Inclusion Policy Lab: Evaluation Results

Andalusia: "POPI Project: Project for socio-family inclusion in families with children in situations of absenteeism and school failure"

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This report has been prepared by the General Secretariat of Inclusion of the Ministry of Inclusion, Social Security, and Migration within the framework of the Inclusion Policy Laboratory, 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, the Regional Government of Andalusia has collaborated in the elaboration of this report. This collaborating entity is one of the implementers of the pilot projects and has collaborated with the General Secretariat of Inclusion in the design of the RCT methodology, actively participating in the provision of the necessary information for the design, monitoring, and evaluation of the social inclusion itinerary. Furthermore, their collaboration has been essential to gathering informed consents, ensuring that participants in the itinerary were adequately informed and that their participation was voluntary.

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

This evaluation report has been performed using the data available at the time of writing and is based on the knowledge gained about the project up to that date. The GSI reserves the right to qualify, modify, or deepen the results presented in this report in the future. These potential variations could be based on the availability of additional data, advances in evaluation methodologies, or the emergence of new project-related information that may influence the interpretation of the results.

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Executive Summary

- The Minimum Income Scheme, established in May 2020, is a minimum income policy that aims to guarantee a minimum income to vulnerable groups and provide ways to promote their social and labor integration.
- Within the framework of this policy, the Ministry of Inclusion, Social Security and Migration (MISSM) fosters a strategy to promote inclusion through pilot projects of social innovation, which is conducted in the Inclusion Policy Lab. These projects are evaluated according to the standards of scientific rigor and using the methodology of Randomized Controlled Trials.
- This document presents the evaluation results and main findings of the "POPI Project: Project for socio-family inclusion in families with children in a situation of absenteeism and school failure", which has been carried out in **cooperation between the MISSM and the Autonomous Community of Andalusia.**
- This study evaluates the implementation of socio-family inclusion itineraries, which involve professional support directed at families and minors. The project targets families with children aged 6 to 16 facing school absenteeism and/or social vulnerability, residing in disadvantaged areas of Andalusia.
- All the participants in the project (control group -CG- and treatment group -GT-) had access to individualized family actions and tutorial action sessions with the academic tutors of the minors. In addition, the adults in charge of the minors in the treatment group had access to group sessions on family dynamics and digital training, and the children in this group had access to group sessions on emotional intelligence and academic skills.
- The project was implemented by 28 local entities spanning the eight provinces of Andalusia: Almeria, Cadiz, Cordoba, Granada, Huelva, Jaen, Malaga, and Seville. The study encompassed 2,313 households, comprising 3,739 minors. Among these, 724 families were assigned to the treatment group, 723 to the control group, and the remainder to a reserve group to account for potential dropouts.
- The primary outcomes of the evaluation indicate that the extended socio-family itinerary implemented for the treatment group did not yield statistically significant positive impacts in reducing absences, improving basic academic skills and school habits, enhancing children's self-esteem, or developing parental skills within the family units. Nonetheless, there has been substantial adherence to the project despite its execution across a diverse array of local entities simultaneously. This adherence underscores the program's importance in a population facing vulnerability or social exclusion, where connections with public systems and resources are often tenuous.

1 Introduction

General Regulatory Framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This report refers to the "POPI Project. Project for socio-family inclusion in families with children in a situation of absenteeism and school failure", executed within the framework of Royal Decree 938/2021[9] by the Autonomous Community of Andalusia. This report contributes to the fulfillment of milestone 351 of the RTRP: "After the completion of at least 18 pilot projects, publication of an evaluation on the coverage, effectiveness and success of the MIS, including recommendations to increase the level of application and improve the effectiveness of social inclusion policies".

Project context

School absenteeism and the social vulnerability of children are two interrelated problems that pose significant challenges in the field of inclusion policies. These phenomena negatively affect the integral

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

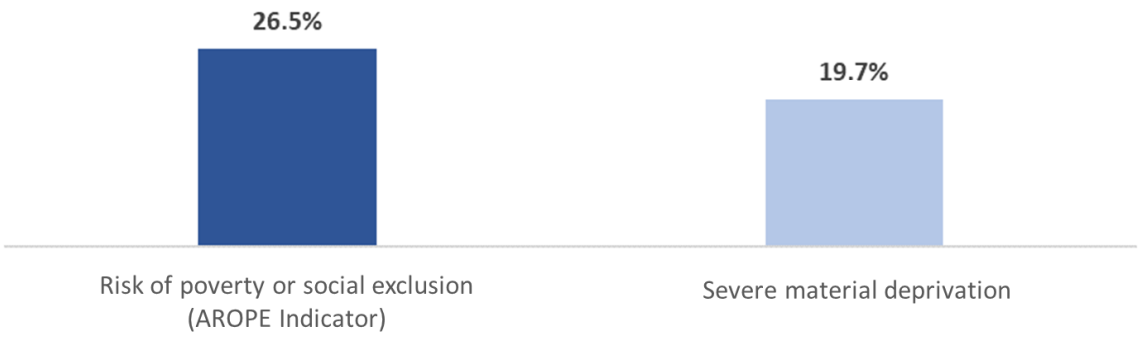
[9] On 24 October 2022, an agreement was signed between the General State Administration, through the SGI, and the Autonomous Community of Andalusia for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Official State Gazette" on 8 November 2022 (BOE no. 268).

development of children and adolescents, compromising their access to education, their emotional well-being, and their socioeconomic future.

Children in situations of social vulnerability are more likely to encounter difficulties in attending school regularly due to economic hardship, lack of family support, or exposure to adverse environments. Consequently, school absenteeism can exacerbate their social vulnerability by limiting access to education, reducing developmental opportunities, and increasing the risk of social exclusion.

In Spain, child vulnerability is a significant issue, as illustrated in Figure 1 (Eurostat, 2024). In 2023, 26.5% of individuals under 16 years old lived in households at risk of poverty or social exclusion, according to the AROPE indicator. Notably, the component of the AROPE indicator reflecting severe material deprivation stands out at 19.7%.

Figure 1: Risk of poverty or social exclusion (AROPE Indicator) under 16 years of age



Source: Living conditions and welfare, Eurostat.

Regulatory framework associated with the project and governance structure

Various regulations and strategic plans exist to combat child poverty and socioeconomic vulnerability, as well as to enhance parenting skills. In June 2021, the European Commission issued Recommendation (EU) 2021/1004, which established a European Child Guarantee. This recommendation encourages member states to develop national plans to secure access to fundamental health and education rights for children at risk of poverty and social exclusion.

At the national level, the Government of Spain adopted the State Action Plan for the Implementation of the European Child Guarantee (2022-2030) in July 2022. A prominent challenge highlighted in this plan is "promoting educational equity through a comprehensive and adaptable education system, capable of meeting the individualized needs of the most vulnerable children."

Additionally, Organic Law 8/2021, which protects children from violence and promotes positive parenting, along with Organic Law 8/2015, which updates the regulatory framework for child protection, are noteworthy. Furthermore, the State Action Plan for the Implementation of the European Child Guarantee aims to break the cycle of child poverty.

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

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

In response to this situation, the Autonomous Community of Andalusia has developed a project aimed at addressing school absenteeism and the social vulnerability of minors and families in disadvantaged areas of Andalusia. This project includes socio-family inclusion itineraries with professional accompaniment designed to support families and minors.

The scientific goal of the project is to assess, via a randomized controlled trial (RCT), the improvement and prevention of school absenteeism, as well as the enhancement of competencies related to family dynamics and minors' skills in fundamental areas. These areas include self-esteem and academic performance in core subjects such as language and mathematics. The objective is to provide both correlational and causal evidence on the importance of mentoring programs in reading and mathematics tutoring. This effort is intended to inform research, policy, and educational practices, highlighting these methodologies as critical elements for human development in both the short and long term.

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

- The **Autonomous Community of Andalusia through the Ministry of Social Inclusion, Youth, Families and Equality,** as the entity responsible for project management and execution.

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

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

Ethics Committee linked to the Social Inclusion Itineraries

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

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

The Ethics Committee has conducted analysis and advice on the ethical issues that have arisen in the execution, development, and evaluation of the itineraries, formulated proposals in those cases that present conflicts of values and approved the evaluation plans of all the itineraries. In particular, the Ethics Committee issued its approval for the development of this evaluation on July 19, 2023.

2 Description of the program and its context

This section describes the program that the Autonomous Community of Andalusia implemented within the framework of the pilot project. Furthermore, it defines the target population, the territorial scope, and provides a detailed description of the intervention.

2.1 Introduction

The main objective of the project is to develop socio-family inclusion itineraries for families who are responsible for children between 6 and 16 years of age who are in a situation of school absenteeism and/or social vulnerability, and who reside in areas identified as disadvantaged. Through professional support aimed at both families and their children, the aim is to increase their level of participation, use and adherence to a series of public and private resources with the aim of improving their situation of social disadvantage and preventing or reducing situations of school absenteeism.

Empirical research on interventions addressing child poverty and promoting social inclusion ranges from purely economic interventions to strategies targeting the labor and social integration of families. Morrison et al. (2014) conducted a meta-analysis that reviewed diverse programs implemented across European countries to enhance parenting skills. Notable examples include the Family Nurse Partnership in Scotland, the Positive Parenting Program in Scotland, and the Preparing for Life intervention in Ireland. These initiatives involve nurse and social worker visits to mothers in socioeconomically vulnerable areas with children aged 0-2/3 years, offering health education and parenting workshops. Evaluation through randomized controlled trials (RCTs) has demonstrated positive effects on parental behavior and children's health outcomes, such as increased immunization rates.

