

Bring A Friend: Leveraging Financial and Peer Support to Improve Women's Reproductive Agency in India^{*}

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Abstract

Agency in the domain of contraceptive and reproductive decision-making is a fundamental determinant of women's well-being. We experimentally evaluate two approaches aimed at improving women's reproductive agency in rural India. We offered treated women subsidized family planning services at a local clinic. Additionally, we enabled a subset of treated women to incentivize others to visit the clinic with them, thereby enabling them to leverage peer support to overcome mobility barriers. Although women who received just the subsidy experienced a significant increase in their clinic visits and contraceptive use relative to the control group, combining the subsidy with the ability to leverage peer support was more effective in strengthening reproductive agency and peer engagement for women who faced greater intrahousehold opposition to contraceptive use.

Keywords: Women's Agency; Family Planning; Contraception; India; Mother-in-law; Vouchers; Social Connections; Peers

JEL codes: J13, J16, O15, O33, I15, Z13.

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1 Introduction

Women’s empowerment is a global priority and a key Sustainable Development Goal. Despite considerable social, political, and economic advances, women continue to have limited agency in many regions of the world (Chang et al., 2020; Donald et al., 2020; Kabeer, 2011). Improving women’s agency is not only valuable in its own right but also offers instrumental returns for other dimensions of female empowerment and economic development (Duflo, 2012; Jayachandran, 2019). We focus on agency in the domain of contraceptive and reproductive decision-making, which is a fundamental determinant of women’s well-being. The lack of control over the number and timing of births can negatively affect women’s health, educational attainment, and labor market outcomes.¹ However, a large fraction of women globally lack reproductive agency² (UNFPA, 2021) and an estimated 270 million women have an unmet need for modern contraception (Kantorová et al., 2020).³

Our study is situated in rural India, specifically in India’s most populous state, Uttar Pradesh (UP). In this setting, women have extremely low levels of reproductive agency, which is reflected both in direct indicators of agency, such as freedom to visit health facilities, and in more indirect measures, such as contraceptive use and social engagement related to family planning (FP). Less than half (43 percent) of currently married women of reproductive age in rural UP use modern contraception and only 23 percent use a modern method besides female sterilization (Government of India, 2022). Moreover, only 38 percent of surveyed women reported being allowed to visit a health facility alone and just 18 percent had visited a health care provider in the last 12 months. In fact, in our own sample at baseline, 65 percent of women had never visited a clinic for FP, and 36 percent had not engaged with anyone besides their husbands and mothers-in-law on FP-related issues (Anukriti et al., 2020).

Like many high-stakes choices, married women often make contraceptive decisions jointly with their husbands. However, in patrilocal societies where extended families are common, other household members such as mothers-in-law may also play a significant role in women’s FP and reproductive decision-making. In fact, as the likely matriarch of the household, a woman’s mother-in-law may play an even stronger role than her husband, especially during the early years of an arranged marriage.⁴ However, the preferences of family members may differ from women’s own preferences. For our study, what is especially relevant is the intrahousehold misalignment in preferences over women’s fertility and mobility. Specifically, we note that family members may want women to have more children than the women themselves want (Anukriti et al., 2022; Ashraf et al., 2014; Bankole and Singh, 1998).⁵

¹Refer to Bailey (2006); Bailey et al. (2012); Becker and Lewis (1973); Canning and Schultz (2012); Goldin and Katz (2002); Joshi and Schultz (2007, 2013); Miller (2010); Willis (1973), among others.

²Reproductive agency is defined as having the power to decide and control contraceptive use, pregnancy, and childbearing (Purdy, 2006; Upadhyay et al., 2014). According to the 2021 State of World Population Report, only 55 percent of women in 57 developing countries have a say in decisions about whether and when to seek health care for themselves (including sexual and reproductive health services), whether to use contraception, and whether and when to have sex with their partner or husband.

³Unmet need is calculated as the proportion of fecund women who are not using contraception but who wish to postpone the next birth or stop childbearing altogether (Bradley et al., 2012).

⁴Although nuclear families have been the predominant family type in many developed societies, patrilocal and extended family structures have been more common in rest of the world. As Bau and Fernández (2021) describe, much of Asia and parts of Europe and Sub-Saharan Africa have traditionally been patrilocal. By the same token, the nuclear family is not the predominant ancestral family type in Africa or South Asia.

⁵In our sample at baseline, 82 percent (67 percent) of mothers-in-law wanted their daughters-in-law to have more sons (children) than what their daughters-in-law wanted. Spousal misalignment is relatively small in our

Similarly, women’s family members may prefer that women not have access to places outside the home, such as FP clinics, either alone or with their friends, which may conflict with women’s own preferences for access and mobility.⁶ Women in our setting may also have a weak outside option and hence low intrahousehold bargaining power due to unequal control over resources and due to social norms such as those that stigmatize women who visit places outside their homes alone or dictate women’s status within the household.⁷ As a result, women’s preferences may receive less weight in household decision-making over contraceptive access and use. In the joint optimum, a woman may therefore be unable to visit FP service providers, either alone or with her chosen peers, which may contribute to her unmet need for FP. These outcomes may significantly differ from her private optimum despite being Pareto efficient in the collective framework (Baland and Ziparo, 2018; Browning and Chiappori, 1998; Chiappori and Mazzocco, 2017).

With this collective bargaining framework in mind, we experimentally evaluate two approaches that seek to improve women’s reproductive agency. Our first intervention enables women to more easily afford FP services, thereby reducing their financial dependence on their family in a setting where most women do not have access to independent income. Our second intervention additionally enables women to leverage the support of their peers to visit FP service providers, further reducing their dependence on their husbands and mothers-in-law, in a setting where women are unable to access places outside the home alone.⁸

More specifically, we randomly allocated our sample women to either a control group or one of two treatment groups. Women in the first treatment arm were provided a voucher package, in private, for subsidized FP services at a local clinic for their own use, including reimbursements for transportation to visit the clinic (the “Own” voucher group). We expect the voucher to implicitly improve the woman’s outside option since it allows her to individually decide whether to use contraception and visit a FP provider. As a result, we expect that receipt of the voucher should increase the likelihood that women will visit FP service providers and use modern contraception. Additionally, for the same reason, we expect that voucher recipients should be more likely to visit the clinic in their preferred manner (e.g., alone or with their chosen companions, such as their friends, rather than with their mothers-in-law).

However, simply having access to a voucher may not be enough to overcome the mobility barriers faced by our sample women. First, visiting a clinic alone may not be women’s preferred option due to concerns about safety, lack of confidence, and fear of social stigma or community disapproval of young women seeking FP services alone.⁹ Thus, in order to visit the clinic to utilize the FP voucher,

context (Anukriti et al., 2022).

⁶For instance, nearly one-third of women in rural UP reported that their husbands do not permit them to meet their female friends (Government of India, 2022). Similarly, at baseline, for a significant fraction of our sample women, their preferred companion for visiting FP providers was different from the most common companion (the mother-in-law) for women who had in fact visited a FP clinic. Intrahousehold misalignment in fertility preferences may doubly disadvantage women if their mobility and access to social connections itself are constrained by those very same discordant family members, such as their mothers-in-law.

⁷These norms, which are gender-based and hierarchically rooted, dictate both a woman’s absolute position in the home based on her relationship to the household head as well as her status relative to other household members.

⁸Based on data from 52 developing countries, Klugman et al. (2014) document that physical mobility barriers are widespread, especially among younger adult women, and can have detrimental effects on women’s opportunities and choices.

⁹Only 6 percent of our sample women who had previously visited a FP provider at baseline reported doing so alone. Nearly 86 percent of women at baseline reported that they would be more likely to go to a health

interested women may need to seek the company of other women.¹⁰ Second, it may be challenging for women in our setting to find the company of other women because they may lack friends or have limited engagement about FP with women besides their mothers-in-law due to social isolation (Andrew et al., 2020; Kandpal and Baylis, 2019; Prillaman, 2021).¹¹ Third, even if women have friends or peers who could accompany them to the clinic, those peers may face their own intrahousehold and financial barriers to visiting FP providers and accessing places outside the home, and may be unwilling or unable to accompany a voucher recipient without an incentive.

Therefore, to enable women to more effectively leverage the support of their female peers, women in the second treatment arm not only received the voucher package for their own use, they could also offer the same package to peers of their choice if these peers accompanied them to the clinic at least once (the “Bring-a-Friend (BAF)” voucher group). Because of this additional incentive or voucher for their accompanying peers, we expect the BAF voucher to be more effective than the Own voucher in enabling treated women who wanted to visit a FP provider with other women to in fact do so by forming new social connections and increasing their FP-related social engagement with other women.

We note that the relevance of peers in the context of FP is *a priori* unclear. A woman in our setting would likely need to carefully reflect on the benefits and costs while deciding: 1) whether to rely on peers as part of her FP decision-making; and 2) the type(s) of peers whom she may solicit for support. Even if we assume that a woman is able to effectively screen and select peers whom she believes are supportive, these choices are not straightforward in the context of FP which is a more private, sensitive, and often stigmatized matter relative to even other health decisions.

We estimate treatment effects of each intervention arm separately and also compare outcomes between the Own and BAF voucher groups to isolate the effect of inducing peer engagement and support by holding financial empowerment constant. In addition, we examine heterogeneity in the treatment effects by mother-in-law opposition to FP at baseline to examine the relative effectiveness of financial and peer support in overcoming intrahousehold discordance and improving women’s agency.

Our analysis produces three key findings. First, both Own and BAF vouchers significantly increased women’s likelihood of visiting a clinic for FP services overall as well as without their husbands or mothers-in-law (i.e., either alone or with female peers), relative to control women. Moreover, the BAF voucher was significantly more effective than the Own voucher—in increasing clinic visits overall and those without husbands or mothers-in-law—for women who faced greater opposition to FP use from their mothers-in-law at baseline. In fact, the Own voucher was ineffective in increasing clinic visits for women whose mothers-in-law were opposed to their FP use at baseline. This suggests that the peer support facilitated by BAF vouchers enabled women to overcome resistance from their mothers-in-law

facility for FP services if a friend or a relative volunteered to come with them.

¹⁰Given the highly gendered nature of social interactions in our setting, and particularly around matters related to FP and reproductive health, we do not expect women to seek the company of men, other than their husbands. Moreover, even if spousal preferences were aligned, husbands are often unavailable due to work-related migration or relatively high opportunity costs of their time on the labor market. At baseline, more than half of our sampled women’s husbands had been away from home for one month or more at a time and a third had been away for six months or more at a time during the last twelve months. In addition, women may prefer the company of women other than their mothers-in-law because they may feel more comfortable sharing a relatively private experience, such as talking to a FP service provider, with a female friend rather than with their mothers-in-law, particularly if their fertility and FP preferences are discordant.

¹¹At baseline, an average woman in our sample reported interacting with less than one other individual besides her husband and mother-in-law in her village about issues related to FP and reproductive health.

to FP use over and above the enabling effect of the Own voucher.

Second, modern contraceptive use increased significantly by 49 percent for the BAF group relative to the control group; the effect of the Own voucher was 44 percent but it was statistically insignificant at conventional levels. Moreover, only the BAF voucher significantly increased modern method use for women who faced social barriers to FP use at baseline, including women who perceived their mothers-in-law to be opposed to FP and women who were embarrassed to use FP at baseline. Crucially, we rule out any unintended backlash effects on treated women in response to increased FP use, even in households where husbands or mothers-in-law were opposed to FP (Ashraf et al., 2014).

Third, the BAF voucher increased a woman’s number of social connections. Specifically, a woman’s number of “close outside peers” in her village, i.e., individuals outside the household with whom she discusses FP-related issues, increased by 26 percent for the BAF group relative to the control group and significantly more so than the Own voucher group. In addition, the BAF voucher enhanced women’s FP-related engagement with their close outside peers. Women in the BAF group were more likely to have at least one close outside peer in their village who had accompanied them to a health facility and who had advised them to use FP relative to women in both the control and Own voucher groups. Most notably, the effect on women’s number of connections is driven by BAF women who potentially had a stronger “need” for new peers because none of their existing peers were FP users at baseline—the number of close outside peers in the village doubled for such women relative to the control group.

The reduction in women’s social isolation that resulted from our interventions also generated additional benefits for treated women. The BAF voucher reduced women’s fear of stigma related to FP use by 40 percent relative to control women; the Own voucher had no such impact. This finding is consistent with previous research showing that peer support can decrease stigma around health outcomes (Burke et al., 2019; Castro and Mang, 2022).¹²

Taken together, our results suggest that although offering women a voucher for their own use, a commonly used policy tool (Ashraf et al., 2014; Athey et al., 2021; Bellows et al., 2015; Karra and Zhang, 2021), may improve women’s FP outcomes on average, such an intervention may be ineffective for women who are socially isolated, mobility constrained, and face intrahousehold opposition to FP use.¹³ Indeed, such barriers can reduce the effectiveness of any intervention that requires women to “cross the boundary” in contexts where their physical mobility and access are constrained (Jayachandran, 2019). Only when we combine a voucher for a woman’s own use with a voucher that encourages a woman’s peers to participate do we observe improvements in FP outcomes for socially constrained women. Moreover, enabling women to incentivize other women to accompany them to the clinic also expands the peer connections of socially isolated women.

Previous literature has established that individuals derive many benefits from their social connections (Breza et al., 2016; Munshi, 2014). The lack of social engagement around typically gendered subjects, such as FP, can limit women’s access to information, sustain fear of stigma, and negatively impact women’s health (Behrman et al., 2001). Recent studies have shown that female peers can

¹²These peer-induced effects potentially may extend to other benefits that are beyond the scope of this study, including improvements in mental health and life satisfaction.

¹³Vouchers have also been used to improve women’s outcomes in other domains, such as employment (Clark et al., 2019), experience of intimate partner violence (Hidrobo et al., 2016), land ownership (Ali et al., 2016), and skills training (Cheema et al., 2020).

empower women (Field et al., 2016; Kandpal and Baylis, 2019); however, little is known about what type of interventions can help women leverage their peers to increase their agency (Diaz-Martin et al., 2021). Although interventions, such as organizing women into groups (e.g., Kumar et al. (2019)), have been used to strengthen women’s social connections, only 20 percent of Indian women are members of such groups (Desai and Vanneman, 2015). Moreover, as argued by Diaz-Martin et al. (2021), improving social connections is only a hypothesized benefit of women’s groups that is insufficiently supported by quantitative evidence, highlighting the need for other innovative approaches. To our knowledge, no other study has tested whether the social engagement of relatively isolated women can be enhanced by enabling them to build new connections by offering other women financial incentives, especially in the context of FP-RH.¹⁴

Our work also contributes to the literatures on intrahousehold bargaining and on the interactions between culture and the family. Prior research based on collective models of the household (Chiappori and Mazzocco, 2017) has mainly focused on spousal interactions, particularly when examining fertility and FP decisions (e.g., Ashraf et al. (2014); McCarthy (2019)). However, a growing body of work in economics (Anukriti et al., 2020; Bau and Fernández, 2021; Gupta et al., 2021; Khanna et al., 2015; McKelway, 2021; Rossi, 2019) and a large literature in other disciplines (Gram et al., 2018; Rassam, 1980) has emphasized the importance of other household members in household decision-making. As our study highlights, family structures and coresidence patterns are key determinants of women’s economic decision-making. Ignoring these features of the household can lead to policies and programs that are ineffective and potentially even harmful for recipients of these programs. Our study is also unique in showing that vouchers and peer connections can be leveraged to improve women’s reproductive agency by overcoming the constraints imposed by mothers-in-law in patrilocal societies.

Finally, women across the globe continue to have limited access to economic opportunities, services, and public spaces due to restrictive gender norms, e.g., Bernhardt et al. (2018); Bursztyn and Jensen (2017); Jayachandran (2015); Olivetti and Petrongolo (2016). In our context, women’s inability to access FP clinics is partly driven by social norms that prevent women from “crossing the boundary,” which governs their (lack of) access to public spaces alone as well as their social interactions with individuals outside the household, similar to the Pakistani context examined in Cheema et al. (2020). Our BAF voucher intervention addresses these mobility barriers not by changing the social norm (although we observe a small but significant increase in women’s ability to visit clinics alone), but by enabling women to “bypass” these confining normative conditions by visiting clinics with their female peers, who may be less likely to constrain their choices than husbands or mothers-in-law.

2 Experimental Design and Data

In this section, we describe our study sample, the experimental design, the interventions that were implemented as part of the randomized experiment, the data, and the landscape of FP service provision in our study area.

¹⁴Our paper is also related to the increasing number of studies that have documented peer effects in the use of health technologies, e.g., Godlonton and Thornton (2012); Goldberg et al. (2018); Miguel and Kremer (2003); Oster and Thornton (2012); Sato and Takasaki (2018)).

2.1 Sample

Our study is based in 28 villages of Jaunpur district in the state of UP (Figure A.1). Although total fertility rate has been declining in rural UP, the share of contraceptive demand satisfied by modern methods is only 58 percent in rural UP relative to 74 percent in India as a whole (Government of India, 2022), making our intervention highly relevant for this context.

Figure A.2 describes our sample selection process. We began by conducting a listing exercise for all households ($N = 2,781$) that were located within a 10-kilometer radius of our partner clinic, the Arogyaneer Diagnostic Clinic (ADC), situated in the village of Chandwak. The ADC was chosen based on its proximity to our sample women (many of whom lived in Chandwak), more reliable supply of a wide range of FP methods, and higher quality of service, relative to other clinics in the area. A total of 698 households were identified to have at least one eligible woman, i.e., a married woman aged 18-30 who (i) had at least one living child, (ii) was neither sterilized nor had undergone a hysterectomy, and (iii) was neither currently pregnant nor within six months postpartum. These inclusion criteria were selected to identify a sample of young married women of reproductive age with a potential unmet need of FP and for whom an FP intervention, such as ours, would likely be effective.¹⁵ We enrolled no more than one woman per household. If multiple women from the same household were eligible, the youngest eligible woman from the household was chosen to participate. From 698 women who were invited to participate in the study, 671 consented and were recruited. Figure A.3 presents the map of our intervention site and study sample.

