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Better Together? The Effects of Integrated Social Services for Women*

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Abstract

We study the effects of integrated social services on the utilization and subjective life satisfaction of women in El Salvador. The Ciudad Mujer "one-stop shop" centers integrate health, legal, employment and other services into a single secure environment for women. These integrated services could boost demand by reducing the cost of access, improving quality and exploiting complementarities in service provision. Using a randomized encouragement design, 4,062 women in the vicinity of three centers 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 who were exposed to Ciudad Mujer through encouragement visited the center an additional 2.1 times, increased the use of public services by 0.47s.d. and reported an improvement of 10% in life satisfaction relative to both the placebo and control groups.

JEL Codes: I38, J16, C93
Keywords: Ciudad Mujer, one-stop shop, social services, women.

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1 Introduction

The modernization and reform of public services in recent decades have been driven by increased demand for a more efficient and accountable government (Osborne, 2006; Osborne, 1993). The new public management of the 1980s and 1990s called for smaller, more competitive, entrepreneurial and integrated governments and public services (Aucoin 1990; Hood, 1991; Hood, 1995), while advocating for the adoption of a more customer-focused, public choice approach centered on accountability for results rather than the process (Osborne and Gaebler, 1992; Hood, 1995; Denhart and Denhart, 2000; Dean, 2011). Public service reforms seeking to improve government efficiency have included privatization, improved measurement, value for money and the integration of government services (Dean, 2011).

This paper reports the effects of an innovative "one-stop shop" model of integrated service delivery for women in El Salvador. Ciudad Mujer (CM) or Women's City concentrates on multiple services for sexual and reproductive health, gender-based violence, legal services and female employment in a single facility accessible only by women. All services offered in CM are existing public programs available through government offices or points of service throughout the country. CM integrated these services in a single location with infrastructure, personnel and attention tailored to women. CM's gender-specific attributes include a safe environment with access to on-site child care and cafeteria facilities. By lowering costs and improving quality, the CM model aimed to boost the utilization of public services for underserved women and to improve their well-being.

We estimate CM's impact on the use of public services and women's subjective well-being using a randomized encouragement design. More than 4,000 women living in the catchment area of three new CM centers were placed in a sample and assigned at random to receive encouragement to attend their local CM center's health clinic (treatment) or the nearest public health center (placebo), or they received no encouragement (control). The encouragement consisted of a $15 voucher redeemable at the nearest CM center (treatment) or public health clinic (placebo). Upon accessing the CM center or public health clinic, women in the treatment and placebo groups could exchange the voucher for a $15 supermarket gift card, valid for use at a national supermarket chain. The encouragement was designed to motivate women to experience CM firsthand and reduce

informational asymmetries regarding the program model. No subsequent visits beyond the first contact with CM were encouraged.

The randomized encouragement to visit CM provides exogenous variation in program participation, which we use in an instrumental variables framework to estimate CM's effects on subsequent service utilization and subjective well-being. Furthermore, the randomized encouragement to a placebo treatment (health center) offered an approximate counterfactual for the alternative utilization of fragmented services and allowed for an indirect test of the exclusion restriction; that is, estimated effects are attributable to CM and not to the encouragement itself.

After 1 year, 60% of women in the treatment group visited CM, compared to 10% in the placebo and control groups. The treatment group had a 66.7 percentage point increase in the probability of returning to CM for more services, with an average of 2.1 subsequent visits, of which 0.7 were for non-health services. These effects on revealed demand suggest that information barriers regarding the existence of CM, how to access services, the nature of those services and the potential benefits could be an important barrier for the use of public services by women.

We measure CM's impacts on the utilization of public services using an aggregated index of 20 services in the realms of sexual and reproductive health, economic autonomy, legal and gender-based violence support services. Our follow-up survey asks women about their use of services independent of location over the past 12 months. We find that CM beneficiaries increased the use of services by 0.47 standard deviations, with significant and large effects in services related to reproductive and sexual health care, legal services to support victims of patrimonial violence and economic autonomy. Finally, women who visited CM are 8.5 percentage points more likely to report being satisfied or very satisfied with their life, which is a relative increase of 10% over the comparison groups. Comparisons to the placebo group, which received encouragement to visit the local health clinic under the fragmented service delivery model, yield identical results to the control group, suggesting that the integrated CM service delivery model, not encouragement, is causing the observed effects on service utilization and subjective well-being.

This study's results are relevant for the design of public service delivery for women. CM offers an integrated response in key areas where the Latin America and Caribbean (LAC) region still faces challenges regarding gender equality. In the region, maternal mortality was 67 deaths

per 100,000 women in 2015 (ECLAC),[1] and pregnancy rates among adolescents (15-19 years old) was 20 points above the world average and more than 40 points above the rate in OECD countries (UNICEF).[2] Although female labor force participation has climbed to 68% over the past half century, the increase was insufficient to close the gap with respect to men, whose participation rate has remained at around 95% (Gasparini and Marchioni, 2015). High levels of occupational segregation by gender also exist, and women's participation is concentrated in low-quality employment (ILO, 2016). Female entrepreneurs face higher barriers compared to their male peers (Klapper and Parker, 2010; Rllis et al., 2010). Furthermore, gender-based violence is widespread. One in three women in LAC experiences physical and/or sexual violence at some point in her life (Bott et al., 2014), and this has a detrimental impact (physical and psychological) on survivors' health. It also increases the likelihood that children will suffer mistreatment, such as physical punishment or negligent/dysfunctional care (Bott et al., 2014; Holt, Buckley, and Whelan, 2008; Gage and Silvestre, 2010). As such, designing effective models to deliver services that benefit women in these areas is of critical policy relevance.

The remainder of the paper is organized as follows. Section II presents the CM model. Section III discusses the methodological framework behind integrated public delivery models. Section IV presents the encouragement design, and section V discusses data sources. Section VI discusses our empirical identification strategy, and section VII presents the main findings. Section VIII concludes our findings.

2 Ciudad Mujer (CM)

The CM program seeks to improve public service delivery for women by providing key services through one-stop-shop centers. The program aims to improve gender equality by providing an integrated response to women's multiple needs in the areas of sexual and reproductive health,

[1] Data downloaded from the ECLAC website on 26 April 2017.
[2] Data downloaded from the UNICEF website on 26 April 2017.

economic autonomy and gender-based violence prevention and care. Each center integrates 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.

