Evaluation of the *Confiance Totale* Campaign in Togo

Levels of Campaign Exposure and Associations with Family Planning and Reproductive Health Outcomes

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Acronyms

B	Non-standardized beta
DMI	Development Media International
EA	Enumeration area
FP	Family planning
IRB	Institutional Review Board
LB	Lower bound
OR	Odds ratio
PSA	Public service announcement
RCT	Randomized controlled trial
SBC	Social and behavior change
SD	Standard deviation
UB	Upper bound
WABA	West Africa Breakthrough ACTION

Background

Family Planning in Togo

Despite decades of family planning (FP) programming, contraceptive prevalence across the West African region remains low and fertility remains relatively high.[1] FP use can positively affect the health and well-being of women and their families and is associated with a number of positive outcomes, including increased women's empowerment, decreased maternal mortality, improved maternal and child health, and improved economic status.[2–5] In Togo, Ahmed and colleagues estimated that 26.6% of maternal mortality could be averted if societies or services could satisfy unmet need for modern contraception.[2]

Even with these benefits, in Togo, only 24% of married women between the ages of 15 and 49 reported currently using a modern FP method, despite an approximate 34% unmet need for contraception.[6] Factors related to FP non-use among those with unmet need include socio-cultural norms and practices, economic constraints, travel-related barriers to accessing FP services, and low education levels among women.[7] One study of married Togolese men demonstrated that men are willing to learn about and participate in fertility and FP decision making, but they also have concerns about side effects and return to fertility.[1] Additionally, research demonstrates that providers' behavior can impact the quality of FP care, client FP method use, and continuation decision making.[8] In a qualitative study, some women reported distrust of providers when it came to FP, and, therefore, these women appeared to be less willing to ask questions and less able to access their preferred method.[8] Thus, in addition to structural barriers and social norms, trust in providers is likely also a factor affecting FP method use.

Social and Behavior Change and FP Use

> SBC can be defined as "activities or interventions that seek to understand and facilitate change in behaviors and the social norms and environmental determinants that drive those behaviors"
> – J. E. Rosen, et al.[9]

Social and behavior change (SBC) campaigns or interventions can provide information about FP method safety and benefits, while also challenging the social and gender norms that restrict FP access and use. Communication theories informing SBC often posit that SBC interventions will affect intermediate outcomes such as attitudes and social norms as well as final behaviors. Such interventions can include radio, television, social media, interpersonal communication, or any combination of these approaches.[9] SBC interventions have been demonstrably effective in affecting FP-related outcomes, but the results are often context-specific and dependent on the types of interventions used.[9]

The West Africa Breakthrough ACTION and *Confiance Totale* Theory of Change

In order to promote client trust in FP methods and providers, the West Africa Breakthrough ACTION (WABA) project developed a quality assurance brand entitled *Confiance Totale* ("total confidence" in English). WABA is part of Breakthrough ACTION, USAID's global SBC flagship project. The campaign is based on Kincaid's Ideational Model of SBC interventions, which suggests that tailored communication can result in improved skills and knowledge and improved ideational constructs such as attitudes, perceived norms, self-efficacy, and social support/influence.[10,11] The theory assumes that through these intermediate outcomes, the communication will increase the adoption of a priority behavior; for example, in the case of *Confiance Totale*, the intention to use and ultimately adopt an FP method.[10,11] **Figure 1** presents the Ideational Model of SBC applied to FP use and the *Confiance Totale* campaign specifically.

WABA conceptualized two *Confiance Totale* radio public service announcements (PSAs) just prior to the onset of the COVID-19 pandemic. These spots focused on promoting confidence in FP methods and services, couple communication about FP use, postpartum FP, and healthy birth spacing. After the

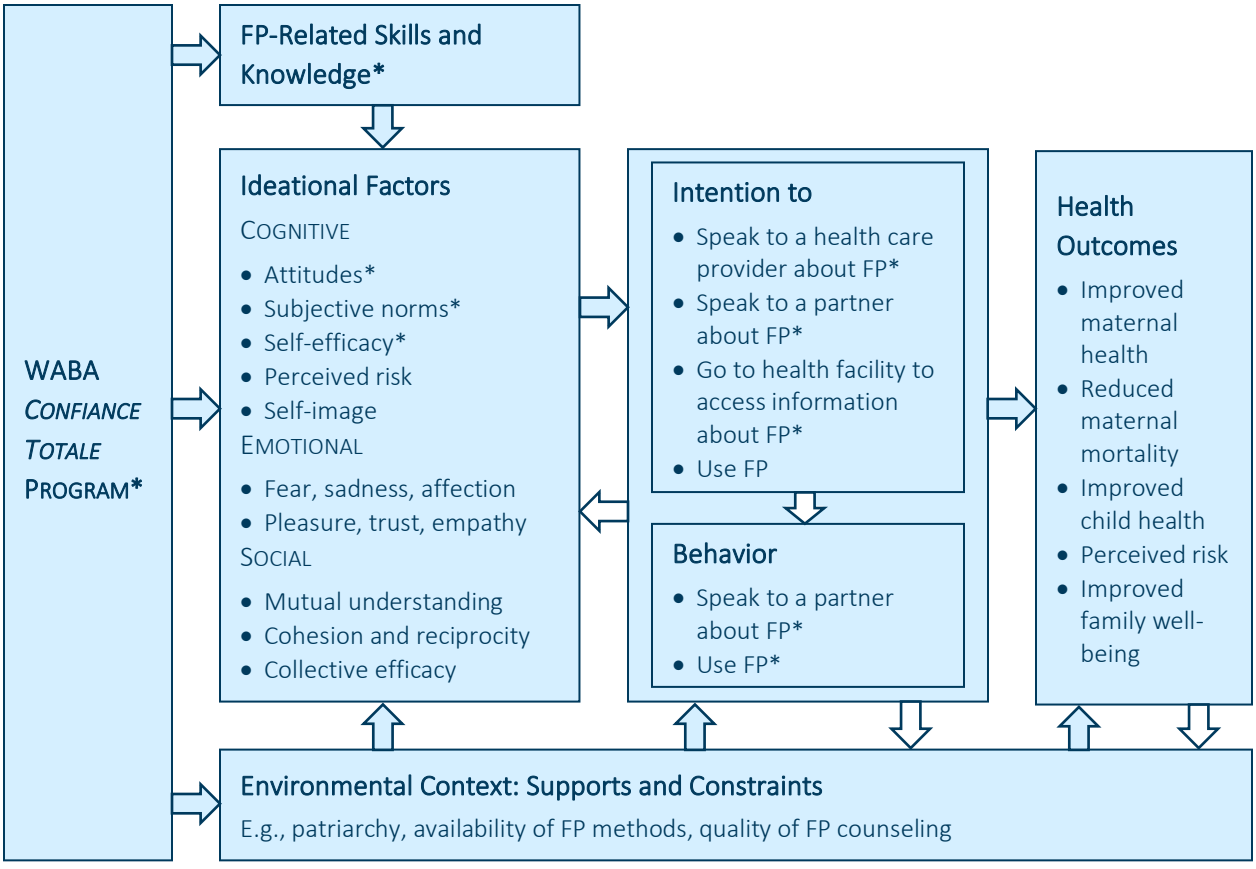

***Figure 1. Kincaid's Ideational Model of Health Behavior Change[10,11] Applied to FP and* Confiance Totale**. *While the 10 Confiance Totale PSAs touch on nearly all constructs in the above diagram, the evaluation survey measured and assessed the constructs marked with an asterisk.*

World Health Organization declared COVID-19 a pandemic in March 2020, the project pivoted to finalize the PSAs and create seven new spots to encourage FP access and use in the context of COVID-19. WABA hypothesized that the emergence of the pandemic might result in uncertainty around the virus and its transmission and, thereby, reluctance among community members to access other services at health facilities. WABA anticipated that people would be spending more time at home due to lockdown orders or personal preference, so it leveraged this as an opportunity to share messages to further promote couple communication about FP and ultimately use in the context of uncertainty and increased time spent at home.