2.2 Experimental Design

Figure 1 presents our experimental design. The experiment consisted of a baseline survey, followed by randomization of women into one of three intervention arms, a 10-month-long intervention, and an endline survey. All communication with the study sample was conducted in Hindi, the local language. The baseline survey was administered by female enumerators during July and August 2018 to 671 women. To address information gaps on FP among our sample women, a brochure on modern FP methods and the benefits of healthy timing and spacing of births was given to all sample women at the conclusion of the baseline survey (Figure A.4).

Soon after completion of the baseline survey, women were individually randomized to either the control group ($N = 350$ women), the Own voucher group ($N = 156$ women), or the BAF voucher group ($N = 165$ women). Following Bruhn and McKenzie (2009), we implemented a stratified randomization protocol by balancing treatment assignment according to the following baseline characteristics of a woman: current use of FP, years of schooling, desire for another child, and the number of peers mentioned by her as part of our social networks module. Tables 1 and A.1 show that treatment assignment was balanced across a range of baseline characteristics of the woman including her age, religion, number of children, whether she had at least one son, marital duration, co-residence with the mother-in-law, number of close peers in the village, contraceptive use, beliefs about her mother-in-law's opposition to FP use, household asset score,¹⁶ and whether her last visit to an FP clinic

¹⁵We excluded married women who had not begun childbearing from our study due to the presence of cultural norms that compel newly married couples to prove their fertility as soon as possible after marriage before considering FP (Jejeebhoy et al., 2014).

¹⁶We construct the household asset score using a principal component analysis with the following variables: source of drinking water, type of toilet facility, floor material, roof material, exterior wall material, type of fuel

was with her husband or mother-in-law.¹⁷ We observe some differences across groups in the mobility score,¹⁸ whether a woman belongs to a Scheduled Caste or Tribe or an Other Backward Class, and the proportion of women who worked at baseline, so we control for these variables in all regressions. Moreover, the joint F-statistics in Tables 1 and A.1 show that the pairwise differences between the three intervention groups are jointly insignificant.

Following randomization, female enumerators revisited women who were assigned to the treatment groups. Enumerators were divided into two teams (one for each treatment group) to prevent an enumerator from either deliberately or mistakenly handing out an incorrect voucher to a woman who had been assigned to the other treatment group. During this second visit to the treatment women, the enumerators explained the terms and conditions of the intervention and confirmed women’s consent to participate in the intervention.¹⁹ No woman refused to accept the voucher; however, 14 treatment women (8 Own voucher and 6 BAF voucher) could not be re-contacted following baseline and therefore did not receive the voucher.²⁰

2.3 Interventions

Women in both treatment groups were provided a voucher for INR 2,000 (USD 24) that could be used to obtain FP services at the ADC over a 10-month period from the date of voucher receipt. At the time of our study, a voucher worth INR 2,000 translated into different proportional discounts depending on the type of FP method that was procured. If a woman chose to purchase oral contraceptive pills or condoms, the voucher constituted a 100 percent discount on the total cost for these methods over the 10-month period. The voucher could be used for any FP-related services that were offered by the ADC. The voucher was designed to resemble an identification card and was personalized for each woman with her name and photograph printed on it. In addition, the first consultation at the clinic, during which time a woman was evaluated to determine if she was medically fit to use FP, was provided for free to all voucher recipients. All voucher recipients were also informed that they would be provided with INR 40 (USD 0.48) as a reimbursement for any transportation expenses that they may incur to travel to the ADC. No receipts were required to receive this reimbursement. The transportation reimbursement was restricted to a maximum of three trips (for a total of INR 120 in reimbursement costs) for any woman over the course of the intervention period.

Women assigned to the BAF voucher group were additionally informed that if they were accompanied by peers to the ADC, these peers, during their first joint visit with them, would be provided with their own voucher package for FP services. BAF voucher women were allowed to bring anyone

used for cooking, ownership of animals, number of rooms in the household used to sleep.

¹⁷Randomization was also balanced across several other variables, including household’s Below Poverty Line (BPL) status and the amount of land owned by the household, whether the woman gave birth last year, her husband’s migration status, the woman’s decision-making ability, the distance from a woman’s home to the ADC and to the closest clinic located in the study area.

¹⁸The composite mobility score is calculated as the sum of six indicator variables that captures whether a woman is allowed to visit the following places alone: 1) homes of relatives or friends; 2) health facilities; 3) grocery stores; 4) short distances by bus or train; 5) markets; or 6) outside their villages or communities.

¹⁹Women assigned to the intervention arms were told that they were free to withdraw their participation from any intervention activity at any time and also could rejoin at any time over the 10-month intervention period without any penalty.

²⁰Out of these 14 women, 4 women were also unreachable at the time of endline data collection—thus, among the sub-sample that we did re-interview at endline, 10 treated women (6 Own and 4 BAF voucher women) did not receive the vouchers as intended.

with them, but since the voucher could only be used for FP, they were encouraged to bring someone who could make use of FP services. BAF voucher women could bring up to two peers during any given visit, and they could either bring different peers or the same peers on subsequent visits. During their first visit to the clinic with a BAF voucher woman, a woman’s peers were provided with their own vouchers and identification cards by one of the field managers who was stationed at the ADC to receive clients; thereafter, these peers could visit the clinic with or without the BAF voucher woman. There was no restriction on the total number of unique peers a BAF voucher woman could bring to the clinic over the 10-month period, as long as she did not bring more than two peers per visit. If a BAF woman came to the clinic with her husband, only one voucher could be used for the couple, and the clinic’s existing FP operating procedure for couples was followed. The intervention team made it clear that women could not apply two vouchers at once to increase the total discount. This ensured that a BAF peer who herself also happened to be assigned to either the Own voucher or BAF voucher arms could not combine her own voucher with the peer discount.

Under this design, the voucher package that peers of a BAF woman received when they accompanied her to the clinic is essentially equivalent to the Own voucher package. Specifically, peers of a BAF woman were not entitled to receive additional vouchers for their other peers. Own voucher women were also free to bring peer(s) with them to the clinic if they chose; however, they were not actively encouraged to do so by the study team and any peers who accompanied them to the clinic were not provided a voucher unless they had their own voucher.

At the end of the 10-month intervention period, 625 women (93.2 percent of the initially recruited sample) were re-interviewed either in person or via phone for the endline survey.²¹ Figure 1 provides details on the reasons for attrition. Table A.2 shows that there are no significant differences between attritors and non-attritors in terms of treatment status and along a range of baseline characteristics that are relevant for the study. Although the joint F-statistic is also insignificant, non-attritors were significantly more likely at baseline to report that their mothers-in-law were opposed to FP and were more likely to use an FP method than non-attritors.²² The imbalance by mother-in-law opposition is less worrisome because it biases us against finding a positive effect on FP access and use. However, it is unclear whether the imbalance by baseline FP is likely to bias our estimates upward or downward.²³

The majority of treated women understood how the vouchers worked: at endline, 81 percent reported knowing about the transportation reimbursement; 67 percent knew about the free FP consultation; 76 percent knew about discounted FP services at the ADC; and only 4 percent of women incorrectly thought that child health services were covered by our intervention. To cross-check whether women understood the differences between vouchers, we asked treated women if the program enabled

²¹We conducted 18 percent of the endline surveys by phone mainly because some women could not be contacted at their recorded locations from baseline, either because they had moved or were visiting someone outside their homes. As per our protocol, we made up to three attempts to contact each woman at her home, after which we attempted to contact her by phone if she was not available in person. As Table A.3 shows, there are no observable differences in the baseline characteristics and treatment status between women who were surveyed in person or by phone at endline.

²²Although our attrition rate is relatively low, we estimated Lee (2009) bounds for the treatment impacts and find that our main results are not driven by selective attrition. These results are available upon request.

²³For instance, women who had previously used an FP method at baseline may be more likely to use our vouchers to switch from other providers to the ADC. However, such women may also be less likely to report an increase in contraceptive use if they were already using an FP method at baseline.

them to offer their friend(s) a voucher if they visited the ADC with them. While 74 percent of women in the BAF arm positively responded to this question, only 6 percent in the Own group did the same.²⁴

2.4 Data

Our survey instruments collected data on household demographics and women’s socioeconomic background, birth history, contraceptive use, marriage and sexual activity, fertility preferences, autonomy, social connections, and utilization of health services, including FP services. To measure the social connectedness of our sample women, we asked each woman to name up to five individuals in the study area, besides her husband and mother-in-law, with whom she converses most often about any issue (e.g., financial support, health, child health, and schooling) that is important to her; we call these individuals her “general peers”. In addition, we asked each woman to name up to five individuals in the study area, besides her husband and mother-in-law, with whom she discusses issues related to FP and reproductive health; we denote these individuals as her “close peers”.²⁵ We then collected socioeconomic, demographic, FP-related, and peer-group-related information (e.g., measures of trust and closeness) from the surveyed woman for each of her identified close peers. Since a woman’s FP decisions may also be shaped by her husband, mother-in-law, and relatives outside the study area, we also asked about her interactions related to FP with these key individuals and documented her beliefs about their attitudes towards fertility and FP. In this manner, we sought to capture each respondent’s immediate social neighborhood and the peer group characteristics through which attitudes about fertility and FP are most likely to be shaped and spread. In the module on health services utilization, we asked each woman about her access to FP clinics, such as whether she has visited an FP clinic and whether she goes to the FP clinic alone or with other individuals.

Tables 1 and A.1 provide context about the types of women who were included in our experiment. Our sample is comprised of young married women who, on average, were 25 years old and had nine years of schooling and 1.9 children at baseline. The sample is predominantly Hindu and comprises women from Scheduled Castes (SC), Other Backward Classes (OBC), and general or upper castes. Women have low mobility, financial autonomy, and reproductive agency. The mobility restrictions faced by the sample women are quite severe, as is reflected in their extremely low composite mobility scores that capture the number of places that a woman is allowed to visit alone. Only 14 percent of women worked in the last year and 90 percent reported wearing a headcovering (*ghunghat* or *purdah*). Nearly 44 percent of our sample women reported having no say in decisions about their health care and 56 percent of women reported not being allowed to visit a health facility alone at baseline. Although 50 percent of women reported not wanting to conceive another child, only 18 percent reported using modern contraception, reflecting significant unmet need.²⁶ Furthermore, our sample women are socially isolated. An average woman has 1.6 general peers and only 0.2 close peers outside her home. Women who live with the mother-in-law (68 percent of our sample) tend to have even lower mobility and fewer

²⁴All results in this paper are robust to the exclusion of treated women who did not understand how their voucher worked from the estimation sample. These results are available upon request.

²⁵In both baseline and endline surveys, all participants reported fewer than five close peers. Thus, five appears to be an effective upper limit on a woman’s number of social connections in our sample and is unlikely to introduce downward bias due to top-coding (Chandrasekhar and Lewis, 2012).

²⁶The lack of contraceptive uptake is unlikely to be driven by a lack of awareness about FP or supply-side issues given that, at baseline, 96 percent of our sample women had heard about FP or birth spacing and in recent decades there have been significant improvements to FP service provision in India (Halli et al., 2019).

social connections outside the home (Anukriti et al., 2020).

In Table A.4, we compare our sample with 18-30-year old married women who were surveyed in the 2019-21 India Demographic Health Survey (DHS). Women in our sample are quite similar to those in the all-India sample and the UP and rural India subsamples in most respects. Notable exceptions include education, where our sample is slightly more educated, and mobility constraints, where our sample women face more severe constraints than those experienced by an average Indian woman (Government of India, 2022).

2.5 Landscape of Family Planning Service Provision

Almost 70 percent of women in India, and 63 percent of women in rural Uttar Pradesh, who use modern contraceptive methods obtain them from a public sector provider or facility (Government of India, 2017). The provision of FP services, including the procurement of contraceptive methods, in the public sector are subsidized by the national government, with the aim of achieving universal access to FP, particularly for rural and marginalized women (MOHFW, 2016).

In addition to the ADC, which was the only private facility in our study area, our sample women had access to 9 public facilities (3 primary health centers, 3 community health centers, and 3 hospitals) within a 10-kilometer radius of our enumeration areas. Our sample women, on average, lived 2.2 kilometers away from their nearest health facility at baseline, with 88 percent of women living within 5 kilometers from their nearest health facility. The ADC was the closest health facility for 46 percent of our sample, with the average distance being 2.4 kilometers. Among the 18 percent of our sample women that were using a modern method at baseline, 24 percent had obtained the method from a public health facility or provider; 11 percent had received it from a private provider, and the majority (54 percent) had received it from friends, relatives, or other local sources (pharmacies, drug stores). Male condoms were the most used modern method (60 percent of users), followed by the contraceptive pill (14 percent), and IUDs (13 percent).²⁷

3 Empirical Strategy

Our experimental set-up allows us to estimate treatment effects by comparing women in the two voucher groups with those in the control group. We estimate the following Ordinary Least Squares regression to estimate the effect of receiving an Own or a BAF voucher, with one endline observation per woman:

$$Y_{iv} = \alpha + \beta Own_{iv} + \theta BAF_{iv} + \mathbf{X}_{iv}^0 \gamma + \mathbf{Z}_{iv}^0 \phi + \delta_v + \epsilon_{iv} \quad (1)$$

Y_{iv} is an outcome variable measured at endline for woman i who lived in village v at baseline. Own_{iv} is an indicator variable that equals one if woman i randomly received a voucher only for herself, while BAF_{iv} is an indicator variable that equals one if the woman was randomized to receive a BAF voucher.

Although our randomization was balanced along a number of characteristics, as shown in Tables 1 and A.1, we include two sets of control variables in our main specification primarily to improve

²⁷Kapoor et al. (2019) find substantial gender gaps in access to health care, with nearly 49 percent of the total female outpatient visits to a large referral public hospital in Delhi being “missing” from the states of Uttar Pradesh, Haryana, Delhi, and Bihar. Moreover, these gender gaps are larger for younger women in the reproductive age group.

the precision of our estimates. The vector \mathbf{X}_{iv}^0 denotes the set of baseline variables that were used to balance treatment assignment—these include a woman’s years of schooling, number of general peers, and indicators for current use of FP and desire for another child.²⁸ The vector \mathbf{Z}_{iv}^0 denotes a second set of baseline variables that can influence FP-RH-seeking behavior, such as woman’s age, her composite mobility score, household asset index, and indicator variables for belonging to a SC or ST, belonging to an OBC, for being Hindu, for practicing ghunghat, for working last year, and for having ever visited an FP clinic.²⁹ We also include village fixed effects, δ_v , in our regressions to control for unobserved and time-invariant characteristics at the village level that may influence the outcomes of interest. However, as we show in the next section, our results are robust to the exclusion of baseline controls and village fixed effects.

We present estimates for intent-to-treat (ITT) effects. The treatment-on-the-treated (TOT) effects of our interventions for all outcomes are similar and are presented later in Online Appendix. The coefficients β and θ measure the impacts of receiving the Own voucher and the BAF voucher, respectively, on the outcome variable of interest. The difference between β and θ captures the additional effect of providing a woman vouchers for her companions, conditional on receiving a voucher for herself. Table A.5 provides descriptive statistics for the variables used in our analysis for the estimation sample.

We use robust standard errors for inference. Although we randomize at the individual level, we confirm that our results are robust to clustering the standard errors by village to allow for correlated errors within village, reflecting, for instance, a common set of peers, access to the same set of clinics, or the similar timing of endline data collection. As we have 28 villages in our sample, we also verify that our main estimates are robust to inference based on wild-clustered bootstrapped errors, which account for the small number of clusters. Lastly, we check that our main findings are robust to multiple hypotheses testing correction. We present these robustness checks in Section 4.

If women in the treatment groups sought the company of or visited the ADC with women in the control group, our estimates of treatment effects would be biased downwards. This concern is especially relevant if BAF women offered a voucher to women in the control group. However, this is unlikely to be a significant concern because, at endline, only 4 women in the control group reported having received a voucher for FP services at the ADC. This is likely due to the fact that we selected only one woman per household for our experiment and our sample women had relatively few connections with women outside their households at baseline.

4 Results

We begin by examining whether treated women invited others to accompany them to our partner clinic and subsequently visited the clinic with them, and who these companions were. We then analyze whether voucher receipt translated into an increase in modern contraceptive use. Next, we assess the impact of voucher receipt—especially the BAF voucher—on a woman’s social interactions and her fear of stigma related to FP use.

We expect that the magnitude of the treatment effect will differ across the sets of outcomes that

²⁸Kernan et al. (1999) and Bruhn and McKenzie (2009) show that the failure to control for stratification variables results in overly conservative standard errors. We lose 5 observations when we include these controls due to missing data for indicators for current use of FP and desire for another child at baseline.

²⁹We lose 4 observations when we include these controls due to missing data for the work variable at baseline.

we examine, and will likely attenuate as we move from seeking companionship to visiting the ADC to contraceptive use. For example, it is plausible that after asking or inviting a peer, some treated women or their invited peers are subsequently prohibited or dissuaded from going to the FP clinic by their households. Similarly, not everyone who visits the ADC may be able to use a contraceptive method afterwards due to contraindications, health concerns, or pregnancy that may be identified during the first visit to the ADC, or if they are unable to meet the health care provider during their visit for some reason.

4.1 Clinic Visits for FP Services

Upon receiving either voucher, a woman in need of FP services can either choose to visit the ADC alone or invite someone to visit the ADC with her. We expect both vouchers to improve a woman’s ability to visit the ADC alone equally; however, most women at baseline preferred to visit FP clinics with someone.³⁰ Consequently, we expect that most treated women who want to visit the ADC will also want to seek company from a relative or a friend rather than visit the clinic alone. Moreover, we expect the BAF voucher to be more effective than the Own voucher in enabling a woman to invite someone other than her husband and mother-in-law to the clinic as only BAF women can offer their peers a voucher of their own as an incentive.

A. Seeking company to visit the ADC.

Consistent with our expectations, in Column 1 of Table 2 we find that women in both treatment groups were significantly more likely than the control group to seek the company of another person to visit the ADC during the intervention period.³¹ Moreover, women in the BAF group were significantly more likely to invite others compared to women in the Own voucher group; the impact of receiving a BAF voucher on seeking company (34 percentage points (p.p.)) is almost double the estimated impact of receiving an Own voucher (18 p.p.).³² We find similar effects on the intensive margin (Panel A of Table A.7). Both vouchers increased the number of individuals that a woman asked to accompany her to the ADC, and the impact of the BAF voucher was significantly larger than that of the Own voucher. These findings also indicate that the treatment women understood the difference between the two types of vouchers and that this difference was salient in encouraging women to seek companionship.