Numerous empirical studies employing RCTs support the effectiveness of tutorials. Meta-analyses by Nickow et al. (2020) and Alegre et al. (2019) consistently emphasize the significant and positive impact of tutoring on learning outcomes, highlighting its versatility, cost-effectiveness, and potential to transform within the current educational framework. Notable national initiatives include the "Leemos en Pareja" program, evaluated via RCTs by Zambrano et al. (2013), and the MENTTORES project assessed by Gortazar et al. (2023), both demonstrating substantial improvements in academic performance and various social and educational aspects among vulnerable students.

Furthermore, different studies corroborate the effectiveness of programs aimed at social-emotional skills training. For instance, the Promoting Alternative Thinking Strategies (PATHS) program, implemented across several countries, has shown positive outcomes in reducing children's aggression rates, enhancing social competence, and boosting academic engagement (Greenberg et al., 1995; Shonfeld et al., 2015). Within the Canadian context, interventions like The Roots of Empathy and MindUP have also proven beneficial by fostering students' engagement in prosocial behaviors and enhancing cognitive control, empathy, and peer acceptance (Schonert-Reichl et al., 2012, 2015).

2.2 Target population and territorial scope

The project is aimed at family units receiving the MIS or the Minimum Insertion Income of Andalusia or those facing vulnerability, residing in disadvantaged areas and with minors between the ages of 6 and 16 who have a significant degree of school absenteeism. The disadvantaged areas of Andalusia, identified in the August 28, 2018, Agreement of the Governing Council approving the "Andalusian Regional Strategy for Social Cohesion and Inclusion" (BOJA no. 172 of 05/09/2018), are characterized by severe poverty, social marginalization, housing challenges, urban deterioration, inadequate infrastructure, and public service deficits. They also experience high rates of absenteeism and school failure, elevated unemployment, a shortage of professional training opportunities, significant health, and sanitary issues, and pronounced social disintegration phenomena.

The project has been implemented by various local entities encompassing disadvantaged areas, including El Ejido, Níjar, Roquetas de Mar, Algeciras, Arcos de la Frontera, Barbate, Cádiz, Chiclana de la Frontera, Jerez de la Frontera, San Roque, Córdoba, Palma del Río, Granada, Loja, Motril, Huelva, Isla Cristina, Diputación de Huelva, Málaga, Marbella, Torremolinos, Vélez-Málaga, Diputación de Málaga, Coria del Río, Dos Hermanas, Los Palacios and Villafranca, Morón de la Frontera, and San Juan de Aznalfarache. In total, there are 28 implementing local entities, including city councils and provincial councils, representing the eight provinces of Andalusia: Almeria, Cadiz, Cordoba, Granada, Huelva, Jaen, Malaga, and Seville.

2.3 Description of interventions

The project addresses the intricate dynamics of individuals and family units experiencing vulnerability and social exclusion through a holistic approach. The intervention aims to significantly reduce school absenteeism, enhance educational success, and decrease early school dropout rates, thereby fostering improved social inclusion processes.

The project defines two types of socio-family inclusion itineraries, depending on whether a family is assigned to the control group or the treatment group. All families, regardless of their group assignment, receive the standard portfolio of community social services tailored to their socio-family diagnosis and directed towards local community resources. Participants benefit from a minimum of four sessions of personalized Social and Family Inclusion Itineraries. Each participating family undergoes a personalized process of support, guidance, training, and inclusion aimed at meeting and enhancing the needs of both adults and minors. Furthermore, the project planning incorporates three coordination sessions involving technical staff responsible for monitoring and supporting families, along with guardians of each minor. The aim of these sessions is to synchronize actions between systems, fostering synergies and comprehensive approaches.

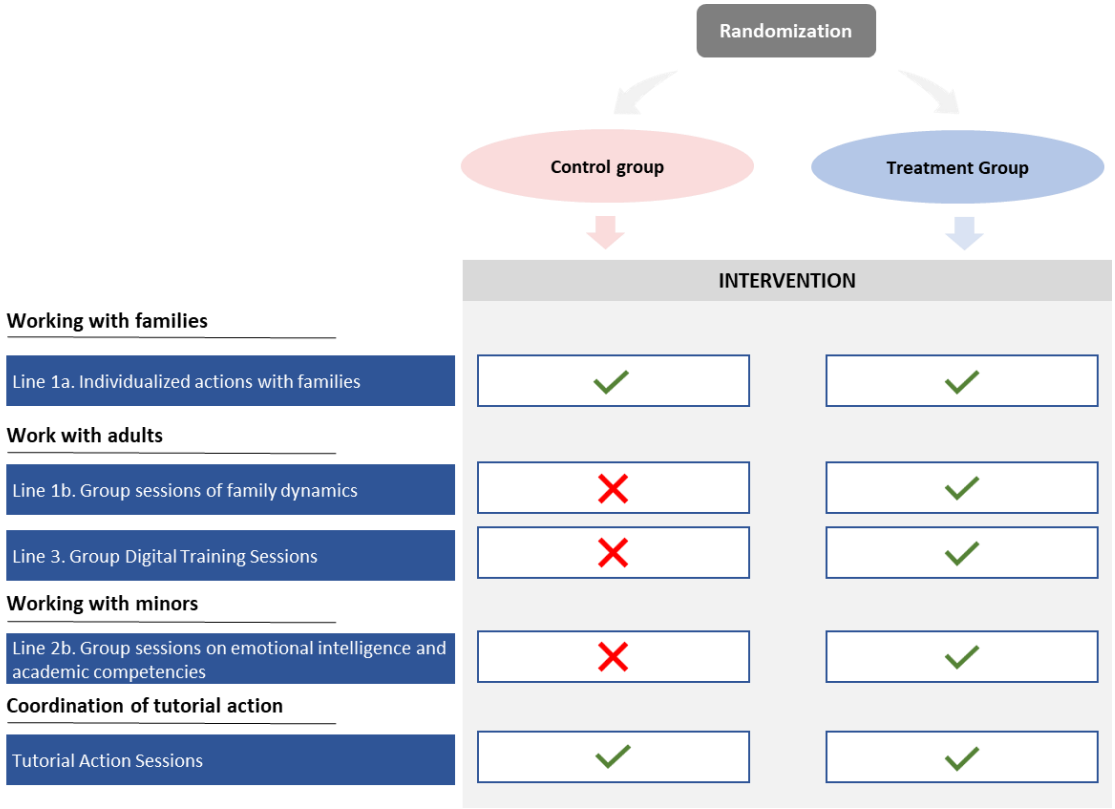
Additionally, families in the treatment group, based on their diagnosis, have access to specific resources designed to reduce school absenteeism:

- **Group sessions of family dynamics** conducted for the adults within each family unit. These sessions consist of a minimum of three 90-minute sessions, involving groups of approximately 10 participants. The primary objective of these sessions is to enhance positive parenting skills and promote greater autonomy among family members.
- **Group sessions on digital skills** conducted for adults within the family unit. These sessions consist of a minimum of three 90-minute sessions, with groups comprising approximately 10 participants. The aim of these sessions is to enhance the digital skills of adults in family units, with a focus on reducing the digital skill gap.
- **Group sessions on self-esteem, emotional intelligence and academic skills** in mathematics and language are organized for minors. These sessions consist of at least ten 90-minute sessions, with groups comprising approximately 10 participants each. They are conducted continuously throughout the socio-family inclusion itinerary period, without interruption during the summer months. The sessions are divided into two age groups: one for minors aged 6 to 10 years old and another for those aged 11 to 16 years old.

To ensure methodological consistency in the intervention conducted by local entities, minimum standards of action were established for each session, applicable to both control and treatment groups.

Figure 2 provides a summary of the interventions assigned to both the treatment and control groups.

Figure 2: Itinerary outline



3 Evaluation design

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

3.1 Theory of Change

This report, with the aim to design an evaluation that enables to understand the causal relationship between the intervention and its final objective, develops a Theory of Change. The Theory of Change schematizes the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long term results sought by the intervention. It explains the relationships between these elements, the assumptions underlying them, and outlines measures or outcome indicators.

Theory of Change

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

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

In this context, the Theory of Change serves as a pivotal tool guiding this initiative focused on tackling the challenges of absenteeism and social vulnerability among minors and families in disadvantaged areas of Andalusia. These issues pose substantial barriers that exacerbate and impede the pathways to social inclusion.

To tackle absenteeism and the social vulnerability of minors, the project introduces a socio-family inclusion itinerary coordinated by a family support team. This approach aims to initiate a cascade effect, utilizing resources and actions as pathways to achieve substantial impacts on the conditions of minors and their families. The itinerary encompasses parental skills training for adults and academic skills development and self-esteem training for children.

