

Ethiopia - The Impact and Sustainability of Community-Led Total Sanitation and Hygiene (CLTSH) 2017-2019

Matthew C. Freeman, Abebe Gebremariam Gobeze

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Identification

SURVEY ID NUMBER

ETH_2017-2019_ISCLTSH-IE_v01_M

TITLE

The Impact and Sustainability of Community-Led Total Sanitation and Hygiene (CLTSH) 2017-2019

SUBTITLE

Andilaye Impact Evaluation - Baseline, Midline, and Endline Surveys

ABBREVIATION OR ACRONYM

ISCLTSH-IE 2017-2019

COUNTRY/ECONOMY

Name	Country code
Ethiopia	ETH

STUDY TYPE

Other Household Health Survey [hh/hea]

SERIES INFORMATION

This impact evaluation consists of the baseline survey (2017) and two follow-up surveys, the midline (2018) and the endline (2019).

ABSTRACT

Important gaps in knowledge related to current sanitation and hygiene programming, and effective approaches for intervention delivery exist - in particular, the effectiveness of these types of interventions in fostering progressive and sustained NTD-preventive, WASH-specific behavioral adoption and maintenance at the community level, and the corresponding impacts on mental well-being. With research grants from the World Bank's Strategic Impact Evaluation Fund (SIEF), the International Initiative for Impact Evaluation (3ie), and the Children's Investment Fund Foundation (CIFF), Emory University and its consortium partners launched a three-year impact evaluation, designed as an ex-ante parallel cluster-randomized, controlled trial (RCT) with a preliminary formative research phase to generate evidence to fill in these knowledge gaps. The purpose of the three-year Andilaye project is to use formative research findings to inform the integration of NTD components into existing community-based WASH behavior change approaches (CLTSH, and the HEP more generally) in Ethiopia, and to evaluate the effectiveness of such an intervention on sustained behavior change and mental well-being. The study's intervention arm includes households from targeted villages (i.e., gotts) within randomly selected sub-districts (i.e., kebeles) receiving the Andilaye intervention. This intervention consists of an integrated sanitation and hygiene programming approach that is enhanced through the incorporation of NTD-preventive components as well as community-oriented behavior change and maintenance strategies facilitated through the leveraging of positive motives. The counterfactual arm includes households from targeted villages (i.e., gotts) within randomly selected sub-districts (i.e., kebeles) receiving the GoE's current standard of care WASH programming (i.e., current CLTSH programming).

The main objectives of this work involve an examination of change along our hypothesized, yet evidence-based Andilaye Theory of Change, and include the following: 1. Determine the impact of Andilaye's enhanced and integrated WASH-NTD intervention on NTD-preventive sanitation and hygiene-related behavioral antecedents (e.g., internalized risk and capability perceptions, attitudes, and norms), intermediate outcomes along the causal chain; 2. Explore whether the promotion of the Andilaye intervention leads to an increase in the uptake, maintenance, and exclusive use of sanitation facilities and improved personal hygiene behaviors, behavioral outcomes along the causal chain; 3. Investigate whether changes in personal hygiene, sanitation, and water behaviors are sustained; 4. Examine whether the integration of official hygiene and other NTD-preventive promotion and monitoring as a component of demand-side sanitation and hygiene programming results in behavioral benefits for NTD prevention and mental well-being, the impacts of interest the terminal end of the causal chain; and 5. Assess whether collective efficacy and water insecurity modify intervention effectiveness.

As indicated above, the study assesses and tracks changes in sanitation and hygiene-related indicators along the causal chain, including behavioral antecedents (e.g., attitudes, capabilities, collective efficacy, norms), contextual changes in household conditions that may facilitate habituation of improved behaviors (e.g., improvements in conditions of household sanitation and hygiene), and behavioral outcomes. We are also measuring and tracking changes in hypothesized behavioral mediators such as water and sanitation insecurity, and health impacts including respondent-reported diarrhea and mental well-being at multiple time points. We are examining behavioral antecedents and other behavioral mediators to establish

causal determinants of behavioral change and maintenance over time and identify mechanisms that lead to behavioral change. There is utility in employing such an approach, as it will help us determine not only if, but how, and why the intervention was successful, and in which contexts. As part of this evaluation, we are developing and validating novel metrics and frameworks to track key outcomes along the causal pathway (e.g., behavioral antecedent indicators; innovative, objective facial and cleanliness indicators; sanitation insecurity, water insecurity, and collective efficacy scales refined and validated during the course of this study).

