





BMJ Open Evidence for Better Lives Study: a comparative birth-cohort study on child exposure to violence and other adversities in eight low- and middle-income countries - foundational research (study protocol)

Sara Valdebenito ,¹ Aja Murray,² Claire Hughes,³ Adriana Băban,⁴ Asvini D Fernando,⁵ Bernadette J. Madrid,⁶ Catherine Ward,⁷ Joseph Osafo,⁸ Michael Dunne,⁹ Siham Sikander,¹⁰ Susan P Walker,¹¹ Vo Van Thang ,¹² Mark Tomlinson ,^{13,14} Pasco Fearon,¹⁵ Yulia Shenderovich ,¹⁶ Marguerite Marlow,¹⁷ Deshanie Chathurika,¹⁸ Diana Taut,⁴ Manuel Eisner¹

To cite: Valdebenito S, Murray A, Hughes C, *et al.* Evidence for Better Lives Study: a comparative birth-cohort study on child exposure to violence and other adversities in eight low- and middle-income countries - foundational research (study protocol). *BMJ Open* 2020;**10**:e034986. doi:10.1136/bmjopen-2019-034986

► Prepublication history for this paper is available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2019-034986>).

Received 14 October 2019

Revised 14 April 2020

Accepted 21 July 2020



© Author(s) (or their employer(s)) 2020. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

For numbered affiliations see end of article.

Correspondence to

Dr Sara Valdebenito; sv331@cam.ac.uk

ABSTRACT

Introduction Violence against children is a health, human rights and social problem affecting approximately half of the world's children. Its effects begin at prenatal stages with long-lasting impacts on later health and well-being. The *Evidence for Better Lives Study* (EBLS) aims to produce high-quality longitudinal data from cities in eight low- and middle-income countries—Ghana, Jamaica, Pakistan, the Philippines, Romania, South Africa, Sri Lanka and Vietnam—to support effective intervention to reduce violence against children. EBLS-Foundational Research (EBLS-FR) tests critical aspects of the planned EBLS, including participant recruitment and retention, data collection and analysis. Alongside epidemiological estimates of levels and predictors of exposure to violence and adversity during pregnancy, we plan to explore mechanisms that may link exposure to violence to mothers' biological stress markers and subjective well-being.

Methods and analyses EBLS-FR is a short longitudinal study with a sample of 1200 pregnant women. Data are collected during the last trimester of pregnancy and 2 to 6 months after birth. The questionnaire for participating women has been translated into nine languages. Measures obtained from mothers will include, among others, mental and physical health, attitudes to corporal punishment, adverse childhood experiences, prenatal intimate partner violence, substance use and social/community support. Hair and dry blood spot samples are collected from the pregnant women to measure stress markers. To explore research participation among fathers, EBLS-FR is recruiting 300 fathers in the Philippines and Sri Lanka.

Ethics and dissemination The study received ethical approvals at all recruiting sites and universities in the project. Results will be disseminated through journal publications, conferences and seminar presentations involving local communities, health services and other

Strengths and limitations of this study

- The study is designed to inform a large-scale, birth cohort study in eight cities across the world.
- Evaluating training materials and tools developed will allow refinements and improvements for the large-scale study.
- The study will enhance engagement with policy-makers, community members and other stakeholders to support efforts to address violence against children in all study sites.
- Data collection uses similar procedures to collect comparable data on exposure to violence.
- Participants are selected using a non-probabilistic sampling strategy. The generalisation to the broader underlying population is limited.

stakeholders. Findings from this work will help to adjust the subsequent stages of the EBLS project.