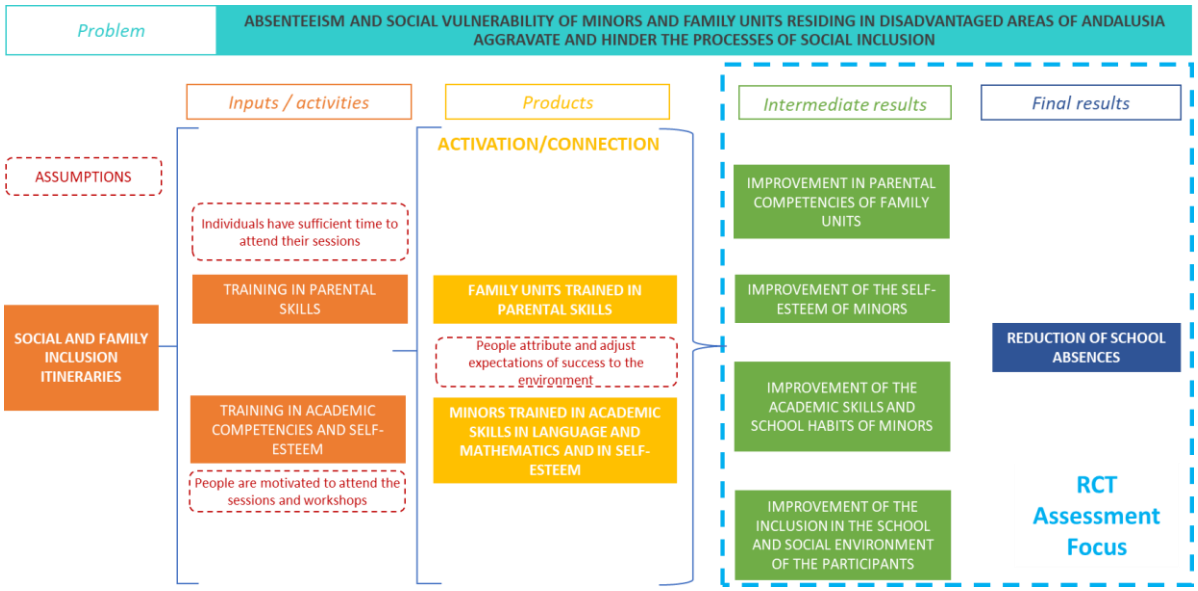
All these resources and activities yield a series of outputs. By measuring the outputs obtained, it is possible to determine whether beneficiaries have received the activities or inputs and to what extent. Proper reception of the resources and activities performed is essential for the program to achieve the expected intermediate and final results. If beneficiaries do not effectively receive the program, it is difficult to observe improvements in the indicators of employment, housing situation or quality of life. Within the framework of this project, the products are the family units trained in parenting skills and the number of children trained in academic skills. Without the receipt of these products or benefits, there can be no expected improvement in the situation of the beneficiaries.

In the short term, it is expected that the actions will have a positive impact on the parenting skills of family units, as well as on the self-esteem and academic skills and school habits of children, and on

their inclusion in the school and social environment. These intermediate results are anticipated to lead to a reduction in school absenteeism.

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

Figure 3: Theory of Change



3.2 Hypothesis

According to the Theory of Change, the ultimate goal of the project is to reduce school absenteeism among children residing in disadvantaged areas of Andalusia. This objective hinges on achieving intermediate outcomes related to enhancing parenting skills, fostering children's self-esteem, academic proficiency, and school habits, and promoting their integration into school and social environments. Consequently, the evaluation of the model involves formulating various hypotheses aligned with these intermediate and final results outlined in the Theory of Change. This methodological approach aims to provide a comprehensive and informed analysis, thereby establishing a robust foundation for strategic decisions in public policy.

The hypotheses to be tested regarding each set of outcomes are outlined below.

1. Improving school attendance

The hypothesis posits that interventions targeting parenting competencies among families and academic competencies alongside self-esteem among children will lead to a reduction in school absenteeism.

2. Improvement of basic academic skills and school habits

The primary hypothesis asserts that interventions targeting academic competencies and self-esteem among children enhance their school performance. Secondary hypotheses suggest that differential interventions received by children in the treatment group improve their self-perceived school performance and school habits.

3. Improved self-esteem

The hypothesis suggests that interventions focusing on emotional intelligence received by children will enhance their self-perceived self-esteem.

4. Improvement in parenting/parenting skills of family units

The primary hypothesis posits that interventions targeting parenting competencies among families improve family dynamics. Additionally, a secondary hypothesis suggests that these interventions enhance the relationship between the family and the school, as well as the parents' attitudes toward their child's educational performance.

5. Improving inclusion in the school and social environment

The primary hypothesis suggests that interventions targeting academic competencies and self-esteem among children improve their classroom behavior. Additionally, a secondary hypothesis posits that interventions focusing on parenting competencies among families enhance the provision of children's basic needs in the classroom and their daily care.

3.3 Sources of information

Three customized questionnaires are utilized to gather the requisite information for constructing the outcome indicators:

- **Diagnosis of self-assessment of family dynamics**: Administered to parents or legal guardians, this questionnaire examines diverse facets of family life and interactions. It includes areas such as daily caregiving, parental skills, the interplay between affection and discipline, communication strategies, conflict resolution, and attitudes towards children's educational achievements.
- **Diagnosis of Absenteeism and Vulnerability**: this survey is completed by the child's school tutor and focuses on assessing the educational and social welfare needs and challenges faced by the child. It collects information on the child's age, educational environment, personal circumstances, and family situation. The questionnaire covers aspects such as basic needs, classroom behavior, interactions with teaching staff, fundamental academic skills, and the relationship between the family and the educational institution.

- **Diagnosis of Self-Esteem and Competencies:** this questionnaire, to be completed by children, investigates their self-perception regarding self-esteem, interactions with classmates and family members, academic performance, and attitude toward school. Two distinct versions of the questionnaire are developed: one tailored for children aged 6 to 10, and another for those aged 11 to 16.

Data collection is conducted by each local entity involved in the project at two stages: first, before the intervention (baseline survey), and then at the conclusion (final line survey).

3.4 Indicators

This section outlines the indicators utilized for assessing the impact of the pathway, categorized by themes aligned with the hypotheses outlined earlier.

1. Improving school attendance

Percentage of absences: this metric calculates the proportion of school days missed by minors compared to the total possible days. In primary school, absences are measured in days, while in secondary school, they are measured in class hours. Baseline data covers the first quarter of the 2022-2023 school year, and the final survey includes absences from the first quarter of the 2023-2024 school year until the project's completion in November 2023.

2. Improvement of basic academic skills and school habits

General estimate of reading comprehension and oral expression: this indicator evaluates the child's academic language skills as assessed by their school tutor. It utilizes a scale from 1 to 3, where 1 denotes a deficiency or absence of skills, 2 indicates occasional or sporadic skill presence, and 3 signifies stable or high-quality skill presence.

General estimation on reasoning and calculation: this indicator evaluates the child's academics skills in mathematics as assessed by their school tutor. The indicator follows a scale from 1 to 3, where the value 1 indicates a lack or non-existence of skills, the value 2 reflects the occasional or sporadic presence of skills, while the value 3 represents a stable presence or a higher quality of skills.

Self-perception of reading comprehension and oral expression: This indicator measures the self-perception of minors regarding their reading and oral expression abilities. For children aged 6 to 10 years, it is based on their agreement with the statement "I like and am good at language subjects," rated on a scale from 1 to 3 (1: no, 2: sometimes, 3: yes). For children aged 11 to 16 years, the indicator is derived from five questions assessing their agreement with statements related to positive performance in specific activities. Each answer is rated from 1 to 3 (1: slightly, 2: moderately, 3: significantly), and the indicator is calculated as the average score of these responses. A higher score indicates a stronger self-perception of reading comprehension and oral expression skills.

Self-perception of reasoning and calculation: this indicator assesses the self-perception of children regarding their competence in mathematics. For children aged 6 to 10 years, it is based on their agreement with the statement "I like and am good at mathematics," rated on a scale from 1 to 3 (1: no, 2: sometimes, 3: yes). For children aged 11 to 16 years, the indicator is derived from six questions evaluating their agreement with statements related to positive performance in specific activities. Each response is rated from 1 to 3 (1: slightly, 2: moderately, 3: significantly), and the indicator is calculated as the average score of these responses. A higher score indicates a stronger self-perception of reasoning and calculation skills.

Self-assessment of school habits: this indicator evaluates children's self-perception of their school habits. For children aged 6 to 10 years, it consists of four statements assessing their agreement with statements related to the successful development of school habits. For children aged 11 to 16 years, the indicator includes five statements. Each statement is rated on a scale from 1 to 3 (1: disagree, 2: somewhat agree, 3: strongly agree). The indicator is calculated as the average of these responses. A higher score indicates a better self-assessment of their school habits.

Average estimate of the relationship between teachers and children and adolescents: this indicator evaluates the level of compliance with five actions related to the behavior and school performance of children and adolescents. It is assessed through a questionnaire completed by their academic tutor. Each action is rated on a scale from 1 to 3, where 1 indicates a lack or non-existence of the aspects, 2 denotes an occasional or sporadic presence, and 3 signifies a stable or higher quality presence. The indicator is calculated as the average of the ratings assigned to each action. A higher score implies a better relationship between teachers and the child or adolescent.

3. Improved self-esteem

Self-rated self-esteem diagnosis: this indicator derives from minors' responses to a series of questions assessing their agreement with statements related to self-esteem. Each answer is scored from 1 to 3, where 3 indicates the highest degree of positive agreement and 1 indicates the lowest, with a negative connotation. For children aged 6 to 10 years, 16 questions are used, while for those aged 11 to 16 years, 18 questions are employed. The indicator's value is computed as the average score of all responses, with a higher value indicating higher self-esteem.

4. Improvement in parenting/parenting skills of family units

Self-rated diagnosis of family competencies: This indicator assesses adults' self-perception of their abilities and emotions as parents through their agreement with 25 statements. Each statement is rated on a scale of 1 to 3, where 3 represents the most positive agreement and 1 indicates the least positive. The indicator's value is calculated as the average score of all responses, reflecting the overall self-perception of family competencies. A higher value indicates a better self-perception in this area.