KIND OF DATA

Sample survey data [ssd]

UNIT OF ANALYSIS

Individuals, households, household facilities (e.g., household latrines, wash stations), communities

Version

VERSION DESCRIPTION

v01: Edited, anonymous datasets for public distribution

Scope

NOTES

This study covers the following topics:

Household: household demographics and other characteristics; household listing including: the head of household, primary caregiver of the index child (youngest child aged 1-9 years at baseline), respondent (if different than the primary caregiver of the index child), and any children between the ages of 0-17 years residing in the household - capturing the following data points on each member: age, sex, school enrollment, animal husbandry and water fetching responsibilities, shoe wearing observation (if present at the time of the survey), defecation and urination practices for all individuals; respondent-reported water collection, storage, treatment practices; water insecurity measures (measured via validated scale); washing station access and observed conditions; household latrine access; respondent-reported construction, operation and maintenance/repairs, and upgrades at household latrine; observed conditions of the household latrine; respondent-reported and observed animal husbandry and waste management practices; respondent-reported household-level hygiene practices, including frequency of washing towels, bedsheets, baby carriers, toys (potential fomites)

Head of Household: highest educational attainment; above-mentioned data; sanitation insecurity; collective efficacy

Primary Caregiver of the Index Child (i.e., youngest child in the household aged 1-9 years at baseline - this person is ideally, and in actuality, often the primary survey respondent): highest educational attainment; marital status; and above-mentioned data

Respondent: relation to head of household; role with regard to caregiving responsibilities; age; sex; religion; ethnicity; observed hand cleanliness; respondent-reported handwashing, facewashing, bathing practices; frequency with which respondent's clothes are washed (respondent-reported); sanitation insecurity; collective efficacy; mental health (measured via validated scale)

Children Aged 0-9: respondent-reported diarrhea, dysentery, fever, nasal congestion; observed hand cleanliness; observed facial cleanliness measured via presence/absence of wet and/or dry nasal discharge, ocular discharge, other dust/dirt/debris, number of fly-face contacts during a 1-minute observation; if aged 0-3: respondent-reported infant and young child feces disposal practices

Index Children (i.e., youngest child in the household aged 1-9 years at baseline): same data as other children aged 0-9 plus a swab-based facial and hand cleanliness assessment; respondent-reported handwashing, facewashing, and bathing practices; respondent-reported frequency with which index child's clothes are washed

KEYWORDS

Keyword

Formative research, sanitation and hygiene promotion, water and sanitation program, access to sanitation facility, behavior change, randomized controlled trial, Ethiopia

Coverage

GEOGRAPHIC COVERAGE

Rural and peri-urban areas only, in three districts (Farta, Fogera, and Bahir Dar Zuria) in the Amhara National Regional State

GEOGRAPHIC UNIT

Village (gott)

UNIVERSE

Original baseline process randomly selected rural and peri-urban households with at least one child between the ages of 1-9 years located within purposively selected villages (i.e., gotts) in randomly selected sub-districts (i.e., kebeles) of the Farta, Fogera, and Bahir Dar Zuria woredas (i.e., districts) in the Amhara National Regional State.

Producers and sponsors

PRIMARY INVESTIGATORS

Name	Affiliation
Matthew C. Freeman	Emory University, Rollins School of Public Health, Department of Environmental Health
Abebe Gebremariam Gobezayehu	Emory Ethiopia

PRODUCERS

Name	Affiliation	Role
Josh V. Garn, PhD, MS	Emory University, Rollins School of Public Health, Department of Environmental Health	Technical assistance in data processing and analysis
Maryann G. Delea, MPH	Emory University, Rollins School of Public Health, Department of Environmental Health	Technical assistance in questionnaire design, sampling methodology / selection, pilot testing, enumerator training, data collection, data analysis
Jedidiah S. Snyder, MPH	Emory University, Rollins School of Public Health, Department of Environmental Health	Technical assistance in sample selection, data collection, data processing
Gloria D. Sclar, MPH	Emory University, Rollins School of Public Health, Department of Environmental Health	Technical assistance in questionnaire design
Bethany Caruso, PhD, MPH	Emory University, Rollins School of Public Health, Department of Environmental Health	Technical assistance in questionnaire design, sampling methodology
Craig Hadley, PhD	Emory University, College of Arts & Sciences, Department of Anthropology	Technical assistance in questionnaire design
Kenneth Maes, PhD	Portland State University, College of Liberal Arts, Department of Anthropology	Technical assistance in questionnaire design