Overall, the centers offer more than 30 services, integrating 18 public agencies in a single setting.[3] The sexual and reproductive health module includes a medical team specializing in the areas of gynecology, breast and cervical-uterine cancer prevention, sexually transmitted diseases and family planning. The economic autonomy module provides employment and small and microenterprise support through labor intermediation services, job training sessions, financial education and microcredits. The gender-based violence module offers medical and psychological care, legal assistance and police protection for victims. The module provides services to address physical, sexual, emotional and/or patrimonial violence.[4] The collective education module provides educational services that outreach to communities near CM centers to promote women's rights and prevent gender-based violence. Finally, the centers provide childcare for children up to 12 years old while the mother or caregiver uses the facility services, and an on-site cafeteria with food for purchase is available.

All areas in the centers are oriented toward women. First, all the staff are women, and only women can access the centers. Second, all staff are trained to listen to and treat beneficiaries within a framework that recognizes their rights and gender. Third, each case is managed with an integral vision, personalized service and one-time-only registration, which reduces waiting times and access cost. When a woman arrives at one of these centers, she receives personalized attention: A

[3] For a detailed description of the 18 public agencies included, visit the CM webpage: http://www.ciudadmujer.gob.sv/.

[4] 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, n.d.).

counselor reviews her situation and prepares a plan that enables her to use the services that best meet her needs.

Services are open to the public and are 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.[5] During the writing, the CM program served 485,000 women, representing approximately 14% of the country's female population.[6]

3 Conceptual Framework

Social services, such as health care, policing and employment services, are provided by governments to address some of society's most pressing challenges and to improve the population's well-being (Osbore and Gaeble, 2012). Social services ultimately seek to improve social welfare, even if benefits are captured privately. For example, health services seek to prevent and treat illness and prolong and improve quality of life, policing services seek to reduce violence and crime and employment services seek improve employment opportunities and incomes for beneficiaries. Social services are provided through the public sector in many countries for the purposes of equity and social responsibility. Moreover, where positive spillovers from these services exist that cannot be captured by the market, such as health spillovers from immunizing children or security spillovers from taking a criminal off the streets, public services play an important role in society that the private market alone would not fill.

The provision of public services in many countries is fragmented geographically and organizationally. Agencies serving the same population groups deliver services independently from one other, with different intake, administration and reference procedures. This fragmentation of services requires the displacement of potential beneficiaries to multiple sites, such as to access health care, employment or legal services, to name a few. The cost of accessing these services,

[5] The six centers are 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.
[6] Ciudad Mujer administrative data.

including the opportunity cost of time, transport costs, childcare and personal safety concerns, can be non-trivial and pose a significant barrier. Moreover, the quality of services is varied and may not cater to the beneficiaries' gender-specific needs. Finally, a fragmented provision of services may reduce complementarities and coordination between services.

The barriers to access may be especially high for certain vulnerable groups, such as individuals with special needs or in low-income areas. One such group in many countries is low-income, rural and indigenous women who tend to underutilize critical social services, such as health services during pregnancy and legal services in the context of gender-based violence.[7] To boost demand, governments have focused on innovative demand-side solutions, such as conditional cash transfers that base income transfers on the utilization of specific services, such as health or education (Fiszbein and Schady, 2009). However, less attention has been focused of late on innovative models of service delivery that seek to reduce barriers to access and boost utilization on the supply side.

During the last decades, government modernization initiatives have increasingly included mechanisms to provide public services in a more integrated way (Kernaghan, 2009). One-window or one-stop shop models aim to improve customer service and satisfaction while reducing costs by consolidating bureaucracies and public offices in one space (Dean, 2011). In doing so, these models shift the organizational paradigm from public services structured around the fragmentation of public administration toward a customer-oriented structure of public services (Wimmer, 2002). As their name suggests, one-stop shop models bring government services together in a single location to reduce the amount of time and effort that citizens must expend to find and obtain the services they need. In doing so, they improve accessibility and convenience and overcome jurisdictional divisions (Bent, Kernaghan, and Marson, 1999).

Canada and Australia are considered to be among the global leaders in moving siloed transactional services to common counters (Dean, 2011). This approach has also been used for providing sexual health services in the United Kingdom (Griffiths, 2008), and many OECD countries have adopted this model to provide services in the welfare sector (Askim et al., 2011).

[7] 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 (UnWomen, n.d.).

Another common approach has been establishing one-stop shop centers to provide comprehensive care to women and girls who are victims of gender-based violence. Although such experiences related to violence against women and girls in African or Asian countries have located the centers in hospitals, they are usually designed as stand-alone centers in Latin America (Ellsberg et al., 2015; Colombini et al., 2012).

Three relevant dimensions behind the concept of one-stop shop centers are [i] transactional cost reduction, [ii] increased quality of services by the complementariness of the services provided and [iii] a focus on the beneficiaries' needs. First, making all public services accessible in the same place reduces transaction costs and duplication for beneficiaries, providers and the government. In theory, one-stop shop centers reduce the time, effort and monetary costs that the beneficiaries must expend to access the services they need; from a government or provider perspective, they reduce the costs of establishing separate services and reduce the duplication of activity across agencies (Askim et al., 2011).

Second, one-stop shop centers entail collaboration between different public agencies or entities, improving access to a full range of complementary services. They also have the potential to contribute to better communication in highly complex agencies, thus increasing the quality of the services provided. Finally, one-stop shop centers join various agencies to provide services that are aligned with the complete beneficiary journey. This means addressing agency silos so that the beneficiaries' needs can be served effectively through a single point of contact (Price Waterhouse and Coopers, 2012). For instance, in the case of gender-based violence, the provision of the proper array of services may better prevent or mitigate the negative consequences for survivors. Moreover, women may be more inclined to report abusive situations and seek help in the context of receiving a broader array of services that are customer centric (UnWomen, 2011).

However, despite the initiatives taking place in different parts of the world, the concept of one-stop shop centers is still underdeveloped in the literature, and there is an insufficient evidence base to support their usefulness. For instance, limited rigorous evidence exists of this approach's effectiveness in improving the outputs of interest, such as reducing gender-based violence or mitigating its negative consequences for survivors (Ellsberg et al., 2015; Fulu et al., 2014; Heise, 2011). This paper aims to contribute to such an understanding by providing insight into how this approach performs in the short run. This paper uniquely identifies the impact on the use of public

services by women in providing—under an one-stop shop center approach—a range of services related to sexual and reproductive health, female economic autonomy and gender-based violence. In this respect, this approach has the potential of increasing the demand of services by increasing the quality of services, reducing the opportunity cost of beneficiaries of using widely dispersed public services and providing customer-centric services.