Radio Dissemination of *Confiance Totale* Program

WABA broadcast the nine 45-second PSAs on the radio between May and September 2020, in Burkina Faso, Côte d'Ivoire, Niger, and Togo using the Saturation+ methodology. Development Media International (DMI) developed the Saturation+ approach, which is based on the importance of three main principles: saturation, science, and stories.[12] According to this approach, intensity—or the frequency of broadcast—is an essential component of any successful behavior change campaign, and therefore, DMI recommends broadcasting the messages in local languages six to 12 times per day for radio spots, three times per day for TV spots, and at least once per day for other formats.[12]

Concurrent with spot development, WABA staff worked with the Breakthrough RESEARCH project to conceptualize an evaluation of the campaign. Breakthrough RESEARCH staff shaped its evaluation using the constructs within the ideational model, and staff from both projects collaborated to identify the variables of most relevance to understanding the program. Breakthrough RESEARCH conducted the evaluation survey between August and October 2020 to evaluate potential effects in Côte d'Ivoire.[13] While the evaluation provided several important lessons learned, the study team limited results to the use of mobile phone surveys for data collection rather than household-based surveys due to study conditions during the COVID-19 epidemic. As such, the study did not include a measure of prompted exposure to *Confiance Totale*.[13] Measures of prompted exposure used a jingle or message to trigger the respondent's memory. Measures of prompted/aided exposure assess the respondent's level of recognition of a campaign, which requires less cognitive engagement and can help with under-reporting associated with unprompted measures of recall.[14]

Following the Breakthrough RESEARCH evaluation, WABA coordinated another round of broadcasts of the same *Confiance Totale* PSAs in Togo from July 2021 to December 2021 on local radio stations. WABA intended, in the process, to conduct a comprehensive household survey to measure the effect of the broadcasts. Seven radio stations broadcast each spot in the three most commonly used languages 15 times per day between the hours of 5:50 a.m. and 10:00 p.m.

The study team then conducted a household survey to assess the level of prompted and unprompted exposure to the *Confiance Totale* campaign among community members and to investigate the relationship between exposure and reproductive health outcomes of interest. The study aimed to show to what extent the 2020 and 2021 *Confiance Totale* broadcasted messages reached the desired

audience during the COVID-19 pandemic, and to understand the extent to which these messages may have affected intermediate and behavioral outcomes outlined in **Figure 1**. In addition, the study team sought to understand whether there were different effects among the men and women sampled.

Methods

The data used in this paper come from a single-wave, cross-sectional, household-based survey that was conducted in Lomé (Agoé Nyivè) and Blitta Ville (Blitta) in April 2022 among 2,200 respondents between the ages of 18 and 49. WABA carried out the survey in collaboration with the Togo-based research firm, CERA Group.

Study Design

The study team used a stratified random sample approach to collect data from 2,200 respondents, who were evenly divided by site and by sex (n = 1,100 males and n = 1,100 females). In each of the two sites (Agoé Nyivè and Blitta Ville), the data collection team identified 44 enumeration areas (EA) and used the random walk technique to approach every third household on the right side of the street. For each EA, the team sampled approximately 25 participants.

Data Collection and Study Procedures

Prior to beginning data collection, WABA conducted a three-day training of 20 data collectors and met with local leaders to describe the upcoming activity and seek their buy-in for the evaluation. Upon securing these approvals, the study team conducted data collection between April 18 and May 2, 2022. All 20 research assistants completed data collection in Agoé Nyivè before the team moved on to Blitta. Upon arrival at each sampled household, the research assistant read a brief recruitment/introductory script that described the reason for his or her visit to the head of household. The research assistant then used a modified Kish Grid approach to list all of the household members between the ages of 18 and 49 who were at home and who matched the sex of the research assistant him or herself. Once the assistant identified that person, they screened the potential interviewee for eligibility to participate in the study. Eligible potential participants were those who did not currently exhibit any signs of COVID-19, were between the ages of 18 and 49, and who reported that they had sexual intercourse within the previous six months. If the individual was deemed eligible to participate, the research assistant read him or her the full consent script that described the study, the risks and benefits, and the participant's rights. Upon agreeing to participate, the research assistant administered the survey using his or her mobile device and the KoboCollect application (KoboToolbox, Cambridge, MA). Male research assistants interviewed males and female research assistants interviewed females. Completion of the survey required about 30 minutes and participants were provided with a small bottle of hand sanitizer as a token of appreciation.

Ethical Approval

This study was approved by the Johns Hopkins University School of Public Health Institutional Review Board (IRB) (approval number 19143) in the United States, and by the *Comité de Bioethique pour la Recherche en Santé* in Togo (approval number 041).

Data Management and Data Analysis

At the end of the data collection period, the study team downloaded data from the KoboCollect platform into CSV files and then uploaded these files into Stata 15 (StataCorp, LLC, College Station, TX) for analysis. All data was stored on Microsoft OneDrive on password-protected computers according to the standards approved by the IRBs.

For certain outcomes of interest—including current FP use, intention to use FP, having spoken to a health care provider about FP in the last month, and the intention to go to the health facility to obtain FP—WABA conducted the analysis among a sub-set of the respondents (analytic sample n = 1,610), because these outcomes were relevant for those who did not want to become pregnant. The analytic sample used in these analyses therefore excluded those who were pregnant (or their partner was pregnant), respondents who reported not using FP because they (or their partner) wanted another child, and those who reported not using FP because they were not having sex. For the outcomes of FP communication, the study team analyzed the full sample (n = 2,200) regarding the following: intention to speak to one's partner about FP, FP attitudes, postpartum FP attitudes, perceived social norms, FP knowledge, self-efficacy to talk about FP at the health facility, self-efficacy to talk to partner about FP, and reproductive autonomy.

After cleaning the data, the team ran basic frequency distributions for all variables of interest and tested bivariate associations between exposure and outcomes of interest. Finally, WABA used multivariable regression modelling to test these potential associations while controlling for other variables of interest including sex, age, site, marital status, educational attainment, religion, and economic status. The study team ran sensitivity analyses in order to assess effects of various measures of exposure on the outcomes of interest.

Descriptions of composite outcomes measured for the *Confiance Totale* evaluation

FP related social norms: Respondent perspectives on whether people/couples in their community talk about, approve of, and/or use FP.

FP attitudes: Respondent reports of the importance of using FP, the safety of FP, the efficacy of FP, and the trustworthiness of FP providers.

Postpartum FP attitudes: Respondent opinions on when and whether women should discuss and/or begin using FP methods following a recent birth.

FP knowledge: The respondent answers a series of questions regarding their knowledge of various contraceptive methods. For example, whether one can use a condom more than once and whether an intrauterine device can move inside a woman's body.

Reproductive autonomy: A measure of an individual's control over decisions related to sex, reproduction, and contraceptive use. This particular measure includes the communication sub-scale, which measures whether they can talk to their partner about sex, FP use, and pregnancy desires.

Additionally, the team ran gender stratified models to separately test the effects of exposure among both male and female respondents.

Measures

Table 1 in the Appendix presents the measures included in this evaluation. These include the exposure measure, the outcomes of interest, and the socio-demographic control variables which we describe further below.

Results

Descriptive Statistics and Characteristics of the Sample

Table 2 in the Appendix presents the socio-demographic characteristics of the sample. By sampling design, the sample was evenly divided between males and females and by site of data collection (Blitta and Agoé Nyivè). The average age of the respondents included in the survey was 30.7 (Standard Deviation [SD] = 8.04). Most of the respondents reported that they were married (n = 1,473, 67%), and almost one-half of them reported that they had attended some school or completed secondary education. The largest proportion of the sample was Catholic (n = 657, 29.9%) and the mean score on the wealth index was 3.87 (range: 0 to 6).

