Improving Women's Mental Health During a Pandemic

Online Appendix

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A Appendix: Additional Tables and Figures

A.1 Figures

Figure A1: Psychological domains and counseling modules
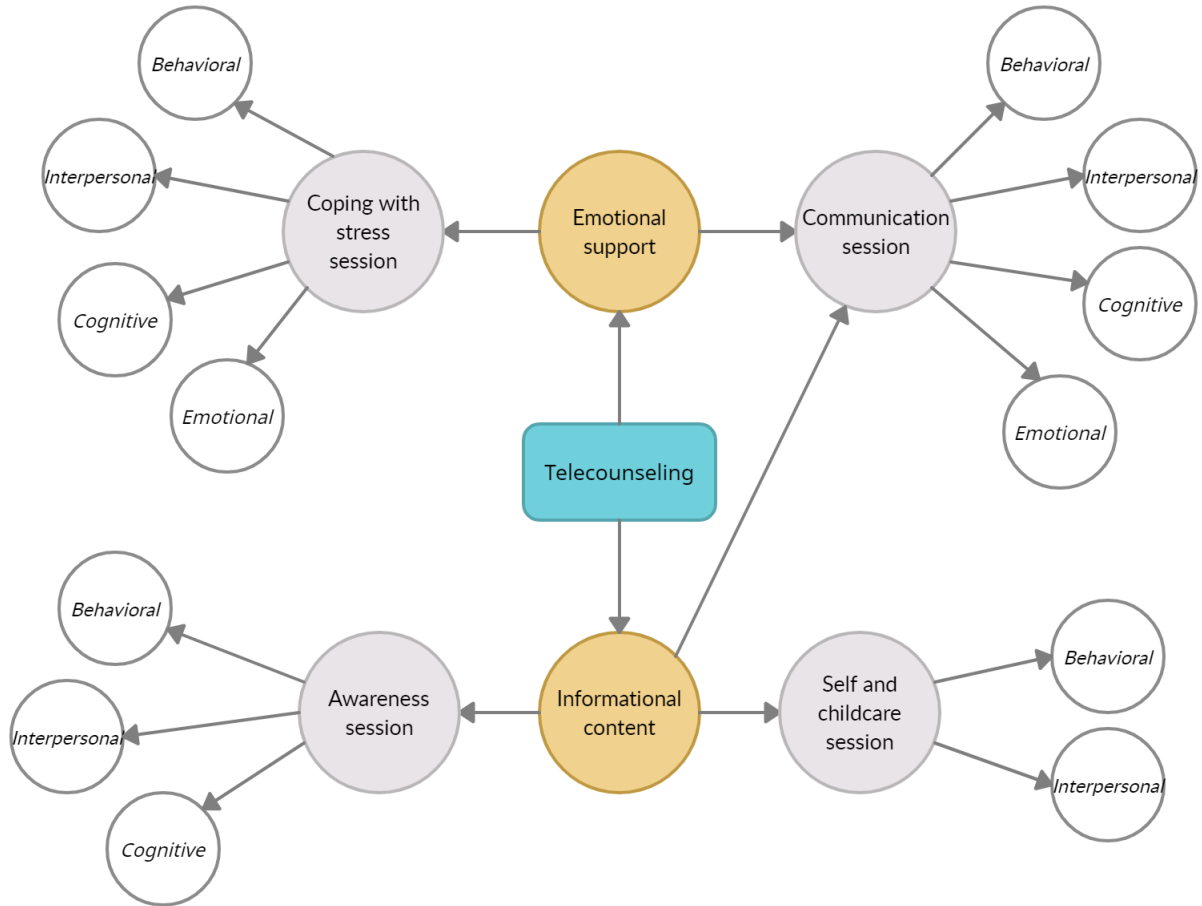
Note: This figure summarizes how our counseling modules are associated with the four psychological domains of processes that contribute to better mental well-being.

Figure A2: Map of the study area
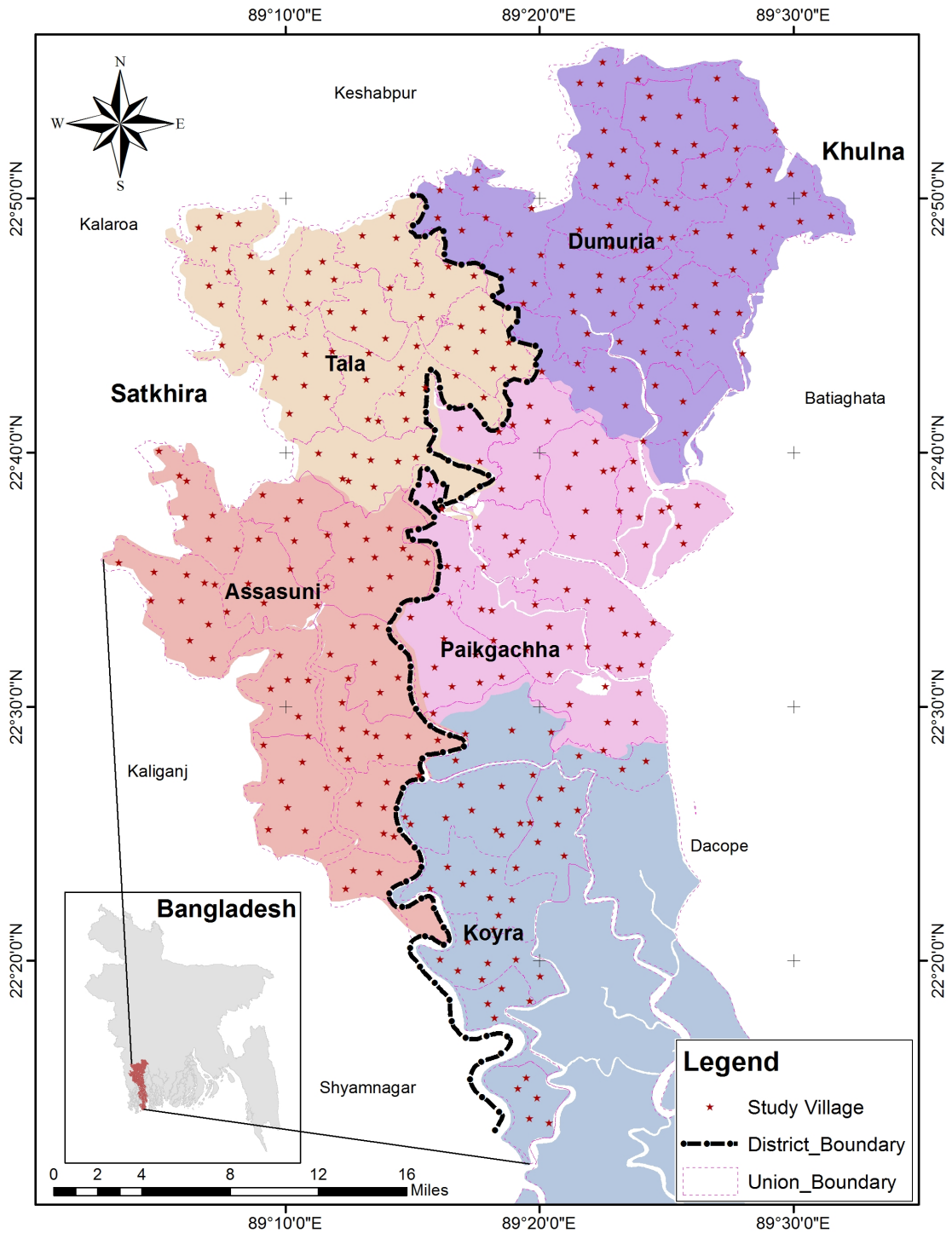
Note: This map shows the location of villages in the five subdistricts (in Khulna and Satkhira districts) in Bangladesh. Stars correspond to our study villages (i.e., both treatment and control). The right side of the Koyra subdistrict, where we do not have any study villages, is part of the Sundarbans mangrove forest.

Figure A3: Distribution of perceived stress at baseline
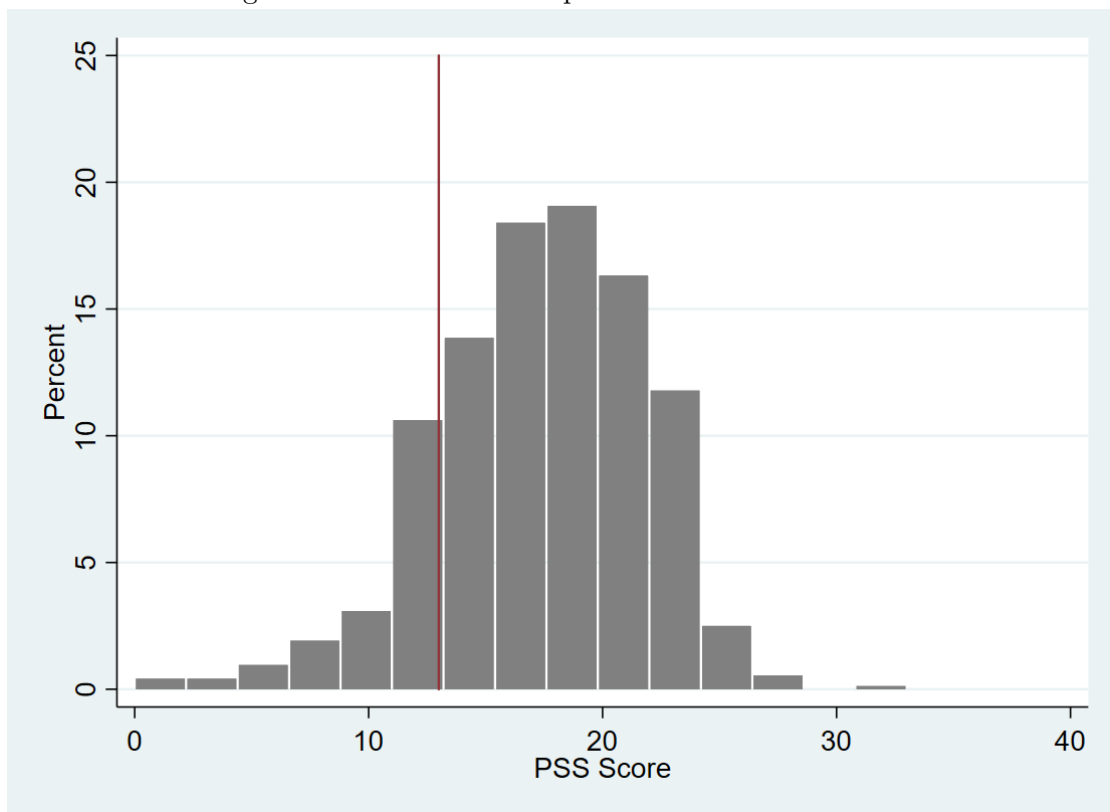
Note: Perceive stress scale score or PSS score is a measure of stress based on 10 questions, each answered on 5-point scales (0-4), and takes the value between 0 and 40. The vertical line is at PSS score = 13, which is the threshold for someone being mentally stressed.