4 Encouragement Design

CM has an "open door" policy of providing services to all women who show up at the center to request a service on a first-come, first-served basis. Given that participation in the program based on spontaneous demand is not random, the identification of treatment effects requires a valid instrument to correct for endogenous treatment. To this effect, the program implemented a randomized encouragement design whereby women between the ages of 18 and 60 years, living in the geographical catchment area of one of three new CMs, would be offered an incentive to visit the nearest CM shortly after the center opened. A second group of women would receive the same incentive to a fragmented service—in this case, the nearest health center—which would serve as a "placebo encouragement."

To design the encouragement strategy, the program hired a marketing specialist to conduct formative research and to design an encouragement strategy 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, 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 visit would then be attributable as effects of the CM model, independent of the initial one-time encouragement.

Members of the experimental group were 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, 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 and control groups. Figure 1 shows that the encouragement resulted in a 50 percentage point increase in initial visits, well above the 10% of women who visit the CM centers based on spontaneous demand. We posit that any effects on social service utilization and related outcomes that take place after the first (encouraged) contact with CM can be considered attributable to CM, independent of the initial encouragement, thanks to lowering initial informational asymmetries regarding the center.

5 Data

The study focused on three CM centers in El Salvador built in the municipalities of San Martin, Santa Ana, and Usulután. The evaluation sample was constructed to be representative of Salvadorian women between 18 and 60 years old living in the 19 municipalities contiguous to the centers, resulting in a total sample of 4,618 women.[8]

[8] The sample selection was identified in four steps: (1) 567 sampling units were randomly selected from 2,212 women in the 19 municipalities with probability proportional to size (households per sample unit); (2) 20 households within each of the 567 units were selected with equal probability; (3) 10 households among the 20 previously selected in each sample unit were selected with probability proportional to the number of eligible women in each household, such as from 18 to 60 years old; and (4) one woman within each of the 10 households in each sample unit was selected with the same probability, for a total of 4,610 women.

Baseline data were collected 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.[9]

A follow-up panel survey was implemented 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 is balanced between the randomized promotion and control groups (see Web Appendix Table A1). The final balanced panel that we use 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. In addition, women were asked to rate their subjective well-being. For the analysis, to measure our sample's utilization of services, we merge our surveyed data with administrative data from CM.

The primary outcome variables are related to the use of public services. We construct both an aggregate index that comprises a total of 20 specialized services on sexual and reproductive health, economic autonomy and gender-based violence support, as well as five sub-indexes that compress services by type. The sub-indexes aggregated services in the following five areas: i) sexual and reproductive health care; ii) promotion of female employment; iii) psychological,

[9] 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.

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:

$$\text{Index}_i = \frac{1}{\text{N}} \sum_{\text{j}=1}^{\text{N}} \text{s}_{\text{ji}}$$

where N is the total number of 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:

$$\text{z-}INDEX_i = \frac{(INDEX_i - INDEX_C)}{SD_C}$$

where $z\text{-}INDEX_i$ is the z-score for *INDEX* in women *i*, $INDEX_C$ is the mean of *INDEX* in the control group and SD_C is the standard deviation of *INDEX* in the control group.

6 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 using an instrumental variables strategy based on random encouragement for an initial CM visit as an instrument for program participation. We specify the two-stage least squares analysis as follows:

$$\text{VisitedCM}_{\text{it}} = \beta_0 + \beta_1 \text{PromotionCM}_{\text{it}} + \gamma_{\text{t}} + \theta_{\text{i}} + \mu_{\text{it}} \qquad (1)$$

$$\text{y}_{\text{it}} = \delta_0 + \delta_1 \widehat{\text{VisitedCM}}_{\text{it}} + \pi_{\text{t}} + \rho_{\text{i}} + \varepsilon_{\text{it}} \qquad (2)$$

where y_{it} is the indicator of interest for women i in period t, γ_t and π_t denote time level fixed effects 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 unobservable characteristics of women that do not change over time. Furthermore, $PromotionCM_{it}$ is a binary variable that captures the assigned encouragement to CM center in period t_0, and μ_{it} and ε_{it} denote idiosyncratic random errors. Standard errors are clustered at the primary sampling unit (PSU) level.

The estimation was conducted in two stages. In the first stage, equation (1) predicts the probability of visiting a CM center according to the randomized promotion group assigned to each individual (Table 4).[10] CM visits are obtained from administrative data sources that record all services rendered in the centers. In the second step, equation (2) shows the estimated impact of having visited CM on subsequent outcomes, denoted by y_{it}. Thus, the coefficient δ_1 in equation (2) is the parameter of interest and represents the local average treatment effect of CM.[11]

We estimate the effects of CM by comparing the treatment group to the placebo and the control groups. Additionally, we estimate the intention to treat effect (ITT) related to the promotion using the full sample and difference-in-differences model (results presented in the Web Appendix):

$$y_{it} = \alpha_0 + \alpha_1 \text{PromotionHU}_{it} + \alpha_2 \text{PromotionCM}_{it} + \omega_t + \varphi_i + \epsilon_{it} \qquad (3)$$

Finally, we implement a stepwise multiple testing method proposed by Romano and Wolf (2005) when the impacts were estimated for individual services used. Multiple testing refers to evaluating several hypotheses simultaneously. Considering the multiplicity of tests, the probability that a certain hypothesis is rejected by pure chance may be too high. To resolve this problem, 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. The stepwise multiple testing method proposed by Romano and Wolf (2005) comprises the estimation using bootstrap resampling of the different specifications, which differ in the

[10] At time t_0, the variable $VisitedCM_{it}$ is 0 for all individuals, whereas it takes a value of 1 at time t_1 for individuals who visited a CM and a value of 0 otherwise.

[11] At time t_0, the variable $PromotionCM_{it}$ is 0 for all individuals, whereas it takes a value of 1 at time t_1 for individuals who received that promotion at t_0 and a value of 0 otherwise.

outcome or dependent variable. Once this is done, for each iteration, the different t-values of the parameter of interest are calculated for each specification (each parameter is a hypothesis to be tested), and the highest t-value of each iteration is extracted. With this, a maximum distribution of t-values is obtained, with several observations equal to the number of repetitions performed. The 90th percentile t-value of the maximum distribution is then obtained, and the original parameters of interest are tested against that critical value. If the hypothesis is rejected, the algorithm starts again but considers successively higher confidence levels (e.g., 95% and 99%) until no hypothesis is rejected.

