BETTER TOGETHER?
THE EFFECTS OF INTEGRATED SOCIAL SERVICES FOR WOMEN

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Abstract

We study the effects of integrated social services for women in El Salvador using a randomized experiment. The Ciudad Mujer "one-stop shop" centers provided 30 public services including health, gender-based violence, legal, financial and employment services on a single campus accessible only to women. These integrated services could boost demand by reducing the cost of access, improving quality and exploiting complementarities in service provision. Over 4,000 women were randomly encouraged to visit Ciudad Mujer (treatment group) or a local health clinic (placebo group), or they received no encouragement (control group). Approximately 1 year later, women exposed to Ciudad Mujer visited the center an additional 2.1 times, increased the use of public services by 0.53 s.d. and reported a 10% improvement in life satisfaction relative to both the placebo and control groups. *JEL Codes*: I38, J1, C93

Keywords: Ciudad Mujer, one-stop shop, randomized promotion, public service provision, gender equality.

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This study was conducted in partnership with the Government of El Salvador. The Ministry of Social Inclusion (SIS) was responsible for the *Ciudad Mujer* program, while the data collection for the impact evaluation was led by the former General Directorate of Statistics and Censuses (DIGESTYC), which was, by law, the governing entity coordinating the national statistical system and conducting research on economic, demographic, and social topics. As *Ciudad Mujer* was a strategic program of the administration, both SIS and DIGESTYC were responsible for disseminating the program's impact results.

As part of the Ministry's political agenda and the Directorate's special projects research agenda, the authors were informed that the data collection did not require an Institutional Review Board review but still needed to adhere to all procedural and ethical standards established by the entities, including data confidentiality and the use of informed consent forms. These forms were indeed collected and stored in accordance with the Offices' requirements.

1. Introduction

Improving access to public services that address women's needs is crucial. In 2020, the maternal mortality rate in Latin America and the Caribbean (LAC) was 50 deaths per 100,000 women, and the adolescent pregnancy rate was among the highest globally (Liang et al., 2019). Despite female labor force participation rising to 61% over the past fifty years, significant gender disparities persist. Women are overrepresented in lower-paying, informal sectors and earn 9% to 25% less than men with similar education levels (Frisancho and Queijo, 2022; Urquidi and Chalup, 2023). Additionally, gender-based violence affects one-quarter of women aged 15-49 in LAC, with severe consequences for their health and well-being (WHO, 2021).

Access barriers for vulnerable groups, such as low-income women, remain high, leading to the underutilization of critical social services. While governments have traditionally focused on demand-side solutions, innovative supply-side models like One-Stop Shops (OSS) aim to improve service accessibility and satisfaction by consolidating services in one location (Post and Arwal, 2011; Pfeil et al., 2017; Fredriksson, 2020). This strategy has been adopted globally, with examples including Brazil's *Poupatempo* program, New Delhi's OSS in India, and Cambodia's one-window service offices for citizens and small businesses (Annenberg, 2006; Singh, 2008; Kochar, 2009). Additionally,

countries like Canada, Australia, and the UK have implemented OSS models to improve customer service and reduce costs by integrating public services in a single facility (Griffiths et al., 2008; Dean, 2011).

Although some OSS approaches in hospitals or as stand-alone services aim to provide comprehensive care to women and girls who are victims of gender-based violence (Colombini et al., 2012; Ellsberg et al., 2015), in general, OSS models are not specifically designed to cater to women's unique needs. Additionally, impact evaluations of OSS are very scarce due to lack of comparison groups and sample selection bias (Fredriksson, 2020).

In early 2011, the first Ciudad Mujer (CM) center opened in El Salvador, introducing an innovative model to facilitate women's access to public services in low-income areas, improve service quality, and ultimately enhance women's well-being. This initiative aimed to address the significant barriers that women face in accessing essential services, consolidating them into a single, women-only facility. CM OSS innovation lies in its gender-specific adaptation of services within a single location, providing a range of services including sexual and reproductive health, support for gender-based violence, legal services, and employment assistance, all tailored to the specific needs of women (CEPAL, 2019).

This study contributes to the limited literature on OSS and public service delivery by evaluating the effectiveness of the CM OSS model using a randomized encouragement design. It focuses on its impact on service utilization and women's well-being and is the first rigorous evaluation of an OSS model specifically designed for women. By employing a randomized encouragement design, this study addresses selection bias and provides robust causal estimates of CM OSS's impact. Additionally, the analysis leverages rich panel survey data and administrative records, enabling a detailed exploration of program effectiveness beyond user satisfaction.

The findings highlight the importance of integrated service delivery models in addressing gender-specific barriers to public service access, with significant policy implications for the LAC region and potentially other developing areas. One-year after the intervention, more than 60% of women in the treatment group visited CM, compared to 10% in the placebo and control groups. The findings indicate a 0.53 standard deviation increase in service use for treated women, particularly in reproductive and sexual health, legal services, and economic autonomy. Older and less-educated women benefitted the most, suggesting that CM effectively targets the most vulnerable populations. Additionally, women in the treatment group were 8.5 percentage points more likely to report being satisfied with their lives, a 10% increase over the comparison groups.

The remainder of the paper is organized as follows. Section 2 presents a literature review, and Section 3 discusses the conceptual framework behind integrated public delivery models. Section 4 describes the CM model. Section 5 outlines the encouragement design, and Section 6 describes the data sources. Section 7 explains the empirical identification strategy, and Section 8 presents the main results. Section 9 concludes our findings.

2. Literature Review

Studies on OSS generally focus on the institutional and political aspects of the supply-side model or on documenting implementation experiences and lessons from different programs (e.g., Esteves de Araújo, 2001; Bussell, 2010; Swiss Agency for Development and Cooperation, 2010; Askim et al., 2011; Inter-American Development Bank, 2013; International Labour Organization, 2016). However, impact evaluations of OSS are scarce due to lack of a comparison group, as these reforms often apply universally, and they often suffer from sample selection bias (Fredriksson, 2020).

Canada implemented OSS in the late 1990s, but the absence of pre-implementation data prevented rigorous impact evaluation (Bent et al., 1999). Nevertheless, the Citizens

First national survey allowed for measuring satisfaction with the service delivery model (Marson and Heintzman, 2009).

Jerome Gallagher et al., (2003) evaluated the implementation of a pilot social assistance OSS in Arzamas, Russia, by interviewing all OSS beneficiaries about the new and old institutional structures. Findings showed that OSS staff offered more services/benefits than non-OSS, and OSS clients saved between 1.3 to 2.4 hours compared to the older system. However, this analysis might suffer from sample selection bias since it used data from OSS users only.

In India, Bussell (2010) studied a private OSS initiative (*Nemmadi Kendras*) and evaluated the program's effects on the quality-of-service delivery and government-citizen relations. The study leveraged the staged implementation of the program and the parallel computerization of the public service office. Using survey data and field experiment data from all three types of service locations, the author found that individuals using the computerized offices took fewer trips to resolve errands, though the total time spent was similar. However, the causal effect is likely affected by the selection bias of citizens choosing which type of office to assist.

Frederiksson (2020) conducted an impact evaluation in Brazil, analyzing the impact of the OSS *Poupatempo* by exploiting the geographical expansion and timing of

OSS implementation. The difference-in-differences estimates indicated large reductions in the time spent by citizens and in proxies for transaction costs, though the social quality of the licensing procedure showed less improvement.

This paper contributes to the limited body of literature by estimating the causal effect of an OSS model on services use, specifically analyzing the overall impact of CM. Unlike many OSS models, CM is designed for women's needs, offering insights into gender-specific service adaptations and marking this study as the first rigorous evaluation of such a model. Due to the integrated and gender-focused nature CM's services, isolating the effects of specific attributes of the model is not possible.

3. Conceptual Framework

Social services, such as health care, policing, and employment services, are provided by governments to address societal challenges and improve the population well-being (Osborne, 1993). These services aim to enhance social welfare, even if benefits are privately captured. For instance, health services prevent and treat illness, thereby improving quality of life, while policing services reduce violence and crime, and employment services enhance job opportunities and incomes. Public provision of these services ensures equity

and addresses positive spillovers that the private market may not capture, such as health benefits from child immunization or security from crime reduction.

In many countries, the provision of public services is fragmented geographically and organizationally, with different agencies serving the same population independently. This fragmentation requires beneficiaries to visit multiple sites, incurring significant costs such us time, transport, childcare and personal safety concerns. Moreover, services quality varies and may not address gender-specific needs. Fragmentation also reduces complementarities and coordination between services, limiting efficiency.

Access barriers are particularly high for vulnerable groups, such as low-income women, who often underutilize critical social services like health care during pregnancy or legal support for gender-based violence.[1] Governments have traditionally focused on demand-side solutions, such as conditional cash transfers, to boost service utilization (Fiszbein and Schady, 2009). However, innovative supply-side models aimed at reducing access barriers and increasing utilization have received less attention.

In recent decades, government modernization initiatives have increasingly adopted mechanisms to provide integrated public services (Kernaghan, 2009). OSS models aim to

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[1] Gender-based violence is defined as any action or omission based on gender that causes a woman's death, injury, physical, sexual or psychological suffering and moral or patrimonial damage (UN Women, 2010). Definition of domestic violence: http://www.endvawnow.org/en/articles/398-definition-of-domestic-violence.html (Accessed on 10 June 2024).

improve customer service and satisfaction while reducing costs by consolidating bureaucracies and public offices in one location (Dean, 2011). These models shift from fragmentated public administration to a customer-oriented structure (Wimmer, 2002), bringing services together to reduce the time and effort citizens expend to access them. OSS models have the potential to improve accessibility, convenience, and overcome jurisdictional divisions (Bent et al., 1999).

Canada and Australia are global leaders in moving siloed transactional services to common counters (Dean, 2011). UK has used this approach for sexual health services (Griffiths et al., 2008), and many OECD countries have adopted it in the welfare sector (Askim et al., 2011). OSS centers also provide comprehensive care to women and girls who are victims of gender-based violence, typically located within hospitals in Africa and Asia or as stand-alone centers in Latin America (Colombini et al., 2012; Ellsberg et al., 2015).

The rationale behind OSS centers includes transaction cost reduction, increased service quality through complementarities, and a focus on beneficiaries' needs. First, consolidating services reduces transaction costs for beneficiaries, providers, and the government, minimizing duplication and effort (Askim et al., 2011). Second, collaboration between public agencies enhances access to complementary services and improves

communication, thus increasing service quality. Finally, OSS centers align services with the complete beneficiary journey, addressing agency silos and serving needs effectively through a single point of contact (PWC, 2012).

However, despite various global initiatives, the concept remains understidied in the literature, with insufficient evidence of its effectiveness. This paper aims to contribute to this understanding by evaluating the short-term performance of a tailored OSS model and its impact on women's use of public services.

4. Ciudad Mujer (CM)

The CM program aimed to improve public service delivery for women by providing key services through OSS centers. The program sought to enhance gender equality by offering an integrated response to women's needs in sexual and reproductive health, economic autonomy, and gender-based violence prevention and care. CM centers provided a comprehensive range of free public services grouped into five modules: (1) sexual and reproductive health, (2) economic autonomy, (3) gender-based violence, (4) collective education and (5) childcare.

The sexual and reproductive health module included a medical team specializing in gynecology, breast and cervical-uterine cancer prevention, sexually transmitted

diseases, and family planning. The economic autonomy module supported employment and small and microenterprises through labor intermediation services, job training sessions, financial education and microcredits. The gender-based violence module offered medical and psychological care, legal assistance, and police protection for victims, addressing physical, sexual, emotional, and patrimonial violence.[2] The collective education module provided educational services that outreach to nearby communities to promote women's rights and prevent gender-based violence. Additionally, the centers offered childcare for children up to 12 years old while the mother or caregiver used the facility's services and hosted an on-site cafeteria with food for purchase. Overall, the centers offered more than 30 services, integrating 18 public agencies in a single setting.