Figure A4: Telecounseling advice followed during lockdown, by treatment arm
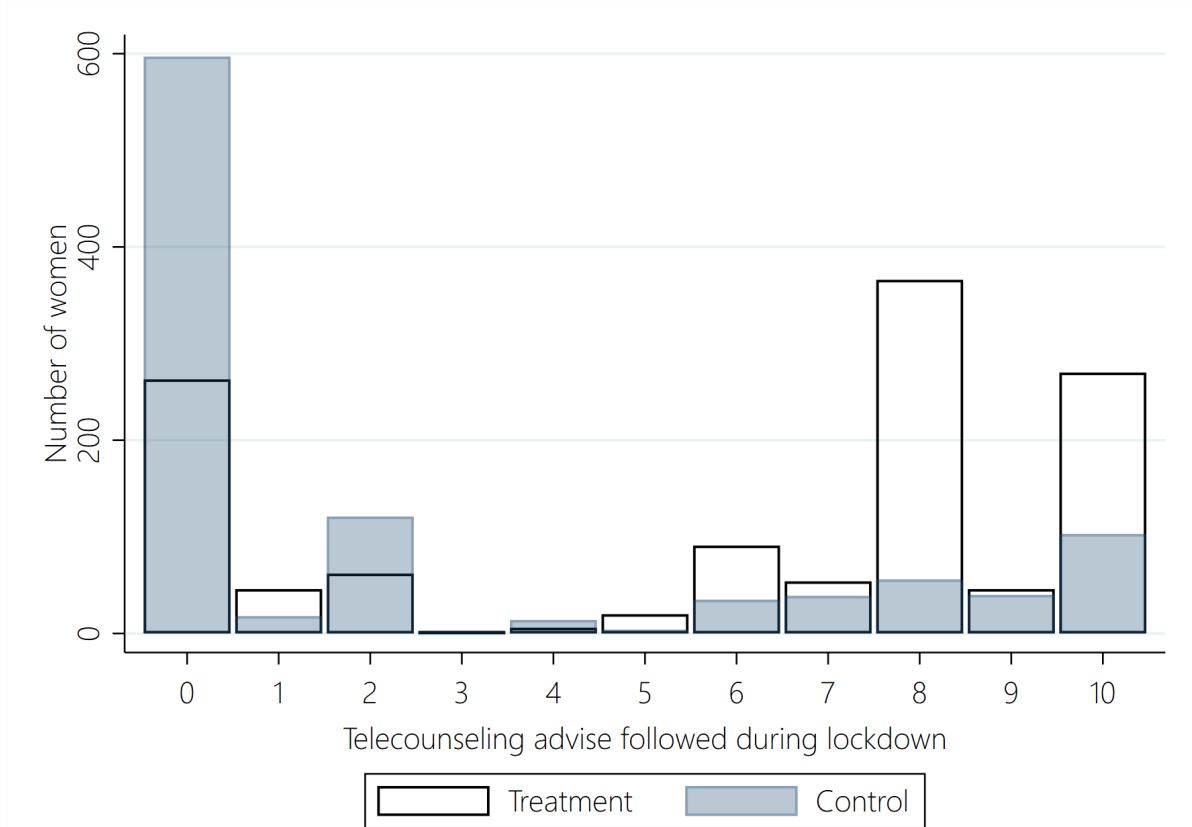
Note: This figure shows the frequency of women that could recall our telecounseling advice and have followed them during the April-August 2021 nationwide lockdown. Throughout our intervention, we provided the following 10 advice to participants: (1) talking and discussing problems to family members within the household, (2) talking to neighbors (while maintaining 2-3 arms distance), (3) avoid blaming oneself if something unexpected happens, (4) walking in the backyard, (5) breathing exercise, (6) praying, (7) talking to relatives or family members over the phone, (8) spending quality time with children, (9) sharing problems with someone they trust, and (10) contacting doctors if they or any household member have health problems or COVID-19 symptoms. In this figure, 0 corresponds to not being able to recall and follow any advice, 1 corresponds to recalling and following advice (1), and so on. Women in the treatment group were asked, *"We gave you some advice about your emotional well-being during the previous lockdown. Are you following any of this advice? If yes, please name the ones you are regularly practising in the current lockdown?"*. Since telecounseling was not provided to women in the control arm, they were asked, *"There are certain ways to take care of your emotional well-being. Are you familiar with any of them? If yes, please name the ones you are regularly practising in the current lockdown?"*. This question was unprompted and enumerators passively recorded responses (i.e., giving 'ticks' to advice from the checklist).

Figure A5: New income generating activities, by treatment arm
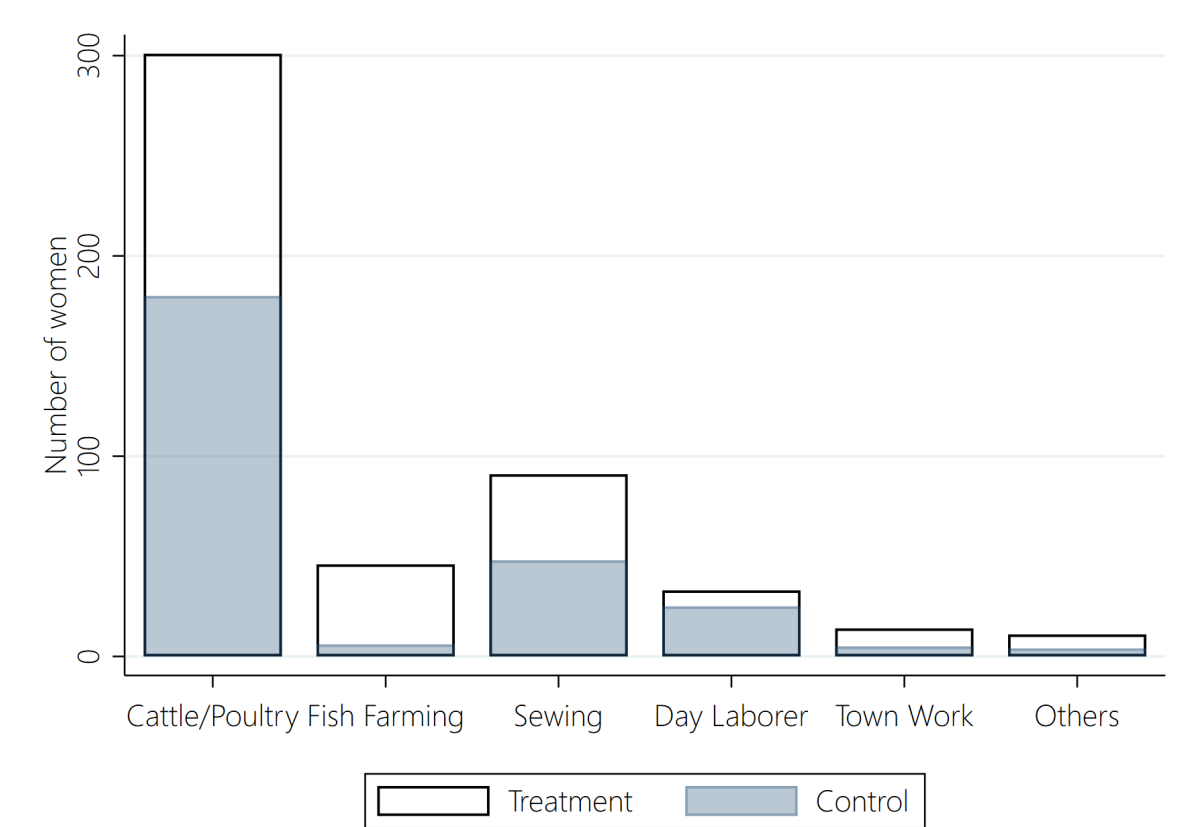
Note: This figure shows the frequency of women that started new income generating activities in the last 10 months. Enumerators were given a list of the 6 most common income generating activities in the village context: (1) cattle or poultry farming, (2) fish farming, (3) sewing, making clothes, or hand embroidery, (4) daily wage laborer, (5) going to the town or city for work, (6) other types of activities. This question was unprompted and enumerators passively recorded responses (i.e., giving 'ticks' on a checklist).

A.2 Tables

Table A1: Teleocounseling preparation

Preparations	Details	Days
Module preparation	4 modules	30
Advertising and hiring of paracounselors	18 paracounselors	-
General training of paracounselors	3 hours per module	4
1-on-1 mock telecounseling with a trainer	30 mins per module, per paracounselor	-
Pilot/field-test of the modules with trainers	-	4
Feedback to paracounselors on pilot/field-test	-	1
Total	-	**39**

Note: Our initial module preparation took 30 days (available here). Module preparation was carried out in parallel with advertising and hiring of paracounselors (the latter took 4 days). General training of paracounselors and 1-on-1 mock telecounseling were also carried out in parallel for 4 days (1 day per module). Two public health experts (including Tabassum Rahman) were involved in the 1-on-1 mock telecounseling; two public health experts and a psychologist were involved in the field-test and feedback session; and, all four trainers (two public health experts, a psychologist, and a GDRI executive) were involved in the general training. 'Total' is the telecounseling preparation time of our study.

Table A2: Balance between takers and non-takers

Variables	Takers (95%) (*Std. Dev.*)	Non-Takers (5%) (*Std. Dev.*)	T-test *p*-values
Age of women/respondent	35.51	35.54	0.049
	(9.44)	*(6.78)*	
Education of women/respondent	8.39	8.34	0.189
	(2.67)	*(2.07)*	
Age of spouse	38.13	38.08	0.193
	(7.95)	*(6.94)*	
Education of spouse	8.14	8.13	0.241
	(3.35)	*(2.80)*	
Number of household members	4.39	4.49	0.654
	(1.37)	*(1.37)*	
Monthly household income	9,218	9,038	0.702
	(6,974)	*(5,875)*	
Number of children under five	0.56	0.56	0.523
	(0.74)	*(0.81)*	
Sample Size	2,402	131	-

Note: 'Takers' are women who agreed to participate in the study and were surveyed at baseline (95% of 2,533 women), whereas 'Non-Takers' are women who did not agree to participate in the study and hence were not surveyed (5% of 2,533 women). Age and education are in years. Income is in Bangladeshi Taka. The remaining variables are self-explanatory. T-test *p*-values are derived from linear regression, with the variable of interest as the dependent variable and the treatment indicator as an independent variable with union council fixed effects and standard errors clustered at the village level.

Table A3: Comparison of rural HIES 2016 sample and study sample characteristics

	A: HIES Rural with mobile phone		B: Our Study Sample	
	Mean (*Std. Dev.*)	**Obs.**	**Mean** (*Std. Dev.*)	**Obs.**
Monthly income	9,494 (10,416)	24,343	9,218 (6,974)	2,402
Number of household members	4.11 (1.46)	24,343	4.39 (1.37)	2,402
Age of women	35.53 (11.35)	23,559	35.51 (9.44)	2,402
Age of spouse	42.13 (12.57)	22,020	38.13 (7.95)	2,402
Education of women	4.27 (3.86)	23,559	8.39 (2.67)	2,402
Education of spouse	4.29 (4.34)	22,020	8.14 (3.35)	2,402
Number of children under five	0.52 (0.68)	24,343	0.56 (0.74)	2,402
Occupation (=1 if agriculture)	0.40 (0.49)	24,343	0.27 (0.45)	2,402

Note: HIES or Bangladesh Household Income and Expenditure Survey was collected in 2016 by Bangladesh Bureau of Statistics (2016). The total HIES sample consists of 46,076 households, among which 32,096 (roughly 70% of total) are in rural areas and 24,343 (roughly 53% of total) are in rural areas and the household heads have at least one mobile phone. Reported summary statistics under *A: HIES Rural with mobile phone* is for rural households in HIES data with at least one mobile phone per household. While, *B: Our study sample* reports characteristics of respondents who are also the owner of their mobile phones. Income reported is in Bangladeshi Taka. *Age* and *Education* of the spouse corresponds to age and education of head of households in HIES data (in case the household head is a female, we took the age and education of her spouse). Likewise, *Age* and *Education* of women corresponds to age and education of spouses of household heads in HIES data (in case the household head is a female, we took the age and education of the household head). Both age and education are measured in years. Occupation is a binary variable that equals 1 if the household head's primary occupation is in agriculture, and 0 otherwise.

Table A4: Session participation in the treatment arm

	No. of participants	% of 1,299
All four sessions	1,248	96.07
Three sessions	1,252	96.38
Two sessions	1,261	97.07
One session	1,272	97.92
Did not participate in any session	27	2.08
Total participants	1,299	-

Note: This table reports the frequency of participation in telecounseling sessions in the treatment arm, where $N = 1,299$. Participants in our intervention could never skip previous sessions before participating in future sessions. For instance, if a participant could not be reached during the 1st session period but could be reached during the 2nd, she was always given the missed 1st session before giving the 2nd. Similarly, after attending the 1st session, if a participant could not be reached during the 2nd and 3rd session periods but could be reached during the 4th session period, she was always given the missed sessions first. Thus, in this table, 'One session' also means women who participated in the 1st session, 'Two sessions' means participated in 1st and 2nd sessions, and 'Three sessions' means participated in 1st, 2nd, and 3rd sessions.

Table A5: Frequency of attrition at endline surveys

	Treatment		Control		Total	
	N	**%**	**N**	**%**	**N**	**%**
(1) Never attrited at any endline	1,165	89.68	959	86.94	2,124	88.43
(2) Attrited at both endlines	25	1.92	27	2.45	52	2.16
(3) Attrited at endline 1 but not 2	61	4.70	69	6.26	130	5.41
(4) Attrited at endline 2 but not 1	48	3.70	48	4.35	96	4.00
Total	**1,299**	**100**	**1,103**	**100**	**2,402**	**100**

Note: This table reports the frequency of attrition at endline surveys. For both endline surveys, all 2,402 women from baseline were approached. Row (1) reports the number of women who participated in both endlines; Row (2) reports the number of women who could not be reached for survey at either endlines; Row (3) reports the number of women who took part in the 1-month endline but not in the 10-month endline; Row (4) reports the number of women who took part in the 10-month endline but not in the 1-month endline.