With the data collected in the baseline survey (*period* t_0), we tested if the characteristics of the treatment, placebo and control groups are on average statistically equal after the randomization process. The lack of balance can arise simply due to chance, even if the random allocation of women to the different groups was implemented correctly. Furthermore, when comparing many different variables between the groups, statistically significant differences will be found in some. 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). Our analysis explores the balance of 37 demographic and socioeconomic variables and 42 outcomes related to sexual and reproductive health, economic autonomy and gender-based violence. Tables 2 and 3 show the number of variables where their means were statistically different between the treatment and placebo and control groups at a 90% significance level. The analysis shows an unbalanced level between groups that is slightly higher than expected based on chance.

To address these differences, we control for baseline differences and all other non-time varying characteristics using a difference-in-differences specification. Thus, the empirical identification strategy exploits both 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. This approach relies on the comparison over time of our indicators of interest in the treatment and comparison groups. The implicit assumption is that unobservable differences in the absence of the program between groups would have similar effects on the indicator of interest over time.

7 Results

7.1 Main findings

A robust and consistent finding is that the provision of integrated services through CM leads to an increased demand for services. Tables 5 and 6 present the paper's main results. Table 5 shows a substantial impact of CM on the demand of public services. We find that women who visit CM have a 66.7 percentage point increase in the probability of returning to the centers one or more times relative to the pure comparison group. The average number of subsequent visits over the course of approximately 8-15 months is 2.1, of which 0.7 are for non-health services. Overall, findings do not show important differences in significance, magnitude and sign when using the placebo or the pure comparison groups. For this reason, Table 6 shows the results in reference to the pure comparison group, whereas Table A8 in the Web Appendix reports the results for the placebo comparison group.

Table 6 reports the impacts of CM on the utilization of public services using the aggregated index of 20 public services on sexual and reproductive health, economic autonomy and gender-based violence support. The results report that CM beneficiaries increase the use of public services by 0.47 standard deviations, 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. Women who visit CM increase the use of reproductive and health services by 0.37 standard deviations compared to the pure control group. The use of legal services to deal with patrimonial violence or to strengthen economic autonomy increases by 0.31 and 0.40 standard deviations, respectively, compared to the control group. We do 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 promote female employment or support survivors of physical, sexual and/or emotional violence. After the establishment of a 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 mid- and long-term impacts is an important avenue for future research.

In addition, women who visit CM are 8.5 percentage points more likely to report being satisfied or very satisfied with their life, which is a relative increase of 10% over the comparison

group. One potential explanation for this result is that the proximity between the different officers within the CM facility leads to a better coordination between different organizations to offer combined services that better address the beneficiary women's needs. Finally, results linked to the placebo control group that received encouragement to visit the local health clinic under the fragmented service delivery model yield identical impacts to the ones described to the pure control group, suggesting that the CM service delivery model, not encouragement, is causing the observed effects on service utilization.

7.2 Additional findings

We also examine the isolated short-term impact of CM on the utilization of each of the 20 public services considered in the aggregated index. Tables A9 through A16 in the Web Appendix report these results. Overall, the findings do not show important differences in significance, magnitude and sign when using the placebo or the pure comparison groups. For this reason, unless some mention to the contrary is made, the description of the results in the following section refers to the pure comparison group.

The services that stand out in the area of sexual and reproductive health are the cytology/Pap or the mammography tests; women who attend CM are 21 and 29 percentage points more likely to perform a cytology/Pap or a mammography test in the last 12 months, respectively (Table A9 in Web Appendix). How large are these effects? The results suggest that women who visit CM use the services of cytology/Pap 36% more often in reference to the comparison group (80% vs. 59%, respectively). Moreover, the increase in the use of mammography services is 162% between the treatment and control groups (47% vs. 18%, respectively).

Concerning legal services to support victims of patrimonial violence, the services that present higher impacts are those related to the request of acknowledgment of paternity or alimony of the children and legalization of property/assets (Table A14 in the Web Appendix). A female beneficiary has a higher probability of 2.4 and 5.4 percentage points of requesting acknowledgment of paternity or alimony of her child, respectively. In addition, a beneficiary woman has a higher probability of 3.3 percentage points of requesting patrimonial recognition. How large are these effects? The demand of legal services related to paternity acknowledgment is two times higher for the treatment than for the pure control group (4.5% vs. 2.1%). We find that

legal services to request alimony for children or patrimonial recognition are about three times higher for women who visit a CM center compared to those who do not visit a center (9% vs. 3% and 5% vs. 2%, respectively).

Regarding services to strengthen economic autonomy, the services that stand out are the application for a woman's birth certificate or identification card (ID) (see Tables A15 and A16 in the Web Appendix). Women who attend CM are 7.8 and 10.9 percentage points more likely to apply for a birth certificate and an ID in the last 12 months, respectively. How large are these effects? Birth certificate and ID applications are requested about five times more by women who visit the centers with respect to the comparison group (10% vs. 2% and 14% vs. 3%, respectively). These results are extremely important, as having these certificates allows women to access relevant economic services, such as opening bank accounts or requesting credit.

Finally, reflecting the results obtained when using the aggregate indexes, we do not find clear evidence in the short run 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 (Tables A11 through A13).

8 Conclusions

This is the first paper that, to our knowledge, measures the impact of a one-stop shop model of service delivery for women on their demand for services and their subjective well-being. We find that, conditional to being exposed to the model through a random encouragement, the provision of services through CM centers increases the use of public services, with particularly large effects in services related to sexual and reproductive health care and legal services to support victims of patrimonial violence or to strengthen economic autonomy. Our identification strategy exploits a placebo-control randomized promotion experiment whereby women near the CM centers are randomly encouraged to visit the health center in either CM (treatment group) or the local public clinic (placebo encouragement group), or they receive no encouragement (pure control group). Approximately 1 year after the initial encouragement, women who attended CM use social services substantially more often and show a 10% increase in self-reported well-being.

A critical reason for studying the short-term impact of the CM approach is that the intervention offers an innovative model for empowering women by providing an integrated response to their multiple needs. From a policy perspective, this approach introduces several new elements to the provision of public services for women. First, by providing multiple services in the same location, the model reduces the economic opportunity cost for beneficiaries of using widely dispersed public services. Concentrating many public services in one location enables women to save time and money when accessing services. Second, the integrated approach allows for the provision of a coordinated and customized package of services to each woman who accesses services in the center, allowing higher interinstitutional coordination and increasing the quality of the services provided.