INTRODUCTION

Around half of children worldwide experience some form of interpersonal violence.¹ Exposure to violence interferes with children's neurological and socio-emotional development, contributes to lasting behavioural problems and has lifelong effects on well-being, health and productivity.¹⁻⁴ While the negative impact of violence has been extensively documented, less is known about the effect of prenatal intimate partner violence (p-IPV) on early child development. Recent research suggests that exposure to IPV during the prenatal period is linked to a number of

morbidities such as low birth weight, preterm delivery⁵ and other indices of poor fetal health.^{6–9} While the mechanisms explaining these outcomes remain unclear, multiple possible pathways linking p-IPV with child development outcomes have been suggested. These include mental illness, substance use, healthcare under-utilisation, poor emotional attachment to the fetus, maternal stress, systemic inflammation and the regulation of specific genes relevant to, for example, the functioning of the hypothalamic-pituitary-adrenal (HPA) axis.^{10–11} Research in humans and other mammals suggests that exposure to dangerous levels of cortisol can have long-lasting impact on multiple areas of the brain, affecting, for instance, the child memory, verbal IQ and behaviour.^{9–12}

Evidence-based preventive policies are known to contribute to the reduction of violence against children.¹³ However, to date, most research into violence during the first years of children's lives has been conducted using cross-sectional, retrospective designs in affluent societies.^{14–15} Little is known from low- and middle-income countries (LMICs), where most of the world's children live and where resources to address these problems are limited.^{1–16}

In this context, the *Evidence for Better Lives Study* (EBLS) aims to produce high-quality evidence from non-western societies to support effective strategies to reduce violence against children from pregnancy onwards. It involves an interdisciplinary policy impact and capacity-building programme of longitudinal research based in eight cities chosen to reflect the diversity of cultural, social and economic conditions across the globe. EBLS is an ambitious research programme developed in four main stages (figure 1), including an initial scoping exercise (December 2015), a feasibility study (October 2016 to March 2018), the current foundational research (July 2018 to December 2019) and a full study expected to start in 2020. While the first two stages helped to articulate the aims of the project and to select the study sites, EBLS-FR tests the main components for the full study (eg, recruitment, data collection instruments, translations).

Four features make EBLS-Foundational Research a significant advance on previous studies. First, it recruits pregnant women in the third trimester of pregnancy, measuring prenatal exposures to violence and other adversities when they are happening and thereby overcoming the limitations of using retrospective recall.^{17–18}

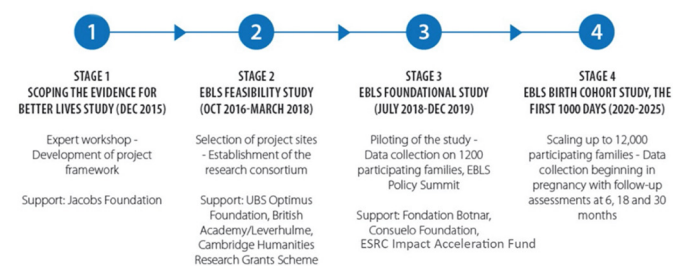


Figure 1 The four main stages of Evidence for Better Lives Study (EBLS).

Second, the longitudinal design of the study allows researchers to collect information on the same families over time, a method that is uniquely well placed to illuminate issues that affect children's development, both in terms of individual and family-level factors, and also higher-level influences, such as changing policies and social norms related to violence and abuse.^{19–20} Longitudinal data collection yields important information on factors which may form part of the causal chain leading to favourable/unfavourable outcomes. Such studies provide essential evidence for prevention knowledge and policy-making.^{21–23} For example, longitudinal studies in Jamaica have found that limited stimulation of children in the home and high levels of parental stress are negatively related to child outcomes, including cognitive function and behaviour.²³ These findings guided the development of Jamaica's National Parenting Policy, public messaging and programmes for parents.

Third, EBLS-FR addresses the lack of longitudinal studies examining violence in LMICs with analogous sampling and measurement to allow comparisons across locations.²⁴ Without the comparable methods used for longitudinal data collection in multiple settings, it is difficult to make cross-cultural comparisons of associations between exposures and outcomes.²⁵ Furthermore, although it is widely accepted that a fetus is influenced by the environment from conception and that the period from conception to age 2 to 3 is critical for development,²⁶ few cohort studies in LMIC have started in pregnancy.²⁷

Fourth, a distinctive component of EBLS-FR is to engage fathers and male partners of the participants and learn more about how they can be motivated to participate in research. Extant research has linked father involvement in parenting to a number of crucial child outcomes, such as better infant cognitive development, more positive relationships with peers, better psychosocial adjustment as well as greater academic achievement.²⁸ Conversely, psychiatric disorders and violent behaviour of fathers, both inside and outside the family, can increase the risk of psychological and developmental difficulties in children.^{29–31} While birth cohort studies report lower participation rates in fathers than mothers, they have also traditionally invested less in the recruitment and retention of fathers.^{27–32–33} Hence, EBLS-FR recruits fathers in two sites, to gain further insight into engaging them in developmental research as well as to run an initial examination of the fathers' characteristics and their associations with maternal and child well-being.