The CM program's multifaceted intervention included several components beyond reduced transportation costs and better coordination among services. The gender-specific design, featuring female-only staff and clientele, on-site childcare, and comprehensive

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[2] Physical violence is understood as any behavior that offends a woman's bodily integrity or health. Sexual violence is understood as any behavior that forces a woman to witness, maintain or participate in unwanted sexual intercourse by means of intimidation, threat, coercion or the use of force. Emotional violence is understood as any behavior that causes emotional damage and reduction of self-esteem, that harms and disturbs full development or that aims at degrading or controlling a woman's actions, behaviors, beliefs and decisions. Patrimonial violence is understood as any behavior that constitutes retention, subtraction, partial or full destruction of a woman's objects, working instruments, personal documents, property, assets and economic rights or resources, including those intended to satisfy her needs (UN Women, 2010). Definition of domestic violence: http://www.endvawnow.org/en/articles/398-definition-of-domestic-violence.html (Accessed on 10 June 2024).

service integration, created a unique and supportive environment. This holistic approach addressed multiple barriers to service utilization simultaneously. All services at the CM centers were designed specifically for women. First, all staff members were women, and only women could access the centers. Second, all staff were trained to listen to and treat beneficiaries within a rights-based and gender-sensitive framework. Third, each case was managed with an integrated approach, offering personalized service and one-time-only registration to reduce waiting times and access costs. Upon arrival, women received personalized attention from a counselor who assessed their situation in terms of health, family relationships, labor status, and safety at home and in the community, and prepared a roadmap to help them access the services that best meet their needs.

Providing these services had an estimated cost of US$12 per service. Services were open to the public and provided on a first-come, first-served basis. Between 2011 and 2016, El Salvador's Secretary for Social Inclusion launched six centers across the country.[3] During the study period, the CM program served 485,000 women, representing approximately 14% of the country's female population.[4]

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[3] The six centers were in the departments of San Salvador, La Libertad, Santa Ana, San Miguel, Usulután and Morazán. The centers' locations were identified using three criteria: maximization of female population coverage, availability of public land or property that could be used for building the facilities and the accessibility for potential beneficiaries through public transportation.

[4] Ciudad Mujer administrative data.

5. Encouragement Design

CM has an "open door" policy of providing services to all women who access the center on a first-come, first-served basis. Given that participation is likely to be correlated with unobservable characteristics, the identification of treatment effects requires a valid instrument to correct for endogenous selection into treatment. To this effect, we implemented a randomized encouragement design whereby women between the ages of 18 and 60 years, living in the geographical catchment area of three new CMs, would be offered an incentive to visit the nearest CM reproductive health module shortly after the center opened. A second group of women would receive the same incentive to a fragmented equivalent service—in this case, the nearest health center/unit (HU)—which would serve as a "placebo encouragement." Average distance and accessibility between households in the catchment areas and the CM or health center were similar, and all services at both locations were provided free of charge. A third group of women was randomized to control and received no encouragement.

To design the encouragement strategy, the program hired a social marketing specialist to conduct formative research and to identify an encouragement mechanism that would increase program participation while not directly affecting the final outcomes. The proposed encouragement was a voucher to be exchanged at the CM or local health

center for a $15 gift card (equivalent to approximately one day's wages for salaried female workers in our sample),[5] redeemable at a national supermarket chain. The voucher was non-transferable, so it could only be claimed by the woman participating in the experiment (this was enforced by noting the woman's name and ID number on the voucher) within a 30-day period. Only one voucher was issued per woman, and once the voucher had been claimed at the local CM or health center, no additional promotion or encouragement activities were implemented.

We hypothesized that the initial exposure to CM would serve to reduce information asymmetries regarding the existence of CM services, how to access them and the quality and potential benefits from utilizing CM services. All utilization of services and related outcomes after the initial encouraged visit would then be attributable as effects of the CM model, independent of the initial one-time encouragement.

A second experimental group was randomly encouraged to visit a local health center, which serves as a proxy for existing service provisions. This placebo group allows us to indirectly test the exclusion restriction; that is, the observed effects of CM are generated through participation in CM and not indirectly through encouragement. For example, we might be concerned about the income effect of the $15 supermarket voucher,

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[5] Baseline survey descriptive statistics indicate an hourly average salary of $1.72 for women in the study sample.

which might free resources to cover the transportation costs to local social services. Furthermore, the placebo encouragement provides an approximate counterfactual estimate of service utilization under the existing fragmented model.

The first stage of the instrument can be tested empirically by comparing participation in CM among the CM encouragement group relative to the placebo encouragement (HU) and a randomly assigned control group with no encouragement at all (NP). Figure 1 presents the proportion of first visits to CM in each treatment group over time according to CM administrative records. We can observe that the encouragement resulted in almost a 50-percentage point increase in initial visits, well above the 10% of women who visit the CM centers based on spontaneous demand. We argue that effects on social service utilization and related outcomes that take place after the first (encouraged) contact with CM are attributable to CM, independent of the initial encouragement, thanks to lowering initial informational asymmetries regarding the center.

6. Data

To design the evaluation and the encouragement design, we took advantage of the timing of launch of three new CM centers. At the moment of the evaluation, only one center in the municipality of El Salvador was fully operational, and three new centers

were about to be launched in the municipalities of San Martin, Santa Ana, and Usulután. The evaluation sample was constructed to be representative of Salvadorian women aged 18 to 60 living in the 19 municipalities contiguous to the three centers that were to be launched, resulting in a total sample of 4,618 women. The government estimated that the population of women located in these 19 municipalities constituted the potential beneficiaries of the program.

We used two types of data in our analyses, administrative data from CM centers and survey data from purpose-specific baseline and follow-up surveys. Baseline data were collected before the launched of the three new CM centers, between January and June 2013. The fieldwork followed the inauguration schedule of each CM center to minimize the chances of recording data from women who had already visited the facilities. Due to security conditions around the San Martin CM center, field teams were unable to interview 503 women in their homes. A total of 150 women were randomly selected for a subsample to be interviewed in shopping centers close to their communities. A sample of 112 women attended the interview. We re-weighted this subsample to compensate for the sample attrition in the San Martin area. The effective sample consisted of 4,062 women.[6]

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[6] Of the total 4,062 women in the sample, 2,707 were assigned to one of the two encouragement groups. A total of 2,626 accepted the voucher, and 71 women rejected the voucher. The encouragement groups were incorrectly assigned for 35 women. These women maintain their original random assignment status for purposes of the analysis.

A follow-up panel survey was collected between February and March 2014, between 8 and 15 months after the inauguration of the centers, following the sample of 4,062 women interviewed at baseline. A total of 216 women were unreachable during the follow-up data collection due to foreign migration, death and incarceration, representing an attrition rate of 5.3%. Attrition was balanced between the randomized promotion and control groups (see Appendix Table A1). The final balanced panel used for analysis consists of 3,846 women with baseline and follow-up data.

The household questionnaire included detailed demographic and socioeconomic information about the sample of women and their households. Each woman was asked about her use of public services related to sexual and reproductive health, employment, and gender-based violence in the 12 months prior to the interview. Additionally, women were asked to rate their subjective well-being.

Administrative data captured women's attendance(s) at the centers, the type of services women was referred to after receiving guidance on their first visit to CM centers, and the services/modules they actually received/visited. This data was then merged with the survey data. The administrative database included data from January 2013 to May 2014, providing around a year for women to attend CM.

For the analyses, we used the CM centers' administrative data to quantify the effectiveness of our encouragement to visit the CM centers and the survey data to measure the utilization of services in the CM centers and in the health centers/units.

The primary outcome variables are related to the use of public services. We constructed both an aggregate index that comprised a total of 20 specialized services on sexual and reproductive health, economic autonomy and gender-based violence support, as well as five sub-indexes grouped by the type of service: i) sexual and reproductive health care; ii) promotion of female employment; iii) psychological, medical and legal support for survivors of physical, sexual and/or emotional violence; iv) legal support for victims of patrimonial violence; and v) legal services to strengthen economic autonomy (see Table 1 for a detailed description of services).

The indices express the proportion of public services used by each woman during a 12-month reference period, independent of where the service took place. The indexes are constructed as follows:

$$Index_i = \frac{1}{N} \sum_{j=1}^{N} s_{ji} \, ,$$

where N is the total number of available services, and s_{ji} represents the service j used by women i, which takes the value of 1 if the woman used the service in the reference period and zero otherwise.

To interpret the magnitude of change in standard deviations, we convert indices to z-scores:

$$z\text{-}Index_i = \frac{(Index_i - \overline{Index_c})}{SD_C} \,,$$

where $\overline{Index_c}$ and SD_C are the mean and standard deviation in the control group respectively (Kling et al., 2007).

It is important to highlight that in our socioeconomic index, higher (lower) values represent worse (better) living conditions.[7]

7. Identification Strategy

As discussed in sections 2 and 4, CM is open for all women in El Salvador, and services are provided for free. As such, the program model precludes the option of restricting access for evaluation purposes. We estimate the impact of CM on public service utilization by leveraging the experimental variation generated by the random encouragement for an initial CM visit (extensive margin). Specifically, we use the treatment (promotion) assignment as an instrument for program participation to estimate

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[7] The variable is the sum of the following dichotomous variables: *Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; Housing has no private toilet-flush water).*

the treatment on the treated (TOT) for compliers.[8] We specify the two-stage least squares

(2SLS) analysis separately for CM compared to HU promoted women, and CM compared

with control NP women. Using the traditional IV approach in the random controlled trials

(RCT) literature and controlling for the dependent variable in the baseline period to

increase precision, the specification is as follows:

(1) $$VisitedCM_i = \alpha_0 + \alpha_1 PromotionCM_i + \alpha_2 y_i^{BL} + \mu_i \ ,$$

(2) $$y_i = \delta_0 + \delta_1 \widehat{VisitedCM_i} + \delta_2 y_i^{BL} + \varepsilon_i \ ,$$

where y_i is the outcome of interest for woman i. $VisitedCM_i$ and $PromotionCM_i$ are

indicator variables for whether woman i has ever visited a CM center and whether she

was encouraged/promoted to visit CM, respectively. Furthermore, y_i^{BL} is the outcome

variable in the baseline period for woman i. Finally, μ_i and ε_i denote idiosyncratic random

errors. We refer to this specification as "Cross-section" estimates in our result tables

because, as explained below, we also report results considering the two periods comprised

in our data.

Following Solon et al. (2015), we reweighted the observations in our estimates

corresponding to equation (1) and (2) by the inverse probability of being selected in the

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[8] Compliers are women who attend a CM center if promoted.

sample. This endogenous sampling correction acknowledges that, as described in section 5, only a randomly selected 150 sub-sample out of the 503 women in the San Martin area could be reached to be surveyed in a safe place near their communities.

The first stage of our 2SLS specification, equation (1), predicts the probability of visiting a CM center according to the randomized promotion group assigned to each individual. CM visits records are obtained from administrative databases of the corresponding CM centers. The second stage, equation (2), estimates the impact of having visited CM on subsequent outcomes (intensive margin), denoted by y_i. The second-stage outcome variables need to capture the subsequent use of services not only in CM centers, but also in health units/centers. For this, we used baseline and follow-up surveys information comprising the three encouragement groups. The coefficient δ_1 in equation (2) is the parameter of interest and represents the TOT of CM for compliers.

With the data collected in the baseline survey, we tested if the characteristics of the treatment, placebo and control groups were, on average, not statistically different after the randomization process[9]. Tables 2 and 3 show balance tests between the encouraged groups for a set of sociodemographic characteristics and for our 5 outcome

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[9] It is expected that, on average, one out of ten variables compared between the groups can be unbalanced at a 90% confidence level (Glennerster and Takavarasha, 2013), and when more than that occurs, it could also be a random event, even if the random allocation of women to the different groups was properly implemented.

variables of interest, respectively. While in most cases the magnitude of the differences is small (or explained by very low baseline levels), our analysis indicates a proportion of unbalanced variables between groups that is higher than expected based on chance.[10] Specifically, the sociodemographic characteristics of the women promoted to CM are balanced with the group of women assigned to no promotion (NP). Nevertheless, the CM group has, on average, a higher probability of being married and living with her partner in the household, less likely to be literate or being employed, and live in worse conditions, relative to women encouraged to visit a health unit (HU). Regarding the outcome variables, women promoted to visit a CM center have previously used fewer services than the HU or NP promotion groups.

To address this imbalance, we control for baseline differences and all other non-time varying observable and unobservable characteristics using a fixed effects (FE) specification. Thus, our preferred empirical identification strategy exploits both the exogenous temporal variation (the baseline survey at time t_0 and the follow-up survey at time t_1) and the exogenous variation in the assigned encouragement. Therefore, in this approach, the variation used for identification comes from differences of our indicators of

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[10] As a reference, we also included some descriptive statistics for women at the national level based on the 2013 Multipurpose Household Survey. The characteristics of women in the study are, in general, similar to those in the whole country.

interest over time within individuals, and between the treatment and comparison groups.

