Online Appendix

Appendix A Comuna populations and pharmacies

Table A1 provides a listing of comunas in the sample along with the number of government pharmacies in that comuna as of December 9th, 2022. This data was hand collected from the cenabast.cl website using the "Find My Pharmacy" tool that allows users to search for pharmacies by comuna name. In the main specification, a comuna will be considered treated if it had at least one pharmacy at the time the data was collected. Population data is gathered from citypopulation.de/en/chile/ and is from 2022 as well.

Table A1: Pharmacies and population by comuna

Comuna	Pharmacies	Population
Arica	4	253,125
Iquique	12	229,072
Alto Hospicio	2	137,263
Pozo Almonte	0	18,172
Huara	0	3,063
Antofagasta	9	437,883
Calama	3	194,575
Tocopilla	1	28,301
Copiapó	4	174,309
Caldera	0	19,746
Tierra Amarilla	0	14,401
Vallenar	1	57,301
Freirina	1	7,779
La Serena	8	258,850
Coquimbo	2	266,502
Vicuña	0	30,187
Illapel	1	32,949
Los Vilos	0	23,924
Ovalle	3	123,013
Valparaíso	14	318,638
Casablanca	0	29,891
Concón	2	47,097
Quintero	1	37,441

Viña del Mar	16	366,981
Los Andes	6	68,602
La Ligua	2	38,117
Quillota	3	99,401
La Calera	2	53,809
San Antonio	4	97,758
San Felipe	5	85,270
Quilpué	6	170,531
Limache	0	50,872
Villa Alemana	8	143,536
Rancagua	12	270,112
Doñihue	0	23,199
Graneros	1	37,390
Las Cabras	1	27,283
Machalí	4	62,480
Mostazal	0	28,035
Pichidegua	1	20,937
Rengo	2	64,831
Requínoa	1	31,087
San Vicente	2	51,518
San Fernando	1	79,964
Chimbarongo	1	38,117
Santa Cruz	1	41,884
Talca	18	239,735
Constitución	3	50,547
Maule	2	64,676
San Clemente	3	47,177
Cauquenes	4	44,327
Curicó	6	167,746
Molina	1	50,983
Teno	0	31,390
Linares	7	102,620
Parral	2	45,103
San Javier	3	50,496
Chillán	5	201,523
San Carlos	0	56,702
Bulnes	1	22,703
Chillán Viejo	0	34,755
Concepción	16	239,077
Coronel	0	127,519
Chiguayante	0	91,632
Lota	1	45,580
Penco	0	50,055
San Pedro de la Paz	2	150,023
Talcahuano	1	158,285

Tomé	0	58,978
Hualpén	0	97,732
Arauco	1	38,834
Los Ángeles	2	221,361
Mulchén	0	31,098
Nacimiento	0	28,002
Temuco	9	306,579
Lautaro	1	41,352
Nueva Imperial	1	33,993
Padre Las Casas	0	83,834
Pucón	0	30,290
Vilcún	2	31,745
Villarrica	6	59,955
Angol	3	56,476
Victoria	0	35,531
Valdivia	2	179,563
Los Lagos	1	20,527
Panguipulli	1	36,130
La Unión	0	39,632
Río Bueno	1	32,968
Puerto Montt	4	275,473
Calbuco	0	37,221
Llanquihue	0	18,755
Puerto Varas	0	50,010
Castro	2	48,219
Ancud	1	42,507
Osorno	2	174,998
Río Negro	0	14,183
Coyhaique	0	61,705
Aysén	0	25,138
Punta Arenas	2	144,116
Natales	0	24,255
Santiago	43	527,014
Cerrillos	4	89,858
Cerro Navia	4	141,507
Conchalí	6	138,638
El Bosque	3	171,201
Estación Central	9	217,664
Huechuraba	5	115,858
Independencia	5	150,074
La Cisterna	4	101,313
La Florida	11	406,229
La Granja	2	121,170
La Pintana	1	189,321
La Reina	2	100,131

