

Education and Sports Sciences Blanquerna Universitat Ramon Llull (FPCEE Blanquera-URL), in collaboration with the Consolidated Research Group of Quantitative Psychology of the Faculty of Psychology of the University of Barcelona and with the support of "la Caixa" Foundation and within the framework of an R+D+i project funded by the Ministry of Science, Innovation and Universities (ref. PID2019-104971RB-I00).[13]

In particular, the family social vulnerability scale is made up of six dimensions, obtaining a coefficient for each of them associated with each family. Specifically, the calculation takes into account risk and protection factors linked to a specific social dimension, and produces a coefficient framed within the following scale of social vulnerability: less than 70 (low vulnerability); between 70 and 84 (medium-low vulnerability); between 85 and 114 (medium vulnerability); between 115 and 129 (high vulnerability); greater than or equal to 130 (very high vulnerability) (Cañete-Massé et al., under review).

Use and appreciation of acquired knowledge and resources

In relation to the assessment of the knowledge and resources acquired during the intervention, several post-intervention indicators are based on a qualitative scale associated with a specific score based on a series of questions related to the use and assessment of the knowledge and resources acquired by each group (control and treatment). As an example, an indicator is created based on satisfaction with the development of the workshops composed of the following scale and associated score: a lot (4); quite a bit (3); sufficient (2); little (1); Nothing (0).

3.5 Design of the experiment

To evaluate the impact of the family workshops developed in the "Children's Spaces: 0-3", an experimental evaluation (RCT) is used in which participants are randomly assigned between the treatment group and the control group. This section details the process of recruiting and selecting the beneficiaries of the intervention, as well as the random assignment and time frame of the experiment.

Recruitment of the beneficiaries of the intervention

This project was defined to be implemented by 20 entities that are part of the territorial networks of the CaixaProinfancia program; where the mentioned family workshops are held in the "Children's Spaces: 0-3". The recruitment process is structured in the same way for each of the 20 entities located in the following autonomous communities: Andalusia, Aragon, the Canary Islands, Castilla y León, Catalonia, the Valencian Community, the Basque Country, the Community of Madrid, and the Region of Murcia. The selection criteria of the participating entities were based on specific aspects related to

---

[13] Research project entitled *Validation of a social vulnerability scale to evaluate the impact of socio-educational programs* directed by Dr. Jordi Riera Romaní and Dr. Jordi Longás Mayayo and funded by the Ministry of Science, Innovation and Universities (ref. PID2019-104971RB-I00).

the suitability of proposals and budgets according to information formulated in a public call and territorial distribution by autonomous communities.

As explained above, the starting population for the development of this project was made up of families in vulnerable situations with children between 0 and 3 years of age. In fact, the main units of analysis of the project are families with an income below the IPREM index.

The phases of the recruitment process included contact with the families potentially benefiting from the program, participation in information sessions about the project and the collection of required informed consent to participate in the itinerary. It is important to understand that, although the main responsibility for recruitment lies mainly within the 20 selected entities, access to the program is made through the referrals agreed in the already constituted and active children's committees. In turn, these committees involve social services, schools, and other local actors. These children's committees are made up of the mentioned social entities, educational centers, and social services from the same territory in which they work within the framework of the CaixaProinfancia program.

In the first place, social entities, and the members of the children's committees have a sample of potentially beneficiary families that they attempt to contact. Once contact is established, information sessions are held to present the project and next steps to be taken. Additionally, a check is also being carried out on the participation requirements. Finally, once the participation criteria have been verified and the project has been explained in detail in the information sessions, the families interested in participating sign the informed consent. With that informed consent participation in the program is approved. If the sample in each local network does not reach the 48 families foreseen in each social entity, joint actions are coordinated with other institutions in the territory to recruit families that meet the inclusion criteria and agree to participate.

Informed Consent

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

Informed consent is required in most research and may be oral or written, depending on different factors such as the literacy of the population or the risks posed by consent. Only under very specific circumstances, such as when the potential risks to 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.

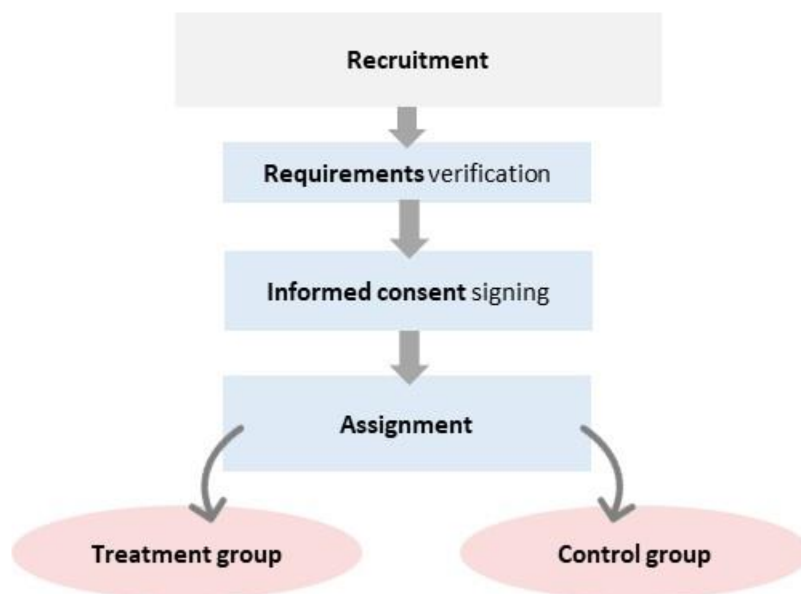
Random assignment of participants

In the context of this pilot project, an experiment was designed for 944 families distributed in 20 networks, with the aim of assigning 50% of these families to the control group and the other 50% to the treatment group. In addition, within the phase of data collection design, the possibility of increasing the number of families per network was included, with the aim of guaranteeing the expected number of participating families by replenishing them with "reserve families" in the event of a possible sample loss during the execution of the itinerary.

Among the families that sign the informed consent, for each of the networks, 48 families are randomly selected to be part of the titular family sample (except for one network in which the titular sample is made up of 32 families), with the rest of the families being reserve families. The sample is stratified at the level of the network and a variable that determines whether there is at least one breastfeeding child in the family, creating 40 strata. In each of these strata, for the titular sample, families are randomly assigned to control and treatment groups. Regarding the reserve families, they are randomly assigned by stratum in an order of substitution by which, in the event of dropouts, they would become part of the titular sample.

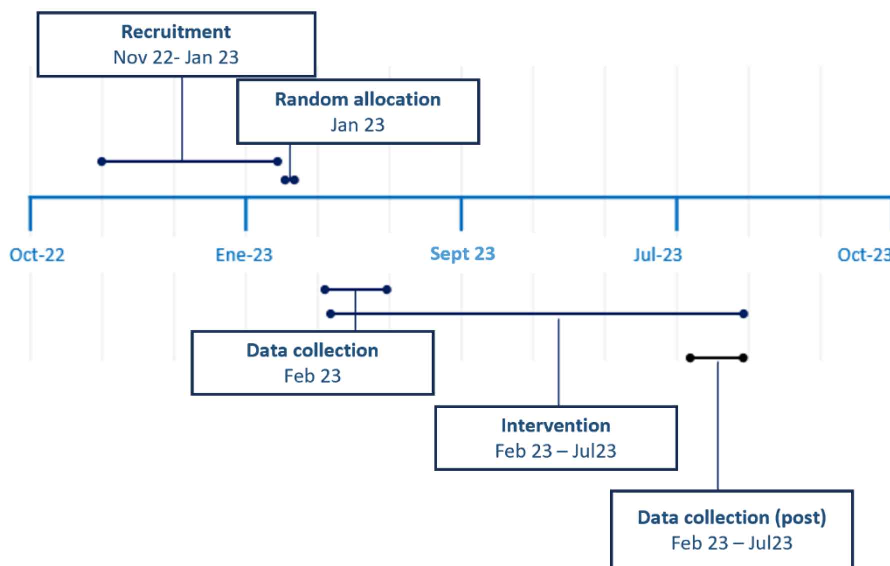
Therefore, randomization is carried out at the family level in each of the mentioned networks of each participating entity, carrying out a stratification between breastfeeding children and non-breastfeeding children, understanding by family with a breastfeeding child the one that has at least one child who is within the age of being a breastfed infant. This stratification was carried out under the consideration that there are different needs for children and their families in the case of "breastfeeding families". Thus, although the treatment is homogeneous for all participants, small adaptations were made to the development of the treatment according to the mobility of the breastfeeding child.

