

ONLINE APPENDIX

Forecasting the Results of Experiments:

Piloting an Elicitation Strategy

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1 Additional Tables

Table A1: Forecasts by Sample and Type

	Mean	SD	SE	n_i	n_f	p
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A: Sample						
Listserv	0.15	(0.16)	(0.01)	39	336	
Twitter	0.19	(0.22)	(0.02)	39	271	0.16
Other	0.15	(0.21)	(0.02)	28	165	0.89
Panel B: Type						
Faculty	0.15	(0.23)	(0.02)	33	193	
PhD student	0.17	(0.17)	(0.01)	40	331	0.48
Researcher	0.17	(0.18)	(0.02)	27	222	0.59
Practitioner	0.13	(0.22)	(0.02)	6	26	0.45

Notes: This table reports summary statistics for forecasts of results from three randomized controlled trials by study sample (Panel A) or self-reported type (Panel B). In Panel A, “Other” includes respondents from the Busara Center for Behavioral Economics, GiveWell, the Global Priorities Institute, IDinsight, and the World Bank. Columns 1, 2, and 3 present the forecast means (raw units are standardized relative to a reference mean), standard deviations, and standard errors clustered at the individual level. n_i (col. 4) and n_f (col. 5) are the number of respondents and forecasts per row. Column 6 presents clustered p values comparing groups within each panel. This analysis was not pre-registered.

Table A2: Forecasts by Experiment and Survey Format

	Reference		Units		Entry		Slider bounds	
	Small	Large	Raw units	Std. dev.	Text	Slider	Small	Large
Panel A: Yang et al.								
HIV testing	0.23 (0.18)	0.22 (0.18)	0.22 (0.13)	0.24 (0.22)	0.25 (0.26)	0.22 (0.13)	0.20 (0.11)	0.23 (0.15)
Panel B: Blimpo et al.								
Dropout (reversed)	-0.01 (0.10)	0.06 (0.15)	0.04 (0.11)	0.00 (0.15)	0.01 (0.07)	0.03 (0.16)	0.01 (0.12)	0.06 (0.18)
Business participation	0.11 (0.11)	0.14 (0.13)	0.13 (0.11)	0.12 (0.13)	0.09 (0.10)	0.14 (0.13)	0.11 (0.10)	0.17 (0.15)
Test scores	0.24 (0.21)	0.34 (0.42)	0.35 (0.43)	0.24 (0.22)	0.38 (0.53)	0.25 (0.2)	0.18 (0.13)	0.32 (0.23)
Panel C: Bouguen et al.								
<i>Food consumption</i>								
T1 (Cash)	0.19 (0.13)	0.19 (0.11)	0.18 (0.10)	0.19 (0.13)	0.19 (0.15)	0.19 (0.10)	0.15 (0.07)	0.22 (0.11)
T2 (T1+Asset)	0.21 (0.2)	0.20 (0.16)	0.16 (0.16)	0.24 (0.18)	0.23 (0.2)	0.19 (0.16)	0.12 (0.12)	0.26 (0.17)
T3 (T2+Nutrition)	0.22 (0.26)	0.20 (0.16)	0.17 (0.14)	0.24 (0.25)	0.21 (0.29)	0.22 (0.16)	0.15 (0.11)	0.28 (0.18)
<i>Health consumption</i>								
T1 (Cash)	0.11 (0.11)	0.10 (0.07)	0.11 (0.13)	0.11 (0.07)	0.09 (0.07)	0.12 (0.10)	0.08 (0.08)	0.15 (0.12)
T2 (T1+Asset)	0.15 (0.14)	0.12 (0.09)	0.11 (0.14)	0.15 (0.10)	0.11 (0.09)	0.15 (0.13)	0.11 (0.10)	0.19 (0.15)
T3 (T2+Nutrition)	0.15 (0.17)	0.14 (0.16)	0.12 (0.19)	0.16 (0.14)	0.10 (0.10)	0.17 (0.19)	0.10 (0.12)	0.23 (0.21)
n_i	50	56	52	54	36	70	33	37
n_f	393	379	332	440	266	506	241	265