Las Condes	12	338,541
Lo Barnechea	3	128,439
Lo Espejo	1	102,530
Lo Prado	5	103,732
Macul	2	137,079
Maipú	19	585,684
Ñuñoa	23	259,712
Pedro Aguirre Cerda	5	106,496
Peñalolén	6	270,707
Providencia	26	161,568
Pudahuel	12	258,535
Quilicura	8	266,818
Quinta Normal	5	140,055
Recoleta	7	195,185
Renca	1	162,517
San Joaquín	2	103,704
San Miguel	1	139,729
San Ramón	1	85,274
Vitacura	4	97,651
Puente Alto	11	660,361
Colina	6	189,757
Lampa	6	135,461
San Bernardo	5	342,411
Buin	2	114,028
Paine	2	85,759
Melipilla	3	145,583
Talagante	4	83,814
Peñaflor	6	104,106
San Pedro de Atacama	0	10,818
Diego de Almagro	0	14,137
Alto del Carmen	0	5,767
Salamanca	2	29,560
Monte Patria	0	32,638
Puchuncavi	0	20,674
Cabildo	1	20,735
Hijuelas	1	19,309
Palmilla	0	13,458
Rio Claro	0	14,952
Sagrada Familia	1	19,627
Longavi	0	33,264
Yerbas Buenas	2	19,515
Canete	3	37,249
Curanilahue	0	33,931
Los Alamos	0	22,755
Cabrero	1	30,937

Santa Barbara	1	14,644
Yumbel	0	22,174
Coihueco	1	28,742
Carahue	0	25,511
Cunco	1	18,067
Freire	1	25,483
Loncoche	1	24,778
Pitrufquen	0	26,375
Saavedra	0	12,727
Teodoro Schmidt	1	15,774
Collipulli	3	26,374
Curacautin	0	18,207
Lumaco	0	9,976
Traiguen	0	19,302
Chonchi	1	16,155
Dalcahue	0	15,275
Quellon	1	29,745
Quinchao	0	8,241
Purranque	2	21,028
San Juan de La Costa	0	7,536
San Pablo	0	10,548
Cisnes	0	5,857
Cochrane	0	3,718
Chile Chico	0	5,148
Porvenir	0	7,500
Lanco	0	17,861
Mariquina	1	23,648
Paillaco	2	20,884
Putre	0	2,548
Catemu	0	15,482
Codegua	0	14,379
Laja	0	23,909
Los Muermos	0	17,831
Olivar	1	14,831
Pica	0	6,165
Putaendo	0	17,862
Santa Juana	0	14,846
Villa Alegre	0	17,787

Appendix B Spillovers

As previously discussed, it is likely that women in comparison comunas also received information about the recalls and therefore may have been partially treated,

but it is also possible that there were spillover effects for women in comparison comunas. Namely, women in comparison comunas could be traveling to treatment comunas to receive birth control pills from Cenabast pharmacies. If it is the case that there are spillovers, it is likely that my primary specification underestimates the true effect of the distribution of defective birth control pills.

Bentancor and Clarke (2016) performed a similar analysis to the one in this paper examining the effect of the distribution of the emergency contraception pill and implement a specification using a vector of $close_{ct}$ controls to test for spillover effects. The controls are a vector of mutually exclusive binary variables indicating how close a comparison group comuna is to the nearest treatment group comuna. There are three close controls that switch on after the treatment for comunas $(0, 10]$, $(10, 20]$, and $(20, 30]$ kilometers from the nearest treatment comuna using Euclidean distance in the primary specification, but they also perform robustness checks using kilometers traveled along roads and total travel time by vehicle. Using this approach, they find no evidence of local spillovers between comunas. Therefore, I think it is reasonable to assume that there are no spillovers in this analysis as well.

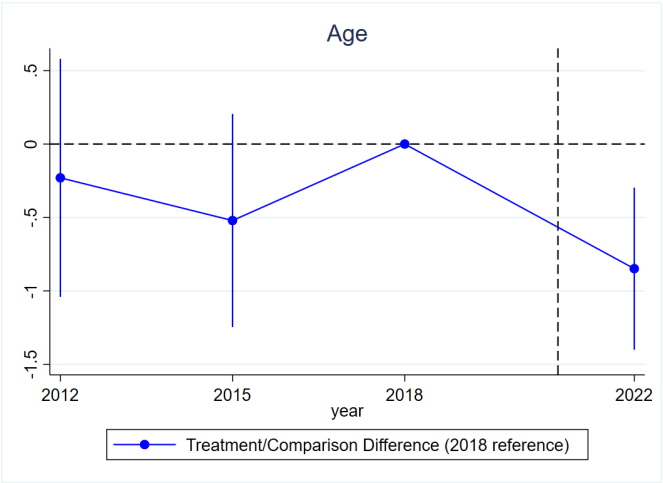
Appendix C Covariate event studies

Figure C1 includes the event study figures for age and sex. There is no significant change in the number of female respondents in treatment and comparison areas, but there is a decrease in age of respondents in treatment areas. However, older women actually respond more strongly to the recalls, so this is likely not a threat to the validity of the results found in this paper. Figure C2 indicates that there are no significant changes in urbanicity or religious affiliation for women in treatment areas compared to women in comparison areas.