Figure 4: Recruitment and randomization process



Given the explanation, **Figure 5** shows the time frame in which the implementation and evaluation took place. The collection took place between the months of November 2022 and January 2023 and, in the same month of January, the random assignment of participants who meet the criteria and who had signed the informed consent and were interested in participating was carried out. Baseline data was collected during the month of February 2023. The development of the itinerary or intervention runs from February to July 2023. Finally, the final survey of the participants was carried out once the intervention had finished.

Figure 5: Timeframe of the evaluation



4 Description of the implementation of the intervention

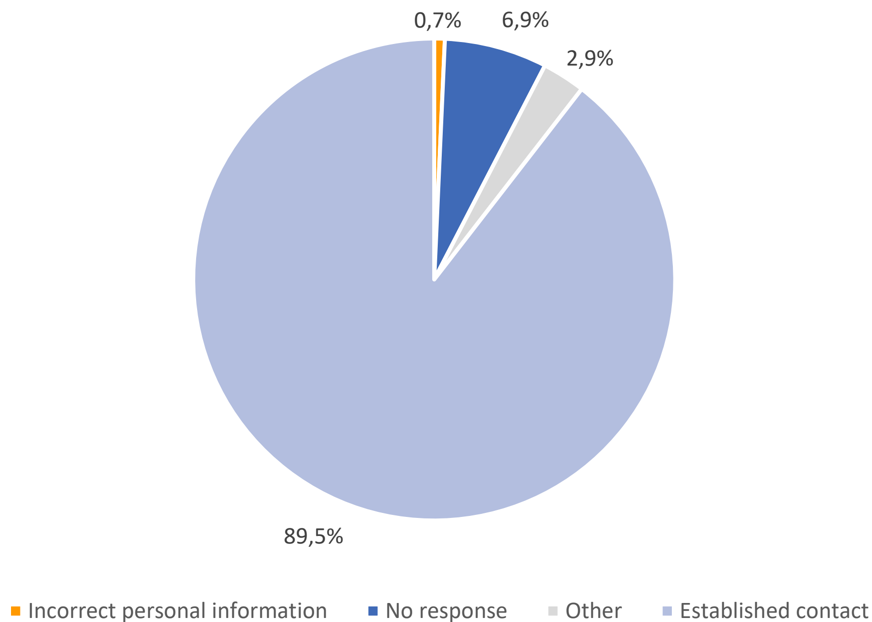
This section describes the practical aspects of how the intervention was implemented as part of the evaluation design. It describes the results of the participant recruitment process and other relevant aspects to contextualize the results of the evaluation.

4.1 Sample Description

As mentioned in the previous section, 20 social entities in collaboration with other constituents of the territorial children's committees selected and contacted the families potentially benefiting from this pilot project.

First, the total number of potential participants was 1,697 people. Of this total, 89.5% (1,519 families) were contacted by the relevant entities. **Figure 6** shows several reasons that explain why it was not possible to establish contact with all the potential beneficiaries of the intervention.

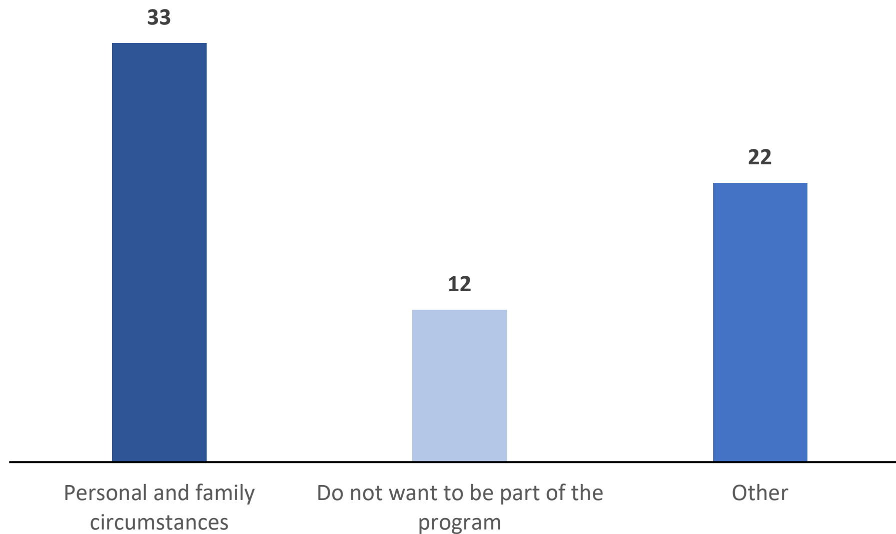
Figure 6: Result of attempted contact with potential participants



Approximately 1 in 10 potential participants could not be contacted. 6.9% of the potential beneficiaries could not be contacted because they did not respond to the entities' attempts to establish communication with them, 0.7% because they did not have correct data on the families and 2.9% due to various reasons.

Secondly, out of the participants contacted, more than 370 families were not part of the entire project because they did not attend the initial interview. Out of the families to whom the project was presented, 67 declined to participate, citing the reasons given in **figure 7**. Specifically, 33 families did not agree to participate for reasons related to their personal and family circumstances, 12 notified that they did not wish to be part of the program and 22 alleged reasons of different kinds.

Figure 7: Reasons for non-participation of families with knowledge of the project



Finally, it should be noted that, out of the families contacted, 1,081 agreed to participate in the project and 1,009 signed the informed consent form and, therefore, were included in the framework of the intervention to be part of the titular sample (944 families) or reserve (65 families).

During the first two weeks of the intervention, 58 of the families on the reserve list were contacted to join the control group or the treatment group (active reserves) according to the order of substitution mentioned earlier in section 3.5; while the other 7 reserve families were not needed (inactive reserves). Therefore, within the framework of this pilot project, the experimental sample is defined as the 1,002 families that form part of the titular group (944) or active reserves (58).

Out of this experimental sample of 1,002 families, there are 54 families who left the program prior to data collection and their information could not be collected. Thus, the initial dataset contains information on 948 families that were either initially assigned to the incumbent sample (regardless of whether they dropped out of the program at any time or not) or are families assigned to the reserve group that replaced some of the dropouts.

In addition, seven of the executing entities did not have reserve lists or had very few families on these lists, so that as the selected families were rejected once they were informed of the results of the random selection, it was not possible to replace them. Given this challenge, the entities made an additional effort to expand their reserve lists by re-contacting families who had expressed interest in participating, but who had finally been excluded for not submitting informed consent. Families contacted after the initial randomization were not considered in the impact assessment.

Characteristics of the final evaluation sample

Table 1 shows the descriptive statistics of the sociodemographic variables, and results of the experimental sample, measured before the intervention with data collected at baseline.

The table is structured in 6 columns: variable name, mean, standard deviation, minimum and maximum value, and the number of families to which the information provided corresponds.

Table 1: Descriptive statistics of the sample

	Mean	Standard deviation	Min	Max	N
Sociodemographic characteristics					
Number of children in the program (0-3)	1,12	0,34	1	3	948
1 child in the family	0,25	0,43	0	1	937
2 child children in the family	0,29	0,45	0	1	937
3 or more child children in the family	0,46	0,5	0	1	937
Proportion of girls (0-3)	0,46	0,48	0	1	948
Children average age (0-3)	2,17	0,9	0,49	4,02	948
Breastfeeding child	0,32	0,47	0	1	948
Proportion of children in school (0-3)	0,05	0,21	0	1	948
Biparental family	0,63	0,48	0	1	948
Extended family	0,01	0,08	0	1	948
Single parent family	0,35	0,48	0	1	948
Other type of family	0,01	0,11	0	1	948
Tutor 1 female	0,84	0,37	0	1	948
Tutor 2 female	0,29	0,46	0	1	487
Tutor 1 age	34,43	7,92	18,05	71,58	948
Tutor 2 age	37,32	8,22	18,56	68,56	487
Tutor 1 Spanish nationality	0,45	0,5	0	1	948
Tutor 2 Spanish nationality	0,38	0,49	0	1	487
Tutor's maximum years of education	7,18	3,42	0	16	948
One tutor employed	0,38	0,49	0	1	948

Tutor 1 temporary job	0,13	0,34	0	1	948
Tutor 1 permanent job	0,08	0,27	0	1	948
Tutor 1 unemployed with public transfer	0,26	0,44	0	1	948
Tutor 1 unemployed without public transfer	0,48	0,5	0	1	948
Tutor 1 occasional works	0,02	0,14	0	1	948
Tutor 1 other working status	0,03	0,17	0	1	948
Tutor 2 temporary job	0,23	0,42	0	1	487
Tutor 2 permanent job	0,09	0,29	0	1	487
Tutor 2 unemployed with public transfer	0,18	0,38	0	1	487
Tutor 2 unemployed without public transfer	0,41	0,49	0	1	487
Tutor 2 occasional works	0,04	0,19	0	1	487
Tutor 2 other working status	0,05	0,21	0	1	487
Other FLC courses attended	2,49	2,97	0	17	948
Outcomes: Parenthood competencies and Vulnerability					
Responsiveness index baseline	0	1	-2,49	1,42	915
Affection index baseline	0	1	-3,05	1,15	915
Encouragement index baseline	0	1	-1,64	1,76	915
Education index baseline	0	1	-1,02	2,89	915
Self-reported responsiveness index baseline	0	1	-4,23	0,95	905
Self-Reported affection index baseline	0	1	-4	1,17	905
Self-reported encouragement index baseline	0	1	-6,34	0,89	905
Self-reported education index baseline	0	1	-5,01	0,86	905
Economic vulnerability baseline	103,39	14,73	55,97	136,63	941
Housing vulnerability baseline	104,32	15,05	67,95	153,26	941