Table 3 in the Appendix presents the frequencies for exposure to the campaign and the FP outcomes of interest. Approximately 45% of the overall sample reported that they had ever heard radio messages with the *Confiance Totale* jingle. Nearly 62% reported that they themselves or their partner were currently using an FP method at the time of the survey. Only 34.7% of respondents reported that they had spoken about FP with their primary partner during the previous month, though 53.4% reported they intend to speak with them during the next month. About 72% of respondents perceived community social norms towards FP to be supportive.

Multivariable Regression Models

In multivariable models controlling for respondent age, sex, district, marital status, religion, educational attainment, and socio-economic status (**Tables 4** and **5** in the Appendix; **Figure 2**), *Confiance Totale* exposure was associated with many outcomes of interest including current FP use (odds ratio [OR] = 1.39, $p = 0.023$), intention to use FP (OR = 2.17, $p < 0.001$), intention to go to a health facility to obtain information about FP (OR = 1.77, $p < 0.001$), having spoken with one's primary partner in the past month (OR = 1.45, $p < 0.001$), intention to talk to one's partner about FP (OR = 1.47, $p < 0.001$), an elevated perception of supportive FP social norms (OR = 1.68, $p < 0.001$), positive postpartum FP attitudes (OR = 1.26, $p = 0.02$), self-efficacy to speak with one's partner about FP (OR = 1.30, $p = 0.008$), more supportive FP attitudes (unstandardized beta [B] = 0.45, $p < 0.001$), higher levels of FP knowledge ($B = 0.42$, $p < 0.001$), and increased reproductive autonomy ($B = 0.73$, $p < 0.001$). Having spoken to a health care provider in the last month and self-efficacy to talk about FP at the health facility did not have

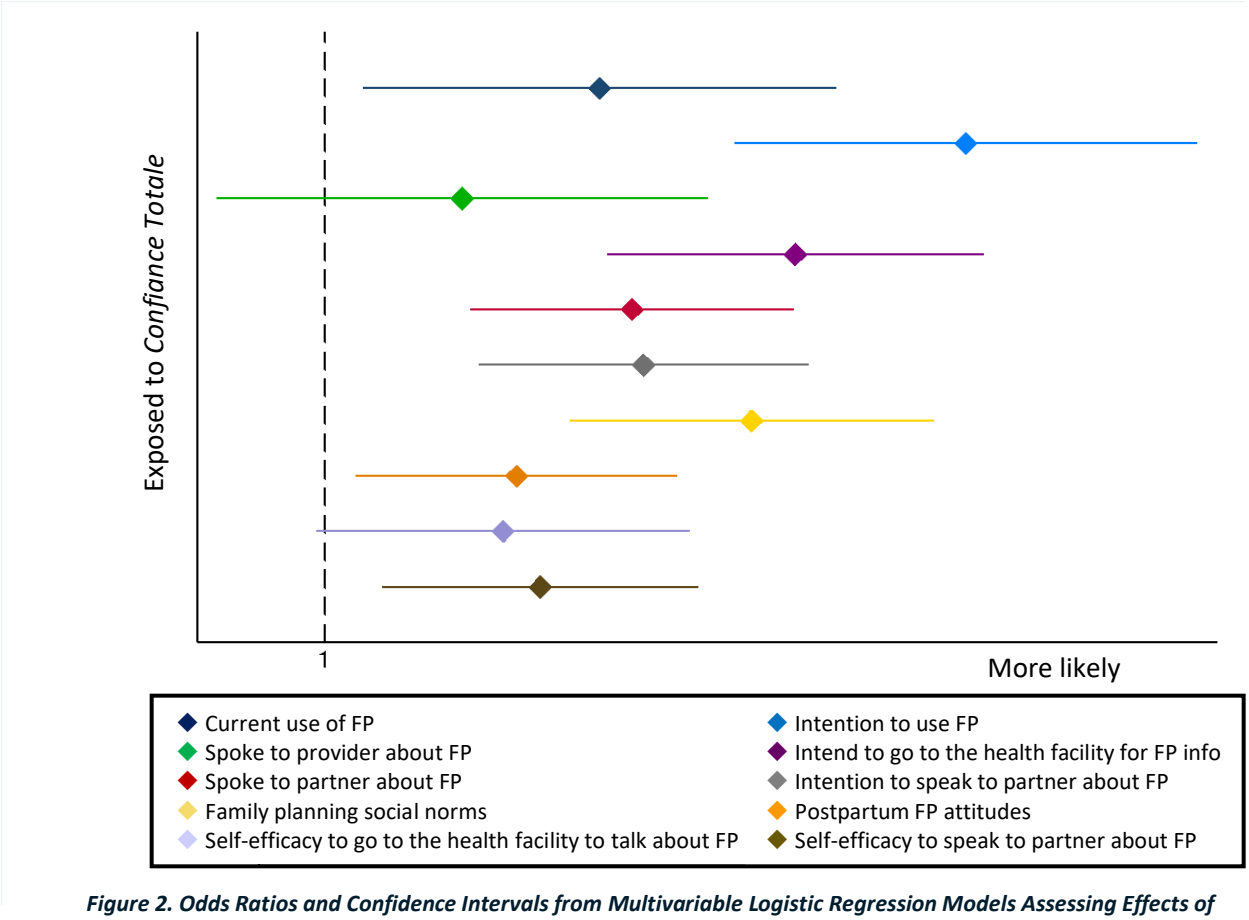

Figure 2. Odds Ratios and Confidence Intervals from Multivariable Logistic Regression Models Assessing Effects of Campaign Exposure.

any statistically significant associations. **Figure 2** presents the odds ratios and the confidence intervals for the binary outcomes of interest in the combined models.

In these combined models (**Tables 4** and **5**), men reported higher odds of reporting current FP use (OR = 2.89, $p < 0.001$), intention to use FP (OR = 3.12, $p < 0.001$), FP communication in the last month (OR = 2.06, $p < 0.001$), supportive FP attitudes ($B = 0.68$, $p < 0.001$), FP knowledge ($B = 0.62$, $p < 0.001$), intention to talk to partner about FP (OR = 3.74, $p < 0.001$), self-efficacy to talk about FP at the health facility (OR = 1.40, $p = 0.005$), self-efficacy to talk to partner about FP (OR = 1.84, $p < 0.001$), and reproductive autonomy (B = 1.26, $p < 0.001$) compared to women. Men reported lower odds of supportive postpartum FP attitudes (OR = 0.61, $p < 0.001$) compared to women. There was not a statistically significant difference between men and women in the odds of speaking to a health care provider in the last month, the intention to go to a health facility for FP information and/or services, and supportive FP-related norms.

Sex Stratified Regression Models

In the sex-stratified models (**Table 6** in the Appendix), WABA found slightly different patterns for men and for women. Associations between exposure to *Confiance Totale* and current FP use were not

statistically significant in either sub-sample, which was perhaps attributable to sample size. Intention to use FP, intention to go to a health facility to access information about FP, intention to talk to one's partner about FP, FP related social norms, FP knowledge, and reproductive autonomy positively associated with exposure to *Confiance Totale* for men and women when assessed separately.

Having spoken to a health care provider in the last month only significantly associated with exposure among women but not among men. The team also only found a significant association regarding communication with one's partner in the last month among women (OR = 1.65, $p = 0.001$); the same for FP attitudes (B among women = 0.56, $p = 0.004$) and postpartum FP attitudes (OR = 1.57, $p = 0.003$).

While self-efficacy to talk to one's partner about FP was associated with exposure to the campaign in the combined model (OR = 1.30, $p = 0.008$), in the sex stratified models, this relationship was only significant among the males (OR = 1.64, $p < 0.001$).

Consistent with the combined model, self-efficacy to talk about FP at the health facility was not associated with exposure to the campaign among either sub-sample. **Table 7** in the Appendix provides a visual summary of the relationships between exposure and outcomes of interest for the combined and stratified adjusted models.