Table A6: Attrition, by treatment and individual characteristics

	A: 1-month endline			B: 10-month endline		
	Control	**Treat**	**Pooled**	**Control**	**Treat**	**Pooled**
VARIABLES	(1)	(2)	(3)	(4)	(5)	(6)
Treatment			-0.042			-0.079
			(0.087)			(0.070)
Age	0.000	-0.000	0.000	0.001	0.003***	0.001
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
Age×Treat			-0.000			0.002*
			(0.001)			(0.001)
Education	0.002	0.001	0.002	0.001	-0.000	0.001
	(0.004)	(0.002)	(0.004)	(0.003)	(0.002)	(0.003)
Education×Treat			-0.001			-0.001
			(0.004)			(0.004)
HH chores increased	-0.018	0.010	-0.018	-0.004	0.012	-0.004
	(0.023)	(0.017)	(0.023)	(0.018)	(0.016)	(0.018)
HH chores increased×Treat			0.029			0.016
			(0.027)			(0.024)
Help on HH chores	-0.006	0.006	-0.006	0.004	-0.000	0.004
	(0.020)	(0.014)	(0.020)	(0.016)	(0.013)	(0.016)
Help on HH chores×Treat			0.012			-0.005
			(0.025)			(0.021)
Trusts neighbors	0.001	0.019	0.001	0.033	0.034*	0.033
	(0.022)	(0.019)	(0.022)	(0.022)	(0.019)	(0.022)
Trusts neighbors×Treat			0.018			0.000
			(0.029)			(0.029)
COVID-19 perception index	0.035	-0.053	0.035	0.087	0.004	0.087
	(0.053)	(0.042)	(0.053)	(0.054)	(0.037)	(0.054)
COVID-19 perception index×Treat			-0.088			-0.083
			(0.064)			(0.062)
Worried: well-being of family	-0.016	0.008	-0.016	-0.018	0.017	-0.018
	(0.019)	(0.014)	(0.019)	(0.015)	(0.014)	(0.015)
Worried: well-being of family×Treat			0.024			0.034
			(0.024)			(0.021)
Worried: food for family	-0.000	-0.004	-0.000	0.012	0.004	0.012
	(0.023)	(0.022)	(0.023)	(0.022)	(0.017)	(0.022)
Worried: food for family×Treat			-0.004			-0.008
			(0.030)			(0.026)
Worried: income	-0.038	0.002	-0.038	-0.001	-0.021	-0.001
	(0.027)	(0.023)	(0.027)	(0.022)	(0.020)	(0.022)
Worried: income×Treat			0.040			-0.020
			(0.035)			(0.028)
Worried: well-being of relatives	0.026	-0.020	0.026	0.014	-0.030	0.014
	(0.024)	(0.019)	(0.024)	(0.021)	(0.021)	(0.021)

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Worried: well-being of relatives×Treat			-0.045			-0.044
			(0.031)			(0.030)
Afraid of contracting coronavirus	-0.007	-0.003	-0.007	-0.007	0.001	-0.007
	(0.005)	(0.003)	(0.005)	(0.005)	(0.003)	(0.005)
Afraid of contracting coronavirus×Treat			0.004			0.008
			(0.006)			(0.006)
Scared of: socializing	0.029	0.023	0.029	0.004	0.016	0.004
	(0.023)	(0.022)	(0.022)	(0.026)	(0.016)	(0.026)
Scared of: socializing×Treat			-0.006			0.012
			(0.030)			(0.031)
Scared of: home visitors	0.096	-0.031	0.096	0.114	-0.035	0.114
	(0.126)	(0.055)	(0.126)	(0.074)	(0.054)	(0.074)
Scared of: home visitors×Treat			-0.127			-0.149
			(0.141)			(0.092)
Scared of: going outside	-0.096	0.057	-0.096	-0.072	0.085	-0.072
	(0.131)	(0.057)	(0.131)	(0.081)	(0.053)	(0.081)
Scared of: going outside×Treat			0.153			0.157
			(0.131)			(0.098)
Feeling: anxious	0.038*	0.003	0.038*	0.017	-0.004	0.017
	(0.022)	(0.022)	(0.022)	(0.020)	(0.019)	(0.020)
Feeling: anxious×Treat			-0.035			-0.021
			(0.028)			(0.026)
Feeling: lonely	0.004	0.007	0.004	0.010	-0.009	0.010
	(0.024)	(0.017)	(0.024)	(0.020)	(0.017)	(0.020)
Feeling: lonely×Treat			0.003			-0.019
			(0.029)			(0.025)
Feeling: hopeless	-0.004	0.010	-0.004	0.010	0.024	0.010
	(0.019)	(0.016)	(0.019)	(0.018)	(0.015)	(0.017)
Feeling: hopeless×Treat			0.015			0.013
			(0.024)			(0.022)
Feeling: worthless	-0.002	0.051*	-0.002	-0.008	0.035	-0.008
	(0.027)	(0.029)	(0.027)	(0.023)	(0.028)	(0.023)
Feeling: worthless×Treat			0.053			0.044
			(0.039)			(0.036)
Observations	1,103	1,299	2,402	1,103	1,299	2,402
R-squared	0.015	0.009	0.013	0.014	0.029	0.022
Attrition rate	0.09	0.07	0.08	0.07	0.06	0.06
Joint F-test p-value on characteristics	0.70	0.92	0.70	0.55	0.00	0.55
Joint F-test p-value on interactions	-	-	0.43	-	-	0.34

Robust standard errors clustered at the village level are in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Note: All columns present estimates using a linear probability model, where the dependent variable is attrition, a binary variable that equals to 1 if a woman did not participate in the endline survey and 0 if she participated in both baseline and endline surveys. The sample in columns 1 and 4 is women in the control group and the sample in columns 2 and 5 is women in the treatment group. Columns 3 and 6 pools all samples together and interacts the treatment dummy variable (=1 if treatment group) with individual characteristics. Overall attrition rate is roughly 7.6% in 1-month endline (182 out of 2,402 women) and 6.2% in 10-month endline (148 out of 2,402 women).

Table A7: Attrition, by treatment and household characteristics

	A: 1-month endline			B: 10-month endline		
	Control	Treat	Pooled	Control	Treat	Pooled
VARIABLES	(1)	(2)	(3)	(4)	(5)	(6)
Treatment			-0.051			-0.049
			(0.101)			(0.080)
Age of spouse	-0.000	-0.001	-0.000	0.001	0.003***	0.001
	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
Age of spouse×Treat			-0.001			0.002
			(0.001)			(0.001)
Education of spouse	0.002	0.004*	0.002	0.001	0.002	0.001
	(0.003)	(0.002)	(0.003)	(0.002)	(0.002)	(0.002)
Education of spouse×Treat			0.001			0.001
			(0.003)			(0.003)
Number of household members	-0.013*	-0.005	-0.013*	0.006	0.006	0.006
	(0.007)	(0.005)	(0.007)	(0.007)	(0.004)	(0.007)
Number of household members×Treat			0.009			-0.000
			(0.008)			(0.008)
Monthly household income	-0.000	-0.000	-0.000	-0.000	-0.000***	-0.000
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Monthly household income×Treat			-0.000			-0.000
			(0.000)			(0.000)
Experienced income loss	-0.042	0.017	-0.042	-0.001	0.004	-0.001
	(0.043)	(0.031)	(0.043)	(0.029)	(0.029)	(0.029)
Experienced income loss×Treat			0.059			0.005
			(0.054)			(0.042)
Experienced complete income loss	-0.000	-0.009	-0.000	0.015	-0.009	0.015
	(0.019)	(0.015)	(0.019)	(0.016)	(0.014)	(0.016)
Experienced complete income loss×Treat			-0.009			-0.024
			(0.023)			(0.021)
HH head works in agriculture	-0.003	-0.006*	-0.003	0.001	-0.006*	0.001
	(0.004)	(0.004)	(0.004)	(0.004)	(0.003)	(0.004)
HH head works in agriculture×Treat			-0.003			-0.007
			(0.006)			(0.005)
Number of children under five	0.011	0.002	0.011	-0.011	-0.009	-0.011
	(0.012)	(0.010)	(0.012)	(0.009)	(0.008)	(0.009)
Number of children under five×Treat			-0.009			0.002
			(0.016)			(0.012)
Observations	1,103	1,299	2,402	1,103	1,299	2,402
R-squared	0.007	0.006	0.008	0.004	0.018	0.011
Attrition rate	0.09	0.07	0.08	0.07	0.06	0.06
Joint F-test p-value on characteristics	0.50	0.34	0.50	0.90	0.01	0.90

Joint F-test *p*-value on interactions	-	-	0.51	-	-	0.30

Note: All columns present estimates using a linear probability model, where the dependent variable is attrition, a binary variable that equals to 1 if a woman did not participate in the endline survey and 0 if she participated in both baseline and endline surveys. The sample in column 1 is household characteristics of women in the control group and the sample in column 2 is that in the treatment group. Column 3 pools all samples together and interacts the treatment dummy (=1 if treatment group) with household characteristics. Overall attrition rate is roughly 7.6% (182 out of 2,401 women did not participate in the endline).

Table A8: Attrition at 1-month: Inverse Probability Weighting & Lee bounds

| | | | Lee (2009) bounds | |
| | Unadjusted | IPW | Lower | Upper |
Dependent variables	(1)	(2)	(3)	(4)
A: Pre-specified outcomes				
Perceived stress‡	-0.696***	-0.696***	-0.782***	-0.663***
	(0.059)	(0.058)	(0.052)	(0.056)
Depression severity‡	-0.652***	-0.648***	-0.685***	-0.514***
	(0.050)	(0.049)	(0.046)	(0.041)
Happiness	0.219***	0.221***	0.227***	0.277***
	(0.042)	(0.042)	(0.041)	(0.044)
Life satisfaction	0.234***	0.236***	0.235***	0.288***
	(0.045)	(0.044)	(0.041)	(0.044)
Future aspirations	0.374***	0.372***	0.394***	0.456***
	(0.044)	(0.043)	(0.041)	(0.045)
COVID-19 Compliance	1.189***	1.174***	1.153***	1.223***
	(0.048)	(0.047)	(0.044)	(0.051)
B: Additional outcomes				
Food insecurity‡	-0.276***	-0.275***	-0.323***	-0.302***
	(0.041)	(0.041)	(0.049)	(0.043)
Time-intensive parental investments	0.220***	0.210***	-0.073	0.556***
	(0.057)	(0.056)	(0.060)	(0.059)
Confidence about tackling COVID-19	0.396***	0.394***	0.379***	0.438***
	(0.048)	(0.047)	(0.041)	(0.046)
Gender empowerment	0.101**	0.100**	0.131***	0.178***
	(0.049)	(0.049)	(0.044)	(0.049)
Attitudes toward gender norms	0.149***	0.141***	0.163***	0.163***
	(0.046)	(0.044)	(0.053)	(0.054)
Attitudes toward IPV	0.231***	0.224***	0.241***	0.245***
	(0.043)	(0.042)	(0.047)	(0.044)

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: All outcomes are standardized indices, such that the control group has mean 0 and standard deviation 1. Column (1) reports unadjusted/unweighted treatment effects, same as column (2) in Tables 2 and 3. Column (2) reports the Inverse Probability Weight (IPW) adjusted treatment effects. Columns (3) and (4) report the lower and the upper bounds on the treatment effects using Lee (2009) bounds. The trimming proportion using Lee (2009) bounds is 0.022. For outcomes with ‡, negative coefficients mean more favorable outcomes.

Table A9: Effects on index components: time-intensive parental investment

VARIABLES	1-month		10-month	
	Education	Playing	Education	Playing
	(1)	(2)	(3)	(4)
Treatment (=1 if treated)	0.094***	0.019	0.052***	0.031
	(0.022)	(0.032)	(0.019)	(0.029)
Control arm mean	0.741	0.478	0.833	0.700
	[0.438]	[0.500]	[0.374]	[0.459]
All controls	Yes	Yes	Yes	Yes
Observations	1,714	1,506	1,920	1,663
R-squared	0.095	0.090	0.109	0.106

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at 1- and 10-month endlines (with standard deviations in brackets). Dependent variables correspond to the 2 questions listed under "Time-intensive parental investment" in Appendix B.4 and are binary (=1 if response to the respective question is the maximum two points implying higher investment and 0 otherwise, all answered on a 5-point Likert scale).

Table A10: Treatment effects on pre-specified outcomes: binary outcomes

		Treatment effects			
	Control mean	Without covar.	With covar.	Stressed baseline	FWER p-val.
Dependent variables	(1)	(2)	(3)	(4)	(5)

		A: 1-month Endline			
***A.1. Mental health outcomes*[‡]**					
Stressed (=1 if stressed)	0.858	-0.229***	-0.220***	-0.234***	0.000
	[0.349]	(0.023)	(0.022)	(0.023)	
Depressed (=1 if depressed)	0.351	-0.200***	-0.207***	-0.210***	0.000
	[0.477]	(0.026)	(0.025)	(0.027)	
A.2. Secondary outcomes					
Happiness (=1 if happy)	0.614	0.166***	0.158***	0.164***	0.000
	[0.487]	(0.023)	(0.022)	(0.024)	
Life satisfaction (=1 if satisfied)	0.679	0.123***	0.122***	0.120***	0.000
	[0.467]	(0.022)	(0.022)	(0.024)	
Future aspirations (=1 if high aspirations)	0.434	0.156***	0.150***	0.160***	0.000
	[0.496]	(0.027)	(0.025)	(0.027)	
COVID-19 compliance (=1 if compliant)	0.240	0.499***	0.499***	0.503***	0.000
	[0.427]	(0.020)	(0.019)	(0.022)	
		B: 10-month Endline			
***B.1. Mental health outcomes*[‡]**					
Stressed (=1 if stressed)	0.957	-0.202***	-0.195***	-0.187***	0.000
	[0.203]	(0.018)	(0.018)	(0.018)	
Depressed (=1 if depressed)	0.583	-0.193***	-0.191***	-0.174***	0.000
	[0.493]	(0.030)	(0.029)	(0.031)	

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model. Column (1): control group means at the endline (with standard deviations in brackets). Column (2): treatment effect estimated without any baseline covariates. Column (3): treatment effect estimated with all baseline covariates (as in equation 1). Column (4): treatment effect only on women that were found to be stressed at the baseline, with all covariates. Standard errors, clustered at the village level, are in parentheses in columns (2)-(4). Column (5) reports FWER p-values for the full model (as in column 3), which are the Westfall-Young familywise error rate adjusted p-values (with 1,000 replications) (Westfall & Young, 1993). For outcomes with [‡], negative coefficients mean more favorable outcomes. N at 1-month is 2,220 and at 10-month is 2,254.