The implicit assumption is that unobservable differences in the absence of the program

between groups would have had similar effects on the indicator of interest over time. The

specification in each stage is described as follows:[11]

(3) $$VisitedCM_{it} = \beta_0 + \beta_1 PromotionCM_{it} + \beta_2 post_t + \theta_i + \epsilon_{it} \ ,$$

(4) $$y_{it} = \gamma_0 + \gamma_1 \widehat{VisitedCM}_{it} + \gamma_2 post_t + \rho_i + \nu_{it} \ ,$$

where y_{it} is the outcome indicator of interest for woman i in period t. The indicator

variable $post_t$ establishes whether the observation is from the second period (follow-up),

controlling for the existence of shocks that may have affected all women over time, and

θ_i and ρ_i denote individual-level fixed effects that capture the time invariant observable

and unobservable characteristics of woman i. Furthermore, $PromotionCM_{it}$ and

$VisitedCM_{it}$ are dichotomous variables that take value 1 *in the second period* if the

woman i was promoted or has visited CM respectively, and 0 otherwise.[12] Therefore, β_1 is

the effect of the incentive to visit a CM center on the probability of visiting one of these

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[11] This specification is analogous to equation (2) but using the change in the outcome variable, Δy_i (i.e., $y_{i,t=1} - y_{i,t=0}$), as the dependent variable.

[12] In other words, $PromotionCM_{it}$ is an indicator for the post-treatment period for individuals who received the treatment (encouragement to visit CM).

three centers, and γ_1 is our parameter of interest and represents the TOT of visiting a CM center on subsequent outcomes (intensive margin). Finally, ϵ_{it} and ν_{it} denote idiosyncratic random errors. For all IV-FE estimates we report second-stage result tables which include the Anderson-Rubin test p-value for weak-instrument-robust inference.

Additionally, we estimate intention-to-treat effects (ITT) related to the promotion using the full sample and the FE model. Importantly, this exercise allows us to understand whether the estimated effects of our main model are a result of the encouragement itself, the \$15 monetary incentive present in both the HU and CM promotion groups, or the CM service delivery model. Specifically, if the two promotions have significant effects on the estimated outcome, it suggests that the results are, at least in part, due to the provided incentive.

The estimated ITT specification is as follows:

$$(5) \qquad y_{it} = \pi_0 + \pi_1 PromotionHU_{it} + \pi_2 PromotionCM_{it} + \pi_3 post_t + \varphi_i + \upsilon_{it} \; ,$$

the parameters π_1 and π_2 capture the ITT effects of promotion to HU and promotion to CM respectively. The results are presented in the Appendix (Tables A2 and A3) and are largely consistent with our main estimates.

To correct for multiple hypotheses, we implement a stepwise multiple testing method, proposed by Romano and Wolf (2005), in all our main estimates. Considering the multiplicity of tests (i.e., the number of dependent variables), the probability that a certain hypothesis is rejected by pure chance may be too high. To tackle this concern, we control using the familywise error rate, which is the probability of having one or more false discoveries, to ascertain (at the confidence level chosen) that the results found are not simply due to chance.

Finally, to understand potential mechanisms at play, we also explored heterogeneous treatment effects by baseline characteristics. We examine differential effects by socioeconomic status, education, age, and the number of children (between 0 to 12 years of age) in the household.[13] The estimated IV second-stage equation corresponds to:

$$(6) \qquad y_{it} = \lambda_0 + \lambda_1 \widehat{VisitedCM}_{it} \cdot H_i + \lambda_2 \widehat{VisitedCM}_{it} + \lambda_3 H_i \cdot post_t + \lambda_4 post_t + \eta_i + v_{it} \ ,$$

where H_i represents the heterogeneity variable (socioeconomic index, years of education, age, and the number of children in the household) at the baseline period. In this case, the heterogeneous differential effect is captured by λ_1.

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[13] We considered the 0-12 age range because it corresponds to the group of children covered by the CM centers' on-site childcare.

We also report ITT heterogeneous effects using the same set of heterogeneity variables and a specification analogous to equation (5) (Tables A4 and A5). All our estimates include standard errors clustered at the primary sampling unit (PSU) level.

8. Results

8.1. Main Findings

Our main finding is that the provision of integrated services through CM leads to an increased demand for services among compliers. Results in Table 4 show the extensive margin effect of the treatment (encouragement to visit CM) on the likelihood of visiting a CM center. There is a large and highly significant first stage, with almost a 50-percentage point increase in the probability of visiting at least once a CM center, relative to both the HU and NP groups respectively. Additionally, the overall take-up was 63% for the group promoted to CM, while 84% of women promoted to visit a HU did so at least once. The higher take-up level in the HU group might be explained by a greater preference for visiting an already known place and by health units/centers being more accessible in geographical terms.[14] Importantly, the large first-stage's F-statistic shows

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[14] The number of health units in the CM influence area is 9, compared to the 3 CM centers.

that our instrument is highly correlated with the endogenous variable and allows us to reject the null hypothesis of weak instruments.

Table 5 shows a substantial impact of CM on the intensive margin of visits, and the demand for additional (beyond the induced first health visit) public services. We find that women who visited CM had a 68-percentage point increase in the probability of returning to the centers at least once. There were 2.1 additional subsequent visits, on average, over the course of approximately 8-15 months, of which 0.7 were for non-health services. Overall, we found few differences in significance, magnitude and sign of estimated impacts when comparing to the placebo (HU) or the non-encouraged (NP) groups.

Table 6 reports the impacts of CM on the utilization of public services using the aggregate index of 20 public services, along with sub-indices by type of services offered, and life satisfaction. The results show that CM increased the use of public services by 0.53 standard deviations compared to the non-promoted group, with significant and large effects in the realm of reproductive and sexual health, and legal services to support victims of patrimonial violence or to strengthen economic autonomy. More specifically, CM increased the use of reproductive and health services by 0.48 standard deviations compared to the pure control group. The use of legal services to deal with patrimonial violence or to strengthen economic autonomy increased by 0.29 and 0.35 standard

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deviations, respectively, compared to the control group. We also find positive effects, but only statistically significant compared to the group promoted to HU, on the use of services to promote female employment. On the other hand, we did not find clear evidence in the short run (i.e., 8-15 months after the inauguration of the centers) of a significant increase in the demand for services that support survivors of physical, sexual and/or emotional violence. After the establishment of CM, the center might require time to reach its full potential, and there might be a need to further strengthen some processes and services during the program's initial stages. In either case, the exploration of longer-term impacts is an important avenue for future research. In addition, women who visited CM were between 8 and 10 percentage points more likely to report being satisfied or very satisfied with their life, which is a relative increase of between 10% and 13% over the comparison groups.

Results linked to the placebo control group that received encouragement to visit the local health clinic under the fragmented service delivery model (HU) yield similar but generally larger impacts than the ones described to the pure control group (NP). These differences may be driven by a dissimilar composition of the compliers' groups. To better understand how compliers might differ when comparing to the placebo or pure control groups, we need to recall that the promotion to CM might have two components that can

potentially remove the constraints to comply. The first one is related to the voucher itself, which can compensate for the opportunity cost of going to a center. The second one is information about CM centers (e.g., location). Women in the pure control group (NP) did not receive the voucher, neither the information. On the other hand, women promoted to HU get the voucher and could also receive (not as part of the promotion itself) some information about CM when visiting a local health unit. If that is the case, a group of women who face an information constraint and are promoted to HU might be considered always-takers, while the same group wouldn't be considered as always-takers if promoted to NP. As the proportion of never-takers is not affected, the result is a different composition of compliers.

Consistently with our analysis, the always-takers group is larger when considering HU promotion than when considering NP promotion. Additionally, despite not being statistically significant, point estimates suggest that compliers in the NP group are, on average, less educated and live in worse conditions relative to compliers in the HU comparison. Thus, these two characteristics of compliers under the NP group seem to constrain the ability to use services relative to compliers in the HU case. More details about compliers are presented in subsection 7.2.

Finally, looking at the ITT results, we only found statistically significant effects on the demand for services (Table A2) or the use of them (Table A3) for the CM promotion but not for the HU promotion. This suggests that the CM service delivery model, and not encouragement, caused the observed effects.

8.2. Compliers Analysis

To better understand the subgroup of women we are making inferences about and properly interpret our TOT estimates, we characterized the groups of compliers and non-compliers in our IV analysis. Following the decomposition by Marbach and Hangartner (2020), Table 7 shows group means and differences of some sociodemographic variables for compliers, never-takers, and always-takers. In our sample, approximately half of the women would attend a CM center if promoted to go (compliers). Around 15% would go regardless of receiving the incentive or not (always-takers), and 35% wouldn't attend even if promoted to go (never-takers). Regarding sociodemographic characteristics, complier women are, on average, closer to always-takers than to never-takers. Compliers are, on average, two to three years older, are less educated compared to non-compliers, and have more children. Having more children is particularly relevant because it might indicate the

relevance of CM centers' childcare to attract women. Also, compliers are more likely to

be affiliated to a social security system and to live in worse conditions than never takers.

In a similar analysis, Table 8 reports differences for services' use indices at baseline

between compliers and non-compliers. Overall, during the 12 months before the baseline

survey, compliers used fewer services than always-takers but used more services relative

to never-takers.

The largest difference between the three groups can be observed in the use of

services for survivors of physical, sexual, or emotional violence. One reason that could

explain the uneven use of these services is a different level of need to use those services

between groups. To test that, we analyzed the balance in women's self-reported level of

intimate partner violence (results not shown), and we found no statistically significant

differences between the three groups.

In this way, there is a small group of women (15%) that have been using more

services relative to the rest and would assist to a CM center even without being

encouraged (always-takers). The reason might be because they face fewer information

constraints and the expected return of attending a CM center is higher than their

alternative cost. Always-takers might face fewer alternative costs than compliers because,

on average, they have fewer children, and therefore don't need daycare or they might

already have someone to leave them with. There is a second group of women (35%) who won't go to CM if promoted (never-takers) and are different from compliers and always-takers. They live in better conditions, have more education, and previously used fewer services. With higher opportunity costs, never-takers might not find the value of the voucher or the free services provided in the CM centers attractive enough. These possible explanations gain strength when we observe that never-takers have a statistically significant higher probability of being covered by a health insurance (results not shown) and have fewer children than compliers, making the need for childcare a non-binding restriction.

Finally, 50% of women for whom we infer effects when interpreting the TOT are compliers, i.e. those who only assist to a CM center if encouraged. They are, on average, older, less educated than non-compliers, and importantly, have more children. Compliers could face a combination of information constraints (not knowing where to access these types of services) and a higher alternative cost of attending any type of centers. Thus, the promotion may have removed the information restriction, and similarly, the voucher value combined with childcare availability within the CM centers may have generated a positive net balance between the costs and benefits of visiting a CM center.

As a result, we conclude that the CM model is more attractive for the most vulnerable group of women and those who didn't have childcare available. These findings hold when considering the placebo or the control group as comparison in the IV model.

8.3. Additional Findings

To better understand how CM may be leading to increased utilization of services, we conducted additional analyses of impacts on our main outcomes by women's baseline socioeconomic condition, years of education, age, and the number of children below 12 years of age living in the household. Instrumental Variables (TOT) heterogeneity effect estimates are presented in Tables 9 and 10 for all the main outcomes.

When we examine heterogeneous effects for the number and the probability of having subsequent visits to CM, the TOT effects reported in Table 9 are significant for years of education, but not for socioeconomic status, age, or the number of children in the household. Women with more years of education were less likely to have a subsequent visit to a CM center and had fewer visits to the centers compared to women in the control and placebo groups. Also, despite not being statistically significant, point estimates suggest a greater propensity to visit a CM center for those women with a higher socioeconomic index (i.e., living in worse conditions).

Similarly, In Table 10, we observe that the estimated TOT on service utilization increases significantly with women's age. This heterogeneous effect by age on the aggregate index of public services is explained, as shown in column I.1, by a larger use of reproductive and health services by older women. We didn't find statistically significant differentiated effects by socioeconomic index, the years of education, or the number of children in the household. Nevertheless, point estimates suggest a lower use of services by women who live in worse conditions and have more children below 12 years of age in the household.