Health vulnerability baseline	104,48	13,81	54,73	152,15	941
Intra-Family Relationships vulnerability baseline	103,31	13,66	65,9	144,89	941
Sociocultural capital vulnerability baseline	105,2	13,47	65,1	145,86	941
Educational vulnerability baseline	102,62	12,3	64,63	138,42	941

As it can be seen in **table 1**, on average, families have a child between the ages of 0 and 3 in the program, which has an average age of two years, and nearly half of them are girls (46%). In addition, 32% of families have a breastfeeding child, and only 5% of children between 0 and 3 years old go to school. 46% of families have 3 or more children under the age of 18, while 25% and 29% have one and two children, respectively. More than half of the families are two-parent families (65%), while 35% are single-parent. In addition, on average, these families had attended more than two courses at "la Caixa" Foundation before the intervention.

In addition, as indicated in **table 1**, caring responsibilities fall mainly into female participants, with 84% of titular tutors being women. The tutors are, on average, between 34 and 37 years old and 38-45% have Spanish nationality. On average, the maximum number of years of tutor education is 7, and only 38% of families have at least one employed tutor. 74% of titular tutors are unemployed, and of those employed, only 8% have a permanent job. With regards to the second tutor, the proportion of unemployed is lower, 59%, but an equally low percentage (9%) have a permanent job.

The second part of **table 1** presents summary statistics for the outcome indicators measured at the beginning of the study (baseline) and the last block of variables presents the initial values of six indices that measure the vulnerability of the families participating in the project in six different aspects: economic situation, housing, health, intra-family relations, sociocultural capital, and education.

4.2 Random Assignment Results

Once the sample has been defined, the participants are randomly assigned to the control group (CG) or treatment group (GT). As explained in section 3.5 this randomization process was carried out by household within each network considering whether there was a breastfeeding child in the family. As a result, this procedure results in 40 strata.

The table below shows the results of the random assignment, detailing the number of participants assigned to each group and breaking down this information according to the different stratification variables.

Table 2: Results of random assignment

Network	BREASTFEEDING CHILD			NON-BREASTFEEDING CHILD			BREASTFEEDING CHILD+NON-BREASTFEEDING CHILD			RESERVES			RESERVES+NON-RESERVES		
	CG	TG	**Tot**	CG	TG	**Tot**	CG	TG	**Tot**	LACT	DO NOT LACT	**LACT NOT LACT**	LACT	DO NOT LACT	**LACT NOT LACT**
1	6	6	12	18	18	36	24	24	48	0	2	2	12	38	50
2	8	8	16	16	16	32	24	24	48	0	0	0	16	32	48
3	7	7	14	17	17	34	24	24	48	0	0	0	14	34	48
4	6	6	12	18	18	36	24	24	48	0	0	0	12	36	48
5	8	8	16	16	16	32	24	24	48	1	4	5	17	36	53
6	8	8	16	16	16	32	24	24	48	3	6	9	19	38	57
7	6	6	12	18	18	36	24	24	48	0	2	2	12	38	50
8	9	9	18	7	7	14	16	16	32	0	0	0	18	14	32
9	10	10	20	14	14	28	24	24	48	2	4	6	22	32	54
10	7	8	15	17	16	33	24	24	48	3	4	7	18	37	55
11	10	10	20	14	14	28	24	24	48	3	8	11	23	36	59
12	12	13	25	12	11	23	24	24	48	1	3	4	26	26	52
13	8	7	15	16	17	33	24	24	48	0	2	2	15	35	50
14	8	9	17	15	16	31	23	25	48	1	2	3	18	33	51
15	8	8	16	16	16	32	24	24	48	0	0	0	16	32	48
16	7	6	13	17	18	35	24	24	48	1	2	3	14	37	51
17	6	6	12	18	18	36	24	24	48	2	2	4	14	38	52
18	9	9	18	15	15	30	24	24	48	0	0	0	18	30	48
19	9	8	17	16	15	31	25	23	48	0	0	0	17	31	48
20	2	3	5	21	22	43	23	25	48	2	5	7	7	48	55
Total	**154**	**155**	**309**	**317**	**318**	**635**	**471**	**473**	**944**	**19**	**46**	**65**	**328**	**681**	**1009**

The table below indicates the distribution of intervention groups after substitutions: 504 families were assigned to the treatment group, 490 to the control group, and 8 active reserves that could not be contacted or refused to participate were not assigned to a group.

Table 3: Intervention groups after substitutions

Intervention group	Families
Treatment group	504
Control group	490
Unknown group	8
Titular families and active reserves	1002
Inactive reserves	7
Total randomized families	1009

Figure 8[14] shows the equilibrium contrasts between the treatment group and the control group based on data collected before the intervention (baseline).

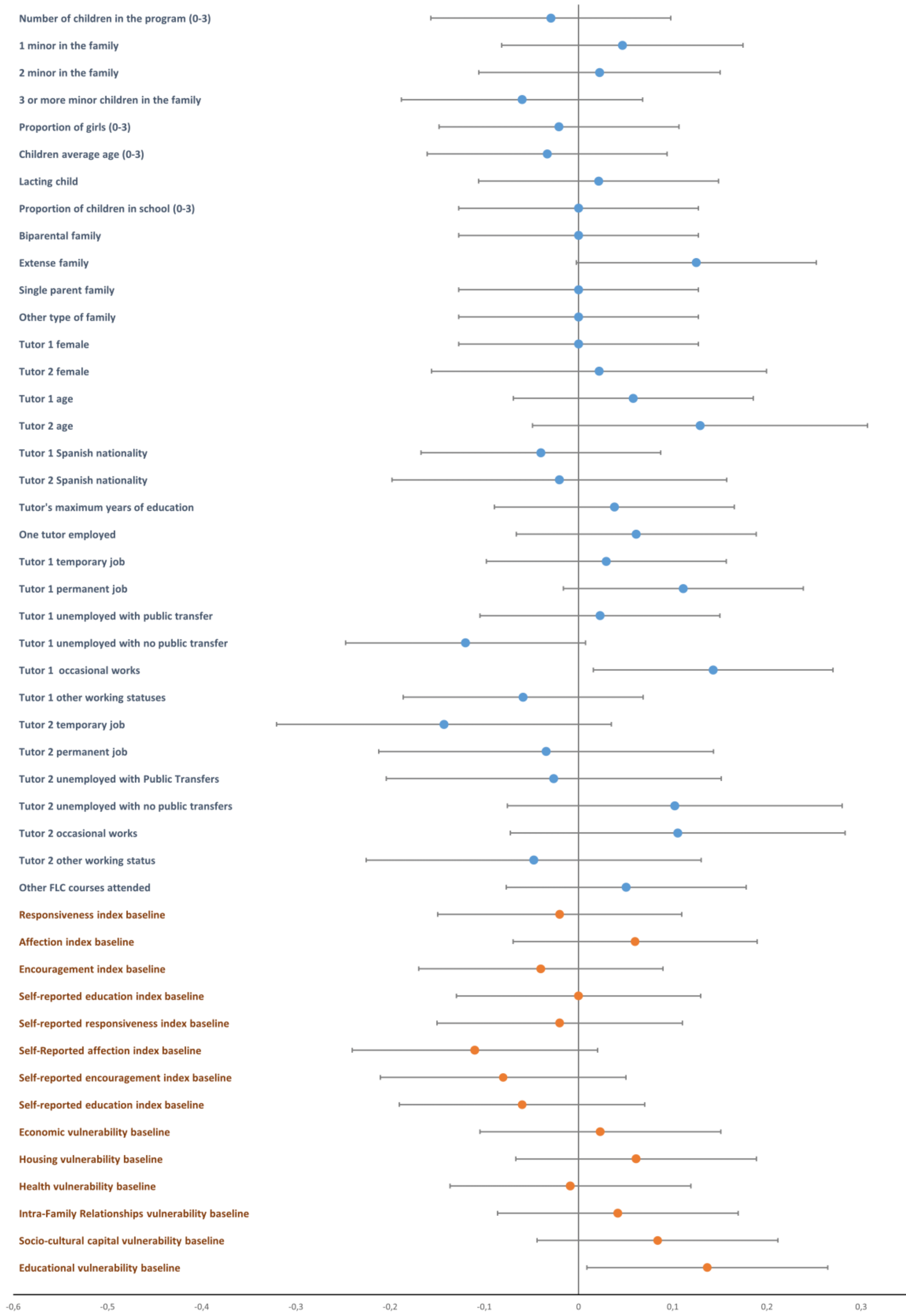
In this sense, this evaluation performed equilibrium tests on all the covariates presented in **table 1**, sociodemographic characteristics, and outcomes, all measured at baseline. For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a dot and 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. Therefore, if that is the case it could be concluded that the intervention groups are balanced in this characteristic. In the case where the confidence interval of the mean difference does not contain zero, it can be concluded that the difference is statistically significant and, therefore, the groups are unbalanced in this characteristic.