Given that a primary objective of our study is to test if the interventions decreased women’s dependence on their husbands and mothers-in-law to access FP, next we examine whether the vouchers enabled a woman to seek company from individuals other than her husband and mother-in-law during

³⁰ Among women in our sample who usually do not visit health facilities alone, 59 percent mentioned concerns about safety, 28 percent cited lack of confidence, and 20 percent mentioned fear about community disapproval as the main reasons for not going alone at baseline.

³¹ Ideally, we would compare treatment and control groups in terms of the likelihood that a woman sought company to visit *any* clinic. Unfortunately, we do not have data on whether a woman invited others to accompany her to visit clinics other than the ADC during the intervention period. Therefore, it is possible that the outcome means for control women in Table 2 are low not because they sought company to visit clinics at a lower rate than treatment women in general, but rather because control women might have sought company to visit *non-ADC* clinics, given that they had no incentive to visit the ADC. Nevertheless, this issue is not pertinent for the comparison that we are most interested in, i.e., between Own and BAF voucher groups, because both groups had a similar incentive to visit the ADC. Moreover, this issue does not arise for our analysis of visits since we collect data on visits to both the ADC and other clinics for FP services.

³² Panel A of Table A.6 shows that these estimates are robust to the inclusion or exclusion of various control variables.

the intervention period. Our interest in examining who was “asked” or “invited” by the woman to visit the clinic with her (which is distinct from who actually “visited” the clinic with the woman) stems from the fact that husbands and mothers-in-law exercise significant control over women’s social interactions and freedom of movement in this setting.³³ In such a context, simply seeking company from individuals other than husbands and mothers-in-law may, in itself, be an expression of women’s agency and empowerment, irrespective of whether this intention translates into clinic visits and health care utilization.

Indeed, Columns 2-5 of Table 2 show that the vouchers, and particularly the BAF voucher, altered the type of companions who were sought by treatment women relative to the control group.³⁴ The likelihood of seeking company of individuals other than husbands or mothers-in-law was 28 p.p. higher for the BAF group and 11 p.p. higher for the Own voucher group relative to the control group. In contrast, the impacts of both vouchers on the likelihood of asking husbands and mothers-in-law were much smaller (3 p.p. for the BAF voucher and 4 p.p. for the Own voucher, respectively). Moreover, the BAF voucher was significantly more effective (by 17 p.p.) than the Own voucher in enabling women to invite individuals other than their husbands and mothers-in-law. In contrast, both vouchers had a statistically similar effect on women’s likelihood of asking their husbands or mothers-in-law.

Notably, treated women were more likely to seek the company of their sisters-in-law and non-relatives (female friends or neighbors), and these effects are significantly larger for the BAF group relative to the Own voucher group. In Column 4 of Table 2, the BAF voucher increased a woman’s likelihood of asking her sister-in-law by 18 p.p., while the effect for women who received an Own voucher was significantly smaller (6 p.p.). Similarly, Column 5 shows that the effect of receiving a BAF voucher on a woman’s likelihood of asking non-relatives was more than double that of receiving an Own voucher. The larger effects for sisters-in-law than for non-relatives are consistent with our understanding of the study context, where women are less likely to be sanctioned by their husbands and mothers-in-law for interacting with other female relatives than for interacting with female friends. Given that our sample women have few pre-existing peer connections outside the home, it might also be easier for women to reach out to their sisters-in-law, some of whom maybe co-resident, than to form new connections with non-relatives.

B. Clinic visits.

In Table 3, we examine the treatment effects on clinic visits for FP services. Column 1 shows that both vouchers significantly increased the likelihood that treated women visited the ADC for FP services during the intervention period relative to control women. Women who received the Own and BAF vouchers were, respectively, 20 p.p. and 19 p.p. more likely than control women to have visited the ADC. However, the effect of the BAF voucher was not statistically different from the effect of the Own voucher.³⁵

³³For instance, 72.4 percent of women in rural UP report that their husbands do not permit them to meet their female friends, insist on knowing their whereabouts at all times, or limit their contact with their families (Government of India, 2022). Therefore, it is not surprising that, at baseline, 79 percent of women who had visited an FP clinic reported being accompanied by their husbands (35 percent) or mothers-in-law (44 percent).

³⁴These outcomes are not conditional on asking someone for company. For example, the indicator for whether a woman asked her sister-in-law for company is coded as zero both when she asked someone else as well as when she did not ask anyone.

³⁵Appendix Table A.8 shows that these results are robust to the inclusion or exclusion of various control

Next, we examine the effect of both interventions on a woman’s likelihood of visiting *any* clinic (either the ADC or a non-ADC clinic) for FP services during the intervention period. This analysis allows us to measure the extent to which the effects on visiting the ADC are driven by (i) substitution away from other clinics to the ADC and (ii) new clients. Column 2 of Table 3 shows that there was a sizable and significant increase in the likelihood of visiting any FP clinic among Own voucher (by 17 p.p.) and BAF voucher (by 13 p.p.) groups relative to the control group (control mean: 0.19).³⁶ The effect of the BAF voucher is statistically similar to that of the Own voucher. These results imply that our intervention effects are not exclusively driven by women substituting away from non-ADC clinics to the ADC, but also by an increase in new visitors to FP clinics.

Consistent with FP vouchers being more relevant for women who have a higher demand for FP, in Column 1 of Table A.9, we find that the effects on clinic visits are driven by women who did not want another child at baseline. Moreover, the effects are larger for women who had at least one son at baseline (Column 2 of Table A.9), which is in line with the high prevalence of son preference and son-biased fertility stopping rules in our setting (Anukriti et al., 2021; Bhalotra and Soest, 2008; Clark, 2000; Jensen, 2012; Rosenblum, 2013). Column 3 of Table A.9 shows that even women who had never visited an FP clinic at baseline had a significant increase in the likelihood of visiting a clinic for FP due to the voucher, indicating that our interventions were effective in bringing in new clients.

In Columns 3-5 of Table 3, we test if the voucher-induced visits to the ADC were more likely to have taken place without women’s husbands or their mothers-in-law, i.e., either alone or with individuals other than husbands and mothers-in-law.³⁷ Unsurprisingly, some women in the treatment groups who visited the ADC did so with their husbands and mothers-in-law (Column 4). Nevertheless, treatment women were also significantly more likely to visit the ADC alone relative to the control group. It is worth noting that, at baseline, only 6 percent of women who had previously visited an FP clinic had done so alone. In comparison, the Own voucher and the BAF voucher increased the likelihood of visiting the ADC alone by 3.4 p.p. and 5.2 p.p., respectively, during the 10-month intervention period (control mean: 0.01). These results suggest that receipt of either the Own or the BAF voucher empowered a small but significant fraction of our sample women to “bypass” the social norm of visiting an FP clinic with somebody else. Moreover, in Column 5 of Table 3, we observe a significant (6 to 7 p.p.) increase in women’s visits to the ADC with individuals besides their husbands and mothers-in-law for both treatment groups.

C. Heterogeneity by mother-in-law opposition to FP use. Although we observe no significant differences in average treatment effects between the BAF and the Own voucher arms on visiting the ADC or any clinic for FP services (Table 3), we find that the BAF voucher was more effective than the Own voucher for women who, at baseline, were more likely to face intrahousehold constraints to FP access, as proxied by their mother-in-law’s opposition to FP. We focus on the mother-in-law because, in our context, a woman’s mother-in-law exerts a stronger influence over her FP decision-making and fertility outcomes than even her husband or other family members (Anukriti et al., 2022, 2020). This is likely because contraception and childbearing are often viewed as the responsibility of women and

variables.

³⁶Similarly, on the intensive margin (Table A.10), both vouchers significantly increased the number of visits to the ADC and to any clinic for FP services during the intervention period.

³⁷Note that the outcomes in Columns 3-5 of Table 3 are not conditional on visiting the ADC.

considered a “gendered sphere of activity” (Ashraf et al., 2022). Compared to their husbands, women and their mothers-in-law have greater levels of discordance in their overall fertility preferences as well as in their preferences for sons. This misalignment in fertility preferences, in turn, contributes to mothers-in-law expressing a stronger level of disapproval of FP than women’s husbands.

In Table 4, we estimate a fully interacted model for each of our outcomes of interest by interacting whether the woman’s mother-in-law was opposed to FP at baseline with each of the covariates that are included in our main specification, controlling for the main effect of mother-in-law opposition to FP. We find that the BAF voucher was significantly more effective than the Own voucher for women who faced greater opposition from their mothers-in-law at baseline in increasing: a) their ability to seek company from and visit the ADC with individuals other than their husbands and mothers-in-law (Columns 3 and 6); b) the likelihood of visiting the ADC (Column 4); and c) their overall likelihood of visiting any FP clinic (Column 7).³⁸ The p-value for the test evaluating the difference between the effects of BAF and Own vouchers by mother-in-law opposition (i.e., $Own \times MIL\ opposed = BAF \times MIL\ opposed$) is 0.033 for the likelihood of a woman visiting the ADC (Column 4), is 0.070 for her overall likelihood of visiting a clinic for FP (Column 8), and is 0.016 for the likelihood of her visiting the ADC with someone other than her husband or mother-in-law (Column 6) during the intervention period. In fact, for women facing opposition to FP use from their mothers-in-law, the Own voucher was statistically ineffective - both in terms of seeking company and visiting the ADC - in lowering a woman’s reliance on her husband and mother-in-law, as is reflected in the p-values for $Own + Own \times MIL\ opposed = 0$ in Columns 3 and 6.

Our estimates suggest that for women who perceived their mothers-in-law to be opposed to FP at baseline, the BAF voucher increased the likelihood of visiting the ADC by 30 p.p., a significantly larger effect than that of the Own voucher (10 p.p.).³⁹ In contrast, both vouchers had a statistically similar and significantly positive effect on clinic visits to the ADC for women who did not perceive opposition from their mothers-in-law. We observe a similar pattern for visits to any clinic for FP services (Column 7 of Table 4).⁴⁰

Taken together, these findings suggest that the BAF voucher was more effective than the Own voucher in enabling women who perceived their mothers-in-law to be opposed to their FP use to seek company from other women, such as their sisters-in-law or female non-relatives, who may have been more likely to support them in their health care-seeking than their mothers-in-law.⁴¹

This heterogeneity analysis also enables us to rule out other mechanisms underlying our results. For instance, it is possible that BAF women may have felt a greater sense of altruism towards other women who could benefit from an FP voucher or may have been reciprocating or exchanging favors

³⁸Table A.11 presents this analysis for the impacts on inviting sisters-in-law or non-relatives to the ADC.

³⁹In fact, the p-value for $Own + Own \times MIL\ opposed = 0$ in Column 4 equals 0.225, implying that the Own Voucher had an insignificant effect on visits to the ADC for women who perceived their mothers-in-law to be opposed to FP at baseline.

⁴⁰One may be concerned that BAF women are over-reporting that they invited others to visit the ADC with them relative to the Own voucher group due to social desirability bias. However, the results in Table 4 are inconsistent with this proposition unless this bias is negatively correlated with mother-in-law opposition to FP use at baseline.

⁴¹It is unlikely that mothers-in-law would have been interested in visiting the clinic with their daughters-in-law to access FP services for themselves given that, on average, they were 50 years old at baseline and, hence, less likely to want or need FP services.

with other women whom they invited and with whom they visited the ADC. However, altruism or reciprocity are unlikely to be negatively correlated with mother-in-law opposition to FP, allowing us to interpret the heterogeneous effects in Table 4 as an enabling effect of the BAF voucher over and above the effect of the Own voucher, which in turn relaxes some of the intrahousehold constraints to FP access that women face in our setting.

4.2 Modern Contraceptive Use

To examine if a woman’s visits to the ADC due to our interventions changed her FP use, in Table 5 we estimate the reduced form effect of receiving the vouchers on a woman’s modern contraceptive use at endline.⁴² For this analysis, we exclude from our estimation sample 15 women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the clinic. However, our results are robust to the inclusion of these women (see Table A.12).

Column 1 of Table 5 shows that the BAF voucher significantly increased modern contraceptive use at endline by 6 p.p. (i.e., 51 percent) relative to the control group (control mean: 0.12). The effect of the Own voucher is not statistically significant (p-value: 0.147), though it is sizable at 41 percent.⁴³ However, we observe no effects of either voucher intervention on the likelihood of a woman adopting *any* contraceptive method, which implies that any voucher effects on contraceptive use are mainly driven by women switching from traditional methods to modern methods of contraception (Table A.13). We also observe a decline in the likelihood of pregnancy and birth during the intervention period; however, these effects are insignificant because we lack statistical power to detect any changes in fertility within the relatively short 10-month intervention and follow-up period.

Column 2 of Table 5 shows that the BAF voucher had a larger effect than the Own voucher on modern method use for women who, at baseline, faced greater opposition to FP use from their mother-in-law. Although the p-value for the $Own \times MIL\ opposed = BAF \times MIL\ opposed$ test (0.18) is above conventional significance levels, likely due to limited power, the coefficient of $BAF\ voucher \times MIL\ opposed$ (0.20) is clearly larger than that of $Own\ voucher \times MIL\ opposed$ (-0.011). Furthermore, the overall effect of voucher receipt on women who faced mother-in-law opposition to FP at baseline is significant only for the BAF group.⁴⁴ Consistent with this pattern, Column 3 shows that the BAF voucher was more effective than the Own voucher in also helping women overcome other social constraints associated with their FP use. The BAF voucher more than doubled modern method use for women who found FP use embarrassing at baseline.⁴⁵ In contrast, the Own voucher had a smaller and

⁴²Modern methods include female sterilization, male sterilization, IUDs, injectables, implants, pills, condoms, female condoms, emergency contraception, diaphragm, foam or jelly, or any other modern method. On average, treated women utilized a third of the voucher amount by spending INR 309 (USD 4.11) across a total of 94 visits to the clinic. Over the 10-month intervention period, women across both the BAF and the Own voucher groups spent a total of INR 28,824 (USD 318.86) on reimbursable FP services.

⁴³The treatment impacts are entirely driven by short-acting modern methods for which our vouchers translated into a 100 percent subsidy over the intervention period. Short-acting methods include pills, condoms, female condoms, emergency contraception, diaphragm, and foam or jelly.

⁴⁴The p-value for $BAF + BAF \times MIL\ opposed = 0$ is 0.070, while the corresponding statistic for the Own voucher, $Own + Own \times MIL\ opposed = 0$, is 0.669.

⁴⁵The p-value for $BAF + BAF \times Covariate = 0$ is 0.009 in Column 3.

statistically insignificant effect on modern method use for this group of women (p-value for $Own + Own \times Covariate = 0$ in Column 3 is 0.152).⁴⁶

Taken together, our results suggest that enabling a woman to visit FP clinics with other women through a BAF voucher allows her to overcome opposition from influential family members and serves to alleviate her own embarrassment related to FP use. These results contribute to a limited evidence base on the impact of vouchers on FP use (Bellows et al., 2015). While a number of previous studies have been unable to identify causal impacts, our findings are in line with some recent studies that rigorously estimate treatment effects using randomized experiments (e.g., Athey et al. (2021); Karra and Zhang (2021); Tran et al. (2020)). In particular, Athey et al. (2021) find that offering long-acting reversible contraceptive methods for free or at a very small price increased adoption by 50 percent in Cameroon, which is similar to the 41 to 51 percent increase in method use due to the vouchers that we observe in Column 1 of Table 5. However, a crucial way in which our study differs from previous work is in our explicit recognition that financial barriers are only one of the many constraints that women in our context face to accessing and adopting FP services; in this manner, our paper more closely follows Ashraf et al. (2014). For women who experience social and intrahousehold barriers to FP use, such as those that are examined in Table 5, combining a voucher for a woman’s own use with a similar voucher for her peers is much more effective in increasing their uptake of modern contraception as compared to just receiving a voucher for her use alone.

4.3 Women’s Social Interactions

The results thus far have shown that the BAF voucher, more so than the Own voucher, enabled women to seek the company of and to visit the ADC with individuals other than their husbands and mothers-in-law. These social interactions, prompted by the BAF voucher, could potentially have increased a woman’s number of social connections if she formed new connections by offering the BAF voucher to other women who were not her peers at baseline. This is particularly likely to have happened if a woman’s baseline peers were unwilling or unable to accompany her to the ADC or if she believed that her baseline peers either did not approve of or need FP. Additionally, through invitations and joint visits to the ADC, the BAF voucher could have strengthened women’s FP-related engagement with their baseline peers as well as with any new connections that were formed as a result of the intervention. In this section, we provide evidence to support both of these possibilities. Moreover, we show that these changes in social interactions led to additional benefits for women, including a reduction in their fear of stigma related to FP use.

Column 1 of Table 6 shows that, at endline, BAF women reported having a higher number of close peers outside their household but within their village (“close outside peers”) relative to control women and relative to women who received an Own voucher.⁴⁷ Relative to control women, who had an average of 0.36 close outside peers in their village at endline, women who received a BAF voucher

⁴⁶The BAF voucher also increased modern method use by a statistically significant 10 p.p. with respect to the control mean of 12 percent for women who considered concealability to be an important feature when selecting an FP method at baseline. These results are available upon request.

⁴⁷The number of observations in this table is lower than in previous tables because questions related to the outcome variables were not asked from women who were surveyed by phone at endline. Moreover, in columns 2-3, the outcome is only defined for women who had at least one close outside peer in her village at endline, further reducing the number of observations.

increased their number of close outside peers in the village by 0.092, or by 26 percent with respect to the control mean. The BAF effect on a woman’s number of close outside peers in her village is also 12 p.p. larger (p-value of the difference = 0.106) than the null impact of the Own voucher, suggesting that the BAF voucher was more effective in connecting treated women with other women in their villages. Our previous results on seeking companionship to visit the ADC and visiting the ADC suggest that these new peers are likely to be women’s non-co-resident sisters-in-law as well as female non-relatives.

In Columns 2 and 3 of Table 6, we examine the effects of the vouchers on peer engagement and communication. Specifically, conditional on having at least one close outside peer in her village at endline, we assess the impact of our vouchers on a woman’s likelihood of having at least one close outside peer in her village who: 1) has accompanied her to a health facility and 2) has ever advised her to use an FP method. Across both measures, BAF women were significantly more likely to have engaged with their close outside peers relative to control and Own voucher women. Moreover, the impact of the Own voucher on these measures of peer engagement was substantially smaller and insignificant, highlighting that the BAF voucher allowed women to invite and offer a voucher to other women to visit the ADC with them and to subsequently visit the ADC together with them, which in turn fostered FP-related discussions with their peers. We note that these results on peer engagement may be driven both by greater engagement with pre-existing peers from baseline as well as with new peer connections that were formed as a result of the BAF voucher; however, our data do not allow us to disentangle these two channels.