Contact relationship between the school and the family unit: This indicator is derived from responses to six questions assessing students' behavior and attitude towards their school. Each answer is rated

on a scale of 1 to 3, where 3 indicates the most positive response and 1 indicates the most negative. The indicator's value is determined by averaging the scores of all responses, providing an assessment of the contact relationship quality. A higher value signifies a stronger and more positive relationship between the school and the family unit.

5. Improving inclusion in the school and social environment

Assessment of the average child and adolescent in class on the attitudes and behaviors of children and adolescents: This indicator evaluates the behavior and conduct of minors in the classroom. It is calculated from the average score of 10 variables that measure negative actions or behaviors exhibited by the child in class. These variables are rated by the academic tutor of the children on a scale of 1 to 3. A higher indicator value indicates better performance in terms of behavior and conduct.

Coverage of basic needs of children and adolescents: This indicator assesses the extent to which the basic needs of children and adolescents are met both in the classroom and at home. It is derived from an examination of the students' needs, based on information provided by the academic center's tutor, and an evaluation of adult behaviors by the legal guardians of the child. The indicator ranges on a scale of 1 to 3, with higher values indicating better coverage of the basic needs of the child and adolescent.

3.5 Experiment design

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

Recruitment of the beneficiaries of the intervention

The recruitment process is managed by local entities involved in the project and primarily utilizes telephone calls, face-to-face appointments, letters, as well as electronic means such as email and SMS. Initially, efforts focus on disseminating information and engaging potential beneficiary family units. Key actions within this recruitment phase involve activating collaborative networks across various sectors, particularly social services, and education. Th actions aim to foster cooperation and facilitate the identification and enrollment of eligible families includes:

- Organization of information days aimed at the Heads of the Social Services Service. These sessions provide a comprehensive overview of the project, including its methodology, timelines, action guidelines, and the presentation of a procedural manual prepared by the Ministry.
- Online session for the Territorial Delegations to present the project and request their collaboration.

- Development of a digital application for registering and systematizing the actions undertaken by Local Entities during the recruitment of participating families.
- Online sessions aimed at guiding entities on how to effectively recruit participating families.

The recruitment of families follows a standardized strategy across all participating local entities, primarily targeting families identified through social services with a specific focus on beneficiaries of minimum income schemes. The effectiveness of dissemination and recruitment efforts within the pilot project's timeline is largely attributed to initiatives conducted in disadvantaged areas under the previous Andalusian Regional Strategy for Social Cohesion and Inclusion (ERACIS).

Informed consent

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

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

Random assignment of participants

After completing the recruitment process and obtaining informed consent from participating households, each local entity proceeds to categorize families into either the primary sample or reserve. This determination is made by assigning a random number between 0 and 1 to each record and sorting them accordingly. Families are then selected sequentially based on this order: those with the first assigned numbers fill the titular sample until the required number is met, while the rest are assigned to the reserve group. This procedure was followed uniformly across most local entities, except in six cases where the first families recruited filled the theoretical sample size.

The sampling methodology employs a stratified approach based on the local entity and a variable indicating whether any child in the family has an active absenteeism protocol, resulting in a total of

56 strata. Within each stratum, families included in the titular sample are evenly split: half are randomly assigned to the control group, and the other half to the treatment group

For families designated as reserves, a random order of substitution is established within each stratum. Should withdrawals occur from either the control or treatment groups, the first available reserve from the corresponding stratum is activated to fill the vacancy, assuming the group (control or treatment) of the departed family.

Figure 4: Sample design

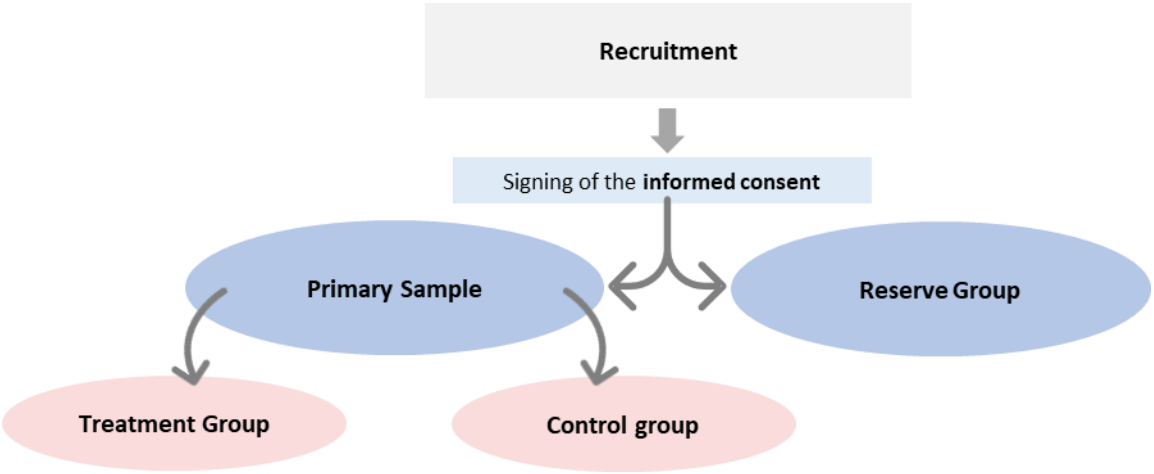
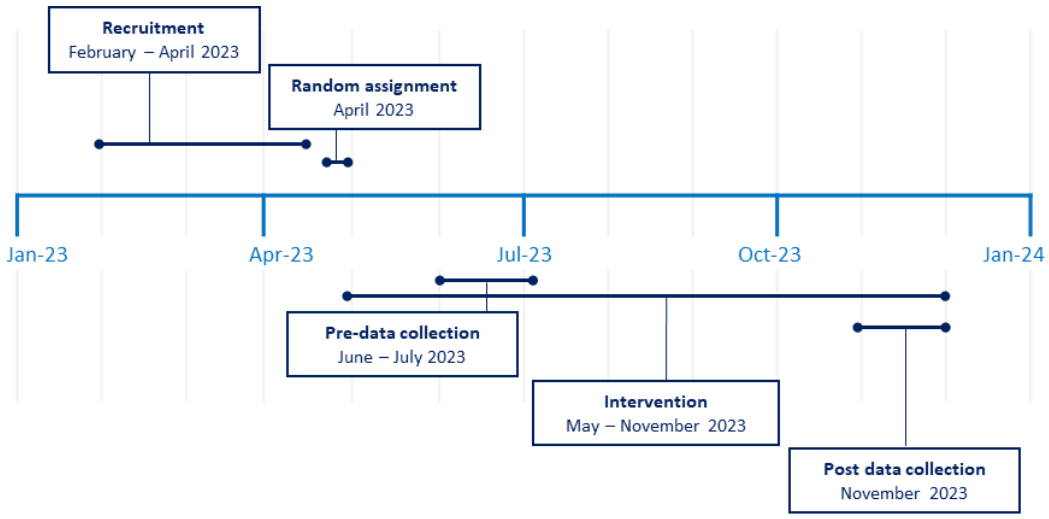


Figure 5 depicts the timeline for implementation and evaluation. Recruitment commences in February 2023 and concludes in April 2023, after which participants are randomly allocated to various experimental groups. The intervention period spans from May to November 2023. Baseline data collection occurs before the start of the differential intervention for the treatment group, conducted in June and July. Final data collection takes place following the completion of the differential intervention in November 2023.

Figure 5: Implementation and evaluation timeframe



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

From an initial pool of 3,931 potential participant households, 14.9% could not be reached. Of the 3,344 households successfully contacted, 69.8% (2,333) indicated interest and affirmed their readiness to participate. Among the remaining 30%, 115 households (3.4%) were ineligible, 302 (9%) lacked interest in the project, and others cited reasons such as illness or relocation for non-participation. Ultimately, the recruitment process culminated in 2,313 households signing the informed consent (IC). **Table 1** provides a succinct overview of the recruitment process outcomes.

Table 1: Record of the recruitment process

Potential beneficiaries	**3.931**
Number of uncontacted households	**587**
Number of households contacted	**3.344**
Unwilling/unable to participate/ Not eligible	**1.011**
Want/can participate	**2.333**
They do not sign the IC	**20**
They sign the IC	**2.313**

Characteristics of the final sample of the evaluation

Among the 2,313 households that signed the informed consent and underwent randomization, 1,447 households (comprising 2,361 children) constituted the titular sample, while 866 households (with 1,378 minors) formed the reserve sample.

Table 2 presents descriptive statistics of the variables related to the intervention, based on the information collected in the baseline survey. A total of 2,199 individual observations (at the child level) are included in the initial sample. The table has six columns: the variable name, the mean, the standard deviation, the minimum value, the maximum value, and the number of observations.

The statistics indicates a predominant participation of females among legal guardians, with only 15% identifying as male. In terms of educational attainment, 50% have not completed any formal education, while 30% have completed only primary education. Most guardians, 84%, are Spanish nationals, with 1% coming from other European Union countries and 14% from outside the EU. Regarding the children participating in the study, there is an even distribution by gender. A significant portion, 67%, are enrolled in primary education, while 33% are in secondary education. In terms of absenteeism, 26% of children belong to households where at least one has an absenteeism protocol open, while the rest are from households without any such protocols.