Notes: This table reports summary statistics for predictions of results of three randomized controlled trials by randomly assigned elicitation strategy. Predictions are of causal treatment effects standardized relative to a reference mean for raw-unit elicitation. Standard deviations are presented in parentheses. Panel A reports forecasts of the impact of a bundled health and education intervention on self-reported HIV testing. Panel B presents forecasts of the impact of a teacher training intervention on student dropout (reverse coded), self-reports of earning money from a business in the last month (dichotomous), and scores on an entrepreneurship test. Panel C reports forecasts of the impact of cash, cash and asset, and cash, asset, and nutrition transfers on food and health consumption. n_i and n_f are the number of individuals making forecasts and the total forecasts for each column. Columns 1 and 2 present forecasts by whether a small (0.1 SD) or large (0.3 SD) reference was used in an example. Columns 3 and 4 present forecasts made in raw units or standard deviations. Columns 5 and 6 present forecasts made using text or slider responses. Columns 7 and 8 present slider responses from small (0.5 SD) or large (1.0 SD) slider bounds.

2 Survey Instruments

This section contains the entire forecasting survey for one randomization. A direct comparison of the different randomizations (for the HIV testing outcome) can be found at the end of the survey.

The [Journal of Development Economics](#) recently became the first economics journal to review and approve projects for publication before the results are known. These articles are evaluated based on the importance of the research questions and the quality of the research design (such as having sufficient statistical power). Building on this work--which emphasizes open and transparent science--we are collecting predictions of empirical findings from the three Registered Reports that were preliminarily accepted before October 2019 that [publicly posted](#) their proposals and have not yet publicly released results:

- [Direct and Spillover Impacts of a Community-Level HIV/AIDS Program: Evidence from a Randomized Controlled Trial in Mozambique](#)
Authors: Dean Yang, Arlete Mahumane, James Riddell, Hang Yu
- [The Impact of a Multidimensional Program on Nutrition and Poverty in Burkina Faso](#)
Authors: Adrien Bouguen, Andrew Dillon
- [Entrepreneurship Education and Teacher Training in Rwanda](#)
Authors: Todd Pugatch, Moussa Blimpo

We ask you to predict the results of one of these three studies, after which you can either end the survey or provide predictions for the additional projects. Predictions for each project should take approximately 10 minutes to complete. The survey is approved by UC Berkeley IRB 2019-10-12690, and Australian National University IRB 2019/836. The principal investigators on this project are Stefano DellaVigna (sdellavi@econ.berkeley.edu), Eva Vivalt (eva.vivalt@anu.edu.au), and Nicholas Otis (notis@berkeley.edu).

Survey details can be found in the box below:

Researchers: The primary investigators in this study are Stefano DellaVigna, an academic staff member in the Department of Economics at the University of California, Berkeley, Eva Vivalt, an academic staff member at the Research School of Economics within the College of Business and Economics at the Australian National University, and Nicholas Otis, a graduate student at the University of California, Berkeley.

Project Title: Social Science Prediction Survey.

You may advance to the survey by selecting "I consent" below.

☒ I consent

☐ I do not consent

Which of the following best describes you?

☐ Faculty

☐ PhD student

☐ Researcher

☐ Practitioner

Which of the following best describes your degree?

☐ Economics

☐ Public Policy

☐ Political Science

☐ Psychology

☐ Other

How familiar are you with the following types of interventions in developing countries?

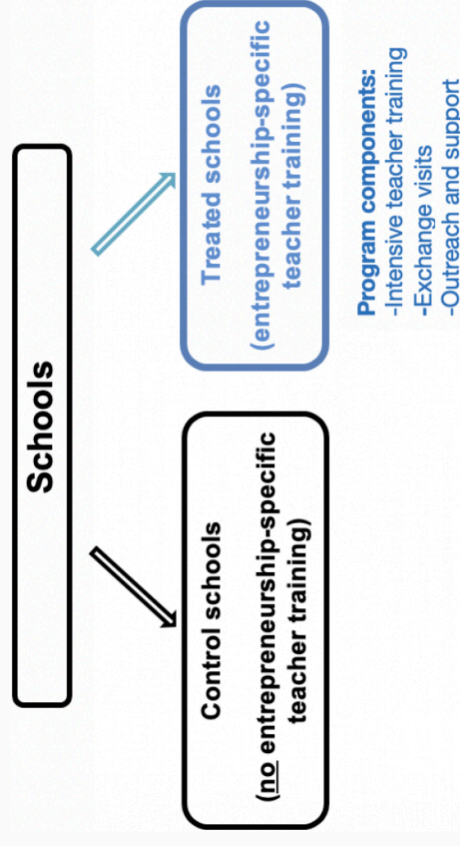
	Not at all familiar	Slightly familiar (Haven't heard of any specific studies)	Familiar (Have heard of some studies)	Very familiar (Know the details of several studies)
Unconditional cash transfers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Education / teacher training interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV / public health interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Study: [Entrepreneurship education and teacher training in Rwanda](#)