In a similar exercise, we report ITT heterogeneous estimates on the demand and the use of public services in the Appendix Tables A4 and A5, respectively. As expected, the estimated effects mirror the heterogeneity results found for TOT. The statistically significant and positive effect of the promotion to CM on the probability and number of visits to CM decreases in magnitude with the women's years of education. There also appears to be a positive differentiated effect of the promotion on the likelihood of going to a CM center by age. Regarding the use of services, again, we only found a statistically significant heterogeneous effect of the promotion to CM by age, which is also explained by higher use of sexual and reproductive health services by older women.

We additionally present the statistically significant heterogeneous ITT estimates graphically (Figures 2 and 3). Specifically, we show linear fit lines for each of the three promotion groups. The y-axis shows the individual difference between the second- and first-period's output, while in the x-axis is the heterogeneity variable. Therefore, the vertical differences between two lines represent the corresponding FE ITT estimator through all values of the heterogeneity variable. For example, Figure 2 shows significant positive differences between women promoted to CM and both the placebo and the control groups on the probability of having a subsequent visit to CM throughout all levels of education. The CM fitted line has a negative slope, so the difference (i.e., the ITT) becomes smaller as years of education increase. On the other hand, Figure 3 shows an analogous relationship between the change on aggregate use of services and women's age. The estimated ITT effects are not statistically different to zero for women below 30 years of age, while it becomes statistically significant and increasing with age for women older than 30.

These results are consistent with the CM model's objective of making services more accessible to the more vulnerable segments of the population who face significant barriers to accessing services, whether those were the cost of time, transport, opportunity cost of childcare or lack of knowledge, information and experience with social services. Overall,

we conclude that CM centers have had larger impacts on the service demand and utilization for what might be characterized as the more vulnerable groups of less educated and older women.

As discussed in our general findings in section 8.1, the increase in the use of the aggregate level of services caused by CM is explained by higher use of sexual and reproductive health services, legal services for victims of patrimonial violence, and legal services to strengthen women's economic autonomy. To better understand which specific services boosted the aggregate use of services, we examined the isolated short-term impact of CM on the utilization of each public service considered in these three services categories. Tables A6, A7 and A8 in the Appendix report these results.

The services that stand out in sexual and reproductive health are the cytology/Pap and the mammography tests; women who attended CM were 26 and 14 percentage points more likely to perform a cytology/Pap or a mammography test in the last 12 months, respectively (Appendix Table A6). The results also suggest that women who visited CM used the services of cytology/Pap 46% more in reference to the comparison group (82% vs. 56%, respectively). Moreover, the increase in the use of mammography services between the treatment and control group was about 200% (21% vs. 7%, respectively). The effect on the other three services, focused on pregnant women, were either not

statistically different to zero or negative. We consider that these last results should be taken with caution, since our sample was not designed to make inference for the specific subgroup of pregnant women.

Concerning legal services to support victims of patrimonial violence, the services that present higher impacts are those related to the request of paternity acknowledgement of children and the legalization of property/assets (Appendix Table A7). Specifically, the effect of visiting the CM centers on receiving help to request paternity acknowledgment of children is a 5 percentage-points increase compared to the placebo group (an increase of more than 300% over a base of 1.2%). The effect is similar in magnitude for the use of services for the legalization of assets and property. As shown by the stepwise multiple testing p-value, none of these effects are statistically significant when comparing to the pure control group.

Regarding services to strengthen economic autonomy, the two services provided; the application for a woman's birth certificate or identification card (ID), and for obtaining a birth certificate, show positive and statistically significant results (see Table A8 in the Appendix). Services to help obtain a birth certificate and an ID were used over 2.5 times more by women who visit the CM centers with respect to the comparison group (7.6% vs. 3.0% and 11.3% vs. 4.0%, respectively). These results are important, as having

these certificates allows women to access relevant economic services, such as opening bank accounts, requesting credit, among others. On the other hand, reflecting the results obtained when using the aggregate indices, we did not find clear evidence of larger demand for each isolated service related to the promotion of female employment or the support for survivors of physical, sexual and/or emotional violence (Appendix Tables A9 and A10).

Finally, even though our data covers only one year of operation of the CM centers, we estimated the impact of CM on a set of women's outcomes that could be affected by using the public services considered in this study. For example, Appendix Tables A11 and A12[15] show estimated results for the use of contraception methods and being on treatment for a group of common health conditions like diabetes, respectively. Also, Appendix Tables A13 to A15 show estimations for labor outcomes, having experienced intimate partner violence, and female empowerment. We do not find significant effects on any of the variables included in the analysis. It is important to contextualize these results within the limited time elapsed between the opening of the three CM centers and the follow-up survey.

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[15] This table shows the cross-section specification results because the health conditions were asked in the follow-up survey but not in the baseline survey.

9. Conclusion

This study represents the first rigorous evaluation of an OSS model specifically designed to cater to women's needs in a developing country context. By employing a randomized encouragement design, we assessed the impact of CM on service utilization and subjective well-being among women in El Salvador. Our findings reveal that the integrated services provided through CM centers significantly increase the use of public services, particularly in areas related to sexual and reproductive health care, legal support for victims of patrimonial violence, and services aimed at strengthening economic autonomy.

Approximately one-year post-intervention, women encouraged to visit CM centers showed a 10% increase in self-reported well-being and a 0.53 standard deviation increase in service use compared to control groups. The most substantial effects were observed in reproductive and sexual health services (0.48 SD), legal services for victims of patrimonial violence (0.29 SD), and legal services to strengthen economic autonomy (0.35 SD). The CM model proved particularly effective for older, less educated, and lower-income women, indicating its potential to target the most vulnerable populations. However, no significant short-term effects were found on female employment services or support for survivors of

physical, sexual, and emotional violence, suggesting these areas may require more time to show measurable impacts or further programmatic adjustments.

Evaluating the short-term impact of the CM approach is crucial as it provides initial insights into the effectiveness of integrating services to address women's multiple needs. From a policy perspective, this approach introduces several crucial elements to the provision of public services for women. First, it reduces the economic opportunity cost for beneficiaries by concentrating multiple services in one location, thereby saving time and money. Second, the integrated woman-focused approach allows for coordinated and customized service delivery, enhancing inter-institutional coordination and service quality. These insights are essential for making informed decisions about further investments and adaptations of the CM model in different regions and contexts.

Our study contributes to the literature gender equality policies by using an experimental approach to obtain causal impacts of the CM program. Overall, the findings suggest that the OSS model effectively boosts the demand of essential services among women. These results provide valuable insights for policymakers aiming to improve the efficiency and equity of public services delivery, emphasizing the importance of addressing barriers to access and tailoring services to the needs of vulnerable populations. However, further research is needed to explore the longer-term impacts of this approach. Future

studies should focus on understanding the effects of OSS models on female employment and support for survivors of physical, sexual, and emotional violence, as well as the sustained benefits of integrated service delivery.

REFERENCES

Annenberg, D. (2006). Poupatempo program: the citizen service center and its innovations. World Bank, E-Development Services Thematic Group.

Askim, J., Fimreite, A. L., Moseley, A., & Pedersen, L. H. (2011). One-stop shops for social welfare: The adaptation of an organizational form in three countries. Public Administration, 89(4), 1451-1468.

Bent, S., Kernaghan, K., & Marson, D. B. (1999). Innovations and good practices in single-window service. Ottawa: Canadian Centre for Management Development.

Bussell, J. L. (2010). Why get technical? Corruption and the politics of public service reform in the Indian states. Comparative Political Studies, 43, 1230–1257.

CEPAL, NU. (2019). Social Panorama of Latin America 2019. ECLAC.

Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R., & Watts, C. (2012). An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC public health*, *12*(1), 1-10.

Dean, T. B. M. (2011). Joint service delivery in federal countries: Research report prepared for the forum of federation. Forum of federation. *The global network on federalism*.

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: what does the evidence say?. The Lancet, 385(9977), 1555-1566.

Esteves de Araújo, J. F. (2001). Improving public service delivery: The crossroads between NPM and traditional bureaucracy. Public Administration, 79, 915–932.

Fiszbein, A., & Schady, N. R. (2009). Conditional cash transfers: reducing present and future poverty. World Bank Publications.

Fredriksson, A. (2020). One stop shops for public services: evidence from citizen service centers in Brazil. Journal of Policy Analysis and Management, 39(4), 1133-1165.

Frisancho, V. y Queijo Von Heideken, V. (2022). Closing Gender Gaps in the Southern Cone: An Untapped Potential for Growth. Inter-American Development Bank, Washington, DC.

Glennerster, R., & Takavarasha, K. (2013). Running randomized evaluations. Princeton University Press.

Griffiths, C., Gerressu, M., & French, R. S. (2008). Are one-stop shops acceptable? Community perspectives on one-stop shop models of sexual health service provision in the UK. *Sexually transmitted infections*, *84*(5), 395-399.

Jerome Gallagher, L., Struyk, R. J., & Nikonova, L. (2003). Savings from integrating administrative systems for social assistance programmes in Russia. *Public Administration and Development: The International Journal of Management Research and Practice*, *23*(2), 177-195.

Kernaghan, K. (2009). Moving towards integrated public governance: improving service delivery through community engagement. *International Review of Administrative Sciences*, *75*(2), 239-254.

Kling, J. R., Liebman, J. B., & Katz, L. F. (2007). Experimental analysis of neighborhood effects. *Econometrica*, *75*(1), 83-119.

Kochar, C. (2009) Citizen Service Bureaus: Making Governance Accessible. In Delhi Citizens Handbook, 2009. https://ccs.in/sites/default/files/2022-08/book_dch_2009.pdf

International Labour Organization (ILO). (2016). A one-stop shop for accessible, transparent and efficient public service delivery. Geneva, Switzerland: ILO Social Protection Department.

Liang, M., Simelane, S., Fillo, G. F., Chalasani, S., Weny, K., Canelos, P. S., ... & Snow, R. (2019). The state of adolescent sexual and reproductive health. *Journal of Adolescent Health*, *65*(6), S3-S15.

Marbach, M., & Hangartner, D. (2020). Profiling Compliers and Noncompliers for Instrumental-Variable Analysis. *Political Analysis*, *28*(3), 435-444.

Marson, B., & Heintzman, R. (2009). From research to results: A decade of results-based service improvement in Canada.

Organisation for Economic Co-operation and Development (OECD) (2023), "Gender Equality: Gender equality in entrepreneurship (Edition 2022)", *OECD Social and Welfare Statistics* (database), https://doi.org/10.1787/a7e7d758-en (accessed on 10 June 2024).

Osborne, D. (1993). Reinventing government. *Public productivity & management Review*, 349-356.

Pfeil, H., Schott, B., & Agarwal, S. (2017). Recent Developments and Key Considerations Impacting the Operations of One-Stop Shops for Citizens. The World Bank.

Post, D., & Agarwal, S. (2011). Citizen Service centers: enhancing access, improving service delivery, and reducing corruption (No. 63891, pp. 1-24). The World Bank.

Price Waterhouse and Coopers (PWC). (2012). Transforming the citizen experience One Stop Shop for public services. Public Service Research Centre, Price Waterhouse Coopers. https://www.pwc.com/gx/en/government-public-sector-

research/pdf/one-stop-shop-2016.pdf (Accessed on 10 June 2024).

Romano, J. P., & Wolf, M. (2005). Stepwise multiple testing as formalized data snooping. *Econometrica*, *73*(4), 1237-1282.

Singh, Janmejay. "One Window Service Systems: Some Global Examples and Lessons of Relevance to Cambodia." Powerpoint Presentation, 2008.

Solon, G., Haider, S. J., & Wooldridge, J. M. (2015). What are we weighting for?. Journal of Human resources, 50(2), 301-316.

Swiss Agency for Development and Cooperation (SDC). (2010). One Stop Shops—in the service of the population of Vietnam. How good governance can cut bureaucracy. Bern, Switzerland: SDC East Asia Division.

UNICEF, Prevention Collaborative and Equimundo (2023). Parenting Programmes to Reduce Violence against Children and Women. Why it is important. Brief 1.

Urquidi, M., & Chalup, M. (2023). The Gender Earnings Gap in Latin America and the Caribbean: An analysis of its components, IDB-TN-2650, Inter-American Development Bank.

Wimmer, M. A. (2002). Integrated service modelling for online one-stop government. Electronic Markets, 12(3), 149-156.