FUNDING AGENCY/SPONSOR

Name	Abbreviation
World Bank, Strategic Impact Evaluation Fund	SIEF
International Initiative for Impact Evaluation	3ie

Sampling

SAMPLING PROCEDURE

We are interested in understanding the impact the Andilaye intervention has on sustained WASH behavior change, diarrhea, and mental well-being. As such, we conducted a sample size determination for mental well-being, as this impact was

deemed the most restrictive in terms of required sample size. Our sample size analysis indicated that we should recruit and enroll a total of 30 households from each of 50 study clusters (25 clusters per study arm), for a total of 1,500 enrolled households. During our power analysis, we considered the possibility of increasing the number of study clusters and decreasing the take size within each cluster. However, this approach presented considerable logistical and financial implications. Our final sample size accommodates for 10% of households being lost to follow-up, poor compliance to intervention allocation, inconsistent adherence to the intervention, and/or household level loss to follow-up. With data collected from 1,589 households, our baseline survey sample exceeded the targeted number of required households, per our sample size calculation, and the midline, with 1,496 met expectations with respect to anticipated attrition.

Sampling Methodology:

The Andilaye team employed a structured sampling strategy to randomly select eligible kebele clusters and study households. The primary sampling unit (PSU) for this study was the kebele; specifically, any rural or peri-urban kebele that is accessible throughout the course of the year. The ultimate sampling unit (USU) for this study is the household; specifically, any household residing in a targeted, sentinel gott within a randomly selected study kebele. While we randomly selected eligible study clusters (i.e., kebeles), we purposively selected gott(s) from which we randomly selected study households. We utilized a 'fried egg' approach to purposively select one or two gotts that are either situated in/near the center of the kebele (if there are centric gotts) or are not adjacent to any other study kebele (in the event there are no centric gotts). The number of targeted gotts depended only on the number of eligible households that consented to participate in the study. The purposive selection of data collection sites within study clusters via the 'fried egg' approach is justified, as it minimizes spill-over of intervention effects and other externalities associated with the research between intervention and control clusters, especially those adjacent to each other. In accordance with our sample size calculation, we randomly selected approximately 30 households total per kebele cluster. Not all households met eligibility criteria for inclusion in the study sample, and some households refused to participate in the study.

Target Study Population:

Our target study population included all households residing in randomly selected rural and peri-urban kebeles that are accessible throughout the course of the year in the Farta, Fogera, and Bahir Dar Zuria woredas. These woredas are located within South Gondar and West Gojjam Zones in Amhara National Regional State.

Inclusion & Exclusion Criteria:

Kebele-level criteria: Rural and peri-urban kebeles in the Farta, Fogera, and Bahir Dar Zuria woredas that are accessible throughout the course of the year were targeted for selection into the evaluation. Given intervention implementation is being supervised by local government officials (e.g., Woreda Health Officers, Health Center HEW supervisors), it was necessary for the kebeles to be accessible throughout the course of the year, to demonstrate proof of concept regarding the effectiveness of the Andilaye intervention. While sanitation coverage and utilization were originally incorporated as inclusion criteria, the veracity of those data were questionable in many kebeles in which initial visits were made (i.e., only one latrine observed in a community in which sanitation coverage was reportedly over 80%, and community reports of this being the case for as long as people could recall). Due to uncertainty with regard to the sanitation coverage and utilization data, and the fact that it became apparent during formative research that behavioral slippage was rampant even in kebeles previously declared as open defecation free, we decided to drop those criteria from inclusion requirements. The Andilaye team did discuss this change in selection criteria with relevant donors, who agreed the study would demonstrate added value if it could include otherwise eligible kebeles, regardless of their sanitation coverage and use or previous CLTSH triggering status, to explore issues related to behavioral maintenance and prevention of behavioral slippage. This evaluation does not include a mass drug administration (MDA) component and has not sought to influence the timing of such activities in study communities. The presence of MDA in the study area will not alter the research questions assessing the impact of the Andilaye intervention on targeted health impacts, behavior change, or sustainability of improved sanitation and hygiene practices.