In terms of socio-demographic variables, the sample is balanced, except for the proportion of primary tutors who are unemployed and do not receive any public transfers. This proportion is 51% in the control group while it is 45% in the treatment group, a difference that is significant at the 10% level. The proportion of unbalanced variables is less than 5% of the variables analyzed. In turn this may be due to chance. Thus, it can be concluded that the sample is balanced with respect to sociodemographic characteristics. In terms of baseline indicators, the sample is also balanced between

[14] See **Table 12** in the appendix for the balance between experimental groups

the treatment and control groups, with two exceptions. On average, sociocultural, and educational vulnerability indices are lower in the control group than in the treatment group. These differences are significant at the level of 10% and 1%, respectively. In the econometric analysis, this evaluation also controls for non-balanced variables.

Figure 8: Standardized mean difference between treatment group and control group (95% confidence interval)



4.3 Degree of participation and attrition by groups

The informed consent group was an experimental sample that was 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 average effects of offering it given the degree of participation. For example, if participation in treatment activities is low, the treatment and control groups will 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

Table 4 shows the level of participation in the intervention in the family workshops developed in the "Children's Spaces: 0-3" for the families in the treatment group[15]. Course attendance is very high, with 86% of families attending more than 25% of sessions, 84% attending more than half, and 76% attending more than 75%. Therefore, the level of adherence to treatment is considered high.

Table 4: Degree of participation in family workshops

	25% attendance	50% attendance	75% attendance
Families in treatment group	434	423	384
% of families in treatment group	86,11%	83,93%	76,19%
Total Families in treatment Group	504		

Attrition and attrition rate by groups

The attrition rate, which corresponds to the proportion of potential respondents at the end of the study with missing results, is 10%, as this information was not collected for 100 of the 1,002 incumbent and active reserve families. **Table 5** shows that 46 of these families did not continue or had irregular participation after completing the initial survey, while 54 of these families dropped out of the intervention before the initial data was collected.

[15] Intervention attendance was not recorded for families in the control group, preventing the researchers from analyzing noncompliance in the control group.

Table 5: Attrition rate by participation

Final status	Attrition before the start of the study	Initial study completed
Active	0	1
Inactive	0	13
Refusal	54	32
Total by group	54	46
Families with missing endline indicators	100	
Total potential endline respondents	1002	

Note: this table shows the total of families that left the intervention; that is, those cases in which the final indicators (at the end of the study) are not available.

Table 6 shows that the attrition rate was 12.7% in the treatment group and 5.7% in the control group. In addition, this itinerary had 8 families who were on the reserve list and could not be contacted to join the program or refused to participate when contacted.

This level of attrition is relatively low compared to similar studies. The high level of adherence to the program and the response rate in the final survey are indications that the program was highly valuable to families. In addition, the dataset compiled by "la Caixa" Foundation for its regular activities has allowed us to retrieve final information for families with missing data at the end of the study, highlighting the benefits of administrative data in alleviating random assessment problems such as attrition rate.

Table 6: Attrition rate by intervention group

	Total	Treatment	Control	Contacted from the reserve list
Attritors	100	64	28	8
Total potential endline respondents	1002	504	490	8
Attrition rate	10,0%	12,7%	5,7%	

Note: the attrition rate is calculated on the 1002 potential respondents at the end of the study, which includes non-reserve families and contacted reserve families.

To assess whether attrition introduces bias into our estimates, it is essential to explore two key aspects: (1) whether attrition differs between intervention groups, differential attrition, and (2) whether the characteristics of dropouts differ significantly between groups, selective attrition.

To test whether the differential attrition between the groups is significant, equation (1) is estimated, with an indicator variable ($Attrition_i$) that takes the value 1 if an individual i has dropped out and 0 if he has not. $Treatment_i$ variable is the indicator of treatment.

$$Attrition_i = \alpha + \beta\ Treatment_i + \varepsilon_i \quad (1)$$

The first column of **Table 7** shows the results of the estimation. As can be observed, the attrition rate in the treatment group is statistically higher by 7% than in the control group. Given the significant difference in dropout rate between the treatment and control groups, this study tested whether families with missing final outcomes in treatment and control differ in observable characteristics from baseline. The second column in **Table 7** shows the results of the estimation of equation (2), constituted by observable features, X_{ik}, and the parameters of interest (δ_k). A significant coefficient δ_k would indicate that attritors from the control group and the treatment group differ significantly in characteristics X_k

$$Attrition_i = \alpha + \beta\ Treatment_i + \Sigma_k \beta_k X_{ik} + \Sigma_k \delta_k X_{ik} \times Treatment_i + \varepsilon_i \quad (2)$$

This analysis observed that families with missing endline results from the treatment group have significantly older children and are single-parent families at a higher rate than those in the control group. Apart from these two significant differences at the 5% level, attritors from the control group and the treatment group do not differ significantly in observable characteristics.

Table 7: Differential and selective attrition test

Differential and selective attrition test

	(1) **Attrition**	**(2)** **Attrition**
Treatment	0,07*** -0,02	
Treatment		0 -0,06
Treatment x Number of children in the program (0-3)		-0,05 -0,04
Treatment x Children average age (0-3)		0,04** -0,02
Treatment x Breastfeeding		0,06 -0,03
Treatment x Proportion of children in school (0-3)		-0,01 -0,06
Treatment x Extended Family		-0,02

		-0,02
Treatment x Single parent family		0,08**
		-0,04
Treatment x Other type of family		-0,03
		-0,02
Treatment x Tutor 1 Spanish nationality		-0,03
		-0,03
Tutor's maximum years of education		0
		0
Treatment x tutor employed		-0,03
		-0,02
Treatment x Other FLC courses Attended		0
		0
Observations	994	948
R-squared	0,01	0,06
Mean	0,06	0.03

Note: The regression in column (1) includes observations from those who dropped out before the start of the study and who had already been assigned to the control or treatment group. Regression (2) only includes families who dropped out after the start of the study, as we lack the covariates of those families who dropped out before the study. Standard errors are grouped at the stratum level. Significance: ***=.01, **=.05, *=.1.

5 Results of the evaluation

Random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable and therefore any differences observed after the intervention can be causally associated with the treatment. In essence, econometric analysis provides this comparison. Adding to this, this type of analysis has the advantage of allowing other variables to be included to gain accuracy in the estimates providing confidence intervals. This section presents the econometric analysis, and the results obtained from it.

5.1 Description of the econometric analysis: estimated regressions

The regression model used to estimate the causal effect of an RCT intervention estimates the difference between the average outcome value for the control group and the treatment group. This difference is what we call the impact of the project. This estimate captures the causal impact of the intervention, as the randomization procedure ensures that, on average, the treatment and control groups are comparable, and any observed differences in outcomes between the two groups can be attributed to the intervention.

The analysis will focus on *Intention-To-Treat* (*ITT*) estimation, which compares people assigned to treatment with those assigned to control, regardless of whether they follow the results of the random assignment. This is generally the policy-relevant estimate of the program's impact, since, in most cases, compliance with the program may not be mandatory (as is the case with the family workshops held in the "Children's Spaces: 0-3").

The main estimates include controls for the initial level (i.e., the reference value of the indicator, the number of children the family has in the program, the type of family, the maximum years of education of the tutors, and the employment status of the main tutor) and fixed effects of strata to correct the small imbalances observed at the initial level and improve the accuracy of our estimates. This analysis groups the standard errors at the level of strata, using the 40 strata defined by the network and a variable that indicates whether there was a breastfeeding child in the family.

Specifically, the following equation is estimated as our main specification:

$$Y_{i,t=1} = \alpha + \beta T_i + \gamma Y_{i,t=0} + X_i \delta + \lambda \eta_i + \varepsilon_i \quad (1)$$

where $Y_{i,t=1}$ is the result, as specified in the previous subsection, measured at the end of the timeline. $T_i$indicates whether the family has been assigned to treatment (1) or control (=0). $Y_{i,t=0}$ is the dependent variable measured at the beginning of the timeline. X_i is a vector of control variables and, η_i represents fixed effects of strata. The coefficient of the treatment variable β captures the ITT, our parameter of interest.