This paper's results contribute to a growing literature that estimates the impact of specific policies to promote gender equality. Our ability to use an experimental approach allows one to obtain the causal impact of the intervention and confirms that the one-stop shop approach used in the CM program boosts the demand of fundamental services for women. This paper's findings also help advance our knowledge on a broader issue, which is the provision of tools and lessons from practice for improving the efficiency and equity of public services delivery. Nonetheless, additional research going forward includes overcoming the limited evidence that exists regarding the mid- to long-term impacts of this type of approach. In particular, it includes deepening our understanding of the effects of one-stop shops in improving the delivery of services in key areas related to female employment or support for survivors of physical, sexual and/or emotional violence.

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Table 1: Public services considered in the aggregate 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 emotional support in the last 12 months ▪ Sought legal support in the last 12 months ▪ Sought injunction for protection in the last 12 months ▪ Sought medical aid in the last 12 months ▪ Sought transportation support in the last 12 months ▪ Sought 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

Table 2: Balance of socioeconomic characteristics

	Mean			Differences		Differences (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Socioeconomic index	0.185 [0.009]	0.172 [0.008]	0.191 [0.008]	0.014** [0.006]	-0.005 [0.007]	8.14	-2.62	1297	1282	1267
Age	37.345 [0.348]	37.098 [0.324]	37.264 [0.333]	0.247 [0.467]	0.081 [0.460]	0.67	0.22	1297	1282	1267
Head of household	0.266 [0.013]	0.271 [0.012]	0.257 [0.012]	-0.005 [0.017]	0.009 [0.017]	-1.85	3.50	1297	1282	1267
Married or with a partner	0.65 [0.014]	0.611 [0.013]	0.631 [0.014]	0.039** [0.018]	0.019 [0.020]	6.38	3.01	1297	1282	1267
N children 0-5 years old living in the household	0.355 [0.017]	0.342 [0.017]	0.328 [0.016]	0.012 [0.023]	0.026 [0.023]	3.51	7.93	1297	1282	1267
N children 6-15 years old living in the household	0.493 [0.020]	0.504 [0.020]	0.488 [0.020]	-0.011 [0.028]	0.005 [0.027]	-2.18	1.02	1297	1282	1267
Literate	0.896 [0.009]	0.921 [0.008]	0.901 [0.009]	-0.025** [0.011]	-0.005 [0.012]	-2.71	-0.55	1297	1282	1267
Years of education	7.837 [0.155]	7.877 [0.151]	7.632 [0.144]	-0.039 [0.171]	0.205 [0.168]	-0.50	2.69	1297	1282	1267

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Socioeconomic Index: Materials of the walls are precarious; Housing has no water; Housing has no electricity; No private flushable toilet water .

Table 3: Balance of outcome variables

	Mean			Differences		Differences (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Aggregate index of public services	0.052	0.061	0.06	-0.009 ***	-0.008 ***	-14.8%	-13.3%	1297	1282	1267
	[0.002]	[0.002]	[0.002]	[0.002]	[0.002]					
Index of sexual and reproductive health services	0.143	0.144	0.148	-0.001	-0.005	-0.7%	-3.4%	1297	1282	1267
	[0.004]	[0.004]	[0.005]	[0.006]	[0.007]					
Index of services to promote female employment	0.021	0.029	0.022	-0.008 ***	0	-27.6%	0.0%	1297	1282	1267
	[0.002]	[0.003]	[0.002]	[0.003]	[0.003]					
Index of psychological, medical and legal services for survivors of physical, sexual and/or emotional violence	0.018	0.021	0.019	-0.003	-0.001	-14.3%	-5.3%	1297	1282	1267
	[0.003]	[0.003]	[0.003]	[0.004]	[0.004]					
Index of legal services for victims of patrimonial violence	0.021	0.036	0.03	-0.016 ***	-0.010 **	-44.4%	-33.3%	1297	1282	1267
	[0.003]	[0.003]	[0.003]	[0.004]	[0.004]					
Index of legal services to strengthen economic autonomy	0.035	0.077	0.082	-0.042 ***	-0.047 ***	-54.5%	-51.2%	1297	1282	1267
	[0.005]	[0.007]	[0.007]	[0.008]	[0.009]					
Very satisfied/satisfied with life in general	0.791	0.827	0.815	-0.036 **	-0.023	-4.4%	-2.8%	1297	1282	1267
	[0.012]	[0.011]	[0.011]	[0.016]	[0.015]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit 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 for women who have given birth in the last 12 months or are currently pregnant; Dental checkup in the last 12 months for women who have given birth in the last 12 months or are currently pregnant; Postnatal checkup in the last 12 months for women who have given birth in the last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months for women older than 40 years.

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

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

Table 4: Impact on demand and use of services, and life satisfaction

	Instrumental Variables Diff-in-Diff First-Stage Estimations	
	(CM vs. NP)	(CM vs. HU)
	Attended CM * Year	Attended CM * Year
Promoted to CM * Year	0.500***	0.476***
	[0.017]	[0.017]
Kleibergen-Paap rk Wald F Statistic	912.096	790.319
Partial R^2	0.264	0.237
N	5128	5158
Individual-Level FE	Yes	Yes
Year-Level FE	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table 5: Impacts on demand (administrative data)

	Instrumental Variables Diff-in-Diff 2nd-Stage Estimates							
	Probability of having a subsequent visit in CM		Number of subsequent visits to CM		Probability of having a non-reproductive health subsequent visit in 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
Attended CM * Year	0.653***	0.667***	1.875***	2.142***	0.353***	0.352***	0.513***	0.695***
	[0.025]	[0.024]	[0.216]	[0.179]	[0.025]	[0.024]	[0.147]	[0.110]
Control Group's Mean	0.1	0.07	0.45	0.27	0.07	0.06	0.27	0.16
N	5158	5128	5158	5128	5158	5128	5158	5128
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