Conclusions

The results of this study provide important insights into the FP use context in Togo, and the potential role of radio campaigns like *Confiance Totale* in its importance to men and women during the COVID-19 pandemic. In the combined regression models, exposure to the campaign was associated with all of the outcomes of interest except for (1) having spoken with a provider about FP in the last month and (2) self-efficacy to go to the health facility for FP information and services. Compared to women, men had higher odds of several key outcomes of interest including current FP use and intention to use FP, and intermediary indicators such as FP communication in the last month, supportive FP attitudes, FP knowledge, intention to talk to partner about FP, self-efficacy to talk about FP at the health, self-efficacy to talk to partner about FP, and reproductive autonomy. The only domain where men had lower scores compared to women was for postpartum FP attitudes.

In sex-stratified models, campaign exposure was significantly and positively associated with intention to use FP, intention to go to a health facility for FP information, intention to talk to one's partner about FP, FP related social norms, FP knowledge, and reproductive autonomy. However, in contrast to the combined model, campaign exposure was not associated with current FP among either men or women in the sex-stratified models. Similarly, self-efficacy to talk about FP at the health facility was not associated with exposure to the campaign (in the combined or stratified models).

While the combined models showed that men had higher couple FP communication scores and FP attitudes overall, these factors were only associated with campaign exposure in the women-only models. In addition, women had significant relationships between exposure and outcomes for

postpartum FP attitudes and for speaking to a health care provider in the past month. Among men only, campaign exposure was associated with self-efficacy to talk about FP with their partner.

Discussion

Results in Context

Generally, the results of this study demonstrate the successes of the *Confiance Totale* campaign in reaching the community, and in the associations between exposure to this campaign and important FP-related outcomes of interest. In the mobile phone survey-based evaluation in Côte d'Ivoire, fewer than 20% of respondents reported that they had seen or heard the campaign.[13] The lower rate in the Côte d'Ivoire study may be attributable to a concurrent presidential election, a more crowded media environment, and/or the lack of a prompted measure of exposure in the exposure survey. In addition, while the Togo study assessed recognition by using a measure or prompted exposure, the evaluation in Côte d'Ivoire used an unprompted measure and thus assessed recall.[14] In this study in Togo, by contrast, these results demonstrated a 45% recognition of, or exposure to, the campaign. While WABA did not design this study to assess a causal relationship between exposure to a campaign and behaviors, this level of exposure falls short of the 61% that Naugle and colleagues reported as most likely to be associated with behaviors such as immunization of antenatal care during most recent pregnancy, mosquito net use, and modern contraceptive use.[15] In a randomized controlled trial (RCT) evaluating a different mass radio campaign in Burkina Faso, the authors report achieving 82% self-reported exposure among women in the intervention group.[16]

Multiple reasons may explain why exposure to the PSAs was not as high as the desired levels in Togo. For example, a gap of about four months occurred between the end of airing the spots and the survey. Thus, respondent recall may have diminished due to this lag in time. Additionally, because the airing of the *Confiance Totale* PSAs occurred during the COVID-19 pandemic, competing messages may possibly have aired around COVID-19 prevention, testing, and vaccination that were more salient for the participants. In addition, the choice of radio stations, radio listening habits, any power outages which limited people's radio listening, and other COVID-19-related or socio-cultural events during the same period might have affected radio listenership.

Associations with Outcomes

Despite the moderate level of exposure achieved by the campaign, *Confiance Totale* exposure was associated with a number of ideational factors proximate to FP behaviors. In the combined multivariable regression models, those who reported campaign exposure had increased odds of many ideational factors compared to people who were not exposed to the campaign, including:

- Intention to use FP.
- Intention to go to a health facility.

- Communication about FP.
- Intention to talk to partner about FP.
- FP-related perceived social norms.
- Postpartum FP attitudes.
- Self-efficacy to talk to one's partner about FP.

In these combined, controlled models, those who were exposed had higher scores on FP attitudes and social norms, higher levels of knowledge related to FP, and higher levels of reproductive autonomy. In the combined multiple logistic regression model, those who were exposed to the campaign had higher odds of currently using FP as well. These results are generally consistent with the Côte d'Ivoire *Confiance Totale* evaluation, which found that exposure to the campaign was associated with belief in the safety of FP methods (men and women), spousal communication about FP (women only), high self-efficacy to communicate with one's partner about FP (women only), intention to communicate with one's partner about FP (women only), intention to go to a health facility to seek FP information (men and women), communication about FP with a health provider in the past month (men and women), and current use of FP (men and women).[13]

Taken together with results from the DMI RCT in Burkina Faso assessing the impact of mass media communication using a Saturation+ approach, these results demonstrate the promise of high intensity and high frequency approaches to SBC.[16] In addition, other studies have demonstrated the cost-effectiveness of high-intensity mass media communication and the potential for economies of scale.[9,17] Thus, the results of this work contribute to the growing body of evidence that suggests that mass media communication remains a cost-effective strategy for SBC and can contribute to reductions in disability-adjusted life years at a reasonable cost.

Gender Analysis

This study also provided valuable insights into gender dynamics and how exposure to the campaign may affect men and women differently. Generally, the results demonstrate that the men sampled have higher scores on most metrics of FP including FP use. Whether this reflects men's true experience, a desirability bias, or lack of male awareness of their female partner's contraceptive behaviors remains uncertain, however. In a recent study in Togo, men reported being supportive of FP use, particularly due to socio-economic concerns.[1] These authors referenced ongoing initiatives in Togo to increase the participation of men in reproductive decisions, including the use of male motivators (positive deviant model), social marketing, and mHealth interventions, among others.[1] These programs may have been effective in affecting men's attitudes and behaviors surrounding FP or at least their awareness of socially desirable responses. Additionally, even in dyadic couples' studies, researchers have long noted the discordance between reports of contraceptive outcomes including use and communication between husbands and wives.[18–20] Men and women may have poor communication regarding FP use, and that could cause them to misinterpret the current use status.

Beyond contraceptive use, men reported higher scores on many constructs related to FP. They had higher self-efficacy, knowledge, communication with their partner, and reproductive autonomy than women in the sample. These differences could arise due to their relatively higher position in society and their decision-making power. In the article by Koffi and colleagues, for example, most men reported that women do not have the right to make FP-related decisions on their own and that this would be grounds for divorce.[1]

Several outcomes were positively associated with exposure to *Confiance Totale* among women, but not men. Women who had been exposed to the campaign had higher odds of speaking to a health care provider in the last month, higher odds of communicating with their partner in the past month, and displayed more accepting FP attitudes generally and postpartum FP attitudes in particular. The relationship between exposure and these outcomes were not significant among men. The effects of the campaign across multiple domains among women only was consistent with the evaluation of the same program in Côte d'Ivoire.[13] Taken together, this may suggest that FP messages generally or the *Confiance Totale* PSAs specifically resonated better with women than with men.

Limitations

This study has several important limitations to consider. First, the data collection period occurred during Ramadan, a period during which consideration and conversation about sex may be considered inappropriate. Perhaps due to this, WABA received a greater than expected number of refusals to participate in the study. Among those approached and eligible for an interview, the response rate was 87.3%. Of the 319 refusals to participate, 34.4% (n = 110) reported that they did not want to discuss FP specifically. This may have resulted in a bias in the sample. A gap occurred between the end of the spots airing (December 2021) and the data collection period (April 2022), which may have reduced respondent recall of the campaign. In addition, the evaluation design utilized a single cross-sectional design which does not allow for understanding of temporality nor considerations of causality and therefore the results cannot claim causal attribution. Rather, respondents who used FP or had more supportive attitudes might be more likely to remember the campaign messages. Furthermore, while the study was adequately powered to detect differences among the entire sample, the sample sizes for the sex specific regression models may have been inadequate to detect the effect of exposure among men and among women. Therefore, caution must be used in interpreting a null result. In addition, the measures of exposure did not capture which of the *Confiance Totale* PSAs each respondent heard nor the frequency with which each PSA was heard. This information would have been challenging to collect due to recall bias but would have been helpful in understanding the most and least effective spots and their relationships with outcomes of interest. In addition, while the study team, in measuring prompted exposure, asked respondents about the *Confiance Totale* campaign, the respondents could have recalled other concurrent FP spots aired in the same period that were part of different campaigns—though the project is not aware of any. Finally, the sample included in this study differed from the general population of Togo in notable ways. The current FP rate, the outcome for the study, was higher in this sample (61.6%) than it is for women in Togo generally (24.1%.[6] This could be related to the urban nature

of the sample or the phrasing of the question, which asked: "Do you or your partner currently do something or use a method to delay or avoid a pregnancy?" Thus, individuals may have reported non-modern methods of pregnancy prevention, thereby increasing the reported "contraceptive prevalence rate." Or, among other factors, perhaps individuals already supportive of FP use were more likely to agree to participate in the survey compared to those who were not supportive of FP. As such, this study includes important limitations in terms of external validity.