World Health Organization. (2021). *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*. World Health Organization.

TABLES

Table 1. Public Services Considered in the Aggregate Service Index, by Area

Sexual and reproductive health services	- Had a cytology/Pap in the last 12 months - Had a mammography in the last 12 months - Had a prenatal checkup for women who have an actual pregnancy/have given birth in the last 12 months - Had a dental checkup for women who have an actual pregnancy/ have given birth in the last 12 months - Had a postnatal checkup for women who have given birth in the last 12 months
Services to promote female employment	- Requested or received job training sessions in the last 12 months - Requested or received job placement services (registration in job opportunities, assistance to prepare CV or help for a job interview) in the last 12 months - Requested or received orientation to start or improve their own business in the last 12 months - Requested or received credit/monetary support to open or expand a business in the last 12 months
Psychological, medical and legal services for survivors of physical, sexual and/or emotional violence	- Sought/received emotional support in the last 12 months - Sought/received legal support in the last 12 months - Sought/received injunction for protection in the last 12 months - Sought/received medical aid in the last 12 months - Sought/received transportation support in the last 12 months - Sought/received support to file a complaint in the last 12 months
Legal services for victims of patrimonial violence	- Received help for the acknowledgment of the paternity of their children in the last 12 months - Received help for food fees in the last 12 months - Received help for legalization of property/assets in the last 12 months
Legal services to strengthen economic autonomy	- Received help to obtain her identification document (ID) in the last 12 months - Received help to obtain her birth certificate in the last 12 months

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Table 2. Balance of Women's Socioeconomic Characteristics

	Mean				Difference		Difference (%)	
	CM	HU	NP	EHPM	CM - HU	CM - NP	CM - HU	CM - NP
	($N = 1,297$)	($N = 1,282$)	($N = 1,267$)	($N = 1,978,692$)				
Age	36.693	36.417	36.762	35.627	0.276	-0.070	0.8	-0.2
	(0.426)	(0.423)	(0.406)		(0.602)	(0.569)		
Head household	0.258	0.269	0.258	0.219	-0.011	0.000	-4.0	0.1
	(0.014)	(0.015)	(0.014)		(0.020)	(0.020)		
Married or with a partner	0.609	0.545	0.573	0.521	0.064***	0.036	11.7	6.3
	(0.017)	(0.017)	(0.018)		(0.023)	(0.025)		
Partner lives in the household	0.589	0.524	0.552		0.065***	0.037	12.4	6.7
	(0.018)	(0.017)	(0.018)		(0.024)	(0.024)		
N alive born children	2.459	2.302	2.411		0.157	0.048	6.8	2.0
	(0.078)	(0.075)	(0.067)		(0.108)	(0.098)		
N children 0-5 years old living in the household	0.324	0.310	0.309		0.014	0.015	4.5	4.9
	(0.017)	(0.018)	(0.018)		(0.024)	(0.025)		
N children 6-15 years old living in the household	0.453	0.432	0.433		0.021	0.020	4.9	4.6
	(0.022)	(0.021)	(0.023)		(0.030)	(0.030)		
Literate	0.884	0.916	0.902	0.880	-0.032**	-0.018	-3.5	-2.0
	(0.011)	(0.010)	(0.010)		(0.014)	(0.015)		
Years of education	7.872	7.858	7.673	7.869	0.014	0.199	0.2	2.6
	(0.189)	(0.188)	(0.164)		(0.232)	(0.209)		
Employed	0.577	0.624	0.569		-0.047**	0.008	-7.5	1.4
	(0.016)	(0.017)	(0.017)		(0.023)	(0.022)		
Labor income (IHS)	3.297	3.465	3.219		-0.167	0.079	-4.8	2.4
	(0.099)	(0.105)	(0.103)		(0.144)	(0.137)		
Affiliated to a public or private social security system	0.158	0.167	0.157		-0.009	0.001	-5.6	0.4
	(0.013)	(0.014)	(0.015)		(0.020)	(0.019)		
Socioeconomic index	0.193	0.182	0.197	0.199	0.011	-0.004	5.9	-2.1
	(0.009)	(0.009)	(0.010)		(0.008)	(0.008)		
Household owner	0.598	0.638	0.625		-0.040*	-0.027	-6.2	-4.3
	(0.016)	(0.017)	(0.017)		(0.022)	(0.022)	0.8	-0.2

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. EHPM = Multipurpose Household Survey 2013.

Socioeconomic index is average of indicators: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table 3. Balance of Outcome Variables

	Mean			Difference		Difference (%)	
	CM	HU	NP	CM - HU	CM - NP	CM - HU	CM - NP
	($N = 1,297$)	($N = 1,282$)	($N = 1,267$)				
Aggregate index of public services	0.051	0.056	0.060	-0.006**	-0.010***	-10.0	-16.3
	(0.002)	(0.002)	(0.002)	(0.003)	(0.003)		
Index of sexual and reproductive health services	0.136	0.133	0.147	0.003	-0.012	2.3	-7.9
	(0.005)	(0.005)	(0.006)	(0.007)	(0.008)		
Index of services to promote female employment	0.021	0.027	0.023	-0.006*	-0.002	-21.5	-7.5
	(0.002)	(0.003)	(0.003)	(0.003)	(0.004)		
Index of psychological, medical and legal services for survivors of physical, sexual, and/or emotional violence	0.019	0.018	0.019	0.001	0.000	7.3	1.9
	(0.004)	(0.003)	(0.003)	(0.004)	(0.005)		
Index of legal services for victims of patrimonial violence	0.021	0.030	0.029	-0.010**	-0.008*	-31.4	-28.5
	(0.003)	(0.003)	(0.003)	(0.005)	(0.005)		
Index of legal services to strengthen economic autonomy	0.036	0.077	0.090	-0.042***	-0.054***	-54.0	-60.4
	(0.005)	(0.008)	(0.009)	(0.009)	(0.011)		
Very Satisfied/Satisfied with life in general	0.801	0.826	0.824	-0.025	-0.024	-3.0	-2.9
	(0.012)	(0.012)	(0.012)	(0.017)	(0.017)		

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, Women older than 40 years old.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children; Has received help for legalization of property/assets; Has received help for food fees.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table 4. Instrumental Variables First-Stage

| | Fixed Effects | | Cross-Section | |
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
	Dep. Variable: Visited CM			
Promoted to CM	0.452***	0.469***	0.455***	0.473***
	(0.020)	(0.020)	(0.019)	(0.020)
F-statistic	521.4	551.8	563.2	548.3
Partial R-squared	0.220	0.239	0.226	0.243
N	5,158	5,128	2,574	2,560

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

Cross-Section: Baseline covariates included; age, head of household, has a couple, couple lives in the household, N rooms in household, N children, N children < 5 living in household, literate, years of education, socioeconomic index, owner of house, employed, labor income, affiliated to a public or private social security system, and the dependent variable in baseline.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$

Table 5. Impacts on Demand

		Instrumental Variables Second Stage							
		(I)		(II)		(III)		(IV)	
		Probability to have a subsequent visit to CM		Number of subsequent visits to CM		Probability to have a non-reproductive health subsequent visit to CM		Number of non-reproductive health subsequent visits to CM	
		CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Fixed Effects	Visited CM	0.678***	0.676***	2.023***	2.191***	0.371***	0.356***	0.622***	0.713***
		(0.027)	(0.027)	(0.222)	(0.199)	(0.027)	(0.027)	(0.144)	(0.128)
		[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]
	Control Group's Mean	0.084	0.074	0.373	0.259	0.059	0.06	0.212	0.158
	Anderson-Rubin test (p-value)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128
Cross-Section	Visited CM	0.671***	0.672***	2.027***	2.190***	0.363***	0.350***	0.641***	0.721***
		(0.028)	(0.027)	(0.226)	(0.201)	(0.027)	(0.027)	(0.152)	(0.133)
		[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]	[0.001]
	Control Group's Mean	0.084	0.074	0.374	0.260	0.059	0.060	0.212	0.158
	Anderson-Rubin test (p-value)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
	N	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

Cross-Section: Baseline covariates included; age, head of household, has a couple, couple lives in the household, N rooms in household, N children, N children < 5 living in household, literate, years of education, socioeconomic index, owner of house, employed, labor income, affiliated to a public or private social security system.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table 6. Impact on Use of Social Services and Life Satisfaction

		Instrumental Variables Second Stage												
		(I)		(I.1)		(I.2)		(I.3)		(I.4)		(I.5)		(II)
		Aggregate index of public services (z-score)		Index of sexual and reproductive health services (z-score)		Index of services to promote female employment (z-score)		Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence (z-score)		Index of legal services for victims of patrimonial violence (z-score)		Index of legal services to strengthen economic autonomy (z-score)		Very Satisfied/Satisfied with life in general
		CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Fixed Effects	Visited CM	0.525***	0.516***	0.288***	0.484***	0.257**	0.126	-0.061	-0.105	0.481***	0.290**	0.399***	0.346***	0.107**	0.083*
		(0.119)	(0.113)	(0.110)	(0.101)	(0.110)	(0.131)	(0.125)	(0.110)	(0.128)	(0.124)	(0.154)	(0.131)	(0.043)	(0.044)
		[0.001]	[0.001]	[0.047]	[0.001]	[0.047]	[0.509]	[0.650]	[0.509]	[0.001]	[0.088]	[0.047]	[0.044]	[0.047]	[0.175]
	Control Group's Mean	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.843	0.851
	Anderson-Rubin p-val	0.000	0.000	0.008	0.000	0.020	0.341	0.625	0.340	0.000	0.018	0.008	0.008	0.012	0.054
	N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128
Cross-Section	Visited CM	0.374***	0.286***	0.295***	0.371***	0.145	0.074	-0.025	-0.122	0.375***	0.188*	-0.007	-0.087	0.062*	0.043
		(0.096)	(0.094)	(0.090)	(0.086)	(0.093)	(0.095)	(0.096)	(0.093)	(0.117)	(0.103)	(0.126)	(0.092)	(0.036)	(0.033)
		0.012	0.096	0.019	0.001	0.387	0.774	0.990	0.774	0.017	0.382	0.990	0.774	0.563	0.774
	Control Group's Mean	0.001	0.000	0.000	-0.001	0.001	0.001	0.001	0.000	0.001	0.000	0.001	0.000	0.843	0.851
	Anderson-Rubin p-val	0.000	0.002	0.001	0.000	0.123	0.436	0.796	0.191	0.001	0.067	0.957	0.344	0.082	0.183
	N	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, women older than 40 years old.

Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare CV or help for job interview in the last 12 months, Independent or unemployed women; Orientation to start or expand the business in the last 12 months, Independent or unemployed women; Credit/monetary support to open or expand business in the last 12 months, Independent or unemployed women who applied to a credit or requested monetary support.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children, Women with children; Has received help for legalization of property/assets; Has received help for food fees, Women with children.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

Cross-Section baseline covariates included; age, head of household, has a couple, couple lives in the household, N rooms in household, N children, N children < 5 living in household, literate, years of education, socioeconomic index, owner of house, employed, labor income, affiliated to a public or private social security system, and the dependent variable in baseline.