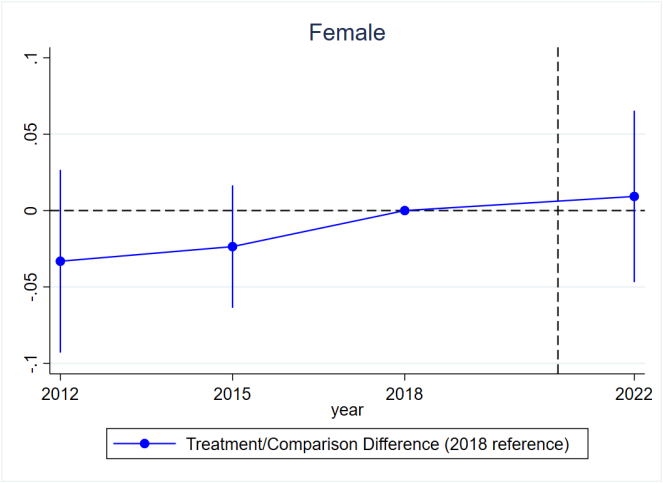
Figure C3 presents the event study results for marriage, cohabitation, and number of children. There are no significant effects except for a decrease in marriage. The decrease in marriage could be cause for concern because it is possible that a decrease in marriage could lead to changes in contraceptive behavior. However, changes in birth control pill usage are similar for women who are married compared to those who are engaged or cohabiting with a partner. Therefore, it seems unlikely that this change is driving results.

Figure C4 displays the event study results for employment outcomes. Although the results are not significant, there is a decrease in employment for treatment women in the post period. However, this seems to be in line with pre-trends, implying that this

Fig. C1: Age and sex results



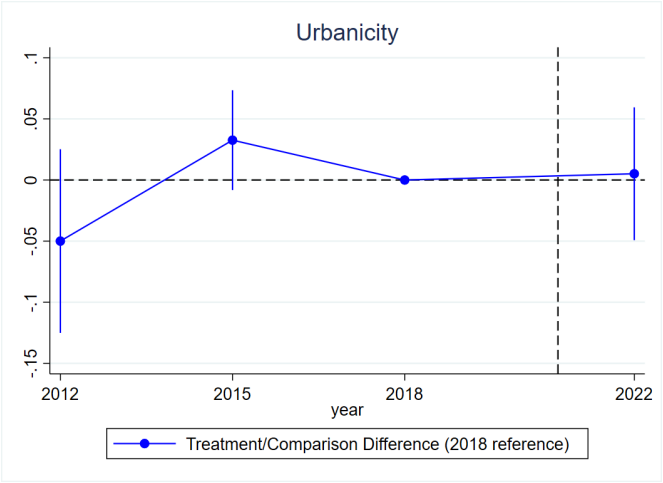
(a) Panel A



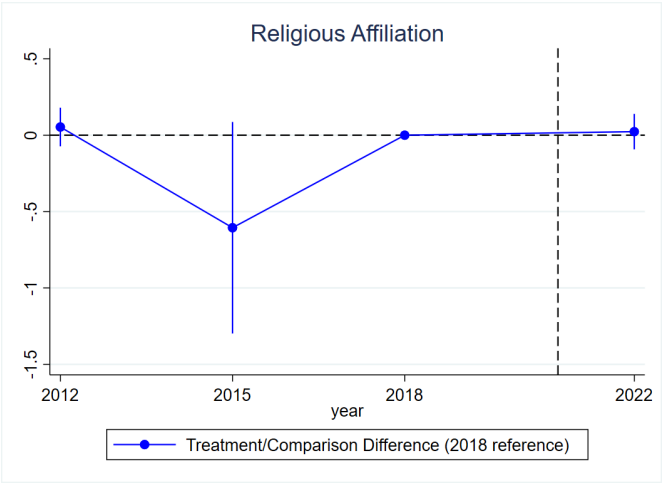
(b) Panel B

Notes: This figure presents event study estimates for age and sex using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). The sample includes women aged 15-25, with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in respondent characteristics. Individual and comuna-level characteristics are included as covariates, and standard errors are clustered at the comuna level. All confidence intervals are at the 95% level.