Table A11: Effects on index components: COVID-19 compliance

VARIABLES	Hand wash 1 (1)	Hand wash 2 (2)	Go outside 1 (3)	Go outside 2 (4)	Distancing (5)	Face mask (6)	Cough or sneeze (7)
Treatment (=1 if treated)	0.230***	0.238***	0.045***	0.044**	0.171***	0.052***	0.450***
	(0.018)	(0.020)	(0.015)	(0.022)	(0.025)	(0.009)	(0.020)
Control arm mean	0.666	0.642	0.876	0.808	0.597	0.939	0.488
	[0.472]	[0.480]	[0.330]	[0.394]	[0.491]	[0.239]	[0.500]
All controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	2,220	2,219	2,220	2,220	2,210	2,218	2,211
R-squared	0.141	0.126	0.064	0.082	0.087	0.083	0.324

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at endline (with standard deviations in brackets). Dependent variables in columns 1-7 correspond to the 7 questions listed under "Compliance with COVID-19 precautionary measures" in Appendix B.3 and are binary (=1 if response to the respective question is the maximum two points implying higher compliance and 0 otherwise, all answered on a 5-point Likert scale).

Table A12: Effects on index components: confidence about tackling COVID-19

VARIABLES	Keep safe (1)	Self precautions (2)	Family precautions (3)	Manage if infected (4)	Ask for help (5)
Treatment (=1 if treated)	0.201***	0.233***	0.193***	0.157***	0.180***
	(0.020)	(0.020)	(0.020)	(0.024)	(0.027)
Control arm mean	0.685	0.681	0.676	0.630	0.544
	[0.465]	[0.466]	[0.468]	[0.483]	[0.498]
All controls	Yes	Yes	Yes	Yes	Yes
Observations	2,220	2,220	2,220	2,220	2,220
R-squared	0.113	0.134	0.111	0.094	0.109

Robust standard errors clustered at the village level are in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at endline (with standard deviations in brackets). Dependent variables in columns 1-5 correspond to the 5 questions listed under "Confidence in dealing with COVID-19 issues" in Appendix B.4 and are binary (=1 if response to the respective question is above the median value implying higher confidence and 0 otherwise, all answered on a 11-point response scale).

Table A13: Treatment effects on additional outcomes: binary outcomes

		Treatment effects			
Dependent variables	Control mean	Without covar.	With covar.	Stressed baseline	FWER *p*-val.
	(1)	(2)	(3)	(4)	(5)
		A: 1-month Endline			
Food insecurity[‡] (=1 if food insecure)	0.689	-0.206***	-0.191***	-0.194***	0.000
	[0.463]	(0.023)	(0.022)	(0.025)	
Time-intensive parental investments (=1 if invests more)	0.663	0.070***	0.072***	0.083***	0.006
	[0.473]	(0.023)	(0.023)	(0.025)	
Confidence about tackling COVID-19 (=1 if confident)	0.423	0.129***	0.124***	0.125***	0.000
	[0.494]	(0.026)	(0.025)	(0.028)	
Gender empowerment (=1 if empowered)	0.551	0.171***	0.163***	0.160***	0.000
	[0.498]	(0.024)	(0.024)	(0.026)	
Attitudes toward gender norms (=1 if improved attitudes)	0.458	0.085***	0.075***	0.067***	0.011
	[0.498]	(0.023)	(0.023)	(0.026)	
Attitudes toward IPV (=1 if improved attitudes)	0.357	0.070***	0.057***	0.055**	0.059
	[0.479]	(0.022)	(0.022)	(0.024)	
		B: 10-month Endline			
Food insecurity[‡] (=1 if food insecure)	0.863	-0.197***	-0.191***	-0.185***	0.000
	[0.344]	(0.020)	(0.020)	(0.022)	
Time-intensive parental investments (=1 if invests more)	0.573	0.077***	0.061**	0.058*	0.059
	[0.495]	(0.026)	(0.026)	(0.030)	
Risk-seeker (=1 if above median)	0.368	0.283***	0.284***	0.291***	0.000
	[0.482]	(0.021)	(0.020)	(0.021)	
Altruistic (=1 if above median)	0.400	0.207***	0.199***	0.209***	0.000
	[0.490]	(0.022)	(0.022)	(0.024)	
Delay gratification (=1 if above median)	0.532	-0.035	-0.042	-0.038	0.225
	[0.499]	(0.029)	(0.029)	(0.031)	
Covid-19 vaccination (=1 if vaccinated)	0.216	0.059***	0.058***	0.053***	0.059
	[0.412]	(0.018)	(0.018)	(0.020)	

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model. Column (1): control group means at the endline (with standard deviations in brackets). Column (2): treatment effect estimated without any baseline covariates. Column (3): treatment effect estimated with all baseline covariates (as in equation 1). Column (4): treatment effect only on women that were found to be stressed at the baseline, with all covariates. Standard errors, clustered at the village level, are in parentheses in columns (2)-(4). Column (5) reports FWER *p*-values for the full model (as in column 3), which are the Westfall-Young familywise error rate adjusted p-values (with 1,000 replications) (Westfall & Young, 1993). For outcomes with [‡], negative coefficients mean more favorable outcomes. *N* at 1-month is 2,220 and at 10-month is 2,254.

Table A14: Effects on index components: gender empowerment

VARIABLES	Own income (1)	Own savings (2)	Spouse income (3)	Spouse savings (4)	Spending food (5)	Finances (6)	Child education (7)	Child health (8)	Go anywhere (9)
Treatment (=1 if treated)	0.029	0.009	0.289***	0.100***	0.154***	0.140***	0.020	0.023	0.057**
	(0.025)	(0.021)	(0.025)	(0.031)	(0.023)	(0.023)	(0.017)	(0.017)	(0.023)
Control arm mean	0.853	0.889	0.500	0.677	0.617	0.629	0.856	0.849	0.643
	[0.354]	[0.314]	[0.500]	[0.468]	[0.486]	[0.483]	[0.352]	[0.358]	[0.479]
All controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	920	1,148	2,131	1,162	2,218	2,220	2,131	2,181	2,216
R-squared	0.094	0.058	0.142	0.107	0.070	0.067	0.071	0.064	0.057

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at endline (with standard deviations in brackets). Dependent variables in columns 1-9 correspond to the 9 questions listed under "Gender empowerment" in Appendix B.4 and are binary (=1 if response to the respective question is either "own" or "joint decision", and 0 otherwise).

Table A15: Effects on index components: attitudes toward gender norms

VARIABLES	Home decision (1)	Society decision (2)	Women decision (3)	Equal rights (4)	Disagree (5)
Treatment (=1 if treated)	0.259***	0.038**	-0.180***	0.020*	0.012
	(0.022)	(0.015)	(0.022)	(0.011)	(0.022)
Control arm mean	0.232	0.156	0.419	0.915	0.702
	[0.423]	[0.363]	[0.494]	[0.279]	[0.458]
All controls	Yes	Yes	Yes	Yes	Yes
Observations	2,219	2,217	2,197	2,216	2,207
R-squared	0.130	0.074	0.086	0.046	0.041

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at endline (with standard deviations in brackets). Dependent variables in columns 1-5 correspond to the 5 questions listed under "Attitudes toward gender norms" in Appendix B.4 and are binary (=1 if response to the respective question is the maximum two points implying improved attitudes and 0 otherwise, all answered on a 5-point response scale).

Table A16: Effects on index components: attitudes toward IPV

VARIABLES	Without permission (1)	Child care (2)	Argument (3)	Cooking (4)
Treatment (=1 if treated)	0.015	-0.091***	0.119***	0.159***
	(0.022)	(0.022)	(0.023)	(0.019)
Control arm mean	0.621	0.391	0.357	0.726
	[0.485]	[0.488]	[0.479]	[0.446]
All controls	Yes	Yes	Yes	Yes
Observations	2,220	2,220	2,220	2,220
R-squared	0.095	0.094	0.117	0.100

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from a linear probability model (with standard errors in parentheses). 'Treatment' is an indicator for the telecounseling treatment. 'Control Mean' shows the means of women in the control arm, measured at endline (with standard deviations in brackets). Dependent variables in columns 1-4 correspond to the 4 questions listed under "Attitudes toward intimate partner violence" in Appendix B.4 and are binary (=1 if disagrees to statements regarding IPV and 0 otherwise).

Table A17: Social desirability bias check using pre-specified outcomes

| VARIABLES | Perceived stress | | Depression | | Compliance | Happiness | Life satisfaction | Aspirations |
| | Endline 1 | Endline 2 | Endline 1 | Endline 2 | Endline 1 | Endline 1 | Endline 1 | Endline 1 |
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	-0.688***	-0.468***	-0.670***	-0.413***	1.117***	0.109	0.108	0.378***
	(0.100)	(0.123)	(0.090)	(0.093)	(0.087)	(0.085)	(0.086)	(0.078)
SDB Score	-0.001	0.028**	-0.013	0.028**	-0.003	-0.010	-0.014	0.005
	(0.011)	(0.013)	(0.011)	(0.011)	(0.010)	(0.011)	(0.011)	(0.010)
Treatment×SDB Score	0.002	-0.016	0.006	-0.019	0.011	0.018	0.021	-0.002
	(0.016)	(0.018)	(0.013)	(0.015)	(0.013)	(0.014)	(0.013)	(0.012)
All other controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Union council FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Observations	2,124	2,254	2,124	2,254	2,124	2,124	2,124	2,124
R-squared	0.201	0.160	0.197	0.190	0.332	0.114	0.107	0.130

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from OLS. DB Score or the social desirability bias score is a score between 0 and 10, and is based on respondents' opinion to the following statement *"I want to be a respectful person in my village"*, where 10 indicates that a respondent fully agrees with the statement and 0 indicates that a respondent does not agree with the statement at all.

Table A18: Social desirability bias: additional 1-month outcomes

VARIABLES	Food insecurity	Child investment	COVID-19 Confidence	Gender empowerment	Attitude norms	Attitude IPV
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	-0.445***	0.232**	0.301***	0.127	0.291***	0.416***
	(0.080)	(0.102)	(0.080)	(0.090)	(0.097)	(0.080)
SDB Score	-0.009	0.016	0.001	0.005	0.015	0.010
	(0.010)	(0.012)	(0.010)	(0.011)	(0.011)	(0.010)
Treatment×SDB Score	0.031**	-0.002	0.016	-0.004	-0.024	-0.031**
	(0.013)	(0.015)	(0.011)	(0.014)	(0.015)	(0.013)
All other controls	Yes	Yes	Yes	Yes	Yes	Yes
Union council FE	Yes	Yes	Yes	Yes	Yes	Yes
Observations	2,124	1,724	2,124	2,124	2,124	2,124
R-squared	0.162	0.099	0.152	0.075	0.076	0.101

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from OLS. SDB Score or the social desirability bias score is a score between 0 and 10, and is based on respondents' opinion to the following statement *"I want to be a respectful person in my village"*, where 10 indicates that a respondent fully agrees with the statement and 0 indicates that a respondent does not agree with the statement at all.

Table A19: Social desirability bias: additional 10-month outcomes

VARIABLES	Food insecurity (1)	Child investment (2)	Vaccine (3)	Risk seeking (4)	Altruistic (5)	Delay gratification (6)
Treatment	-0.457***	0.316***	0.105***	0.647***	0.772***	0.025
	(0.083)	(0.090)	(0.038)	(0.101)	(0.090)	(0.100)
SDB Score	0.021**	0.015	0.014***	0.051***	0.034***	0.000
	(0.009)	(0.011)	(0.004)	(0.012)	(0.011)	(0.012)
Treatment×SDB Score	-0.012	-0.023*	-0.009	-0.040**	-0.063***	-0.004
	(0.013)	(0.014)	(0.006)	(0.016)	(0.015)	(0.017)
All other controls	Yes	Yes	Yes	Yes	Yes	Yes
Union council FE	Yes	Yes	Yes	Yes	Yes	Yes
Observations	2,254	1,978	2,254	2,254	2,254	2,254
R-squared	0.194	0.149	0.132	0.106	0.129	0.069

Robust standard errors clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: Treatment effects are estimated from OLS. SDB Score or the social desirability bias score is a score between 0 and 10, and is based on respondents' opinion to the following statement *"I want to be a respectful person in my village"*, where 10 indicates that a respondent fully agrees with the statement and 0 indicates that a respondent does not agree with the statement at all. Only the 'vaccine' outcome is a dummy (=1 if got vaccinated), while the remaining outcomes are control group-standardized indices.