All observations weighted by the inverse probability of being selected in the sample (IPW). Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values by Romano and Wolf (2015) in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table 7. Compliers and Non-Compliers Sociodemographic Profile

	CM vs. HU					CM vs. NP				
	Mean			Difference		Mean			Difference	
	Compliers	Always-Takers	Never-Takers			Compliers	Always-Takers	Never-Takers		
	(N = 1,228)	(N = 406)	(N = 945)	C - AT	C - NT	(N = 1,283)	(N = 342)	(N = 939)	C - AT	C - NT
Age	38.246	36.554	36.179	1.692*	2.067***	38.702	35.160	36.179	3.542***	2.523***
	(0.465)	(0.765)	(0.556)	(0.895)	(0.725)	(0.467)	(0.867)	(0.520)	(0.985)	(0.699)
Head household	0.288	0.282	0.238	0.006	0.050**	0.273	0.284	0.238	-0.011	0.035
	(0.017)	(0.031)	(0.019)	(0.035)	(0.025)	(0.018)	(0.035)	(0.020)	(0.039)	(0.027)
Married or with a partner	0.625	0.619	0.642	0.006	-0.017	0.651	0.598	0.642	0.053	0.009
	(0.020)	(0.034)	(0.022)	(0.039)	(0.030)	(0.019)	(0.039)	(0.022)	(0.043)	(0.029)
Partner lives in the hh	0.603	0.619	0.619	-0.016	-0.016	0.636	0.574	0.619	0.062	0.017
	(0.020)	(0.035)	(0.023)	(0.040)	(0.030)	(0.019)	(0.039)	(0.022)	(0.043)	(0.029)
N alive born children	2.520	2.604	2.225	-0.084	0.295**	2.683	2.320	2.225	0.363**	0.458***
	(0.082)	(0.137)	(0.093)	(0.160)	(0.124)	(0.077)	(0.147)	(0.095)	(0.166)	(0.122)
N children 0-5 in hh	0.340	0.366	0.352	-0.026	-0.012	0.334	0.343	0.352	-0.009	-0.018
	(0.024)	(0.042)	(0.026)	(0.048)	(0.035)	(0.023)	(0.043)	(0.027)	(0.049)	(0.035)
N children 6-12 in hh	0.510	0.574	0.451	-0.064	0.059	0.533	0.438	0.451	0.095	0.082*
	(0.029)	(0.052)	(0.033)	(0.060)	(0.044)	(0.027)	(0.055)	(0.032)	(0.061)	(0.042)
Literate	0.889	0.941	0.920	-0.052**	-0.031*	0.884	0.893	0.920	-0.009	-0.036**
	(0.012)	(0.017)	(0.012)	(0.021)	(0.017)	(0.012)	(0.023)	(0.013)	(0.026)	(0.018)
Years of education	7.314	7.272	8.815	0.042	-1.501***	7.009	7.503	8.815	-0.494	-1.806***
	(0.199)	(0.294)	(0.227)	(0.355)	(0.302)	(0.185)	(0.355)	(0.226)	(0.400)	(0.292)
Employed	0.619	0.599	0.568	0.020	0.051*	0.578	0.538	0.568	0.040	0.010
	(0.021)	(0.034)	(0.023)	(0.040)	(0.031)	(0.020)	(0.038)	(0.022)	(0.043)	(0.030)
Labor income (IHS)	3.407	3.239	3.344	0.168	0.063	3.201	2.886	3.344	0.315	-0.143
	(0.123)	(0.200)	(0.147)	(0.235)	(0.192)	(0.118)	(0.219)	(0.147)	(0.249)	(0.189)
Affiliated to soc. sec. system	0.127	0.059	0.221	.068***	-0.094***	0.100	0.065	0.221	0.035	-0.121***
	(0.015)	(0.017)	(0.019)	(0.023)	(0.024)	(0.014)	(0.019)	(0.019)	(0.024)	(0.024)
Socioeconomic index	0.191	0.198	0.153	-0.007	0.038***	0.206	0.215	0.153	-0.009	0.053***
	(0.009)	(0.017)	(0.010)	(0.019)	(0.013)	(0.009)	(0.018)	(0.010)	(0.020)	(0.013)
Household owner	0.596	0.609	0.600	-0.013	-0.004	0.611	0.556	0.600	0.055	0.011
	(0.020)	(0.034)	(0.022)	(0.039)	(0.030)	(0.019)	(0.041)	(0.023)	(0.045)	(0.030)

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Socioeconomic index: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water. Decomposition following Marbach and Hangartner (2020). Bootstrap standard errors in parentheses (reps. = 1,000). *** p<0.01, ** p<0.05, * p<0.1

Table 8. Service Use in Baseline for Compliers and Non-Compliers

	CM vs. HU					CM vs. NP				
	Mean			Difference		Mean			Difference	
	Compliers	Always-Takers	Never-Takers			Compliers	Always-Takers	Never-Takers		
	$(N=1{,}228)$	$(N=406)$	$(N=945)$	C - AT	C - NT	$(N=1{,}283)$	$(N=342)$	$(N=939)$	C - AT	C - NT
Aggregate index of public services	-0.058	0.104	-0.174	-0.162*	.116**	-0.053	0.136	-0.151	-0.189**	0.098*
	(0.040)	(0.080)	(0.042)	(0.089)	(0.058)	(0.038)	(0.087)	(0.042)	(0.095)	(0.057)
Index of sexual and reproductive health services	0.049	-0.031	-0.058	0.080	0.107*	-0.003	0.116	-0.081	-0.119	0.078
	(0.042)	(0.071)	(0.043)	(0.082)	(0.060)	(0.040)	(0.081)	(0.041)	(0.090)	(0.057)
Index of services to promote female employment	-0.064	0.110	-0.002	-0.174*	-0.062	-0.025	0.013	0.010	-0.038	-0.035
	(0.040)	(0.091)	(0.047)	(0.099)	(0.062)	(0.038)	(0.083)	(0.045)	(0.091)	(0.059)
Index of psychological, medical and legal services for survivors of physical, sexual, and/or emotional violence	-0.047	0.236	-0.159	-0.283**	0.112**	0.012	0.201	-0.095	-0.189*	0.107**
	(0.035)	(0.104)	(0.028)	(0.110)	(0.045)	(0.038)	(0.095)	(0.034)	(0.102)	(0.051)
Index of legal services for victims of patrimonial violence	-0.073	0.001	-0.085	-0.074	0.012	-0.069	0.030	-0.039	-0.099	-0.030
	(0.038)	(0.081)	(0.038)	(0.089)	(0.054)	(0.037)	(0.071)	(0.042)	(0.080)	(0.056)
Index of legal services to strengthen economic autonomy	-0.067	-0.002	-0.171	-0.065	0.104**	-0.066	-0.011	-0.186	-0.055	0.120**
	(0.036)	(0.067)	(0.033)	(0.076)	(0.049)	(0.034)	(0.077)	(0.032)	(0.084)	(0.047)
Very Satisfied/Satisfied with life in general	0.834	0.748	0.802	0.086**	0.032	0.823	0.728	0.802	0.095**	0.021
	(0.017)	(0.031)	(0.019)	(0.035)	(0.025)	(0.016)	(0.036)	(0.017)	(0.039)	(0.023)

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, Women older than 40 years old.

Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare CV or help for job interview in the last 12 months, Independent or unemployed women; Orientation to start or expand the business in the last 12 months, Independent or unemployed women; Credit/monetary support to open or expand business in the last 12 months, Independent or unemployed women who applied to a credit or requested monetary support.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children, Women with children; Has received help for legalization of property/assets; Has received help for food fees, Women with children.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

Decomposition following Marbach and Hangartner (2020). Bootstrap standard errors in parentheses (reps. = 1,000). *** p<0.01, ** p<0.05, * p<0.1

Table 9. Impacts on Demand. Heterogeneous Effects

	Instrumental Variables Fixed Effects Second Stage							
	(I)		(II)		(III)		(IV)	
	Probability to have a subsequent visit to CM		Number of subsequent visits to CM		Probability to have a non-reproductive health subsequent visit to CM		Number of non-reproductive health subsequent visits to CM	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM × Socioeconomic Index	0.095	0.170	0.701	1.081	0.119	0.165	0.155	0.422
	(0.137)	(0.115)	(1.051)	(0.870)	(0.135)	(0.124)	(0.722)	(0.619)
Visited CM × Years of Educ.	-0.009	-0.013**	-0.064*	-0.099***	-0.010*	-0.014**	-0.019	-0.046
	(0.006)	(0.006)	(0.037)	(0.038)	(0.006)	(0.006)	(0.022)	(0.030)
Visited CM × Years of Age	-0.004	-0.001	0.018	0.023*	0.001	0.003	0.001	0.005
	(0.002)	(0.002)	(0.014)	(0.013)	(0.002)	(0.002)	(0.009)	(0.008)
Visited CM × N Children (0-12) in HH	0.035	0.040	-0.319	-0.201	0.014	0.034	-0.225	-0.045
	(0.028)	(0.025)	(0.227)	(0.175)	(0.029)	(0.026)	(0.155)	(0.118)
Control Group's Mean	0.084	0.074	0.373	0.259	0.059	0.060	0.212	0.158
N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Socioeconomic index: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table 10. Impact on Use of Social Services and Life Satisfaction. Heterogeneous Effects

	Instrumental Variables Fixed Effects Second Stage												
	(I)		(I.1)		(I.2)		(I.3)		(I.4)		(I.5)		(II)	
	Aggregate index of public services (z-score)		Index of sexual and reproductive health services (z-score)		Index of services to promote female employment (z-score)		Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence (z-score)		Index of legal services for victims of patrimonial violence (z-score)		Index of legal services to strengthen economic autonomy (z-score)		Very Satisfied/Satisfied with life in general	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM × Socioeconomic Index	-0.707	0.026	-0.361	0.072	-0.503	0.696	-0.187	0.107	-0.138	-0.294	-0.476	-0.375	-0.044	-0.072
	(0.499)	(0.483)	(0.506)	(0.461)	(0.500)	(0.64)	(0.553)	(0.400)	(0.523)	(0.565)	(0.525)	(0.496)	(0.223)	(0.202)
Visited CM × Years of Educ.	0.008	0.017	-0.019	-0.013	0.017	0.029	-0.029	0.014	0.030	-0.003	0.003	0.029	-0.005	0.000
	(0.025)	(0.028)	(0.023)	(0.023)	(0.024)	(0.035)	(0.029)	(0.029)	(0.027)	(0.027)	(0.040)	(0.028)	(0.010)	(0.011)
Visited CM × Years of Age	0.023***	0.017**	0.027***	0.021**	0.007	0.007	0.012*	0.011	-0.002	-0.005	-0.002	-0.006	0.006*	0.002
	(0.009)	(0.008)	(0.009)	(0.008)	(0.009)	(0.012)	(0.007)	(0.007)	(0.009)	(0.009)	(0.015)	(0.012)	(0.004)	(0.004)
Visited CM × N Children (0-12) in HH	-0.109	-0.073	-0.074	-0.037	-0.066	0.036	-0.067	-0.108	0.082	0.002	-0.007	-0.059	-0.094**	-0.015
	(0.112)	(0.110)	(0.121)	(0.105)	(0.103)	(0.131)	(0.119)	(0.107)	(0.133)	(0.118)	(0.146)	(0.120)	(0.043)	(0.043)
Control Group's Mean	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.843	0.851
N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, Women older than 40 years old.

Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare CV or help for job interview in the last 12 months, Independent or unemployed women; Orientation to start or expand the business in the last 12 months, Independent or unemployed women; Credit/monetary support to open or expand business in the last 12 months, Independent or unemployed women who applied to a credit or requested monetary support.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children, Women with children; Has received help for legalization of property/assets; Has received help for food fees, Women with children.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

Socioeconomic index: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Figure 1. Take-up Rate. Proportion of Women Who Made an Initial Visit to CM Centers
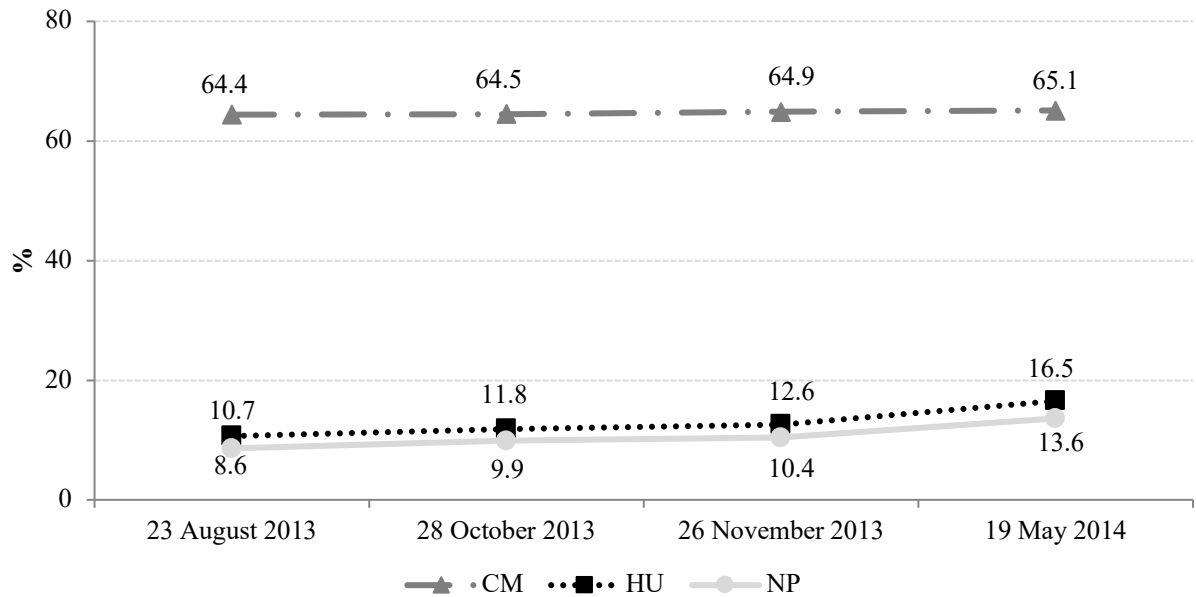
SOURCE: Ciudad Mujer Centers' administrative data.
Notes: CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion. Source: Administrative data from Ciudad Mujer centers.

