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Ethical reporting of research on violence against women and children: a review of current practice and recommendations for future guidelines

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ABSTRACT

Changes in research practice during the COVID-19 pandemic necessitates renewed attention to ethical protocols and reporting for data collection on sensitive topics. This review summarises the state of ethical reporting among studies collecting violence data during early stages of the pandemic. We systematically searched for journal publications from the start of the pandemic to November 2021, identifying 75 studies that collected primary data on violence against women and/or violence against children. We developed and applied a 14-item checklist of best practices to assess the transparency of ethics reporting and adherence to relevant global guidelines on violence research. Studies reported adhering to best practices on 31% of scored items. Reporting was highest for ethical clearance (87%) and informed consent/assent (84/83%) and lowest for whether measures to promote interviewer safety and support (3%), for facilitating referrals for minors and soliciting participant feedback were in place (both 0%). Violence studies employing primary data collection during COVID-19 reported on few ethical standards, obscuring stakeholder ability to enforce a 'do no harm' approach and to assess the reliability of findings. We offer recommendations and guidelines to improve future reporting and implementation of ethics within violence studies.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Despite existing ethical guidance on how to safely collect data on violence against women and violence against children, there is no standardised or accepted guidance on ethical reporting when research on violence is published.

WHAT THIS STUDY ADDS

⇒ This study develops a 14-item checklist of best practices for the transparent and ethical reporting of violence research accounting for challenges during COVID-19 comprised of four domains: (1) Institutional Review Board approval, (2) interviewer selection, training and support, (3) sampling and engaging with respondents and (4) referrals and adverse events, and applies this checklist to 75 studies which collected data on violence published since the start of the pandemic.

⇒ Results show reporting on ethics is low, regardless of type of violence assessed or modality of data collection, with studies adhering to best practices in reporting in 31% of scored items: the highest reporting was for ethical clearance (87%) and informed consent/assent (84/83%) and lowest reporting was for measures to promote interviewer safety and support (3%), facilitating referrals for minors and soliciting participant feedback (both 0%).

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Efforts to improve the reporting of violence research are an important step to improve the quality and safety of studies and, as violence researchers, to fulfil our commitment to listen to and learn from participants while ensuring a 'do no harm' approach.

⇒ This study serves as a starting point to improve the reporting of violence research by proposing a checklist of items and providing strategies that can be used and adapted by researchers, journal editors, ethics committees and funders.

INTRODUCTION

Research has demonstrated increases in violence against women and violence against children (VAW/VAC) across numerous settings during the COVID-19 pandemic.[1–4] This widespread evidence within a relatively short time period is due to creative use of available administrative data, as well as analysis of ongoing and new data collection efforts. In many parts of the world, data collection during the pandemic required adopting remote or other novel methods to successfully and safely reach and interview participants. Such methods were rarely used

for VAW/VAC prior to the pandemic, particularly in low-income settings.[5] These efforts challenged teams to ensure the appropriate adaptation of violence-specific safeguarding and ethical protocols. For example, data collected online or over the phone may leave participants vulnerable to lack of privacy, where responses could be overheard or where questionnaire forms or information might be viewed online by perpetrators or household members.[6 7] In addition, shut-downs and reductions in service provision of violence and social services added complications, particularly for assuring the quality of, and continuous access to, referral services and for implementing response measures for adverse events.[8] Research teams were forced to choose between collecting violence data with women and children in ethically challenging and uncertain contexts or opting to forgo primary data collection altogether.[9]

There remain differing opinions as to if, and how, data on VAW/VAC can be safely and ethically collected in such circumstances. Some early guidance during the pandemic suggested not to collect remote data at all, with the WHO and UN Women emphasising the mantra 'Do not prioritise data over women's safety'.[10] Others suggested conditions which must be met in order to justify proceeding, including the ability to address safety concerns for participants, implement quality referrals and the critical use of data for immediate policy action.[6 7] To date, no universal protocols exist for the design and reporting of remote research on VAW/VAC and ethical review boards are often ill-equipped to advise on violence-specific protocols even in face-to-face data collection efforts. Therefore, the decision of what VAW/VAC measures to collect and how go about setting up sufficient safeguards during COVID-19 was often made on a case-by-case basis by individual research teams.

This paper reviews reporting on ethics and safeguarding among studies where primary data on VAW/VAC were collected during the pandemic, including using remote methods to guide future research ethics and practice. In a field where methods and approaches continue to evolve and where the risk of harm is high, a commitment to transparently reporting the ethical choices research teams made is essential. We argue for greater attention to the development, implementation and reporting of ethics protocols within future studies and publications, to meet commitments to protect participant and researcher safety, to enhance data quality and to ensure researchers can learn from, and are accountable to, each other. To that end, we offer recommendations for researchers and journals across disciplines on which aspects are critical to ensure transparency, offering a 14-item checklist both to guide study design, research reporting and peer-review. Although our study presents new findings explicitly focused on data collection during COVID-19, poor reporting on ethical practices predates the COVID-19 pandemic.[11] The stocktaking on ethics for VAW/VAC research comes at a critical time, when changes in data collection methodologies, advances in information technology and macrochanges across settings have raised debates around harmful practices in data collection. Results suggest the need for greater consensus, guidance and accountability in order to ensure a 'do no harm' approach.

METHODS

Information sources and search strategy

We searched the studies compiled in the Global Tracker of Studies of VAW/VAC during COVID-19 (referred to as 'the tracker'), compiled from Google scholar, as well as studies found via multiple listservs, newsletters and social media posts and updated weekly starting in April 2020 by the lead author (search terms: 'COVID-19' and 'violence').[12] On 5 November 2021, there were 279 studies in the tracker representing a universe of 3250 hits on google scholar. Titles and abstracts were screened by the lead author and all studies including analysis of VAW/VAC measures during COVID-19 were incorporated in the tracker, including physical, sexual and emotional violence and proxy measures.

Selection process and inclusion criteria

From the tracker, we selected all peer-reviewed studies where primary data collection methods were used to collect data on VAW and/or VAC, including studies which collected data on their co-occurrence. The following types of studies were excluded: (1) those in non-English languages, (2) published in grey literature, (3) analysis of administrative or social media data, (4) modelling studies using prepandemic data, (5) studies analysing proxy measures of violence (eg, conflict, attitudes and perceptions of violence risk) and (6) data from services providers or healthcare workers. online supplemental figure A1 provides additional detail on the sample selection.

Development of criteria for reporting violence research

We developed a checklist for the ethical reporting of violence research drawing on best practice guidelines for implementation of safe data collection for VAW/VAC established prior to the pandemic.[13–16] In addition, as the pandemic increased use of remote data collection methods and challenges in accessing service provision, existing guidelines were augmented by key publications outlining best practices for VAW/VAC research during the pandemic.[6 7] Finally, a review of literature was undertaken to explore any studies summarising or proposing guidelines for ethical reporting of interpersonal violence prepandemic, as to build on or complement existing reporting guidelines.[11 17 18]

We developed a 14-item checklist of best practices for reporting violence research grouped into four domains: (1) Institutional Review Board (IRB) approval, (2) interviewer selection, training and support, (3) sampling and engaging with respondents and (4) referrals and adverse events (table 1). Recognising that guidelines for the ethical reporting of violence research do not currently