Program and Research Implications

Research Implications

This evaluation contributes meaningfully to the body of evidence around radio mass media and FP-related ideational and behavioral outcomes. Future work should explore the differential effects among men and women and understand specific messages that resonate with each group. In addition, the use of advanced statistical methods (path analysis or structural equation modeling) could provide insight into how exposure to the campaign affected behaviors. In addition, the promising results of this study demonstrate the value of building program evaluation designs into overall implementation budgets and timelines. Future work should replicate such designs or build in more robust longitudinal designs, which can result in an even stronger level of inference. This will allow for ongoing generation of evidence on the most effective approaches for SBC interventions.

Program Implications

The results of this program evaluation demonstrate effectiveness of mass media communication using a Saturation+ dissemination approach. These results demonstrate that the frequent *Confiance Totale* broadcasts resulted in relatively high levels of reported campaign exposure, and that exposure was associated with nearly all FP-related outcomes of interest. Interestingly, the effects of the campaign appeared to be more pronounced among women, who typically had lower overall scores on the outcomes of interest. This result provides evidence for additional programming to increase women's reproductive autonomy and continuing to work with men to support women's reproductive decisions and joint FP decision making. Given men's often-reported concerns about FP side effects, which the *Confiance Totale* campaign did not address outright, engaging men on the manageability of FP method secondary effects might also be an interesting programmatic tack to take on via mass media and other SBC campaigns to further speak to men.

Seven of the nine PSAs included references to the COVID-19 pandemic and behaviors to prevent COVID-19 infection, such as mask wearing, getting several months' worth of FP methods, and calling hotlines or FP providers when clients had questions or concerns rather than coming into the health centers. Making the links between the prevention of COVID-19 and unplanned pregnancies was not evaluated but may have been a welcome complement to the FP messages. The PSAs were also developed with a positive, uplifting tone about actions that could be taken to prevent COVID-19 and an unplanned pregnancy,

rather than exacerbate the community-level anxiety already present in a situation where there was some degree of unknowns and fear.

Further, the results of this evaluation suggest that mass media campaigns can be an effective way to reach individuals about FP within the context of disruptive or emergency contexts, such as those created by the COVID-19 pandemic.

Program Effectiveness

Studies have demonstrated the cost-effectiveness of high-intensity mass media communication and the potential for economies of scale.[9,17] This study did not examine cost effectiveness. However, the fact that the same, pre-recorded PSAs could be broadcast and re-broadcast without additional production costs and achieve intended results contributes to the growing body of evidence that suggests mass media communication can be a cost-effective SBC strategy and can contribute to reductions in disability-adjusted life years.

The results of this campaign also underline the value of strengthening FP ideation during the COVID-19 pandemic. For both men and women, the PSAs were effective in increasing the intention to use FP and the intention to go to a health facility, which was a primary concern during the pandemic. The campaign increased communication about FP, intention to talk to one's partner about FP, self-efficacy to talk to one's partner about FP, and perceived approval for FP in the community. As the Breakthrough RESEARCH SBC Business Case clarifies, FP approval and couple communication are two important intermediate/proximate variables to FP use.[9] The *Confiance Totale* campaign was successful in shoring up the associated behaviors linked to FP use during the COVID-19 pandemic.

After the Saturation+ campaigns, these same radio spots again broadcast in Togo in selected areas to promote *Confiance Totale*-branded FP service delivery sites. The radio spots broadcast in conjunction with other *Confiance Totale*-branded radio programs and the distribution of branded banners, posters, stickers, and leaflets. The project also conducted service site "walk-throughs" as well, which included provider recognition and appreciation activities. The continued radio broadcasts of these same PSAs suggest they are a cost-effective element of a multi-channel campaign to accomplish key FP program goals, such as achieving informed, voluntary FP use, even during the disruptive time of the COVID-19 pandemic.

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Appendix: Tables

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
Campaign Exposure				
Exposure to *Confiance Totale*	**Binary**	**Yes (1)** **No (0)**	**Have you ever heard radio messages with this sound and the name *Confiance Totale*?**	**Those who reported, "I don't know" or refused to respond were dropped (n = 33).**
Outcomes of Interest				
FP use	**Binary**	**Yes (1)** **No (0)**	**Do you or your partner currently do something or use a method to delay or avoid a pregnancy?**	**Those who responded, "I don't know," "I don't have a sexual partner," or refused to respond were dropped (n = 79)**
Intention to use FP	**Binary**	**Yes (1)** **No (0)**	**Do you have the intention, you or your partner, to use FP to space or limit pregnancies during the next six months?**	**Those who reported, "I don't know" or refused to respond were dropped (n = 141)**
Intention to visit a health facility	**Binary**	**Yes (1)** **No (0)**	**Do you have the intention to go to a health facility to obtain information about FP during the next six months?**	**Those who reported, "I don't know" or refused to respond were dropped (n = 107)**
Spoke with partner about FP in the last month	**Binary**	**Yes (1)** **No (0)**	**During the previous month, have you spoken about FP with your primary partner?**	**Those who reported, "I don't know" or refused to respond were dropped (n = 13)**
Intention to speak with partner about FP in the next month	**Binary**	**Yes (1)** **No (0)**	**During the next month, do you have the intention to speak about FP with your primary partner?**	**Those who responded, "I don't know," "I don't have a sexual partner," or refused to respond**
	Continuous	**0 to 16**	**Continuous scale resulting from adding the following items:**	**n = 9 missing values**

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
FP related attitudes; Cronbach's alpha = 0.78	Ordinal	Strongly agree (4) Agree (3) Don't know (2) Disagree (1) Strongly disagree (0)	To what extent do you agree or disagree with the following statement: "It is important to use FP methods to space or limit pregnancies?"	n = 9 missing values
	Ordinal	Strongly agree (4) Agree (3) Don't know (2) Disagree (1) Strongly disagree (0)	To what extent do you agree or disagree with the following statement: "In general, FP methods to delay or limit pregnancy are SAFE to use?"	n = 9 missing values
	Ordinal	Strongly agree (4) Agree (3) Don't know (2) Disagree (1) Strongly disagree (0)	To what extent do you agree or disagree with the following statement: "In general, FP methods to delay or limit pregnancy are EFFECTIVE?"	n = 9 missing values
	Ordinal	Strongly agree (4) Agree (3) Don't know (2) Disagree (1) Strongly disagree (0)	To what extent do you agree or disagree with the following statement: "Health care providers in your area provide trustworthy FP services?"	n = 9 missing values
FP related social norms; Cronbach's alpha = 0.82	**Binary**	**Agreed with all items (1)** **Agreed with 0, 1, or 2 items (0)**	**Binary measure comparing those who agree with all items to those who agree with 0, 1, or 2 items**	**n = 259 missing**
	Binary	Yes (1) No (0)	In general, do you think that the couples in your community talk to each other about FP?	n = 201 missing who said don't know or refused to respond