Fig. C2: Urbanicity and religious affiliation results



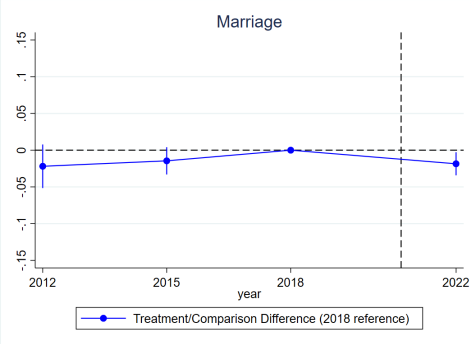
(a) Panel A



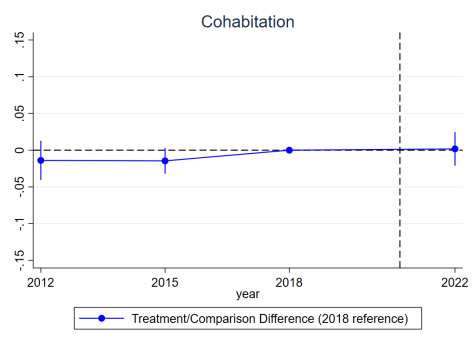
(b) Panel B

Notes: This figure presents event study estimates for urbanicity and religious affiliation using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). The sample includes women aged 15-25, with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in respondent characteristics. Individual and comuna-level characteristics are included as covariates, and standard errors are clustered at the comuna level. All confidence intervals are at the 95% level.

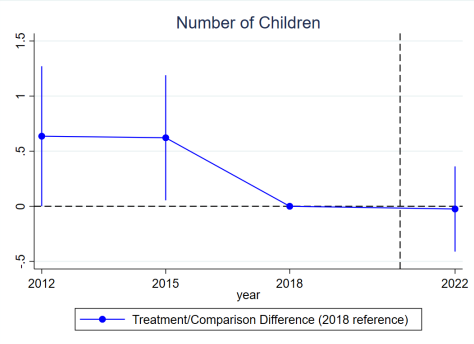
Fig. C3: Marriage, cohabitation, & number of children results



(a) Panel A



(b) Panel B



(c) Panel C

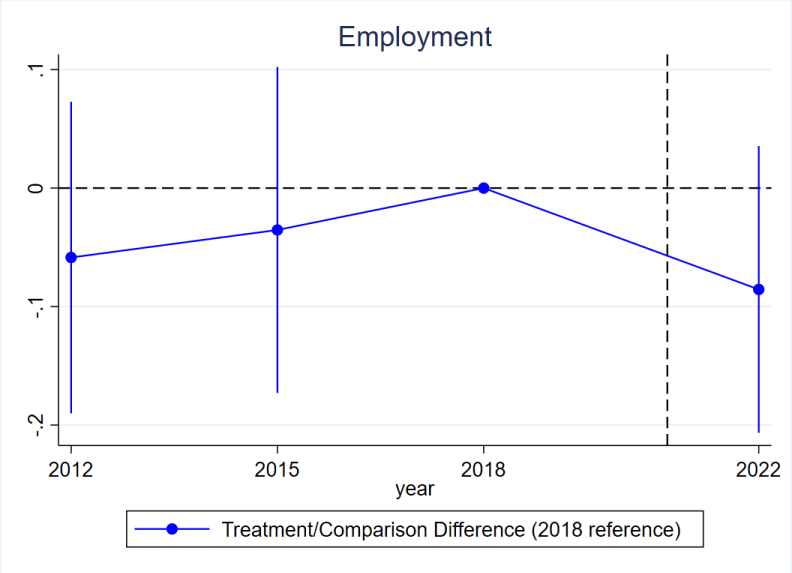
Notes: This figure presents event study estimates for marriage, cohabitation, and number of children using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). The sample includes women aged 15-25, with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in respondent characteristics. Individual and comuna-level characteristics are included as covariates, and standard errors are clustered at the comuna level. All confidence intervals are at the 95% level.

change is driven by an increase in employment for treatment women in 2018 rather than a decrease in 2022.

