Inclusion Policy Lab: Evaluation Results

Cáritas Spain – ACCEDE: Comprehensive Care Project for the Fight against Social Exclusion

April 2024

Financiado por la Unión Europea NextGenerationEU
MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES
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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, Cáritas Española 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, Yarine Fawaz, researcher at CEMFI, Laura Hospido, researcher at the Bank of Spain and CEMFI, and Júlia Martí Llobet, researcher at the Bank of Spain, under the coordination of Mónica Martínez-Bravo (until 8 January 2024) and Samuel Bentolila, professors at CEMFI. The researchers have actively participated in all phases of the project, including the adaptation of the initial proposal to the needs of the evaluation through randomized experiments, the evaluation design, the design 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 is based on the knowledge acquired about the project up to that date. The researchers reserve the right to clarify, modify, or delve into the results presented in this report in future publications. These potential variations could be based on the availability of additional data, advances in evaluation methodologies, or the emergence of new information related to the project that may affect the interpretation of the results. The researcher is committed to continuing exploring and providing more accurate and updated results for the benefit of the scientific community and society in general.

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Index

Executive Summary

- The **Minimum Income Scheme,** established in May 2020, is a policy that guarantees a minimum income to vulnerable groups and provides methods 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 social innovation pilot projects carried out in the Inclusion Policy Lab. These projects are evaluated according to scientific rigor standards and the **methodology of Randomized Controlled Trials**.
- This document presents the evaluation results and key findings of the project "ACCEDE: Comprehensive Care Project for the Fight against Social Exclusion," which has been conducted in **cooperation between the MISSM and Cáritas Española**, an organization of the Third Sector of Social Action dedicated to charitable and social action provided by the Catholic Church in Spain.
- This study evaluates an **intervention aimed at reducing social exclusion** and enhancing socio-occupational integration **through personalized attention and intensive support**, in comparison to Cáritas' traditional support model. The **treatment group** received, in addition to traditional support, a series of **personalized actions**, including training in **digital skills** to access rights and interact with Public Administrations, as well as workshops to enhance **interaction and socio-occupational integration**. These workshops were hosted in physical spaces named "ACCEDE," established by the parishes, where participants followed personalized itineraries, including **planned training sessions and group workshops**. Moreover, they were provided with internet access and computer resources. The control group received Cáritas' traditional support services aimed at meeting families' basic needs.
- The project took place in **the area of influence of the 18 Diocesan Cáritas** (Barbastro-Monzón, Barcelona, Bilbao, Cartagena-Murcia, Ciudad Real, Huelva, Huesca, Madrid, Mallorca, Mérida-Badajoz, Ourense, La Rioja, Salamanca, Segorbe-Castellón, Sigüenza-Guadalajara, Tenerife and Zamora) and 2,625 people participated (1,420 in the treatment group and 1,205 in the control group).
- On average, 66% of participants were unemployed and 14% had not completed primary education. About a quarter of the participants were men. Before the intervention, over 70% of participants were renters who had experienced non-payment of utility bills on multiple occasions within the past six months.
- The participation of the treatment group varied across different actions. The personalized itinerary had the highest participation rate at 86.5%.
- The main results of the evaluation are as follows:
    - **Improved income:** The treatment increased total income per person over the last six months by €797.
    - **Improved employability:** Cáritas' personalized employment aid has had a positive and significant effect on all indicators that measure employability:
        - The treatment increases the **number of applications to job offers** by participants by 0.12 standard deviations.

- The treatment increases the **number of interviews conducted** by 0.07 standard deviations.
- The treatment increases **occupational training actions** by 0.37 standard deviations.
- The treatment increases **job training actions** by 0.23 standard deviations.

- **Treatment guarantees rights:** Cáritas' personalized treatment has a **positive effect** of 0.14 standard deviations on the **degree of access to rights**. Intervention assists participants in understanding their rights, leading some to initiate claims for social benefits or entitled aid.
- **Reducing the digital divide:** Thanks to the "ACCEDE" space and the access to internet and computer resources provided by Cáritas, participants in the treatment group have experienced the following increases: (i) their **use of the internet for work purposes** by 0.30 standard deviations; (ii) their **access to the internet at home** by 0.19 standard deviations; and (iii) their **access to the internet through any means** by 0.16 standard deviations.
- **Increased social relationships:** Cáritas' personalized treatment has increased the degree of participation in a group of their environment by 0.48 standard deviations.

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 MIS has a dual objective: to provide economic support to those in need and to promote social inclusion and employability. This is one of the social inclusion policies designed by the General State Administration, together with the support of 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 people 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, dated December 20, establishing the Minimum Income Scheme (BOE-A-2021-21007).

[2] Article 31.1 of Law 19/2021, dated December 20, 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 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 whether the policy is adequate to achieve the planned public policy objectives. Experimental evaluations enable us to obtain rigorous results of the intervention effect, i.e., what changes the participants have experienced in their lives due to the intervention. In addition, these evaluations provide an exhaustive analysis of the program and its effects, providing insights into why the program was effective, who has benefited most from the interventions, whether there were indirect or unexpected effects, and which components of the intervention worked, and which did not.

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

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

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

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

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

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

This report refers to the "ACCEDE: Comprehensive Care Project for the Fight against Social Exclusion", executed within the framework of Royal Decree 938/2021[9] by Cáritas (Official Confederation of Charitable and Social Action Entities of the Catholic Church), a Third Sector of Social Action entity, dedicated to the reception and accompaniment of vulnerable and excluded people. This report contributes to the fulfillment of milestone 351 of the PRTR: "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

The project targets the most vulnerable groups, those at risk of poverty and social exclusion, who receive care at Cáritas parishes within the participating Diocesan Churches. These individuals face daily vulnerabilities and immediate needs. The analysis must consider poverty and social exclusion from a multidimensional perspective. This includes not only material or income deficiencies but also challenges in accessing essential goods and services necessary for adequate well-being, as well as difficulties in social participation within their communities.

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

[9] On January 21, 2022, an agreement was signed between the General State Administration, through the SGI, and Cáritas Española 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 February 1, 2022 (BOE no. 27).

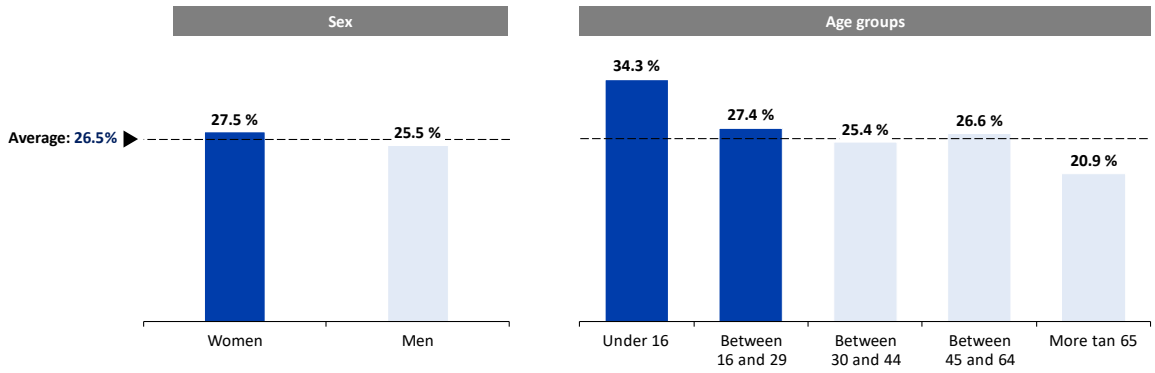
Hence, social exclusion manifests in various spheres and yields diverse consequences. For instance, limited access to digital resources or inadequate digital literacy inhibits individuals from effectively integrating socially and professionally in an increasingly digital world. Consequently, this digital divide compromises their ability to assert their social rights, disproportionately impacting those at risk of poverty and social exclusion.

Failure to address basic needs, facilitate labor integration, enable the exercise of rights, and foster social support networks hinders the integration of individuals at risk of social exclusion and poverty.

According to FOESSA Foundation[10] (Promotion of Social Studies and Applied Sociology, promoted by Cáritas), social exclusion is "a phenomenon of accumulation of difficulties in different areas, which includes economic poverty but also employment, housing, social relations or access to social protection systems". In this sense, the analysis must understand social exclusion as a multi-layered process that distances individuals from integration as these difficulties accumulate.

Under a purely economic and occupational approach, the Living Conditions Survey (INE) publishes the AROPE rate[11], which measures the group of people at risk of poverty and/or social exclusion. According to this indicator, in 2023, around 12.6 million people in Spain were at risk of poverty or social exclusion, representing 26.5% of the population. By sex, women had a 2-percentage-point higher rate of poverty or social exclusion than men (25.5%). In addition, children (under 16 years of age) and young people (between 16 and 29 years of age) were the age groups with the highest rates of social exclusion in 2023, with 34.3% and 27.4%, respectively.

Figure 1: AROPE rate by sex and age group (% of total for each group, 2023)



Source: Living Conditions Survey (INE)

Moreover, the recent health and economic crisis generated by COVID-19 has exacerbated this phenomenon. According to FOESSA data, the number of people at risk of social exclusion increased from 8.6 million before the pandemic (2018) to over 11 million in 2021 (latest available data). Although

[10] Established in 1965, this foundation seeks to objectively understand the social situation in Spain. She conducts empirical research through her reports on the situation and social change in Spain.

not to the same extent, the AROPE indicator shows a slight increase in the percentage of households at risk of poverty or social exclusion, from 26.2% in 2019 to 26.5% in 2023.

In this context, where more than a quarter of the population in Spain is affected by poverty and social exclusion, the ACCEDE pilot project aims to enhance access to and exercise of rights for individuals in this situation by developing their capacities.

Regulatory framework associated with the project and the governance structure.

The Charter of Fundamental Rights of the European Union includes the right to social security and assistance to ensure a dignified life for those lacking sufficient resources. Similarly, the ACCEDE pilot project recognizes groups at risk of or experiencing social exclusion, such as children and young people, the elderly, and people with disabilities.

The European Union and its member states have made combating poverty and social exclusion a key objective, as established by the Treaty on the Functioning of the European Union (Articles 151 and 153), which came into force in 2009. Building on this, the European Pillar of Social Rights (EPSR), proclaimed in 2017 by the European Parliament, the European Council, and the European Commission at the Gothenburg Summit, consists of 20 principles aimed at creating a stronger, fairer, and more inclusive Europe with greater opportunities for all.

At the national level, the National Strategy for the Prevention and Fight against Poverty and Social Exclusion (2019-2023) is noteworthy. This strategy aims to combat poverty, with a particular focus on child poverty, and to reduce income inequality and disparities in our country. It addresses the growing social demand for action on poverty and social exclusion and contributes to equitable economic growth by considering those who have been most severely affected by recent economic crises.