Figure 2. ITT on The Probability of Having a Subsequent Visit to CM and Women's Education
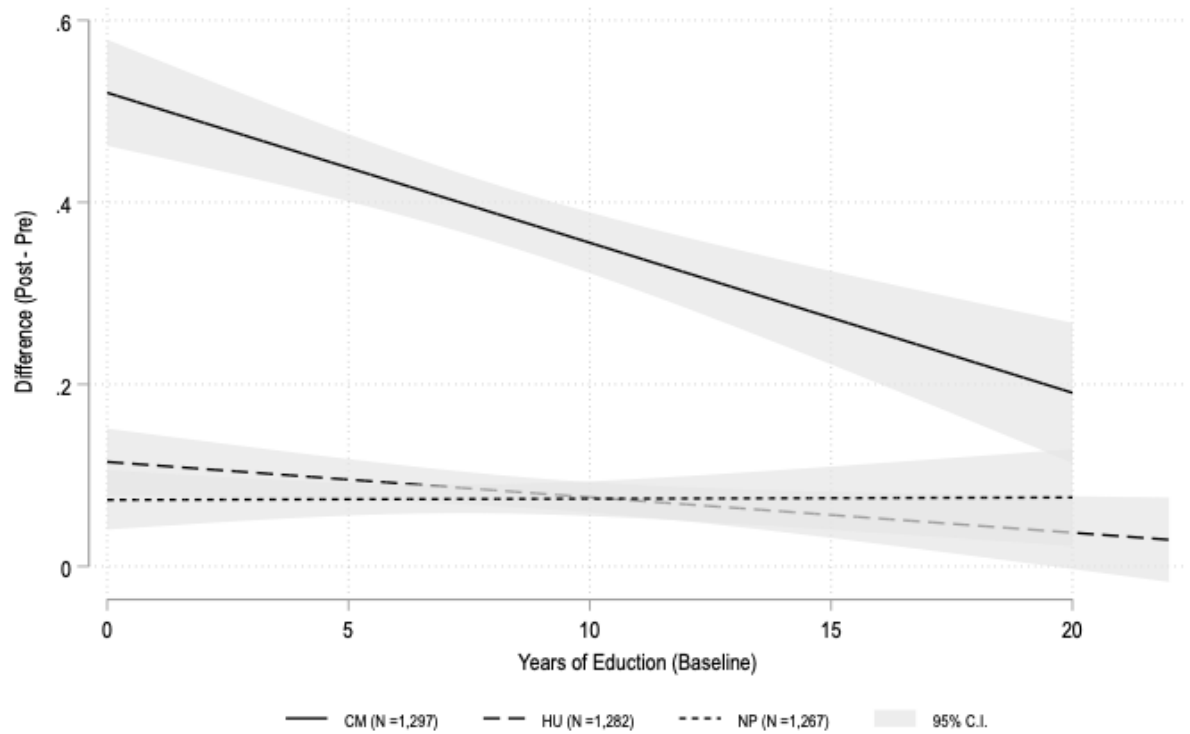
Notes: CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Each fitted line represents the change in the outcome by assignment group. The y-axis shows the second- and first-period outcome difference, so the vertical distance between the solid line and the two other dashed lines represents the corresponding FE (ITT) estimator across the values of the heterogeneity variable.

Figure 3. ITT on Aggregate Services' Index and Women's Age
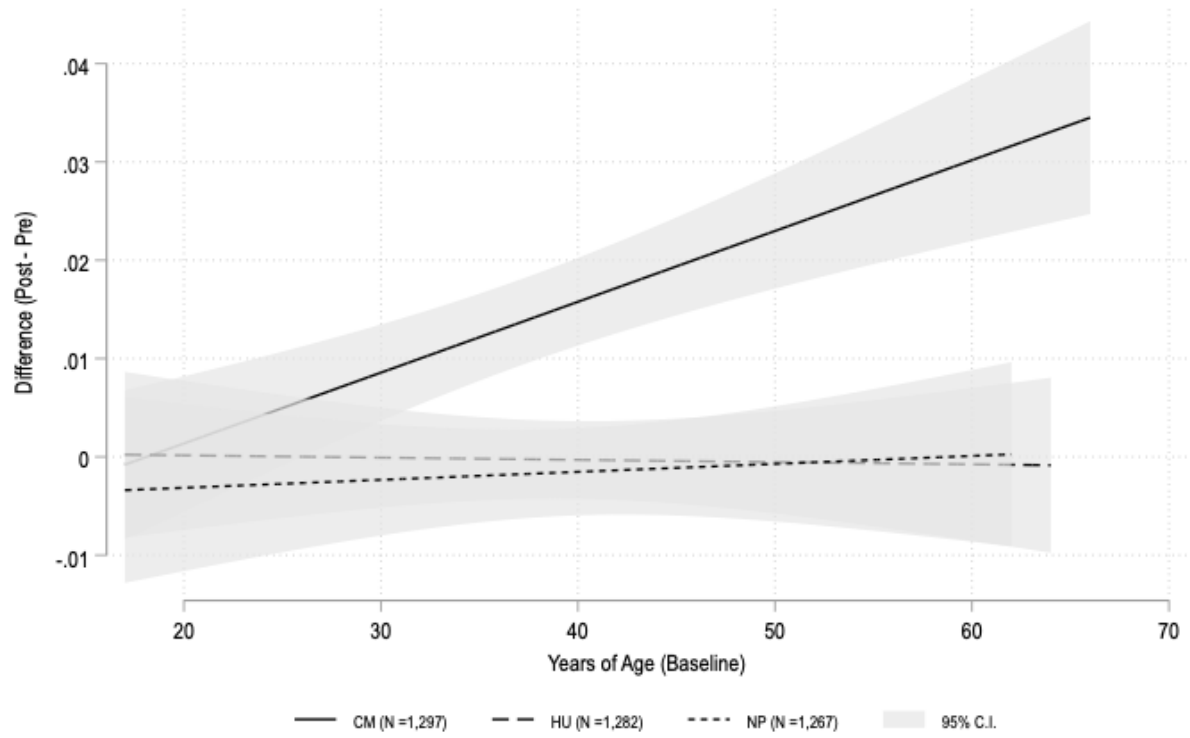
Notes: CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Each fitted line represents the change in the outcome by assignment group. The y-axis shows the second- and first-period outcome difference, so the vertical distance between the solid line and the two other dashed lines represents the corresponding FE (ITT) estimator across the values of the heterogeneity variable.

APPENDIX

	Table A1. Sample Composition and Attrition			
	Promotion Group			Total
	CM	HU	NP	
Original selected sample	1,538	1,539	1,541	4,618
Base Line	1,354	1,353	1,355	4,062
Follow-Up	1,297	1,282	1,267	3,846
Attrition (%)	4.2	5.2	6.5	5.3

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Table A2. Intention-to-Treat (ITT) Impacts on Demand

	Fixed Effects Model			
	(I)	(II)	(III)	(IV)
	Probability to have a subsequent visit to CM	Number of subsequent visits to CM	Probability to have a non-reproductive health subsequent visit to CM	Number of non-reproductive health subsequent visits to CM
Promoted CM	0.317***	1.027***	0.167***	0.334***
	(0.026)	(0.143)	(0.021)	(0.088)
	[0.001]	[0.001]	[0.001]	[0.001]
Promoted HU	0.010	0.113	-0.001	0.054
	(0.015)	(0.098)	(0.013)	(0.068)
	[0.615]	[0.368]	[0.923]	[0.615]
Control Group's Mean (NP)	0.074	0.259	0.06	0.158
N	7,692	7,692	7,692	7,692

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values by Romano and Wolf (2015) in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A3. Intention-to-Treat (ITT) Impacts on Use of Services and Life Satisfaction

	Fixed Effects Model						
	(I)	(I.1)	(I.2)	(I.3)	(I.4)	(I.5)	(II)
	Aggregate index of public services (z-score)	Index of sexual and reproductive health services (z-score)	Index of services to promote female employment (z-score)	Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence (z-score)	Index of legal services for victims of patrimonial violence (z-score)	Index of legal services to strengthen economic autonomy (z-score)	Very Satisfied/Satisfied with life in general
Promoted CM	0.242***	0.227***	0.059	-0.051	0.136*	0.162*	0.039
	(0.073)	(0.065)	(0.088)	(0.074)	(0.082)	(0.086)	(0.029)
	[0.002]	[0.001]	[0.621]	[0.621]	[0.169]	[0.114]	[0.264]
Promoted HU	0.020	0.100	-0.062	-0.027	-0.061	-0.006	-0.009
	(0.070)	(0.067)	(0.085)	(0.062)	(0.074)	(0.103)	(0.031)
	[0.979]	[0.355]	[0.885]	[0.914]	[0.873]	[0.979]	[0.979]
Control Group's Mean (NP)	0.000	0.000	0.000	0.000	0.000	0.000	0.851
N	7,692	7,692	7,692	7,692	7,692	7,692	7,692

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, women older than 40 years old.

Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare CV or help for job interview in the last 12 months, Independent or unemployed women; Orientation to start or expand the business in the last 12 months, Independent or unemployed women; Credit/monetary support to open or expand business in the last 12 months, Independent or unemployed women who applied to a credit or requested monetary support.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children, Women with children; Has received help for legalization of property/assets; Has received help for food fees, Women with children.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A4. Intention-to-Treat (ITT) Impacts on Demand. Heterogeneous Effects

	Fixed Effects Model			
	(I)	(II)	(III)	(IV)
	Probability to have a subsequent visit to CM	Number of subsequent visits to CM	Probability to have a non-reproductive health subsequent visit to CM	Number of non-reproductive health subsequent visits to CM
Promoted CM × Socioeconomic Index	0.216*	0.956	0.150	0.345
	(0.112)	(0.651)	(0.094)	(0.436)
Promoted HU × Socioeconomic Index	0.077	0.359	0.045	0.189
	(0.080)	(0.456)	(0.065)	(0.312)
Promoted CM × Years of Educ.	-0.017***	-0.077***	-0.012***	-0.031*
	(0.005)	(0.025)	(0.004)	(0.018)
Promoted HU × Years of Educ.	-0.004	-0.024	-0.002	-0.015
	(0.004)	(0.026)	(0.003)	(0.017)
Promoted CM × Years of Age	0.003	0.022**	0.003*	0.006
	(0.002)	(0.010)	(0.002)	(0.006)
Promoted HU × Years of Age	0.002	0.005	0.002	0.003
	(0.001)	(0.008)	(0.001)	(0.006)
Promoted CM × N Children	0.040	-0.039	0.028	-0.002
	(0.026)	(0.136)	(0.023)	(0.086)
Promoted HU × N Children	0.031*	0.134	0.025	0.111
	(0.018)	(0.126)	(0.016)	(0.089)
Control Group's Mean (NP)	0.074	0.259	0.060	0.158
N	7,692	7,692	7,692	7,692

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Socioeconomic index: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A5. Intention-to-Treat (ITT) Impacts on Use of Services and Life Satisfaction. Heterogeneous Effects