For the analysis of heterogeneity, this evaluation investigates whether the results differ depending on whether families have at least one breastfeeding child. For this analysis, this evaluation runs a complete interaction model. This means interacting with treatment, control variables, and outcome at the start of the timeline with an indicator variable of whether the household has at least one breastfeeding child. Thus, B_i indicates whether the household has at least one breastfeeding child (=1) or not (=0).

$$Y_{i,t=1} = \alpha + \beta T_i + \gamma Y_{i,t=0} + X_i \delta + \beta_2 T_i * B_i + \gamma_2 Y_{i,t=0} * B_i + X_i * B_i \delta_2 + \lambda \eta_i + \varepsilon_i \quad (2)$$

5.2 Analysis of the results

5.2.1 Primary and secondary outcomes

Table 8 and **Table 9** estimate the effect of treatment on the outcome variables of interest. This specification includes controls (namely, the baseline value of the index, the number of children in the program, the type of family (single-parent, two-parent, extended or other), the maximum years of education of the tutors and the employment status of the main tutor) and the fixed effects of the strata.

The program improves observable measures of parenting skills (professionals' report on parents' competencies). Columns (1) to (4) of **Table 8** show a positive and statistically significant effect,

indicating that the program increases observable measures of parental competencies in terms of parental responsiveness, affection, encouragement, and education by about half a standard deviation.

However, when parenthood competencies are self-reported (with parents reporting their own competencies), the significance of the effect becomes less consistent and the size of the effects, when they are significant, is considerably smaller. The coefficients are not statistically significant for two of the four measures, although all remain positive (**Table 8**, columns (5) to (8)). The exceptions are the relative encouragement index, which remains significant at the 5% level, with families in the treatment group showing an encouragement index 0.15 standard deviations higher than families in the control group. The affection index shows that parents in the treatment group report a measure 0.13 standard deviations higher than control parents.

The effects on observed measures of parenting skills should be taken with caution, as differences with effects on self-perceived measures could be the result of demand effects. Families may have consciously or unconsciously changed their behavior to try to confirm the hypotheses they believed the evaluator was trying to test. In addition, these behavior-driven effects could also affect practitioners, who were aware of each family's treatment status when they reported the observed measures.

Table 9 shows the results for the vulnerability of families. The effect of the family workshops developed in the "Children's Spaces: 0-3" on economic, intrafamily, and educational vulnerability is significant at the significance level of 10%, 5% and 1%, respectively, compared to the control group. Columns (1), (4) and (6) show that families in the treatment group show lower levels of social vulnerability compared to families in the control group. Economic vulnerability decreases by 1.4 per cent in treated families, vulnerability in intra-family relations by 1.2 per cent and vulnerability in education by 1.3 per cent.

Table 8: Impact on parenting skills

	Observational indicators				**Self-Reported Indicators**			
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**
	Responsiveness	**Affection**	**Encouragement**	**Education**	**Responsiveness**	**Affection**	**Encouragement**	**Education**
Treatment	0,44***	0,33***	0,58***	0,63***	0,11	0,13*	0,15**	0,04
	-0,09	-0,1	-0,1	-0,1	-0,06	-0,07	-0,06	-0,07
Observations	882	882	882	882	883	883	883	883
R-squared	0,48	0,41	0,49	0,57	0,27	0,31	0,23	0,29
Mean control group	-0,21	-0,17	-0,28	-0,31	-0,05	-0,05	-0,06	-0,01

Note: Standard errors are grouped at the stratum level, regressions include controls for the number of children in the program, type of family, maximum years of tutors' education, the indicator at baseline, and fixed effects at the stratum level, Significance: ***=.01, **=.05, *=.1

Table 9: Impact on vulnerability dimensions

	Vulnerability indices					
	(1)	(2)	(3)	(4)	(5)	(6)
	Economic	Housing	Health	Intra-family relations	Socio-cultural capital	Education
Treatment	-1,40*	-0,71	-0,85	-1,19**	-0,7	-1,36***
	-0,76	-0,66	-0,61	-0,57	-0,62	-0,37
Observations	791	791	791	791	791	791
R-squared	0,59	0,69	0,61	0,68	0,66	0,64
Mean control group	100,97	101,36	100,73	101,69	102,47	100,41

Note: Standard errors are grouped at the stratum level. The regressions include controls for the number of children in the program, type of family, maximum years of education of the tutors, the indicator at the beginning of the study, and fixed effects at the stratum level. Significance: ***=.1 **=.05 *=.1

Table 10: Impact of heterogeneity on parenthood competencies when having at least one breastfeeding child

	Observational indicators				Self-Reported Indicators			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Responsiveness	Affection	Encouragement	Education	Responsiveness	Affection	Encouragement	Education
Treatment	0,48***	0,39**	0,60***	0,69***	0,11	0,19**	0,17**	0,04
	-0,13	-0,15	-0,13	-0,14	-0,08	-0,09	-0,08	-0,08
Breastfeeding	0,55	0,66	0,59	0,87*	1,02	1,19**	1,54**	1,40**
	-0,5	-0,48	-0,63	-0,5	-0,77	-0,44	-0,69	-0,68
Treatment x Breastfeeding	-0,1	-0,16	-0,06	-0,16	-0,1	-0,21	-0,14	-0,02
	-0,18	-0,17	-0,18	-0,18	-0,13	-0,13	-0,12	-0,14
Observations	882	882	882	882	883	883	883	883
R-squared	0,49	0,42	0,5	0,58	0,29	0,33	0,25	0,31
Mean control group	-0,21	-0,17	-0,28	-0,31	-0,05	-0,05	-0,06	-0,01

Note: Standard errors in parentheses have been grouped at the stratum level. The regressions include controls for the number of children in the program, type of family, maximum years of education of the tutors and employment status of the first tutor, the indicator at the beginning of the study, and its interaction with the dummy variable of breastfeeding. Regressions also include stratum fixed effects. Significance: ***=0.01, **=0.05, *=0.1

5.2.2 Heterogeneity analysis

The family workshop program developed in the "Children's Spaces: 0-3" is designed for families with children from 0 to 3 years old, adapting to both those who have at least one breastfeeding child (breastfeeding families) and those who do not. The program is slightly modified to accommodate the needs of breastfeeding families. In addition, the size of the groups in the workshops is adjusted according to this factor, varying from a maximum of 8 to 12 participants. As previously mentioned, to

ensure the effectiveness of this approach, the presence of at least one breastfeeding child in the family was considered as a stratification variable in the randomization process. Thus, a heterogeneity analysis is carried out to determine whether the impact of the program varies among families with at least one breastfeeding child.

Table 10 and **Table 11** explore whether results vary depending on whether families have at least one breastfeeding child. In general, the average effect of treatment does not differ between families with and without at least one breastfeeding child.

In these regressions, the coefficient of the *Treatment* variable shows the effect on non-lactating families (those that do not have any breastfeeding child), with the effect on breastfeeding families being the sum of the coefficients of the *Treatment variable* and the Treatment *x Breastfeeding variable*. The coefficient of *Treatment x Breastfeeding* shows the difference between the effects of treatment in both subsamples (families with and without breastfeeding children).

Table 10 shows the results for parenthood competencies. The term interaction (*Treatment x Breastfeeding*) is not statistically significant, suggesting that the average effect of treatment on parenting skills does not differ between families with and without breastfeeding children.

Table 11 shows the heterogeneous analysis for the vulnerability of families. Similarly, this evaluation found that the term interaction is generally not statistically significant, suggesting that the average effect of treatment on family vulnerability does not differ between families with and without breastfeeding children. The only exception is the effect on housing vulnerability, where treatment has a statistically significant and negative effect on the vulnerability of families without breastfeeding children, while it has a statistically significant and positive effect on families with breastfeeding children. This heterogeneous impact of treatment could explain the non-statistically significant effect on housing vulnerability observed in the full sample.

Table 11: Impact of heterogeneity on the dimensions of vulnerability when having at least one breastfeeding child

	Vulnerability indicators					
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
	Economy	**Housing**	**Health**	**Intra-family relations**	**Socio-cultural capital**	**Education**
Treatment	-1,12	-1,70**	-0,93	-0,48	-0,68	-1,44***
	-0,78	-0,63	-0,8	-0,56	-0,83	-0,4
Breastfeeding	-21,00*	8,33	-7,92	8,19	8,52	-0,36
	-10,53	-10,26	-12,77	-12,25	-10,19	-13,39
Treatment x breastfeeding	-0,54	3,41**	0,38	-2,16	0,2	0,32
	-1,93	-1,57	-1,29	-1,44	-1,25	-0,85
Observations	791	791	791	791	791	791
R-squared	0,59	0,69	0,61	0,69	0,67	0,64
Mean control group	100,97	101,36	100,73	101,69	102,47	100.41

Note: Standard errors are grouped at the stratum level. The regressions include controls for the number of children in the program, type of family, maximum years of education of the tutors, work status of the first tutor, indicator at the beginning of the study, and the interaction of all these with a "dummy" variable for breastfeeding. Regressions also include fixed effects at the stratum level. Significance: ***=.01, **=.05, *=.1.