On the other hand, specific regional regulations on minimum incomes, along with other regional and municipal plans, complement the national strategies to combat poverty and social exclusion.

This pilot project aligns with European and national strategies for combating poverty and social exclusion, as well as with the 2030 Agenda for Sustainable Development, specifically contributing to SDGs 1, 2, 8, 10, and 11.

Cáritas has designed a project aimed at enhancing the socio-occupational inclusion of its participants. The project focuses on increasing their economic autonomy, improving access to public services, and fostering the development of social relationships.

The scientific objective of the project is to determine whether the pathways designed to provide individuals with rights and empower them to make self-sufficient decisions are more effective and efficient than the traditional support and assistance provided by Cáritas.

The governance framework established for efficient and effective project management includes the following actors:

- **Cáritas** (Official Confederation of Charitable and Social Action Entities of the Catholic Church) is the responsible entity for project execution. Established in 1947, its mission is to implement

the charitable and social work of the Catholic Church in Spain through its confederated members.

Cáritas promotes the holistic development of individuals, particularly the poorest and most excluded, by supporting vulnerable people. They focus on empowering individuals to advocate for their rights through three fundamental areas of integral development: basic needs, the meaning of life, and social participation.

Within Cáritas, there are a total of 70 Diocesan Cáritas (CCDD), each one is responsible for coordinating, guiding, and promoting charitable and social action within their respective dioceses. Specifically, 18 of these CCDDs have served as the primary executors of the project within their geographic areas of operation.

Cáritas' extensive experience in supporting vulnerable individuals and those at risk of social exclusion makes it the ideal entity to execute this project.

- The **Ministry of Inclusion, Social Security and Migration** (MISSM) is the funding source of the project and responsible for the RCT evaluation. For this reason, the General Secretariat for Inclusion assumes a series of commitments with Cáritas:
    - Provide the beneficiary entity with support for the design of the actions to be carried out, for the execution and monitoring of the object of the subsidy, as well as for the profiling of the potential participants of the pilot project.
    - Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary entity and scientific collaborators. Also, carry out the evaluation of the project.
    - 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: s**ection 2** provides a **description of the project**, detailing the issue to be addressed the specific interventions associated with each experimental group, and the target audience to which the intervention is directed. Next, **section 3** contains information related to the **evaluation design**, defining the Theory of Change linked to the project and the hypotheses, sources of information, and indicators used. **Section 4** describes the **Implementation of the intervention**, the analysis of the sample, the results of randomization, and the degree of participation and attrition of the intervention. This section is followed by **section 5** where the **results of the evaluation** are presented, along with a detailed analysis of the econometric analysis carried out and the results for each of the indicators used. Finally, the **Conclusions** of the project evaluation are described in **section 6**. Besides, in the appendix **Economic and regulatory management,** additional information is provided on the management tools and governance of the pilot project.

Ethics Committee linked to 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 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 October 4, 2022.

2 Description of the program and its context

This section describes the program that Cáritas implemented in the framework of the pilot project. Furthermore, it describes the target population and the territorial framework and provides a detailed description of the intervention.

2.1 Introduction

This project and its evaluation aim to determine whether implementing itineraries focused on offering rights and empowering individuals to make self-sufficient decisions leads to greater effectiveness compared to the traditional itineraries of the current Cáritas model, which focus on addressing immediate needs. The pilot project has the following specific objectives:

– In the short term:

• Participants stabilize their situation by meeting basic needs.

• Participants engage in training and collaborative processes, taking on new challenges.

• Participants visit the ACCEDE space and engage in social interactions

– In the medium term:

• Participants improve their access to social goods and services.

• Participants enhance their skills for digital and labor integration.

• Participants strengthen their relational networks.

– In the long term:

• Individuals and their families gain access to social resources as rights holders and develop more stable support networks, facilitating their social and labor integration.

Cáritas' ACCEDE pilot project is a model of empowerment and access to rights. It aims to promote individuals' access to rights and enhance their capacities for integration into society and the labor market, with a particular emphasis on digital skills as a key driver for this access.

The project is implemented across 18 Diocesan Cáritas (CCDD) in various Autonomous Communities. The goal of this pilot project was to develop expertise that can be scaled up and applied across all Diocesan Cáritas.

Scientific studies relevant to the project include research in the field of combating social exclusion, such as the study by McFarland (2017). This study explores various experiments related to basic income, some of which use randomized controlled trial methodology. These experiments are a significant reference for understanding the impact of public policies that provide basic income.

There are precedents in scientific literature that show positive results of support programs. Of note is the study on the B-MINCOME pilot program (Todeschni & Sabes-Figuera, 2019), implemented in the city of Barcelona. This study evaluated an innovative policy that combines cash transfers with social and labor inclusion measures, such as training and socialization activities. The results indicated a reduction in material deprivation and food insecurity, as well as improvements in life satisfaction, sleep quality, and community participation. However, there was no significant effect on employment status or perceived health.

Additionally, a relevant study is currently underway in the United States examining the impact of a program designed to help adults overcome economic challenges (Espinosa, Evans, & Phillips, Elaboration in progress). This comprehensive program assigns mentors to participants to assist with goal setting and action plan development and provides financial incentives. Support staff are also assigned to help with job placement and address dependency-related needs.

Regarding the digital branch of treatment, there is also scientific evidence to support it. The study by Lee et al. (2022), carried out in South Korea, found positive impacts of digital literacy training on the use of digital devices among adults over 65 years of age, evidencing improvements in well-being and cognitive function. On the other hand, Choudhary and Bansal (2022) conducted a literature review on the effectiveness of digital training programs in various settings (rural/urban) and for marginalized population groups (e.g., due to gender, age, immigration). Their review demonstrated a range of impacts, which largely depend on the quality of services and the program's structure. The authors found that, at the administrative level, planning and design were the most critical factors for program effectiveness, while at the individual level, a lack of family support significantly hindered learning.

In addition to the evidence from RCTs, Cáritas has drawn on two key references for the conception and definition of the ACCEDE project. First, the Ministry of Social Rights and Agenda 2030 (2019) provides a definition of poverty and social exclusion that includes two dimensions: (i) the monetary dimension, related to individual income, and (ii) the material dimension, related to the availability of goods and services. Second, Maíllo et al. (2019) offer a more detailed definition of poverty and social exclusion by reviewing the 35 indicators used to calculate the Synthetic Social Exclusion Index (ISES) created by FOESSA. FOESSA's index includes eight dimensions: (i) employment, (ii) consumption, (iii) political participation, (iv) education, (v) housing, (vi) health, (vii) social conflict, and (viii) social isolation.

2.2 Target population and territorial scope

The target population consists of vulnerable individuals at risk of social exclusion who either live alone or are part of a household unit and lack the economic resources to meet their basic needs. These individuals are either beneficiaries of the MIS and/or regional minimum income, or they meet the eligibility criteria for these aids but do not receive them. This specificity is important because the program addresses three key areas: economic, social, and relational.

The following groups are specifically considered when defining individuals at risk of social exclusion: children and young people; older adults; people with disabilities; migrants; victims of gender-based violence; discriminated individuals; homeless people; ethnic minorities; prisoners or former prisoners; people with addiction problems; and others identified by Cáritas as experiencing poverty or at risk of social exclusion.

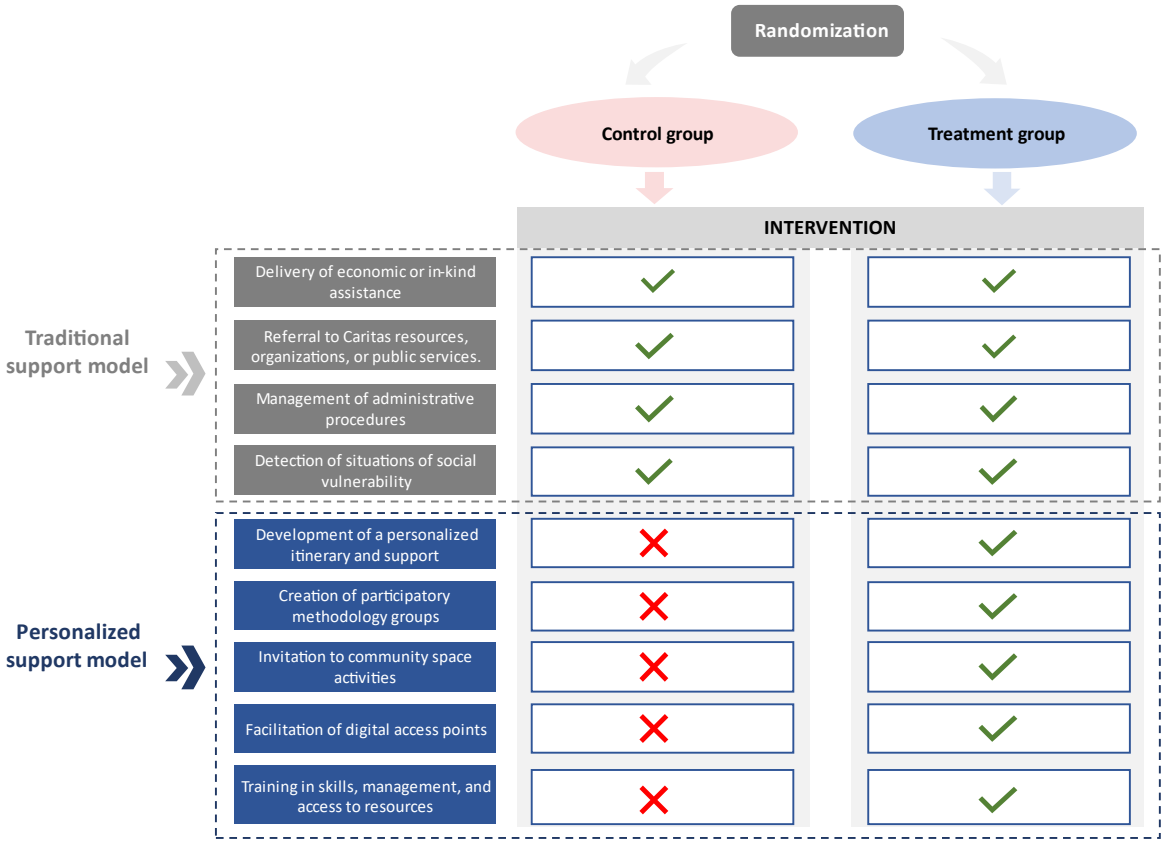
More details on the recruitment process are provided in **section 3.5** as part of the evaluation design.

The territorial scope of the project is made up of the area of influence of the 18 Diocesan Cáritas (CCDD) executing the project, being the following: CD Barbastro-Monzón, CD Barcelona, CD Bilbao, CD Cartagena-Murcia, CD Ciudad Real, CD Huelva, CD Huesca, CD Madrid, CD Mallorca, CD Mérida-Badajoz, CD Ourense, CD La Rioja, CD Salamanca, CD Segorbe-Castellón, CD Sigüenza-Guadalajara, CD Tenerife, and CD Zamora.