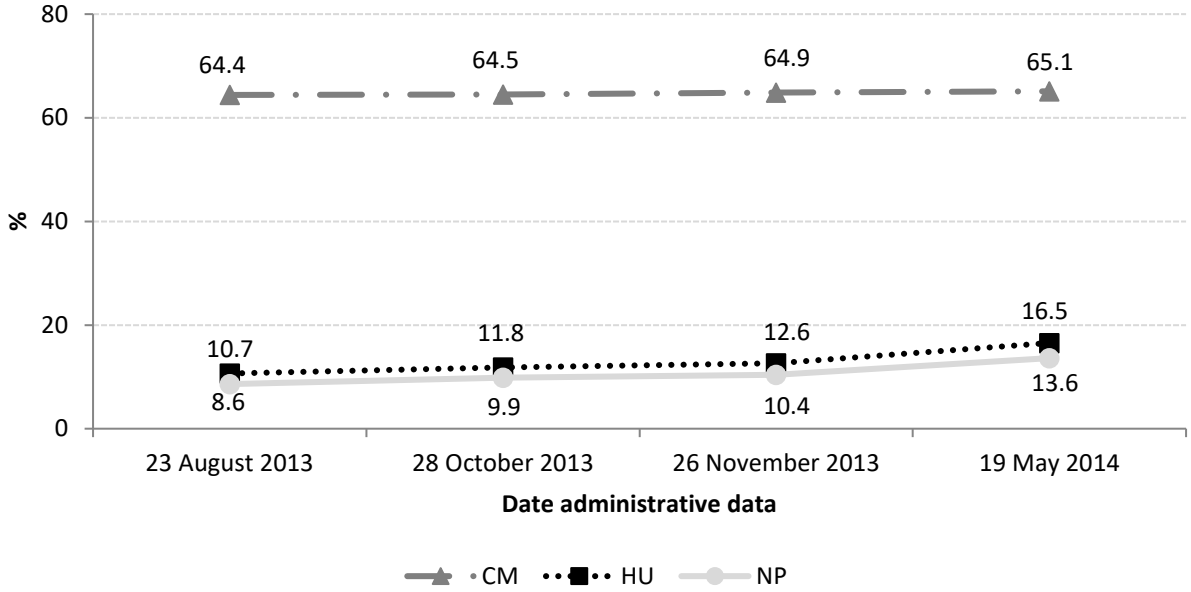
Note: *** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table 6: Impact on the use of services and life satisfaction

	Instrumental Variables Diff-in-Diff Second-Stage Estimations (CM vs. NP)						
	(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
Attended CM * Year	0.473***	0.374***	0.084	-0.071	0.314***	0.396***	0.085**
	[0.087]	[0.088]	[0.100]	[0.076]	[0.093]	[0.110]	[0.034]
Control Group's Mean	0	0	0	0	0	0	0.845
Wald Test (p-value)	0.139	0.436	0.075	0.227	0.075	0.369	0.668
N	5128	5128	5128	5128	5128	5128	5128
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.
For the Wald test (p-value) the H_0: Attended CM (CM vs. HU) – Attended CM (CM vs. NP) = 0.
Index of sexual and reproductive health services: Prenatal checkup in the last 12 months for women who have given birth in the last 12 months or are currently pregnant; Dental checkup in the last 12 months for women who have given birth in the last 12 months or are currently pregnant; Postnatal checkup in the last 12 months for women who have given birth in the last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months for women older than 40 years.
Index of services to promote female employment: Job training in the last 12 months; Registration for job opportunities, assistance to prepare a CV or help for a job interview in the last 12 months for independent or unemployed women; Orientation to start or expand a business in the last 12 months for independent or unemployed women; Credit/monetary support to open or expand a business in the last 12 months for independent or unemployed women who applied for 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 file a complaint.
Index of legal services for victims of patrimonial violence: Has received help for acknowledgment of the paternity of their children for women with children; Has received help for legalization of property/assets; Has received help for food fees for 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.

Figure 1. Take-up rate. Proportions of women who made an initial visit to CM centers.



Note: 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.

Web Appendix

Table A1: Sample composition and attrition

	Promotion Group			Total
	CM	HU	NP	
Original Selected Sample	1,539	1,539	1,539	4,617
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: Balance of variables related to sexual and reproductive health services

	Mean			**Difference**		**Difference (%)**		**Observations**		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Prenatal checkup in the last 12 months	0.077	0.069	0.075	0.008	0.002	11.59	2.67	1297	1282	1267
	[0.007]	[0.007]	[0.008]	[0.010]	[0.011]					
Dental checkup in the last 12 months	0.046	0.044	0.047	0.003	0.000	6.82	0.00	1297	1282	1267
	[0.006]	[0.006]	[0.006]	[0.008]	[0.008]					
Postnatal checkup in the last 12 months	0.036	0.034	0.042	0.003	-0.006	8.82	-14.29	1297	1282	1267
	[0.005]	[0.005]	[0.006]	[0.007]	[0.008]					
Citology/Papanicolau in the last 12 months	0.513	0.516	0.522	-0.004	-0.009	-0.78	-1.72	1297	1282	1267
	[0.014]	[0.014]	[0.015]	[0.018]	[0.019]					
Mammography in the last 12 months	0.042	0.056	0.056	-0.015*	-0.014*	-26.79	-25.00	1297	1282	1267
	[0.006]	[0.006]	[0.006]	[0.008]	[0.008]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A3: Balance of variables related to services to promote female employment

	Mean			Differences		Differences (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Job training in the last 12 months	0.004	0.011	0.009	-0.007**	-0.006	-63.64	-66.67	1297	1282	1267
	[0.002]	[0.003]	[0.003]	[0.003]	[0.003]					
Registration for job opportunities, assistance to prepare a CV or help for a job interview in the last 12 months	0.016	0.018	0.013	-0.002	0.004	-11.11	30.77	1297	1282	1267
	[0.003]	[0.004]	[0.003]	[0.005]	[0.004]					
Orientation to start or expand a business in the last 12 months	0.001	0.008	0.004	-0.007***	-0.003*	-87.5	-75	1297	1282	1267
	[0.001]	[0.002]	[0.002]	[0.003]	[0.002]					
Credit/monetary support to open or expand a business in the last 12 months	0.064	0.081	0.06	-0.017*	0.004	-20.99	6.67	1297	1282	1267
	[0.007]	[0.008]	[0.007]	[0.010]	[0.010]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A4: Balance of variables related to psychological, medical and legal services for survivors of physical, sexual and/or emotional violence