Finally, the indicator related to the use and valuation of the knowledge and resources acquired is shown in **table 13** in the appendix**.** The appendix shows satisfaction with the products and services received in both the treatment group and the control group after the intervention.

6 Conclusions of the evaluation

Initial development lays the foundation for numerous outcomes in later life, including academic achievement, social skills, and overall well-being. However, in Spain, the likelihood that children under the age of three will receive school education or vocational care is still closely linked to the socioeconomic status of their families. Therefore, it is crucial to provide vulnerable families with tools to promote parenthood competencies for the early development of their children.

In this context, this study analyzes the RCT implemented by "la Caixa" Foundation, which involves 1,009 families in 20 local networks in Spain. By randomly assigning families to participate in family workshops or in a control group, this evaluation sought to capture the causal effect of a program aimed at vulnerable families with children aged 0 to 3 years focused on their parenthood competencies and social vulnerability. Both the control and treatment groups receive social accompaniment and support for labor inclusion and can participate in regular meetings for parents. In addition, the treatment group participates in family workshops developed in the "Children's Spaces: 0-3", which span 32 sessions over 16 weeks, designed to improve parenting skills in families with children aged 0-3 years. Key themes in these workshops include supporting positive parent-child interactions, developing parenting skills, and establishing a caring parent-child relationship.

The outcomes measured encompass parenting skills (both observed and self-perceived) in areas such as responsiveness, affection, encouragement, and education. In addition, the program evaluates measures of vulnerability in economic situation, housing, health, intra-family relations, sociocultural capital and education, an index developed by the consolidated research group.

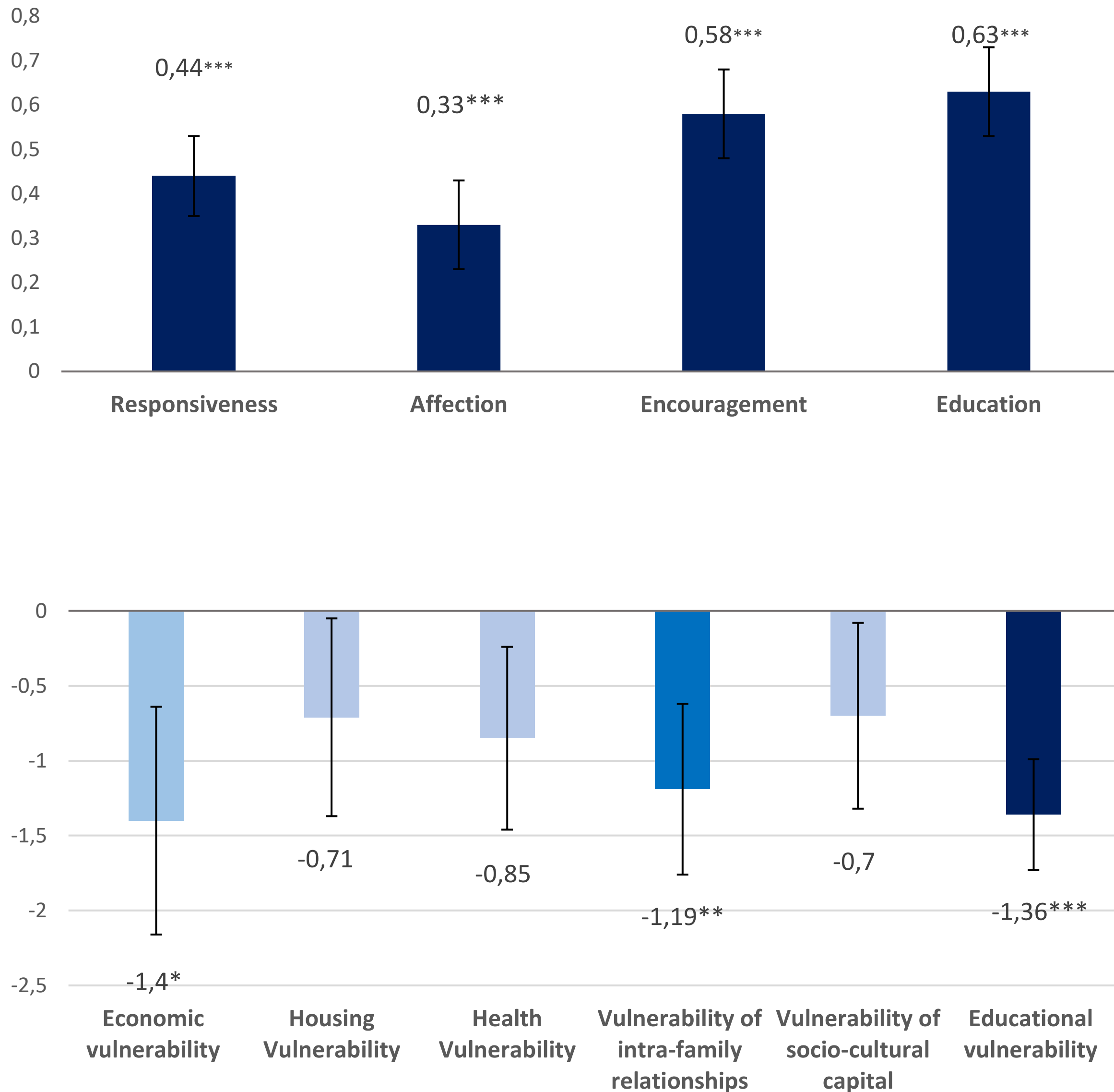
The high level of adherence to the program and the response rate on the end-line survey are indications that the program was very valuable to families. In addition, the dataset collected by the "la Caixa" Foundation for its regular activities has allowed us to retrieve end-line information for families with missing data, highlighting the benefits of administrative data in mitigating randomized assessment issues, such as dropout.

As shown by **figure 9**, the results indicate an improvement in parenting skills, such as responsiveness, affection, encouragement, and education, within the treatment group when observed by professionals. However, these effects become less significant and smaller when using perceived

measures of the same parenthood competencies. This could indicate the existence of demand effects, i.e., a change in behavior in families or professionals to try to confirm the hypothesis that the evaluator is trying to test.

In addition, this analysis has found a reduction in economic, intra-family, and educational vulnerabilities for those in the treatment group compared to the control group, highlighting the potential effectiveness of the program in these areas. This report has also explored whether the effects are different for those families with breastfeeding children and found no evidence of this in the main results.

Figure 9: Effect of the intervention on key indicators



Note: the darkest blue presents the indicators whose treatment effect is significant at 1%; The next shade of blue presents the significant results at 5%. Thus, the last two shades of blues (from darkest to lightest) represent the results that are significant at 10% and non-significant (lighter blue). The effects included in the graphs refer to regressions with controls.

In conclusion, this study shows the potential of programs that promote parenthood competencies to improve initial development and well-being of children in vulnerable families. These results can contribute to the development of policies aimed at reducing inequalities, poverty, and social

exclusion. In this sense, programs, such as the one evaluated here, offer the first opportunity to influence children's future trajectories.