2.3. Description of interventions

The intervention strategy aims to enhance the effectiveness of Cáritas' traditional support model by increasing participants' autonomy and facilitating their social and employment integration, ultimately reducing their vulnerability to social exclusion and poverty. In this context, the treatment group receives a novel intervention, characterized by intensive accompaniment and personalized support, as opposed to the traditional approach, which primarily addresses immediate needs. These needs include providing economic aid, referring individuals to available resources, managing administrative procedures with public institutions, and identifying instances of social vulnerability, among other tasks. To rigorously evaluate the impact of the intervention, the study randomly divides participants into two groups: the control group, which receives the traditional support and accompaniment model offered by Cáritas, and the treatment group, which, in addition to this support, receives a series of personalized actions. These include training in digital skills and abilities, as well as group and community activities designed to enhance their interaction and social integration. **Figure 2** summarizes the actions carried out in each model—traditional and personalized—according to the experimental group that receives them.

Figure 2: Intervention scheme



Both the control group and the treatment group receive traditional support and accompaniment services. These services include financial or in-kind support, access to resources from Cáritas, social entities, or public services, assistance with administrative procedures, and detection of social vulnerability situations, among others.

In addition to traditional support, the treatment group receives a series of specific personalized actions. These include training in skills to access rights and digital training, activities designed to improve community relations and create support networks, and other tailored activities based on each participant's specific needs. Furthermore, the parishes have established a physical space named "ACCEDE," equipped with internet access and computer resources, specifically for the treatment group. This space facilitates access to many of the personalized services offered by Cáritas.

The aim is to evaluate the effectiveness of these personalized actions with intensive accompaniment in comparison to the traditional support and accompaniment model. The following section outlines the main components of both itineraries:

Traditional support and accompaniment services

This Cáritas support service, provided to both the control and treatment groups, includes a range of assistance designed to address the basic needs of recipients and their families or household units.

These traditional actions include financial or in-kind aid (such as food, clothing, and footwear), referrals to Cáritas services (such as food distribution centers or soup kitchens), public services, and other entities (such as health centers, social services, and resources for children and teenagers). They also involve identifying situations of social vulnerability (such as gender-based violence, mental health issues, and addictions), assisting with administrative procedures (including participant requirements and documentation), and providing information on public and private resources and services that participants may need (such as social benefits or dependency assistance).

Personalized support and accompaniment services

For the treatment group, the parishes established the ACCEDE physical space. In this space, participants had access to computers and digital resources, and received eight additional actions: (i) development of a personalized itinerary, (ii) training in accessing the Minimum Insertion Income (MIS) and other benefits, (iii) training in active job search techniques, (iv) training in skills, service management, and resource access, (v) creation of groups using participatory methodologies, (vi) provision of digital access points (devices and internet connection), (vii) intensive support across various areas of action, and (viii) training in procedures and claims with administrations.

In other words, beyond the activities provided to the control group, participants in the treatment group receive additional training aimed at achieving self-sufficiency, such as instruction on obtaining the Minimum Insertion Income (MIS) and other benefits, as well as active job search techniques. They also benefit from specialized training on how to effectively navigate and conduct these procedures, rather than just receiving information or referrals to public resources and services.

Furthermore, a key differentiating factor for the treatment group is the emphasis on training in digital skills. This training focuses on using digital channels to process and obtain aid, such as the Minimum Insertion Income (MIS) or other social benefits, conducting job searches online, and accessing rights and public services through digital platforms.

Finally, to enhance their level of social participation, the treatment group receives targeted actions designed to reduce isolation and disconnection from society. The ACCEDE space plays a crucial role in this by serving as a platform for fostering relationships among participants, facilitating the formation of new connections, and building support networks.

Considering the intervention scheme outlined above, the treatment phases are broadly as follows:

Figure 3: Phases of treatment

- At the **reception**, the initial contact with the participant occurs. Both the treatment and control group participants provide consent to participate in the project and complete the initial or baseline survey. This survey gathers and documents initial information about the

participants across various areas, including economic status, social factors, access to rights, and social relationships.

- In the **Intervention** or activation and development phase, the project implements the actions of each personalized support and intensive accompaniment itinerary. The treatment group participants receive, in addition to traditional services, a series of personalized and comprehensive actions, with a special focus on training in digital skills. The ACCEDE space provides a suitable environment for these actions and facilitates participant interaction and the creation of support networks. Throughout the intervention phase, the study conducts continuous monitoring and provides advice to ensure the proper development and execution of each itinerary.
- The **Exit** or Closing phase focuses on collecting information and feedback from the participants through a final survey and evaluating the results.

3 Evaluation design

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

3.1 Theory of Change

This report, with the aim of designing an evaluation that enables understanding the causal relationship between the intervention and its final objective, develops a Theory of Change. The Theory of Change makes it possible to schematize the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long term results sought by the intervention, 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 effect(s) based on the initial hypothesis, i.e., what changes – in behavior, expectations, or knowledge – are expected to be obtained in the short term with the actions conducted. Finally, the process concludes with the definition of the medium- to long-term results that the intervention aims to achieve. Sometimes, the effects directly obtained with the actions are identified as intermediate results, and one identifies the indirect effects in the results.

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

The perspective of change begins with identifying a specific need within a particular area. In this case, it involves recognizing the evidence of social and labor exclusion among individuals seeking assistance from parish Cáritas. This identification leads to the construction of a causal chain, focusing on harnessing the potential of individuals to transform their current circumstances. Consequently, this extends to improving the situation of their families by dignifying their circumstances and effectively utilizing their rights, ultimately aiming for complete socio-labor integration. the desired change encompasses enabling individuals and their families to live with dignity, ensuring their access to social resources as rights holders, and establishing support networks to facilitate their social and labor integration.

The theory of change is based on three axes: the economic axis, the social rights axis, and the relational axis. The starting point for the participants in these areas is:

- **Economic Axis**: Not covering basic needs.
- **Social Rights Axis**: Not having full access to rights.

- **Relational Axis**: Being in a situation of isolation and/or conflict.

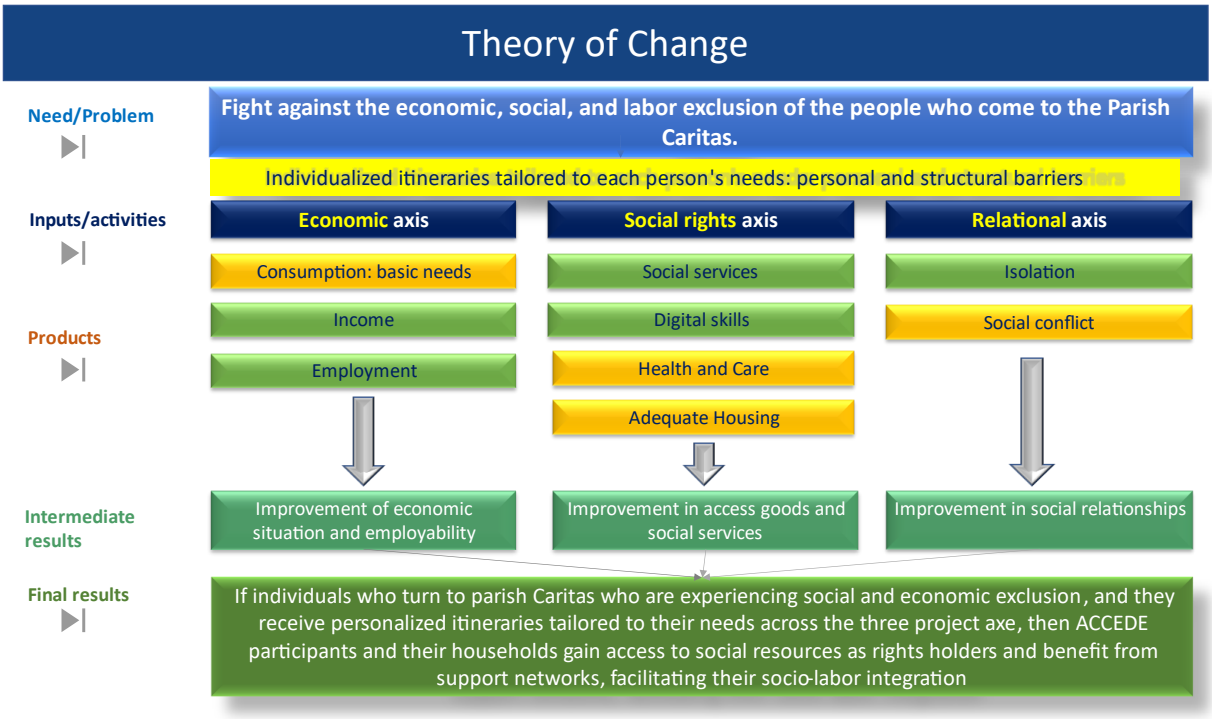
Participants will go through several phases (reception, activation, and development) and will advance in the three axes mentioned above.

Regarding the economic and social rights axes, participants will initially stabilize their situation by addressing their basic needs and those of their household. Following this, they will engage in training and collaborative processes. In the medium term, the goal is to enhance their situation through improved access to goods and services (such as increased income, better access to education and healthcare) and by achieving digital and labor integration through training in digital and vocational skills.

Regarding the relational axis, participants start by visiting the ACCEDE space and interacting with others. In the medium term, they improve their relational situation through the establishment of social ties and participation in community activities.

As mentioned above, the long-term vision and goal are for individuals and their families to live with dignity, access social resources as rights holders, and have support networks that facilitate their social and labor integration. **Figure 4** illustrates the progression in the various axes through different phases towards the desired goal and change, considering the initial situation.

Figure 4. Outline of the Theory of Change towards labor and social inclusion



3.2 Hypothesis

The ACCEDE Project proposes a series of hypotheses to be tested to evaluate the impact of the described actions and their contribution to the overarching goal (enabling individuals to dignify their situation and access social resources as rights holders) and the long-term objective or desired change (achieving labor and social inclusion).

The following are the hypotheses to be tested:

Increased income or reduced difficulty making ends meet

The hypothesis posits that participation in Cáritas' ACCEDE program will result in higher income, or at the very least, fewer difficulties in making ends meet, compared to the traditional accompaniment service.

Improved employability

To assess the effect of the pilot project on employability, the study postulates the following hypothesis: "Participants, through Cáritas' personalized employment support, will significantly improve employability outcomes by identifying jobs that align with their skill sets and interests and by receiving guidance on effective job search strategies."

Enhancement of rights guarantee

The hypothesis suggests that participants, after receiving training on accessing the Minimum Insertion Income (MIS) and other benefits, will become more knowledgeable about their rights. Consequently, some individuals may initiate applications for social benefits or assistance related to education, health, housing, and other areas.

Bridging the digital divide

To assess the impact on the digital divide, the hypothesis suggests that the target group will utilize the Internet more frequently to address everyday challenges, due to the specialized training they receive in digital skills.