Table 1 Domain and item definition for ethical reporting

Domain	No	Item	Description of criteria
Institutional Review Board (IRB)	1	Reports ethical clearance from an IRB?	Any mention of IRB clearance is recorded as 'Yes.' While ideally some studies would have both national and international IRB clearance, this requirement is variable based on location and institutional affiliation of authors. In addition, although national IRB is expected at a minimum, some countries do not have functioning, appropriate IRBs during periods of conflict or depending on disciplinary focus of the study. An international IRB is often preferred, in addition to national IRB, however this would only be sought if at least one coauthor is resident outside the country of study. As all studies collect primary data, there should be no IRB exemptions, therefore statements asserting ethical clearance is not needed are treated as 'No'.
Interviewer selection, training and support	2	Reports how appropriate interviewers were selected?	This includes prior experience working on similar topics, with specific qualifications (eg, health or social workers), same-sex interviewers, checks on interviewer criminal records, checks with law enforcement, etc (recorded as NA if web-based).
	3	Reports undertaking a dedicated training of interviewers to collect violence data?	Must be beyond general ethics training, to include in-depth modules or specialised trainers/ training to equip interviewers to deal with topic with greater sensitivity, confidentiality, respond to adverse events, etc (reported as NA if web-based).
	4	Mention support in place to protect safety and health of the study team to avoid vicarious trauma?	This could include debriefs, periodic check-ins or support for adverse events experienced via provision of services or counselling (reported as NA if web-based).
Sampling and engaging with respondents	5	Describes how sampling was designed to support participant safety?	Includes specific actions such as sampling only one person per household, split-sample approaches, safe/secure devices as an inclusion criteria (for remote surveys), screening approaches for web-surveys to support safety, participant-driven sampling approaches and data security approaches if survivors are purposefully sampled. Must go beyond random sampling or snowball sampling to explain why this was the safest approach taken and safety considerations within these approaches.
	6	Explains informed consent was obtained or the informed consent procedure?	Explicitly mentions informed consent was obtained, consent was sought or explains participants were told their participation is voluntary, the general content of questions and that they are able to stop the interview at any time. For violence in particular, additional components could include safety protocols in approaching participants, and if graduated consent was implemented or the true intent of the study was not disclosed until interviewers were alone with the participant.
	7	For samples focused on interviewing minors: explains process for or waiver of (1) parent/ guardian consent and (2) minor assent?	For surveys focused on interviewing minors (0–17 years): explains precautions or processes taken in the informed consent/assent process. This could include requests for waivers of parental/guardian consent (if applicable) (NA if the sample does not focus on VAC measures and target minors).
	8	Mentions if participation incentives and/or reimbursement for time were given?	Mentions if participants were given any compensation, incentive or benefits for participating in the data collection, including in-kind (eg, air time, soap) or monetary (eg, mobile money, small payment). Alternatively, mentions if no participant incentive was given.
	9	Reports actions taken to obtain privacy and ensure participant safety during the interview/data collection?	Reports on at least one specific action taken to ensure participant privacy and/or safety. Privacy actions could include ensuring participants are interviewed out of listening range of other individuals, or for phone surveys, instructing participant to turn off speaker phone or find a private place to talk at the beginning of the interview. For web-based surveys, indicating script messages were provided at the start of the survey to instruct the participant to complete the survey alone, a protocol or instructions for if privacy is lost or mentioning how challenges of shared technology (computers, phones) and shared access to messages, webpages and texts were considered or dealt with. Safety actions could include periodic safety checks, option to end survey if participants need to quickly exit or drop the call, implementing a safe word for interviewers to understand safety was compromised remotely, describing steps taken to reduce participant distress or increase comfort during the interview itself. This must go beyond informed consent procedures which may generally tell participants that they can exit the interview at any time if they wish.
	10	Reports whether feedback was collected from respondents on their participation experience?	Includes questions which attempt to assess if the participant felt comfortable answering the questions, had feedback on the interview process, felt safe during the data collection or if they incurred distress, emotional or other repercussions.

Continued

Table 1 Continued

Domain	No	Item	Description of criteria
Referrals and adverse events	11	Reports providing respondents with referral information, ideally deidentified to maintain privacy and modified to assure services are available during COVID-19?	Includes a reference to standard practice or protocols providing participants with the option of obtaining additional information, assistance to counselling or specialised services, often via a hotline/helpline or physical cards with contact information (ideally all participants regardless of disclosure of violence). As physical cards carry a risk if perpetrators uncover this information—cards are typically deidentified, without clear information as to their purpose, and participants should be warned of this risk. An assessment of if services were functioning or available during COVID-19 lockdowns could accompany this information.
	12	Mention actions taken, an adverse event protocol or response plan for acute cases where participants or family members require short-term follow-up, suitable to be implemented during COVID-19?	Includes mention of how teams identified or addressed cases where participants or family members were in immediate danger or in need of active assistance in accessing services, including facilitating services directly contacting individuals within a short time span (eg, 24 or 48 hours), providing immediate transport to services or conducting a safety follow-up check (via phone or in person). Includes description of protections for individual identifying information and data security issues in cases of disclosure to third parties in monitoring of follow-up to services. Good practice includes monitoring to ensure cases of adverse events and risks are counted, addressed and actioned in a timely manner.
	13	For samples focused on interviewing minors and measuring VAC, or targeting people with disabilities: report to what extent and how referrals and help seeking were facilitated?	For samples focused on interviewing minors (0–17 years) and measuring VAC, or targeting people with disabilities: gives additional information on how referrals and help-seeking were facilitated, including help in making calls, transport or accessing information (NA if the sample does not focus on VAC measures and target minors, or does not target people with disabilities).
	14	For samples focused on interviewing minors and/or measuring VAC: report if and how mandatory reporting laws were considered or followed?	For samples focused on interviewing minors (0–17 years) and/or measuring VAC: includes mention of how confidentiality might be limited based on mandatory reporting laws, what steps were actively taken to address (obtain waivers) or comply with law, or why the study is exempt from or does not have to consider these issues (NA if the sample does not focus on VAC measures and target minors).

All studies were assessed drawing on published information in the main article or online supplemental material, rather than reviewing additional cited material.
NA, not applicable; VAC, violence against children.

exist, checklist items were defined to give studies maximum flexibility for a 'yes' coding. For example, for item one regarding IRB approval, a 'yes' coding was given regardless of where the IRB was located, or the quality of the IRB assessment. For item two regarding appropriate interviewer selection, any relevant selection criteria was accepted with justification (eg, prior experience with sensitive topics, sex of interviewer, etc), rather than imposing prespecified criteria which might differ by setting, survey objectives or target population. For several items, not all studies qualified to be assessed and these were coded as 'not applicable'. For example, interviewer selection, training and support items were not applicable for studies that exclusively collected self-administered web-based studies and items 7, 13 and 14, were only relevant to studies focused on collecting VAC data, either from minors or from other adults.

Data extraction and analysis

The lead author extracted the background characteristics of each study, including the country of data collection, methodology, mode of data collection and violence measures collected, which was cross-checked by individual reviewers (online supplemental table A1). The 14-item checklist was then applied to each study, drawing on information in the main article or online supplemental material. To ensure consistency in coding, four reviewers (AP, AB, SM and RQHL) first used the checklist to score five studies independently and discussed concordance of answers. Subsequently, each study was randomly assigned to two reviewers and scored independently. Considering all studies and all items, the total percentage of discordant results after the first round of scoring was low (4%). Discrepancies were subsequently discussed and resolved, when required, by a third reviewer.

Scores for each checklist item were descriptively summarised overall and by study characteristic (eg, methodology, violence type, etc). Scores only include studies which are relevant by item or characteristic. For example, for items related to collecting data on VAC, the denominator is all applicable studies with data collection on VAC and/or among minors. In addition, a summary measure was created by averaging the proportion of items reported on (coded as 'yes'), among the total applicable number of items (all items coded as 'not appliable' were not included in this score). There is no missing data for this analysis, as may be present in traditional

reviews, as if studies did not report on a particular ethics item that was applicable in their study, they were coded as 'No'. We report checklist items and summary overall, by methodology, violence and reporting type, and by mode of data. Note that in some cases, a study can fall into more than one category, thus appear for both face-to-face and web-based data collection if a combination of the two approaches were used. We do not assess risk of bias, as this review assesses ethics reporting, which is related to rigour of methodology, but is not focused on exposure outcome relationships. All descriptive analysis was conducted in Stata V.15.[19] This study is exempt from ethical approval, as it uses data fully in the public domain and does not use data on human subjects. All stages of the review were documented, but a protocol was not prepared or registered. While there are no standardised reporting guidelines for rapid reviews, we report on best-practice Preferred Reporting Items for Systematic reviews and Meta-Analyses in online supplemental table A5.[20]

RESULTS

Studies included

Table 2 describes the adherence to each checklist item among all 75 eligible studies. The first column under each category (n) shows the total number of eligible studies for which the checklist item is applicable (the denominator from which the score is calculated), while the second column under each category (%) reflects the percentage meeting (scoring 'Yes') to each checklist item, among those applicable. Most studies collected quantitative data (88%, n=66), in comparison to qualitative data (17%, n=13). The sample was similarly heavily skewed towards collection of VAW data (88%, n=67) and self-reported experience measures (75%, n=64), as compared with VAC data (17%, n=13) or proxy reports (eg, reporting by household members of violence experienced by children in the same household) (21%, n=16). Web-based methods were the most frequently used (65%, n=49), followed by telephone (21%, n=16) and face-to-face data collection (20%, n=15). The majority of publications were published in public health journals (55%, n=41), while a smaller percentage was in medical journals and other social science journals (23%, n=17 for both disciplines). Data collection occurred in the following regions: South Asia (n=15), sub-Saharan Africa (n=13), Middle East and North Africa (n=13), Europe (n=13), North America (n=12), Asia-Pacific (n=5), Latin America and the Caribbean (n=3) and global (cross regional, n=1). Recall that if studies collected more than one type of data, using multiple methodologies or in multiple settings, the study appears in multiple categories.

