

Appendix to the pre-analysis plan

The following differences between the pre-registered analysis plan and the final study/manuscript exist.

Table 1: Differences between final manuscript and pre-registered analysis plan

Pre-registered analysis plan	Final manuscript	Reason and explanations
Design: “We will randomize different groups of ads, with each group representing one of the channels outlined above. Each ad group consists of 2-3 different ads.” (Six ad groups were presented).	We randomized five different ad groups with one ad per group.	The restriction to five groups was required, since this is the maximum number of ad groups that can be randomized with Facebook’s A/B split function. Further, we limited the groups to one ad each, since otherwise we would have had variation within a treatment arm. We decided to keep only the variation between treatment arms to keep the design as clean as possible.
Targeting: “The target group of the study includes all Indonesian male and female Facebook users above the age of 21, which live in either Jakarta or Yogyakarta”	“Our diabetes campaign targeted all Indonesian male and female Facebook users above the age of 35 who live either in the city of Jakarta or in the Special Region of Yogyakarta”	We adjusted the age categories such that we would have a 10-year age range for all four age categories requested in the FINDRISC test. This allowed us to compare statistics per age group with the data from the Indonesian RISKESDAS and BPS data, which are available per 10-year age cohort.
Budget: “Each ad group receives a budget of €10 per day, summing to a total budget of €60 per day for a total of 6 different ad groups.”	“Each ad received an equal budget of US\$5 per day, summing to a total daily budget of US\$50 for both cities.”	Due to geographical targeting, we split the budget equally between the two locations. Due to Facebook’s restriction of randomizing a maximum of 5 ads, the number of groups was set to 5.
Hypothesis: “Randomizing these different ads allows to identify the most effective channel, i.e. to test which kind of approach would be well suited in the context of Indonesia to raise awareness about a health concern and which approach can effectively encourage individuals to seek for more information.”	Instead of testing all different ads against each other, we narrowed the hypothesis down to “we hypothesize that a diabetes awareness campaign that encourages diabetes screening might be most effective if a shocking or loss-framed perspective is taken [in the ads]”.	This exploratory hypothesis was added/re-adjusted after the pilot study.

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Table 1 - continued

Pre-registered analysis plan	Final manuscript	Reason and explanations
Analysis: We pre-specified the following analyses: 1) Webpage visit as a function of ads, 2) FINDRISC test participation as a function of different ads, 3) Follow-up survey participation as a function of different ads, 4) Follow-up survey participation as a function of FINDRISC score, 5) FINDRISC score as a function of ads, 6) FINDRISC score as a function of characteristics observed in follow-up survey.	Analyses 1) and 2) are presented in the manuscript as outlined in the PAP, analyses 3) and 4) are presented in Table D2 in Appendix D to confirm that participants from all treatment arms are equally likely to participate in the follow-up survey, analysis 5) is discussed in Section 5, analysis 6) is not discussed in the manuscript.	Due to time restrictions, we limited the questions in the follow-up survey to the topic of plans for a professional follow-up survey and those questions as outlined in Section 4.2. We did not collect further individual characteristics that would allow for a meaningful analysis as intended for analysis 6).