Improvement in social relationships

To examine the impact of the intervention on social relations, this study considers the hypothesis that the treatment group will improve its social relationships because of the activities conducted in the ACCEDE space.

3.3 Sources of information

The primary source of information for gathering data on the indicators used to validate or refute the initial hypotheses consists of questionnaires specifically designed for evaluation purposes. These questionnaires were developed by Cáritas in collaboration with the evaluation team at CEMFI, J-PAL Europe, and the MISSM. Participants answered these questionnaires both in the pre-experiment phase (the baseline survey) and at the end phase (the endline survey). Cáritas professionals supervised the process and used a computer system to input the information directly into the corresponding databases.

The baseline survey aims to understand the participants' situation prior to the intervention, while the final survey assesses the effects of the pilot project after its implementation.

The baseline survey consists of a questionnaire with over 100 specific questions, divided into the different axes (economic, access to rights, and relational). Each axis includes various subsections tailored to the specific areas within that axis.

Initially, a questionnaire comprising at least 100 questions was proposed, covering actions from all areas, and based on at least 35 indicators. Subsequently, to streamline measurement and refine the final itinerary, the project retained the three axes but focused on a narrower set of impact areas to achieve the expected intermediate results and final impact. These areas include right to income, right to employment, administrative rights, digital literacy, social isolation, and social coexistence.

Other areas are addressed through information and training sessions on accessing social rights (such as consumption, health, education, etc.), including a cross-sectional module on digital skills training. As a result, the number of intermediate and final outcome indicators was reduced to 10, in line with

the working hypotheses. Consequently, the questionnaire was configured with 27 questions, maintaining the three axes while focusing on a catalog of common and specific actions.

This analysis uses the remaining questions in the questionnaire to evaluate Cáritas' contribution as part of an internal assessment.

Here is a brief description of the general theme for each of these subdivisions:

Economic axis

- **Right to consumption (food):** Questions aimed at understanding the participant's situation and their core of coexistence concerning food. These questions seek to gather information from various angles, including the number of meals per day, occurrences of food scarcity (whether recurrent or occasional), substitution of regular foods with cheaper alternatives, and the overall quality of food.
- **Right to consumption (clothing):** Questions aimed at understanding the participant's situation regarding access to clothing. These questions focus on the participant's and their family's ability to acquire appropriate clothing and footwear for different seasons, climates, and contexts (both formal and informal)
- **Right to income (income):** This subcategory collects information on the participant's prior situation regarding access to social benefits, salary income, and other sources of income (such as from family or NGOs). It also assesses whether the income received is sufficient to cover the expenses of the participant and their household.
- **Right to employment:** Questions related to the work history of the participant or the person supporting their household. These questions gather information on the quantity and quality of employment, if applicable, as well as other variables related to labor market participation, such as job training, CV preparation, access to job offers, and interview opportunities.

Access to social rights axis

- **Administrative rights:** Questions aimed at understanding the participants and their household's status regarding the ability to exercise their rights with public administrations. This includes access to essential documentation such as census registration, official identity documents, family books, and bank accounts
- **Digital divide:** Questions related to the quality and frequency of digital connections, focusing on three main aspects:
    1. Material: Number and quality of devices available.
    2. Access: Internet connection and its quality.
    3. Knowledge: Digital skills of household members

- **Health:** Questions related to the health and hygiene status of the participants and their household members. These questions cover a broad range of health issues, including exercise, diet, access to medical services and medications, specialized treatments, and addictions.

- **Housing:** Questions aimed at understanding the participant's living situation and the characteristics of their primary residence, if applicable.
- **Education and training:** Questions related to the education of minors in the participant's household. These questions address aspects such as schooling, availability of school materials, access to nursery schools, educational support, and limitations on training capacity

Relational axis

- **Social Isolation:** Questions aimed at understanding the degree of social isolation experienced by the participant and their feelings about it.
- **Social coexistence:** Questions aimed at understanding the level of social coexistence and the participant's initial situation regarding their relationships with the community.

The final line survey contains largely the same information as the baseline survey. Additionally, it includes a new section focused on the participants' self-perception of their living conditions. This section has been integrated into all itineraries and is explained below.

Self-perception of living conditions

This section is added to the final questionnaire to assess participants' self-perception regarding overall life satisfaction, job satisfaction, satisfaction with their income level, satisfaction with their health, and perceived improvement in their quality of life over the medium term (compared to a year ago).

The responses from the end-line survey are used to track the evolution of the indicators and assess the impact of the pilot project.

3.4 Indicators

This section outlines the indicators used to evaluate the impact of the intervention pathways, categorized by themes related to the hypotheses described earlier. All indicators have been standardized to have a mean of zero and a standard deviation of one. Each indicator is described below, and where applicable, the initial values before standardization are provided.

Revenue

Two indicators will be used for the income situation of the participants.

Total monthly income per capita: It is constructed with the sum of income from different sources in the last 6 months. The sources of income used are welfare money, earned income money, and money from other sources.

Ability to make ends meet: Measured through the number of occasions when the participant has not been able to meet the payment of household supplies in the last 6 months.

Employability

Four indicators are used to measure employability:

Number of job interviews conducted by the participant in the last 6 months.

Number of job openings the participant has applied for in the last 6 months.

Number of training actions for employment to which the participant has applied in the last six months.

Number of career guidance actions in which you have participated in the last 6 months.

Guarantee of rights

It is measured with one indicator:

Degree of access to social rights in the last 6 months: using the Anderson index, which has a mean of 0 and a standard deviation of 1. It gathers information from various questions in the questionnaire about experiences with social services, public health, education, and the Treasury. Each question uses a six-point scale, allowing respondents to indicate whether they could access these services and the level of difficulty they encountered in managing this access.

Digital divide

The differential effect of the treatment on reducing the digital divide of the participants is measured with three indicators:

Degree of use of the Internet for personal, work, educational, family, or administrative purposes: Constructed with the Anderson index, which has a mean of 0 and a standard deviation of 1, this indicator uses qualitative variables from the questionnaire on self-perception of the ability to complete various procedures online. The individual questions that form this index reveal whether the person has managed to complete procedures in these areas and the difficulty they encountered in the process, using a six-point scale.

Internet access at home: A binary variable that takes a value of 1 when the participant has access to the internet at home and 0 when he or she does not.

Internet access anywhere: Binary variable that takes a value of 1 when the participant has access to the internet outside the home and 0 when he or she does not.

Social Relationships

The increase in the relational situation of the participants is measured with the following two indicators.

Degree of regular contact with other people in their environment and receipt of the necessary support: Constructed with the Anderson Index, which has a mean of 0 and a standard deviation of 1, this indicator uses variables related to: visits to friends and family, self-perception of love and affection, the participant's ability to communicate personal and work problems to others, receiving invitations to social events, obtaining useful advice during important events, receiving help during illness, and getting assistance with domestic matters.

Degree of participation in group activities (community involvement): Measures whether the person regularly participates in a group in their environment in the last 6 months (AMPA, parish, neighborhood organization, etc.). It takes values between 1 (minimum involvement) and 3 (maximum involvement).

3.5 Design of the experiment

To assess the effect of personalized and comprehensive treatment versus traditional treatment on the indicators, an experimental evaluation (RCT) is used. In this evaluation, participants are randomly assigned to either the treatment group or the control group.

Given the rationale behind the intervention, which aims to evaluate potential improvements in addressing the needs of these groups compared to previously established practices, the design involves comparing the new treatment with the conventional approach. Accordingly, participating parishes are randomly allocated to either the treatment group (which undergoes the intervention being evaluated) or the control group (which follows the traditional methodology).

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

Recruitment of the beneficiaries of the intervention

The target population for this intervention consists of individuals at risk of social exclusion or severe poverty who were either already part of the intervention conducted by the participating parish Cáritas or who contacted the participating parish Cáritas during the recruitment phase. Given the project's formulation, it is not feasible to implement a differentiated approach for these individuals within each parish, particularly due to the significance of the ACCEDE community access space. Therefore, although the actions are aimed at individuals, the unit of randomization and the focus of the intervention are the parishes.

There are no specific criteria required to participate in the project. However, the target population includes individuals who are either beneficiaries of the MIS or minimum income, or those who meet the requirements to obtain these benefits but, as of the pilot project's start date, do not access them. Additionally, the target population encompasses other people at risk of poverty and social exclusion, such as those who live alone or are part of household units but lack the economic resources to meet their basic needs. This includes families with dependent children, single-parent families, long-term unemployed individuals, immigrants, homeless people, and others.

Those interested in participating signed an informed consent form, thereby approving their participation in the program. This signatory group then defined the study sample. Since random assignment by parish had already been completed, each participant's allocation to either the treatment or control group was predetermined based on their parish affiliation. However, participants were not aware of their assigned group before signing the consent form.

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 harms 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

Randomization is the cornerstone of RCTs for identifying causal relationships between treatment and outcomes. When executed correctly, this process ensures that the treatment and control groups are statistically comparable, encompassing both observable and unobservable variables. This comparability provides the foundation necessary to accurately measure the potential effects of the intervention.

The randomization unit was formed at the parish level or, if necessary, by grouping several parishes (clusters) to ensure homogeneous units and facilitate a balance between the treatment and control groups. Within each cluster, the intervention was applied to all families who agreed to participate in the project by signing the informed consent form.