Authors: Todd Pugatch, Moussa P. Blimpo

Background on education in Rwanda: Primary school (grades 1-6) in Rwanda is compulsory. All Rwandan secondary students are required to enroll in entrepreneurship courses through six years of secondary school (S1-S6, equivalent to grades 7-12). In 2016, Rwanda reformed its required upper secondary (S4-S6, equivalent to grades 10-12) entrepreneurship course by introducing interactive pedagogy and a focus on business skills, which covers the full cycle of business creation and development, including product development, registration and legal issues, marketing, accounting, and customer relations.

Intervention: In that year, a subset of schools was randomly selected for two years of intensive teacher training and support (treated schools). The program covered more than 100 schools, 260 teachers, and 6,800 students, and was implemented by the government and a large international NGO. A control group of equal size received the curriculum and standard government training only. The training received by treated teachers was subject-specific (entrepreneurship), incorporated peer feedback meetings, and included follow-up support.



The training had three main components:

-Intensive teacher training: Entrepreneurship teachers received multi-day training sessions each academic term beginning April 2016 through January 2018. Each of the six sessions was held during holidays between terms and lasted four days. Training emphasized lesson planning, engaging students in classroom discussions, encouraging students to create entrepreneurship “portfolios” of their work, and assisting student business clubs to form and grow. Trainings culminated in a “mock day” in which teachers rehearsed upcoming lessons.

-Exchange visits: Teachers participating in the intervention visited each other’s schools to learn from and provide feedback to their peers.

-Outreach and support: Teachers received ongoing outreach to support their implementation of the curriculum, including visits from trained “Youth Leaders” which contained product-making demonstrations (e.g., for household goods such as soap or candles) co-taught with the teacher, advising of student business clubs, classroom observation, participating in teacher exchange visits, and addressing any other concerns. Student business clubs were encouraged to submit their ideas to regular business competitions held for treated schools.

Target population: The study focused on the cohort entering S4 (10th grade) in 2016, with training provided to this cohort’s entrepreneurship teacher as they progressed to S6 (12th grade). The control group and the treated group received the new entrepreneurship curriculum. Teachers in control schools did not receive the intensive training, exchange visits, or outreach provided to treatment schools.

Outcomes overview: Outcomes were measured at the student level. Approximately 15 students were sampled from each school. We ask you to predict the experimental results for three outcomes: scores on a standardized entrepreneurship test, whether students dropped out of school, and business participation.

We are interested in what you think the impact of these treatments will be. For each outcome, please provide your prediction. Even if you do not have strong beliefs about the effects of the interventions, we are still interested in your best guess. As a reference, we will provide the mean value of the control group at endline.

One outcome we are interested in is the percent of respondents who dropped out of school. This outcome measures dropout at any time after baseline (April 2016) through when the endline surveys were completed June-October 2018. The final training was in January 2018, with final exchange visits and outreach in April.

Please predict the difference in the percent of respondents who dropped out of school between the group in which teachers received entrepreneurship-specific training and the control group (the average treatment effect).

Notes:

- [Click here](#) for a reminder of the intervention and study background, which will open in a new window.
- **Reference:** In the control group, an average of 9% of respondents dropped out over the duration of the study (with a standard deviation of 29 percentage points).
- As an example, if you enter **8.7** it means you think student dropout will be **8.7** percentage points **higher** in the treatment group. If you enter **-8.7** it means you think student dropout will be **8.7** percentage points **lower** in the treatment group. If you enter **0** it means you think the program had **no impact**.

Difference in student dropout between treatment and control condition (percentage points)

One outcome we are interested in is scores on an entrepreneurship test. Students took the test in November 2018. The final training was in January 2018, with final exchange visits and outreach in April.

Please predict the difference in entrepreneurship test scores between the group in which teachers received entrepreneurship-specific training and the control group (the average treatment effect).

Notes:

- [Click here](#) for a reminder of the intervention and study background, which will open in a new window.
- **Reference:** The mean entrepreneurship test score at endline for the control group is 2.20 (with a standard deviation of 1.47), on 1-6 scale, where 6 is the highest number of points that can be scored.
- As an example, if you enter **0.45** it means you think test scores will be **0.45** test points **higher** in the treatment group. If you enter **-0.45** it means you think test scores will be **0.45** test points **lower** in the treatment group. If you enter **0** it means you think the program had **no impact**.