Event study results for educational outcomes are presented in figure C5. There are no significant changes in education level. The lack of change in education level indicates that it is unlikely that the results found in this paper are driven by changes in educational attainment in treatment areas.

Event study results for fertility, birth, and poverty rates are displayed in figure C6. There are no significant changes in the birth or poverty rates, although there is a decrease in the fertility rate following the recalls. The observed decline in the

Fig. C4: Employment results



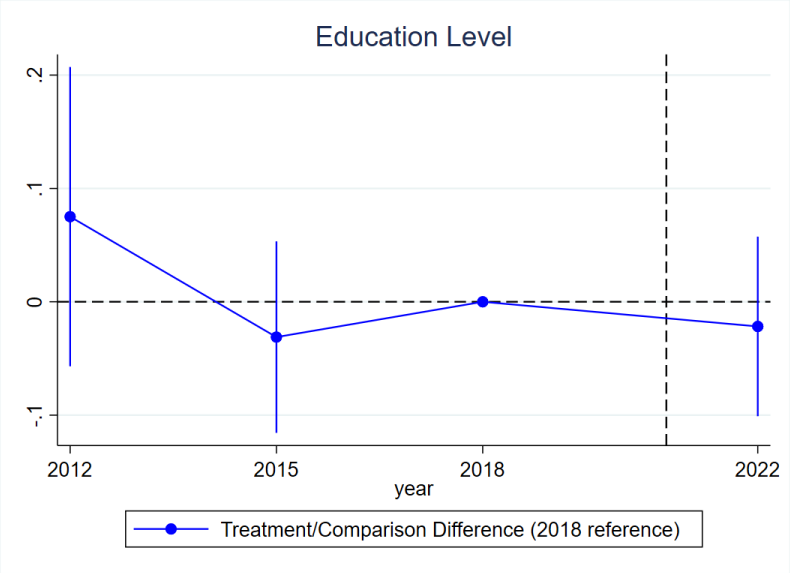
Notes: This figure presents event study estimates for employment status using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). The sample includes women aged 15-25, with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in respondent characteristics. Individual and comuna-level characteristics are included as covariates, and standard errors are clustered at the comuna level. All confidence intervals are at the 95% level.

fertility rate is likely driven by a long-term shift in contraceptive behavior, as some women who discontinued birth control pill use may have adopted long-acting reversible contraceptives (LARCs) or other effective methods, leading to fewer overall births over time. This trend does not threaten the validity of the main results, as the decline in fertility is a downstream consequence of changing contraceptive choices, rather than an independent factor driving the observed reduction in birth control pill usage.

Appendix D Robustness

Table D2 presents results using the main specification when the outcome variable is ever engaging in sexual activity. Comunas that experienced Pill recalls do not demonstrate a decreased share of individuals reporting ever having engaged in sexual intercourse. Therefore it is unlikely that a change in sexual behavior generally is driving the results found.

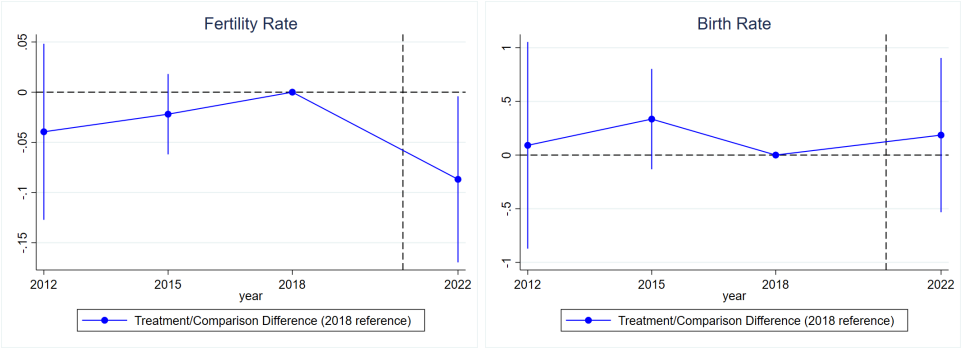
Fig. C5: Education results



Notes: This figure presents event study estimates for education level using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Education levels are classified as 1 if the individual reports some or completed primary school, 2 if the individual reports some or completed secondary school, and 3 if the individual reports some or completed higher education. The sample includes women aged 15-25, with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in respondent characteristics. Individual and comuna-level characteristics are included as covariates, and standard errors are clustered at the comuna level. All confidence intervals are at the 95% level.