Regarding the indicators described in **section 3.4**, it is observed that prior to the initiation of the differential intervention, children, on average, miss approximately 12% of their total scheduled classes. The overall assessment of mathematical and language skills averages around 2 out of 3, indicating that these skills are sporadically present among the average students. However, the self-perception of these competencies among students is higher, averaging around 2.3 for both areas. Concurrently, children receive an average rating of 2.52 for their attitudes and behaviors, while their self-assessment of school habits averages 2.39.

The average self-rated self-esteem diagnosis is 2.45, while the average self-rated family competencies diagnosis is 2.4. In addition, the average rating of the relationship between teachers and children is 2.18, and the ratio between the school and the family unit has an average of 2.44.

Table 2: Descriptive statistics of the sample

Variable	Obs.	Mean	Standard deviation	Min	Max
Sociodemographic variables					
Gender of the legal guardian. Male	2199	0.15	0.35	0	1
Educational level of the legal guardian. No studies	2199	0.49	0.50	0	1
Educational level of the legal guardian. Primary Education	2199	0.30	0.46	0	1
Educational level of the legal guardian. Secondary education	2199	0.19	0.39	0	1
Educational level of the legal guardian. University studies	2199	0.02	0.13	0	1
Nationality of the legal guardian. Spain	2199	0.84	0.36	0	1
Nationality of the legal guardian. EU (without Spain)	2199	0.01	0.11	0	1
Nationality of the legal guardian. Outside the EU	2199	0.14	0.35	0	1
Gender of the minor. Woman	2199	0.47	0.50	0	1
Gender of the minor. Man	2199	0.53	0.50	0	1
Gender del minor. Trans	2199	0.00	0.03	0	1
Age of the child	2199	10.55	2.96	5	16
School stage of the minor. Primary	2199	0.67	0.47	0	1
School stage of the minor. High school	2199	0.33	0.47	0	1
School stage of the minor. FP	2199	0.00	0.05	0	1
Marital status. Absenteeism	2199	0.26	0.44	0	1
Performance indicators					
Absences for one	2197	0.12	0.16	0	1
General estimate of reading comprehension and oral expression	2188	1.92	0.76	1	3
General estimation on reasoning and calculation	2188	1.91	0.75	1	3
Self-rated diagnosis of self-esteem	2196	2.45	0.37	1	3
Self-rated diagnosis of family competencies	2199	2.40	0.23	1	3

Variable	Obs.	Mean	Standard deviation	Min	Max
Assessment of the average class of the child's attitudes and behaviors	2186	2.52	0.43	1	3
Self-perception of reading comprehension and oral expression	2196	2.37	0.58	1	3
Self-perception about reasoning and calculation	2196	2.28	0.65	1	3
Self-assessment of school habits	2197	2.39	0.45	1	3
Average estimate of the relationship between teachers and children and adolescents	2186	2.18	0.57	1	3
Contact relationship between the school and the family unit	2192	2.44	0.36	1	3
Coverage of basic needs of minor	2176	2.53	0.31	1	3

4.2 Random Assignment Results

Once the sample is established, participants are randomly allocated to either the control group or treatment group as described in **section 3.5**. In total, 2,313 households (3,739 children) were randomly assigned, with 1,447 households (2,361 minors) comprising the titular sample and 866 households (1,378 children) serving as reserves to replace potential dropouts in the initial stages of the intervention. The subsequent table presents the outcomes of the random assignment, delineating participant numbers per group and categorized by various stratification variables.

Table 3*:* Random assignment results

	Primary Sample									Reserves			Total		
	Absentees (ABS)			In prevention (PREV)			Total								
Local entity	Total	C	T	Total	C	T	Total	C	T	Total	ABS	PREV	TOTAL	ABS	PREV
Ayto. El Ejido	4	2	2	40	20	20	44	22	22	18	9	9	62	13	49
Ayto. Níjar	1	0	1	16	8	8	17	8	9	27	1	26	44	2	42
Ayto. Roquetas de Mar	5	2	3	26	13	13	31	15	16	23	2	21	54	7	47
Ayto. Algeciras	11	6	5	48	24	24	59	30	29	88	17	71	147	28	119
Ayto. Arcos de la Frontera	18	9	9	12	6	6	30	15	15	56	30	26	86	48	38
Ayto. Barbate	2	1	1	29	14	15	31	15	16	12	2	10	43	4	39
Ayto. Cádiz	2	1	1	77	38	39	79	39	40	41	1	40	120	3	117
Ayto. Chiclana de la Frontera	4	2	2	37	19	18	41	21	20	21	2	19	62	6	56

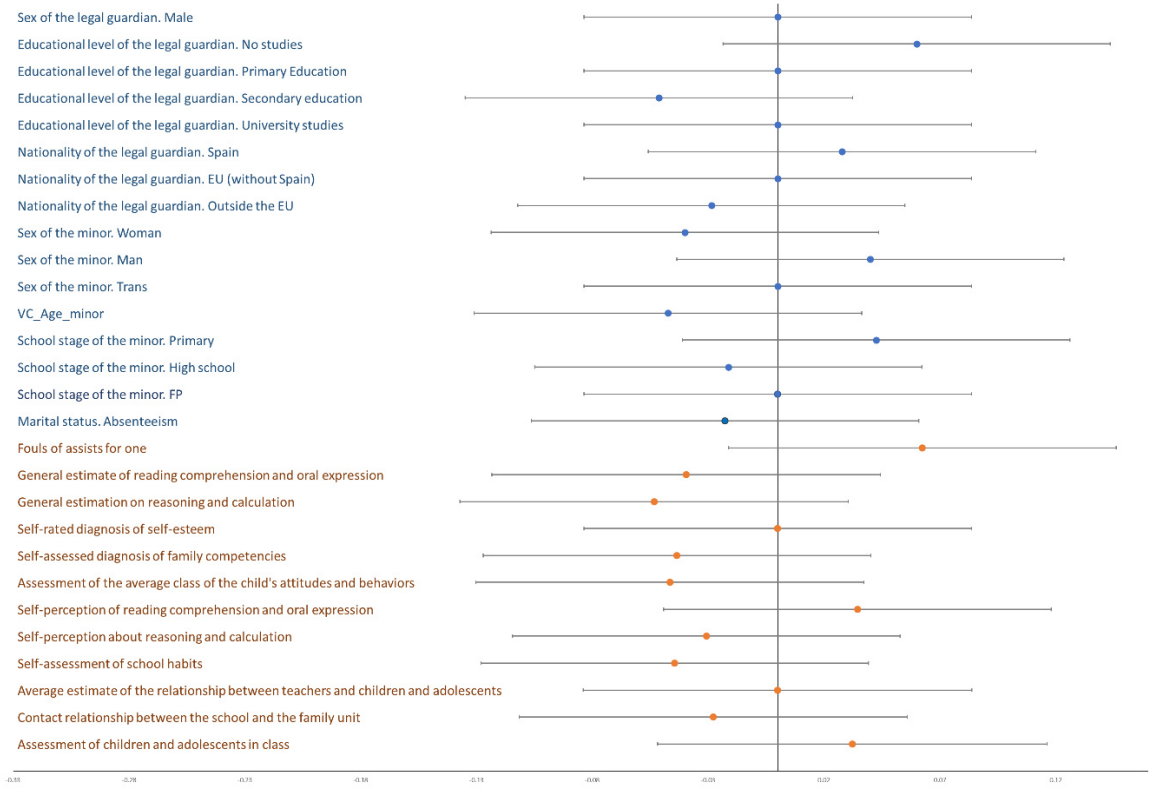
	Primary Sample									Reserves			Total		
	Absentees (ABS)			In prevention (PREV)			Total								
Local entity	**Total**	**C**	**T**	**Total**	**C**	**T**	**Total**	**C**	**T**	**Total**	**ABS**	**PREV**	**TOTAL**	**ABS**	**PREV**
Ayto. Jerez de la Frontera	22	11	11	154	77	77	176	88	88	106	17	89	282	39	243
Ayto. San Roque	3	2	1	10	5	5	13	7	6	2	0	2	15	3	12
Ayto. Córdoba	35	17	18	66	33	33	101	50	51	70	28	42	171	63	108
Ayto. Palma del Río	13	7	6	14	7	7	27	14	13	21	3	18	48	16	32
Ayto. Granada	18	9	9	145	73	72	163	82	81	23	2	21	186	20	166
Ayto. Loja	17	8	9	20	10	10	37	18	19	21	14	7	58	31	27
Ayto. Motril	13	6	7	47	23	24	60	29	31	41	10	31	101	23	78
Ayto. Huelva	16	8	8	78	39	39	94	47	47	92	18	74	186	34	152
Ayto. Isla Cristina	11	6	5	13	7	6	24	13	11	6	2	4	30	13	17
Diputación Huelva	2	1	1	35	18	17	37	19	18	22	1	21	59	3	56
Ayto. Málaga	95	48	47	85	43	42	180	91	89	26	14	12	206	109	97
Ayto. Marbella	4	2	2	10	5	5	14	7	7	26	10	16	40	14	26
Ayto. Torremolinos	2	1	1	31	15	16	33	16	17	17	0	17	50	2	48
Ayto. Vélez-Málaga	14	7	7	16	8	8	30	15	15	12	4	8	42	18	24
Diputación Málaga	1	1	0	16	8	8	17	9	8	9	0	9	26	1	25
Ayto. Coria del Río	6	3	3	7	3	4	13	6	7	10	4	6	23	10	13
Ayto. Dos Hermanas	21	10	11	16	8	8	37	18	19	29	14	15	66	35	31
Ayto. Los Palacios y Villafranca	12	6	6	14	7	7	26	13	13	9	0	9	35	12	23
Ayto. Morón de la Frontera	3	1	2	12	6	6	15	7	8	15	3	12	30	6	24
Ayto. San Juan de Aznalfarache	16	8	8	2	1	1	18	9	9	23	23	0	41	39	2
TOTAL	**371**	**185**	**186**	**1076**	**538**	**538**	**1447**	**723**	**724**	**866**	**231**	**635**	**2313**	**602**	**1711**

To ensure the random assignment yields statistically comparable control and treatment groups, an equilibrium test is conducted to verify that the average observable characteristics of participants in both groups are equivalent. The results of the balance test between the control group and the treatment group are shown below in **Figure 6**[10]. All data reflected in this figure refer to the survey conducted before 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 and focused on it, the 95% confidence interval of that difference. A confidence interval containing zero, i.e., the vertical axis, will indicate that the mean difference between groups is not statistically significant or, in other words, is not statistically different from zero, meaning that the intervention groups are balanced. In case the confidence interval of the mean difference does not contain zero, the difference is statistically significant meaning the groups are unbalanced in this characteristic.