Bibliography

High Commissioner Against Child Poverty. Investment in family and children in the European Union. https://www.comisionadopobrezabreastfeeding childil.gob.es/es/inversion-en-familia-e-infancia-en-la-union-europea-sobre-el-pib-2021

Ayoub, M., & Bachir, M. (2023). A meta-analysis of the relations between socioeconomic status and parenting practices. *Psychological Reports*, 00332941231214215. https://journals.sagepub.com/doi/abs/10.1177/00332941231214215

Cañete-Massé, C., Cussó-Parcerisas, I., Longás Mayayo, J., Guàrdia-Olmos, J., Riera Romaní, J. (s.f.). Developing a Social Vulnerability Scale for Families living in poverty: A Multi-dimensional Instrument for social assessment

Council of Europe. (n.d.). *Policies to support positive parenting*. https://www.mdsocialesa2030.gob.es/derechos-sociales/familias/Parentalidad_Positiva/docs/TripticoParentalidadPositiva.pdf

Hoff, E., & Laursen, B. (2019). Socioeconomic status and parenting. In *Handbook of parenting* (pp. 421-447). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780429401459-13/socioeconomic-status-parenting-erika-hoff-brett-laursen

Leijten, P., Raaijmakers, M. A., Orobio de Castro, B., van den Ban, E., & Matthys, W. (2017). Effectiveness of the incredible years parenting program for families with socioeconomically disadvantaged and ethnic childity backgrounds. https://www.tandfonline.com/doi/abs/10.1080/15374416.2015.1038823

Määttä, S., Lehto, R., Nislin, M., Ray, C., Erkkola, M., Sajaniemi, N., & the DAGIS research group. (2015). Increased health and well-being in preschools (DAGIS): rationale and design for a randomized controlled trial. BMC public health, 15, 1-10. https://link.springer.com/article/10.1186/s12889-015-1744-z

Milligan, K., & Stabile, M. (2011). Do child tax benefits affect the well-being of children? Evidence from Canadian child benefit expansions. American Economic Journal: Economic Policy, 3(3), 175-205. https://www.aeaweb.org/articles?id=10.1257/pol.3.3.175

Morrison, J., Pikhart, H., Ruiz, M., & Goldblatt, P. (2014). Systematic review of parenting interventions in European countries aiming to reduce social inequalities in children's health and development. *BMC public health*, *14*, 1-13. https://link.springer.com/article/10.1186/1471-2458-14-1040

Spain Children's Platform (2023). Analysis of the 2023 Living Conditions Survey with a Focus on Children. Children's platform in Spain.

Recommendation (2006) 19 of the Committee of Ministers of the Council of Europe to Member States on Policies to Support the Positive Exercise of Parenthood (Adopted by the Committee of Ministers on 13 December 2006 at the 983rd meeting of the Ministers' Delegates)

Rodrigo López, M., Martín Quintana, J. C., Cabrera Casimiro, E., & Máiquez Chaves, M. (2009). Parenthood competencies in contexts of psychosocial risk. *Psychosocial Intervention*, *18*(2), 113-120. https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1132-05592009000200003

Roggman, L. A., Cook, G. A., Innocenti, M. S., Jump Norman, V., & Christiansen, K. (2013). Parenting interactions with children: Checklist of observations linked to outcomes (PICCOLO) in diverse ethnic groups. Breastfeeding child Mental Health Journal, 34(4), 290-306. https://onlinelibrary.wiley.com/doi/abs/10.1002/imhj.21389

Vilaseca, R., Rivero, M., Bersabé, R.M., Navarro-Pardo, E., Cantero, M.J., Ferrer, F., Valls-Vidal, C. (2021). *Piccolo. Parental interactions with children. List of developmental observation items*. Universitat de Barcelona and Universitat de València Publications. https://www.edicions.ub.edu/ficha.aspx?cod=13918

Weisleder, A., Cates, C. B., Dreyer, B. P., Berkule Johnson, S., Huberman, H. S., Seery, A. M., ... & Mendelsohn, A. L. (2016). Promotion of positive parenting and prevention of socioemotional disparities. *Pediatrics*, *137*(2). https://publications.aap.org/pediatrics/article-abstract/137/2/e20153239/52737/Promotion-of-Positive-Parenting-and-Prevention-of

Appendix

Economic and regulatory management

1. Introduction

Within the framework of the Recovery, Transformation, and Resilience Plan, the General Secretariat for Inclusion 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".

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

Royal Decree 938/2021, of October 26, 2021, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of 109,787,404 euros, within the framework of the Recovery, Transformation and Resilience Plan[16] contributed to the fulfillment of the critical milestone (set out in the Council Implementing Decision) number 350 for the first quarter of 2022 "Improving 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 carry out the itineraries. The objectives of these partnership agreements are: (i) to improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies." Likewise, along with Royal Decree 378/2022, of May 17, 2022[17], "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"

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

[17] 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. It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-8124

contributed to compliance with monitoring indicator number 351.1 in the first quarter of 2023. linked to the Operational Arrangements document[18].

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

In accordance with Article 3 of Royal Decree 378/2022, of May 17, 2022, the granting of subsidies will be carried out by means of 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 entities.

On **2 September 2022**, the Caixa d'Estalvis i Pensions de Barcelona Banking Foundation, "la Caixa" (hereinafter, "la Caixa" Foundation), was notified of the Resolution of the General Secretariat for Inclusion and Social Welfare Objectives and Policies granting a subsidy of €2,737,370 to the "la Caixa" Foundation, and, On **6 September 2022**, an Agreement was signed between the General State Administration, through the General Secretariat for Inclusion and Social Welfare Objectives and Policies and the Caixa d'Estalvis i Pensions de Barcelona Banking Foundation, "la Caixa" for the implementation of a project for social inclusion within the framework of the Recovery Plan, Transformation and Resilience, which was published in the "Official State Gazette" on **September 17, 2022** (BOE no. 224).[19]

2. Timeframe of the intervention

Article 17(1) of Royal Decree 378/2022 of 17 May 2022 established that the deadline for the implementation of pilot projects for social inclusion itineraries covered by the subsidies provided for in this text shall not exceed the deadline of 30 November 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.

Within this generic time frame, the implementation begins in the week **of February 6, 2023**, when the intervention begins with the first two Family Encounters 0-3, continuing until the **second half of July**

[18] 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

[19] Resolution of 8 September 2022, of the General Secretariat for Inclusion and Social Welfare Objectives and Policies, which publishes the Agreement with the Caixa d'Estalvis i Pensions de Barcelona Banking Foundation "la Caixa", for the implementation of a project for social inclusion within the framework of the Recovery Plan, Transformation and Resilience. It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-15202

2023, and subsequently developing dissemination and evaluation tasks of the project until **March 31, 2024**.

3. Relevant Agents

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

- **"La Caixa" Foundation**, as the beneficiary entity and coordinator of the project.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the sponsor of the project, and as the main responsible for the RCT evaluation process. The General Secretariat for 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 of the potential participants of 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.
- 20 entities from the **Third Sector of Social Action** that form part of the territorial network of **Caixaproinfancia** contracted by **La Caixa Foundation for the execution of the project.**

Name of the entity	Autonomous Community	Province
Asociación Arrabal AID.	Andalucía	Málaga
Prodiversa - Progreso y Diversidad.	Andalucía	Málaga
Asociación Entre Amigos de Sevilla	Andalucía	Sevilla
YMCA (Red Delicias).	Aragón	Zaragoza
Fundación Federico Ozanam.	Aragón	Zaragoza
Aldeas Breastfeeding childiles SOS de España.	Canarias	Santa Cruz de Tenerife
Asociación Canaria Sociosanitaria Te Acompañamos.	Canarias	Las Palmas
Fundación Juan Soñador.	Castilla y León	Valladolid
ABD – Associació Benestar I Desenvolupament.	Cataluña	Barcelona
Fundació Carles Blanch.	Cataluña	Barcelona
Associació Casal Dels Breastfeeding childs .	Cataluña	Barcelona
Fundació de l'Esperança.	Cataluña	Barcelona
Fundació IDEA.	Cataluña	Barcelona
Asociación El Arca	Comunidad Valenciana	Valencia

Asociación De Desarrollo Comunitario Gazteleku.	País Vasco	Vizcaya
Asociación Yuna.	Comunidad de Madrid	Madrid
Redes Sociedad Cooperativa Madrileña.	Comunidad de Madrid	Madrid
Fundación Amigó.	Comunidad de Madrid	Madrid
Fundación CEPAIM.	Región de Murcia	Murcia
Caritas Diócesis Cartagena.	Región de Murcia	Murcia

- The **consolidated research group PSITIC of the Ramon Llull University**, subcontracted by the "la Caixa" Foundation for scientific advice and support in the project.
- **CEMFI** and **J-PAL Europe**, as scientific and academic institutions that support MISSM in the design and RCT evaluation of the project.

Sample Balance

Table 12 reports balance contrasts between the control group and the treatment group. All data reflected in this table refer to the survey conducted prior to the intervention (baseline). The mean value of each variable for both groups is reported, as well as the number of observations in each group and the p-value resulting from a mean difference contrast (using the *t the Student*). The lower the p-value, the more confidently one can reject the hypothesis that the mean of the variable in both groups is equal. For example, if the p-value is less than 0.05, the hypothesis of equality of means can be rejected at a 5% confidence level. If the p-value is greater than 0.10, then the hypothesis of equal means in both groups cannot be rejected.