Figure 5: Recruitment and randomization process

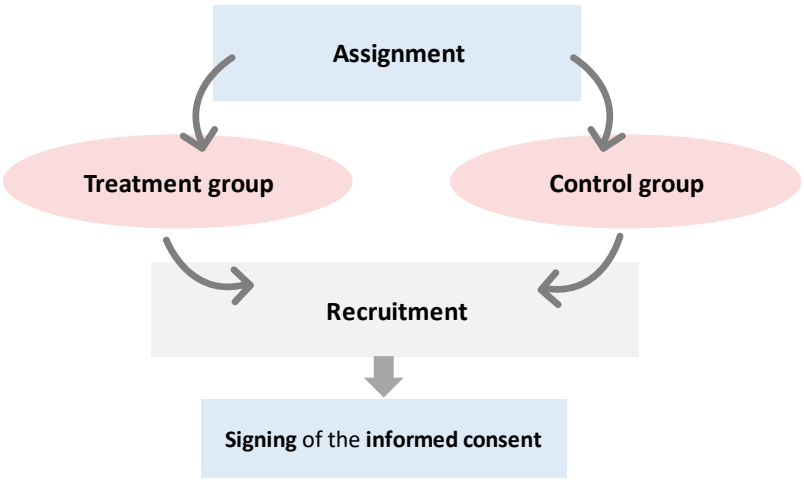
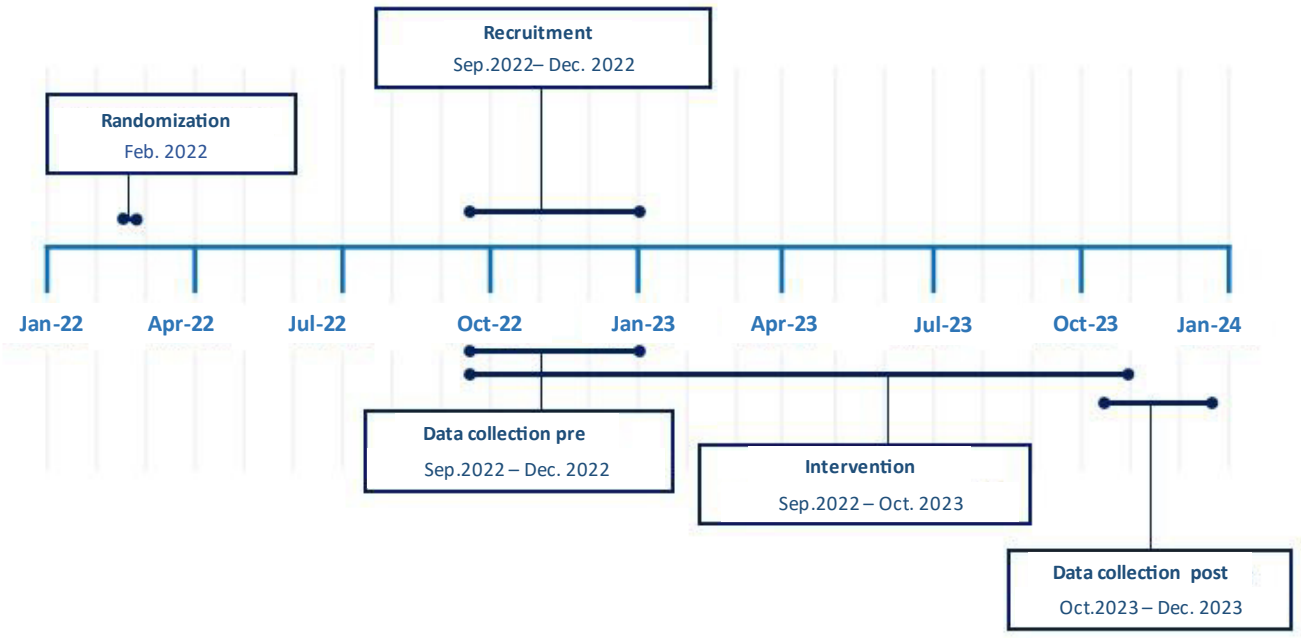


Figure 6 illustrates the timeline of the project evaluation process. Randomization was conducted in February 2022 to assign parish clusters to the treatment and control groups. Recruitment began in September 2022 and continued until January 2023, during which 2,625 individuals signed the informed consent and completed the baseline survey. The intervention concluded in October 2023, followed by the collection of the final survey, which was completed in December 2023.

Figure 6: 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 logistical aspects to contextualize the results of the evaluation.

4.1 Sample Description

Initially, 96 parishes participated, with 48 assigned to the treatment group and 48 to the control group. These parishes were distributed across 18 different territories.

Initially, all individuals who were already in contact with the participating parishes or who attended during the recruitment period were eligible to participate in the project. The projection estimated 3,851 potential beneficiaries based on the list of assigned parishes. However, by the end of the recruitment phase, 2,625 people had signed the informed consent form and completed the baseline survey, constituting the final sample of the study. According to the randomization conducted by the General Secretariat for Inclusion (SGI), 1,205 families (46%) were assigned to the control group, while 1,420 families (54%) were assigned to the treatment group.

Characteristics of the final evaluation sample

Table 1 displays the descriptive statistics of the participants at the onset of the project. The average age of participants was 43.67 years, with 27% being men and the remaining 73% being women. Additionally, 39% of the participants held Spanish nationality, and the average number of members in the cohabitation units was slightly higher than 3.

Only 16% were working, while 66% of the participants were unemployed, with the remaining 18% being inactive.

The most common level of education among participants was Primary Education, secondary education, or basic vocational training, comprising 51% of the group, while 72% of the participants lived in a rented or re-rented home and the average household income in the last 6 months amounted to €1,274.64.

Finally, 71% of the participants had internet access at home and 84% could access the internet from anywhere.

Table 1: Descriptive statistics of the initial sample

Variable	N	Mean	Standard deviation	Minimal	Maximum
Sociodemographic variables (pre-intervention)					
Treatment	2,625	0.54	0.50	0.00	1.00
Age	2,625	43.67	12.84	18.00	92.00
Man	2,625	0.27	0.44	0.00	1.00
Country of Birth: Spain	2,625	0.39	0.49	0.00	1.00
Spanish nationality	2,625	0.46	0.50	0.00	1.00
No. of members	2,625	3.09	1.58	1.00	11.00
Citizenship: Non-EU	2,625	0.46	0.50	0.00	1.00
Citizenship: Spanish	2,625	0.46	0.50	0.00	1.00
Non-Spanish EU Citizenship	2,625	0.04	0.20	0.00	1.00
Citizenship: Family members of EU citizens	2,625	0.02	0.12	0.00	1.00
Citizenship: Non-EU family member of Spanish/EU	2,625	0.02	0.13	0.00	1.00
Laboring	2,625	0.16	0.36	0.00	1.00
Standing	2,625	0.66	0.47	0.00	1.00
Inactive	2,625	0.18	0.38	0.00	1.00
Illiterate	2,625	0.14	0.34	0.00	1.00
Primary education or ESO or basic vocational training	2,625	0.51	0.49	0.00	1.00
Baccalaureate or intermediate vocational training	2,625	0.21	0.40	0.00	1.00
University or higher vocational training	2,625	0.13	0.33	0.00	1.00
Individual dwelling	2,625	0.84	0.36	0.00	1.00
Shared Housing	2,625	0.14	0.34	0.00	1.00
Substandard or unhoused housing	2,625	0.02	0.13	0.00	1.00
Paid or Paying Property	2,625	0.16	0.36	0.00	1.00
Rented or re-rented	2,625	0.72	0.45	0.00	1.00
Occupied or ceded	2,625	0.12	0.33	0.00	1.00
Outcome indicators (pre-intervention)					
Non-payment of household supplies in the last 6 months	2,625	1.35	2.00	0.00	6.00
Job openings you've applied for in the last 6 months	2,625	4.53	12.86	0.00	120.00

Variable	N	Mean	Standard deviation	Minimal	Maximum
Interviews conducted in the last 6 months	2,625	1.02	4.02	0.00	80.00
Occupational training actions in the last 6 months	2,625	0.33	1.13	0.00	22.00
Job training actions in the last 6 months	2,625	0.51	1.86	0.00	48.00
Degree of participation in a group in the last 6 months	2,625	1.34	0.70	1.00	3.00
Average revenue over the last 6 months	2,625	1,274.64	1,113.25	0.00	10,966.67
Level of success in utility management in the last 6 months	2,625	3.47	1.28	1.00	6.00
Proficiency level in using the internet for personal purposes	2,625	4.15	1.48	1.00	6.00
Level of social inclusion	2,625	3.41	1.12	1.00	5.00
Internet access at home	2,625	0.71	0.45	0.00	1.00
Internet access by any means	2,625	0.84	0.37	0.00	1.00

4.2 Random Assignment Results

To ensure that the random assignment yields statistically comparable control and treatment groups, a balance test is conducted to verify that, on average, the observable characteristics of the participants in both groups are similar. Achieving balance between the experimental groups is crucial for inferring the causal effect of the program by comparing its outcomes. This balance ensures that any observed differences in outcomes between the groups can be attributed to the intervention rather than to pre-existing differences between the participants.

Table 2 shows the random assignment results, breaking down the number of participants in each group according to the parish or cluster of parishes, which serves as the randomization variable for this pilot project. As outlined in section **3.5**, the random assignment was conducted prior to participant recruitment, resulting in a total of 3,851 potential beneficiaries at the time of the random assignment.

Table 2: Result of random assignment

	Parishes		People		
Diocesan Cáritas	Treatment	Control	Treatment	Control	Total
Barbastro	1	1	33	33	66
Barcelona	4	4	200	200	400
Bilbao	1	1	50	50	100
Cartagena	3	3	208	173	381

	Parishes		People		
Diocesan Cáritas	Treatment	Control	Treatment	Control	Total
Ciudad Real	3	3	90	88	178
Huelva	4	4	160	160	320
Huesca	1	1	60	60	120
La Rioja	2	2	60	60	120
Madrid	6	6	195	195	390
Mallorca	2	2	140	140	280
Menorca	2	2	60	60	120
Mérida-Badajoz	4	4	120	120	240
Ourense	2	2	80	80	160
Salamanca	4	4	119	119	238
Segorbe	1	1	100	100	200
Sigüenza-Guadajara	3	3	135	140	275
Tenerife	4	4	74	74	148
Zamora	1	1	70	45	105
TOTAL	48	48	1,954	1,897	3,851

The results of Balance contrasts between the control group and the treatment group are presented below in **Figure 7**[12]. All data shown in this figure pertains to the survey conducted prior to the intervention (baseline). For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a dot, with the 95% confidence interval of that difference focused on it. A confidence interval containing zero on the vertical axis indicates that the mean difference between groups is not statistically significant, or in other words, is not statistically different from zero. Therefore, it will be concluded that the intervention groups are balanced in this characteristic. In cases 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.