Ethical reporting

Results show adherence to best practices was reported on average for 31% of scored items across the 75 studies. Reporting was highest for: ethical clearance (87%) and informed consent/assent (84%/83%, assent scored for six eligible studies). Reporting was lowest for facilitating referrals for minors (0%, scored for six eligible studies), soliciting participant feedback (0%), measures to promote interviewer safety and support (3%, scored for 30 eligible studies), safe sampling designs (5%), implementation of adverse event protocols and if mandatory reporting for violence against minors was considered (both at 8%, the latter scored for 13 eligible studies). Other items were scored as follows: 33% of studies noted how interviewers were selected to support participant safety (scored for 30 eligible studies), 31% of studies report if incentives were given for participation in the study, 25% of studies report giving some type of violence referral information, 21% report any measure taken to support participant safety and privacy during the interview and 13% report specialised enumerator training on violence topics (the latter scored for 30 eligible studies). Findings suggest little overall variation on the proportion of items reported on by study methodology, type of violence and type of reporting (questions about self experience of violence vs proxy reporting)—however, there is some divergence by modality of data collection. In particular, studies using face-to-face data collection appeared to report fewer items (22% of items), while telephone-based surveys report higher adherence to ethics (35% of items). Finally, we examine ethics reporting by discipline of the journal where studies were published, finding little variation across public health, medical and other social science journals (online supplemental table A2). Tables with study-specific results by item are provided in online supplemental table A3.

Examples of best practice reporting by domain and item from the highest scoring papers in online supplemental table A4.[21–28] For example, regarding interviewer selection and training, a study undertaken in Bolivia interviewing adolescents reported that 'enumerators were training in each case by an expert on Child Safeguarding Policy, following stringent ethical guidelines on how to ask questions', which included measures to verify privacy and use of same-sex enumerators.[23] With respect to sampling and participant engagement, a study asking about violence online in Australia offered seven considerations of how participants were approached, including how 'the survey was designed with multiple landing pages and eligibility questions (including a 'safety trap') to screen out ineligible participants (eg, men) from accessing the survey' to promote participant safety.[21] Finally, with respect to referrals and adverse events, a study in Ethiopia noted how women who were in need of urgent help or who had experienced severe intimate partner violence were accompanied to a local referral hospital to access counselling care units.[28] Likewise, a study in India among survivors of violence noted that as per government guidelines, follow-up measures were taken by counsellors via phone to call each woman to understand their situation and offer support.[27] While the variety of actions reported is diverse, these cases can serve as examples of what and how to report ethically on VAW/VAC data collection.

Table 2 Descriptive statistics for ethical items by study characteristic

	All studies		Methodology				Type of violence				Type of reporting				Modality of data collection					
			Quantitative		Qualitative		VAW		VAC		Self-reports		Proxy reports		Face to face		Telephone		Web based	
	n=75		n=66		n=13		n=67		n=13		n=64		n=16		n=15		n=16		n=49	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Domain 1: Institutional Review Board																				
1. Ethics clearance	75	0.87	66	0.88	13	0.85	67	0.87	13	0.92	64	0.88	16	0.88	15	0.73	16	1.00	49	0.88
Domain 2: Interviewer selection, training and support																				
2. Interviewer selection	30	0.33	21	0.43	12	0.17	29	0.34	3	0.33	29	0.34	3	0.33	15	0.27	16	0.38	4	0.00
3. Interviewer training	30	0.13	21	0.14	12	0.08	29	0.14	3	0.00	29	0.14	3	0.00	15	0.13	16	0.13	4	0.00
4. Interviewer safety and support	30	0.03	21	0.00	12	0.08	29	0.03	3	0.00	29	0.03	3	0.00	15	0.00	16	0.06	4	0.00
Domain 3: Sampling and engaging with respondents																				
5. Sampling design	75	0.05	66	0.03	13	0.15	67	0.04	13	0.08	64	0.06	16	0.00	15	0.00	16	0.13	49	0.06
6. Informed consent	75	0.84	66	0.85	13	0.85	67	0.84	13	0.85	64	0.86	16	0.81	15	0.80	16	0.81	49	0.84
7. Informed assent (minors)	6	0.83	6	0.83	2	1.00	3	1.00	5	0.80	5	0.80	2	1.00	1	0.00	2	1.00	4	1.00
8. Participant incentives	75	0.31	66	0.33	13	0.23	67	0.30	13	0.38	64	0.28	16	0.56	15	0.00	16	0.31	49	0.39
9. Interview privacy and safety	75	0.21	66	0.21	13	0.23	67	0.24	13	0.15	64	0.25	16	0.06	15	0.20	16	0.50	49	0.12
Domain 4: Referrals and adverse events																				
10. Participant feedback	75	0.00	66	0.00	13	0.00	67	0.00	13	0.00	64	0.00	16	0.00	15	0.00	16	0.00	49	0.00
11. Referral information	75	0.25	66	0.27	13	0.15	67	0.28	13	0.15	64	0.30	16	0.13	15	0.20	16	0.38	49	0.20
12. Adverse event protocol	75	0.08	66	0.08	13	0.08	67	0.09	13	0.00	64	0.09	16	0.00	15	0.13	16	0.19	49	0.02
13. Facilitated referrals (minors)	6	0.00	6	0.00	2	0.00	3	0.00	5	0.00	5	0.00	2	0.00	1	0.00	2	0.00	4	0.00
14. Mandatory reporting (minors)	13	0.08	13	0.08	2	0.00	6	0.17	12	0.08	7	0.00	9	0.11	1	0.00	3	0.00	10	0.10
Total (among non-missing items)	75	0.31	66	0.31	13	0.26	67	0.31	13	0.29	64	0.32	16	0.29	15	0.22	16	0.35	49	0.31

The first column under each category (n) shows the total number of eligible studies for which the checklist item is applicable (the denominator from which the score is calculated), while the second column under each category (%) reflects the percentage meeting (scoring 'Yes') to each checklist item, among those applicable. Items 7, 13 and 14 only apply to certain studies, those that either target minors for interviews, ask minors violence questions directly or ask about VAC. Items 2, 3 and 4 only apply to studies that use interviewers to collect data and do not apply to studies that exclusively use web-based data collection. All eligible studies are included by subcharacteristic and therefore may appear in more than one category—eg, collect both VAW and VAC measures, collection both qualitative and quantitative data, collect data using multiple methodologies (face to face and telephone) and so forth.
VAC, violence against children; VAW, violence against women.

DISCUSSION

Our results indicate insufficient reporting on ethics of VAW/VAC research across disciplines. Given the number of studies that fail to report checklist items, findings raise important questions about the application of existing global guidance in violence research, the limited guidance issued by IRBs and the seeming lack of criteria used and enforced by journals. Although our study includes research conducted up to November 2021 of the COVID-19 pandemic, poor reporting on ethical practices predates the COVID-19 pandemic. The limited reporting of research ethics we document is illustrative of a larger and more systemic limitation in the field of violence research. For example, a review of studies on childhood sexual abuse in India in 2018 found that only 2/3 of the 51 included studies reported approval by an ethics committee, obtaining informed consent and ensuring confidentiality for participants. Engagement with safeguarding of participants was also poor, with only 25% assessing further risk of sexual abuse and providing services, and no studies describing whether they adhered to the mandatory reporting requirement in India.[11] In addition, a review of methodology and ethics in 21 studies including gender-based violence outcomes using remote data collection methods (focused on humanitarian and fragile settings) showed only four studies reported offering referral services and only five studies reported any other safety-related measures.[29] Qualitative studies of study interviewers show that they often bear the psychological burden/experience secondary trauma if robust procedures to ensure both their own, and participant, safety are not in place.[30–32]

This lack of documentation on adherence to ethical guidance for VAW/VAC research raises serious concerns about the possibility of harm to research participants and interviewers, the quality of data and the standards of acceptability and accountability within our field. We contend that limited attention to ethics affects both participants who disclose violence and researchers who receive these disclosures, what happens when these disclosures are received, as well as the comfort participants have disclosing in the first instance. Limited ethical reporting in peer-reviewed literature also makes it challenging for violence researchers to learn from each other and for early career researchers to learn approaches to ethical data collection and reporting.