	Mean			Difference		Difference (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Sought/received emotional support	0.022	0.033	0.025	-0.010*	-0.003	-30.30	-12.00	1297	1282	1267
	[0.004]	[0.005]	[0.004]	[0.006]	[0.006]					
Sought/received legal support	0.029	0.028	0.027	0.001	0.002	3.57	7.41	1297	1282	1267
	[0.005]	[0.005]	[0.005]	[0.007]	[0.007]					
Sought/received injunction for protection	0.013	0.016	0.02	-0.003	-0.007	-18.75	-35.00	1297	1282	1267
	[0.003]	[0.004]	[0.004]	[0.005]	[0.005]					
Sought/received medical aid	0.013	0.012	0.013	0.001	0	8.33	0.00	1297	1282	1267
	[0.003]	[0.003]	[0.003]	[0.004]	[0.004]					
Sought/received transportation support	0.005	0.008	0.006	-0.003	-0.001	-37.50	-16.67	1297	1282	1267
	[0.002]	[0.002]	[0.002]	[0.003]	[0.003]					
Sought/received support to put a a complaint	0.025	0.027	0.026	-0.002	-0.001	-7.41	-3.85	1297	1282	1267
	[0.004]	[0.004]	[0.004]	[0.006]	[0.006]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A5: Balance of variables related to legal services for victims of patrimonial violence

	Mean			Difference		Difference (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Has received help for the acknowledgment of the paternity of their children	0.015	0.031	0.022	-0.016***	-0.007	-51.61	-31.82	1297	1282	1267
	[0.003]	[0.005]	[0.004]	[0.006]	[0.006]					
Has received help for the legalization of property/assets	0.034	0.041	0.042	-0.007	-0.008	-17.07	-19.05	1297	1282	1267
	[0.005]	[0.005]	[0.006]	[0.007]	[0.008]					
Has received help for food fees for women with children	0.012	0.037	0.027	-0.024***	-0.014**	-64.86	-51.85	1297	1282	1267
	[0.003]	[0.005]	[0.005]	[0.006]	[0.006]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A6: Balance of variables related to legal services to strengthen economic autonomy

	Mean			Difference		Difference (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
Has received help to obtain her ID	0.042	0.091	0.095	-0.050***	-0.053***	-54.95	-55.79	1297	1282	1267
	[0.006]	[0.008]	[0.009]	[0.010]	[0.011]					
Has received help to obtain her birth certificate	0.029	0.063	0.07	-0.035***	-0.042***	-55.56	-60	1297	1282	1267
	[0.005]	[0.007]	[0.008]	[0.009]	[0.009]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A7: Balance of socioeconomic variables

	Mean			Difference		Difference (%)		Observations		
	CM	**HU**	**NP**	**CM-HU**	**CM-NP**	**CM-HU**	**CM-NP**	**CM**	**HU**	**NP**
N of rooms in the house	2.647	2.503	2.323	0.144***	0.324***	5.75	13.95	1297	1282	1267
	[0.039]	[0.037]	[0.037]	[0.049]	[0.048]					
Property owner	0.581	0.618	0.619	-0.036*	-0.037*	-5.83	-5.98	1297	1282	1267
	[0.015]	[0.015]	[0.015]	[0.020]	[0.020]					
Substandard housing	0.056	0.045	0.047	0.01	0.009	22.22	19.15	1297	1282	1267
	[0.007]	[0.006]	[0.007]	[0.009]	[0.009]					
Public service garbage collection	0.584	0.585	0.573	-0.001	0.011	-0.17	1.92	1297	1282	1267
	[0.020]	[0.020]	[0.020]	[0.011]	[0.012]					
House with electricity	0.948	0.965	0.952	-0.017**	-0.004	-1.76	-0.42	1297	1282	1267
	[0.007]	[0.006]	[0.007]	[0.008]	[0.008]					
Kitchen with gas/electricity	0.772	0.754	0.729	0.018	0.042***	2.39	5.76	1297	1282	1267
	[0.015]	[0.015]	[0.016]	[0.015]	[0.014]					
Toilet with access to public sewer network	0.507	0.488	0.45	0.019	0.057***	3.89	12.67	1297	1282	1267
	[0.020]	[0.020]	[0.020]	[0.013]	[0.013]					
Private toilet with water trawl	0.601	0.618	0.575	-0.017	0.026*	-2.75	4.52	1297	1282	1267
	[0.018]	[0.018]	[0.019]	[0.015]	[0.015]					
House has water	0.782	0.817	0.807	-0.035***	-0.025*	-4.28	-3.10	1297	1282	1267
	[0.015]	[0.014]	[0.015]	[0.012]	[0.013]					

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit Health Unit. NP = randomly assigned to control group with No Promotion.

Table A8: Impact on the use of services and life satisfaction

	Instrumental Variables Diff-in-Diff Second-Stage Estimations (CM vs. HU)						
	(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
Attended CM * Year	0.609***	0.300***	0.259***	0.029	0.489***	0.500***	0.100***
	[0.098]	[0.099]	[0.096]	[0.092]	[0.098]	[0.111]	[0.036]
Control Group's Mean	0	0	0	0	0	0	0.852
Wald Test (p-value)	0.139	0.436	0.075	0.227	0.075	0.369	0.668
N	5158	5158	5158	5158	5158	5158	5158
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*** Significant at 1%, ** 5% and * 10%. Robust SE clustered at PSU level in brackets. CM = randomly encouraged to visit Ciudad Mujer. HU = randomly encouraged to visit 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 for women who have given birth in the last 12 months or are currently pregnant; Dental checkup in the last 12 months for women who have given birth in the last 12 months or are currently pregnant; Postnatal checkup in the last 12 months for women who have given birth in the last 12 months; Citology/Papanicolau in the last 12 months; Mammography in the last 12 months for women older than 40 years.