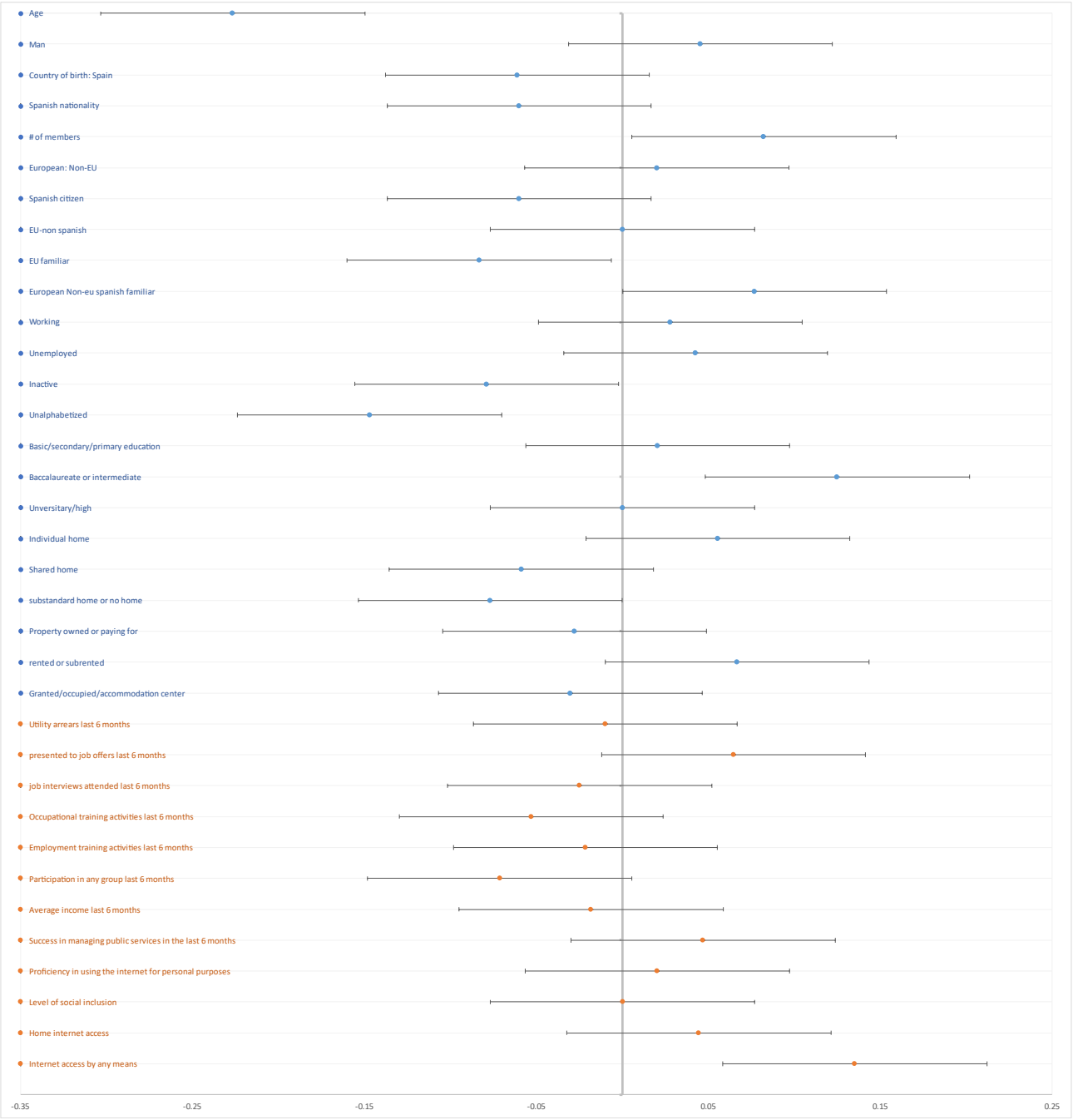
The treatment and control groups are not statistically different in most variables. Regarding the unbalanced sociodemographic variables, this analysis found age (45.25 years for the control group compared to 42.34 for the treatment group), the percentage of EU familiars (2% in the control group compared to 1% in the treatment group), the percentage of inactivity (20% in the control group and 17% in the treatment group). Some variables that have to do with educational level, such as the percentage of illiterate people or the percentage of people with high school/intermediate vocational training are also unbalanced.

[12] See **¡Error! No se encuentra el origen de la referencia.** in the Appendix for the details of the results of the balance tests.

Regarding the intervention indicators, the only unbalanced variable is the percentage of people with access to the internet by any means. In this case, the treatment group showed higher values than the control group (86% vs. 81%).

Overall, the imbalances between the experimental groups are not highly significant, though they do prevent perfect comparability. These imbalances may result from the limited sample size. Smaller sample sizes can decrease the statistical comparability between intervention groups that randomization aims to ensure. Therefore, in the regressions presented in the results section, this project controls for the value of the dependent variable at the initial period (baseline survey). This approach accounts for the fact that the treatment and control groups may not start from the same level. Additionally, the results include controls for variables such as education level, gender, and nationality.

Figure 4: Standardized mean difference between treatment group and control group (95% confidence interval)



* Socio-demographic variables are shown in blue, and the indicators used for the evaluation of the project are shown in orange.

4.3 Degree of participation and attrition by groups

The group that provided informed consent form comprises the experimental sample that was randomly assigned to the control and treatment groups. Chronologically, the random assignment was conducted at the parish level prior to obtaining informed consent. Nevertheless, individuals signing the consent form were unaware of the random assignment outcome at the time of signing, which had been determined at the parish level. Both participation in the program and response to the initial and final surveys are voluntary. On one hand, it is beneficial to analyze the level of participation in the program, as the estimation of results will focus on the average effects of providing it, considering the degree of participation. For instance, if participation in treatment is low, the treatment and control groups will be very similar, and it will be harder to find an effect. On the other hand, this section tests whether the non-response of the final survey by some of the participants reduces the comparability of the treatment and control groups after the intervention, as they do not have information to do so or have it in a biased way.

Degree of participation

Prior to the commencement of the itinerary, logistical challenges in some Diocesan Cáritas led to the inability to implement the project in several parishes. Consequently, multiple parishes withdrew from the project, including 6 in Barcelona (3 in the treatment group and 3 in the control group) and 2 in Mallorca (1 in the treatment group and 1 in the control group).

As for the different actions carried out during the itinerary, the degree of participation has been uneven between the different types of actions. The performance of intensive accompaniment showed the highest degree of participation with more than 85%, while the facilitation of digital access points obtained a participation of less than 20%. The training activities all recorded a participation of around 50%.

Table 3 Summarizes the different actions and the degree of participation for the treatment group.

Table 3: Degree of participation in the different actions

Activity	% Treatment Group Participation
Intensive accompaniment in the different areas of action included in the personalized itinerary	86.5%
Creation of groups with participatory methodology	61.0%
Facilitation of digital access points (devices and connection)	18.8%
Skills training, service management and access to resources	49.5%
Training in procedures, procedures and claims with public administrations	53.9%
Training in access to the MIS and other benefits and financial management	50.2%

Activity	% Treatment Group Participation
Training on active job search techniques and socio-occupational skills	52.6%

Table 4 presents the total number of participants who responded to the baseline and final line surveys, categorized by treatment group. Out of the initially registered participants (2,625), 86.3% (2,265) completed the final line survey. Specifically, 88.8% of those assigned to the treatment group (1,261) completed the final line survey, while 83.3% (1,004) of those assigned to the control group did so.

Table 4 Early Dropout Rate

Group	Baseline survey	Final line survey
Total	**2,625**	**2,265** (86.3%)
Treatment	1,420	1,261 (88.8%)
Control	1,205	1,004 (83.3%)

Attrition by groups

To determine whether the difference in sample attrition rates between experimental groups is statistically significant, a simple regression of the final uncompleted survey binary variable on treatment allocation is estimated.

As shown in **Table 5**, this regression includes only the strata as regressors in column 1 while additional controls are included in column 2. In addition, to check whether the sampling attrition is selective, this study estimated regressions including family characteristics together with the treatment variable as additional regressors.

The coefficient of the treatment variable is -0.051 and statistically significant at 1%, which means that participants in the treatment group are less likely to not respond in the final interview or survey, whereas those in the control group tend to drop out more easily. In column 2, it is observed that only the interaction of treatment with the variable sex (male) is negative and significant at the 5% level. Therefore, this variable was also incorporated as an additional regressor in the analysis of results.

Table 5: Regressions of the probability of non-response in the final interview

Non-response in the final interview	(1)	(2)
Treatment	-0.051***	-0.053
	(0.05)	(0.069)
Treatment x Age of the respondent		-0.001
		(0.001)
Treatment x Sex of the respondent: male		-0.073**
		(0.034)
Nationality of the reporting person: Spanish		-0.047
		(0.036)
Treatment x Number of members in the household		-0.008
		(0.011)
Treatment x Employment Status: Working		-0.002
		(0.037)
N	2,625	2,625

Note: Standard errors, grouped by parish, reported in parentheses.
All columns include the randomization layers as controls
Column 2 also includes the non-interacted variables as additional controls

5 Results of the evaluation

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

5.1 Description of the econometric analysis: estimated regressions

The regression model specified to estimate the causal effect in a randomized experiment typically involves comparing the difference in the variable of interest between the treatment group and the control group. This approach is valid because randomization ensures that these groups are statistically comparable, if stratification and any unbalanced baseline variables are considered. This ensures that pre-existing differences between the treatment and control groups are accounted for in the analysis. Additionally, the following analysis includes regressions where the initial value of the dependent variable—its value before the intervention—is introduced whenever possible to improve the accuracy of the estimates.

The specification is the following:

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

where $Y_{i,t=1}$is the dependent variable of interest observed after the intervention for the person *i*, T_i indicates whether the family has been assigned to the treatment (=1) or to the control (=0), $Y_{i,t=0}$ is the lagging value of the dependent variable (i.e., before the intervention), $X_i$is a vector of controls (the cluster indicators and the unbalanced variables in **Table 5** and **Table 12** in the appendix) and ε_i is the error term.

Standard errors are always grouped at the parish level or group of parishes, with a total of 64.

5.2 Analysis of the results

5.2.1 Main results

This section presents the evaluation results for the indicators, following the structure outlined in the evaluation scheme. As previously mentioned, most outcome variables have been standardized to have a mean of zero and a standard deviation of one. This standardization allows regression coefficients to be interpreted in terms of standard deviations, facilitating the comparison of effect sizes across different domains.

Revenue

Table 6 shows the results of the intervention in participants of the personalized treatment compared to those of the traditional treatment. For each indicator, two specifications are presented: one without controls (only controlling for the strata and for the initial value of the dependent variable, i.e., the value of this variable before starting the program) and another with additional controls (age, sex, educational level, etc.).

Income is measured by the sum of the participants' last six-monthly incomes. Both without adding controls (column 1) and with controls included in the regressions (column 2), the coefficients indicate a positive effect of €903 and €797, respectively, on total income per person over the last six months (statistically significant at the 1% level). There are no significant effects of the intervention on improving participants' ability to pay for household supplies.

Table 6: Effects on income

	Total Revenue Per Person		Non-payment of household supplies	
	(1)	(2)	(3)	(4)
Treatment	903.261***	797.053***	0.024	0.016
	(197.610)	(190.550)	(0.075)	(0.077)
Observations	2,265	2,265	2,265	2,265
Initial value dep. var	Yes	Yes	Yes	Yes
Controls	No	Yes	No	Yes
Mean dep. var	4,906.974	4,906.974	-0.023	-0.023

Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Employability

Table 7 reports the intervention's impact on various employability indicators over the last six months: the number of jobs offers to which participants applied, the number of job interviews conducted, participation in occupational training for employment, and involvement in job orientation activities.

The coefficient for job offers is 0.121 standard deviations (statistically significant at the 10% level). For interviews conducted and job training actions, the coefficients are 0.074 and 0.231, respectively, both significant at the 5% level. Finally, the study found a statistically significant positive coefficient of 0.375 (significant at the 1% level) for participation in job orientation actions.

In summary, Cáritas personalized employment aid for the treatment group, which aims to help individuals find jobs that match their skills and interests, has positively and significantly impacted all the indicators used to measure employability.