	(I) Aggregate index of public services (z-score)	(I.1) Index of sexual and reproductive health services (z-score)	(I.2) Index of services to promote female employment (z-score)	(I.3) Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence (z-score)	(I.4) Index of legal services for victims of patrimonial violence (z-score)	(I.5) Index of legal services to strengthen economic autonomy (z-score)	(II) Very Satisfied/Satisfied with life in general
Promoted CM × Socioeconomic Index	0.114	0.130	0.361	0.029	-0.085	-0.114	-0.018
	(0.321)	(0.307)	(0.448)	(0.259)	(0.381)	(0.331)	(0.139)
Promoted HU × Socioeconomic Index	0.339	0.251	0.563	0.104	-0.127	0.037	-0.014
	(0.295)	(0.302)	(0.471)	(0.229)	(0.351)	(0.358)	(0.161)
Promoted CM × Years of Educ.	-0.002	-0.014	0.010	0.008	-0.006	0.006	-0.001
	(0.016)	(0.013)	(0.019)	(0.017)	(0.015)	(0.015)	(0.007)
Promoted HU × Years of Educ.	0.008	-0.002	0.005	0.018	-0.009	0.009	0.002
	(0.016)	(0.012)	(0.018)	(0.016)	(0.014)	(0.022)	(0.007)
Promoted CM × Years of Age	0.011*	0.012**	0.004	0.004	-0.001	-0.001	0.001
	(0.005)	(0.005)	(0.008)	(0.004)	(0.006)	(0.008)	(0.002)
Promoted HU × Years of Age	-0.001	-0.001	-0.001	-0.001	-0.002	-0.001	-0.002
	(0.006)	(0.005)	(0.007)	(0.004)	(0.006)	(0.010)	(0.003)
Promoted CM × N Children	-0.022	-0.005	0.022	-0.055	0.009	-0.020	-0.005
	(0.081)	(0.076)	(0.095)	(0.078)	(0.085)	(0.083)	(0.031)
Promoted HU × N Children	0.032	0.032	0.053	-0.033	-0.013	-0.012	0.041
	(0.078)	(0.072)	(0.094)	(0.081)	(0.076)	(0.096)	(0.034)
Control Group's Mean (NP)	0.000	0.000	0.000	0.000	0.000	0.000	0.851
N	7,692	7,692	7,692	7,692	7,692	7,692	7,692

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Index of sexual and reproductive health services: Prenatal checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Dental checkup in the last 12 months, women who have given birth in last 12 months or currently pregnant; Postnatal checkup in the last 12 months, women who have given birth in last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months, Women older than 40 years old.

Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare CV or help for job interview in the last 12 months, Independent or unemployed women; Orientation to start or expand the business in the last 12 months, Independent or unemployed women; Credit/monetary support to open or expand business in the last 12 months, Independent or unemployed women who applied to a credit or requested monetary support.

Index of psychological, medical, and legal services for survivors of physical, sexual, and/or emotional violence: Sought/received emotional support; Sought/received legal support; Sought/received injunction for protection; Sought/received medical aid; Sought/received transportation support; Sought/received support to put a complaint.

Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of paternity of their children, Women with children; Has received help for legalization of property/assets; Has received help for food fees, Women with children.

Index of legal services to strengthen economic autonomy: Has received help to obtain her ID; Has received help to obtain her birth certificate.

Socioeconomic index: Has a substandard housing (it is not a private or independent house, apartment, or condominium); Materials of the walls are precarious (it is not concrete, brick, or wood); Housing has no water; Housing has no electricity; No private toilet-flush water.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6. Impact on Use of Sexual and Reproductive Health Services

	Instrumental Variables FE Model Second Stage									
	(I)		(II)		(III)		(IV)		(V)	
	Cytology/Pap in the last 12 months		Mammography in the last 12 months		Prenatal checkup in the last 12 months		Dental checkup in the last 12 months		Postnatal checkup in the last 12 months	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.190***	0.257***	0.144***	0.143***	-0.069**	-0.022	-0.056**	-0.029	0.013	0.050*
	(0.054)	(0.051)	(0.028)	(0.028)	(0.028)	(0.027)	(0.024)	(0.020)	(0.022)	(0.026)
	[0.007]	[0.001]	[0.001]	[0.001]	[0.037]	[0.434]	[0.037]	[0.244]	[0.555]	[0.127]
Control Group's Mean	0.563	0.559	0.069	0.067	0.057	0.051	0.041	0.036	0.026	0.030
Anderson-Rubin test (p-value)	0.000	0.000	0.000	0.000	0.013	0.429	0.019	0.144	0.565	0.048
N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A7. Impact on Use of Legal Services for Patrimonial Violence

	Instrumental Variables FE Model Second Stage					
	(I)		(II)		(III)	
	Received help for paternity acknowledgment of children in the last 12 months		Received help for food fees in the last 12 months		Received help for legalization of property/assets in the last 12 months	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.053***	0.032*	0.028	0.033	0.048***	0.022
	(0.019)	(0.017)	(0.018)	(0.020)	(0.017)	(0.020)
	[0.018]	[0.182]	[0.117]	[0.210]	[0.018]	[0.278]
Control Group's Mean	0.012	0.014	0.022	0.026	0.013	0.020
Anderson-Rubin test (p-value)	0.005	0.063	0.120	0.103	0.004	0.267
N	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A8. Impact on Use of Services to Strength Economic Autonomy

	Instrumental Variables FE Model Second Stage			
	(I)		(II)	
	Received help to obtain her ID in the last 12 months		Received help to obtain her birth certificate in the last 12 months	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.124***	0.113***	0.058**	0.076***
	(0.032)	(0.034)	(0.029)	(0.029)
	[0.001]	[0.001]	[0.044]	[0.009]
Control Group's Mean	0.026	0.040	0.026	0.030
Anderson-Rubin test (p-value)	0.000	0.001	0.043	0.008
N	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$

Table A9. Impact on Use of Psychological, Medical, and Legal Services for Survivors of Physical, Sexual, and/or Emotional Violence

	Instrumental Variables FE Model Second Stage											
	(I) Sought/received emotional support		(II) Sought/received legal support		(III) Sought/received injunction for protection		(IV) Sought/received medical aid		(V) Sought/received transportation support		(VI) Sought/received support to put a complaint	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.030	0.006	-0.020	-0.023	-0.006	-0.008	-0.012	-0.017	-0.011	-0.002	-0.011	-0.041*
	(0.020)	(0.020)	(0.021)	(0.020)	(0.011)	(0.015)	(0.012)	(0.014)	(0.009)	(0.009)	(0.020)	(0.021)
	[0.503]	[0.958]	[0.735]	[0.698]	[0.814]	[0.926]	[0.735]	[0.682]	[0.643]	[0.958]	[0.814]	[0.249]
Control Group's Mean	0.018	0.023	0.022	0.027	0.011	0.020	0.007	0.012	0.008	0.004	0.024	0.037
Anderson-Rubin test (p-value)	0.128	0.776	0.354	0.269	0.579	0.580	0.313	0.224	0.207	0.803	0.582	0.052
N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A10. Impact on Use of Services to Promote Female Employment

	Instrumental Variables FE Model Second Stage							
	(I)		(II)		(III)		(IV)	
	Requested/received job training in the last 12 months		Requested/received job placement services in the last 12 months		Requested/received orientation to start or improve own business in the last 12 months		Requested/received credit/monetary support to open or expand business in the last 12 months	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.056***	0.037	-0.005	0.002	0.033***	0.018	0.016	-0.007
	(0.018)	(0.024)	(0.020)	(0.024)	(0.012)	(0.014)	(0.026)	(0.025)
	[0.007]	[0.411]	[0.798]	[0.967]	[0.021]	[0.474]	[0.781]	[0.967]
Control Group's Mean	0.024	0.037	0.037	0.031	0.010	0.016	0.078	0.071
Anderson-Rubin test (p-value)	0.002	0.127	0.805	0.936	0.006	0.194	0.535	0.796
N	5,158	5,128	5,158	5,128	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A11. Impact on Reproductive Health Outcomes

	Instrumental Variables FE Model Second Stage			
	(I)		(II)	
	Uses any contraceptive method (women between 15-49 years of age, sexually active, and not looking for pregnancy)		Uses a modern contraceptive method (women between 15-49 years of age, sexually active, and not looking for pregnancy)	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.054	0.007	0.011	-0.010
	(0.050)	(0.042)	(0.041)	(0.040)
	[0.148]	[0.512]	[0.148]	[0.512]
Control Group's Mean	0.802	0.836	0.265	0.304
Anderson-Rubin test (p-value)	0.279	0.869	0.786	0.797
N	2,912	2,862	2,910	2,860

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A12. Impact on Health Outcomes

	Instrumental Variables (Cross-Section) Second Stage									
	(I) Follows any treatment: mammogram, hypertension, diabetes, overweight/obesity		(II) Received treatment after the problem detected in the last mammogram		(III) Follows treatment for hypertension		(IV) Follows treatment for diabetes		(V) Follows treatment to control overweight/obesity	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Visited CM	0.019	-0.006	0.000	-0.001	-0.001	-0.01	-0.005	-0.015*	-0.029	0.004
	(0.029)	(0.028)	(0.008)	(0.007)	(0.021)	(0.021)	(0.010)	(0.009)	(0.023)	(0.021)
	[0.954]	[0.991]	[0.993]	[0.991]	[0.993]	[0.984]	[0.954]	[0.398]	[0.627]	[0.991]
Control Group's Mean	0.209	0.221	0.017	0.018	0.129	0.145	0.05	0.052	0.093	0.082
Anderson-Rubin test (p-value)	0.523	0.833	0.977	0.912	0.954	0.642	0.599	0.086	0.206	0.846
N	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560	2,574	2,560

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

We report cross-section estimates (instead of FE model) in this table because the information of these five outcomes was only collected in the follow-up survey.

Baseline covariates included; age, head of household, has a couple, couple lives in the household, N rooms in household, N children, N children < 5 living in household, literate, years of education, socioeconomic index, owner of house, employed, labor income, affiliated to a public or private social security system, and an indicator for being diagnosed with the problem/disease in each column.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A13. Impact on Labor Outcomes

	Instrumental Variables FE Model Second Stage					
	(I)		(II)		(III)	
	Employment		IHS Labor Income (Unconditional)		Formal Work (Unconditional)	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Attended CM	0.079*	0.014	0.396	0.155	0.041*	0.041*
	(0.045)	(0.042)	(0.261)	(0.240)	(0.022)	(0.023)
	[0.158]	[0.732]	[0.158]	[0.618]	[0.158]	[0.173]
Control Group's Mean	0.601	0.575	3.338	3.218	0.170	0.159
Anderson-Rubin test (p-value)	0.077	0.734	0.129	0.518	0.064	0.078
N	5,158	5,128	5,136	5,106	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

	Instrumental Variables FE Model Second Stage									
	(I)		(II)		(III)		(IV)		(V)	
	Violence Phys/Sex/Emo/Pat, Couple/Ex, Last 12 months		Violence Phys, Couple/Ex, Last 12 months		Violence Sex, Couple/Ex, Last 12 months		Violence Emo, Couple/Ex, Last 12 months		Violence Pat, Couple/Ex, Last 12 months	
	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP	CM vs. HU	CM vs. NP
Attended CM	-0.031	0.026	-0.001	-0.004	-0.019*	0.003	-0.029	0.014	-0.005	0.007
	(0.025)	(0.027)	(0.014)	(0.017)	(0.010)	(0.010)	(0.023)	(0.024)	(0.019)	(0.019)
	[0.514]	[0.796]	[0.944]	[0.968]	[0.235]	[0.968]	[0.514]	[0.938]	[0.944]	[0.968]
Control Group's Mean	0.037	0.041	0.007	0.015	0.010	0.010	0.024	0.025	0.013	0.017
Anderson-Rubin test										
(p-value)	0.214	0.332	0.914	0.804	0.066	0.752	0.212	0.549	0.77	0.712
N	5,158	5,128	5,158	5,128	5,156	5,126	5,158	5,128	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. Stepwise multiple testing p-values, by Romano and Wolf (2015), in brackets. *** p<0.01, ** p<0.05, * p<0.1

Table A15. Impact on Female Empowerment

	Instrumental Variables FE Model Second Stage	
	Decision making at home index (z-score)	
	CM vs. HU	CM vs. NP
Attended CM	0.147	0.004
	[0.102]	[0.088]
Control Group's Mean	0.000	0.000
Anderson-Rubin test (p-value)	0.149	0.966
N	5,158	5,128

Notes: CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion.

Decision making at home index (woman participates taking decisions about): The children's clothing; The children's education; Health services for the children; Health services for her; Purchase of household assets; Large household repair expenses; If she should work or not.

In all 2SLS estimates, the *Promoted to CM* variable instruments for the second-stage dependent variable *Visited CM*.

All observations weighted by the inverse probability of being selected in the sample (IPW).

Standard errors clustered at PSU level in parentheses. *** p<0.01, ** p<0.05, * p<0.1