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

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

Table A9. Use of sexual and reproductive health services (1)

	Cytology/Pap test in the last 12 months			**Mammography test in the last 12 months (Women older than 40 years old)**		
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.189***	0.213***		0.277***	0.291***	
	[0.046]	[0.042]		[0.058]	[0.050]	
	(0.000)	(0.000)		(0.000)	(0.000)	
Promoted CM * Year			0.106***			0.159***
			[0.021]			[0.027]
			(0.000)			(0.000)
Promoted HU * Year			0.016			0.019
			[0.021]			[0.026]
			(0.441)			(0.460)
Control Group's Mean	0.599	0.588	0.588	0.202	0.179	0.179
N	5158	5128	7692	2126	2132	3174
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A10: Use of sexual and reproductive health services (2). Not conditioned to women who have given birth 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**		
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	-0.056***	-0.036*		-0.039**	-0.037*		0.010	0.025	
	[0.022]	[0.022]		[0.019]	[0.019]		[0.020]	[0.020]	
	(0.010)	(0.109)		(0.042)	(0.052)		(0.621)	(0.214)	
Promoted CM * Year			-0.018			-0.018			0.013
			[0.011]			[0.009]			[0.010]
			(0.110)			(0.053)			(0.213)
Promoted HU * Year			0.009			0.000			0.008
			[0.011]			[0.009]			[0.010]
			(0.421)			(0.991)			(0.422)
Control Group's Mean	0.053	0.051	0.051	0.034	0.037	0.037	0.028	0.028	0.028
N	5158	5128	7692	5158	5128	7692	5158	5128	7692
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A11: Use of services to promote female employment

	Requested or received job training in the last 12 months			**Requested or received registration for job opportunities, assistance to prepare a CV or help for a job interview in the last 12 months**			**Requested or received orientation to start or expand a business in the last 12 months**			**Requested or received credit/monetary support to open or expand a business in the last 12 months**		
				Independent or unemployed women						**Independent or unemployed women who applied for credit or requested monetary support**		
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.043***	0.022		0.005	0.018		0.042***	0.015		0.037	-0.015	
	[0.017]	[0.017]		[0.022]	[0.021]		[0.017]	[0.017]		[0.031]	[0.030]	
	(0.013)	(0.372)		(0.833)	(0.404)		(0.013)	(0.372)		(0.229)	(0.622)	
Promoted CM * Year			0.011			0.008			0.008			-0.007
			[0.009]			[0.010]			[0.009]			[0.015]
			(0.374)			(0.407)			(0.374)			(0.622)
Promoted HU * Year			-0.01			0.006			-0.013			-0.025
			[0.008]			[0.010]			[0.008]			[0.014]
			(0.112)			(0.521)			(0.112)			(0.070)
Control Group's Mean	0.029	0.037	0.037	0.047	0.035	0.035	0.019	0.026	0.026	0.11	0.104	0.104
N	5154	5128	7688	3958	3962	5904	3612	3602	5372	3918	3906	5830
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A12: Use of psychological, medical and legal services for survivors of physical, sexual and/or emotional violence (1)

	Sought emotional support			**Sought legal support**			**Sought injunction for protection**		
Population of women who have experienced violence at some time in their lives (reported in baseline)									
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.090	0.020		-0.047	-0.071		0.018	0.000	
	[0.048]	[0.044]		[0.052]	[0.046]		[0.031]	[0.032]	
	(0.064)	(0.654)		(0.356)	(0.124)		(0.605)	(0.990)	
Promoted CM * Year			0.011			-0.037			0.000
			[0.023]			[0.024]			[0.017]
			(0.654)			(0.12)			(0.990)
Promoted HU * Year			-0.031			-0.016			-0.008
			[0.021]			[0.020]			[0.016]
			(0.168)			(0.459)			(0.640)
Control Group's Mean	0.057	0.077	0.077	0.061	0.085	0.085	0.031	0.057	0.057
N	1668	1532	2444	1668	1532	2444	1668	1532	2444
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A13: Use of psychological, medical and legal services for survivors of physical, sexual and/or emotional violence (2)

	Sought medical aid			**Sought transportation support**			**Sought support to file a complaint**		
	Population of women who have experienced violence at some time in their lives (reported in baseline)								
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	-0.023	-0.021		-0.016	0.005		0.004	-0.064	
	[0.032]	[0.030]		[0.026]	[0.021]		[0.048]	[0.045]	
	(0.474)	(0.483)		(0.537)	(0.821)		(0.97)	(0.157)	
Promoted CM * Year			-0.011			0.002			-0.034
			[0.016]			[0.011]			[0.023]
			(0.483)			(0.821)			(0.155)
Promoted HU * Year			0.000			0.010			-0.036
			[0.016]			[0.012]			[0.021]
			(0.986)			(0.419)			(0.104)
Control Group's Mean	0.02	0.028	0.028	0.024	0.01	0.01	0.066	0.111	0.111
N	1668	1532	2444	1668	1532	2444	1668	1532	2444
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A14: Use of legal services for victims of patrimonial violence

	Received help for paternity acknowledgment of the children			**Received help for alimony for the children**			**Received help for legalization of property or assets**		
	Women with children								
	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.066***	0.024*		0.055***	0.054***		0.060***	0.033***	
	[0.020]	[0.017]		[0.021]	[0.022]		[0.015]	[0.014]	
	(0.001)	(0.168)		(0.009)	(0.013)		(0.000)	(0.021)	
Promoted CM * Year			0.012			0.028**			0.016**
			[0.009]			[0.011]			[0.007]
			(0.169)			(0.013)			(0.021)
Promoted HU * Year			-0.020**			0.001			-0.012
			[0.010]			[0.011]			[0.008]
			(0.043)			(0.925)			(0.135)
Control Group's Mean	0.016	0.021	0.021	0.034	0.033	0.033	0.013	0.016	0.016
N	3896	3898	5824	3896	3896	5822	5154	5120	7684
Individual-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A15: Use of legal services to strengthen economic autonomy: Received help to obtain birth certificate application

	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.076***	0.078***	
	[0.021]	[0.022]	
	(0.000)	(0.000)	
Promoted CM * Year			0.039***
			[0.011]
			(0.000)
Promoted HU * Year			0.003
			[0.012]
			(0.807)
Control Group's Mean	0.019	0.023	0.023
N	5156	5126	7690
Individual-Level FE	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.

Table A16: Use of legal services to strengthen economic autonomy: Received help to obtain her identification document (ID)

	IV Diff-in-Diff 2nd-Stage		ITT Diff-in-Diff
	CM vs. HU	CM vs. NP	All
Attended CM * Year	0.127***	0.109***	
	[0.025]	[0.026]	
	(0.000)	(0.000)	
Promoted CM * Year			0.055***
			[0.013]
			(0.000)
Promoted HU * Year			-0.005
			[0.013]
			(0.676)
Control Group's Mean	0.022	0.031	0.031
N	5154	5124	7686
Individual-Level FE	Yes	Yes	Yes
Year-Level FE	Yes	Yes	Yes

Note: *** Significant at 1%, ** 5% and * 10%, from Romano and Wolf's (2005) stepwise multiple testing. CM = randomly encouraged to Ciudad Mujer. HU = randomly encouraged to Health Unit. NP = randomly assigned to control group with No Promotion. Robust SE clustered at PSU level in brackets. P-values given in parentheses.