The increased FP-related peer engagement that resulted from our BAF intervention may have generated additional benefits for treated women. One such potential benefit is a reduction in women’s fear of stigma related to their FP use. Prior research suggests that a fear of stigma is an important barrier to women’s modern contraceptive use (Ayehu et al., 2016; Bender and Fulbright, 2013; Jain et al., 2019; Nyblade et al., 2017; Sulemana Watara et al., 2020) and peer support can play a key role in decreasing fear of stigma around health issues, such as mental health (Burke et al., 2019) and take-up of health technologies (e.g., menstrual products) (Castro and Mang, 2022). In Column 4 of Table 6, we present treatment effects on women’s fear of stigma, proxied by whether a woman would be afraid of being seen by someone she knew at an FP clinic. This variable captures a respondent’s “anticipated stigma” or the belief that others will discriminate against her (Quinn and Chaudoir, 2009; Weiss, 2008). Indeed, anticipated stigma is significantly associated with unmet need for FP-RH services in the literature (Jain et al., 2019); in our sample too we observe a negative correlation between fear of stigma and FP use for control women. We find that women who received a BAF voucher are 10 p.p. less likely to fear stigma at endline than control women, 24 percent of whom fear such stigma at endline. This effect is statistically significant and sizable, representing a 40 percent reduction with respect to the control mean. In contrast, we find no impact of the Own voucher on this outcome.

In addition, in Table A.14 we analyze heterogeneity in treatment effects on a woman’s social connections by the baseline availability of peers who could support her access to FP services. We expect that women who lacked suitable peers at baseline may have had a stronger incentive to form new connections during the intervention period. Indeed, Column 1 in Table A.14 shows that the larger effect of the BAF voucher on a woman’s number of close outside peers in her village, relative to the effect of the Own voucher, is driven by women who, conditional on having at least one close peer at baseline, believed that none of their close outside peers were currently using FP, and hence may not

have had a demand for these services. Indeed, BAF women in this sub-group substantially increased their number of close peers in the village by 0.35 peers ($BAF + BAF \times Covariate$), doubling their number of peers with respect to the control group. On the other hand, the coefficient of $Own + Own \times Covariate$ is insignificant. Moreover, the differential effect of the BAF voucher relative to the Own voucher is significantly larger for women who lacked close outside peers at baseline than for women who did not (p-value = 0.048). These patterns are consistent with: a) the hypothesis that the increase in a woman’s number of social connections is being driven by a greater “need” to form new social connections among women who believed that none of their baseline close village peers were FP-users; and b) the stronger ability of BAF women to form new connections than Own voucher women as a result of their voucher. We observe a similar pattern for peer engagement, measured by whether a woman had at least one close outside peer in her village who accompanied her to a health facility. Our results in Column 2 of Table A.14 indicate that BAF women who lacked suitable peers at baseline, i.e., peers with a perceived demand for FP, acquired more supportive peers at endline.

In sum, our results suggest that the BAF voucher, more so than the Own voucher, enabled women to seek out peer support, both by increasing women’s number of FP peers as well as by increasing their engagement with their old and new peers. These results are important in their own right, given the high level of social isolation experienced by women not only in our sample, but also in other parts of rural India (Andrew et al., 2020; Kandpal and Baylis, 2019; Prillaman, 2021), which prevents them from directly and independently taking advantage of the numerous benefits that social and peer networks confer to their members. Evidence from Anukriti et al. (2020) shows that the benefits of having even a few close peers outside the household are substantial in terms of shaping women’s health-seeking behavior. The magnitude of our treatment effect on a woman’s number of close peers in her village is comparable to that in Prillaman (2021), who finds that access to a self-help group in Madhya Pradesh increased a woman’s total number of friends in her village by 23 percent.

4.4 Additional Results

A. Backlash effects. One may be concerned that the increase in women’s visits to an FP clinic and her use of modern contraception might have led to unintended “backlash” effects from husbands or mothers-in-law, especially in households with greater discordance in fertility preferences. In the context of Zambia, Ashraf et al. (2014) find that women given access to concealable methods of contraception had lower subjective well-being, reflecting greater marital tensions. Although we lack data on domestic violence and mental health, we have the following evidence to indicate that the vouchers did not negatively affect women’s well-being.

First, treatment women did not conceal their receipt of the voucher or visits to the ADC from their husbands and mothers-in-law. Almost all treated women who visited the ADC during the intervention period reported that they had informed their husbands and mothers-in-law about receiving the voucher and visiting the ADC.⁴⁸ Second, in Anukriti et al. (2022), we show that vouchers increased mother-in-law approval of FP, and one potential mechanism for this effect is that treated women were more likely than control women to have initiated discussions about FP with their mothers-in-law. This evidence suggests that women did not try to “hide” their intentions to visit the ADC for FP from their mothers-

⁴⁸Overall, 94 (92) percent of treated women informed their husbands (mothers-in-law) about receiving the voucher and visiting the ADC.

in-law. Third, there was no significant endline difference between treatment and control women in the likelihood of ever facing any problems or negative experiences from discussing or accessing or using a method of FP.⁴⁹ Fourth, we do not find any significant effect of the vouchers on women’s or their husbands’ (as reported by the sample women) satisfaction with their sex life or overall satisfaction with their marriage. These results are available in Table A.15.

B. The Role of Financial Constraints. Our interventions also relax women’s financial constraints to accessing and using FP by providing vouchers that lower the monetary costs of visiting FP clinics and adopting contraception. Key monetary costs that are alleviated by our intervention include fees for FP services and methods, transportation costs, and opportunity costs of visiting any FP clinic. Therefore, we expect that the observed positive treatment effects on clinic visits and contraceptive use will be more pronounced for women who belonged to poorer households at baseline. In Table A.16, we examine the heterogeneity in treatment effects by women’s household poverty status at baseline using a fully interacted model. Ideally, we would like to use a woman’s household income at baseline to capture her financial constraints; however, it is difficult to measure income in rural households like those in our sample (Meyer and Sullivan, 2003). Instead, we define a woman to be poor at baseline if her household is below the poverty line and is in the bottom two terciles of the asset index distribution in our sample. For this analysis, we pool the two treatment groups (BAF and Own vouchers) because (a) women in both groups received exactly the same voucher, and therefore the same monetary incentives, for their own use and (b) we do not expect that a woman’s financial constraints are affected by her peers’ access to vouchers for themselves since the vouchers are not transferable.⁵⁰

Table A.16 shows that the positive effects of voucher receipt on a woman’s likelihood of visiting the ADC or any clinic for FP services and on her modern contraceptive use were larger for women who were poorer at baseline. For instance, poorer women experienced a 13 p.p. larger increase in the likelihood of visiting the ADC and a 19 p.p. larger increase in modern method use relative to less poor women. These effects are substantial given that the poorer women in the control group had almost never visited the ADC at baseline and suggest that the ADC, which is a private clinic, might have been out of reach for financially constrained women. Overall, these results are consistent with prior literature in showing that vouchers can overcome financial barriers and constraints to women’s FP access and use (Bellows et al., 2016, 2015).

C. Robustness Checks. In Table A.17, we test the robustness of our findings to alternate modes of inference for our main outcomes. Our inferences from our primary specifications do not significantly change when we cluster standard errors by village or implement wild-clustered bootstrapped errors at the village level. In addition, our findings are robust to conducting a stepwise bootstrapped multiple hypothesis testing (MHT) correction that controls for the familywise error rate (FWER) and also accounts for the joint dependence structure of the test statistics (Romano and Wolf, 2005a,b). We implement this approach, which corrects for false discovery rates under multiple outcomes and multiple

⁴⁹About 8 percent of our sample women at endline reported ever experiencing problems or negative experiences from discussing or accessing or using a method of FP and only 1 percent of the sample reported having a negative experience with their husbands or parents-in-law.

⁵⁰This would not be the case if BAF women, for instance, were able to extract transfers from their peers in exchange for inviting them to visit the ADC with them. However, treated women did not report doing so in our endline survey.

treatments, to account for the fact that our outcomes (and their corresponding p-values when we test them) are likely to be on the same causal path and therefore be correlated.⁵¹ We prefer the [Romano and Wolf \(2005a,b\)](#) adjustment over other MHT corrections because this approach calculates adjusted p-values that control for the FWER while also allowing for the inclusion of baseline control variables, other controls, and village fixed effects in our specifications.

Our results so far are based on an ITT analysis that captures the causal effect of being assigned to one of the two treatment groups. However, as previously mentioned, we were unable to deliver vouchers to 10 women who had been assigned to a treatment group. Although we do not observe any significant differences between compliers and non-compliers, in order to estimate the causal effect of treatment on the treated that takes into account potentially nonrandom compliance decisions, we use the randomly assigned intent to treat as an instrumental variable for voucher receipt. Table [A.18](#) shows that our TOT estimates are similar in magnitude and statistical significance to the ITT estimates across all of our key outcomes.

5 Conclusions

Restrictive norms, resource constraints, and social isolation can limit women’s access to and utilization of various public services and programs, especially in developing countries. These constraints are more pronounced in contexts like rural India, where women lack freedom of movement and are socioeconomically dependent on family members, and in critically sensitive domains such as fertility and FP. In this study, we evaluate an innovative approach to improve married women’s access to FP that not only overcomes financial barriers but also social barriers to FP use, such as opposition from mothers-in-law and lack of peer support.

Although our study is based in one Indian district, its findings are relevant not only to other parts of India and South Asia, but also to a number of settings where women face significant socioeconomic and mobility barriers to access and where extended households are prevalent. Moreover, the relevance of our findings and interventions extends to areas beyond FP-RH (e.g., female education and labor force participation) where women’s inability to access public spaces, combined with restrictions that are imposed by family members, are key barriers to their access ([Bernhardt et al., 2018](#); [Bursztyn and Jensen, 2017](#)) and where peer support can make a substantive difference ([Field et al., 2016](#); [Kandpal and Baylis, 2019](#)). We draw a number of lessons from this study that are relevant for policy and future research. First, our results highlight a need to move beyond dyadic models of household bargaining and decision-making that are based on nuclear family structures. In most household surveys and collective models of the household, a woman’s decision-making ability within the household is benchmarked against that of her husband. As a result, programs and policies that are informed by these data and studies rely on strategies that seek to exclusively engage husbands as a means to improve women’s bargaining power and outcomes.⁵² In many low- and middle-income settings, however, extended families are common and comprise a broader range of kinship structures, such as joint, multi-generational,

⁵¹Specifically, our outcomes may be direct functions of each other, where women who are assigned to a treatment group may: a) seek company as a result of the voucher; b) visit a facility conditional on having sought company; and c) receive services conditional on having visited a facility.

⁵²Examples of such strategies include couples’ counseling, “husbands’ clubs” or the creation of partner-friendly spaces within the health sector (father-friendly clinics, couples-oriented child visits), among others ([Bank, 2019](#); [Davis et al., 2016](#); [Hawkins et al., 2008](#); [Sicouri et al., 2018](#); [Tiedje and Darling-Fisher, 2003](#)).

and polygamous relationships within the household (Kramer, 2020). Variations in kinship strength and relative bargaining power across extended household members make it necessary to understand the influence of, and potentially even target, household members other than the woman’s husband on her well-being. More broadly, policy impacts on women’s well-being can vary by household structure, particularly when extended families are prevalent (Heath et al., 2020).

Second, our findings underscore the role of the mother-in-law as a key “influencer” in patrilocal South Asian households. Well-intended interventions that exclusively target women or married couples may be ineffective if they naïvely fail to account for the status and position of mothers-in-law in the household, especially if preferences and incentives between women and their mothers-in-law are misaligned. In contrast, mothers-in-law who have an incentive to support their daughters-in-law can also exert a positive impact on outcomes related to childcare, employment, and health during pregnancy (Khanna and Pandey, 2020; Varghese and Roy, 2019). Future research can inform policy makers about how to effectively engage mothers-in-law to improve women’s outcomes.

Third, our findings motivate us to reflect on approaches that can expand women’s social connections and thereby improve women’s welfare. Forming women’s collectives (e.g., microfinance and self-help groups) is a commonly used policy instrument that has been effective in strengthening women’s social connections (e.g., Kumar et al. (2019)); however, women’s participation in such groups is low (Diaz-Martin et al., 2021). Moreover, the potential role of women in impacting other women’s lives extends well beyond such groups. In contexts such as ours, women often turn to other female family members, such as sisters-in-law, for support since familial interactions are less likely to be socially sanctioned. Our study suggests that enabling women to leverage support from their sisters-in-law or female friends may, therefore, be an effective way to lower women’s reliance on more constraining members of their household.⁵³

⁵³Although sisters-in-law could serve as potential “allies” to counterbalance the influence of the mother-in-law, strategic interactions between sisters-in-law, including potential competition for resources within the household, also need to be considered, in a manner similar to polygamous households, e.g., Rossi (2019).

References

- Ali, Daniel Ayalew, Matthew Collin, Klaus Deininger, Stefan Dercon, Justin Sandefur, and Andrew Zeitlin, “Small price incentives increase women’s access to land titles in Tanzania,” *Journal of Development Economics*, November 2016, 123, 107–122.
- Andrew, Alison, Orazio Attanasio, Britta Augsburg, Jere Behrman, Monimalika Day, Pamela Jervis, Costas Meghir, and Angus Phimister, “Mothers’ Social Networks and Socioeconomic Gradients of Isolation,” Technical Report w28049, National Bureau of Economic Research, Cambridge, MA November 2020.
- Anukriti, S, Catalina Herrera-Almanza, Mahesh Karra, and Rocío Valdebenito, “Convincing the Mummy-ji: Improving Mother-in-Law Approval of Family Planning in India,” *AEA Papers and Proceedings*, May 2022, 112, 568–572.
- Anukriti, S., Catalina Herrera-Almanza, Praveen K. Pathak, and Mahesh Karra, “Curse of the Mummy-ji: The Influence of Mothers-in-Law on Women in India,” *American Journal of Agricultural Economics*, 2020, 102 (5), 1328–1351.
- Anukriti, S, Sonia Bhalotra, and Eddy H F Tam, “On the Quantity and Quality of Girls: Fertility, Parental Investments and Mortality,” *The Economic Journal*, April 2021, (ueab035).
- Ashraf, Nava, Erica Field, Alessandra Voena, and Roberta Ziparo, “Gendered Spheres of Learning and Household Decision Making over Fertility,” Technical Report Working Paper No. wp2027, Stanford University, Stanford King Center on Global Development 2022.
- , —, and Jean Lee, “Household Bargaining and Excess Fertility: An Experimental Study in Zambia,” *American Economic Review*, July 2014, 104 (7), 2210–2237.
- Athey, Susan, Katy Bergstrom, Vitor Hadad, Julian C. Jamison, Berk Ozler, Luca Parisotto, and Julius Dohbit Sama, “Shared Decision-Making: Can Improved Counseling Increase Willingness to Pay for Modern Contraceptives?,” September 2021. `tex.ids= athey_shared_2021-2`.
- Ayehu, Atitegeb, Teketo Kassaw, and Getachew Hailu, “Level of Young People Sexual and Reproductive Health Service Utilization and Its Associated Factors among Young People in Awabel District, Northwest Ethiopia,” *PLOS ONE*, March 2016, 11 (3), e0151613.
- Bailey, M. J., “More Power to the Pill: The Impact of Contraceptive Freedom on Women’s Life Cycle Labor Supply,” *Quarterly Journal of Economics*, 2006, 121 (1), 289–320.
- Bailey, Martha J., Brad Hershbein, and Amalia R. Miller, “The Opt-In Revolution? Contraception and the Gender Gap in Wages,” *American Economic Journal: Applied Economics*, July 2012, 4 (3), 225–254.
- Baland, Jean-Marie and Roberta Ziparo, “Intra-Household Bargaining in Poor Countries,” in Siwan Anderson, Lori Beaman, and Jean-Philippe Platteau, eds., *Towards Gender Equity in Development*, Oxford, UK: Oxford University Press, October 2018, pp. 69–96.
- Bank, World, “Burkina Faso: Welcome to Mamboué’s School for Husbands and Future Husbands,” 2019.
- Bankole, Akinrinola and Susheela Singh, “Couples’ fertility and contraceptive decision-making in developing countries: hearing the man’s voice,” *International Family Planning Perspectives*, 1998, pp. 15–24.
- Bau, Natalie and Raquel Fernández, “Culture and the Family,” Technical Report w28918, National Bureau of Economic Research, Cambridge, MA June 2021.
- Becker, G. S. and H. G. Lewis, “On the Interaction between the Quantity and Quality of Children,” *Journal of Political Economy*, 1973, 81 (2), S279–88.
- Behrman, J. R., Hans-Peter Kohler, and S. C. Watkins, “How Can We Measure the Causal Effects of Social Networks Using Observational Data? Evidence from the Diffusion of Family Planning and AIDS Worries in South Nyanza District, Kenya,” *MPIDR Working Paper WP 2001-022*, 2001.
- Bellows, Ben, Carol Bulaya, Sophie Inambwae, Craig L. Lissner, Moazzam Ali, and Ashish Bajracharya, “Family Planning Vouchers in Low and Middle Income Countries: A Systematic Review,” *Studies in Family Planning*, December 2016, 47 (4), 357–370.
- Bellows, Benjamin, Ashish Bajracharya, Carol Bulaya, and Sophie Inambwae, “Family planning vouchers to improve delivery and uptake of contraception in low and middle income countries: A systematic review,” Technical Report, Population Council 2015.