We acknowledge it is possible that both journal editors and ethics committees themselves were affected by COVID-19. For example, a study of Italian ethics committees found that the workload of committees in highly affected areas of the country increased substantially during COVID-19. This, coupled with a decrease in the ability of committee members to work, led some participants to report that 'it was impossible to perform an accurate analysis of the submitted documentation'.[33] The reprogramming of research to use remote methods required ethics committees and other research stakeholders to rapidly make decisions about new methodologies without centralised guidance. Deviations from established ethical protocols are not unprecedented, and have been deemed acceptable in some circumstances in the context of rapidly evolving humanitarian and emergency situations.[34] However, a review of studies more generally with human participants during COVID-19, not specific to violence, found that even more basic ethical reporting has been insufficient—finding up to 24% of observational studies did not report approval by an ethics committee, and up to 38% did not report informed consent from participants.[35] Our findings suggest that violence research during the pandemic faces similar shortcomings.

Case studies and learning from practice can help ensure ethical guidance is relevant, complete, logistically feasible and appropriate for new modalities and contexts of data collection. For example, a study reflecting on practical lessons from eight studies collecting data on VAW/VAC during COVID-19 in Brazil, Britain, Kenya, Nepal, Uganda and Zimbabwe suggests that several factors were critical in successfully redesigning studies.[9] First, strong existing research partnerships were essential, with teams who were experienced in collecting sensitive data and had existing contact and rapport with participants and local referral structures. Second, it was necessary to adapt data collection strategies, with most studies pivoting to remote modalities and modifying consent and privacy protocols. For example, as part of the *Maisha Fiti* study in Kenya, interviewing female sex workers, the study team made an initial phone call to participants to assess privacy and safety, setting a time and day for a future interview when conditions were optimal for the interview. Third, additional safeguarding processes were necessary in the context of remote data collection. For example, in the Contexts of Violence in Adolescence Cohort (CoVAC) study in Uganda, the team hired a counselling team to coordinate referrals and revised the referral directory—recontacting all referral services to assess if they were still functional during the pandemic and their ability to act on cases, including options to engage in phone counselling and remote service provision.[36] The challenges of ensuring access to quality referral services, particularly for children, are not unique to the pandemic context, however are an additional investment study that teams must consider as they plan for data collection.[37] Finally, teams facilitated remote support for interviewers. These types of reflection and documentation of strategies in different contexts can help future researchers understand options and assess trade-offs in the ethical collection of violence data.

Our study has limitations. First, although we aimed to be comprehensive, it is possible that we missed studies published during the search period. Second, we only scored whether studies mentioned the presence of a particular criterion, rather than on the quality of their adherence to it, or the level of detail provided. Third, we do not exclude the possibility that studies employed good ethical practices in data collection, without reporting this

explicitly in the resulting publication. Due to the diversity of possible contexts and target groups, we did not explicitly score all potential considerations for special populations which may require additional considerations, including attention to legality around diverse types of violence (eg, undocumented migrants, trafficked persons, prisoners and pregnant women). Finally, there are other generalised ethical aspects not scored here which are also relevant. These include, among others: general data protection protocols (particularly with technology-facilitated data collection via Apps or interactive voice recall), assessment of whether results are actionable and useful to communities, policy equipoise (for intervention studies), an emphasis on equity and inclusion in sampling, positionality of researchers and whether community members and survivors were included in the research design and in study steering committees, and fair, safe, adequate working conditions for data collection staff.[38–40] We choose not to score these criteria, as many of these aspects fall outside the timelines of journal articles or are less likely to be documented in publications. However, these additional criteria as well as the quality or content of the criteria we propose could be further evaluated or assessed.

CONCLUSIONS

Poor reporting of ethical practices in violence research is widespread. In VAW/VAC research, there is a clear risk of harm to participants if guidance is not followed as well as an impact on the quality of the data produced. Our findings point to the importance of the development and use of reporting guidelines for research on VAW/VAC. Based on our work, the domains and checklist items outlined in table 1 provide a starting point for such guidance. For violence researchers, the checklist does not substitute for following recommended ethical guidelines, however can providing strategies that can be incorporated into the design, implementation and reporting of research studies. Both ethics committees and journal editors can assess violence research against reporting guidance, similar to the Consolidated Standards of Reporting Trials or Strengthening the Reporting of Observational Studies in Epidemiology guidance for reporting of trials and observational studies, respectively.[41 42] Additionally, funders could use the checklist to assess research proposals for violence research to ensure mechanisms for safety referrals and feedback are integrated into the study from its design. Finally, the checklist could be integrated into efforts to build capacity, particularly in the context of training students, researchers and data collection teams globally. Efforts to improve the reporting of VAW/VAC research are an important step to improve the quality and safety of violence research and fulfil the commitments to listen to and learn from participants.[40] As methodologies for collecting and analysing data evolve, we should continue to promote production of actionable evidence to improve understanding and practice surrounding prevention of VAW/VAC, as well as commitment to a do no harm approach.

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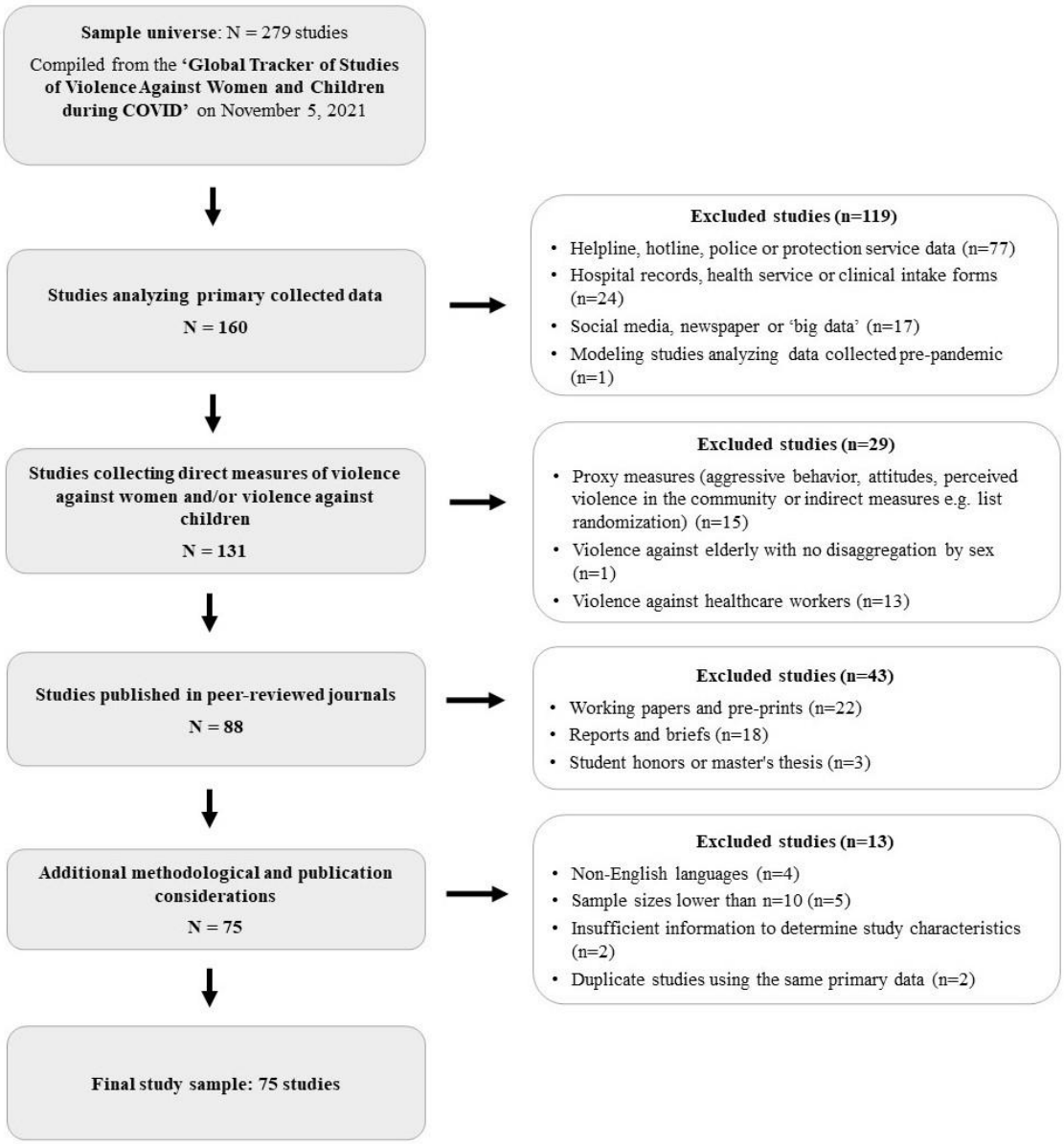
Supplementary file: Ethical reporting of research on violence against women and children: A review of current practice and recommendations for future guidelines