Table 7: Effects on employability

	Job Openings Submitted		Interviews conducted		Occupational training actions		Job training actions	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.136**	0.121*	0.118***	0.074**	0.397***	0.375***	0.243**	0.231**
	(0.058)	(0.062)	(0.038)	(0.033)	(0.070)	(0.070)	(0.103)	(0.104)
Observations	2,265	2,265	2,265	2,265	2,265	2,265	2,265	2,265
Initial value dep. var	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Controls	No	Yes	No	Yes	No	Yes	No	Yes
Mean dep. var	-0.076	-0.076	-0.060	-0.060	-0.211	-0.211	-0.126	-0.126

Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Guarantee of rights

Table 8 reports the results of the intervention related to access to rights. This refers to the participant's experience with procedures involving social services, finance, public health, and education entities.

This analysis observed that receiving the personalized treatment of Cáritas has a positive effect of 0.142 standard deviations, statistically significant at 10%. The intervention helps participants to know their rights, and some of them have begun to claim social benefits.

Table 8: Effect on access to rights

	F Degree of access to social rights	
	(1)	(2)
Treatment	0.183**	0.142*
	(0.088)	(0.082)
Observations	2,265	2,265
Initial value dep. var	Yes	Yes
Controls	No	Yes
Mean dep. var	-0.11	-0.11

Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Digital divide

Table 9 reports the results of the intervention on digital skills. Columns 1 and 2 report the results for the participant's ability to carry out personal, family, work, training, and Public Administration procedures through the internet. The effect in column 2 is 0.296 standard deviations, statistically significant at 1%.

The results are also promising for internet access, as reported in the other four columns. Internet access is measured in two ways: access in the person's own home (whether limited or unlimited), and access through any other means (including their own home) such as public places or through neighbors or friends. In both cases, there is a clear improvement in internet access, with increases of 0.193 and 0.160 standard deviations, respectively, both of which are significant at the 1% level.

Table 9: Effects on digital skills

	Degree of use of the internet for personal, work, or educational purposes		Internet access at home		Internet access by any means	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	0.380***	0.296***	0.248***	0.193***	0.199***	0.160**
	(0.066)	(0.065)	(0.071)	(0.066)	(0.063)	(0.059)
Observations	2,265	2,265	2,265	2,265	2,265	2,265
Initial value dep. var	Yes	Yes	Yes	Yes	Yes	Yes
Controls	No	Yes	No	Yes	No	Yes
Mean dep. var	-0.217	-0.217	-0.145	-0.145	-0.144	-0.144

Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Social Relationships

Table 10 reports the results of the intervention on social relationships. There are no significant effects on usual relationships with other people. However, columns 3 and 4 report positive coefficients of 0.474 and 0.476, both statistically significant at the 1% level, for the degree of participation in any group over the last 6 months.

Therefore, the treated group improves their social relations thanks to the ACCEDE program through greater participation in some group in their environment such as the PTA[13] (Parent-Teacher Association), the parish, neighborhood and/or sports organizations, NGOs, political parties, etc.

Table 10: Effects on social relationships

	Degree of regular contact with other people		Degree of participation in a group in the last 6 months	
	(1)	(2)	(3)	(4)
Treatment	0.082	0.056	0.474***	0.476***
	(0.066)	(0.065)	(0.107)	(0.105)
Observations	2,265	2,265	2,265	2,265
Initial value dep. var	Sí	Sí	Sí	Sí
Controls	No	Sí	No	Sí
Mean dep. var	-0.044	-0.044	-0.234	-0.234

Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

5.2.2 Heterogeneity analysis

This section analyzes the heterogeneity of the effects based on participants' characteristics. It conducts regressions like those in the previous section but including an additional variable to estimate the heterogeneous effects. It also adds the interaction of this variable with the treatment.

Table 11 reports the results depending on the number of parishes included in the cluster. This analysis distinguishes the following groups: clusters with fewer than 6 parishes vs. clusters with 6 or more parishes.

[13] Commonly known as AMPA (Asociación de Madres, Padres y Alumnos) in Spain

Table 11: Heterogeneity

	Revenue	Occupational training actions	Access to social rights	Internet access by any means	Degree of participation in a group
	(1)	(2)	(3)	(4)	(5)
Diocesans with 6 or more parishes	233.011	0.084	0.537***	-0.283***	-0.042
	(178.038)	(0.072)	(0.077)	(0.057)	(0.085)
Treatment	1,149.710***	0.390***	0.021	0.96	0.260*
	(245.144)	(0.132)	(0.130)	(0.079)	(0.130)
Treatment x Diocesans with 6 or more parishes	-511.811	-0.022	0.175	0.093	0.314
	(349.873)	(0.082)	(0.101)	(0.081)	(0.139)
Observations	2,265	2,265	2,265	2,265	2,265
Mean dep. var	4,906.974	-0.211	-0.109	-0.144	-0.234

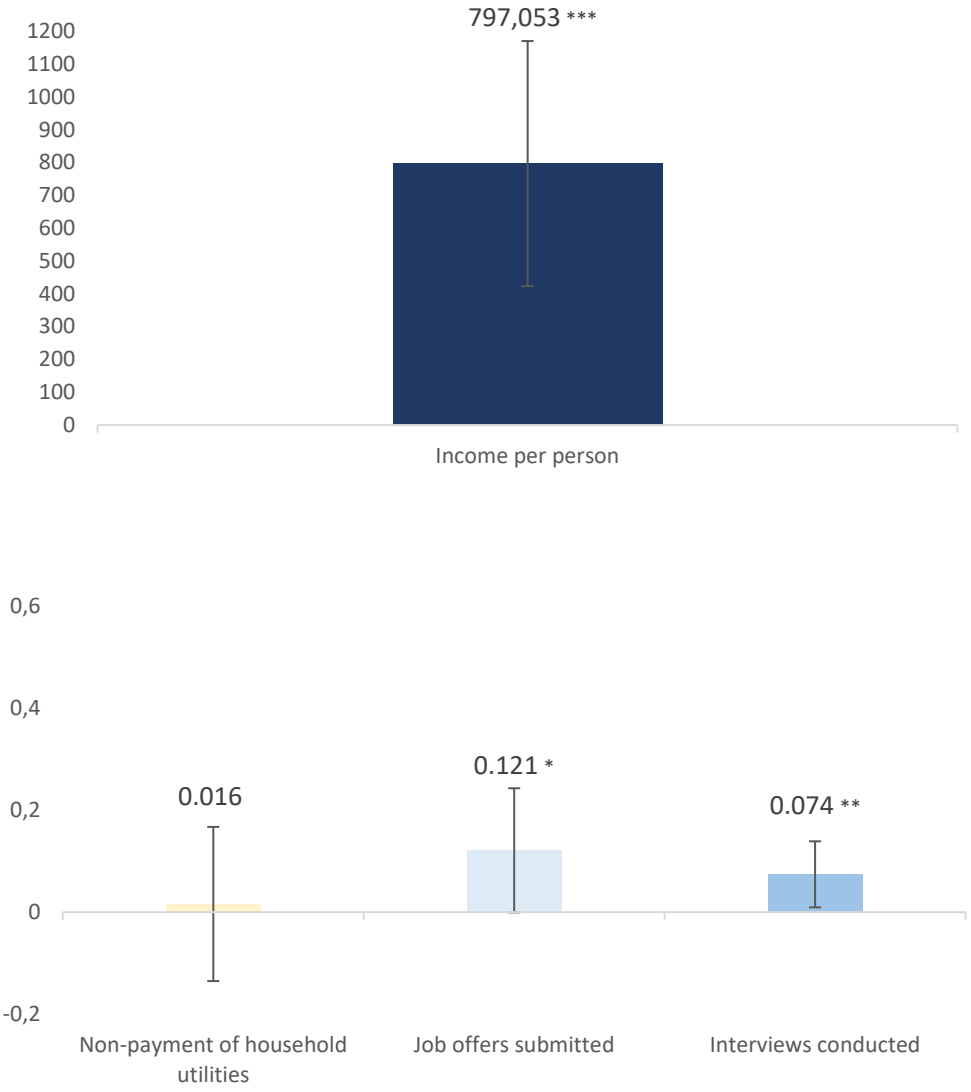
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

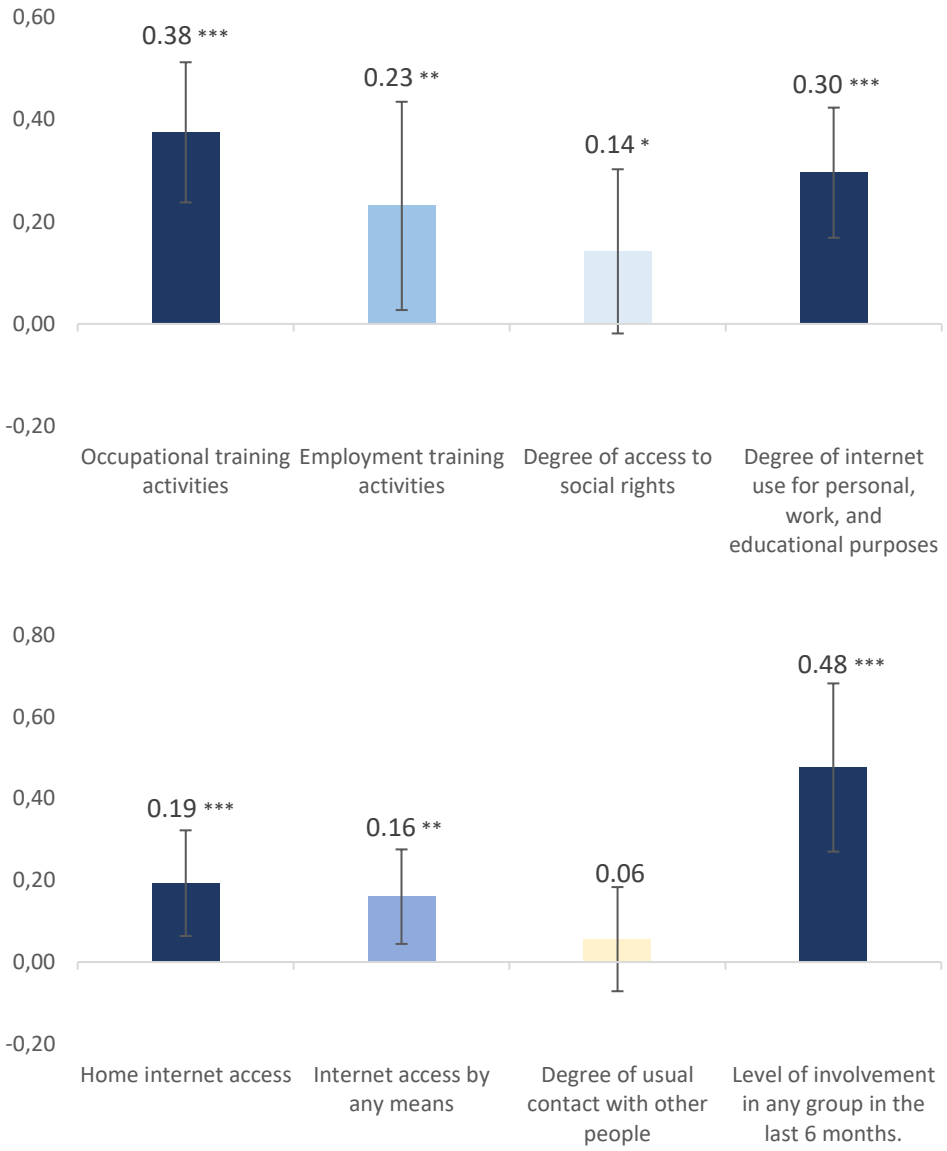
It is worth noting the positive and significant effects of similar magnitudes reported for income, occupational training actions and internet access in columns 1 and 4, respectively. However, regarding access to social rights and the degree of participation in community groups, diocesan churches with a larger number of participating parishes present higher coefficient values. However, there is not enough precision to determine whether this additional effect is statistically significant.