Table A20: Heterogeneity by baseline stress: adjusting for spurious correlations

Dependent variables	Coefficient on interaction (1)	Coefficient on interaction (2)
	A: 1-month	**B: 10-month**
Mental health outcomes[‡]		
Perceived stress	-0.244**	0.158
	(0.097)	(0.112)
Depression severity	-0.183**	0.035
	(0.086)	(0.099)
Secondary outcomes		
Happiness	0.152*	-
	(0.082)	
Life satisfaction	0.117	-
	(0.082)	
Future aspirations	0.046	-
	(0.085)	
COVID-19 Compliance	0.154*	-
	(0.088)	
All controls	✓	✓
No. Children×Treatment	✓	✓
HH Chores×Treatment	✓	✓

Robust SE clustered at the village level are in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Note: This table recreates column (3) from Table 4. At both end-lines, only the 'number of children (No. Children)' and 'whether respondent's household chores increased following the lockdown (HH Chores)' were correlated with high/low PSS score. We interacted both 'No. Children' and 'HH Chores' with the treatment dummy, added as additional controls, and recreated column (3) from Table 4. We report the 1-month endline results in Column (1) and 10-month endline results in Column (2).

Table A21: Cost of the intervention

Cost details	Unit	Per unit cost (USD)	Total cost (USD)
A: Fixed cost			
Office space and equipment (one office)	3 months	150	450
Rent for the GDRI training center	2 days	60	120
Salary of one program management staff from GDRI	3 months	250	750
Development of session modules	4 modules	150	600
B: Variable cost			
Advertisement to recruit para-counselors	1 advert	35	35
Cost of hiring 18 para-counselors (out of 30 applicants)	30 applicants	5	150
Salary of the external trainer	4 days	75	300
Other para-counselors training cost	4 days	150	600
Salary of para-counselors (4 sessions×12 days)	18 para-counselors	12.5	10,800
Mobile top-up for para-counselors (4 sessions×25 minutes)	129,900 minutes	0.0075	974.25
Mobile top-up for participants (twice)	1,299 participants	1.25	3,247.5
C: Total cost (A + B)	-	-	**18,026.75**
D: Per unit cost of the intervention (cost per treated woman)	-	-	**13.88**

Note: All costs are in USD and in 2020 value.

B Appendix: Data, Survey, and Additional Analysis

B.1 Standardized index construction

Out of the 16 outcome variables, 10 outcomes are indices constructed by aggregating responses to several individual questions from the survey, and 5 outcome variables – *happiness*, *life satisfaction*, and *economic preferences* – are also indices but are constructed using response scales to single questions. Finally, *vaccination* is measured using a binary response and has not been standardized. The remaining 15 outcomes have been control group-standardized following Kling et al. (2007), so that each variable has mean 0 and standard deviation 1 for the control group. Specifically, we follow the following steps to construct the outcome indices:

1. All questions from the questionnaire are answered on a specific scale (e.g., 5-point Likert scale). For 5-point scale questions, we assign values 0-4 to each point, such that 0 corresponds to "Never" and 4 corresponds to "Very often" to a perceived stress question (where higher value implies deteriorating stress). Thus, each individual response receives a score (0-4 when 5-point scale).

2. Sum up the individual scores to get a total score. For an outcome that aggregates 10 question with each question answered on a 5-point scale, the aggregated total score would be in the range of 0 to 40 (e.g., perceived stress).

3. From each total score, subtract the control group mean score and divide this difference by the control group standard deviation.

Specific survey questions used for index constructions are listed in the following subsections.

B.2 Pre-specified outcomes: mental health

Stress. Participants' perceived stress level is measured using an adapted version of the Perceived Stress Scale (PSS) (Cohen et al., 1997). The scale consists of 10-items that are answered on a 5-point Likert scale (never (= 0), almost never (= 1), sometimes (= 2), fairly often (= 3), and very often (= 4)). Therefore, the PSS score can take values between 0 and 40. The standard score cut-offs are: low perceived stress $= 0 - 13$; moderate perceived stress $= 14 - 26$; and high perceived stress $= 27 - 40$. We use the continuous PSS score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the standard score cut-off: equals to 1 if the PSS score> 13 and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

In the past 7 days...

1. how often have you been upset because of something that happened unexpectedly?
2. how often have you felt that you were unable to control the important things in your life?
3. how often have you felt nervous and stressed?
4. how often have you felt confident about your ability to handle your personal problems?*

5. how often have you felt that things were going your way?*
6. how often have you found that you could not cope with all the things that you had to do?
7. how often have you been able to control irritations in your life?*
8. how often have you felt that you were on top of things?*
9. how often have you been angered because of things that were outside of your control?
10. how often have you felt difficulties were piling up so high that you could not overcome them?

*Indicates reverse-scored items.

Depression. Depression level is measured using the 10-item version of the Center for Epidemiologic Studies Depression Scale (CES-D-10) (Andresen et al., 1994). The scale consists of 10 items that are answered on a 4-point Likert scale (rarely or none of the time (less than 1 day) $(= 0)$, some or a little of the time (1-2 days) $(= 1)$, occasionally or a moderate amount of time (3-4 days) $(= 2)$, most of the time (5-7 days) $(= 3)$). Therefore, the CES-D-10/depression score is between 0 and 30, where a score greater than 10 means someone has depressive symptoms (which is the standard cut-off). We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the standard score cut-off: equals to 1 if the depression score> 10 and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

1. I was bothered by things that usually do not bother me.
2. I had trouble keeping my mind on what I was doing.
3. I felt depressed.
4. I felt like everything I did was an effort.
5. I felt hopeful about the future.*
6. I felt fearful.
7. My sleep was restless.
8. I was happy.*
9. I felt lonely.
10. I could not get going.

*Indicates reverse-scored items.

B.3 Pre-specified outcomes: secondary

Happiness. We measure happiness with the following question from the World Values Survey: *"Taking all things together, how happy are you these days?"* The question measures happiness on a numerical 11-point scale, where 0 means "not happy at all" and 10 means "extremely happy". We use this continuous score to construct the standardized index following the steps mentioned in section B.1. In case the variable is a binary variable, 1 equals to the happiness score being> 5 and 0 otherwise.

Life Satisfaction. We measure life satisfaction with the following question from the World Values Survey: *"How satisfied are you with your life as a whole these days?"* The question measures life satisfaction on a numerical 11-point scale, where 0 means "completely dissatisfied" and 10 means "completely satisfied". We use this continuous score to construct the standardized index following the steps mentioned in section B.1. In case the variable is a binary variable, 1 equals to the life satisfaction score being> 5 and 0 otherwise.

Future Aspirations. We measure future aspirations using the following questions focusing on life, income, and overall hopefulness for the future: *"How hopeful are you about returning to the way life was before?" (Life); "How hopeful are you about (you and/or your husband) earning the same as before?" (Income); "Considering everything, how hopeful are you about the future?" (Overall).* These questions measure future aspirations on a numerical 11-point scale, where 0 means "not hopeful at all" and 10 means "extremely hopeful". We aggregate the three scale points and use the total continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the aspirations score is above the median value (> 24) and 0 otherwise.[7]

Compliance with COVID-19 precautionary measures. Compliance is measured using 7-items that are answered on 5-point Likert scales. For questions that ask opinions about a statement, the scales are: strongly disagree ($= 0$), disagree ($= 1$), neither agree nor disagree ($= 2$), agree ($= 3$), and strongly agree ($= 4$)). For questions that ask about the frequency of a certain behavior, the scales are: not at all ($= 0$), very few days ($= 1$), sometimes ($= 2$), most days ($= 3$), and everyday ($= 4$)). Therefore, the compliance score can take values between 0 and 28. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the compliance score is above the median value and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

1. Apart from using toilet, I washed my hands with soap and water at least 5 times a day.
2. I often forget to wash my hands after returning home from outside.*
3. In the last seven (7) days, how frequently did you go outside to buy grocery?*
4. In the last month, how frequently did you go outside for social visits (e.g., to see friends or neighbours, attending wedding or other occasions)?*
5. I often forget to keep distance (at least 2-arms length) from other people when outside.*
6. If I ever go outside of my house, I use face mask.

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[7]We use the median instead of a cut-off at 15 because the distribution is very left-skewed. We follow this median-cut-off rule for subsequent outcomes if aggregated outcome scores are very left-skewed.

7. If I need to cough or sneeze, I cough or sneeze into my elbow.

*Indicates reverse-scored items.

B.4   Additional outcomes

Food insecurity. We measure how food insecure households are using the Food Insecurity Experience Scale (FIES) (Ballard et al., 2013). FIES consists of 8-items that can capture how food insecure households are and each answered as either "no (= 0)" or "yes (= 1). Therefore, the aggregated FIES score is between 0 and 8, where a higher score means the household is more food insecure. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the standard FIES cut-off: equals to 1 if the FIES score≥ 1 and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

Has the following happened in the last 2-3 weeks?
1. You have been worried that there might not be enough food in the house to arrange three meals for everyone in a day?
2. You or anyone in your family could not have nutritious food due to lack of money?
3. There was lack of variety in food items due to lack of money?
4. Someone in the family could not have a meal due to lack of money?
5. You had three meals a day but the food was not sufficient?
6. There was scarcity of food in your family
7. You or anyone in your family were hungry but you could not buy food due to lack of money?
8. Someone in your family was unfed for a day due to lack of money?

Time-intensive parental investment. We ask 2 questions on time-intensive parental investment, *"How often in the last month have you helped your children with their education?"* and *"How often have you played with your children in the last month?"*. Both are answered on 5-point Likert scales (once a month (= 0), once a week (= 1), several times a week (= 2), once a day (= 3), and several times a day (= 4)). Therefore, the aggregated parental investment score is between 0 and 8. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the parental investment score is above the median value and 0 otherwise.

Confidence in dealing with COVID-19 issues. We ask 5-item questions on confidence in handling the virus. Each question measures confidence on dealing with different situations induced by COVID-19. These questions are answered on a numerical 11-point scale (between 0 and 10), where 0 means "not confident at all" and 10 means "extremely confident". Therefore, the aggregated confidence score is between 0 and 50. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score

cut-off: equals to 1 if the confidence score is above the median value and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

1. How confident are you that you know how to keep yourself and your family safe from the coronavirus?

2. How confident are you that you have been maintaining precautions well enough to keep yourself safe from the coronavirus?

3. How confident are you that your household members have been maintaining precautions well enough to keep themselves safe from the coronavirus?

4. How confident are you that if any of your family members catch the coronavirus you will be able to manage the crisis?

5. How confident are you that if any of your family members catch the coronavirus and if you need help to manage the crisis, you know where to ask for help?

Vaccination (self or family). To measure vaccination status, participants were asked at the 10-month endline, *"Have you or has any of your family members got vaccinated already?"* Response was either *Yes* or *No*. We coded *Yes* as 1 and *No* as 0, making it a dummy variable.

Gender attitudes.

Gender empowerment. We measure gender empowerment using 9-items following the 'women's empowerment' section of the 2017-18 Bangladesh Demographic and Health Survey (BDHS, 2017). We ask respondents to give opinions about who in the household should have controls over income, borrowings, household expenditures, and children's health and education. Opinions about self or joint controls over such intra-household decisions were considered empowering (coded as 1 and 0 otherwise). Thus, higher cumulative scores (maximum 9) correspond to more empowerment. That is, we ask 9 questions on gender empowerment, each answered on 4-point Likert scales (own decision (= 0), husband's decision (= 1), joint decision (= 2), other family member's decision (= 3)). We convert each item into a binary variable that equals 1 if the response is either "own decision" (= 0) or "joint decision" (= 2), and 0 otherwise (i.e., if "husband's decision" (= 1) or "other family member's decision" (= 3)), such that 1 indicates empowerment. Therefore, the aggregated empowerment score is between 0 and 9. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the empowerment score is above the median value and 0 otherwise. We aggregate the follow questions from the survey to construct this index.

Who in the household has control over...

1. your own income?

2. your own savings?

3. your husband's income?

4. your husband's savings?

5. the decision on spendings on food?
6. the decision on household financial matters?
7. the decision regarding children's education?
8. the decision regarding children's health/medical needs?
9. the decision to go anywhere on your own?

Attitudes toward gender norms. This outcome is measured by asking whether respondents consider various statements about gender norms as acceptable or not. For example, opinions about men's decision-making power in households and village councils, equal gender rights, and women's right to oppose men's opinions were considered. We use questions from the 2017-18 Bangladesh Demographic and Health Survey (BDHS, 2017) to measure attitudes toward gender norms. We ask 5 questions on attitudes toward gender norms, where each question is a statement and answered on a 5-point Likert scale (strongly agree ($= 0$), agree ($= 1$), neither agree nor disagree ($= 2$), disagree ($= 3$), and strongly disagree ($= 4$)). Therefore, the gender norms score is between 0 and 20, where higher cumulative scores correspond to more favorable outcomes. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the gender norms score is above the median value and 0 otherwise. We aggregate the follow questions from the survey to construct this index.
1. Most decisions in the home should be made by men.
2. Most decisions in the society should be made by men.
3. You can make better calculations and decisions than your husband.*
4. Women and men in general should have equal rights.*
5. A wife can disagree to any decisions made by her husband.*
*Indicates reverse-scored items.