Difference in exam score between treatment and control condition (test points)



One outcome we are interested in is business participation. The final training was in January 2018, with final exchange visits and outreach in April, and at endline (June-October 2018) respondents were asked if they earned money from running a business (in the last month).

Please predict the difference in the percent of students who reported earning money from running a business in the last month between the group in which teachers received entrepreneurship-specific training and the control group (the average treatment effect).

Notes:

- [Click here](#) for a reminder of the intervention and study background, which will open in a new window.
- **Reference:** In the control group, an average of 30% of respondents reported earning money from running a business in the last month (with a standard deviation of 46 percentage points).
- As an example, if you enter **13.8** it means you think the number of respondents who report earning money from running a business will be **13.8** percentage points **higher** in the treatment group. If you enter **-13.8** it means you think the number of students respondents who report earning money from running a business will be **13.8** percentage points **lower** in the treatment group. If you enter **0** it means you think the program had **no impact**.

Difference in business participation between treatment and control condition (percentage points)



How confident are you in your predictions for this study? If you are confident it means that you believe your predictions are very accurate.

☐ Not at all confident

☐ Not very confident

☐ Somewhat confident

☐ Very confident

If you have any comments, please enter them below. We would love to hear your feedback.



Thank you for your predictions! You can now choose to end the survey, or you can continue and provide predictions for an additional study.

☐ Continue to the project *Direct and Spillover Impacts of a Community-Level HIV/AIDS Program: Evidence from a Randomized Controlled Trial in Mozambique.*

☐ Continue to the project *The Impact of a Multidimensional Program on Nutrition and Poverty in Burkina Faso.*

☐ End the survey



Study: [The Impact of a Multidimensional Program on Nutrition and Poverty in Burkina Faso](#)
Authors: Adrien Bouguen and Andrew Dillon

Study introduction: A large number of people in Burkina Faso live in poverty. This problem is compounded by the Sahel environment, which leaves households vulnerable to food insecurity. This impact evaluation examines the effects of a multi-faceted anti-poverty program in rural Burkina Faso implemented by two local partner nonprofits.

Target population: The program targets ultra-poor and poor households with a child under the age of five, and/or a pregnant/breastfeeding woman. Ultra-poor and poor households were identified before randomization using quantitative and qualitative targeting methods. On average, 21 households per village were selected to be eligible for the program.

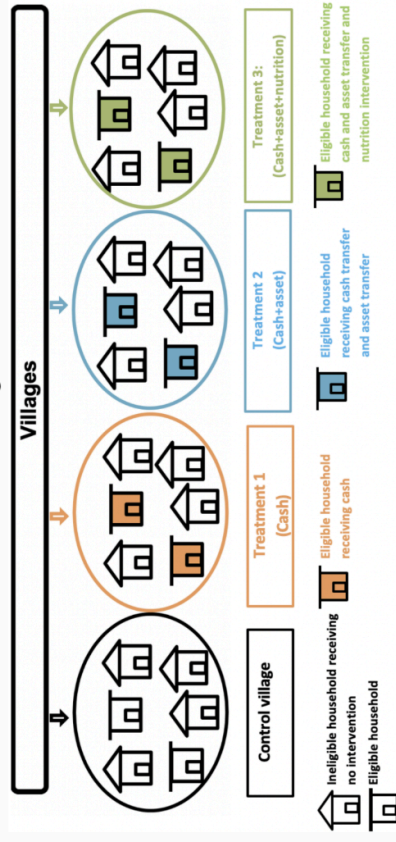
Randomization: This study is a cluster randomized controlled trial. Randomization took place at the village level: 168 villages were randomized into one of three treatment conditions or a control condition. Note that treatments varied slightly based on region. The main components of these three treatments are described below:

Treatment 1: Unconditional cash transfer. The cash transfer lasted a total of two years. In the first year, households received 20,000 FCFA per month for four months (~40% of monthly household consumption; ~100 USD, PPP adjusted), for a total annual transfer of 80,000 FCFA (~400 USD, PPP adjusted). In the second year they received 15,000 FCFA per month for four months (~30% of monthly household consumption; ~75 USD, PPP adjusted), for a total annual transfer of 60,000 FCFA (~300 USD, PPP adjusted). Cash was distributed during the lean season between planting and harvesting (June-September).