Figure A1. Flow diagram of study selection



Notes: The tracker is an open access database of analysis studies compiled through weekly searches of google scholar ("COVID-19" AND "violence", hits = 3,250), as well as studies found via multiple listservs, newsletters and social media posts. Parameters for inclusion are: 1) Violence against women and/or violence against children studies (excludes studies only analyzing violence against men), 2) studies analyzing psychological/emotional, physical and sexual violence experienced in and outside the home, including attitudes and proxy measures (exclude broader forms of gender-based violence, e.g. child marriage, female genital mutilation, child labor etc.) and self-harm (suicide, self-injury) as well as surveys and data from service provider, 3) No restrictions on study methodology, location or type of publication.

Table A1. Included study characteristics

No	Study	Location	Methods	Sample	Mode of data collection	Type of measure	Report	Violence measure(s) / themes explored (recall period)
1	AboKresha et al. (2021)	Egypt	Quant	1,118 parents of children <18 years	Web-based	VAC	Proxy	Child abuse screening tool (ICAST-P) (last 2 weeks)
2	Abrahams et al. (2021)	South Africa	Quant	885 women aged ≥ 15 years	Telephone	VAW	Self	Composite Abuse Scale, short form (last 12 months)
3	Abuhammad (2020)	Jordan	Quant	687 women aged 18-55 years	Web-based	VAW	Self	24 questions, scale NR (during COVID-19)
4	Adibelli et al. (2021)	Turkey	Quant	332 women aged ≥ 18 years	Face-to-face; Web-based	VAW	Self	Domestic violence against women scale (recall NR)
5	Ajayi et al. (2021)	Nigeria	Qual	30 men & women in 3 FGDs aged 30-60 years	Face-to-face	VAW	Proxy	IPV (during lockdown)
6	Alharbi et al. (2021)	Saudi Arabia	Quant	2,254 women aged ≥ 18 years	Web-based	VAW	Self	WHO multi-country study IPV tool (before & after COVID-19)
7	Aolymat (2021)	Jordan	Quant	200 women aged ≥ 18 years	Web-based	VAW	Self	Domestic abuse, scale NR (during COVID-19)
8	Arenas-Arroyo et al. (2021)	Spain	Quant	8,951 women aged 18-60 years	Web-based	VAW	Self	IPV, scale NR (before & during COVID-19)
9	Augusti et al. (2021)	Norway	Quant	3,545 adolescents age 13-16	Web-based	VAC	Self	Modified Parent-Child Conflict Tactics Scale; witnessing domestic violence; sexual abuse; online sexual abuse, scales NR (during COVID-19)
10	Behera et al. (2021)	India	Mixed	45 women aged 21-61 years	Telephone	VAW	Self	Domestic violence, scale NR (recall NR)
11	Boxall et al. (2020)	Australia	Quant	15,000 women aged ≥ 18 years	Web-based	VAW	Self	Physical &/or sexual IPV; Stalking; Psychological Maltreatment of Women Inventory–Short Form (last 3 months)
12	Cannon et al. (2021)	United States	Quant	374 men & women > 18 years	Web-based	VAW	Self	IPV, scale NR (last 10 weeks, during COVID-19)
13	Cano-Lozano et al. (2021)	Spain	Quant	2,245 youth aged 18-25 years	Web-based	VAW	Proxy	Child-to-parent Violence Questionnaire, youth version; The Violence Exposure Scale (domestic violence sub-scale) (during confinement)
14	Chatzifotiou & Andreadou (2021)	Greece	Qual	15 female survivors aged 30-50 years	Face-to-face	VAW	Self	IPV (during the pandemic)
15	Chung et al. (2020)	Singapore	Quant	258 parents of children ≤ 12 years	Web-based	VAC	Proxy	Harsh parenting (during lockdown)

No	Study	Location	Methods	Sample	Mode of data collection	Type of measure	Report	Violence measure(s) / themes explored (recall period)
16	Das et al. (2021)	India	Qual	50 women aged 15-49 years	Telephone; Web-based	VAW	Self	Domestic violence (lifetime & during lockdown)
17	Das et al. (2021b)	India	Quant	159 women aged 15-49	Face-to-face	VAW	Self	WHO multi-country survey IPV tool (last 2 months)
18	Dekel & Abrahams (2021)	South Africa	Qual	16 female survivors aged 20-52 years	Telephone	VAW	Self	IPV (during COVID-19 lockdowns)
19	Diaz et al. (2021)	United States	Quant	417 female youth aged 15-28 years	Web-based	VAW	Self	Adverse Childhood Experiences scales, sexual abuse & IPV (during COVID-19)
20	Ebert & Steinert (2021)	Germany	Quant	3,818 women aged 18-65 years	Web-based	VAC; VAW	Proxy; Self	Modified WHO multi-country study IPV tool, short form; Corporal punishment of children, scale NR (last month)
21	Egger et al. (2021)	Kenya	Quant	8,572 households (female respondents)	Telephone	VAC; VAW	Proxy; Self	Emotional, physical & sexual IPV; Child physical punishment, scale NR (last 2 weeks)
22	El-Nimr et al. (2021)	Cross-country	Quant	490 women ≥ 18 years	Web-based	VAW	Self	Modified WHO IPV instrument (before & after lockdown)
23	Every-Palmer et al. (2020)	New Zealand	Quant	2,426 men & women aged 18-90 years	Web-based	VAW	Self	Physical assault; Harassment & threatening behavior; sexual assault, scales NR (during lockdown)
24	Gebrewahd et al. (2021)	Ethiopia	Quant	682 women aged ≥ 18 years	Face-to-face	VAW	Self	WHO multi-country survey IPV tool (during COVID-19)
25	Ghimire et al. (2020)	Nepal	Quant	556 men & women aged ≥ 18 years	Web-based	VAW	Proxy; Self	IPV; interpersonal violence, scales NR (during lockdown)
26	Gibbons et al. (2021)	Argentina	Quant	1,502 women ≥ 18 years	Web-based	VAW	Self	WHO multi-country survey IPV tool (1 year prior & 2 months during quarantines)
27	Gresham et al. (2021)	United States	Quant	1,803 men & women	Web-based	VAW	Self	Experience with Battering Scale; Abusive Behavior Inventory (during COVID-19)
28	Gulesci et al. (2021)	Bolivia	Quant	511 male & female youth aged 16-19 years	Telephone	VAW	Self	Gender-based violence, scale NR (last 3 months)
29	Hamadani et al. (2021)	Bangladesh	Quant	2,174 women average age 24 years	Telephone	VAW	Self	WHO multi-country survey IPV tool (since March 2020)
30	Haq et al. (2020)	Pakistan	Quant	389 women	Web-based	VAW	Self	Emotional, verbal & physical violence, scale NR (during lockdown)