Attitudes toward intimate partner violence. This outcome is measured by asking whether respondents consider various statements about intimate partner violence (IPV) as acceptable or not. For example, respondents gave opinions about whether husbands hitting wives can be justified if wives burn food while cooking, leave home without permission, argue, etc. We use questions from the 2017-18 Bangladesh Demographic and Health Survey (BDHS, 2017) to measure IPV. We ask 4 questions on attitudes toward IPV, where each question is a statement and answered as either "agree ($= 0$)" or "disagree ($= 1$)". Therefore, the IPV score is between 0 and 4, where higher cumulative scores correspond to more favorable outcomes. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the IPV score is above the median value and 0 otherwise. We aggregate the follow questions from the survey to construct this index.
1. If a wife leaves the house without her husband's permission, does her husband have

the right to hit her?

2. If a wife does not take proper care of her child, does her husband have the right to hit her?

3. If a wife argues with her husband about something, does her husband have the right to hit her?

4. If a wife burns food while cooking, does her husband have the right to hit her?

Economic preferences. We measure risk, social, and time preferences following Falk et al. (2018). We asked the following questions at the 10-month endline:

Risk-seeker. *"Are you generally a person who is fully prepared to take risks or do you try to avoid taking risks? Please use the following scale, where the value 0 means: 'risk averse' and the value 10 means: 'fully prepared to take risks'."* Thus, this response is between 0 and 10, where 10 corresponds to very risk-seeking. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the risk preference score is above the median value and 0 otherwise.

Altruistic. *"Imagine the following situation: Today you unexpectedly received 5,000 Taka. How much of this amount would you donate to a good cause?"* Thus, this response is between 0 and 5,000, where higher amount corresponds to being highly altruistic. We use this continuous value to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the donation amount is above the median value and 0 otherwise.

Delay gratification. *"How willing are you to give up something that is beneficial for you today in order to benefit from that in the future? Please use the following scale, where the value 0 means: 'completely unwilling to do so' and the value 10 means: 'very willing to do so'."* Thus, this response is between 0 and 10, where 0 corresponds to very present biased. We use this continuous score to construct the standardized index following the steps mentioned in section B.1. When the outcome is a binary variable, we use the median score cut-off: equals to 1 if the time preference score is above the median value and 0 otherwise.

We also list and categorize outcomes that were pre-specified or not in Table B1.

B.5 Baseline variables

Individual characteristics. In addition to the outcomes defined above, we also collected data on respondent's characteristics, such as household head's occupation, whether the respondent is the household decision-maker or not* (an indicator), etc.[8] We combine this with previously collected information (by our partner NGO) on respondents and their spouses' age (in years) and years of schooling, household size, number of children under the age of 5, and monthly household income (in BDT).

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[8]We ask these questions at 1-month endline as these were not collected at baseline.

Table B1: Which outcomes were pre-specified?

OUTCOMES	Pre-registered	Not pre-registered
Perceived stress	✓	
Depression severity	✓	
Happiness	✓	
Life satisfaction	✓	
Aspirations	✓	
Covid-19 compliance	✓	
Food insecurity		✓
Time-intensive parental investments		✓
Confidence about tackling Covid-19		✓
Gender empowerment		✓
Attitudes toward gender norms		✓
Attitudes toward IPV		✓
Risk-seeker		✓
Altruistic		✓
Delay gratification		✓
Vaccination (self or family)		✓

Note: All outcomes are defined in section IV.B of the paper. We also pre-registered 'Physical health of the respondents, children, and other household members' (measured using questions on the prevalence of common COVID-19 symptoms) as a health outcome but we dropped it at endline because all respondents and their household members did not report any symptoms at baseline. We also report this deviation in section IV.B.

In addition, on household chores, we asked, *"Now that everyone is home all the time, how have your household chores increased?"*, which is answered as "1=a little more/25% extra", "2=increased quite a bit/50% extra", "3=doubled", or "4=did not increase". Using this, we create an indicator variable called *Household Chores Increased* that equals to 1 if the respondent answered either 1, 2, or 3, and 0 if answered 4. To measure if someone helps with daily household chores, we asked, *"Who helps you with household chores these days?"* and then the enumerator listens to the response and ticks on (can be multiple responses): "husband", "son", "daughter", "other female members in the house (e.g., mother-in-law, sister-in-law, etc.)", "others", or "no one helps". Using this, we create an indicator variable called *Someone Helps with Household Chores* that equals to 1 if the respondent mentioned at least one person from the household and 0 if answered *"no one helps"*. We also measure to what extent the respondent trusts and socializes with neighbors (to create an indicator called *Trusts Neighbors*) and their perceptions of COVID-19 (to create *COVID-19 Perception*). For *Trusts Neighbors*, we ask *"Do you trust your neighbors or relatives to the extent you did before this crisis?"*, with options "(i) Trust everyone and socialize as usual, (ii) Trust most of them and socialize with them, (iii) Trust very few and socialize only with them, (iv) Do not trust anyone and do not

socialize with anyone." We then create a binary variable that equals 1 if answered either (i) or (ii) (i.e., maximum two points), and 0 otherwise. On the other hand, *COVID-19 Perception* is based on 16-items, answered as either "wrong (= 0)" or "accurate (= 1)". Therefore, the aggregated perception score is between 0 and 16. To create the *COVID-19 Perception* variable, we divide the perception score by 16, so that the value is between 0 and 1 (where a higher value means more accurate perception). We ask the follow questions from the survey to construct this variable.

Are these statements "accurate" or "wrong" (correct answers are given in brackets).

1. Anyone regardless of age can be infected by the virus. [Accurate]
2. Anyone infected with the virus will die. [Wrong]
3. The coronavirus is contagious, it can spread from one person to another. [Accurate]
4. If anyone in the neighborhood/village gets infected with the virus, everyone will get infected. [Wrong]
5. There is no vaccine for the coronavirus.[9] [Accurate]
6. If anyone in the neighborhood/village dies from the coronavirus they cannot be buried within this neighborhood/village. [Wrong]
7. Staying home can protect us from the coronavirus. [Accurate]
8. If anyone in the neighborhood/village gets infected, they need to be ostracised. [Wrong]
9. One gets infected with the coronavirus because of their sins. [Wrong]
10. This virus is a curse. [Wrong]
11. Foreigners/people who come from abroad spread the virus. [Wrong]
12. I will not give anyone from my family into marriage in families that had anyone infected with the coronavirus. [Wrong]
13. No one will give anyone from their family into marriage in my family if any of my family members gets infected with the coronavirus. [Wrong]
14. If I get infected with the virus, no one will ever hire me for work. [Wrong]
15. This is a disease of the poor. [Wrong]
16. This is a disease of the rich. [Wrong]

We also measure how worried respondents are in terms of *"health and well-being of family/medical support"*, *"putting food on the table"*, *"being able to earn income for the family"*, and *"financial situation of relatives/neighbors"*. Each question is answered on a 3-point scale: "1=not at all worried", "2=somewhat worried", "3=extremely worried". Using this, we create four indicator variables, each equals to 1 if the respondent answered "3=extremely worried" and 0 if answered otherwise. Besides, we also measured to what extent they are afraid of contracting the virus by asking *Generally, people are more or less worried about catching coronavirus. On a scale of 0-10, how scared are you that you, your spouse, children, or anyone in your family might catch the virus? Here, 0 mean "not at all scared" and 10 means "extremely scared".* In addition, we also measure how scared they are in terms of *"socializing with their relatives/neighbors/friends"*, *"if they have a*

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[9]This statement was accurate when the baseline was conducted in May 2020.

visitor who is a stranger", and *"going outside such as for work/shopping/a walk"*. These questions are answered as either *"yes"* or *"no"*. Using these, we create three indicator variables, each recorded as 1 if answered *"yes"* and 0 if answered *"no"*.

Finally, we also measure their various mental health conditions, such as their feeling of anxiousness, loneliness, hopelessness, and worthlessness, which are some of the major symptoms of depression (American Psychiatric Association, 2013). To measure each, we asked, *"We all are more or less worried about the current situation of Coronavirus. Overall, (i) how anxious are you?, (ii) how lonely do you feel?, (iii) how hopeless are you about the future?, and (iv) how worthless do you feel?"*. These are answered on a 4-point scale (1=very, 2=somewhat, 3=a little bit, 4=not at all), which is analogous to the scale of the Center for Epidemiologic Studies Depression Scale (CES-D-10) questions, our measure of depression. Using these, we create four indicators, each recorded as 1 if the respondent answered 1 or 2 ("very" or "somewhat"), and 0 otherwise.

Summary statistics of these variables are given in Table 1.

Household characteristics. In addition to individual-level data, we also collected information on various household characteristics, such as the age of spouse (in years), education of spouse (in years), the number of household members, the number of children under five, and the head of the household's main occupation. For occupation, we asked, *"What is your/your household head's main occupation?"*, with options "1=farmer, 2=agricultural laborer, 3=day laborer, 4=business, 5=public service, 6=private service, 7=others".

To measure whether the household experienced a loss of income following the lockdown, we asked, *"To what extent, your/your household head's income has been affected due to the coronavirus situation?"*, with options "1=total loss of income, 2=partial loss of income, 3=income remained unchanged". Using this, we created two indicator variables: *Experienced Income Loss*, which is recorded as 1 if the respondent answered 1 or 2, and 0 otherwise, and *Experienced Complete Income Loss*, which is recorded as 1 if the respondent answered 1, and 0 otherwise.

Summary statistics of these variables are given in Table 1.

B.6   Social desirability bias

To measure the respondent's tendency to give socially desirable responses to our survey questions, we followed Bandiera et al. (2020) and asked respondents: *How true is the following statement on a scale of 0-10, where 0 indicates 'not at all' and 10 indicates 'a lot': "I want to be a respectful person in my village."* This SDB scale is between 0 and 10, where a higher number corresponds to higher tendency to give a socially desirable response. We measured this at the 10-month endline.

B.7 Phone survey logistics

Households were required to have a mobile phone to participate in our surveys and counseling sessions. However, we do not know whether our (female) respondents were using their own phones, "home" phones (mobile phones that remain at home and can be used by all household members), or phones that belong to their spouses. This was not a problem because qualitative feedback from enumerators and para-counselors suggest that there were no issues associated with husbands blocking their wives' access to mobile phones. If calls were received by husbands and women were not available, then enumerators/para-counselors asked for a different day/time convenient to them and called again on the agreed-upon day/time. On logistical issues, we note that there was no issue of enumerators being unable to complete calls. If calls got disconnected for any reason, participants were immediately called again. Participants only received phone calls from enumerators, so they were not charged for the airtime. They also did not receive any incentive to participate in the surveys. We nevertheless observe high participation at the endline survey, possibly because, most households were often in a lockdown and the interview was short, so the opportunity cost of participating in the endline survey was fairly low for our respondents.

B.8 Attrition analysis in detail

To check whether any baseline characteristics, both individual and household-level characteristics, explain attrition at 1-month endline (Panel A in Tables A6 and A7 in Appendix A), we regress the attrition dummy (=1 if the respondent attrited at endline and 0 otherwise) on baseline characteristics separately for control (Column 1) and treatment (Column 2) arms, and then on the treatment dummy (=1 if women are in the treatment arm), baseline characteristics, and interactions between baseline characteristics and the treatment dummy (Column 3). We find that neither individual nor household characteristics at baseline predict attrition, as suggested by the p-values on the joint significance of these observable characteristics (Table A6: $p = 0.70$ and $p = 0.92$ (column 1); Table A7: $p = 0.53$ and $p = 0.35$ (column 2)). More importantly, we do not find attrition to be differential by baseline characteristics of women, which is suggested by the large p-values on the joint significance of the interaction terms (Table A6: $p = 0.56$ (column 3); Table A7: $p = 0.81$ (column 3)). Although we do not observe differential attrition at 10-month (CS-test: $p = 0.23$), we nevertheless check whether any baseline characteristics predict attrition during this second endline (Panel B in Tables A6 and A7 in Appendix A). Large p-values on the joint significance of observables and their interactions with treatment suggest neither observables jointly explain attrition nor there is differential attrition by baseline characteristics.

Because attrition at 1-month endline was marginally differential by treatment groups, we check the robustness of our 1-month endline results by re-estimating our main treatment effects (reported and discussed in section IV) in two ways: (i) using inverse prob-

ability weighting (IPW), where women with characteristics similar to women that are missing at endline are up-weighted in the analysis; and, (ii) using an attrition bounds analysis following the non-parametric approach of Lee (2009), where outcomes are first sorted from better to worse within the treatment and control arms, and then 'additional' samples are trimmed from above and below in the treatment arm (i.e., the arm with fewer attrition) to get the lower- and upper-bound estimates respectively. We report these results in Table A8 in Appendix A, which shows that our main results (later discussed in section IV) remain robust to such corrections.

C Appendix: Telecounseling session details

The four modules (translated from *Bangla*) are briefly described below (in chronological order).

Awareness. The first session aims to create awareness about COVID-19 among the counselees. During this session, counselors discussed the implications of contracting the virus, the main symptoms to look out for (fever, cough, difficulty breathing, etc.), how the coronavirus spreads, and what could be done to prevent it from spreading (social distancing, face coverings, hand washings, etc). Moreover, counselees were given information on whom to contact locally if someone from the household shows COVID-19 symptoms, how to take care of household members diagnosed with COVID-19, and how to take care of oneself and other unaffected household members. More importantly, counselees were advised to stay calm while handling such situations. Therefore, by providing important information on things-to-do during the pandemic, counselees would feel less anxious and worried about managing their households, would be more able to cope with the fear of infection/disease, and fight misinformation about COVID-19. At the end of this session, contact information of public officials (e.g., of *Upazila Nirbahi Officers*, who are subdistrict-level public chief executive officers and are in charge of managing COVID-19 related issues at the subdistrict level) and local doctors was also provided via text messages, composed in the local *Bangla* language. Counselees were also encouraged to contact local public officials in case of food shortages.