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
	Binary	Yes (1) No (0)	In general, do you think that the couples in your community use FP to space or limit births?	n = 152 missing who responded don't know or refused to respond
	Binary	Yes (1) No (0)	In general, would people in your community approve or disapprove of a married couple using FP to space or limit pregnancies?	n = 93 missing who responded don't know or refused to respond
Postpartum FP norms; Cronbach's alpha = 0.90	**Binary**	**Agreed with all items (1)** **Agreed with 0, 1, or 2 items (0)**	**Binary measure comparing those who agree with all items to those who agree with 0, 1, or 2 items**	**n = 211 missing**
	Binary	Yes (1) No (0)	Do you think that women should start using a FP method within the first six weeks after giving birth?	n = 147 missing who said don't know or refused to respond
	Binary	Yes (1) No (0)	Do you think that women should start using a FP method within the first six weeks after giving birth, even if they are breastfeeding their baby?	n = 134 missing who said don't know or refused to respond
	Binary	Yes (1) No (0)	Do you think that you should discuss using a FP method within 6 weeks of giving birth with your spouse or partner before the baby is born?	n = 125 missing who said don't know or refused to respond
FP-related knowledge	**Continuous summative index**	**0 to 6**	**Please tell me if you agree or disagree with the following statements:**	**n = 5 missing**
	Binary	Yes or don't know (0) No (1)	It is possible to use the same condom more than one time (false).	N = 5 missing
	Binary	Yes (1) No or don't know (0)	Condoms have an expiration date (true).	N = 5 missing

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
	Binary	Yes or don't know (0) No (1)	Women should take a break from taking the pill every two years (false).	N = 5 missing
	Binary	Yes or don't know (0) No (1)	When a woman stops taking the birth control pill, she cannot get pregnant for at least two months. (false).	N = 5 missing
	Binary	Yes or don't know (0) No (1)	IUDs can move inside a woman's body. (false)	n = 5 missing
	Binary	Yes (1) No or don't know (0)	Women who use Depo need to receive an injection every three months. (true)	n = 5 missing
Self-efficacy to talk about FP at the health facility	**Binary**	**Strongly agree (1)** **Agree, disagree, strongly disagree (0)**	**I am at ease and I have confidence in my capacity to talk about FP with a provider and ask questions in a health center.**	**Omitted 66 individuals who responded don't know or refused to respond**
Self-efficacy to talk to partner about FP	**Binary**	**Very confident (1)** **Moderately confident, slightly confident, not confident (0)**	**How confident are you that you can talk about FP with your primary partner?**	**Omitted 106 individuals who responded don't know or refused to respond**
Reproductive autonomy communication sub-scale; Cronbach's alpha = 0.85	**Continuous**	**0 to 20**	**Continuous scale resulting from adding the following items:**	**n = 222 missing**
	Ordinal	Strongly disagree (0) Disagree (1) Don't know (2) Agree (3) Strongly agree (4)	My partner would support me if I wanted us to use a method to avoid pregnancy	n = 13 missing who refused to respond
	Ordinal	Strongly disagree (0) Disagree (1) Don't know (2) Agree (3) Strongly agree (4)	It is easy to talk about sex with my partner	n = 221 missing who refused to respond

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
	Ordinal	Strongly disagree (0) Disagree (1) Don't know (2)	If I didn't want to have sex, I could tell my partner	n = 12 missing who refused to respond
	Ordinal	Strongly disagree (0) Disagree (1) Don't know (2) Agree (3) Strongly agree (4)	If I was worried about being or not being pregnant or about my partner being pregnant, I could talk to my partner.	n = 12 missing who refused to respond
	Ordinal	Strongly disagree (0) Disagree (1) Don't know (2) Agree (3) Strongly agree (4)	If I really didn't want to be pregnant or my partner to be pregnant, I could get his or her approval.	n = 12 missing who refused to respond
Socio-demographic characteristics				
Age	**Continuous**	**18 to 49**	**How old is the participant?**	**No missing data**
Respondent sex	**Binary**	**Male (1)** **Female (0)**	**What is the sex of the participant?**	**No missing data**
District	**Binary**	**Agoé Nyivè (1)** **Blitta (0)**	**In which district does the participant live?**	**No missing data**
Marital status	**Categorical**	**Married (0)** **Single (1)** **In a relationship (2)** **Previously married (3)**	**How would you describe your current relationship status?**	**No missing data**

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
Educational attainment	**Categorical**	**No formal schooling (0)** **Some or complete primary (1)** **Some or complete secondary (2)** **Vocational university (3)**	**What is the highest level of education that you have achieved?**	**n = 2 missing data on this variable**
Religion	**Categorical**	**Catholic (0)** **No religion (1)** **Islam (2)** **Traditional religion (3)** **Other Christian (4)** **Evangelical (5)**	**What is your religion?**	**n = 4 missing data on this variable**
Wealth index	**Continuous**	**0 to 6**	**Continuous index from the following items:**	**n = 1 missing data on this variable**
	Binary	Non-metal substance such as tiles or grass (0) Metal sheets (1)	What is the material of the roof of your home or shelter?	No missing data
	Binary	Outside of the house (0) Inside of the house (1)	Do you have water in the house or outside?	n = 1 missing data on this variable
	Binary	Traditional housing (0) Modern housing or apartment (1)	In which type of housing do you live?	n = 1 missing data on this variable
	Binary	No (0) Yes (1)	The household, does it have a television?	n = 1 missing data on this variable
	Binary	No (0) Yes (1)	Do you have electricity in the house?	n = 1 missing data on this variable

TABLE 1: SUMMARY OF MEASURES OF INTEREST INCLUDED IN THE *CONFIANCE TOTALE* EVALUATION ANALYSIS				
MEASURE	**TYPE OF VARIABLE**	**RANGE**	**ITEMS INCLUDED**	**MISSING DATA**
	Binary	No (0) Yes (1)	Is there a health center in close proximity to your home?	n = 1 missing data on this variable

Please note that bolded items are the final variables that were used in the analyses while non-bolded items are the composite measures used to create the final variables.

TABLE 2: DESCRIPTIVE STATISTICS FOR KEY CONTROL VARIABLES OF INTEREST				
	FULL SAMPLE (n = 2,200)		**ANALYTIC SAMPLE (n = 1,610)**	
	n/mean	**%/SD**	**n/mean**	**%/SD**
Age (range: 18 to 49)	30.7	8.04	30.4	8.2
Respondent sex				
Female	1,100	50.0%	783	48.6%
Male	1,100	50.0%	827	51.4%
District				
Blitta	1,099	50.0%	808	50.2%
Agoé Nyivè	1,101	50.0%	802	49.8%
Marital status				
Married	1,473	67.0%	1027	63.8%
Single	215	9.8%	166	10.3%
In a relationship	440	20.0%	378	23.5%
Previously married	72	3.3%	39	2.4%
Education				
No formal schooling	185	8.4%	132	8.2%
Some or complete primary	570	25.9%	391	24.3%
Some or complete secondary	1024	46.5%	782	48.6%
Vocational or university	419	19.0%	303	18.8%
Religion				
Catholic	657	29.9%	494	30.8%
No religion	146	6.6%	96	6.0%
Islam	409	18.6%	281	17.5%
Traditional religion	114	5.2%	78	4.9%
Other Christian	358	16.3%	266	16.6%
Evangelical	512	23.3%	391	24.3%
Wealth index	3.87	1.5	3.89	1.5