- Bender, Sóley S. and Yvonne K. Fulbright**, “Content analysis: A review of perceived barriers to sexual and reproductive health services by young people,” *The European Journal of Contraception & Reproductive Health Care*, June 2013, 18 (3), 159–167. Publisher: Taylor & Francis _eprint: <https://doi.org/10.3109/13625187.2013.776672>.
- Bernhardt, Arielle, Erica Field, Rohini Pande, Natalia Rigol, Simone Schaner, and Charity Troyer-Moore**, “Male Social Status and Women’s Work,” *AEA Papers and Proceedings*, May 2018, 108, 363–367.
- Bhalotra, Sonia and Arthur van Soest**, “Birth-spacing, fertility and neonatal mortality in India: Dynamics, frailty, and fecundity,” *Journal of Econometrics*, April 2008, 143 (2), 274–290.
- Bradley, Sarah E.K., Trevor Croft, Joy Fishel, and Charles Westoff**, “Revising Unmet Need for Family Planning,” DHS Analytical Studies No. 25, ICF International, Calverton, MD 2012.
- Breza, Emily, Arun Chandrasekhar, and Horacio Larreguy**, “Network Centrality and Informal Institutions: Evidence from a Lab Experiment in the Field,” 2016, p. 45.
- Browning, M. and P. A. Chiappori**, “Efficient Intra-Household Allocations: A General Characterization and Empirical Tests,” *Econometrica*, November 1998, 66 (6), 1241.
- Bruhn, Miriam and David McKenzie**, “In Pursuit of Balance: Randomization in Practice in Development Field Experiments,” *American Economic Journal: Applied Economics*, September 2009, 1 (4), 200–232.
- Burke, Eilish, Melissa Pyle, Karen Machin, Filippo Varese, and Anthony P. Morrison**, “The effects of peer support on empowerment, self-efficacy, and internalized stigma: A narrative synthesis and meta-analysis,” *Stigma and Health*, August 2019, 4 (3), 337–356. place: US publisher: Educational Publishing Foundation.
- Bursztyn, Leonardo and Robert Jensen**, “Social Image and Economic Behavior in the Field: Identifying, Understanding, and Shaping Social Pressure,” *Annual Review of Economics*, 2017, 9 (1), 131–153. _eprint: <https://doi.org/10.1146/annurev-economics-063016-103625>.
- Canning, D. and T. P. Schultz**, “The economic consequences of reproductive health and family planning,” *Lancet*, 2012, 380 (9837), 165–171.
- Castro, Silvia and Clarissa Mang**, “Breaking the Silence - Group Discussions, Social Pressure, and the Adoption of Health Technologies,” April 2022.
- Chandrasekhar, Arun G. and Randall Lewis**, “Econometrics of sampled networks,” Technical Report 2012.
- Chang, Wei, Lucia Diaz-Martin, Akshara Gopalan, Eleonara Guarnieri, Seema Jayachandran, and Claire Walsh**, “What works to enhance women’s agency: Cross-cutting lessons from experimental and quasi-experimental studies,” J-PAL Working Paper, J-PAL, Cambridge, MA 2020.
- Cheema, Ali, Asim I Khwaja, M Farooq Naseer, and Jacob N Shapiro**, “Glass Walls: Experimental Evidence on Access Constraints Faced by Women,” 2020, p. 102.
- Chiappori, Pierre-Andre and Maurizio Mazzocco**, “Static and Intertemporal Household Decisions,” *Journal of Economic Literature*, September 2017, 55 (3), 985–1045.
- Clark, Shelley**, “Son Preference and Sex Composition of Children: Evidence from India,” *Demography*, 2000, 37 (1), 95–108. Publisher: Springer.
- , **Caroline W. Kabiru, Sonia Laszlo, and Stella Muthuri**, “The Impact of Childcare on Poor Urban Women’s Economic Empowerment in Africa,” *Demography*, August 2019, 56 (4), 1247–1272.
- Davis, Jessica, Joseph Vyankandondera, Stanley Luchters, David Simon, and Wendy Holmes**, “Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific,” *Reproductive Health*, July 2016, 13 (1), 81.
- Desai, Sonalde and Reeve Vanneman**, “India Human Development Survey-II (IHDS-II), 2011-12: Version 6,” Technical Report, ICPSR - Interuniversity Consortium for Political and Social Research, New Delhi, India 2015. Version Number: v6 Type: dataset.
- Diaz-Martin, Lucia, Akshara Gopalan, Eleonara Guarnieri, and Seema Jayachandran**, “Greater than the Sum of the Parts? Evidence on Mechanisms Operating in Women’s Groups,” 2021.

- Donald, Aletheia, Gayatri Koolwal, Jeannie Annan, Kathryn Falb, and Markus Goldstein**, “Measuring Women’s Agency,” *Feminist Economics*, July 2020, 26 (3), 200–226. Publisher: Routledge _eprint: <https://doi.org/10.1080/13545701.2019.1683757>.
- Duflo, Esther**, “Women Empowerment and Economic Development,” *Journal of Economic Literature*, December 2012, 50 (4), 1051–1079.
- Field, Erica, Seema Jayachandran, Rohini Pande, and Natalia Rigol**, “Friendship at Work: Can Peer Effects Catalyze Female Entrepreneurship?,” *American Economic Journal: Economic Policy*, May 2016, 8 (2), 125–153.
- Godlonton, Susan and Rebecca Thornton**, “Peer effects in learning HIV results,” *Journal of Development Economics*, January 2012, 97 (1), 118–129.
- Goldberg, Jessica, Mario Macis, and Pradeep Chintagunta**, “Leveraging Patients’ Social Networks to Overcome Tuberculosis Under-detection in India: A Field Experiment,” 2018, p. 40.
- Goldin, C. and L. F. Katz**, “The power of the pill: oral contraceptives and women’s career and marriage decisions,” *The Journal of Political Economy*, 2002, 110 (4), 730–770.
- Government of India**, “National Family Health Survey, 2015-16,” Technical Report, Ministry of Health and Family Welfare, Mumbai 2017.
- , “National Family Health Survey, 2019-2021,” Technical Report, Ministry of Health and Family Welfare, New Delhi, India 2022.
- Gram, Lu, Jolene Skordis-Worrall, Jenevieve Mannell, Dharma S. Manandhar, Naomi Saville, and Joanna Morrison**, “Revisiting the patriarchal bargain: The intergenerational power dynamics of household money management in rural Nepal,” *World Development*, December 2018, 112, 193–204.
- Gupta, Sweta, Christopher Ksoll, and Annemie Maertens**, “Intra-household Efficiency in Extended Family Households: Evidence from Rural India,” *The Journal of Development Studies*, July 2021, 57 (7), 1172–1197.
- Halli, Shiva S., Damaraju Ashwini, Bidyadhar Dehury, Shajy Isac, Antony Joseph, Preeti Anand, Vikas Gothwal, Ravi Prakash, B. M. Ramesh, James Blanchard, and Ties Boerma**, “Fertility and family planning in Uttar Pradesh, India: major progress and persistent gaps,” *Reproductive Health*, August 2019, 16 (1), 129.
- Hawkins, Alan J., Kimberly R. Lovejoy, Erin K. Holmes, Victoria L. Blanchard, and Elizabeth Fawcett**, “Increasing Fathers’ Involvement in Child Care With a Couple-Focused Intervention During the Transition to Parenthood,” *Family Relations*, 2008, 57 (1), 49–59. _eprint: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1741-3729.2007.00482.x>.
- Heath, Rachel, Melissa Hidrobo, and Shalini Roy**, “Cash transfers, polygamy, and intimate partner violence: Experimental evidence from Mali,” *Journal of Development Economics*, March 2020, 143, 102410.
- Hidrobo, Melissa, Amber Peterman, and Lori Heise**, “The Effect of Cash, Vouchers, and Food Transfers on Intimate Partner Violence: Evidence from a Randomized Experiment in Northern Ecuador,” *American Economic Journal: Applied Economics*, July 2016, 8 (3), 284–303.
- Jain, Aparna, Hussein Ismail, Elizabeth Tobey, and Annabel Erulkar**, “Stigma as a barrier to family planning use among married youth in Ethiopia,” *Journal of Biosocial Science*, July 2019, 51 (4), 505–519. [tex.ids= jain_stigma_2018-2](https://doi.org/10.1080/00213179.2018.1512222).
- Jayachandran, Seema**, “The Roots of Gender Inequality in Developing Countries,” *Annual Review of Economics*, August 2015, 7 (1), 63–88.
- , “Social Norms as a Barrier to Women’s Employment in Developing Countries,” 2019.
- Jejeebhoy, Shireen J., K.G. Santhya, and A.J. Francis Xavier**, “Demand for Contraception to Delay First Pregnancy among Young Married Women in India,” *Studies in Family Planning*, June 2014, 45 (2), 183–201.
- Jensen, Robert**, “Another Mouth to Feed? The Effects of (In)Fertility on Malnutrition,” *CESifo Economic Studies*, June 2012, 58 (2), 322–347.
- Joshi, S. and T. P. Schultz**, “Family planning as an investment in development: Evaluation of a program’s consequences in Matlab, Bangladesh,” *Economic Growth Center Discussion Paper*, 2007, 951.

- and —, “Family Planning and Women’s and Children’s Health: Long-Term Consequences of an Outreach Program in Matlab, Bangladesh,” *Demography*, February 2013, *50* (1), 149–180.
- Kabeer, Naila**, “Between Affiliation and Autonomy: Navigating Pathways of Women’s Empowerment and Gender Justice in Rural Bangladesh: Women’s Empowerment and Gender Justice in Rural Bangladesh,” *Development and Change*, March 2011, *42* (2), 499–528.
- Kandpal, Eeshani and Kathy Baylis**, “The social lives of married women: Peer effects in female autonomy and investments in children,” *Journal of Development Economics*, September 2019, *140*, 26–43.
- Kantorová, Vladimíra, Mark C. Wheldon, Philipp Ueffing, and Aisha N. Z. Dasgupta**, “Estimating progress towards meeting women’s contraceptive needs in 185 countries: A Bayesian hierarchical modelling study,” *PLOS Medicine*, February 2020, *17* (2), e1003026. Publisher: Public Library of Science.
- Kapoor, Mudit, Deepak Agrawal, Shamika Ravi, Ambuj Roy, S. V. Subramanian, and Randeep Guleria**, “Missing female patients: an observational analysis of sex ratio among outpatients in a referral tertiary care public hospital in India,” *BMJ Open*, August 2019, *9* (8), e026850. Publisher: British Medical Journal Publishing Group Section: Public health.
- Karra, Mahesh and Kexin Zhang**, “User-Centered Counseling and Male Involvement in Contraceptive Decision Making: Protocol for a Randomized Controlled Trial,” *JMIR Research Protocols*, April 2021, *10* (4), e24884. Company: JMIR Research Protocols Distributor: JMIR Research Protocols Institution: JMIR Research Protocols Label: JMIR Research Protocols Publisher: JMIR Publications Inc., Toronto, Canada.
- Kernan, W. N., C. M. Viscoli, R. W. Makuch, L. M. Brass, and R. I. Horwitz**, “Stratified randomization for clinical trials,” *Journal of Clinical Epidemiology*, January 1999, *52* (1), 19–26.
- Khanna, Madhulika and Divya Pandey**, “Reinforcing Gender Norms or Easing Housework Burdens? The Role of Mothers-in-Law in Determining Women’s Labor Force Participation,” 2020.
- , **Nishtha Kochhar, and Nethra Palaniswamy**, “A Retrospective Impact Evaluation of the Tamil Nadu Empowerment and Poverty Alleviation (Pudhu Vaazhvu) Project,” *The Journal of Development Studies*, September 2015, *51* (9), 1210–1223. Publisher: Routledge _eprint: <https://doi.org/10.1080/00220388.2015.1028538>.
- Klugman, Jeni, Lucia Hanmer, Sarah Twigg, Tazeen Hasan, Jennifer McCleary-Sills, and Julieth Santamaria**, “Voice and Agency : Empowering Women and Girls for Shared Prosperity,” Technical Report, World Bank, Washington, DC 2014. Accepted: 2014-07-28T22:22:00Z ISBN: 9781464803598.
- Kramer, Stephanie**, “With billions confined to their homes worldwide, which living arrangements are most common?,” 2020.
- Kumar, Neha, Kalyani Raghunathan, Alejandra Arrieta, Amir Jilani, Suman Chakrabarti, Purnima Menon, and Agnes R. Quisumbing**, “Social networks, mobility, and political participation: The potential for women’s self-help groups to improve access and use of public entitlement schemes in India,” *World Development*, February 2019, *114*, 28–41. tex.ids= kumar_social_2019-2.
- Lee, David S.**, “Training, Wages, and Sample Selection: Estimating Sharp Bounds on Treatment Effects,” *The Review of Economic Studies*, July 2009, *76* (3), 1071–1102.
- McCarthy, Aine Seitz**, “Intimate partner violence and family planning decisions: Experimental evidence from rural Tanzania,” *World Development*, February 2019, *114*, 156–174.
- McKelway, Madeline**, “Women’s Employment in India: Intra-Household and Intra-Personal Constraints,” 2021, p. 102.
- Meyer, Bruce D. and James X. Sullivan**, “Measuring the Well-Being of the Poor Using Income and Consumption,” *The Journal of Human Resources*, 2003, *38*, 1180–1220. Publisher: [University of Wisconsin Press, Board of Regents of the University of Wisconsin System].
- Miguel, E. and M. Kremer**, “Worms: identifying impacts on education and health in the presence of treatment externalities,” *Econometrica*, 2003, *72* (1), 159–217.
- Miller, G.**, “Contraception as development? New evidence from family planning in Colombia,” *The Economic Journal*, 2010, *120*, 709–736.
- MOHFW**, “Annual Report of the Department of Family Health and Welfare, 2015-16,” Technical Report, Ministry of Health and Family Welfare, New Delhi, India 2016.
- Munshi, Kaivan**, “Community Networks and the Process of Development,” *Journal of Economic Perspectives*, November 2014, *28* (4), 49–76.

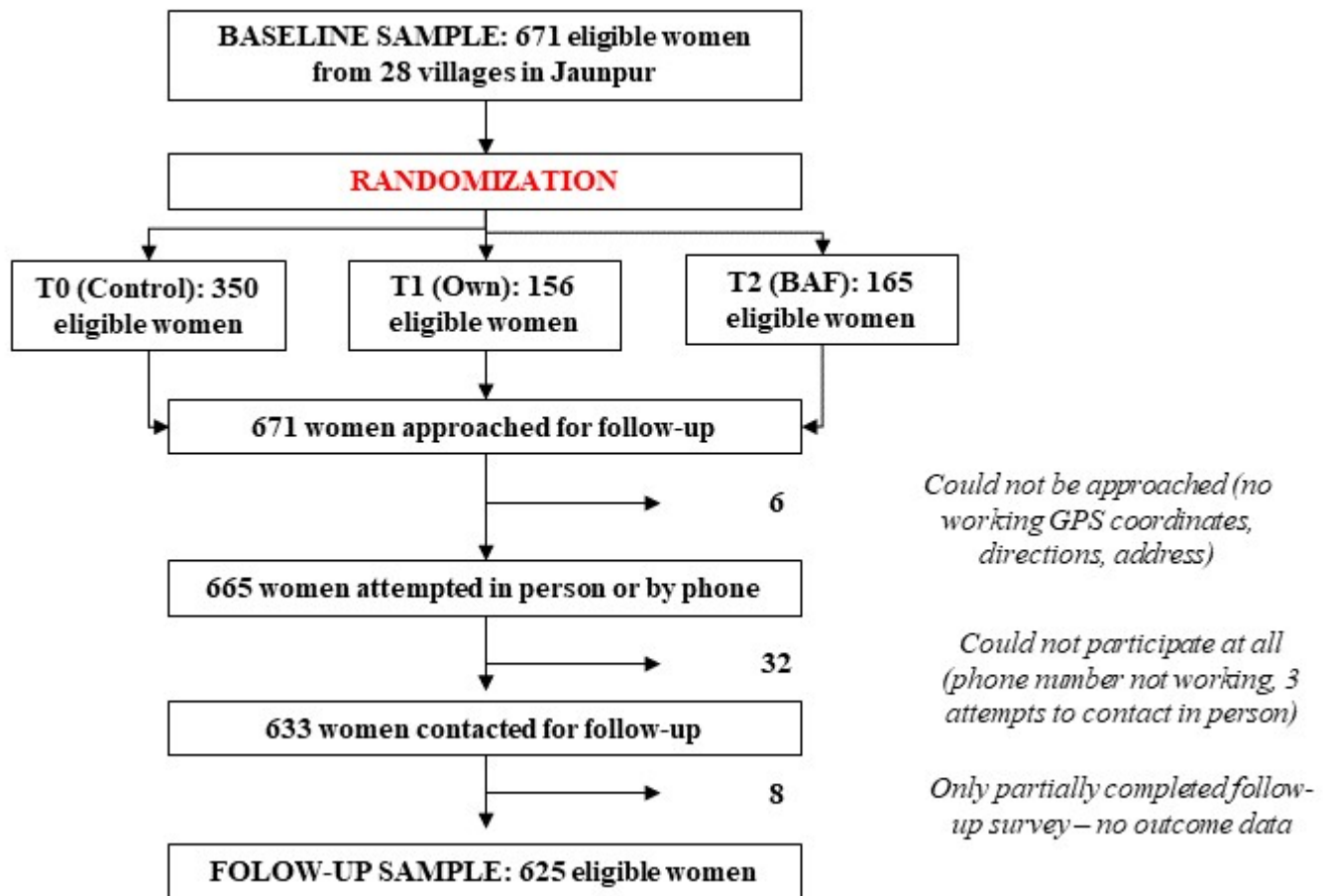
- Nyblade, Laura, Melissa Stockton, Daniel Nyato, and Joyce Wamoyi, "Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania," *Culture, Health & Sexuality*, October 2017, 19 (10), 1092–1107. Publisher: Taylor & Francis _eprint: <https://doi.org/10.1080/13691058.2017.1293844>.
- Olivetti, Claudia and Barbara Petrongolo, "The Evolution of Gender Gaps in Industrialized Countries," Technical Report w21887, National Bureau of Economic Research January 2016.
- Oster, Emily and Rebecca Thornton, "Determinants of Technology Adoption: Peer Effects in Menstrual Cup Take-Up," *Journal of the European Economic Association*, December 2012, 10 (6), 1263–1293.
- Prillaman, Soledad Artiz, "Strength in Numbers: How Women's Groups Close India's Political Gender Gap," *American Journal of Political Science*, 2021, n/a (n/a).
- Purdy, L., "Women's reproductive autonomy: medicalisation and beyond," *Journal of Medical Ethics*, May 2006, 32 (5), 287–291.
- Quinn, Diane M. and Stephenie R. Chaudoir, "Living With a Concealable Stigmatized Identity: The Impact of Anticipated Stigma, Centrality, Salience, and Cultural Stigma on Psychological Distress and Health," *Journal of Personality and Social Psychology*, October 2009, 97 (4), 634–651.
- Rassam, Amul, "Women and Domestic Power in Morocco," *International Journal of Middle East Studies*, September 1980, 12 (2), 171–179. Publisher: Cambridge University Press.
- Romano, Joseph P and Michael Wolf, "Exact and Approximate Stepdown Methods for Multiple Hypothesis Testing," *Journal of the American Statistical Association*, March 2005, 100 (469), 94–108. Publisher: Taylor & Francis _eprint: <https://doi.org/10.1198/016214504000000539>.
- Romano, Joseph P. and Michael Wolf, "Stepwise Multiple Testing as Formalized Data Snooping," *Econometrica*, 2005, 73 (4), 1237–1282. _eprint: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1468-0262.2005.00615.x>.
- Rosenblum, Daniel, "The effect of fertility decisions on excess female mortality in India," *Journal of Population Economics*, January 2013, 26 (1), 147–180.
- Rossi, Pauline, "Strategic Choices in Polygamous Households: Theory and Evidence from Senegal," *The Review of Economic Studies*, May 2019, 86 (3), 1332–1370.
- Sato, Ryoko and Yoshito Takasaki, "Peer Effects on Vaccination Behavior: Experimental Evidence from Rural Nigeria," *Economic Development and Cultural Change*, September 2018, 68 (1), 93–129. Publisher: The University of Chicago Press.
- Sicouri, Gemma, Lucy Tully, Daniel Collins, Matthew Burn, Kristina Sargeant, Paul Frick, Vicki Anderson, David Hawes, Eva Kimonis, Caroline Moul, Roshel Lenroot, and Mark Dadds, "Toward Father-friendly Parenting Interventions: A Qualitative Study," *Australian and New Zealand Journal of Family Therapy*, 2018, 39 (2), 218–231. _eprint: <https://onlinelibrary.wiley.com/doi/pdf/10.1002/anzf.1307>.
- Tiedje, Linda Beth and Cynthia Darling-Fisher, "Promoting Father-Friendly Healthcare," *MCN: The American Journal of Maternal/Child Nursing*, December 2003, 28 (6), 350–357.
- Tran, Nguyen Toan, Armando Seuc, Béatrice Tshikaya, Maurice Mutuale, Sihem Landoulsi, Brigitte Kini, Bernadette Mbu Nkolomonyi, Jean Nyandwe Kyloka, Félicité Langwana, and Asa Cuzin-Kihl, "Effectiveness of Post-Partum Family Planning Interventions on Contraceptive Use and Method Mix at 1 Year after Childbirth in Kinshasa, DR Congo (Yam Daabo): A Single-Blind, Cluster-Randomised Controlled Trial," *The Lancet Global Health*, 2020, 8 (3), e399–e410.
- UNFPA, "State of the World's Population 2021," Technical Report, UNFPA, New York, NY 2021.
- Upadhyay, Ushma D., Shari L. Dworkin, Tracy A. Weitz, and Diana Greene Foster, "Development and Validation of a Reproductive Autonomy Scale," *Studies in Family Planning*, 2014, 45 (1), 19–41. _eprint: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1728-4465.2014.00374.x>.
- Varghese, Rekha and Manan Roy, "Coresidence with mother-in-law and maternal anemia in rural India," *Social Science & Medicine*, April 2019, 226, 37–46.
- Watara, Abubakari Sulemana, Abu Mumuni, Yidana Zuwera, Apraku Anane Edward, Mutaru Goro Iddrisu, Badasu Delalali Margret, Abubakari Sulemana Watara, Abu Mumuni, Yidana Zuwera, Apraku Anane Edward, Mutaru Goro Iddrisu, and Badasu Delalali Margret, "Young people's experiences in accessing sexual and reproductive health services in sub-Saharan Africa from 1994 to 2019 - A content analysis," *International Journal of Sexual and Reproductive Health Care*, May 2020, 3 (1), 017–026.