Coping with stress. The aim of the second session is to help counselees to cope with increased stress caused by COVID-19. During this session, para-counselors discussed the consequences of over-thinking, stress, and not taking adequate rest throughout the day, and how that would affect their own physical and emotional well-being and the well-being of their household members. Para-counselors also discussed why counselees should not blame themselves or other family members for the current situation. To control various emotional outbursts, counselees were encouraged to discuss their state of mind with someone from their family, neighbors (while maintaining 1.5 meters distance), or with other close relatives (over the phone). The final part of the session focused on the importance of praying and exercising daily, such as walking in the front or backyard of the house early morning and breathing exercises, for both physical and emotional comfort.

Self and childcare. The goal of the third session is to cover issues on self and childcare. This session is similar to the first session on awareness but with more emphasis on the steps to take care of oneself, their children, and someone in pregnancy. Counselees were reminded about the COVID-19 health guidelines and ways to take care of a sick person. In addition, more advice was given regarding care during pregnancy (applicable to both self and other female household members), with contact details of local doctors for regular advice and emergencies. Counselors also asked whether counselees have saved or noted down the contact information of local doctors and public officials, provided during the first session. If not, the contact information was again sent over via text messages,

composed in the local *Bangla* language. Furthermore, advice on childcare, such as timely feeding (in case of infants), their cleanliness, helping with study, asking children to play in the front or backyard, and spending quality time with children, was also provided during this session.

Communication. The fourth (and final) session focuses on improving communication between the counselee and her family members, neighbors, and relatives (remotely with the latter two groups), primarily to help them cope with isolation. The session starts with the importance of sharing various concerns and problems with neighbors and helping each other during emergencies, and how counselees should communicate with neighbors while maintaining a safe distance. In addition, because rumors and myths about COVID-19 are prevalent in almost all rural areas (United Nations, 2020), counselees were reminded about the facts surrounding COVID-19 and why blaming, shaming, and outcasting neighbors with COVID-19 infections should be avoided at all cost. Instead, helping out neighbors with food and medicine (while maintaining a safe distance and wearing masks) was encouraged during the session. In the end, the importance of keeping in touch with relatives, particularly elderly relatives, was discussed. Counselees were asked to call their parents and in-laws (if they live elsewhere) to stay in touch. To help initiate such calls, mobile phones of counselees were topped up with a small amount at the end of this session.

The exact four session module are available in the next appendix section.

D Appendix: Session Modules

<u>**Session 1**</u>

Instruction for the counselors: Following topics will be discussed over the phone. The counselors will discuss these topics in simple language so that the counselee can easily understand. The counselor should talk slowly so that the counselee understands everything. The counselor should talk at least 20 minutes with each counselee.

Greetings,

I am _____. I am working with GDRI. How are you? In the last few weeks, we have spoken with you about what is coronavirus and how to remain safe and from the virus. In this pandemic, all of us are somewhat worried. There are a lot of things we could do a few days ago such as, going outside, working outside, going to a neighbor's house, which we cannot do now. It may feel like we do not get to hear good news as much as we used to get. We called today to discuss the things we can do to be mentally healthy. Also, If there is anything you want to know, you can ask me.

> **Though you have just mentioned how you are you doing today, I would still like to ask you, how would you rate yourself regarding how you are doing on a scale of 0-10? Here 0 means "not good at all" and 10 means "extremely well". -----------------**

> **We may have things in our minds that we are worried about. On a scale of 0-10, how worried are you? Here 0 means "I am extremely worried" and 10 means "I am not worried at all". ---------------------------------**

Firstly, it should be noted that we are going through something none of us experienced before. We do not have a clear understanding of what is happening around us. Naturally, we are worried about keeping ourselves and our family members safe. We are worried about daily needs, health, and our future. At this time, it is very natural to panic, get anxious, or having difficulty sleeping. Some people may react differently compared to how they would normally. But if we know how to get out of these negative thoughts, we can decrease mental pressure and live a better life.

To live a better life, we need to shake off the fears in our minds. How do we do that? At this time, we can be afraid of a lot of things. We can be worried someone like myself or family members getting affected by coronavirus. We can be worried about poverty, our future, etc. One way to deal with fear is to know about what we are afraid of. If we know what is coronavirus and how to be safe from COVID-19 disease, we will be able to protect ourselves and our family members by following what to do. Thus, we will be less afraid of coronavirus. This knowledge will help to get courage.

We will know how to be safe from coronavirus, will follow those rules and live without tension

So, first, we need to know how can we be safe from coronavirus.

What do you know about coronavirus? **(Instruction: Listen carefully to what counselee says. If she cannot tell about coronavirus, tell her the following points. Counselee who correctly discussed these points. Appreciate her and discuss following points)**

- ➢ Coronavirus is a very tiny germ that is not visible to human eyes. People usually experience difficulty breathing in this disease.
- ➢ Some usual symptoms of coronavirus are Fever, Cough, difficulty breathing.
- ➢ It is also possible that a person has coronavirus but does not have any symptom
- ➢ People can die due to coronavirus
- ➢ Coronavirus can spread through cough, sneeze, etc.

➢ Until now, there is no medicine or vaccine for coronavirus. That is why the easiest way to be safe from coronavirus is to take preventive measures.

You have already got information on how to be safe from Coronavirus through Television, Radio, Newspaper, and Mobile phone. Do you know what measures you should take to keep yourself and your family members safe from coronavirus? *(Instruction: Listen carefully to what counselee says. If she cannot clearly tell about coronavirus, tell her the following points. Counselee who correctly discussed these points. Appreciate her and discuss following points)*

➢ One way to stay safe from coronavirus is to stay at home. For emergencies, we all go outside the home, but the less you go outside the home is better.

➢ If you have a fever, cough, or difficulty breathing, you must stay at home and stay away from healthy peoples.

➢ We should avoid going to places where a lot of people gathers such as social ceremonies, general meeting with people. In this place, the possibility of corona spread is higher.

➢ If we go outside the home, we should keep a distance of a minimum of 1.5 meters or three times your arm's length.

➢ We should wash our hands with soap and water for at least 20 seconds after coming home.

➢ People staying at home should also regularly wash hands in the same way.

➢ We should cover our mouth with a handkerchief or with the fold of our elbow while coughing or sneezing.

➢ We should avoid touching our eyes, nose, or mouth.

➢ If someone gets sick, we should call 16263, take and follow instruction from them

➢ If someone is diagnosed with corona, there is no need to ostracized him/her. It is a disease like any other disease. If he/she follows proper rules and take medicine, they will get well. **It should be noted that people can die due to coronavirus but many people also get well.**

➢ It is not mandatory to hospitalize a corona patient. Most of the patients can be treated at home.

➢ This disease is contagious. That means if we are not cautious enough, other people can get affected by a corona patient. So, some measures should be taken while treating a patient.

➢ While treating a patient at home, both the patient and the person treating him/her should wear cloth made mask. It reduces the probability of spreading disease with others. The person who is treating corona patients should be cautious. There is no alternative for him but to wash hands regularly.

➢ All the tv news, newspaper, local government office, the health center is saying to take these measures.

➢ It is possible to think that we are overreacting by taking all these steps. But we are calling over and over; also everyone is telling to take these measures because we can only be safe by following these steps.

➢ We can also think that we do not have enough money to buy this amount of soap. If we do not have soap, we can easily make soap water with the following step.

➢ Usually, every one of us has washing powder. If we mix four tea-spoon of washing powder with 1.5 liters of water and shake it properly, we can use that water to wash our hands. Before each use, we will have to shake the bottle. It will be easier to use if we make a hole in the bottle cap. Even if there is less foam, this soap water cleans germs properly.

➢ We get anxious by thinking about what we will do if someone in our family gets sick. If we know what we need to do, we are less likely to be worried.

➢ If you and your family members face any food crisis you can ask for help from the nearest government representative. Usually, the Upazila Nirbahi Officer (UNO) is helpful to support you during this pandemic. After this session, we will provide you the contact number of your UNO through SMS.

Do you understand everything I have talked about until now? (If the answer is no, ask her which part she did not understand and try to explain that part again)

Have you learned some new today, from what we have just discussed?

(If Yes) Could you please mention them? ---------------------------------------

(If No, Write 0 here) --

We hope that you will follow these instructions. Be careful. We will keep in touch. Greetings.

For text messages:

Please call the following numbers for any advice:

Shasthyobatayan Helpline: 16263

Specialist Helpline: 09611677777

If you are in Khulna or Shatkhira district you may call the following numbers for advice:

Dr. Asheem Kumar Sarkar: 01957410585 (Pediatrics and Diarrhea)

Dr. Tamanna Nushrat Khan: 014108507324 (Medicine, Asthma, Dermatology)

Dr. Md Shahinoor Hassan: 01777270282 (Medicine, Neurology, Rheumatoid Arthritis)

You may contact the following persons in your local government area should you or any of your family members face any food crisis or financial crisis to buy food during this pandemic. Also, you may contact them if you or your family members had any symptoms of COVID-19. They will arrange a test for you/your family if required.

Subdistrict	Name	Designation	Mobile
Asasuni	Meer Alif Reza	Assistant Executive Officer	01726702172
Tala	Md Iqbal Hossain	Do	01738917192
Paikgacha	Julia Sukayana	Do	01969655888
Dumuria	Mst Shahnaz Begum	Do	01969655888
Koyra	Shimul Kumar Shaha	Do	01794492164

Session 2

Instruction for the counselors: Following topics will be discussed over the phone. The counselors will discuss these topics in simple language so that the counselee can easily understand. The counselor should talk slowly so that the counselee understands everything. The counselor should talk at least 20 minutes with each counselee.

Greetings,

I am _____. I am working with GDRI. How are you? In the last few weeks, we have talked with you about what is coronavirus and how to be safe from coronavirus. In this pandemic, all of us are somewhat worried. Also, we are not always in a good state of mind. Today we have called to talk about how to be in a better mental state.

Though you have just mentioned how you are you doing today, I would still like to ask you, how would you rate yourself regarding how you are doing on a scale of 0-10? Here 0 means "not good at all" and 10 means "extremely well". -----------------

We may have things in our minds that we are worried about. On a scale of 0-10, how worried are you? Here 0 means "I am extremely worried" and 10 means "I am not worried at all". --------------------------------

Keeping the mind healthy:

➢ Last week we discussed that this is an unusual time. This is a more or less difficult time for all of us. Since we have never seen such a disease before, we are afraid.

➢ In day or night, we may think about many things - the thought of getting food, the health and education of children, the thought of keeping everyone in the family healthy, how long this situation will last, what will happen in the future.

➢ These thoughts may come to our mind. But we also need to know that if we are always thinking, it is not good for our health.

➢ You may have noticed that when you are over-thinking or under a lot of stress, you may feel very restless, do not feel like doing anything, have no appetite, may have headaches, have less sleep, or have scary dreams. These symptoms may be different for everyone.

➢ None of this is good for our bodies.

➢ Now we are all worried about coronavirus. But many of us may not know that those whose bodies are already weak or who fall ill very easily, that is, those whose bodies are already less able to protect themselves from diseases, are more likely to be infected with this virus.

➢ If we have anxious for a long time, we become mentally weak; we may even suffer from mental illness, such as restlessness of mind, worrying too much about everything, fear of anything. These are not good for health. For those who already have it, the extra stress on the mind can add to these problems.

➢ So, we need to remember that the time we are going through now will come to an end, we may not know when, but we should not be afraid.

➢ It is often seen that if we talk to family members or relatives or neighbors with whom we have a good relationship, then we feel less burdened.

Not blaming yourself or anyone in the family

➢ We often blame ourselves in times of danger or problems.

➢ We get a little angry. Maybe we get angry with the people in the house or misbehave with them.

➢ But with a little thought, we realize that none of us has a hand in the current situation.

➢ In such a time of danger, there may be no food in the house, or there may not be money to buy food. Or there may be a fear of getting sick. If someone in the house is sick, you may have worries about where to go, or someone may scold you, or you may have a bad experience, all in all, we may feel frustrated. You have done nothing wrong.

➢ We need to remember that we are blaming ourselves or others out of our stress. Many times, when we have a problem, we either blame ourselves or blame others. But with a little thought, we can realize that we often have no control over the problems we are in.

➢ If you feel frustrated or afraid, talk to your family, tell them about your state of mind. If you want you can talk to someone in the area on the phone. You can try and speak with your neighbors maintaining physical distance standing in front of your respective houses. You will see that they are in a similar mental state. Everyone will feel less isolated when they get to communicate with somebody or vent.

➢ It would not be right to feel guilty for no reason.

Keeping your mind healthy

➤ Now that everyone is at home, many of us have more housework than before.