6 Conclusions of the evaluation

The ACCEDE pilot project has proven to be a promising initiative for fostering social inclusion and enhancing digital skills among vulnerable families. By establishing a common reference space and conducting training sessions, the project has positively impacted several key aspects of participants' lives, showing significant improvements compared to those in the control group.

Figure 5: Effect of the intervention on key indicators





* In dark blue, the indicators whose effect of the treatment is significant at 1% (Income per person, Occupational training actions, degree of access to the internet for work, educational, personal purposes and Internet access at home) in blue the significant effects are presented at 5% (Interviews conducted, Job training actions and Internet access by any means); in light blue those indicators that are significant at 10% (Job offers submitted, degree of access to social rights) and, in light yellow, those indicators that are not significant (Non-payment of household supplies, degree of habitual contact with other people). The effects included in the graphs refer to regressions with controls.

Personalized treatment significantly improves participants' economic situations by increasing their income. Additionally, the results show positive effects on employability, with increases in both the number of job interviews and job offers. These improvements are largely attributed to the personalized support provided to participants in the treatment group through the pilot project's itinerary.

In terms of effectively accessing rights and services, the pilot project has shown positive effects. These improvements are again attributed to the personalized care itineraries, intensive support, and tailored assistance provided to participants.

Regarding the digital divide, the personalized treatment model and training of the ACCEDE pilot project have shown positive results both in improving digital skills and in accessing the internet.

Finally, it has also allowed personalized treatment to have a positive effect on the participation of the treated in community groups, which implies more active social integration.

In summary, the participative methodology and the personalized itinerary provided by the ACCEDE space, together with the specific trainings to curb the digital divide and the multidimensional approach of Cáritas to the problem of social exclusion, has allowed this pilot project to become an example of valuable lessons for future interventions.

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Appendix

Economic and regulatory management

1. Introduction

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

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

Royal Decree 938/2021, dated October 26, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation and Resilience Plan[14], contributed to meeting milestone 350 for the first quarter of 2022 as outlined in the Council's Implementing Decision: "Improve the rate of access to the Minimum Income Scheme, and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to conduct the pathways. The objectives of these partnership agreements are: (i) improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies". Likewise, along with Royal Decree 378/2022, of May 17[15], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to implement pilot projects to support the socio-economic inclusion of the beneficiaries of MIS through itineraries" contributed to compliance with

[14] Royal Decree 938/2021 dated October 26, 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). It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-17464.

[15] Royal Decree 378/2022, dated May 17, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of 102,036,066 euros, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124). It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-8124.

monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document[16].

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

On **December 29, 2021**, the organization "Fundación Red de Apoyo a la Integración Sociolaboral" (RAIS Foundation – known as HOGARSÍ, trade name registered in the Official Gazette of Industrial Property of June 2, 2020) was notified of the Resolution of the General Secretariat of Inclusion and Social Welfare Objectives and Policies granting a subsidy in the amount of €2,891,015 to the RAIS Foundation. On the same date, the General State Administration and the Social and Labor Integration Support Network Foundation, through the General Secretariat of Inclusion and Social Welfare Objectives and Policies, signed an agreement for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Boletín Oficial del Estado" on January 31, 2022 (BOE no.26).[17]

2. Time frame of the intervention

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

However, in accordance with section 2 of the first final provision of Royal Decree 378/2022, of May 17, Article 6(4) and Article 16(1) are redrafted to extend the maximum term of the pilot projects of social inclusion itineraries subject to the subsidy until **October 31, 2023**, maintaining the deadline **of March 31, 2024,** for its evaluation.

On July 29, 2022, the RAIS Foundation requested an extension of the implementation period until **September 30, 2023**, which was authorized by resolution of the SGOPIPS dated August 15, 2022. Likewise, on May 11, 2023, it requested an extension of the implementation period until **October 31, 2023**, which was authorized by resolution of the SGOPIPS dated August 26, 2022.

[16] 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.

[17] Resolution of January 21, 2022, of the General Secretariat OF Inclusion and Social Welfare Objectives and Policies, which publishes the Agreement with the Foundation for the Support Network for Socio-Labor Integration, for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-1530.

Within this general timeframe, the implementation begins on **September 14, 2022**, with the start of the intervention itinerary, continuing the execution tasks until **October 31, 2023**, and subsequently developing only dissemination and evaluation tasks of the project until **March 31, 2024**.

3. **Relevant Agents**

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

- **Cáritas Española**, as the applicant and beneficiary of the project, which also assumes the role of coordinating entity with the participating Diocesan Cáritas.
- **18 Diocesan Cáritas** as executors and beneficiaries of the project (as stated in article 11.2 of the General Law on Subsidies): Barbastro-Monzón, Barcelona, Bilbao, Cartagena-Murcia, Ciudad Real, Huelva, Huesca, Madrid, Mallorca, Menorca, Mérida-Badajoz, Ourense, La Rioja, Salamanca, Segorbe-Castellón, Sigüenza-Guadalajara, Tenerife, Zamora.
- **Cooperative Society Networks** to give the following workshops: "Procedures and procedures with Social Security", "Access to the MIS and economic management" and "Digital skills".
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the sponsor of the project, and 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.
- **CEMFI and J-PAL Europe**, as scientific and academic institutions that support MISSM in the design and RCT evaluation.

Sample Balance

Table 12 reports the balance contrasts between the control group and the treatment group. All data presented in this table refers 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-statistic*). The lower the p-value, the more confidently the hypothesis that the mean of the variable in both groups is equal can be rejected. 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: Equilibrium Contrasts Between Experimental Groups

	Mean				Observations		
Variable	**Control**	**Treatment**	**Dif.**	**P-value**	**Total**	**Control**	**Treatment**
Sociodemographic variables (pre-intervention))							

	Mean				Observations		
Variable	**Control**	**Treatment**	**Dif.**	**P-value**	**Total**	**Control**	**Treatment**
Age	42.48	41.96	-0.52	0.71	322	168	154
	(12.46)	(12.62)					
Woman	0.24	0.23	-0.01	0.82	322	168	154
	(0.43)	(0.42)					
Non-EU nationality	0.35	0.31	-0.04	0.45	322	168	154
	(0.48)	(0.46)					
EU Nationality	0.08	0.16	0.07**	0.04	322	168	154
	(0.28)	(0.36)					
Spanish Nationality	0.57	0.53	-0.03	0.55	322	168	154
	(0.50)	(0.50)					
Work experience (months)	53.51	61.25	7.74*	0.08	315	166	149
	(40.07)	(38.44)					
Time of unemployment (months)	24.13	26.76	2.63	0.44	295	150	145
	(29.38)	(29.29)					
Educational Level (years)	6.57	8.71	2.14***	0.00	316	166	150
	(4.08)	(3.96)					
Illiterate	0.02	0.03	0.01	0.61	316	166	150
	(0.13)	(0.16)					
Incomplete Primary	0.40	0.13	-0.28***	0.00	316	166	150
	(0.49)	(0.33)					
Comprehensive Primary	0.25	0.27	0.01	0.78	316	166	150
	(0.44)	(0.44)					
High school	0.15	0.30	0.15***	0.00	316	166	150
	(0.36)	(0.46)					
High school	0.11	0.19	0.07*	0.07		166	150
	(0.32)	(0.39)					
University	0.06	0.09	0.03	0.27		166	150
	(0.24)	(0.29)					
Mental Health Issue	0.30	0.35	0.05	0.37		168	154
	(0.46)	(0.48)					
Locality - A Coruña	0.13	0.14	0.01	0.76		168	154
	(0.33)	(0.34)					
Location - Madrid	0.24	0.27	0.02	0.65		168	154
	(0.43)	(0.44)					
Locality - Murcia	0.20	0.19	-0.01	0.85		168	154
	(0.40)	(0.39)					
Locality - Palma	0.21	0.14	-0.07*	0.09		168	154
	(0.41)	(0.34)					
Locality - Valencia	0.13	0.15	0.02	0.53		168	154
	(0.33)	(0.36)					

	Mean				Observations		
Variable	**Control**	**Treatment**	**Dif.**	**P-value**	**Total**	**Control**	**Treatment**
Location - Cartagena	0.10	0.12	0.02	0.53		168	154
	(0.30)	(0.33)					
Outcome indicators (pre-intervention)							
ETHOS Scale	2.99	2.69	-0.30	0.24		168	154
	(2.41)	(2.13)					
Residential Stability	1.96	4.17	2.21***	0.00		162	148
	(4.52)	(6.87)					
Satisfaction with accommodation	2.42	2.60	0.18	0.27		157	139
	(1.33)	(1.42)					
Residential Security	-0.39	-0.28	0.11	0.31		157	139
	(0.95)	(0.91)					
Total Revenue	187.87	145.06	-42.81	0.13		167	153
	(278.66)	(223.57)					
Economic Satisfaction	1.63	1.60	-0.03	0.75		157	139
	(0.93)	(0.91)					
Employment Income	34.91	30.84	-4.07	0.81		167	154
	(164.12)	(144.76)					
Employability (professional)	-0.04	-0.30	-0.26**	0.02		160	143
	(1.03)	(0.92)					
Employability (self-declared)	-0.08	-0.06	0.02	0.86		152	138
	(1.04)	(0.83)					
Work activity (days)	8.42	9.23	0.81	0.76		165	150
	(22.90)	(24.77)					
Employee	0.05	0.05	-0.00	0.96		166	151
	(0.23)	(0.22)					
Employment Status	2.02	2.12	0.09	0.43		160	143
	(0.87)	(1.20)					
Job Satisfaction	1.64	1.66	0.02	0.82		157	139
	(0.99)	(0.87)					
Quality of life	-0.32	0.00	0.33***	0.01		146	138
	(0.96)	(1.01)					

Note: Standard errors, grouped by randomization layers, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.