No	Study	Location	Methods	Sample	Mode of data collection	Type of measure	Report	Violence measure(s) / themes explored (recall period)
31	Hastuti et al. (2021)	Indonesia	Qual	20 female survivors in 12 IDIs & 1 FGD	Face-to-face	VAW	Self	Violence against women (during COVID-19)
32	Huq et al. (2021)	India	Qual	586 female survivors primarily aged 20-49 years	Telephone	VAW	Self	Violence against women (during COVID-19)
33	Ibitoye & Ajagunna (2021)	Nigeria	Qual	45 women aged 15-49 years	Face-to-face	VAW	Self	Sexual violence & abuse (during COVID-19)
34	Jetelina et al. (2020)	United States	Quant	1,759 men & women aged ≥ 18 years	Web-based	VAW	Self	Extended Hurt, Insulted, Threatened & Screen (E-HITS) construct (change since COVID-19)
35	Jung et al. (2020)	Germany	Mixed	3,545 men & women average age 40 years	Web-based	VAW	Self	Interpersonal violence, scale NR (last 4 weeks)
36	Karp et al. (2021)	Kenya	Mixed	756 female adolescents & youth aged 15-24 years; 57 female adolescents & youth aged 15-24 years	Telephone	VAC; VAW	Self	Modified IPV Conflict Tactics Scale (last month)
37	Lampe et al. (2021)	Germany	Quant	67 male & female adult survivors average age 49 years	Telephone	VAW	Self	Modified Hurt-Insult-Threaten-Scream (HITS) scale (last 2 weeks)
38	Lawson et al. (2020)	United States	Quant	342 parents of children aged 4-10 years	Web-based	VAC	Proxy	The Conflict Tactics Scale Parent-Child version (last 2 weeks)
39	Lee et al. (2021)	United States	Quant	291 male & female adults aged ≥ 18 years	Web-based	VAW	Self	Verbal & physical fights, scale NR (last 2 weeks during COVID-19)
40	Machlin et al. (2021)	United States	Quant	120 primary caregivers of children aged 4-11 years	Web-based	VAC; VAW	Proxy	Conflict Tactics Scale (last 8 weeks during COVID-19)
41	Maftei & Danila (2021)	Romania	Quant	1,113 men & women aged 18-65 years	Web-based	VAW	Proxy; Self	Cyber Aggression in Relationships Scale (CARS) (last 6 months)
42	Mahapatro et al. (2021)	India	Quant	36 female survivors	Telephone	VAW	Self	Domestic violence, scale NR (during COVID-19)
43	Mahmood et al. (2021)	Iraq	Quant	346 women aged 19-66 years	Web-based	VAW	Self	Modified WHO multi-country survey IPV tool (before & during lockdown)
44	Moawad et al. (2021)	Egypt	Quant	509 women aged ≥ 18 years	Web-based	VAW	Self	Modified WHO multi-country survey VAW tool (during COVID-19)
45	Moya et al. (2021)	Colombia	Quant	1,376 primary caregivers of children aged 2-5 years	Face-to-face; Telephone	VAW	Self	Victim of violence, scale NR (recall NR)

No	Study	Location	Methods	Sample	Mode of data collection	Type of measure	Report	Violence measure(s) / themes explored (recall period)
46	Muldoon et al. (2021)	Canada	Quant	216 women ≥ 16 years	Web-based	VAW	Self	Modified WHO multi-country survey IPV tool (before & during pregnancy & postpartum)
47	Naghizadeh et al. (2021)	Iran	Quant	250 women average age 31 years	Face-to-face	VAW	Self	Modified WHO multi-country survey IPV tool (during COVID-19)
48	Oguntayo et al. (2020)	Nigeria	Quant	356 men & women aged ≥ 18 years	Web-based	VAW	Self	Composite Abuse Scale for IPV, short form (lifetime, recent & current)
49	Ojeahere et al. (2021)	Nigeria	Quant	474 men & women aged 18-65 years	Web-based	VAW	Self	IPV, scale NR (prior to & during lockdown)
50	Parrott et al. (2021)	United States	Quant	510 men & women ≥ 18 years	Web-based	VAW	Proxy	Psychological Aggression & Physical Aggression subscales of the Revised Conflict Tactics Scale (6 months before & since lockdown)
51	Pattojoshi et al. (2020)	India	Quant	560 women average age 37 years	Web-based	VAW	Self	Spousal violence, scale NR (before or since COVID-19 lockdown)
52	Phillimore et al. (2021)	Cross-country	Qual	52 male & female survivors aged 20-60 years	Telephone; Web-based	VAW	Self	Structural & gender-based violence (before & during COVID-19)
53	Pinchoff et al. (2021)	Kenya	Quant	2,009 men & women ≥ 18 years	Telephone	VAW	Self	Household violence, scale NR (due to COVID-19)
54	Plasilova et al. (2021)	Czech Republic	Quant	429 women ≥ 18 years	Web-based	VAW	Self	Modified WHO multi-country survey IPV tool (last 3 months)
55	Poonam et al. (2020)	India	Quant	300 men & women	Web-based	VAW	Self	Domestic violence, scale NR (during lockdown)
56	Raj et al. (2020)	United States	Quant	2,081 men & women ≥ 18 years	Web-based	VAW	Self	IPV & forced sex, scale NR (lifetime)
57	Rayhan & Akter (2021)	Bangladesh	Quant	605 women aged 16-49	Face-to-face	VAW	Self	WHO multi-country survey IPV tool (since COVID-19)
58	Sabri et al. (2020)	United States	Qual	45 female survivors	Telephone	VAW	Self	IPV, stalking & controlling behaviors (during COVID-19)
59	Sari et al. (2021)	Netherlands	Quant	206 parents of toddlers	Web-based	VAC	Proxy	Modified Parent-Child Conflict Tactics Scale (last 2 weeks)
60	Schokkenbroek et al. (2021)	Belgium	Quant	1,491 men & women ≥ 18 years	Web-based	VAW	Self	Aggression subscale of the Conflict and Problem Solving Scales, short version (during lockdown)
61	Sediri et al. (2020)	Tunisia	Quant	751 women aged 18-69 years	Web-based	VAW	Self	Domestic violence, scale NR (before & during lockdown)
62	Sharma & Khokhar (2021)	India	Quant	94 men and women ≥ 20 years	Web-based	VAW	Self	Domestic violence, scale NR (last year & changes during lockdown)

No	Study	Location	Methods	Sample	Mode of data collection	Type of measure	Report	Violence measure(s) / themes explored (recall period)
63	Shokair & Hamza (2020)	Egypt	Quant	160 child survivors in 5th or 6th grade	Face-to-face	VAC	Self	Family Violence Diagnosing Scale (lifetime)
64	Siegel & Lahav (2021)	Israel	Quant	710 men & women aged 18-81 years	Web-based	VAC	Self	Childhood Trauma Questionnaire (lifetime)
65	Soron et al. (2021)	Bangladesh	Quant	136 men & women aged 17-50 years	Web-based	VAW	Self	Domestic violence, scale NR (lifetime & during lockdown)
66	Spencer et al. (2021)	United States	Quant	365 men & women aged 17-78 years	Web-based	VAW	Proxy	Adapted Universal Violence Prevention Screening Protocol (last year)
67	Steinhoff et al. (2021)	Switzerland	Quant	786 youth average age of 22 years	Web-based	VAW*	Proxy	Adaptation of the Conflict Tactics Scale (last 2 weeks)
68	Tadesse et al. (2020)	Ethiopia	Quant	617 women aged ≥ 16 years	Face-to-face	VAW	Self	WHO multi-country survey IPV tool (last 3 months)
69	Tesfaw et al. (2021)	Ethiopia	Quant	1,288 men & women aged ≥ 18 years	Face-to-face	VAW	Self	Sexual violence, scale NR (during the pandemic)
70	Teshome et al. (2021)	Ethiopia	Quant	464 women	Face-to-face	VAW	Self	WHO multi-country survey IPV tool (lifetime & change during the pandemic)
71	Tierolf et al. (2021)	Netherlands	Mixed	87 families, including caregivers of children aged 8-18 years or children aged 8-18 years; 30 caregivers & 9 children (same age ranges)	Telephone; Web-based	VAW	Proxy; Self	Revised Conflict Tactics Scale Parent Child & Revised Conflict Tactics Scale-2 (last year); Child abuse & IPV (during COVID-19)
72	Vijayathi Indu et al. (2021)	India	Quant	209 women aged 18-55 years	Face-to-face	VAW	Self	Domestic Violence Questionnaire (last 12 months)
73	Yamaoka et al. (2021)	Japan	Quant	5,344 parents of children aged 0-17 years	Web-based	VAC; VAW	Proxy	Child maltreatment & domestic violence, scales NR (during the pandemic)
74	Yari et al. (2021)	Iran	Quant	203 women aged 19-65 years	Web-based	VAW	Self	WHO multi-country survey IPV tool (during quarantine)
75	Zhang et al. 2021	China	Quant	1,062 children aged 12-16 years	Web-based	VAC	Self	Violence Against Children Survey measures (lifetime before & during lockdown)

Notes: Quant = quantitative; Qual = qualitative; Mixed = mixed methodologies (both quantitative and qualitative); NR = not reported; * = may include components related to VAC, however it is unclear due to the phrasing of violence measures; For mode of data collection, if not explicitly mentioned in the publication, it is assumed that data was collected face-to-face; For type of violence, in cases where participants spanned VAC and VAW categories, for simplicity a study was assigned to the majority category (i.e., VAC if the majority of the same was under age 18 and otherwise, VAW); For type of report, all measures other than self-experienced measures are categorized as proxy reports, including measures of perpetration, as violence is experienced by someone else in the household or community.