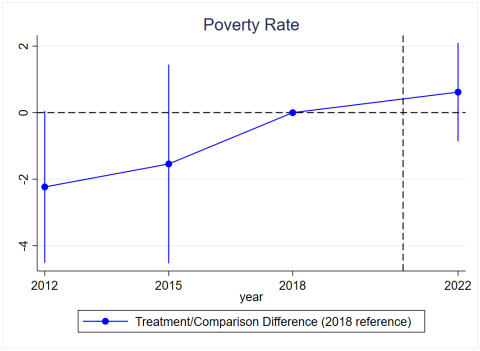
As discussed, there are some differences in the treatment and comparison comunas, namely with regards to size and how heavily affected the areas were by COVID-19. Therefore, I re-run the results restricting the sample first to comunas with populations of less than 200,000. While treatment comunas do still tend to be slightly larger on average than comparison comunas, this restricts the sample to comunas that are more similar. The point estimates are slightly smaller when restricting the sample in this way, but results are overall similar, as shown in Table D3. Additionally, treatment comunas tended to be more heavily affected by the COVID-19 pandemic than comparison comunas, likely because they tend to be larger and more urban. Therefore, I also restrict the sample to comunas with a COVID-19 rate, which was the percentage of their population that had tested positive as reported by the Chilean government, prior to the recalls of less than 2%. When the sample is restricted in this way, results remain similar, although women do seem slightly more likely to stop using any effective method of contraception.

Fig. C6: Fertility, birth, and poverty rate results



(a) Panel A

(b) Panel B



(c) Panel C

This figure presents event study estimates for fertility rate, birth rate, and poverty rate using administrative comuna-level data. Fertility rates are sourced from SINIM, birth rates from the Chilean Ministry of Health, and poverty rates from CASEN. The treatment group consists of comunas with a CENABAST pharmacy. Estimates are obtained using the event study specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in comuna-level characteristics. Standard errors are clustered at the comuna level, and all confidence intervals are at the 95% level.

As an additional robustness check, I incorporate total municipal healthcare expenditures as a control variable to account for potential differences in healthcare investment across comunas. Data on comuna-level healthcare expenditures were obtained from the Sistema de Información Municipal (SINIM) and include a broad range of costs, such as personnel salaries, operating expenses, and other healthcare-related expenditures. Since total expenditures vary with comuna size, I normalize this measure by dividing total healthcare expenditures by the comuna population to estimate per-person healthcare spending.

Table D2: Likelihood of engagement in sexual activity

	(1)	(2)	(3)
Engagement in Sexual Activity	0.015	0.016	0.017
	(0.030)	(0.030)	(0.031)
Comuna and year fixed effects	Yes	Yes	Yes
Region linear time trends	No	Yes	Yes
Comuna linear time trends	No	No	Yes
N	14,820	14,820	14,820

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing trends in engagement in sexual activity as a robustness check to determine whether underlying differences in sexual behavior could be driving the main results. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022), with treatment defined as residing in a comuna with a CENABAST pharmacy. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends in sexual activity. Column (1) presents results with full controls. Column (2) adds region-level linear time trends, and Column (3) adds comuna-level linear time trends, making it the full specification from Equation 1. Standard errors are clustered at the comuna level.

Appendix Table D4 presents results from a specification that includes per-person healthcare expenditures as a control variable. The inclusion of this control does not meaningfully change the estimated effect of the recall on contraceptive choice, as the point estimate remains similar in magnitude. However, the standard errors increase substantially, likely due to the fact that total healthcare expenditures do not specifically capture spending on primary care services, which would be more directly relevant to the provision of contraception. Given this limitation, and to maintain precision in the main results, I do not include this variable in the primary specification. Instead, I provide this robustness check to demonstrate that the findings hold even under more demanding data specifications.

I also perform a sensitivity analysis to my choice of age ranges for the main analysis, as shown in Table D5. Results are not particularly sensitive to the choice of age, with similar estimates being found when I choose to samples of women aged 15-24, 15-25, or 15-26. For the reasons listed in the paper, I will continue to use 15-25 as the age range for my main sample.