[10] See **Table 13** in the Appendix on **Balance between the experimental groups**.

As depicted in the figure, both groups exhibit no significant differences in sociodemographic variables or indicators prior to the intervention, indicating that all variables are balanced at baseline.

Figure 6: Standardized mean difference between treatment group and control group (95% confidence interval)



Note: the variables used for the stratification of the sample are shown in black, the rest of the sociodemographic variables are shown in blue, and the specific indicators used for the evaluation of the project are shown in orange.

4.3 Degree of participation and attrition by groups

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

Degree of participation

As discussed in **section 3.5**, a reserve group was established to handle dropouts from the treatment group. In total, 449 randomized reserve households (725 children) were utilized: 187 (290 children) were included in the control group, 176 (290 children) in the treatment group, and 86 (145 children) did not join any group due to reasons such as refusal or inability to establish contact.

Data is available for 2,199 children and their families who completed the baseline questionnaire, providing insight into their level of engagement. Both the treatment and control groups participated in a structured program consisting of at least 6 individualized sessions with families—4 sessions targeted at adults within the family unit and 2 sessions focused on children —as well as 3 tutorial sessions specifically designed for the academic tutor of the child. In addition, the treatment group program had at least 16 additional sessions (6 group sessions on family dynamics and digital training aimed at the adults in the family unit and 10 group sessions on emotional intelligence and academic skills aimed at children). This theoretical minimum number of sessions had to be provided in a homogeneous way by all local entities.

For 93% of the participants in the control group who completed the baseline assessment, both the child and their family unit attended at least the total theoretical minimum number of sessions assigned to their group (6). Specifically, 96% of the children in the control group and 92% of the adults attended the mandated minimum number of sessions implemented consistently across all local entities (2 sessions for children and 4 sessions for adults).

Regarding the treatment group, over 78% of the families that completed the baseline assessment ensured that both the child and their family unit (FU) attended at least the total theoretical minimum of sessions assigned to their group (22). Specifically, more than 76% of the children in the treatment group and 77% of the adults attended the minimum number of sessions consistently implemented across all local entities (12 for children and 10 for adults).

Table 4*:* Distribution of participants according to their attendance at the training sessions

Attendance	Minor sessions			FU Sessions			Total Sessions		
	Total	GC	GT	Total	GC	GT	Total	GC	GT
Below the theoretical minimum	311 (14%)	48 (4%)	263 (24%)	343 (16%)	91 (8%)	252 (23%)	310 (14%)	78 (7%)	232 (22%)
At least the theoretical minimum	1888 (86%)	1072 (96%)	816 (76%)	1856 (84%)	1029 (92%)	827 (77%)	1889 (86%)	1042 (93%)	847 (78%)
Total	2199	1120	1079	2199	1120	1079	2199	1120	1079

To classify the itinerary as complete, participants in the control group were required to attend at least three out of four individual sessions for itinerary design and development with their families. Meanwhile, participants in the treatment group were expected to attend a total of 16 sessions, including a minimum of 13 specific sessions: at least two individual sessions for itinerary design, at least three of the six group sessions for adults (including one on digital skills and two on family

dynamics), and at least eight of the 10 group sessions for minors focused on emotional intelligence and academic competencies.

Adherence to these criteria has been robust, with over 94% of participants in the control group and 83% of those in the treatment group who completed the baseline survey successfully completing their respective itineraries.

Attrition by groups

Table 5 provides information on participation and response to baseline (PRE) and end-line (POST) surveys in the treatment and control groups. Out of the total 3,086 minors included in the sample and reserves, 887 did not complete any questionnaire: 366 were from the control group, 376 from the treatment group, and 145 were not assigned to any group.

Among the 2,199 respondents to the baseline survey, 2,033 completed the final survey, indicating a retention rate of 92%. All participants who completed the final survey had also responded to the initial survey. Specifically, in the treatment group comprising 1,455 individuals, 66% (958 individuals) completed both the initial and final surveys, indicating a 34% attrition rate. Conversely, in the control group, 72% completed both surveys, resulting in a lower attrition rate of 28%.

Table 5: Registration of participants and conduct of surveys

Group	Total	No survey	PRE survey only	PRE & POST Survey
Total	**3086**	**887 (29%)**	**166 (5%)**	**2033 (66%)**
Control Group	1486	366 (25%)	45 (3%)	1075 (72%)
Treatment Group	1455	376 (26%)	121 (8%)	958 (66%)
No group	145	145 (100%)	-	-

To assess whether the difference in the attrition rate of the sample between the experimental groups is statistically significant, a simple regression is performed where the dependent variable takes the value 1 if the participant has not responded to the final survey and 0 otherwise. As shown in **Table 6**, the regression coefficient is 0.06, with a significance level of 1%, i.e., there are 6% more people in the treatment group than in the control group who do not complete the POST questionnaire among the total number of participants. Regarding selective attrition, it is identified that the treatment has a differential effect on the attrition by gender of the child, nationality of the legal guardians and the family situation in relation to absenteeism.

Table 6: Regressions of the probability of not answering the final interview

	Attrition (1)	Selective Attrition (2)
Treatment	0.06***	0.10
	(0.02)	(0.27)
Treatment x Male		0.05
		(0.05)
Treatment x educational level of the legal guardian. No studies		-0.09
		(0.09)
Treatment x Educational level of the legal guardian. Primary Education		-0.12
		(0.09)
Treatment x Educational level of the legal guardian. Secondary education		-0.11
		(0.09)
Title x Nationality of the legal guardian. Spain		-0.02
		(0.04)
Title x Nationality of the legal guardian. EU (without Spain)		-0.26**
		(0.12)
Treatment x Gender of the minor. Woman		0.13**
		(0.06)
Treatment x Gender of the minor. Man		0.15**
		(0.06)
Treatment x Age minor		0.01
		(0.01)
Treatment x School stage of the minor. Primary		-0.15
		(0.21)
Treatment x School stage of the minor. High school		-0.13
		(0.21)
Treatment x Family situation. Absenteeism		0.06*
		(0.04)
Observations	2941	2199

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.

5 Evaluation results

Randomization of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable and therefore any differences observed after the intervention can be causally associated with the treatment. Econometric analysis provides, in essence, this comparison. However, it has the advantages of allowing other variables to

be included to gain precision in estimates and of providing confidence intervals for estimates. This section presents the econometric analysis conducted, including the estimated regressions, as well as the analysis of the results obtained.

5.1 Description of Econometric Analysis: Estimated Regressions

In the context of a randomized experiment, the regression model typically employed to estimate causal effects involves comparing the treatment group with the control group regarding the variable of interest. This approach relies on the assumption of statistical comparability between both groups due to randomization. Additionally, regression models often control the initial value of the dependent variable, when possible, to enhance the precision of the estimates.

The specification used in this study is:

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

where is $Y_{i,t=1}$ the dependent variable of interest observed after the intervention for person i; $T_i$indicates whether the person has been assigned to treatment (=1) or control (=0), $Y_{i,t=0}$ is the initial value of the dependent variable (i.e., before the intervention), and ε_i is the error term. Standard errors are grouped at the household level.

5.2 Analysis of the results

5.2.1 Primary and secondary outcomes

This section exhibits the results of the evaluation on primary and secondary indicators, following the structure of the evaluation framework.

School attendance

Table 7 presents the results of the intervention on the attendance of children in class. In both specifications, whether excluding or including the variable of interest at baseline, the coefficient associated with this variable is approximately zero and lacks statistical significance. This suggests that the intervention has no discernible effect on decreasing absences from treated children.

Table 7: Effect on attendance

	Percentage of absences	
	(1)	(2)
Treatment	-0.00	-0.00
	(0.01)	(0.01)
Observations	2021	2021
R^2	0.00	0.19
Mean control var.dep.	0.11	0.11
Additional controls	No	No
Initial value var.dep.	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.

Basic academic skills and school habits

Table 8 provides a detailed analysis of the treatment effects on academic competencies, focusing on language and mathematics, as assessed by both academic tutors and students themselves. The results indicate no statistically significant impacts at a 5% confidence level in either the perceptions of tutors or those of students. These findings suggest that the treatment did not produce observable effects on students' competencies in the short term.