Table A2. Descriptive statistics for ethical items by journal discipline of publication

	All studies N=75		Public health N=40		Medical N=17		Social science N=18	
	n	%	n	%	n	%	n	%
Domain 1: Institutional Review Board								
1. Ethics clearance	75	0.87	40	0.95	17	0.94	18	0.61
Domain 2: Interviewer selection, training & support								
2. Interviewer selection	30	0.33	17	0.35	5	0.40	8	0.25
3. Interviewer training	30	0.13	17	0.12	5	0.20	8	0.13
4. Interviewer safety & support	30	0.03	17	0.06	5	0.00	8	0.00
Domain 3: Sampling & engaging with respondents								
5. Sampling design	75	0.05	40	0.03	17	0.00	18	0.17
6. Informed consent	75	0.84	40	0.88	17	0.94	18	0.67
7. Informed assent (minors)	6	0.83	4	1.00	..	..	2	0.50
8. Participant incentives	75	0.31	40	0.33	17	0.35	18	0.22
9. Interview privacy & safety	75	0.21	40	0.23	17	0.12	18	0.28
10. Participant feedback	75	0.00	40	0.00	17	0.00	18	0.00
Domain 4: Referrals & adverse events								
11. Referral information	75	0.25	40	0.30	17	0.24	18	0.17
12. Adverse event protocol	75	0.08	40	0.13	17	0.00	18	0.06
13. Facilitated referrals (minors)	6	0.00	4	0.00	..	..	2	0.00
14. Mandatory reporting (minors)	13	0.08	10	0.10	..	..	3	0.00
Total (among non-missing items)	75	0.31	40	0.33	17	0.31	18	0.26

Notes: The first column under each category (n) shows the total number of eligible studies for which the checklist item is applicable (the denominator from which the score is calculated), while the second column under each category (%) reflects the percentage meeting (scoring 'Yes') to each checklist item, among those applicable. Items 7, 13 and 14 only apply to certain studies, those that either target minors for interviews, ask minors violence questions directly or ask about VAC. Items 2, 3 and 4 only apply to studies that use interviewers to collect data, and do not apply to web-based data collection.

Table A3. Ethics coding for individual items by study

Ethics items		**IRB**	**Interviewer selection & training**			**Sampling & engaging with participants**						**Referrals & adverse events**			
No	**Study**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
1	AboKresha et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	No
2	Abrahams et al. (2021)	Yes	No	No	No	No	Yes	NA	Yes	No	No	No	No	NA	NA
3	Abuhammad (2020)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
4	Adibelli et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
5	Ajayi et al. (2021)	No	No	No	No	No	No	NA	No	No	No	No	No	NA	NA
6	Alharbi et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
7	Aolymat (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
8	Arenas-Arroyo et al. (2021)	Yes	NA	NA	NA	No	No	NA	Yes	No	No	No	No	NA	NA
9	Augusti et al. (2021)	Yes	NA	NA	NA	No	Yes	Yes	No	No	No	No	No	No	No
10	Behera et al. (2021)	Yes	Yes	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
11	Boxall et al. (2020)	Yes	NA	NA	NA	Yes	Yes	NA	Yes	Yes	No	Yes	No	NA	NA
12	Cannon et al. (2021)	Yes	NA	NA	NA	No	No	NA	No	No	No	No	No	NA	NA
13	Cano-Lozano et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
14	Chatzifotiou & Andreadou (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
15	Chung et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	No
16	Das et al. (2021)	Yes	No	No	No	No	No	NA	No	No	No	No	No	NA	NA
17	Das et al. (2021b)	No	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
18	Dekel & Abrahams (2021)	Yes	No	No	Yes	No	Yes	NA	No	No	No	Yes	Yes	NA	NA
19	Diaz et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	Yes	NA	NA
20	Ebert & Steinert (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	Yes	No	NA	No
21	Egger et al. (2021)	Yes	Yes	No	No	No	Yes	NA	No	Yes	No	No	No	NA	No
22	El-Nimr et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
23	Every-Palmer et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	Yes	No	NA	NA
24	Gebrewahd et al. (2021)	Yes	Yes	No	No	No	Yes	NA	No	Yes	No	No	No	NA	NA
25	Ghimire et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
26	Gibbons et al. (2021)	No	NA	NA	NA	No	No	NA	Yes	No	No	No	No	NA	NA
27	Gresham et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	Yes	No	Yes	No	NA	NA
28	Gulesci et al. (2021)	Yes	Yes	Yes	No	No	No	NA	No	Yes	No	Yes	Yes	NA	NA
29	Hamadani et al. (2021)	Yes	Yes	No	No	No	Yes	NA	Yes	Yes	No	Yes	No	NA	NA
30	Haq et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA

Ethics items		**IRB**	**Interviewer selection & training**			**Sampling & engaging with participants**						**Referrals & adverse events**			
No	**Study**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
31	Hastuti et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
32	Huq et al. (2021)	Yes	Yes	Yes	No	No	Yes	NA	No	Yes	No	No	No	NA	NA
33	Ibitoye & Ajagunna (2021)	No	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
34	Jetelina et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
35	Jung et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
36	Karp et al. (2021)	Yes	No	No	No	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No
37	Lampe et al. (2021)	Yes	No	No	No	No	Yes	NA	No	Yes	No	Yes	No	NA	NA
38	Lawson et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	No
39	Lee et al. (2021)	No	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
40	Machlin et al. (2021)	Yes	NA	NA	NA	No	Yes	Yes	No	No	No	No	No	No	Yes
41	Maftei & Danila (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	Yes	No	NA	NA
42	Mahapatro et al. (2021)	Yes	Yes	No	No	No	Yes	NA	No	Yes	No	Yes	Yes	NA	NA
43	Mahmood et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	Yes	No	Yes	No	NA	NA
44	Moawad et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
45	Moya et al. (2021)	Yes	No	No	No	No	No	NA	No	No	No	No	No	NA	NA
46	Muldoon et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	Yes	No	Yes	No	NA	NA
47	Naghizadeh et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
48	Oguntayo et al. (2020)	No	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
49	Ojeahere et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	Yes	No	NA	NA
50	Parrott et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
51	Pattojoshi et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
52	Phillimore et al. (2021)	Yes	No	No	No	Yes	Yes	NA	No	Yes	No	No	No	NA	NA
53	Pinchoff et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
54	Plasilova et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	Yes	No	No	No	NA	NA
55	Poonam et al. (2020)	No	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
56	Raj et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	Yes	No	NA	NA
57	Rayhan & Akter (2021)	Yes	Yes	No	No	No	Yes	NA	No	Yes	No	No	No	NA	NA
58	Sabri et al. (2020)	Yes	No	No	No	Yes	Yes	NA	Yes	No	No	No	No	NA	NA
59	Sari et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	No
60	Schokkenbroek et al. (2021)	Yes	NA	NA	NA	No	No	NA	No	No	No	No	No	NA	NA