Treatment 2: Unconditional cash and asset transfer. The cash transfer is as above. These households also received a coupon for animals which can be exchanged at markets. The coupons varied by area in two ways. First, whether a household receives a coupon for sheep or poultry varied based on the suitability of the village for raising each animal, as determined by a local implementing partner. Second, the amount of the voucher varied by region: poultry coupons were worth either 25,000 (~125 USD, PPP adjusted) or 44,000 FCFA (~220 USD, PPP adjusted), and sheep coupons were worth either 90,000 (~450 USD, PPP adjusted) or 114,000 FCFA (~570 USD, PPP adjusted).

Treatment 3: Unconditional cash and asset transfer and nutrition intervention. The cash and asset transfers are as above. These households also received nutritionally fortified flour for children aged 6 to 23 months. Pregnant or lactating women received bread flour on a monthly basis.

The intervention contents are summarized in the figure and table below:



Timing: The second wave of the intervention was delivered in November, 2019. Endline is estimated to take place in April-May, 2020.

Treatment delivery: The table below depicts the proportion of households in each group that had received an intervention at midline (households should have received treatment by this point).

- For the **bold values**, treatment should be 100% if all intended recipients were treated. For example, only **75.3%** of households in T1 (cash) had received some cash at midline.
- Red text indicates households that should not have received a treatment. For example, **1.8%** of households in the control group had received some cash at midline.

Component	Experimental group			
	Control	T1 (cash)	T2 (cash+asset)	T3 (cash+asset+nutrition)
Cash	1.8%	75.3%	81.7%	83.5%
Asset	<1%	<1%	62.0%	76.3%
Nutrition	<1%	<1%	<1%	53.5%

We are interested in what you think the impact of these treatments will be. For each outcome, please provide your prediction. Even if you do not have strong beliefs about the effects of the interventions, we are still interested in your best guess. As a reference, we will provide the mean value of the control group at midline.

Type	Group/Period	Region 1	Region 2
Unconditional cash	First year	20,000 FCFA (~100 USD) per month for 4 months (~400 USD total)	20,000 FCFA (~100 USD) per month for 4 months (~400 USD total)
	Second year	15,000 FCFA (~75 USD) per month for 4 months (~300 USD total)	15,000 FCFA (~75 USD) per month for 4 months (~300 USD total)
Asset	Poultry	44,000 FCFA (~220 USD total)	25,000 FCFA (~125 USD total)
	Sheep	114,000 FCFA (~570 USD total)	90,000 FCFA (~450 USD total)
Nutrition	Children (6-23 months)	2.5 kg per child per month for 4 months (10 kg total)	2.5 kg per child per month for 3 months (7.5 kg total)
	Pregnant / breastfeeding women	0.7 kg per month for 4 months (2.8 kg total)	2.1 kg per month for 3 months (6.3 kg total)

Note: All USD are PPP adjusted.

One outcome we are interested in is the average household health expenditure. This includes expenses related to outpatient visits, hospitalization, medical transportation costs, insurance fees, and all other medical expenses.

Please predict the difference in monthly health expenditure between households assigned to each of the three treatment groups and the control group.

Notes:

- [Click here](#) for a reminder of the interventions and study background, which will open in a new window.
- **Reference:** At midline, the average monthly household health consumption expenditure in the control group was about 13 USD (PPP adjusted; 2,600 FCFA) with a standard deviation of about 25 USD (PPP adjusted; 5,000 FCFA).
- As an example, if you enter **7.5** it means you think average monthly household health consumption expenditure will be **7.5 USD higher** in the treatment group. If you enter **-7.5** it means you think average monthly household health consumption expenditure will be **7.5 USD lower** in the treatment group. If you enter **0** it means you think the program had **no impact**.

	Difference: Health consumption expenditure (USD)
Difference between (T1) unconditional cash transfer and control condition	<input type="text"/>
Difference between (T2) unconditional cash + asset transfer and control condition	<input type="text"/>
Difference between (T3) unconditional cash + asset transfer + nutrition intervention and control condition	<input type="text"/>



One outcome we are interested in is monthly household food consumption expenditure. This includes purchased food, home produced food, food received from other household members, friends and in the form of in-kind payments.

Please predict the difference in monthly food expenditure between households assigned to each of the three treatment groups and the control group.