Household-level criteria: Inclusion criteria for the Andilaye Impact Evaluation included any household randomly selected from the gott census book that resides in the target gott(s) that: 1. Has at least one child aged 1-9 years and consented to allowing study staff to observe the children, specifically their faces and hands; 2. Provided consent to participate in our study, with at least one adult household member consenting to serve as the survey respondent. We excluded from enrollment in our study any household that: 1. Refused to provide consent to participate in our survey; 2. Was repeatedly vacant or does not have an appropriate member of the household (capable adult) home to serve as the household's respondent after three attempts to engage the household; and 3. Did not have a household member aged 1-9 years (at baseline) living in the household. After consulting with the field supervisor, the enumerator replaced these households with the next randomly selected household on the eligible household register. Field supervisors and study supervisors from Emory supervised field activities and ensured enumerators were only surveying households within the eligible household sampling frame in order to guarantee the sample was random and equitable. Actual recruitment of households selected for

the Andilaye Impact Evaluation took place within the home compounds. The enumerator made contact with adult members of the household; she explained the purpose of the visit, the purpose of the study, and asked the respondent if s/he would like to participate in the study. Enumerators assessed household level eligibility by asking potential survey respondents a series of questions that lead to a determination of eligibility. Potential survey respondents were informed that they could choose not to participate in the study, that they could refuse to answer any question, and that they could stop the survey for any reason at any point in time.

Sampling Frames & Sample Selection:

All kebeles that are rural or peri-urban, and are accessible throughout the course of the year, per Woreda Health Office definition, situated in the three targeted woredas were eligible for inclusion in our study. The enumerated list of all kebeles the three respective Woreda Health Offices maintain served as the first level sampling frame. From this sampling frame, we employed a random number generator and a stratified (at the woreda level) selection approach to identify 50 eligible kebele level clusters from across the three woredas for inclusion in our study. Given each of the three woredas vary with regard to their hydrogeological conditions and the size and number of kebeles, we deemed a stratified selection approach appropriate, and used it to select study clusters. Of the 50 clusters, 22 were selected from Farta, 12 from Fogera, and 16 from Bahir Dar Zuria. An even number of clusters were selected from each woreda to ensure an equivalent sample size between the intervention and control clusters selected from each woreda. Once an appropriate gott was selected from each kebele, the team worked with the HEW to obtain a list of all of the households within the gott, specifically those with a child aged 1-9 years, as per study inclusion criteria. In order to operationalize this in a standardized manner, we used The Carter Center's (TCC) household census books, which are kept at the Health Post and enumerate all households and all household members (by age) residing within the household. At each Health Post, we obtained all TCC census books pertaining to the relevant gott(s). When there was more than one version of the TCC census book (i.e., books from censuses conducted during different years), the book with the latest census data was used as the gott sampling frame. After all relevant books were gathered, the total number of households in the gott was determined (by counting up the number of households from each of the gott's TCC census books), and a random number generator was used to generate a list of 60 households per gott that reportedly had a child between the ages of 1-9 years. The list exceeded the total number of households that would be required for enrollment in each gott in order to allow for replacement in the field if the household did not, in reality, meet inclusion criteria (i.e., have at least one child aged 1-9 years), have an eligible respondent available after three attempts, or have an eligible respondent who consented to participate in the study. During data collection, each field supervisor and enumerator were provided a list of households, and instructed to visit each household, starting with the first household on the list, to invite them for enrollment in the study, ask an eligible adult representative to provide informed consent, and administer the household survey. If households were absent, no eligible adult respondent was available or refused to consent, or upon further conversation with the household it became apparent that the household was not eligible (e.g., the death of the only child between 1-9 years, the child was actually older than 9 years), the enumerator electronically recorded the information and notified the field supervisor. If the household was absent or no eligible adult was available, the enumerator visited the household three times prior to replacing that household with the next household on the list - after contacting the field supervisor to confirm the replacement. If the household was otherwise ineligible (e.g., refused consent, no children within the targeted age range), the enumerator replaced that household with the next household on the list - after contacting the field supervisor to confirm the replacement.