There is a decrease in the age of surveyed women in treatment areas, so I perform the analysis in Table D6 to better understand whether this is driving the contraceptive choice results. I examine changes in contraceptive behavior for women ages 15-20 and 21-25 and find that the decrease in birth control usage following the recalls is larger for the older grouping of women, leading me to believe that this decrease in average age surveyed is not driving the main results.

There is a decrease in marriage for women in treatment areas, so I perform the analysis in Table D7 to better understand whether this is driving the contraceptive choice results. I examine changes in contraceptive behavior for women ages married and unmarried women, although it is worth noting that the sample size for married women is extremely small. I find that married women exhibit a larger decrease in birth control pill usage following the recalls, so it the decrease in marriage among treatment group women is driving the observed decrease in birth control pill usage following the recalls.

There is some decrease in employment for women in treatment areas. I perform the analysis in Table D8 to better understand whether this is driving the contraceptive choice results. While results are smaller for women who are employed, there is still a 6.0 percentage point decrease in birth control usage for treated women who are employed. Therefore, I do not believe that these changes in employment are driving my results.

I also examine household, labor market, and educational outcomes for men in table D9. In particular, I am interested in the labor market outcomes for men since there was an overall decrease in employment for women. If we were to see a similar decrease in employment for men as is found for women, it would seem more likely that there is a general downturn in the labor market around this time that could be leading to the observed results for contraceptive choice. However, I find no change in employment for men, so it seems likely that the labor market results for women may be as a result of the changes in contraceptive choice if they are related at all.

Finally, I use other behaviors that may be considered risky in order to gauge whether risk aversion generally may be changing among young adults in treatment areas, leading to changes in contraceptive behavior. First, I examine other behaviors related to sexual activity, namely HIV testing and usage of contraception to prevent pregnancy. A change in HIV testing behavior may indicate either an increase or decrease in risk aversion. For example, women may choose to be tested for HIV if they have recently engaged in sexual intercourse with a partner they perceive to be more risky, or they may choose to test for HIV without changing sexual behavior if they are becoming more concerned about the risks of sexual encounters. I find no change in HIV testing, indicating that it is unlikely that either scenario is occurring. Additionally, I examine whether women are changing the rates at which they use contraception to prevent pregnancy. If there was an increase or decrease in that being the primary reason for women to utilize contraception, we may see a change in types of contraceptive usage. Again, I do not find evidence that this is the case. Finally, I examine outcomes related to alcohol and drug use. These behaviors may be indicative of risk

aversion and are often associated with sexual activity among young individuals. I find no significant changes in behavior among treatment individuals for any outcomes.

Table D3: Sample restricted results

Outcome	Full sample	Population < 200,000	Covid rate < 2%	FONASA beneficiaries
Panel A: Contraceptive usage				
Birth control pill usage	-0.081**	-0.086**	-0.108***	-0.066
	(0.040)	(0.041)	(0.040)	(0.043)
LARC usage	0.069	0.062	0.045	0.073
	(0.051)	(0.026)	(0.047)	(0.056)
Other effective contraception usage	-0.006	-0.004	0.002	-0.010
	(0.026)	(0.025)	(0.026)	(0.035)
No effective contraception usage	0.033	0.042	0.055	0.016
	(0.034)	(0.034)	(0.039)	(0.040)
N	9,509	8,930	5,501	5,988

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing the impact of restricting the sample to more comparable comunas as a robustness check. Column (1) replicates the full sample results from Column (3) of Table 3 for reference. Column (2) restricts the sample to comunas with populations under 200,000 to account for potential differences in comuna size. Column (3) further restricts the sample to comunas with pre-recall COVID-19 rates below 2%, as treatment comunas were more heavily affected by the pandemic. Column (4) restricts the sample to women covered by FONASA, Chile's public health insurance system, to examine whether effects differ across insurance coverage. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D4: Contraception results with additional control

Outcome	**(1)**	**(2)**
Birth control pill usage	-0.081**	-0.076
	(0.040)	(0.056)
LARC usage	0.069	0.094
	(0.051)	(0.055)
Other effective contraception usage	-0.006	-0.023
	(0.026)	(0.031)
No effective contraception usage	0.033	0.038
	(0.032)	(0.043)
N	9,509	9,509
Healthcare Expenditure Control	No	Yes

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing the robustness of the main results to the inclusion of comuna-level healthcare expenditures as a control variable. Healthcare expenditure data is sourced from SINIM and normalized as per capita spending to account for differences in comuna size. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Column (1) replicates the full specification from Equation 1 for reference. Column (2) includes per capita healthcare expenditures as an additional control. Standard errors are clustered at the comuna level.