Notes:

- [Click here](#) for a reminder of the interventions and study background, which will open in a new window.
- **Reference:** At midline, the average monthly household food consumption expenditure in the control group was about 200 USD (PPP adjusted; 40,000 FCFA) with a standard deviation of about 130 USD (PPP adjusted; 26,000 FCFA).
- As an example, if you enter **39** it means you think average monthly household food consumption expenditure will be **39 USD higher** in the treatment group. If you enter **-39** it means you think average monthly household food consumption expenditure will be **39 USD lower** in the treatment group. If you enter **0** it means you think the program had **no impact**.

	Difference: Food expenditure (USD)
Difference between (T1) unconditional cash transfer and control condition	<input type="text"/>
Difference between (T2) unconditional cash + asset transfer and control condition	<input type="text"/>
Difference between (T3) unconditional cash + asset transfer + nutrition intervention and control condition	<input type="text"/>



How confident are you in your predictions for this study? If you are confident it means that you believe your predictions are very accurate.

- ☐ Not at all confident
- ☐ Not very confident
- ☐ Somewhat confident
- ☐ Very confident

If you have any comments, please enter them below. We would love to hear your feedback.



Thank you for your predictions! You can now choose to end the survey, or you can continue and provide predictions for an additional study.

- ☐ Continue to the project *Direct and Spillover Impacts of a Community-Level HIV/AIDS Program: Evidence from a Randomized Controlled Trial in Mozambique*.
- ☐ End the survey



Study: [Direct and Spillover Impacts of a Community-Level HIV/AIDS Program: Evidence from a Randomized Controlled Trial in Mozambique](#)

Authors: Dean Yang, Arlete Mahumane, James Riddell, Hang Yu

Introduction: Mozambique has high levels of HIV (7.1% of the population). This study examines the impacts of Força à Comunidade e Crianças (FCC, “Strengthening Communities and Children”), a U.S. government-funded program targeting households with orphaned and vulnerable children which is designed to combat HIV/AIDS. The focus of this study is to understand how home visits by local community workers (hired by a local implementing partner of the FCC program) impact HIV-related outcomes in these households.

Home visits: Local community workers conduct home visits to identify households with orphans and vulnerable children, which are then linked to appropriate programs and services in communities, schools, and health facilities. Local community workers are 80% female and usually between 25 and 40 years old.

Home visits and HIV testing: A key component of the home visits is referrals for HIV testing at the nearest affiliated health clinics. All FCC beneficiaries (both adults and children of all ages) who do not know their HIV status (or were negative and have not been tested in the last 12 months) are supposed to be referred by the community workers to HIV testing services. Those testing positive for HIV are referred to receive antiretroviral therapy (ART) through a nearby affiliated clinic. Local community workers follow up with individuals initiating ART to promote ART adherence on an ongoing basis. During these home visits, the local community workers try to increase HIV testing rates through:

- **Information related to HIV/AIDS:** FCC beneficiaries receive information on HIV/AIDS, such as on methods of disease transmission, progression of the disease, treatment, HIV testing, and locations of health clinics providing testing.
- **Discussions to reduce stigma concerns:** FCC beneficiaries also engage in discussions to reduce stigmatizing attitudes among program beneficiaries. Community workers are expected to provide psychosocial support, gradually gaining program beneficiaries' trust over repeated interactions.
- **Education:** In home visits, community workers are also expected to give caregivers advice and encouragement regarding children's education.
- **Other components:** Households are connected to other relevant services after the home visits, based on needs assessments conducted by the local community workers. These other services are expected to reach only a relatively small fraction of those reached by home visits. More information on these subcomponents can be found in [this document](#) (pages 5-6).

Experimental design

Randomization took place at multiple levels. In this survey, we focus on the two types of households depicted in the figure below:



Households with orphaned and vulnerable children receiving no intervention in village where nobody is visited by FCC community workers.



Households with orphaned and vulnerable children assigned to be visited by local community workers. Data collected by the local implementing partners suggests that around 77% of targeted households receive a visit, though these rates have not yet been independently verified.

Home visits are supposed to include:

- Referrals for HIV testing
- Information related to HIV/AIDS
- Discussions to reduce stigma concerns

At baseline, the average household contained 5.9 members. The experiment contains several other levels of randomization, including an individual level of randomization that took place in all villages. For simplicity, this survey focuses on those households that were not assigned to receive any intervention beyond the FCC program. For more information, [see this document](#) (pages 7-9)

Study sites: Communities were selected on the basis of being close to health clinics offering HIV testing and treatment, having sufficient populations of orphans and vulnerable children, and having no other active donor-funded HIV/AIDS programs.