Table 12: Sample balance by experimental groups

	(1) Control		(2) Treatment		(2)-(1) Pairwise t-test	
Variable	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**P-value**
Sociodemographic characteristics						
Number of children in the program (0-3)	474	1,13	474	1,12	948	0,65
	40	(1,41)	40	(1,39)	40	
1 child in the family	467	0,24	470	0,26	937	0,35
	40	(2,17)	40	(2,34)	40	
2 child children in the family	467	0,28	470	0,29	937	0,89
	40	(2,44)	40	(2,48)	40	
3 or more child children in the family	467	0,48	470	0,45	937	0,39
	40	(2,99)	40	(2,98)	40	
Proportion of girls (0-3)	474	0,47	474	0,46	948	0,84
	40	(2,83)	40	(2,88)	40	
Children average age (0-3)	474	2,18	474	2,15	948	0,51
	40	(9,45)	40	(9,99)	40	
Breastfeeding child	474	0,32	474	0,33	948	0,43
	40	(2,65)	40	(2,67)	40	

	(1) Control		(2) Treatment		(2)-(1) Pairwise t-test	
Variable	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**P-value**
Proportion of breastfeeding children in school (0-3)	474	0,05	474	0,05	948	0,72
	40	(0,57)	40	(0,51)	40	
Biparental family	474	0,63	474	0,63	948	0,86
	40	(2,84)	40	(2,82)	40	
Extended family	474	0,00	474	0,01	948	0,43
	40	(0,05)	40	(0,10)	40	
Single parent family	474	0,35	474	0,35	948	0,93
	40	(2,77)	40	(2,77)	40	
Other type of family	474	0,01	474	0,01	948	0,38
	40	(0,18)	40	(0,10)	40	
Tutor 1 female	474	0,84	474	0,84	948	1,00
	40	(1,64)	40	(1,64)	40	
Tutor 2 female	237	0,29	250	0,30	487	0,90
	39	(1,29)	39	(1,37)	40	
Tutor 1 age	474	34,20	474	34,66	948	0,35
	40	(793,63)	40	(728,11)	40	
Tutor 2 age	237	36,78	250	37,84	487	0,12
	39	(394,55)	39	(466,09)	40	
Tutor 1 Spanish nationality	474	0,46	474	0,44	948	0,61
	40	(3,01)	40	(2,99)	40	
Tutor 2 Spanish nationality	237	0,38	250	0,37	487	0,72
	39	(1,48)	39	(1,54)	40	

	(1) Control		(2) Treatment		(2)-(1) Pairwise t-test	
Variable	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**P-value**
Tutor's maximum years of education	474	7,11	474	7,24	948	0,55
	40	(142,46)	40	(141,30)	40	
One employed tutor	474	0,37	474	0,40	948	0,19
	40	(2,82)	40	(2,92)	40	
Tutor 1 temporary job	474	0,13	474	0,14	948	0,61
	40	(1,34)	40	(1,46)	40	
Tutor 1 permanent job	474	0,06	474	0,09	948	0,14
	40	(0,72)	40	(1,02)	40	
Tutor 1 unemployed with public transfer	474	0,25	474	0,26	948	0,63
	40	(2,29)	40	(2,36)	40	
Tutor 1 unemployed without public transfer	474	0,51	474	0,45	948	0,08*
	40	(3,04)	40	(3,01)	40	
Tutor 1 occasional works	474	0,01	474	0,03	948	0,40
	40	(0,18)	40	(0,30)	40	
Tutor 1 other working status	474	0,04	474	0,03	948	0,19
	40	(0,42)	40	(0.30)	40	
Tutor 2 temporary job	237	0,26	250	0,20	487	0,13
	39	(1,19)	39	(1,05)	40	
Tutor 2 permanent job	237	0,10	250	0,09	487	0,82
	39	(0,55)	39	(0,55)	40	
Tutor 2 unemployed with public transfer	237	0,18	250	0,17	487	0,75
	39	(0,93)	39	(0,94)	40	

	(1) Control		(2) Treatment		(2)-(1) Pairwise t-test	
Variable	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**P-value**
Tutor 2 unemployed without public transfer	237	0,39	250	0,44	487	0,21
	39	(1,48)	39	(1,62)	40	
Tutor 2 occasional works	237	0,03	250	0,05	487	0,11
	39	(0,15)	39	(0,32)	40	
Tutor 2 other working status	237	0,05	250	0,04	487	0,68
	39	(0,30)	39	(0,28)	40	
Other FLC courses Attended	474	2,41	474	2,56	948	0,44
	40	(94,54)	40	(119,56)	40	
Results						
Responsiveness Index baseline	461	0,01	454	-0,01	915	0,75
	40	(11,66)	40	(11,78)	40	
Affection Index baseline	461	-0,03	454	0,03	915	0,45
	40	(12,20)	40	(11,22)	40	
Encouragement Index baseline	461	0,02	454	-0,02	915	0,55
	40	(11,30)	40	(12,12)	40	
Education Index baseline	461	0,00	454	-0,00	915	0,90
	40	(11,35)	40	(12,08)	40	
Self-reported responsiveness Index baseline	458	0,01	447	-0,01	905	0,70
	40	(11,70)	40	(11,48)	40	
Self-Reported Affection Index baseline	458	0,05	447	-0,06	905	0,14
	40	(10,21)	40	(12,90)	40	
	458	0,04	447	-0,04	905	0,27

	(1) Control		(2) Treatment		(2)-(1) Pairwise t-test	
Variable	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**Mean/(Var.)**	**N/Clusters**	**P-value**
Self-reported encouragement Index baseline	40	(10,06)	40	(13,09)	40	
Self-reported Education Index baseline	458	0,03	447	-0,03	905	0,32
	40	(9,69)	40	(13,47)	40	
Economic vulnerability baseline	471	103,22	470	103,56	941	0,76
	40	(2618,08)	40	(2609,56)	40	
Housing vulnerability baseline	471	103,86	470	104,78	941	0,34
	40	(2636,06)	40	(2816,04)	40	
Health vulnerability baseline	471	104,54	470	104,42	941	0,89
	40	(2229,15)	40	(2364,37)	40	
Intra-Family Relationships vulnerability baseline	471	103,03	470	103,60	941	0,36
	40	(2560,99)	40	(1931,55)	40	
Socio-cultural capital vulnerability baseline	471	104,64	470	105,77	941	0,09*
	40	(2362,78)	40	(2004,08)	40	
Educational vulnerability baseline	471	101,78	470	103,46	941	0,01***
	40	(1903,35)	40	(1726,65)	40	

Columns (1) and (2) show the sample size and the mean and variance of the sociodemographic covariates measured at the start of the study in the two groups (control and treatment). Column (3) contains the results of the mean comparison test: the total sample size and the p-value associated with the test. Standard errors are clustered at the stratum level. Significance: *** = .01, ** = .05, * = .1.

Results on the use and assessment of the knowledge and resources acquired

Families rated their satisfaction, or the usefulness of the different goods and services provided to them as 0 (not at all), 1 (little), 2 (sufficient), 3 (quite a lot), 4 (a lot). In the case of satisfaction with the workshops, only the families in the treatment group were asked, since those in the control group did not receive such an intervention. **Table 13** shows that, on average, general satisfaction is above 3.50 (quite a lot), with the Goods and Social Support programs being the most Valued. The Utility of the Voucher (Passport from 0-3) It is an exception, with a considerably lower average value of 1.31 (little-enough). Overall, families in the treatment group appear to be more satisfied with the interventions than those in the control group. Their overall satisfaction is (statistically) significantly higher, as well as satisfaction with social accompaniment and the value they attribute to relationships with other parents through activities, relationships with social workers, learning parenthood, and learning about the parent/child relationship.

Table 13: Sample balance by experimental groups

	Control		Treatment		Pairwise t-test	
Variable	N/Clusters	Mean/(Var)	N/Clusters	Mean/(Var)	N/Clusters	P-value
Utility of goods	453	3,81	430	3,77	883	0,41
	40	-3,05	40	-3,31	40	
Voucher Utility 0-3	453	1,31	430	1,31	883	0,98
	40	-37,35	40	-35,01	40	
Satisfaction with social accompaniment	453	3,74	430	3,79	883	0,07*
	40	-3,03	40	-2,17	40	
Meeting Satisfaction	453	3,74	430	3,75	883	0,89
	40	-2,79	40	-3,32	40	
Overall Satisfaction	453	3,67	430	3,77	883	0,05**
	40	-4,97	40	-2,55	40	
Value of Relationship with Other Parents	453	3,5	430	3,75	883	0,00***
	40	-6,24	40	-2,48	40	
Value of the relationship with social workers	453	3,71	430	3,8	883	0,02**
	40	-3,68	40	-2,17	40	
Value of Parental Learning	453	3,49	430	3,7	883	0,00***
	40	-5,21	40	-3,39	40	
Value of parent-child learning	453	3,68	430	3,77	883	0,03**
	40	-3,97	40	-2,86	40	

Note: Columns (1) and (2) show the sample size, mean, and variance of sociodemographic covariates measured at baseline by intervention groups. Column (3) contains the results of the mean comparison test: the total sample size and the P-value associated with the test. Standard errors are grouped at the stratum level. Significance: *** = .01, ** = .05, * = .1.