Field Procedures:

During the household surveys, enumerators sought out adult (i.e., person over the age of 18 years who was capable of understanding and undergoing the informed consent process) respondents within selected households, with preference going first to the primary female caretaker of the index child (i.e., the youngest child between the ages of 1-9 years residing in the household), as she would tend to know the most about the latrine use, defecation, and personal hygiene practices of most members of her household. If she was not available, enumerators sought out other household members in the following order: eldest available female caretaker, eldest available female household member, eldest available male caretaker, or eldest available male household member. All household members present during survey administration were asked to self-report on their own sanitation and hygiene habits, and hand cleanliness and facial and hand cleanliness were assessed for the primary survey respondent and all children under the age of ten years, respectively. If, after three attempts at a household, no eligible adult respondent was available or agreed to consent to participate in the study, the household was replaced by the next randomly selected household in the gott.

RESPONSE RATE

1,472 respondents in the endline from 1,589 at baseline implies a 93% response rate at endline.

WEIGHTING

We did not use sample weights in our analyses, and our final analyses are not meant to be representative of the larger Bahir Dar Zuria, Fogera, and Farta woredas. We randomly selected and assigned our 50 study kebeles using a stratified selection approach (at the woreda level), but we purposively selected gotts, from which we randomly selected study households.

Data collection

DATES OF DATA COLLECTION

Start	End	Cycle
2017-03-01	2017-04-30	Baseline
2018-03-01	2018-04-30	Midline
2019-03-01	2019-05-31	Endline

DATA COLLECTION MODE

Computer Assisted Personal Interview [capi]

SUPERVISION

To ensure data quality, the supervisory team, comprised of faculty and staff from Emory University and Emory Ethiopia, coordinated and supervised data collection along with field supervisors. Field supervisors duplicated data entry on all objective measures at 10% of households in each study kebele. The Andilaye team analyzed the resulting data to determine inter-rater reliability of related metrics.

DATA COLLECTION NOTES

Tool Development:

When developing the survey instrument, the Andilaye team pulled from its reserve of existing WASH and NTD survey instruments, and leveraged formative research data to contextually adapt the survey prompts and answer choices. To the greatest extent possible, the team included validated metrics for assessment. Prior to enumerator training, the Andilaye survey instrument was translated into Amharic, and back-translated by two independent Amharic speakers. The team discussed any discrepancies noted between the intended English prompts and the Amharic translations (identified via the back-translations). Survey prompts were revised accordingly. In order to ensure face validity, the vast majority of the survey instrument was tested via cognitive interviews. Through the use of this qualitative method, which included a 'think-aloud' technique, the Andilaye team obtained feedback from formative research households about the meaning, comprehensiveness, and appropriateness of survey prompts and their related answer choices. Once the Amharic version of the tool was complete, four enumerators were trained on the tool, and brought on to conduct a week-long field pilot in targeted formative research communities. At the end of each day of piloting, the team discussed issues related to respondent comprehension of survey prompts and answer choices, survey logic and skip patterns, and suggested revisions. At the end of the piloting period, key data were checked and analyzed, and related modifications were made to the tool prior to finalizing for supervisor and enumerator training.

Training:

Prior to engaging with the full team of 18 enumerators (two of whom were involved in the piloting phase), senior research staff oriented three field supervisors (two of whom were involved in the piloting phase) to the Andilaye project, their roles and responsibilities as supervisors, field and debriefing check-lists, and the supervisor validation survey (i.e., a sub-set of the survey). The supervisors were also involved in the enumerator training, so they received additional information on the survey tool during that time so as to ensure the entire enumeration team had the same understanding of the survey prompts.

Subsequent to enumerator recruitment, senior research staff conducted a training with enumerators that included topics related to research ethics, rights and protection of research participants, the informed consent process, data collection tools and procedures, and the use of electronic mobile data collection applications. The training was conducted in both English and Amharic (i.e., some more technical topics were first presented in English, but to ensure thorough comprehension among the enumeration team, were also summarized in Amharic immediately after the English explanation was presented). In order to ensure enumerators had a thorough understanding of the survey instrument, senior staff facilitated a group training and discussion with all enumerators. After the purpose and meaning of each prompt and set of answer choices had been discussed, enumerators broke out into teams of two to practice administering the survey. Upon the conclusion of the office-based practice session, the team came back together to discuss any questions, concerns, or suggested revisions. Only after that point did the entire enumeration team move to the field for piloting. Survey piloting occurred iteratively, with an initial visit to the field, followed by revisions to the survey, and a subsequent day of piloting. Prior to the initial collection of official survey data, all enumerator and supervisor survey concerns had been resolved. Trainings on data collection tools and field procedures included discussion among all field supervisors and enumerators to ensure a standardized approach to data collection via household surveys and structured observation. Pilot testing of the instrument ensured enumerators were

familiar and comfortable with the survey prior to official baseline data collection, while also allowing senior research staff to check that the instrument was an appropriate tool for collecting desired data.