➤ It is very normal to be stressed due to the burden of daily chores and various thoughts. We may be upset or angry at everything, or we may get angry. These reactions are very normal.

➤ But by doing something very simple, we can take care of ourselves.

➤ We all know that exercise keeps the body well. You may think 'I am a woman, there is no place for me to go and exercise' or 'What will people say if there are people at home' or 'Why to exercise after working all day'. Or it may seem that 'exercise will not solve my problem'. Indeed, this will not solve the problem, but exercise will keep your mind and body healthy so that you do not get sick because of all the problems. If we get sick, the problem may get worse, which we do not want.

➤ You can take a short walk in the yard or in front of or behind the house before starting work in the morning.

➤ When the stress is high or the fear increases, take a long breath through the nose, as much as possible. In this case, slowly count to 1 to 5, then slowly exhale. Do this 10-12 times. During this time, pay attention to exercise, such as stomach and chest ups and downs, swelling of the nose. Doing this will move your attention from what you are thinking about for a while; both of you may feel better. This exercise will calm your mind, reduce stress. Even if there is no fear or worry in your mind, if you practice doing it every day, the mind stays healthy. You can do this exercise at any time.

➤ Generally, we all follow a religion - some perform *Namaz*, some worship, some pray. Many people feel calm after Namaz, worship, or pray. You can do that if you want.

➤ Everyone else in the house can do these exercises.

➤ We want to be good mentally and physically so that we do not get infected with coronavirus.

Do you understand everything I have talked about until now? (If the answer is no, ask her which part she did not understand and try to explain that part again)

Have you learned some new today, from what we have just discussed?

(If Yes) Could you please mention them? --------------------------------------

(If No, Write 0 here) --

We hope that you will follow these instructions. Be careful. We will keep in touch. Greetings.

<u>**Session 3**</u>

Instruction for the counselors: Following topics will be discussed over the phone. The counselors will discuss these topics in simple language so that the counselee can easily understand. The counselor should talk slowly so that the counselee understands everything. The counselor should talk at least 20 minutes with each counselee.

Greetings,

I am _____. I am working with GDRI. How are you? In the last few weeks, we have talked with you about how to stay safe from coronavirus. In this pandemic, we all are concerned about our health. So, today we have called you to give the guideline about what are the things to do for maintaining good health and keeping the children healthy.

Though you have just mentioned how you are you doing today, I would still like to ask you, how would you rate yourself regarding how you are doing on a scale of 0-10? Here 0 means "not good at all" and 10 means "extremely well". -----------------

We may have things in our minds that we are worried about. On a scale of 0-10, how worried are you? Here 0 means "I am extremely worried" and 10 means "I am not worried at all". -------------------------------

Maintaining good health:

➢ We have already talked with you about how to stay safe from Coronavirus. Just maintaining a few basic hygiene rules and being careful can help us to stay healthy during this pandemic time, for example-
   1. Frequently washing hand using soap and water
   2. While sneezing/coughing covering face using folded elbow or using a handkerchief
   3. Not touching face, eyes, and nose unnecessarily
   4. Without emergency not going out of home
   5. If you have fever, cough, and difficulty breathing, should not go out at all and maintaining quarantine or staying away from others at home

   Hope you and your family members maintaining these basic rules

➢ Every group of people like child, female, male everyone one of the members of a family will have to maintain these rules equally because this is the best way to stay away from coronavirus and maintain good health.

➢ As during this pandemic, everyone is staying home, children are not going to school, so we have a heavy workload at home. In addition to that, if someone becomes sick, we have to take care of that person as well.

➢ After doing all the chores, very often we are not able to take care of our health, henceforth we have a probability of becoming sick. Because of this, we all need to take care of ourselves according to our convenience.

➢ If we feel sudden fever, cough, and difficulty breathing, we must stay at home and maintain quarantine from the family members so that we all do not become sick. If we all become sick at the same time, this will only rise our difficulty.

➢ At home, if someone becomes sick and has a fever, cough, and difficulty breathing or that person is infected with coronavirus, then we need to stay conscious during taking care of that person so that we also do not get infected. So we have to wear a mask while taking care of the patient. In case we do not have a mask, at least we will have to wrap a handkerchief or a cloth around our face.

➢ It is important to wear a mask or handkerchief over your nose and mouth properly. We will have to wear masks or handkerchief in a way so that our nose, mouth, chin, and some area between our chin and throat are covered.

➢ If possible, while taking care of the patient, we need to use gloves. In case we do not have gloves at home, after being in contact with the patient, we need to wash our hands with soap and water.

➢ If we have to step out of the home due to an emergency, after returning we will have to change our clothes and immediately wash our hands using soap and water. Every member of the family must maintain this.

➢ We need to boil fish, meat, and egg properly, and it is recommended not to drink raw milk. Before eating fruits and cooking vegetables, we need to wash them properly. These rules apply to everyone.

Staying more cautious because of pregnancy

- If you are pregnant, you will have to be more careful. Due to pregnancy or during pregnancy, the probability of being infected with coronavirus does not increase. But, our body changes a lot because of pregnancy. Due to this, there is a high probability that we can have few sicknesses like- cough for a long time, difficulty breathing, and pneumonia.
- So during this pandemic time if you are pregnant, then you need to be more careful so that you do not have these problems. Keep in mind that if we become sick, then our body loses the capacity to fight against the sickness, henceforth we become ill very easily.
- Apart from that fever, cough, shortness of breath, and sore throat is the symptom of coronavirus. So if you get these symptoms, you need to stay away from the family members and maintain quarantine like said I have before so that they do not become sick as well. In this case, 14 days of quarantine is mandatory. This rule is for everyone. In addition to that, the rest of the rules should be maintained.
- If you become sick the person who would come to take care of you, you both need to wear a mask or handkerchief or a folded big piece of cloth around the face.
- Drink a lot of water and liquid food. Try to eat warm food.
- Collet the phone number of the doctor in your area so that if an emergency, the doctor can be contacted. If necessary to take advice call 16263 and 333, IEDCR hotline number 01937000011, 01937110011, 01927711784, and 0192771178. We will send these numbers via SMS or message.
- If someone is sick at home, stay away from that person. If there is no way and you have to take care of the patient then abide by the rules we mentioned before like wearing a mask or covering nose and mouth using a handkerchief and after being in contact with the patient washing hands.
- To remove the stress and keep the body healthy, do breathing exercises and regular walking as we recommended last week.

Taking care of the children

- If you have an infant whom you breastfeed, you have to continue that.
- Even if you become sick, you need to continue breastfeeding. Coronavirus cannot infect the baby via breast milk, so do not worry about that. Breast milk enhances the immune system of the baby, so it is important to continue it.
- But is you have fever, cough, and difficulty breath and sore throat while breastfeeding the baby you must ware mask or handkerchief and cover the nose and face. Before feeding the baby, washing hands with soap and water is mandatory.
- If you become so sick, then you need to breast pump and keep the milk in a hygienic bowl or spoon, and someone else will feed the baby.
- If anyone else of the home becomes sick, keep the baby away from the person.
- The dishes and bowls that are used need to be kept separated so that others do not use it. The child should not be fed things eaten by you or others.
- It is prohibited to smooch babies; this can spread disease.
- If it is time for the vaccination of the baby, you need to search for the nearest vaccination center and learn about their system. Some vaccines can be given at other times. Learn about that from the vaccination center. If you need to go out for the vaccination of the baby, you need to stay careful. It is recommended to take the appointment and go according to that time.
- A little grown-up baby should be taught washing hands and not touching face, nose, and also not putting a thumb in mouth. They need to be taught why it is important.
- If a person comes from outside children, tend to go to them jumping. After coming from outside without changing clothes, no one should touch the baby.

- It is important to keep children busy with studies and indoor sports. In the backyard, children can play.
- Children may become bored due to staying home all the time. Do not scold them and make them understand why they should not go out. We need to behave with children in a good way so that they do not get scared of us. Like elderly people, children can become stressed, and it is not good for them.

The things I have said, have you understood? (If you answer is No, ask which part you did not understand and will try to make you understand that part again.)

Have you learned some new today, from what we have just discussed?

(If Yes) Could you please mention them? ---------------------------------------

(If No, Write 0 here) --

Hope the conversation we had today will help you to stay healthy. We will check on you again. Greetings.

<u>**Session 4**</u>

Instruction for the counselors: Following topics will be discussed over the phone. The counselors will discuss these topics in simple language so that the counselee can easily understand. The counselor should talk slowly so that the counselee understands everything. The counselor should talk at least 20 minutes with each counselee.

Greetings,

I am _____. I am working with GDRI. How are you? In the last few weeks, we have talked with you about what is Coronavirus and how to be safe from Coronavirus. At this time everyone is at home. It is less likely to get to meet with relatives/neighbors than before. There are fewer people around who can help if we are in danger because everyone is in their home. In this situation, it is very normal for us to feel alone. We have called today to discuss how we can keep in touch with everyone from our homes, and how we can help each other.

Though you have just mentioned how you are you doing today, I would still like to ask you, how would you rate yourself regarding how you are doing on a scale of 0-10? Here 0 means "not good at all" and 10 means "extremely well". -----------------

We may have things in our minds that we are worried about. On a scale of 0-10, how worried are you? Here 0 means "I am extremely worried" and 10 means "I am not worried at all". ---------------------------------

Keeping communication with neighbors

- We have been told to stay at home to avoid coronavirus. This situation has been going on for a long time. As we used to be able to visit our relatives and neighbors, cannot do that now.
- Besides, we used to go to work outside the house, We would meet many people on the road, but that does not happen now. In this way, our communication with everyone has decreased.
- This condition is not normal for us. We usually stay in touch with relatives and neighbors.
- But now we cannot do that for this unusual situation. We know that at this time we have to stay at home.
- Since the coronavirus spreads from one person to another, the fewer people we interact with, the safer we will be.

- But this way we can feel alone while staying away from everyone. More importantly, if we are suddenly in danger, we may not be able to find someone around us who can help us. For many of us, this can be a cause for concern.
- However, we can keep in touch with each other from home.
- Now we all have at least one mobile phone in our house. We can keep track of the phone numbers of our neighbors, who live nearby, and if possible, get in touch with once a week. We will not feel alone if we do this.
- We may think, 'There is no time to look for someone else as we are struggling to run our own family'. It is just that we are all very busy. But talking to our neighbors, looking for them will reduce our stress a bit. Talking to someone about your thoughts makes the mind light and calm; the stress on the mind also decreases.
- After talking with your neighbors, you may find that they too are under pressure of quality, fearing for their well-being and future. If you talk to him, his/her mind will also feel better.
- Often, when we talk to each other, we may find a solution to a problem that both of us are having.
- Also, when we are in danger, our neighbors come forward to help first. If there is communication between us, we can help each other in danger.
- Get the phone number of someone you are in good terms with. You may need this sometime.
- If you are currently in trouble or danger, talk to someone you trust, he/she may be able to help you.
- It will be beneficial for everyone to share the news of emergency assistance provided by the government or NGOs such as food, health care information, zakat, etc.

Do not blame a neighbor or someone in the vicinity for being infected with coronavirus

- In many parts of the country, when someone is infected with the coronavirus, people or neighbors in the area blame the sick person, slander him or her family, or look down on him or her.
- We must remember that illness can happen to anyone; it is not a fault to get sick.
- If someone is infected with coronavirus, he and his family can be emotionally broken. We should all be kind to the patient and his family.
- We need to remember, 'If I had this disease, how would I expect others to treat me'.
- If someone is infected with coronavirus, he can get better with proper treatment. However, since it is a contagious disease, if anyone in the area is affected, we must stay away from them.
- It is a contagious disease. So we should keep the patient isolated. It is not the patient's fault. they should not be ostracized
- The affected person may be your friend or neighbor, and you may think you should be able to treat. But for the good of yourself and everyone in the family, you have to stay away from the patient.
- If possible, you can help your sick neighbor by arranging food or medicine by following all the rules, i.e. wearing a face mask or handkerchief, wearing gloves, and keeping a safe distance. However, you cannot go inside the neighbor's house; you can leave it within the boundaries of the house so that they can take it from there.
- If someone in that area has a fever, cough, and difficulty breathing, you should also stay away from that patient. Keep your family members away from her too.

Staying in touch with relatives

- Similarly, we can keep in touch with relatives by phone. So that you will know how they are, whether they are healthy or not. This will reduce your worries about them.
- If mother, father-in-law, and mother-in-law are not in the same house, we can call them and get the news.
- Older people are getting affected more and dying from coronavirus. They are also scared and worried after hearing various news about this disease. If we talk to them, their minds will be lightened, and they will have confidence.

- Older people are getting affected more and dying from coronavirus. However, many of them are also getting better. Giving this positive information will reduce their fear.
- Older people usually want their children to talk to them. So, at this time, when they are thinking or worrying about their well-being or survival, if you communicate with them frequently, they will have the courage, and the fear will decrease.

Do you understand everything I have talked about until now? (If the answer is no, ask her which part she did not understand and try to explain that part again)

Have you learned some new today, from what we have just discussed?

(If Yes) Could you please mention them? --------------------------------------

(If No, Write 0 here) --

We hope that you will follow these instructions. Be careful. We will keep in touch. Greetings.

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