Table 8: Effect on academic competencies

	General estimate of reading comprehension and oral expression		General estimation on reasoning and calculation		Self-perception of reading comprehension and oral expression		Self-perception about reasoning and calculation	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	-0.06	-0.06*	-0.04	-0.02	-0.00	-0.01	-0.01	-0.00
	(0.04)	(0.03)	(0.04)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)
Observations	1961	1956	1939	1935	1961	1960	1963	1962
R^2	0.00	0.17	0.00	0.15	0.00	0.15	0.00	0.30
Mean control var.dep.	2.01	2.01	1.99	1.99	2.37	2.37	2.29	2.29
Additional controls	No	No	No	No	No	No	No	No
Initial value var.dep.	No	Yes	No	Yes	No	Yes	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.

Table 9 presents the results of regressions to evaluate the relationship between treatment and school habits, specifically the impact on self-perception of the school habits of children and the estimation

of the relationship between teachers and students. Again, the coefficients are not significant in any specification. Therefore, no significant impact on the variables analyzed is appreciated.

Table 9: Effect on school habits and the teacher-student relationship

	Self-assessment of school habits		Average estimate of the relationship between teachers and children and adolescents	
	(1)	(2)	(3)	(4)
Treatment	0.00	0.01	-0.03	-0.03
	(0.02)	(0.02)	(0.03)	(0.03)
Observation	1961	1961	1947	1941
R^2	0.00	0.26	0.00	0.14
Mean control var.dep.	2.42	2.42	2.30	2.30
Additional controls	No	No	No	No
Initial value var.dep.	No	Yes	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.

Self-esteem

Table 10 shows the impact of the treatment on the self-esteem of the children. The coefficients close to zero and not significant indicate that the treatment did not have an observable effect on the perceived self-esteem of the participating students.

Table 10: Effect on self-esteem

	Self-rated diagnosis of self-esteem	
	(1)	(2)
Treatment	-0.00	-0.01
	(0.02)	(0.01)
Observation	1955	1954
R^2	0.00	0.50
Mean control var.dep.	2.47	2.47
Additional controls	No	No
Initial value var.dep.	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.

Parenting/Parental Competencies of Family Units

Table 11 displays the impact of the treatment on parental competencies within family units. It assesses the effect on self-perceived family competencies of mothers, fathers, or legal guardians, as well as on the relationship between the school and the family unit. The results reveal a statistically significant, albeit small, negative effect on family competencies at a 10% significance level. However, no discernible effect of the treatment on the contact relationship between the school and the family unit is observed.

Table 11: Effect on parenting/parenting skills

	Self-assessed diagnosis of family competencies		Contact relationship between the school and the family unit	
	(1)	(2)	(3)	(4)
Treatment	-0.02*	-0.02*	0.00	0.00
	(0.01)	(0.01)	(0.02)	(0.02)
Observation	1957	1957	1842	1839
R^2	0.00	0.28	0.00	0.25
Mean control var.dep.	2.46	2.46	2.50	2.50
Additional controls	No	No	No	No
Initial value var.dep.	No	Yes	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01

Inclusion in the school and social environment

Table 12 provides information on the effect of the intervention on the attitude of children in class and the coverage of children's basic needs in the classroom and the daily care they receive. The lack of significant impact, represented by the coefficients close to zero, indicates that the treatment has not altered the behaviour of students in the classroom or improved the attention to their basic needs.

Table 12: Effect on inclusion in the school and social environment

	Assessment of the average class of the child's attitudes and behaviors		Coverage of basic needs of children and adolescents	
	(1)	(2)	(3)	(4)
Treatment	-0.02	-0.01	0.00	-0.00
	(0.02)	(0.02)	(0.02)	(0.01)
Observations	1935	1930	1803	1797
R^2	0.00	0.23	0.00	0.17
Mean control var.dep.	2.58	2.58	2.60	2.60
Additional controls	No	No	No	No
Initial value var.dep.	No	Yes	No	Yes

Note: standard errors grouped by household (cluster variable).
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01

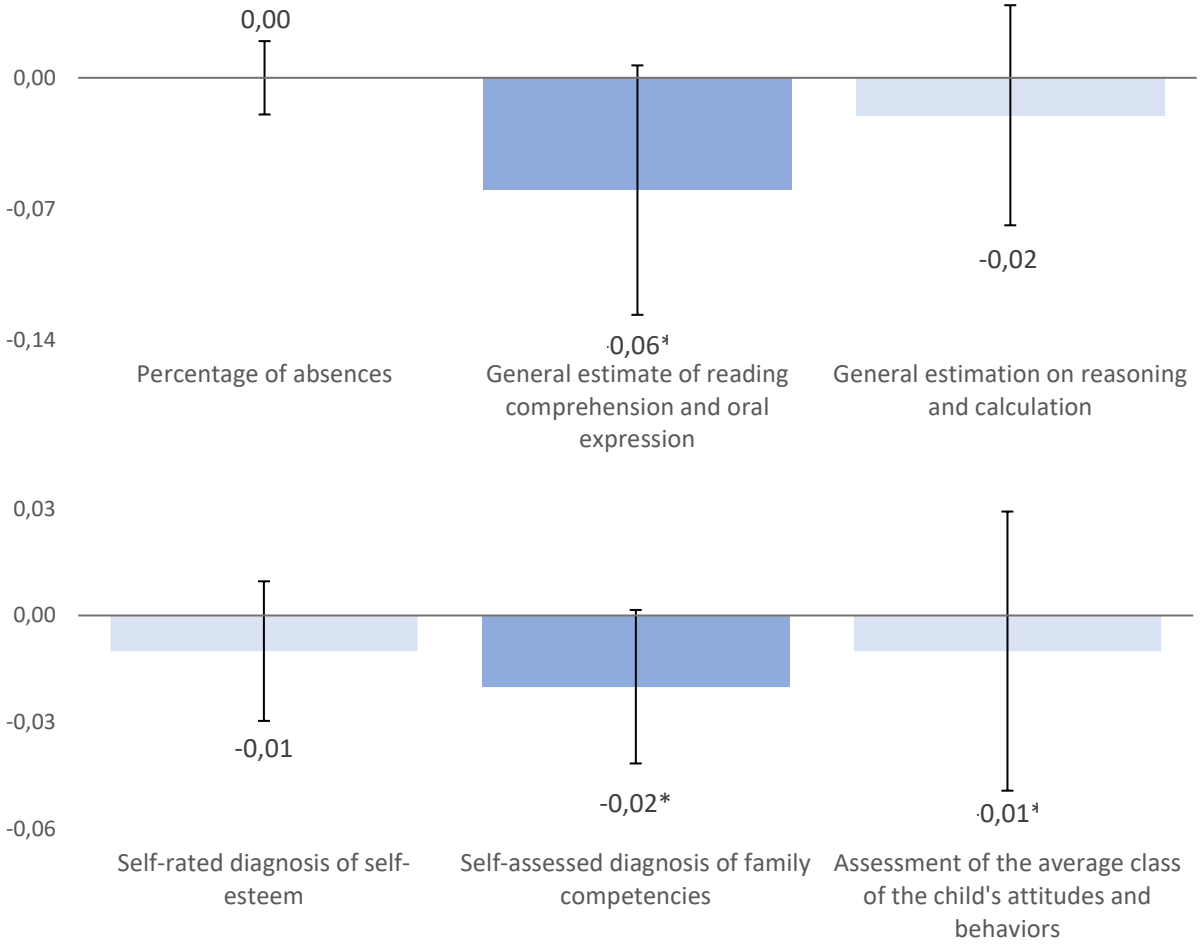
6 Conclusions of the evaluation

This report provides a comprehensive evaluation of a Randomized Controlled Trial (RCT) addressing the issues of absenteeism and social vulnerability among children and families residing in disadvantaged areas of Andalusia. The intervention evaluated includes socio-family inclusion itineraries, incorporating professional support for both families and children. The primary goal of the intervention was to enhance family engagement, utilization of public and private resources thereby mitigating or preventing school absenteeism.

The implemented itineraries were structured around four key areas: personalized sessions with families, group sessions with minors, group sessions with legal guardians of minors, and coordination through tutorial actions. While both control and treatment groups followed socio-family pathways, participants in the treatment group had access to a more extensive program with 22 sessions, compared to 6 sessions in the control group. Furthermore, the treatment group had access to additional resources from Social Services and Third Sector entities, whereas the control group had access only to resources provided by Social Services.

When assessing the model, the impact of the extended itinerary provided to the treatment group is compared with that of the control group across various domains, including attendance rates, academic skills and habits, satisfaction of basic needs for children, and family dynamics. This holistic approach enables a comprehensive evaluation of the intervention's impact, offering deeper insights into its effectiveness across different dimensions.

Figure 7: Effect of the intervention on the main indicators



Note: blue shows indicators whose treatment effect is significant at 10% and light blue those indicators that are not significant. The effects included in the graphics refer to regressions with controls.

The results of the econometric analysis suggest that the extended intervention did not yield a significant positive effect on any of the variables studied. Instead, A slight but statistically significant negative impact, observed at a 10% significance level, is evident in both children's reading comprehension and oral expression, as well as in the self-assessment of family skills. This outcome may stem from the self-perception nature of the evaluation tools, where participants initially assessed their skills possibly higher than their actual abilities. This initial overvaluation might have influenced subsequent self-assessments, posing challenges in generating markedly different self-perceptions in the final questionnaire.

Moreover, the relatively short duration of the project may have limited its ability to effectuate immediate changes in the routines of participating families and children. Nevertheless, it is noteworthy that there was high adherence to the project among those who embarked on the itinerary, despite the project's execution across diverse local entities simultaneously. This adherence

is particularly significant in the context of a population facing vulnerability or social exclusion, which often maintains fragile connections with public systems and resources.