Weiss, Mitchell G., “Stigma and the Social Burden of Neglected Tropical Diseases,” *PLOS Neglected Tropical Diseases*, May 2008, 2 (5), e237.

Willis, Robert J., “A New Approach to the Economic Theory of Fertility Behavior,” *Journal of Political Economy*, March 1973, 81 (2), S14–S64. 01465 ArticleType: research-article / Issue Title: Part 2: New Economic Approaches to Fertility / Full publication date: Mar. - Apr., 1973 / Copyright © 1973 The University of Chicago Press.

Figures and Tables

Figure 1: Experimental Design



Notes: BAF denotes the Bring-a-Friend voucher group.

Table 1: Balance at baseline: Individual characteristics

	Control (C)		Own		BAF		C - Own	C - BAF	Own - BAF
	N (1)	Mean/SD (2)	N (3)	Mean/SD (4)	N (5)	Mean/SD (6)	Diff. (7)	Diff. (8)	Diff. (9)
Age	350	25.617 (2.653)	156	25.590 (2.745)	165	25.867 (2.560)	0.027	-0.250	-0.277
Years of schooling	350	9.420 (4.536)	156	9.737 (4.090)	165	9.564 (4.675)	-0.317	-0.144	0.174
Hindu	350	0.949 (0.221)	156	0.910 (0.287)	165	0.927 (0.260)	0.038	0.021	-0.017
Scheduled Caste or Tribe	350	0.437 (0.497)	156	0.449 (0.499)	165	0.448 (0.499)	-0.012	-0.011	0.000
Other Backward Class	350	0.460 (0.499)	156	0.449 (0.499)	165	0.382 (0.487)	0.011	0.078*	0.067
Wears ghunghat	350	0.871 (0.335)	156	0.891 (0.313)	165	0.903 (0.297)	-0.020	-0.032	-0.012
Worked last year	346	0.173 (0.379)	155	0.097 (0.297)	165	0.115 (0.320)	0.077**	0.058*	-0.018
Co-residence with MIL	350	0.683 (0.466)	156	0.699 (0.460)	165	0.648 (0.479)	-0.016	0.034	0.050
Mobility score	350	1.003 (1.729)	156	0.737 (1.507)	165	0.824 (1.577)	0.266*	0.179	-0.087
Asset score	350	-0.098 (1.588)	156	0.046 (1.534)	165	0.164 (1.797)	-0.144	-0.262	-0.118
Number of general peers	350	1.643 (1.033)	156	1.654 (1.039)	165	1.655 (1.004)	-0.011	-0.012	-0.001
Number of close peers in village	350	0.549 (0.607)	156	0.500 (0.585)	165	0.612 (0.686)	0.049	-0.064	-0.112
Number of children	350	1.943 (0.910)	156	1.987 (0.930)	165	1.945 (0.945)	-0.044	-0.003	0.042
Wants another child	346	0.500 (0.501)	156	0.494 (0.502)	165	0.497 (0.502)	0.006	0.003	-0.003
Using any FP method	349	0.481 (0.500)	156	0.468 (0.501)	165	0.473 (0.501)	0.013	0.009	-0.005
Using modern FP method	349	0.175 (0.380)	156	0.205 (0.405)	165	0.164 (0.371)	-0.030	0.011	0.041
Ever visited a clinic for FP	350	0.360 (0.481)	156	0.333 (0.473)	165	0.352 (0.479)	0.027	0.008	-0.018
MIL opposed to FP	349	0.172 (0.378)	154	0.130 (0.337)	164	0.140 (0.348)	0.042	0.032	-0.010
F-test of joint significance: p-value							0.383	0.324	0.895
F-test: Number of observations							493	504	317

Notes: Standard deviations (SD) are presented in parentheses. BAF denotes Bring-a-Friend, FP denotes family planning, and MIL denotes mother-in-law. Variable definitions are presented in Online Appendix. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 2: Seeking company for clinic visits during the intervention period

	Sought company to visit the ADC from:				
	Someone (1)	Husband/ MIL (2)	Non-husband/ MIL (3)	Sister-in-law (4)	Non-relative (5)
Own Voucher	0.178*** [0.035]	0.037* [0.021]	0.107*** [0.028]	0.060*** [0.020]	0.041** [0.019]
BAF Voucher	0.340*** [0.039]	0.031* [0.018]	0.276*** [0.038]	0.178*** [0.032]	0.095*** [0.027]
Observations	613	596	596	596	596
Endline control mean	0.034	0.016	0.022	0.003	0.009
p-value: Own = BAF	0.001	0.806	0.000	0.001	0.070

Notes: All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, Scheduled Castes and Scheduled Tribes (SC-ST), Other Backward Classes (OBC), whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 3: Clinic visits for family planning services during the intervention period

	Visited the ADC (1)	Visited any clinic (2)	Visited the ADC:		
			Alone (3)	with husband/ MIL (4)	with non-husband/ MIL (5)
Own Voucher	0.199*** [0.034]	0.166*** [0.047]	0.034* [0.018]	0.044* [0.025]	0.063** [0.026]
BAF Voucher	0.186*** [0.033]	0.131*** [0.045]	0.052** [0.021]	0.034 [0.024]	0.075*** [0.027]
Observations	616	613	616	525	525
Endline control mean	0.015	0.193	0.009	0.018	0.022
p-value: Own = BAF	0.759	0.531	0.482	0.754	0.727

Notes: All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 4: Heterogeneous treatment effects by mother-in-law opposition to family planning at baseline

	Sought company to visit the ADC from:			Visited the ADC	Visited the ADC with:		Visited any clinic
	Someone	Husband/ MIL	Non-husband/ MIL		Husband/ MIL	Non-husband/ MIL	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Own Voucher	0.194*** [0.040]	0.048* [0.025]	0.105*** [0.032]	0.208*** [0.037]	0.027 [0.024]	0.061** [0.031]	0.162*** [0.052]
BAF Voucher	0.326*** [0.043]	0.036* [0.021]	0.247*** [0.041]	0.150*** [0.034]	0.015 [0.025]	0.047* [0.028]	0.088* [0.050]
Own Voucher \times MIL opposed to FP	-0.172** [0.072]	-0.059* [0.034]	-0.072 [0.064]	-0.111 [0.088]	0.096 [0.070]	-0.039 [0.040]	-0.043 [0.132]
BAF Voucher \times MIL opposed to FP	0.097 [0.116]	0.013 [0.043]	0.127 [0.105]	0.144 [0.098]	0.129 [0.084]	0.149* [0.076]	0.255** [0.121]
Observations	609	592	592	612	521	521	610
Endline control mean	0.034	0.016	0.022	0.015	0.018	0.022	0.193
p-values:							
Own = BAF	0.015	0.684	0.004	0.218	0.705	0.712	0.220
Own \times MIL opposed = BAF \times MIL opposed	0.037	0.164	0.088	0.033	0.738	0.016	0.069
Own + Own \times MIL opposed = 0	0.715	0.622	0.553	0.225	0.063	0.380	0.326
BAF + BAF \times MIL opposed = 0	0.000	0.200	0.000	0.002	0.071	0.006	0.002

Notes: All columns present fully-interacted regressions, where all covariates are interacted with an indicator for whether the MIL was opposed to FP at baseline. The main effect of MIL opposition to FP at baseline is also included as a control variable. All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 5: Modern contraceptive use at endline

Outcome: Using modern FP method	All (1)	Covariate at baseline:	
		MIL opposed to FP (2)	Found FP embarrassing to use (3)
Own Voucher	0.054 [0.037]	0.056 [0.041]	0.028 [0.047]
BAF Voucher	0.061* [0.037]	0.018 [0.039]	-0.023 [0.045]
Own Voucher \times Covariate		-0.011 [0.113]	0.058 [0.077]
BAF Voucher \times Covariate		0.200 [0.126]	0.214** [0.085]
Observations	594	590	590
Endline control mean	0.124	0.124	0.124
p-values:			
Own = BAF	0.869	0.432	0.328
Own \times Covariate = BAF \times Covariate		0.180	0.112
Own + Own \times Covariate = 0		0.669	0.152
BAF + BAF \times Covariate = 0		0.070	0.009

Notes: The estimation sample in this table excludes women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC. Columns 2 and 3 present fully-interacted regressions, where all controls are interacted with the covariate used for examining heterogeneous effects; the main effect of that variable is also included as a regressor. All columns also include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variable for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 6: Social connections at endline

	No. of social connections	Peer engagement		Stigma
	Number of close peers outside HH in village (1)	Has close peers outside HH in village that: Accompanied to health facility (2)	Advised woman to use FP (3)	Afraid of being seen (4)
Own Voucher	-0.034 [0.061]	-0.019 [0.060]	-0.014 [0.053]	-0.016 [0.046]
BAF Voucher	0.092 [0.069]	0.120** [0.060]	0.132** [0.057]	-0.097** [0.040]
Observations	525	347	346	514
Endline control mean	0.357	0.278	0.222	0.239
p-value: Own = BAF	0.106	0.043	0.019	0.097

Notes: All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (i.e., baseline values of woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. FP denotes family planning, and BAF denotes Bring-a-Friend, and HH denotes household. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Bring A Friend: Leveraging Financial and Peer Support to Improve Women's Reproductive Agency in India

S Anukriti, Catalina Herrera-Almanza, and Mahesh Karra

A Variable Definitions

1. Sought company to visit the ADC from someone: Indicator variable that equals one if a woman asked someone to accompany her to the ADC since September 2018. This variable is not conditional on visiting the ADC.
2. Sought company to visit the ADC from husband or mother-in-law: Indicator variable that equals one if at least one of the individuals that the woman invited to accompany her to the ADC is her husband or her mother-in-law.
3. Sought company to visit ADC from someone other than husband or mother-in-law (non-husband/mother-in-law): Indicator variable that equals one if at least one of the individuals that the woman invited to accompany her to the ADC is neither her husband nor her mother-in-law.
4. Sought company to visit ADC from sister-in-law: Indicator variable that equals one if at least one of the individuals that the woman invited to accompany her to the ADC is her sister-in-law.
5. Sought company to visit ADC from a non-relative: Indicator variable that equals one if one of the individuals that the woman invited to accompany her to the ADC is a friend, neighbor, or any other peer that is not her relative.
6. Number of peers sought to visit the ADC: The number of people a woman asked to accompany her to the ADC since September 2018.
7. Visited the ADC for FP services: Indicator variable that equals one if a woman visited the ADC to obtain family planning services since September 2018.
8. Visited any clinic for FP services: Indicator variable that equals one if, since September 2018, the woman visited any health facility to obtain family planning services.
9. Visited the ADC alone: Indicator variable that equals one if a woman went alone to the ADC in all the visits she mentioned since September 2018. This variable equals zero either when the woman went with someone else in at least one FP visit or when she did not visit the ADC.⁵⁴
10. Visited the ADC with husband or mother-in-law: Indicator variable that equals one if a woman went with her husband or mother-in-law in at least one of her visits to the ADC since September 2018. The variable equals zero when a woman i) visited the ADC alone, ii) visited the ADC with individuals different from her husband or her mother-in-law, or iii) did not visit the ADC.⁵⁵

⁵⁴Phone surveys are included in this variable.

⁵⁵Phone surveys are excluded from this variable.

11. Visited the ADC with someone other than husband or mother-in-law (non-husband/mother-in-law): Indicator variable that equals one if a woman went with individuals other than her husband or her mother-in-law in at least one of her visits to the ADC since September 2018. The variable equals zero when a woman i) visited the ADC alone, ii) visited the ADC with her husband or her mother-in-law, or iii) did not visit the ADC.⁵⁶
12. Using modern FP method: Indicator variable that equals one if a woman is using a modern contraceptive method at the time of endline survey.⁵⁷
13. Using any FP method: Indicator variable that equals one if a woman is using either a traditional or a modern contraceptive method at the time of endline survey.⁵⁸
14. Number of close peers in village: The number of individuals a woman reports, at endline, with whom she discusses relatively more private matters like reproductive health, fertility, and family planning, and who live in the same village as her.
15. Number of close peers outside household in village: The number of individuals a woman reports, at endline, with whom she discusses relatively more private matters like reproductive health, fertility, and family planning, and who live in the same village as her but not in the same household.
16. Has close peers outside household in village that accompanied to health facility: Indicator variable that equals one if a woman reported, at endline, that she has at least one close peer outside her household in her village that accompanied her to the health facility. This variable is conditional on having at least one close peer outside her household in her village.
17. Has close peer outside household in village that advised to use FP: Indicator variable that equals one if a woman reported, at endline, that she has at least one close peer outside her household in her village that had ever advised her to use a family planning method. This variable is conditional on having at least one close peer outside her household in her village.
18. Satisfaction with sex life: Indicates, on a scale from 1 to 10, the woman's satisfaction with her sex life at endline, with 1 being extremely dissatisfied and 10 being extremely satisfied.
19. Marital satisfaction: Indicates, on a scale from 1 to 10, the woman's satisfaction with her marriage overall at endline, with 1 being extremely dissatisfied and 10 being extremely satisfied.
20. Afraid of being seen: Indicator variable that equals one if a woman is afraid of being seen by someone she knows at the family planning facility. This is our "fear of stigma" variable, which is measured at endline.
21. Negative experience with FP: Indicator variable that equals one if a woman faced any problems or negative experiences from discussing, accessing, or using a method of family planning as reported at endline.
22. Age: a woman's completed age in years at baseline.
23. Years of schooling: a woman's completed years of school attainment at baseline.

⁵⁶Phone surveys are excluded from this variable.

⁵⁷Modern methods include female sterilization, male sterilization, IUD/PPIUD, injectables, implants, pill, condom, female condom, emergency contraception, diaphragm, foam/jelly, standard day method, or any other modern method.

⁵⁸Traditional methods include lactational amenorrhea method, rhythm method, withdrawal, and any other traditional method.

