

# Randomized Controlled Trials - Overview

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# Why RCT?

- Randomized Controlled Trials are the gold standard of impact analysis
- Random individuals represent an ideal control group
- This section: overview the idea of a randomized control trial, frequent pitfalls, etc.

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- For the first year, the program can only be implemented in 1/3 of households because of costs
- Suppose we want to investigate the effects of this program on child health and nutrition

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- But, we can't say whether this is due to the program – we don't know how people who received it are different from those who did not.
- Maybe the province with the program is a richer province where people have more money to spend on health services
- These children might have been healthier even without the program. If we just compare them and attribute that effect to the program, we might have a bad estimate

# Treatment on the Treated

Important distinction: let  $G_1$  be the program group and  $G_2$  be the non-program group. What we want to measure is

$$\bar{Y}_{G_1+G_2}^P - \bar{Y}_{G_1+G_2}^{NP}$$

What we actually measure is

$$\bar{Y}_{G_1}^P - \bar{Y}_{G_2}^{NP}$$

If  $\bar{Y}_{G_1}^P \neq \bar{Y}_{G_2}^P$  or  $\bar{Y}_{G_1}^{NP} \neq \bar{Y}_{G_2}^{NP}$  then, we are measuring the wrong thing. This happens if  $G_2$  is different from  $G_1$  in a way which causes them to be more or less healthy without the program or more or less impacted by the program.

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- We could use group 2 as a control group – then we can compare  $\bar{Y}_{G_1,t+1}^P - \bar{Y}_{G_1,t-1}^P - (\bar{Y}_{G_2,t+1}^{NP} - \bar{Y}_{G_2,t-1}^{NP})$

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- That is, use the changes in group 2 as a control group for changes in group 1
- but, if people get to choose to participate in the program, might expect the biggest changes to be in group 1 – that's why they want to be in the program

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- When/how to do this?

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    - If we don't know who would have adopted, and compare adopters in treatment to everyone in control group, not a perfect control group.
    - So, either need to use  $G_1^{all}$  or would need to know who would and wouldn't adopt in each group.

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- Can we generalize the result to learn more about other programs that might work?

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- Household level disadvantage - ethics – other households may demand treatment



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- What are the ethics of giving the program to some and not others?

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- In other words, with spillovers, the control group may become invalid. May be a case for village-level randomization.

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  - Don't observe everything about these villages; villages that look similar but behave differently may be the most different from each other



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- Importance: In this case, can only pick up effects that happen within 1 year

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- But, worry about honesty – people may try to give the "correct" answer to official surveyors

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- But... what can we learn?

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- For scale-up, it might be useful to know how effective each was in case one is much cheaper than the other
- How would we solve this? Could randomize separately for the two treatments, maybe could collect data on taking vitamins
- Also, we only know that the program was effective for the group who we studied. Ideally, we can design programs which would be effective for more people so that we know we can scale up.

# Generalizability

- We learned that the program worked, that providing both information and vitamins improved child health in this context.
- Because program did both vitamins and information, we don't know which is more important
- For scale-up, it might be useful to know how effective each was in case one is much cheaper than the other
- How would we solve this? Could randomize separately for the two treatments, maybe could collect data on taking vitamins
- Also, we only know that the program was effective for the group who we studied. Ideally, we can design programs which would be effective for more people so that we know we can scale up.
- Over the rest of the afternoon, we'll discuss more case-studies which work on these issues and how best to do RCTs.