TABLE 3: DESCRIPTIVE STATISTICS FOR EXPOSURE VARIABLE AND OUTCOMES OF INTEREST				
	FULL SAMPLE (n = 2,200)		**ANALYTIC SAMPLE (n = 1,610)**	
	n/mean	**%/SD**	**n/mean**	**%/SD**
Exposure to CT				
Have you ever heard radio messages with this sound and the name *Confiance Totale*? (play the jingle for *Confiance Totale* before asking for the participant's response)				
Yes	963	45.4%	696	45.1%
No	1,158	54.6%	847	54.9%
FP Use				
Do you or your partner currently do something or use a method to delay or avoid pregnancy?				
Yes	1,304	61.6%	1,254	79.5%
No	812	38.4%	323	20.5%
Intention to use FP				
Do you have the intention, you or your partner, to use FP to space or limit pregnancies during the next six months?				
Yes	1,306	63.6%	1,146	75.1%
No	746	36.4%	380	24.9%
Intention to visit a health facility				
Do you have the intention to go to a health facility to obtain information about FP during the next six months?				
Yes	1,308	62.6%	642	42.3%
No	780	37.4%	877	57.7%
Spoke with partner about FP in the last month				
During the previous month, have you spoken about FP with your primary partner?				
Yes	758	34.7%	667	41.8%
No	1,424	65.3%	928	58.2%
Intention to speak with partner about FP				
During the next month, do you have the intention to speak about FP with your primary partner?				
Yes	1,091	53.4%	940	62.0%

TABLE 3: DESCRIPTIVE STATISTICS FOR EXPOSURE VARIABLE AND OUTCOMES OF INTEREST				
	FULL SAMPLE (n = 2,200)		**ANALYTIC SAMPLE (n = 1,610)**	
	n/mean	**%/SD**	**n/mean**	**%/SD**
No	953	46.6%	575	38.0%
FP attitudes				
FP attitudes: range: 0 to 16; n = 2191	11.5	2.9	11.7	2.8
FP-related social norms				
Supportive FP norms	1,399	72.1%	1,018	72.5%
Less supportive FP norms	542	27.9%	386	27.5%
Postpartum FP norms				
Supportive postpartum FP norms	1,139	57.3%	892	61.2%
Less supportive postpartum FP norms	850	42.7%	565	38.8%
FP-related knowledge				
FP-related knowledge: range: 0 to 6; n = 2195	3.40	1.34	3.44	1.31
Self-efficacy to talk about FP at the health facility				
I am at ease, and I have confidence in my capacity to talk about FP with a provider and ask questions in a health center.				
Strongly agree	464	21.8%	339	21.7%
Agree, disagree, strongly disagree	1,668	78.2%	1,225	78.3%
Self-efficacy to talk to partner about FP				
How confident are you that you can talk about FP with your primary partner?				
Very confident	1,109	53.0%	847	55.1%
Moderately confident, slightly confident, nor confident	985	47.0%	691	44.9%
Reproductive autonomy				
Reproductive Autonomy: range: 0 to 20; n=1978	15.03	3.32	15.28	3.15

TABLE 4: MULTI-VARIABLE LOGISTIC REGRESSION MODELS ASSESSING ASSOCIATIONS BETWEEN EXPOSURE TO CT AND OUTCOMES OF INTEREST, CONTROLLING FOR SOCIO-DEMOGRAPHIC CHARACTERISTICS OF INTEREST (AMONG THE ANALYTIC SAMPLE)

	AMONG ANALYTIC SAMPLE							
	Current use of FP		**Intention to use FP**		**Spoke to health care provider in the last month**		**Intention to go to a health facility**	
OUTCOMES	**OR**	**p**	**OR**	**p**	**OR**	**p**	**OR**	**p**
***Confiance Totale* Exposure**								
No (referent)	1.00		1.00		1.00		1.00	
Yes	**1.39**	**0.023**	**2.17**	**< 0.001**	1.18	0.271	**1.77**	**< 0.001**
Sex								
Female (referent)	1.00		1.00		1.00		1.00	
Male	**2.89**	**< 0.001**	**3.12**	**< 0.001**	0.84	0.288	1.25	0.071
Age	**0.98**	**0.030**	**0.95**	**< 0.001**	1.01	0.591	0.99	0.096
District								
Blitta (referent)	1.00		1.00		1.00		1.00	
Agoé Nyivè	1.05	0.743	0.80	0.138	0.74	0.064	**0.55**	**< 0.001**
Marital status								
Married (referent)	1.00		1.00		1.00		1.00	
Single, never married	0.72	0.203	**0.56**	**0.019**	1.13	0.639	1.00	0.982
In a relationship	**2.46**	**< 0.001**	0.75	0.115	**0.63**	**0.035**	**0.46**	**< 0.001**
Previously married	**4.00**	**0.014**	2.30	0.074	**2.27**	**0.031**	1.73	0.135
Educational attainment								
No formal schooling (referent)	1.00		1.00		1.00		1.00	
Some or completed primary	1.43	0.125	1.03	0.910	0.94	0.824	0.78	0.273

TABLE 4: MULTI-VARIABLE LOGISTIC REGRESSION MODELS ASSESSING ASSOCIATIONS BETWEEN EXPOSURE TO CT AND OUTCOMES OF INTEREST, CONTROLLING FOR SOCIO-DEMOGRAPHIC CHARACTERISTICS OF INTEREST (AMONG THE ANALYTIC SAMPLE)								
	AMONG ANALYTIC SAMPLE							
	Current use of FP		**Intention to use FP**		**Spoke to health care provider in the last month**		**Intention to go to a health facility**	
OUTCOMES	**OR**	**p**	**OR**	**p**	**OR**	**p**	**OR**	**p**
Some or completed secondary	**1.91**	**0.005**	1.16	0.539	0.71	0.184	0.98	0.912
Vocational training or university	1.26	0.381	0.91	0.713	0.68	0.206	1.21	0.440
Religion								
Catholic (referent)	1.00		1.00		1.00		1.00	
No religion	0.57	0.054	0.71	0.234	1.31	0.364	1.03	0.897
Islam	0.73	0.123	**0.48**	**< 0.001**	**1.60**	**0.024**	0.86	0.389
Traditional religion	**0.48**	**0.016**	0.70	0.256	0.70	0.339	1.11	0.708
Other Christian	0.89	0.594	0.74	0.141	0.91	0.684	0.96	0.801
Evangelical	0.81	0.280	0.81	0.248	0.86	0.455	0.82	0.201
Economic status score	1.01	0.815	1.02	0.685	0.98	0.711	**1.22**	**< 0.001**

TABLE 5: MULTI-VARIABLE LOGISTIC AND LINEAR (SHADED) REGRESSION MODELS ASSESSING ASSOCIATIONS BETWEEN EXPOSURE TO *CONFIANCE TOTALE* AND OUTCOMES OF INTEREST, CONTROLLING FOR SOCIO-DEMOGRAPHIC CHARACTERISTICS OF INTEREST (AMONG THE FULL SAMPLE)

	AMONG THE FULL SAMPLE																	
OUTCOMES	**FP communication in the last month**		**Intention to talk to partner about FP**		**FP attitude score**		**FP-related norms**		**Postpartum FP attitudes**		**FP knowledge**		**Self-efficacy to talk about FP at health facility**		**Self-efficacy to talk to partner about FP**		**Reproductive autonomy**	
	OR	***p***	**OR**	***p***	***B***	***p***	**OR**	***p***	**OR**	***p***	***B***	***p***	**OR**	***p***	**OR**	***p***	***B***	***p***
***Confiance Totale* Exposure**																		
No (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
Yes	**1.45**	**< 0.001**	**1.47**	**< 0.001**	**0.45**	**< 0.001**	**1.68**	**< 0.001**	**1.26**	**0.020**	**0.42**	**< 0.001**	1.24	0.061	**1.30**	**0.008**	**0.73**	**< 0.001**
Sex																		
Female (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
Male	**2.06**	**< 0.001**	**3.74**	**< 0.001**	**0.68**	**< 0.001**	1.14	0.274	**0.61**	**< 0.001**	**0.62**	**< 0.001**	**1.40**	**0.005**	**1.84**	**< 0.001**	**1.26**	**< 0.001**
Age	0.99	0.262	**0.98**	**0.001**	−0.01	0.450	1.00	0.864	1.00	0.870	0.01	0.059	1.01	0.440	1.01	0.423	0.01	0.298
District																		
Blitta (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
Agoé Nyivè	1.18	0.130	0.87	0.196	**−0.54**	**< 0.001**	1.15	0.242	0.94	0.536	**−0.43**	**< 0.001**	**1.53**	**0.001**	0.88	0.218	0.00	0.999
Marital status																		
Married (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
Single, never married	1.05	0.775	1.39	1.000	0.16	0.503	0.90	0.594	1.37	0.080	−0.09	0.373	1.08	0.704	**0.43**	**< 0.001**	−0.38	0.786
In a relationship	0.81	0.133	0.79	0.081	−0.21	0.231	**0.72**	**0.025**	0.95	0.692	−0.04	0.573	**0.65**	**0.009**	0.91	0.473	**0.39**	**0.046**
Previously married	0.60	0.098	1.02	0.956	0.32	0.380	1.62	0.170	1.22	0.492	−0.13	0.404	0.68	0.276	0.78	0.404	0.78	0.057