24. Wants another child: Indicator variable that equals one if a woman wants another child at baseline.
25. Wants another son: Indicator variable that equals one if a woman wants another son at baseline.
26. Number of general peers: Number of individuals a woman reports with whom she discusses her personal affairs related to issues such as children's illness, schooling, health, work, and financial support at baseline.
27. Hindu: Indicator variable that equals one if a woman practices Hinduism at baseline.
28. SC or ST: Indicator variable that equals one if the woman belongs to a Scheduled Caste or a Scheduled Tribe at baseline.
29. OBC: Indicator variable that equals one if the woman belongs to an Other Backward Class at baseline.
30. Wears ghunghat: Indicator variable that equals one if a woman practices ghunghat at baseline.
31. Worked last year: Indicator variable that equals one if a woman worked last year at baseline.
32. Mobility Score: Calculated as the sum of six indicator variables for whether a woman is allowed to visit/go alone the following places at baseline: 1) homes of relatives or friends, 2) health facilities, 3) grocery stores, 4) short distances by bus or train, 5) markets, and 6) outside their villages or communities.
33. Ever visited a clinic for FP: Indicator variable that equals one if a woman has ever visited a health clinic or facility for reproductive health, fertility, or family planning services at baseline.
34. Asset Index: Household-level index constructed using principal component analysis using with the following household variables: source of drinking water, type of toilet facility, floor material, roof material, exterior wall material, type of fuel used for cooking, ownership of animals, and the number of rooms in the household used to sleep. This variable is constructed at baseline.
35. Number of children: Total number of alive children a woman had at the time of the baseline survey.
36. At least one son: Indicator variable that equals one if the woman had at least one son at the time of baseline survey.
37. Co-residence with mother-in-law: Indicator variable that equals one if a woman co-resides with her mother-in-law at the time of baseline survey.
38. Mother-in-law opposed to FP: Indicator variable that equals one if a woman expressed at baseline that one of the disadvantages of using FP is that her mother-in-law is opposed to it.
39. Valued concealability of FP method: Indicator variable that equals one if a woman expressed at baseline that one of the most important features of a contraceptive method is that it can be used without anyone else knowing.
40. Found FP embarrassing to use: Indicator variable that equals one if, at baseline, a woman expressed that one of the disadvantages of using family planning is that it is embarrassing to use.
41. Lack of close peers in village that use FP: Indicator variable that equals one if none of the woman's close peers in her village at baseline were using a family planning method at baseline. This variable is conditional on having at least one close peer in her village at baseline.

42. Poor: Indicator variable that equals one if, at baseline, a woman's household is below the poverty line and in the bottom two terciles of the asset index distribution, and is zero otherwise.

B Appendix Figures and Tables

Figure A.1: Study area



Figure A.2: Sample selection

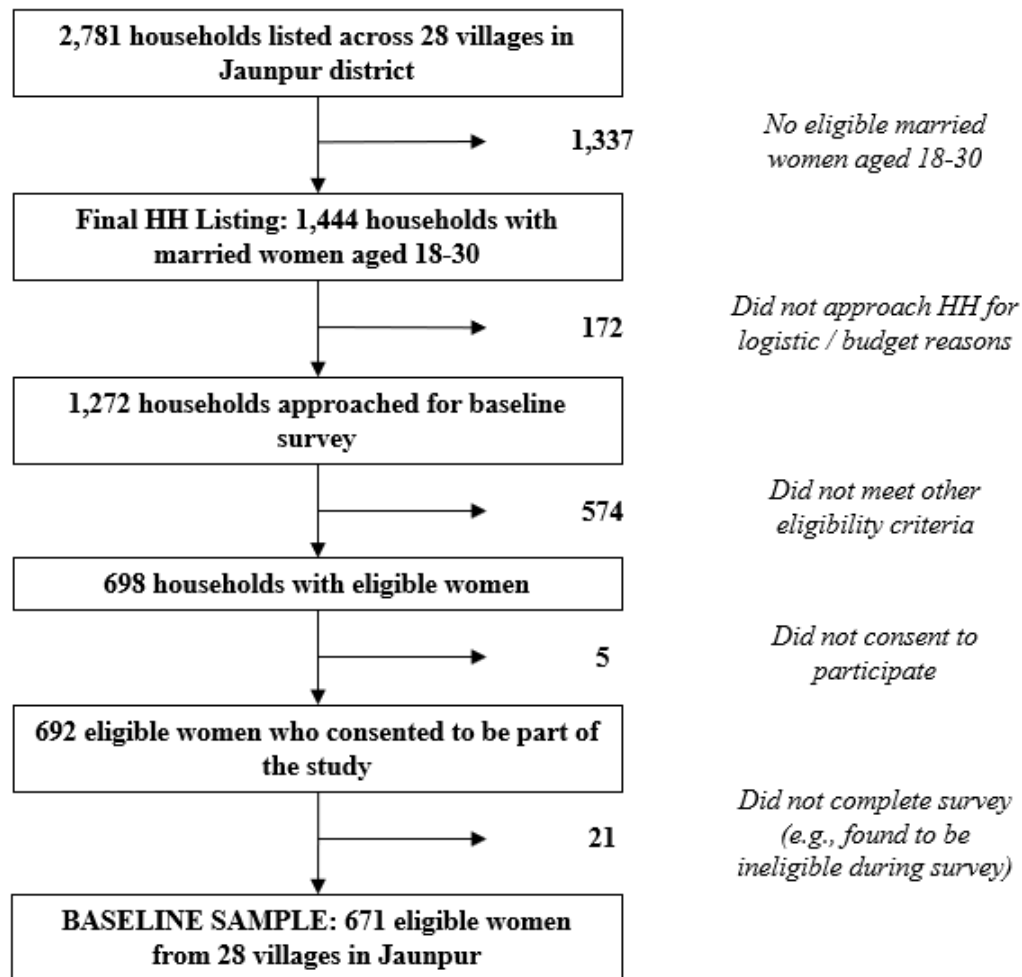
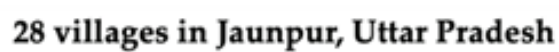


Figure A.3: Map of treatment and control women



Note: This figure shows the location of our partner clinic, the ADC, and of women in the three intervention arms in 28 villages of Jaunpur, Uttar Pradesh.

Figure A.4: Information brochure

Long-Acting Methods

These family planning methods are typically effective for more than 6 months.



Implants (Jadelle)



Intrauterine Contraceptive Device (IUCD)

Your Return to Fertility

- A new mother can become pregnant again as soon as 3 weeks after her delivery!
- Family planning through breastfeeding can help prevent pregnancy for up to 6 months
- Three requirements for using breastfeeding as family planning correctly:
 - Continuous, exclusive breastfeeding
 - No return of menses (period)
 - Up to 6 months postpartum only
- Mothers who are not breastfeeding are recommended to start a family planning method after 3 weeks from delivery.

If you just had a baby, when is a good time to get pregnant again?

- You should wait at least **2 years** before trying to get pregnant again



Images for this grid was obtained from: istock, iStock, Shutterstock, and Google Image search

Talk to your health provider and visit your local family planning clinic today!

Effectively planning your family today may improve your health, your children's health, and your family's future tomorrow.

Visit your local family planning clinic today to learn more



This guide was developed as part of the Janpur Social Networks Family Planning Study
Department of Geography
Delhi School of Economics, University of Delhi
E-mail: plpatilak@geography.du.ac.in



Why should you wait for 2 years?

- Mothers who wait for two years are less likely to die from childbirth.
- Children who are healthily spaced are:
 - Less likely to die during childbirth
 - Less likely to be born prematurely
 - Less likely to be underweight
 - More likely to grow up bigger and healthier

How can you healthily space and time your next birth?

Correctly and consistently use a family planning method of your choice

About Fertility, Healthy Birth Spacing, and Family Planning

A Guide for Couples



Short-Acting Methods

These family planning methods are typically effective at the point of use and for less than 6 months.



Condoms (Male or Female)



Oral Contraceptive Pills



Injectable Contraceptive (Depo-Provera)

Figure A.5: Voucher - English

Jaunpur Social Networks Study – Clinic Voucher	
This voucher covers the cost of family planning services at the ADC Clinic for up to Rs. 2000 . The voucher can only be redeemed for family planning services at the ADC Clinic. For more information, refer to the JSNS Terms of Services. The date of expiration of this voucher is:	
[INSERT CLIENT PHOTO HERE]	_____ / _____ / _____ (DD / MM / YY)
To redeem this voucher, or if you have any questions or concerns, please call Ms. Field Manager 1 or Ms. Field Manager 2 at:	
Field Manager 1: +91 XXX	Field Manager 2: +91 XXX
Client Name:	_____
Client Program ID:	_____
Client Phone Number:	_____
Date:	_____ / _____ / _____ (DD / MM / YY)

[illegible]

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Table A.1: Balance at baseline, additional individual characteristics

	Control (C)		Own		BAF		C - Own	C - BAF	Own - BAF
	N	Mean/SD	N	Mean/SD	N	Mean/SD	Diff.	Diff.	Diff.
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Poor	346	0.168 (0.374)	153	0.150 (0.359)	158	0.165 (0.372)	0.017	0.003	-0.014
Marital duration	343	7.219 (3.502)	153	7.288 (3.542)	159	7.509 (3.904)	-0.069	-0.291	-0.222
Has at least one son	350	0.743 (0.438)	156	0.744 (0.438)	165	0.679 (0.468)	-0.001	0.064	0.065
Valued concealability of FP	350	0.514 (0.501)	156	0.474 (0.501)	165	0.467 (0.500)	0.040	0.048	0.008
Found FP embarrassing to use	349	0.367 (0.483)	154	0.377 (0.486)	164	0.293 (0.456)	-0.010	0.074*	0.084
Number of close peers outside HH in village	350	0.257 (0.493)	156	0.250 (0.477)	165	0.279 (0.513)	0.007	-0.022	-0.029
Lack of close peers in village that use FP	225	0.733 (0.443)	99	0.717 (0.453)	103	0.670 (0.473)	0.016	0.063	0.047
Last visit to a FP clinic was with husband or MIL	338	0.263 (0.441)	155	0.284 (0.452)	162	0.278 (0.449)	-0.021	-0.014	0.006
F-test of joint significance: p-value							0.731	0.429	0.533
F-test: Number of observations							314	317	199

Notes: Standard deviations (SD) are presented in parentheses. BAF denotes Bring-a-Friend, FP denotes family planning, and MIL denotes mother-in-law. Variable definitions are presented in Online Appendix. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.2: Balance at baseline by attrition status at endline

	Non-attritor		Attritor		Non-attritor – Attritor
	N (1)	Mean/SD (2)	N (3)	Mean/SD (4)	Difference (5)
Own Voucher	625	0.234 (0.423)	46	0.217 (0.417)	0.016
BAF Voucher	625	0.250 (0.433)	46	0.196 (0.401)	0.054
Age	625	25.718 (2.663)	46	25.043 (2.422)	0.675*
Years of schooling	625	9.574 (4.445)	46	8.913 (4.760)	0.661
Hindu	625	0.931 (0.253)	46	0.978 (0.147)	-0.047*
Scheduled Caste or Tribe	625	0.435 (0.496)	46	0.543 (0.504)	-0.108
Other Backward Class	625	0.446 (0.498)	46	0.326 (0.474)	0.120
Wears ghunghat	625	0.891 (0.312)	46	0.783 (0.417)	0.109*
Worked last year	621	0.138 (0.346)	45	0.178 (0.387)	-0.039
Co-residence with MIL	625	0.683 (0.466)	46	0.609 (0.493)	0.075
Mobility score	625	0.870 (1.602)	46	1.261 (2.134)	-0.390
Asset score	625	0.026 (1.635)	46	-0.356 (1.556)	0.382
Number of general peers	625	1.658 (1.035)	46	1.522 (0.888)	0.136
Number of close peers in village	625	0.554 (0.626)	46	0.543 (0.585)	0.010
Number of children	625	1.960 (0.923)	46	1.870 (0.909)	0.090
Wants another child	621	0.493 (0.500)	46	0.565 (0.501)	-0.072
Using any FP method	624	0.486 (0.500)	46	0.348 (0.482)	0.138*
Using modern FP method	624	0.186 (0.389)	46	0.087 (0.285)	0.099**
Ever visited a clinic for FP	625	0.358 (0.480)	46	0.261 (0.444)	0.098
MIL opposed to FP	621	0.163 (0.369)	46	0.043 (0.206)	0.119***
F-test of joint significance: p-value					0.241
F-test: number of observations					657

Notes: Standard deviations (SD) are presented in parentheses. BAF denotes Bring-a-Friend, FP denotes family planning, and MIL denotes mother-in-law. Variable definitions are presented in Online Appendix. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.3: Balance at baseline by survey modality at endline

	In-person		Phone		In-person – Phone
	N (1)	Mean/SD (2)	N (3)	Mean/SD (4)	Difference (5)
Own Voucher	541	0.233 (0.423)	123	0.220 (0.416)	0.013
BAF Voucher	541	0.238 (0.427)	123	0.285 (0.453)	-0.046
Age	541	25.601 (2.623)	123	26.024 (2.744)	-0.424
Years of schooling	541	9.616 (4.400)	123	9.252 (4.721)	0.363
Hindu	541	0.933 (0.249)	123	0.935 (0.248)	-0.002
Scheduled Caste or Tribe	541	0.449 (0.498)	123	0.407 (0.493)	0.043
Other Backward Class	541	0.429 (0.495)	123	0.488 (0.502)	-0.059
Wears ghunghat	541	0.882 (0.323)	123	0.894 (0.309)	-0.013
Worked last year	537	0.140 (0.347)	122	0.131 (0.339)	0.009
Co-residence with MIL	541	0.673 (0.470)	123	0.699 (0.460)	-0.026
Mobility score	541	0.935 (1.686)	123	0.772 (1.487)	0.163
Asset score	541	0.031 (1.660)	123	-0.124 (1.490)	0.155
Number of general peers	541	1.682 (1.030)	123	1.520 (1.019)	0.162
Number of close peers in village	541	0.545 (0.618)	123	0.593 (0.651)	-0.048
Number of children	541	1.928 (0.888)	123	2.041 (0.995)	-0.113
Wants another child	537	0.501 (0.500)	123	0.480 (0.502)	0.021
Using any FP method	540	0.470 (0.500)	123	0.488 (0.502)	-0.017
Using modern FP method	540	0.169 (0.375)	123	0.220 (0.416)	-0.051
Ever visited a clinic for FP	541	0.342 (0.475)	123	0.390 (0.490)	-0.048
MIL opposed to FP	539	0.148 (0.356)	121	0.190 (0.394)	-0.042
F-test of joint significance: p-value					0.569
F-test: number of observations					650

Notes: Standard deviations (SD) are presented in parentheses. BAF denotes Bring-a-Friend, FP denotes family planning, and MIL denotes mother-in-law. Variable definitions are presented in Online Appendix. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.4: External validity: Comparing our sample with DHS data

	JSNS Baseline (1)	Rural UP (2)	UP (3)	Rural India (4)	India (5)
Years of schooling	9.57	7.74	7.98	7.65	8.11
Using any FP method	0.49	0.52	0.54	0.53	0.53
Wants another Child	0.49	0.47	0.48	0.46	0.46
Age	25.72	25.22	25.34	25.19	25.33
Hindu	0.93	0.87	0.84	0.79	0.77
Scheduled Caste or Tribe	0.44	0.29	0.28	0.43	0.41
Other Backward Class	0.45	0.55	0.55	0.41	0.42
Worked last year	0.14	0.15	0.15	0.27	0.25
Allowed to visit market alone	0.18	0.29	0.31	0.47	0.49
Allowed to visit health facility alone	0.14	0.28	0.30	0.42	0.44
Allowed to visit places outside community alone	0.19	0.28	0.30	0.42	0.42
N	625	23,708	28,215	163,712	206,659

Notes: Columns 2 to 5 are based on data from the 2019-21 India Demographic Health Survey (DHS); the sample is restricted to 18-30-year old married women to make the samples comparable to our baseline sample.

Table A.5: Descriptive statistics for the analytic sample

	N	Mean	SD	Min	Max
	(1)	(2)	(3)	(4)	(5)
<i>Endline variables</i>					
Number of peers sought company from to visit the ADC	622	0.22	0.63	0	6
<i>Sought company to visit the ADC from:</i>					
Someone	622	0.15	0.36	0	1
Husband or MIL ^a	605	0.03	0.17	0	1
Someone other than husband or MIL ^a	605	0.11	0.31	0	1
Sister-in-law ^a	605	0.06	0.23	0	1
Non-relative ^a	605	0.04	0.19	0	1
Number of close peers outside HH in village ^a	532	0.36	0.60	0	3
Number of close peers in village ^a	532	0.65	0.72	0	3
Afraid of being seen at a health facility ^a	521	0.21	0.41	0	1
Visited the ADC for FP	625	0.11	0.31	0	1
Visited any clinic for FP	622	0.26	0.44	0	1
<i>Visited the ADC:</i>					
Alone	625	0.03	0.17	0	1
With husband or MIL ^a	532	0.04	0.19	0	1
With someone other than husband or MIL ^a	532	0.05	0.22	0	1
Currently using modern FP method ^c	603	0.16	0.36	0	1
Currently using FP method ^c	603	0.39	0.49	0	1
<i>Baseline variables</i>					
Years of schooling	625	9.57	4.45	0	15
Currently using FP	624	0.49	0.50	0	1
Wants another child	621	0.49	0.50	0	1
Number of general peers	625	1.66	1.04	0	7
Age	625	25.72	2.66	18	30
Hindu	625	0.93	0.25	0	1
Scheduled Caste or Tribe	625	0.44	0.50	0	1
Other Backward Class	625	0.45	0.50	0	1
Wears ghunghat	625	0.89	0.31	0	1
Worked last year	621	0.14	0.35	0	1
Mobility score	625	0.87	1.60	0	6
Ever visited a clinic for FP	625	0.36	0.48	0	1
Asset score	625	0.03	1.63	-4	4
MIL opposed to FP	621	0.16	0.37	0	1
Valued concealability of a FP method	625	0.51	0.50	0	1
Found FP embarrassing to use	621	0.35	0.48	0	1
No baseline close peers in village using FP ^b	399	0.72	0.45	0	1
Poor	612	0.16	0.37	0	1

Notes: This table presents summary statistics for the intent-to-treat (ITT) sample of 625 women used in the analysis. MIL denotes mother-in-law and FP denotes family planning. Variable definitions are presented in Online Appendix. ^aindicates missing values due to implementation of the phone survey, which did not capture this data, ^bindicates that the variable is conditional on having at least one close peer at baseline. ^cindicates the exclusion of women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC.