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Appendix

Economic and regulatory management

1. Introduction

Within the framework of the Recovery, Transformation, and Resilience Plan, the General Secretariat for Inclusion (SGI) of the Ministry of Inclusion, Social Security, and Migration is significantly involved in Component 23, "New public policies for a dynamic, resilient, and inclusive labor market," framed in policy area VIII, "New care economy and employment policies."

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

Royal Decree 938/2021, of October 26, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migrations in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation, and Resilience Plan[11], 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[12], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to conduct implement pilot projects to support the

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

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

socio-economic inclusion of the beneficiaries of the MIS through itineraries" contributed to compliance with monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document[13].

Furthermore, following the execution and evaluation of each of the subsidized pilot projects, an assessment will be conducted to evaluate the coverage, effectiveness, and success of the minimum income schemes. The publication of this evaluation, which will include specific recommendations to improve the access rate to the benefit and enhance the effectiveness of social inclusion policies, contributes to the achievement of milestone 351 of the Recovery, Transformation, and Resilience Plan scheduled for the first quarter of 2024.

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

On October 21, 2022, the Autonomous Community of Andalusia was notified of the Resolution of the General Secretariat for Inclusion and Social Welfare Objectives and Policies granting a subsidy in the amount of 15,000,000.00 euros to the Autonomous Community of Andalusia and, on October 24, 2022, an agreement is signed between the General State Administration, through the General Secretariat for Inclusion and Social Welfare Objectives and Policies, and the Autonomous Community of Andalusia, through the Ministry of Social Inclusion, Youth, Families and Equality, for the implementation of a social inclusion project within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Official State Gazette" on 8 November 2022 (BOE no. 268).14

2. Time frame of the intervention

Article 17(1) of Royal Decree 378/2022, dated May 17 established that the deadline for the implementation of the social inclusion itineraries pilot covered by the subsidies provided for in this text shall not exceed the deadline of 30 November 2023, while the evaluation shall not extend beyond March 31, 2024, in order to meet the milestones set by the Recovery, Transformation, and Resilience Plan with regard to social inclusion policies.

[13] 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.

[14] https://www.boe.es/boe/dias/2022/11/08/pdfs/BOE-A-2022-18340.pdf

Within this generic time frame, the implementation begins on May 1, 2023, with the start of the intervention itinerary, continuing the execution tasks until November 30, 2023, and subsequently developing dissemination and evaluation tasks of the project until March 31, 2024.

3. Relevant Agents

Among the relevant agents for the implementation of the project can be mentioned:

- The Autonomous Community of Andalusia, beneficiary entity and coordinator of the project, through the Ministry of Social Inclusion, Youth, Families and Equality, and especially the General Directorate of Social Protection and Neighborhoods of Preferential Action.

- The 29 local entities, as responsible for the capture and implementation of the interventions in each of the territories.

LOCAL ENTITY	PROVINCE
1. Ayto. El Ejido	Almeria
2. Ayto. Níjar	Almeria
3. Ayto. Roquetas de Mar	Almeria
4. Ayto. Algeciras	Cadiz
5. Ayto. Arcos de la Frontera	Cadiz
6. Ayto. Barbate	Cadiz
7. Ayto. Cádiz	Cadiz
8. Ayto. Chiclana de la Frontera	Cadiz
9. Ayto. Jerez de la Frontera	Cadiz
10. Ayto. San Roque	Cadiz
11. Ayto. Córdoba	Córdoba
12. Ayto. Palma del Río	Córdoba
13. Ayto. Puente Genil	Córdoba
14. Ayto. Granada	Grenade
15. Ayto. Loja	Grenade
16. Ayto. Motril	Grenade
17. Ayto. Huelva	Huelva
18. Ayto. Isla Cristina	Huelva

LOCAL ENTITY	PROVINCE
19. Diputación Huelva	Huelva
20. Ayto. Málaga	Malaga
21. Ayto. Marbella	Malaga
22. Ayto. Torremolinos	Malaga
23. Ayto. Vélez Málaga	Malaga
24. Diputación Málaga	Malaga
25. Ayto. Coria del Río	Seville
26. Ayto. Dos Hermanas	Seville
27. Ayto. Los Palacios y Villafranca	Seville
28. Ayto. Morón de la Frontera	Seville
29. Ayto. San Juan de Aznalfarache	Seville

Note: Finally, in Puente Genil (Córdoba) the interventions were not carried out with the participants, although the collection and collection of PRE data was carried out.

- The Ministry of Inclusion, Social Security, and Migration (MISSM) as the sponsor of the project, and as the main responsible for the RCT evaluation process. The General Secretariat for Inclusion (SGI) assumes the following commitments:
  a) Assist the beneficiary entity in the design of the activities to be carried out for the implementation and monitoring of the object of the subsidy, 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 evaluation of the RCT.

Balance between experimental groups

Table 13: Equilibrium contrasts between experimental groups

Variable	(1) Control		(2) Treatment		(2)-(1) t-test in pairs	
	N/ Clusters	Mean/ (Where)	N/ Clusters	Mean/ (Where)	N/ Clusters	P-Value
Sociodemographic variables						
Gender of the legal guardian. Man	1,120	0.15	1,079	0.15	2,199	0.86
	676	(0.21)	680	(0.20)	1,356	
Educational level of the legal guardian.	1,120	0.48	1,079	0.51	2,199	0.28
No studies	676	(0.41)	680	(0.40)	1,356	
Educational level of the legal guardian.	1,120	0.30	1,079	0.30	2,199	0.82
Primary Education	676	(0.35)	680	(0.33)	1,356	
Educational level of the legal guardian.	1,120	0.20	1,079	0.18	2,199	0.27
Secondary education	676	(0.27)	680	(0.23)	1,356	
Educational level of the legal guardian.	1,120	0.02	1,079	0.02	2,199	0.97
University studies	676	(0.03)	680	(0.03)	1,356	
Nationality of the legal guardian.	1,120	0.84	1,079	0.85	2,199	0.66
Spain	676	(0.22)	680	(0.20)	1,356	
Nationality of the legal guardian. EU	1,120	0.01	1,079	0.01	2,199	0.95
(Without Spain)	676	(0.02)	680	(0.02)	1,356	
Nationality of the legal guardian.	1,120	0.15	1,079	0.14	2,199	0.64
Outside the EU	676	(0.21)	680	(0.19)	1,356	
Gender of the child. Female	1,120	0.48	1,079	0.46	2,199	0.32
	676	(0.41)	680	(0.40)	1,356	
Gender of the child. Man	1,120	0.52	1,079	0.54	2,199	0.32
	676	(0.41)	680	(0.40)	1,356	
Gender of the child. Trans	1,120	0.00	1,079	0.00	2,199	0.98
	676	(0.00)	680	(0.00)	1,356	
Age of the child	1,120	10.62	1,079	10.48	2,199	0.27
	676	(15.05)	680	(13.40)	1,356	
School stage of the child and adolescent. Primary	1,120	0.66	1,079	0.68	2,199	0.38

	676	(0.37)	680	(0.35)	1,356	
School stage of the child and adolescent. High school	1,120	0.33	1,079	0.32	2,199	0.30
	676	(0.37)	680	(0.34)	1,356	
School stage of the child and adolescent. FP	1,120	0.00	1,079	0.00	2,199	0.17
	676	(0.00)	680	(0.01)	1,356	
Marital status. Absenteeism	1,120	0.26	1,079	0.25	2,199	0.88
	676	(0.32)	680	(0.30)	1,356	
Performance indicators						
Percentage of absences	1,118	0.12	1,079	0.13	2,197	0.57
	675	(0.04)	680	(0.04)	1,355	
General estimate of reading comprehension and oral expression	1,114	1.94	1,074	1.91	2,188	0.33
	675	(0.99)	676	(0.87)	1,351	
General estimation on reasoning and calculation	1,114	1.93	1,074	1.89	2,188	0.24
	675	(0.97)	676	(0.85)	1,351	
Self-assessed diagnosis on self-esteem	1,119	2.45	1,077	2.45	2,196	0.88
	676	(0.22)	680	(0.21)	1,356	
Self-assessed diagnosis of family competencies	1,120	2.41	1,079	2.40	2199	0.46
	676	(0.08)	680	(0.10)	1,356	
Assessment of the average class of the child's attitudes and behaviors	1,113	2.53	1,073	2.51	2,186	0.32
	675	(0.30)	676	(0.30)	1,351	
Self-perception of reading comprehension and oral expression	1,119	2.36	1,077	2.38	2,196	0.45
	676	(0.56)	680	(0.52)	1,356	
Self-perception about reasoning and calculation	1,119	2.29	1,077	2.27	2,196	0.41
	676	(0.70)	680	(0.68)	1,356	
Self-assessment of school habits	1,120	2.40	1,077	2.38	2,197	0.34
	676	(0.36)	680	(0.31)	1,356	
Average estimate of the relationship between teachers and children and adolescents	1,113	2.18	1,073	2.18	2,186	0.97
	675	(0.53)	676	(0.51)	1,351	
Contact relationship between the center and the family unit	1,116	2.44	1,076	2.43	2,192	0.72
	675	(0.20)	678	(0.24)	1,353	
Coverage of basic needs of the child	1,110	2.53	1,066	2.54	2,176	0.80
	674	(0.15)	673	(0.16)	1,347	

Significance: ***=.01, **=0.05, *=.1.

Note: standard errors grouped by household (cluster variable).