TABLE 5: MULTI-VARIABLE LOGISTIC AND LINEAR (SHADED) REGRESSION MODELS ASSESSING ASSOCIATIONS BETWEEN EXPOSURE TO *CONFIANCE TOTALE* AND OUTCOMES OF INTEREST, CONTROLLING FOR SOCIO-DEMOGRAPHIC CHARACTERISTICS OF INTEREST (AMONG THE FULL SAMPLE)

	AMONG THE FULL SAMPLE																	
OUTCOMES	**FP communication in the last month**		**Intention to talk to partner about FP**		**FP attitude score**		**FP-related norms**		**Postpartum FP attitudes**		**FP knowledge**		**Self-efficacy to talk about FP at health facility**		**Self-efficacy to talk to partner about FP**		**Reproductive autonomy**	
	OR	***p***	**OR**	***p***	***B***	***p***	**OR**	***p***	**OR**	***p***	***B***	***p***	**OR**	***p***	**OR**	***p***	***B***	***p***
Educational attainment																		
No formal schooling (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
Some or completed primary	**0.64**	**0.018**	0.76	0.154	0.22	0.376	0.79	0.277	0.87	0.459	**0.25**	**0.023**	0.92	0.726	1.39	0.088	**0.59**	**0.035**
Some or completed secondary	0.80	0.221	0.97	0.863	0.43	0.075	0.87	0.512	1.13	0.536	**0.39**	**< 0.001**	1.05	0.821	**1.85**	**0.001**	**1.08**	**< 0.001**
Vocational training or university	0.71	0.104	0.91	0.670	0.34	0.214	**0.55**	**0.012**	0.85	0.452	**0.60**	**< 0.001**	1.55	0.074	**2.25**	**< 0.001**	**1.72**	**< 0.001**
Religion																		
Catholic (referent)	1.00		1.00		0.00		1.00		1.00		0.00		1.00		1.00		0.00	
No religion	0.78	0.230	0.72	0.123	**−0.59**	**0.027**	0.67	0.068	0.74	0.132	−0.20	0.083	1.19	0.453	0.79	0.234	−0.44	0.146
Islam	1.08	0.571	0.86	0.303	**−0.39**	**0.033**	**0.56**	**<0.001**	**0.72**	**0.020**	−0.09	0.281	1.13	0.460	0.86	0.292	0.03	0.907
Traditional religion	0.89	0.614	0.78	0.296	**−1.17**	**<0.001**	**0.43**	**<0.001**	**0.57**	**0.014**	−0.10	0.468	1.16	0.585	0.90	0.652	−0.27	0.422
Other Christian	1.07	0.650	0.97	0.829	−0.23	0.235	0.11	0.651	0.75	0.057	−0.03	0.721	1.08	0.637	1.08	0.611	−0.01	0.966
Evangelical	1.14	0.327	0.85	0.222	−0.15	0.370	**0.74**	**0.045**	**0.76**	**0.036**	0.05	0.532	0.91	0.554	1.02	0.881	−0.05	0.811
Economic status score	**0.85**	**<0.001**	1.04	0.279	0.03	0.600	0.96	0.376	0.94	0.097	**0.06**	**0.006**	0.98	0.632	**1.12**	**0.001**	**0.14**	**0.016**

Please note that bolded OR's and p values designate significant associations

TABLE 6: COEFFICIENTS FOR DEPENDENT VARIABLES OF INTEREST FROM OVERALL AND STRATIFIED LOGISTIC AND LINEAR REGRESSION MODELS- INDEPENDENT VARIABLE OF INTEREST IS PROMPTED EXPOSURE TO THE *CONFIANCE TOTALE* CAMPAIGN

	Overall				Females				Males			
Logistic Regression models	**OR**	***p***	**LB**	**UB**	**OR**	***p***	**LB**	**UB**	**OR**	***p***	**LB**	**UB**
Currently using FP	1.39	0.023	1.05	1.86	1.34	0.121	0.93	1.94	1.29	0.291	0.80	2.09
Intention to use FP	2.17	< 0.001	1.64	2.87	2.22	< 0.001	1.52	3.23	2.04	0.002	1.31	3.16
Spoke to health care provider in the last month	1.18	0.271	0.88	1.59	1.86	0.004	1.22	2.84	0.77	0.222	0.50	1.17
Intention to go to a health facility to access information about FP	1.77	< 0.001	1.41	2.22	1.99	< 0.001	1.41	2.82	1.63	0.002	1.19	2.24
Communicated with partner about FP in the last month	1.45	< 0.001	1.19	1.76	1.65	0.001	1.23	2.22	1.27	0.074	0.98	1.65
Intention to talk to partner about FP	1.47	< 0.001	1.20	1.79	1.44	0.036	1.02	2.03	1.44	0.022	1.05	1.98
FP social norms	1.68	< 0.001	1.34	2.09	2.10	< 0.001	1.50	2.94	1.37	0.041	1.01	1.86
Postpartum FP attitudes	1.26	0.020	1.04	1.53	1.57	0.003	1.17	2.12	1.08	0.569	0.83	1.41
Self-efficacy to talk about FP at the health facility	1.24	0.061	0.99	1.55	1.23	0.253	0.86	1.76	1.22	0.196	0.90	1.65
Self-efficacy to talk about FP with partner	1.30	0.008	1.07	1.57	1.03	0.808	0.79	1.36	1.64	< 0.001	1.25	2.15
	Overall				**Females**				**Males**			
Linear Regression models	***B***	***p***	**LB**	**UB**	***B***	***p***	**LB**	**UB**	***B***	***p***	**LB**	**UB**
FP attitudes scale	0.45	< 0.001	0.20	0.71	0.56	0.004	0.18	0.94	0.33	0.057	-0.01	0.67
FP knowledge	0.42	< 0.001	0.31	0.53	0.61	< 0.001	0.43	0.79	0.20	0.004	0.06	0.34
Reproductive autonomy	0.73	< 0.001	0.43	1.02	0.66	0.005	0.20	1.13	0.76	< 0.001	0.40	1.12

Note that all models control for age, sex, district, marital status, educational attainment, religion, and wealth index.
LB = Lower bound; UB = Upper bound

TABLE 7: SUMMARY OF ASSOCIATIONS IDENTIFIED IN COMBINED AND STRATIFIED ADJUSTED MODELS			
OUTCOME	**OVERALL**	**FEMALES**	**MALES**
Currently using FP	*		
Intention to use FP	***	***	**
Spoke to health care provider in the last month		**	
Intention to go to a health facility to access information about FP	***	***	**
Communicated with partner about FP in the last month	***	***	
Intention to talk to partner about FP	***	*	**
FP related social norms	***	***	*
Postpartum FP attitudes	*	**	
Self-efficacy to talk about FP at the health facility			
Self-efficacy to talk about FP with partner	**		***
FP attitudes scale	***	**	
FP knowledge	***	***	**
Reproductive autonomy	***	**	***
$*p < 0.05$; $**p < 0.01$, $***p < 0.001$			