Table A.6: Sought company to visit the ADC during the intervention period

	(1)	(2)	(3)	(4)
A: Sought company from someone				
Own Voucher	0.166*** [0.035]	0.165*** [0.035]	0.165*** [0.034]	0.178*** [0.035]
BAF Voucher	0.318*** [0.040]	0.319*** [0.039]	0.323*** [0.039]	0.340*** [0.039]
Observations	622	617	613	613
Endline control mean	0.034	0.034	0.034	0.034
p-value: Own = BAF	0.003	0.002	0.002	0.001
B: Sought company from husband or mother-in-law				
Own Voucher	0.035* [0.020]	0.036* [0.020]	0.035* [0.020]	0.037* [0.021]
BAF Voucher	0.025 [0.018]	0.026 [0.018]	0.024 [0.017]	0.031* [0.018]
Observations	605	600	596	596
Endline control mean	0.016	0.016	0.016	0.016
p-value: Own = BAF	0.690	0.694	0.660	0.806
C: Sought company from someone other than husband or mother-in-law				
Own Voucher	0.094*** [0.029]	0.094*** [0.028]	0.099*** [0.028]	0.107*** [0.028]
BAF Voucher	0.257*** [0.038]	0.259*** [0.038]	0.267*** [0.038]	0.276*** [0.038]
Observations	605	600	596	596
p-value: Own = BAF	0.000	0.000	0.000	0.000
Endline control mean	0.022	0.022	0.022	0.022
Balancing controls	No	Yes	Yes	Yes
Other balancing covariates	No	No	Yes	Yes
Village FE	No	No	No	Yes

Notes: Balancing controls are the baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers. Other baseline covariates include woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score and asset index. BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.7: Number and composition of peers sought company from to visit the ADC

	(1)	(2)	(3)	(4)
A: Number of peers sought				
Own Voucher	0.192*** [0.048]	0.190*** [0.047]	0.199*** [0.046]	0.215*** [0.047]
BAF Voucher	0.495*** [0.080]	0.496*** [0.078]	0.514*** [0.080]	0.538*** [0.080]
Observations	622	617	613	613
Endline control mean	0.050	0.050	0.050	0.050
p-value: Own=BAF	0.001	0.000	0.000	0.000
B: Sought company from sister-in-law				
Own Voucher	0.055*** [0.020]	0.055*** [0.020]	0.056*** [0.020]	0.060*** [0.020]
BAF Voucher	0.174*** [0.032]	0.175*** [0.032]	0.175*** [0.032]	0.178*** [0.032]
Observations	605	600	596	596
Endline control mean	0.003	0.003	0.003	0.003
p-value: Own=BAF	0.002	0.001	0.002	0.001
C: Sought company from a non-relative				
Own Voucher	0.034* [0.018]	0.033* [0.018]	0.038** [0.019]	0.041** [0.019]
BAF Voucher	0.086*** [0.025]	0.087*** [0.025]	0.095*** [0.026]	0.095*** [0.027]
Observations	605	600	596	596
Endline control mean	0.009	0.009	0.009	0.009
p-value: Own=BAF	0.084	0.073	0.066	0.070
Balancing controls	No	Yes	Yes	Yes
Other balancing covariates	No	No	Yes	Yes
Village FE	No	No	No	Yes

Notes: Balancing controls are the baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers. Other baseline covariates include woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and asset index. BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.8: Clinic visits for family planning services during the intervention period

	(1)	(2)	(3)	(4)
A: Visited the ADC				
Own Voucher	0.204*** [0.035]	0.202*** [0.035]	0.202*** [0.035]	0.199*** [0.034]
BAF Voucher	0.170*** [0.032]	0.170*** [0.032]	0.168*** [0.032]	0.186*** [0.033]
Observations	625	620	616	616
Endline control mean	0.015	0.015	0.015	0.015
p-value: Own = BAF	0.473	0.485	0.463	0.759
B: Visited any clinic				
Own Voucher	0.162*** [0.046]	0.161*** [0.046]	0.164*** [0.046]	0.166*** [0.047]
BAF Voucher	0.109** [0.043]	0.108** [0.043]	0.110** [0.043]	0.131*** [0.045]
Observations	622	617	613	613
Endline control mean	0.193	0.193	0.193	0.193
p-value: Own = BAF	0.331	0.335	0.327	0.531
Balancing controls	No	Yes	Yes	Yes
Other balancing covariates	No	No	Yes	Yes
Village FE	No	No	No	Yes

Notes: Balancing controls are the baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers. Other baseline covariates include woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and asset index. FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.9: Heterogeneous treatment effects on clinic visits for family planning services

Outcome: Visited any clinic	Covariate at baseline:		
	Wanted another child (1)	Had at least one son (2)	Had ever visited a clinic for FP (3)
Own Voucher	0.301*** [0.068]	0.017 [0.088]	0.109* [0.058]
BAF Voucher	0.198*** [0.065]	0.093 [0.085]	0.148** [0.057]
Own Voucher \times Covariate	-0.226** [0.095]	0.190* [0.105]	0.126 [0.111]
BAF Voucher \times Covariate	-0.112 [0.094]	0.094 [0.102]	0.000 [0.094]
Observations	613	613	613
Endline control mean	0.193	0.193	0.193
p-values:			
Own = BAF	0.198	0.450	0.582
Own \times Covariate = BAF \times Covariate	0.303	0.428	0.316
Own + Own \times Covariate = 0	0.259	0.000	0.014
BAF + BAF \times Covariate = 0	0.209	0.001	0.048

Notes: All columns present fully-interacted regressions, where all controls are interacted with the covariate that is used for examining heterogeneous effects; the main effect of that variable is also included as a regressor. All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. FP denotes family planning and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.10: Number of clinic visits for family planning services during the intervention period

	(1)	(2)	(3)	(4)
A: Number of visits to the ADC				
Own Voucher	0.316*** [0.096]	0.313*** [0.097]	0.323*** [0.106]	0.280*** [0.075]
BAF Voucher	0.278*** [0.080]	0.277*** [0.079]	0.277*** [0.078]	0.290*** [0.081]
Observations	625	620	616	616
Endline control mean	0.074	0.074	0.074	0.074
p-value: Own=BAF	0.749	0.760	0.704	0.922
B: Number of visits to any clinic				
Own Voucher	0.151* [0.087]	0.146* [0.088]	0.149* [0.089]	0.171* [0.091]
BAF Voucher	0.132 [0.111]	0.127 [0.111]	0.123 [0.107]	0.139 [0.107]
Observations	615	610	606	606
Endline control mean	0.339	0.339	0.339	0.339
p-value: Own = BAF	0.876	0.877	0.822	0.770
Balancing controls	No	Yes	Yes	Yes
Other balancing covariates	No	No	Yes	Yes
Village FE	No	No	No	Yes

Notes: Balancing controls are the baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers. Other baseline covariates include woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and asset index. FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.11: Heterogeneous treatment effects on type of peers sought, by mother-in-law opposition to family planning

	Sought company to visit the ADC from:	
	Sister-in-law (1)	Non-relative (2)
Own Voucher	0.062*** [0.023]	0.033 [0.020]
BAF Voucher	0.159*** [0.034]	0.090*** [0.031]
Own Voucher \times MIL opposed to FP	-0.025 [0.052]	-0.025 [0.026]
BAF Voucher \times MIL opposed to FP	0.122 [0.101]	0.020 [0.071]
Observations	592	592
Endline control mean	0.003	0.009
p-values:		
Own = BAF	0.016	0.097
Own \times MIL opposed = BAF \times MIL opposed	0.187	0.518
Own + Own \times MIL opposed = 0	0.417	0.627
BAF + BAF \times MIL opposed = 0	0.003	0.085

Notes: All columns present fully-interacted regressions, where all covariates are interacted with an indicator for whether the MIL was opposed to FP at baseline. The main effect of MIL opposition to FP at baseline is also included as a control variable. All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.12: Modern contraceptive use at endline, all sample women

Outcome: Using modern FP method	All (1)	Covariate at baseline:	
		MIL opposed to FP (2)	Found FP embarrassing to use (3)
Own Voucher	0.053 [0.036]	0.055 [0.041]	0.037 [0.047]
BAF Voucher	0.052 [0.036]	0.016 [0.039]	-0.029 [0.044]
Own Voucher \times Covariate		-0.000 [0.111]	0.027 [0.075]
BAF Voucher \times Covariate		0.144 [0.116]	0.206** [0.082]
Observations	609	605	605
Endline control mean	0.123	0.123	0.123
p-values:			
Own = BAF	0.966	0.402	0.207
Own \times Covariate = BAF \times Covariate		0.317	0.059
Own + Own \times Covariate = 0		0.597	0.266
BAF + BAF \times Covariate = 0		0.147	0.011

Notes: Columns 2 and 3 present fully-interacted regressions, where all controls are interacted with the covariate that is used for examining heterogeneous effects; the main effect of that variable is also included as a regressor. All columns also include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variable for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.13: Contraceptive use at endline

	(1)	(2)	(3)	(4)
A: Using any FP method				
Own Voucher	0.005 [0.050]	-0.002 [0.049]	0.005 [0.050]	-0.001 [0.051]
BAF Voucher	0.018 [0.049]	0.015 [0.048]	0.008 [0.048]	-0.002 [0.050]
Observations	603	598	594	594
p-value: Own=BAF	0.823	0.759	0.962	0.995
Endline control mean	0.381	0.381	0.381	0.381
B: Using modern FP method				
Own Voucher	0.062 [0.038]	0.055 [0.037]	0.052 [0.036]	0.054 [0.037]
BAF Voucher	0.072* [0.038]	0.071* [0.037]	0.054 [0.037]	0.061* [0.037]
Observations	603	598	594	594
Endline control mean	0.124	0.124	0.124	0.124
p-value: Own = BAF	0.826	0.719	0.952	0.869
Balancing controls	No	Yes	Yes	Yes
Other balancing covariates	No	No	Yes	Yes
Village FE	No	No	No	Yes

Notes: The analytic sample in this table excludes women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC. Balancing controls refer to baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers. Other baseline covariates include woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index. FP denotes family planning, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.14: Heterogeneous treatment effects on social connections at endline by baseline social connections

Outcomes:	Covariate at baseline: Lack of close peers in village that use FP	
	Number of close peers in village outside HH	Has peers in village outside HH that accompanied to health facility
	(1)	(2)
Own Voucher	-0.152 [0.215]	0.002 [0.158]
BAF Voucher	-0.286 [0.210]	0.024 [0.211]
Own Voucher \times Covariate	0.137 [0.238]	-0.111 [0.186]
BAF Voucher \times Covariate	0.637*** [0.234]	0.230 [0.231]
Observations	329	224
Endline control mean	0.357	0.278
p-values:		
Own = BAF	0.541	0.905
Own \times Covariate = BAF \times Covariate	0.048	0.108
Own + Own \times Covariate = 0	0.884	0.263
BAF + BAF \times Covariate = 0	0.001	0.008

Notes: All columns present fully-interacted regressions, where all covariates are interacted with the covariate that is used for examining heterogeneous effects; the main effect of that variable is also included as a regressor. All columns also include balancing controls (i.e., baseline values of whether a woman is currently using family planning, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variable for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a family planning clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, FP denotes family planning, BAF denotes Bring-a-Friend, and HH denotes household. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.15: Backlash effects

	Negative experience with FP	Satisfaction with sex life	Marital satisfaction
	(1)	(2)	(3)
Own Voucher	-0.012 [0.027]	0.200 [0.196]	0.098 [0.208]
BAF Voucher	0.013 [0.033]	0.309 [0.209]	0.223 [0.199]
Observations	503	513	519
Endline control mean	0.076	8.207	8.763
p-value: Own = BAF	0.494	0.638	0.605

Notes: All columns include balancing controls (i.e., baseline values of whether a woman is currently using family planning, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a family planning clinic, her mobility score, and her asset index) and village fixed effects. MIL denotes mother-in-law, and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.16: Heterogeneous treatment effects of voucher receipt by baseline financial constraints

	Visited the ADC (1)	Visited any clinic (2)	Using a modern FP method (3)
Any Voucher	0.184*** [0.029]	0.150*** [0.042]	0.034 [0.035]
Any Voucher \times Poor at baseline	0.132 [0.083]	0.097 [0.110]	0.190* [0.097]
Observations	603	600	581
Endline control mean	0.015	0.193	0.124
p-value: Any Voucher + Any Voucher \times Poor = 0	0.000	0.016	0.013

Notes: *Any Voucher* equals one if the woman received either an Own or a Bring-a-Friend voucher, and zero otherwise. Column 3 excludes women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC. All columns present fully-interacted regressions, where all covariates are interacted with Poor at baseline. The main effect of Poor at baseline is also included as a control variable. All columns include balancing controls (i.e., baseline values of whether a woman is currently using family planning, her years of education, whether she wants another child, and the number of peers she mentions in the social networks module), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a family planning clinic, her mobility score, and her asset index) and village fixed effects. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A.17: Robustness checks

Panel A	Sought company to visit the ADC from non-husband/MIL (1)	Visited the ADC with non-husband/MIL (2)	Visited the ADC (3)	Visited any clinic (4)	Using modern FP method (5)
Own Voucher	0.107	0.063	0.199	0.166	0.054
<i>Robust (p-value)</i>	(0.000)	(0.017)	(0.000)	(0.000)	(0.147)
<i>Clustered (p-value)</i>	(0.001)	(0.025)	(0.000)	(0.005)	(0.157)
<i>WC Bootstrap (p-value)</i>	(0.000)	(0.008)	(0.000)	(0.003)	(0.209)
<i>Romano and Wolf (2005a,b) MHT Correction (p-value)</i>	(0.009)	(0.172)	(0.000)	(0.013)	(0.564)
BAF Voucher	0.276	0.075	0.186	0.131	0.061
<i>Robust (p-value)</i>	(0.000)	(0.006)	(0.000)	(0.003)	(0.099)
<i>Clustered (p-value)</i>	(0.000)	(0.049)	(0.000)	(0.018)	(0.033)
<i>WC Bootstrap (p-value)</i>	(0.000)	(0.021)	(0.000)	(0.032)	(0.022)
<i>Romano and Wolf (2005a,b) MHT Correction (p-value)</i>	(0.000)	(0.084)	(0.000)	(0.063)	(0.471)
Panel B	Number of close peers outside HH in village (6)	Has close peers outside HH that accompanied to health facility (7)	Has close peers outside HH that advised to use FP (8)	Afraid of being seen (9)	
Own Voucher	-0.034	-0.019	-0.014	-0.016	
<i>Robust (p-value)</i>	(0.575)	(0.748)	(0.784)	(0.727)	
<i>Clustered (p-value)</i>	(0.573)	(0.752)	(0.765)	(0.707)	
<i>WC Bootstrap (p-value)</i>	(0.578)	(0.754)	(0.747)	(0.710)	
<i>Romano and Wolf (2005a,b) MHT Correction (p-value)</i>	(0.951)	(0.980)	(0.980)	(0.980)	
BAF Voucher	0.092	0.120	0.132	-0.097	
<i>Robust (p-value)</i>	(0.183)	(0.044)	(0.021)	(0.018)	
<i>Clustered (p-value)</i>	(0.180)	(0.077)	(0.094)	(0.005)	
<i>WC Bootstrap (p-value)</i>	(0.256)	(0.121)	(0.147)	(0.013)	
<i>Romano and Wolf (2005a,b) MHT Correction (p-value)</i>	(0.589)	(0.278)	(0.172)	(0.172)	

Notes: p-values are reported in parentheses. *Robust* reports p-values from robust standard errors. *Clustered* reports p-values based on standard errors clustered at the village level. *WC Bootstrap* reports p-values based on wild-clustered bootstrapped standard errors, obtained from the *boottest* command in Stata. *Romano and Wolf (2005a,b) MHT Correction* reports p-values that are computed using the *Romano and Wolf (2005a,b)* method based on the *rwolf2* command in Stata with 3,000 bootstrap replications; this correction allows for the inclusion of covariates and village fixed effects in the model specifications. The outcome in Panel A Column 5 excludes women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC. MIL denotes mother-in-law and FP denotes family planning. Variable definitions are presented in Online Appendix.

Table A.18: Treatment-on-Treated (2SLS) estimates for the main outcomes

	Sought company to visit the ADC from non-husband/MIL	Visited the ADC with non-husband/MIL	Visited the ADC	Visited any clinic	Using modern FP method
Panel A	(1)	(2)	(3)	(4)	(5)
Own Voucher	0.111*** [0.029]	0.066** [0.026]	0.207*** [0.034]	0.171*** [0.046]	0.056 [0.037]
BAF Voucher	0.282*** [0.037]	0.077*** [0.026]	0.189*** [0.032]	0.134*** [0.044]	0.062* [0.036]
Observations	596	525	616	613	594
p-value: Own=BAF	0.000	0.739	0.688	0.494	0.883
Endline control mean	0.022	0.022	0.015	0.193	0.124
	Number of close peers outside HH in village	Has close peers outside HH that accompanied to health facility	Has close peers outside HH that advised to use FP	Afraid of being seen	
Panel B	(6)	(7)	(8)	(9)	
Own Voucher	-0.036 [0.061]	-0.020 [0.059]	-0.015 [0.052]	-0.017 [0.046]	
BAF Voucher	0.094 [0.068]	0.124** [0.057]	0.136** [0.055]	-0.099** [0.040]	
Observations	525	347	346	514	
p-value: Own=BAF	0.091	0.032	0.012	0.087	
Endline control mean	0.357	0.278	0.222	0.239	

Notes: Treatment-on-Treated estimates are obtained using two-stage least squares (2SLS), in which treatment assignment is used as an instrument for voucher receipt. Of the 625 women, 10 treatment women (six from the Own voucher group and four from the BAF voucher group) were not available to receive the voucher. All columns include balancing controls (i.e., baseline values of whether a woman is currently using FP, her years of education, whether she wants another child, and her number of general peers), other baseline covariates (woman's age, indicator variables for Hindu, SC-ST, OBC, whether the woman works, wears ghunghat, and had ever visited a FP clinic, her mobility score, and her asset index) and village fixed effects. The outcome in Panel A Column 5 excludes women who visited the ADC during the intervention period but who were unable to use a method after their visit due to the following reasons: a) they were identified to have a health risk or medical contraindication that prevented them from adopting a contraceptive method; b) they were found to be pregnant during their visit; or c) they were unable to meet the health provider during their visit due to long waiting times at the ADC. MIL denotes mother-in-law and BAF denotes Bring-a-Friend. Variable definitions are presented in Online Appendix. Robust standard errors are presented in brackets.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

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