Timing: The FCC program began activities in early 2017. Over the calendar year they gradually enrolled beneficiaries and scaled up program activities. The follow-up survey began in May 2019, and was scheduled to be completed near the end of 2019. Households in treated communities can therefore have had up to two years of exposure to the FCC program at the time of the follow-up survey, but some households may have had a few months' less program exposure, if they happened to have been enrolled in the program towards the end of 2017.



We are interested to hear your predictions about the effects of this intervention on one outcome: self-reported HIV testing. Even if you do not have strong beliefs about the effects of the intervention on this outcome, we are still interested in your best guess.

Self-reported HIV testing was measured in the endline survey. Respondents were asked if anyone in the household had been tested for HIV in the last 12 months. The outcome is a household-level variable equal to 1 if at least one household member is reported to have had an HIV test in the last 12 months, and 0 otherwise.

Please predict the difference in self-reported HIV testing (in percentage points) between households assigned to be visited by local community workers and the control group.

Notes:

- [Click here](#) for a reminder of the interventions and study background, which will open in a new window.
- **Timing:** Households in treated communities can have had up to two years of exposure to the FCC program at the time of the follow-up survey, but some households may have had a few months' less program exposure, depending on enrollment date.
- **Reference:** As a reference, at baseline about 41.9% (with a standard deviation of 49.4 percentage points) of households self-reported having any household member receive HIV testing in the last 12 months.
- As an example, if you enter **14.7** it means that you think self-reported HIV testing will be **14.7** percentage points **higher** in the group assigned to be visited by local community workers. If you enter **-14.7** it means that you think self-reported HIV testing will be **-14.7** percentage points **lower** in the group assigned to be visited by local community workers. If you enter **0** it means you think the treatment had **no impact**.

Difference between treatment and control condition in percentage points



How confident are you in your predictions for this study? If you are confident it means that you believe your predictions are very accurate.

- ☐ Not at all confident
- ☐ Not very confident
- ☐ Somewhat confident
- ☐ Very confident

If you have any comments, please enter them below. We would love to hear your feedback.



We thank you for your time spent taking this survey.
Your response has been recorded.

3 Treatment Comparison

0.1 standard deviation reference

As an example, if you enter **0.10** it means that you think self-reported HIV testing will be **0.10** standard deviations **higher** in the group assigned to be visited by local community workers. If you enter **-0.10** it means that you think self-reported HIV testing will be **-0.10** standard deviations **lower** in the group assigned to be visited by local community workers. If you enter **0** it means you think the treatment had **no impact**.

0.3 standard deviation reference

As an example, if you enter **0.30** it means that you think self-reported HIV testing will be **0.30** standard deviations **higher** in the group assigned to be visited by local community workers. If you enter **-0.30** it means that you think self-reported HIV testing will be **-0.30** standard deviations **lower** in the group assigned to be visited by local community workers. If you enter **0** it means you think the treatment had **no impact**.

Standard deviations (text entry)

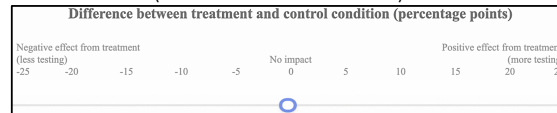
Difference between treatment and control condition in standard deviations

Raw units (text entry)

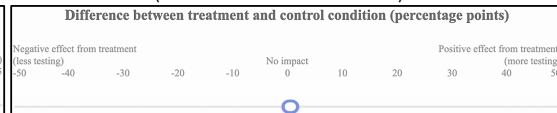
Difference between treatment and control condition in percentage points

Respondents providing forecasts in standard deviations are also provided with the following statement: *As a reference, a recent survey of many impact evaluations in development economics suggests that the average effect size is around 0.10 standard deviations (Vivalt, 2019).*

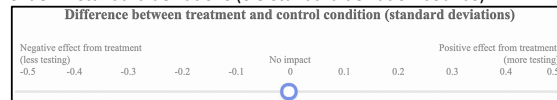
Slider in raw units (0.5 standard deviation bounds)



Slider in raw units (1.0 standard deviation bounds)



Slider in standard deviations (0.5 standard deviation bounds)



Slider in standard deviations (1.0 standard deviation bounds)