Quality Assurance:

Field data were captured electronically on password-protected mobile phones (stored securely when not in use) to improve accuracy of data entry and enable immediate review of results. Logic, range, and consistency checks were incorporated into the electronic data collection file to further improve data quality and minimize data entry errors.

Other Data Collection-Related Details:

Enumerators were native Amharic-speakers, who administered the surveys in Amharic (the local dialect spoken in our study clusters). On average, the survey took 45 minutes to 1 hour to administer, depending on the size of the household.

DATA COLLECTORS

Name
Field team of 18 enumerators

Questionnaires

QUESTIONNAIRES

We administered the same survey instruments at baseline, midline, and endline. The household survey consisted of several modules aimed at collecting data on key outcome indicators through reports from respondents and other household members. The modules included are: a household enumeration module, a water module, a hygiene module, a mental health indicator module, an animal husbandry and reported waste management module, a latrine information module, a behavioral antecedent survey module, a sanitation insecurity module, a collective efficacy module, a discrete choice experiment module, and a household assets and wealth indicator module.

The questionnaires are provided both in English and Amharic and are available for download.

Access policy

CONTACTS

Name	Affiliation	Email
Strategic Impact Evaluation Fund	The World Bank Group	siefimpact@worldbank.org
Matthew C. Freeman	Emory University	matthew.freeman@emory.edu
Aidan Coville	The World Bank Group	acoville@worldbank.org

ACCESS CONDITIONS

Public Access

CITATION REQUIREMENTS

Use of the dataset must be acknowledged using a citation which would include:

- the identification of the Primary Investigator
- the title of the survey (including country, acronym and year of implementation)
- the survey reference number
- the source and date of download

Example:

Matthew C. Freeman (Emory University, Rollins School of Public Health, Department of Environmental Health) and Abebe Gebremariam Gobezeayehu (Emory Ethiopia). Ethiopia - The Impact and Sustainability of Community-Led Total Sanitation and Hygiene (CLTSH) 2017-2019. Ref: ETH_2017-2019_ISCLTSH-IE_v01_M. Dataset downloaded from [URL] on [date].

ACCESS AUTHORITY

Name	Affiliation	Email	URL
Strategic Impact Evaluation Fund	The World Bank Group	siefimpact@worldbank.org	Link
Aidan Coville	The World Bank Group	acoville@worldbank.org	
Matthew C. Freeman	Emory University	matthew.freeman@emory.edu	

LOCATION OF DATA COLLECTION

World Bank Microdata Library

Disclaimer and copyrights

DISCLAIMER

The user of the data acknowledges that the original collector of the data, the authorized distributor of the data, and the relevant funding agency bear no responsibility for use of the data or for interpretations or inferences based upon such uses.

Metadata production

DDI DOCUMENT ID

DDI_ETH_2017-2019_ISCLTSH-IE_v01_M_WB

PRODUCERS

Name	Abbreviation	Affiliation	Role
Development Economics Data Group	DECDG	The World Bank Group	Documentation of the study

DATE OF METADATA PRODUCTION

2023-08-01

DDI DOCUMENT VERSION

Version 01 (August 2023)

Data Dictionary

Data file	Cases	Variables
all_hh_lat_baseline_0723.dta This dataset includes baseline survey data with latrine level information for each household.	1695	339
all_hh_lat_endline_0723.dta This dataset includes endline survey data with latrine level information for each household.	1570	493
all_hh_lat_midline_0723.dta This dataset includes midline survey data with latrine level information for each household.	1595	309
all_hh_members_baseline_0723.dta This dataset includes baseline survey data with household level information.	4829	326
all_hh_members_endline_0723.dta This dataset includes endline survey data with household level information.	4461	246
all_hh_members_midline_0723.dta This dataset includes midline survey data with household level information.	4581	290