Ethics items		**IRB**	**Interviewer selection & training**			**Sampling & engaging with participants**						**Referrals & adverse events**			
No	**Study**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
61	Sediri et al. (2020)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	Yes	No	NA	NA
62	Sharma & Khokhar (2021)	No	NA	NA	NA	No	No	NA	No	No	No	No	No	NA	NA
63	Shokair & Hamza (2020)	No	No	No	No	No	No	No	No	No	No	No	No	No	No
64	Siegel & Lahav (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
65	Soron et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
66	Spencer et al. (2021)	No	NA	NA	NA	No	No	NA	Yes	No	No	No	No	NA	NA
67	Steinhoff et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	Yes	No	No	No	No	NA	NA
68	Tadesse et al. (2020)	Yes	Yes	Yes	No	No	Yes	NA	No	Yes	No	Yes	Yes	NA	NA
69	Tesfaw et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	No	No	NA	NA
70	Teshome et al. (2021)	Yes	No	No	No	No	Yes	NA	No	No	No	Yes	Yes	NA	NA
71	Tierolf et al. (2021)	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No
72	Vijayathi Indu et al. (2021)	Yes	Yes	Yes	No	No	Yes	NA	No	No	No	Yes	No	NA	NA
73	Yamaoka et al. (2021)	Yes	NA	NA	NA	No	No	NA	No	No	No	No	No	NA	No
74	Yari et al. (2021)	Yes	NA	NA	NA	No	Yes	NA	No	No	No	No	No	NA	NA
75	Zhang et al. 2021	Yes	NA	NA	NA	Yes	Yes	Yes	No	No	No	No	No	No	No

Notes: NA = not applicable

Table A4: Good practice box on ethical reporting from high scoring studies

Domains	Illustrative text from high scoring studies
Institutional Review Board (IRB) [Item 1]	All work was approved by the institutional ethical review boards at the International Center for Diarrhoeal Diseases Research, Bangladesh, and Melbourne Health (2016.269) (Hamadani et al. 2021). **[Item 1]** Ethical approval was obtained from Dream Science and Technology Institutional Health Research Ethics Review Committee with approval letter of DSTC/ DHS/002/2020. Then, permission letter was written for Dessie city administration office (Tadesse et al. 2020). [**Item 1]**
Interviewer selection, training & support [Items 2-4]	To guarantee respondent's safety, enumerators were trained in each case by an expert on Child Safeguarding Policy following stringent ethical guidelines on how to ask these questions. Enumerators were instructed to take measures to verify the privacy of the interviews. Same-sex enumerators were used when possible (Gulesci et al. 2021). [**Items 2, 3, 9]** Two days training were provided for data collectors and supervisors regarding the sensitivity and personal nature of the questions, objective, and how to approach study participants with ensuring their privacy (Tadesse et al. 2020). [**Items 3, 9]** We recognized that support for participants was vital and thus, prior to each interview we asked each social worker whether he/she would be willing to meet with the women after the interview, if she felt this was needed. This would have been followed up by the first author to ensure that all participants requesting this service, received it, however, no participants requested additional therapy. Psychological support was also arranged for the first author, who conducted the interviews (Dekel &Abrahams 2021) [**Item 4, 12]**
Sampling & engaging with respondents [Items 5-10]	The safety of women participating in the survey was of paramount concern. Given the sensitive nature of the information being collected, a range of safety measures were employed. Safety measures used as part of the survey included: ● Potential respondents were approached by a social research company with an established online panel rather than by the AIC because it would be less likely to raise the suspicion of an abusive partner; ● The survey was designed with multiple landing pages and eligibility questions (including a 'safety trap') to screen out ineligible participants (eg men) from accessing the survey; ● The content of the survey, and its explicit focus on women, was revealed to respondents only after they had gone through multiple landing pages, stated they met the eligibility criteria and confirmed that they were in a safe place where they were not being observed; ● Women were advised in the information page that, if they felt that answering questions about their relationship experiences would cause them distress or make them unsafe, they should not complete the survey; ● Women who closed the survey at any point were not approached again; ● The survey was kept as short as possible and piloted to ensure that women would spend no more than 10 minutes completing all the questions; and ● Participants were provided with information about a range of support services, including services that could be contacted online or over the phone. Finally, all of the survey questions were closed-response, meaning that respondents did not have to write any responses. This limited the potential for abusive partners to use keyloggers to access information their partners provided in the survey (Boxall et al. 2020) [**Items 5, 9, 11]** The women were approached by the female counselors of MSSK over the phone. They had to be telephoned several times before they could be reached. A few limitations that were encountered in virtual communication included fear of a lack of privacy and confidentiality. In many cases, women

	were reluctant to answer questions about violence that they deemed unimportant in comparison to their immediate concerns regarding food, money, health, and the prevailing situation. Some women refused to answer questions over the phone and wanted to talk through a physical confrontation in MSSK only. However, measures were taken to minimize the risk of this non-response bias by allowing respondents to choose a suitable date and time. Thereafter, the counselor tried several times to contact the women when they could respond without the fear of their conversation being interrupted or eavesdropped. This was essential to guarantee their safety, apart from pre-serving the ethics and protocols of research so that respondents were comfortable enough to respond freely (Mahapatro et al. 2021). [**Items 5, 9]** We had obtained verbal consent from individual study participants before beginning of data collection (Tadesse et al. 2020) [**Item 6]** Verbal informed consent was obtained from participants aged 18 and older; those younger than 18 provided verbal assent with a parent/guardian providing consent (Karp et al. 2021) [**Item 7]** Participants were not compensated for their time in this study, although they had been compensated during the main trial at each visit (baseline, midline, endline). Women were warned before commencement of the intimate partner violence module and encouraged to seek privacy; they could decline to answer any module (Hamadani et al. 2021). [**Items 8, 9]** In the case of phone interviews, additional steps were taken to prevent potential perpetrators from listening to participants' answers. In particular, the interviewer provided examples of what types of actions are considered as violent; participants were asked to answer only ''yes'' or ''no'' and given the option of not answering the question if they did not feel comfortable with it. (Gulesci et al. 2021) [**Item 9**]
Referrals & adverse events [Items 11-14]	Authors provided text from the questionnaire in a technical appendix: "If you feel upset about anything (now or while completing the survey), the details of someone you can talk to will be made available to you. We have also provided the contact details for services that can support women who are experiencing violence. If you need any kind of help or support, it is available" (Boxall et al. 2020). [**Item 11]** Respondents were also provided with a list of all the institutions where a violence victim can receive help and protection as well as the procedure to file a complaint (Appendix A.2 shows pictures of the material given to participants). Enumerators received an adverse event protocol explaining what they had to do in cases of abuse (Gulesci et al. 2021). [**Items 11, 12]** The women who were victims of IPV at the time of data collection were reassured and counseled. However, women who experienced severe IPV and were in need of help were taken to Dessie referral hospital counseling care units (Tadesse et al. 2020). [**Item 12]** As per the government guidelines, follow-up measures were taken by the counselors and they were expected to call each survivor and understand their situation, extend support, and ensure their safety (Mahapatro et al. 2021). [**Item 12]** If parents or children reported prior experiences of family violence at baseline, the study reported violence exposure to child protective services if not previously reported (Machlin et al. 2021) **[Item 14]**

Notes: Table is based primarily on the five studies which reported on more than half the items in the ethics reporting checklist (Boxall et al. 2020, 75%; Tadesse et al. 2020, 64%; Gulesci et al. 2021, 55%; Hamadani et al. 2021, 55%; Mahapatro et al. 2021, 55%). In addition, examples are augmented by additional studies providing examples of rarely reported items (Dekel &Abrahams 2021; Karp et al. 2021; Machlin et al. 2021). All text included is a direct quotation.

Table A5: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 checklist

Section and Topic	Item #	Checklist item	Location where item is reported [pre-layout page references]
TITLE			
Title	1	Identify the report as a systematic review.	Title – we have specified it is a review
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	P1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	P4
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	P4
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	P5
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	P5
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	P5
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	P5
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	P6
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	P6
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	P6, Table 1
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	N/A
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention	P6 and 7

Section and Topic	Item #	Checklist item	Location where item is reported [pre-layout page references]
		characteristics and comparing against the planned groups for each synthesis (item #5)).	
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	P7
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	P7
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	P7
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	P7
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	P8 and Supplementary file P1 (Figure A1)
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	Supplementary file P2-6 (Table A1)
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	N/A
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	P22 (Table 2)
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	N/A
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	P22 (Table 2) and Supplementary file P7 (Table A2)

Section and Topic	Item #	Checklist item	Location where item is reported [pre-layout page references]
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	P22 (Table 2) and Supplementary file P7 (Table A2)
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	P10-11
	23b	Discuss any limitations of the evidence included in the review.	P13
	23c	Discuss any limitations of the review processes used.	P13
	23d	Discuss implications of the results for practice, policy, and future research.	P12,14
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	P7
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	P7
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	P15
Competing interests	26	Declare any competing interests of review authors.	P15
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	P15

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

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