Table D5: Sensitivity analysis

Outcome	**Age $\leq$24**	**Age $\leq$25**	**Age $\leq$26**
Birth control pill usage	-0.079*	-0.081**	-0.078*
	(0.046)	(0.040)	(0.043)
LARC usage	0.070	0.069	0.049
	(0.055)	(0.051)	(0.040)
Other effective contraception usage	-0.016	-0.006	0.008
	(0.029)	(0.026)	(0.027)
No effective contraception usage	0.018	0.033	0.027
	(0.039)	(0.034)	(0.031)
N	8,367	9,509	10,485

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing the sensitivity of the main results to different age range definitions using ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Column (1) restricts the sample to women aged 15-24, Column (2) uses the primary specification with women aged 15-25, and Column (3) expands the sample to include women aged 15-26. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D6: Contraception results by age

Outcome	**Age 15-20**	**Age 21-25**
Birth control pill usage	-0.059	-0.088**
	(0.069)	(0.045)
LARC usage	0.034	0.089
	(0.074)	(0.048)
Other effective contraception usage	-0.036	0.021
	(0.035)	(0.052)
No effective contraception usage	0.069	-0.001
	(0.056)	(0.049)
N	4,094	5,376

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates examining whether the decrease in the average age of surveyed women in treatment areas affects the main results. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Column (1) restricts the sample to women aged 15-20, while Column (2) includes only women aged 21-25. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D7: Contraception results by marital status

Outcome	**Married**	**Unmarried**
Birth control pill usage	-0.232	-0.079*
	(0.280)	(0.044)
LARC usage	-0.251	0.070
	(0.450)	(0.052)
Other effective contraception usage	-0.607	0.000
	(0.344)	(0.025)
No effective contraception usage	0.975***	0.022
	(0.201)	(0.034)
N	271	9,199

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing whether changes in marriage rates among women in treatment areas affect the main results. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Column (1) reports estimates for married women, while Column (2) includes unmarried women. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D8: Contraception results by employment status

Outcome	Employed	Unemployed
Birth control pill usage	-0.060	-0.102*
	(0.064)	(0.054)
LARC usage	0.075	0.053
	(0.067)	(0.059)
Other effective contraception usage	0.019	-0.005
	(0.038)	(0.030)
No effective contraception usage	-0.010	0.061
	(0.056)	(0.047)
N	3,098	6,372

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates examining whether employment status affects the main results. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Column (1) reports estimates for employed women, while Column (2) includes unemployed women. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D9: Covariate outcomes for men

Outcome	Full Sample
Marriage	0.005
	(0.008)
Cohabitation	0.011
	(0.011)
Number of children	0.162
	(0.308)
Employment	0.013
	(0.070)
Hours worked	2.456
	(2.661)
Education level	-0.018
N	8,458

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates examining whether trends in household, labor market, and educational outcomes for men in treatment areas could influence the main results. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). The outcomes examined include marriage, cohabitation, number of children, employment, hours worked, and education level. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.

Table D10: Other risky behaviors

Outcome	
Panel A: Other sexual activity outcomes	
HIV Testing	-0.014
	(0.034)
Contraception to Prevent Pregnancy	0.000
	(0.000)
Panel B: Alcohol and drug usage	
Alcohol Usage	0.013
	(0.044)
Cigarette Usage	-0.032
	(0.046)
Marijuana Usage	0.017
	(0.035)
Cocaine Usage	0.030
	(0.009)
Cocaine Paste Usage	0.002
	(0.003)
N	9,059

Notes: * $p \leq .1$; ** $p \leq .05$; *** $p \leq .01$. This table presents event study estimates assessing whether risk-related behaviors changed among women in treatment areas, which could explain shifts in contraceptive behavior. Estimates use ENJUV survey data from waves VII to X (2012, 2015, 2018, and 2022). Panel A examines changes in sexual activity-related behaviors, including HIV testing and contraception usage for pregnancy prevention. Panel B examines changes in alcohol and drug use, including usage of alcohol, cigarettes, marijuana, cocaine, and cocaine paste. Estimates are obtained using the specification outlined in Equation 1, which includes comuna and year fixed effects, as well as comuna- and region-level linear time trends to account for differential secular trends. Standard errors are clustered at the comuna level.