In sum, a multi-country birth cohort study in LMICs, such as the planned EBLS, has major potential to influence local and international policies to prevent exposure to violence. It may also provide invaluable opportunities for knowledge transfer by promoting inter-country and global learning about how families and communities in different societies support their children to achieve their full developmental potential. EBLS-FR serves as a critical step towards generating such evidence for violence prevention and the promotion of healthy early child

development by testing rigorous and comparable ways to collect multi-country longitudinal data starting from pregnancy.

STUDY AIMS

This protocol outlines the motivation and methods for the EBLs-FR, developed as a pilot to inform EBLs, and examines the key uncertainties in the project design.^{34 35}

The aims of the EBLs-FR are:

1. To develop and test strategies for recruiting pregnant women and following them up during the perinatal period across eight EBLs-FR sites.
2. To assess the feasibility of fathers' and male partners' participation in the study.
3. To test the strategies to collect, manage and analyse comparable high-quality data across the eight EBLs sites, including questionnaires and biological samples.
4. To produce initial sample prevalence estimates of key indicators, such as prenatal exposure to violence, women's levels of well-being, stress, depressive symptoms, prenatal and perinatal complications and to describe the characteristics of their male partners.
5. To explore associations of the key indicators reported by mothers and fathers with maternal and birth outcomes.
6. To build and strengthen local capacity for longitudinal research by coordinating skill development opportunities and establishing local and international collaborative networks that include early career researchers.
7. To enhance engagement with policymakers, community members and other stakeholders and ensure that future stages of EBLs produce relevant knowledge and strategies to support efforts to address violence against children in all study sites.

DESIGN

EBLs-FR is a prospective birth cohort study that targets 1200 pregnant women (150 in each of the sites) and 300 fathers (150 in each of two sites) in different cultural contexts across the world. Measurements are carried out during the third trimester of pregnancy and when the child is aged 2 to 6 months.

Study settings

Participating sites were selected according to the following criteria: (1) country status of a low-middle and upper-middle income economy,³⁶ (2) representation of different regions of the world, (3) a political environment receptive to research-based evidence, (4) the presence of local research teams with the expertise and willingness to conduct comparative research and engage in advocacy based on the findings and (5) existing links of the research teams with local prenatal healthcare services to facilitate access to the target sample. In 2017, the participating sites and associated research teams were decided as follows (figure 2): Valenzuela (University



Figure 2 Evidence for Better Lives Study sites.

of the Philippines, Philippines), Hue (Hue University, University of Medicine and Pharmacy, Vietnam), Ragama (University of Kelaniya, Sri Lanka), Tarlai Kalan (Health Services Academy, Pakistan), Cluj-Napoca (Babes-Bolyai University, Romania), Worcester (Universities of Cape Town and Stellenbosch, South Africa), Koforidua (University of Ghana, Ghana) and Kingston (University of the West Indies, Jamaica).

The sites were chosen to reflect the heterogeneity of social and cultural conditions across major world regions: the Caribbean, Europe, sub-Saharan Africa, the Indian subcontinent and South-East Asia. An overview of several international indices provides an account of such diversity (table 1). For instance, a comparison of the homicide rates in each site (ie, rate of intentional homicide per year per 100 000 inhabitants), suggests that while Romania, Sri Lanka and Vietnam report rates under the global average (6.4 per 100 000 population), Jamaica displays a rate of violence almost seven times higher than the global average.³⁷ The Gender Inequality Index shows that Vietnam and Pakistan report the lowest and the highest rates of inequalities, respectively, in reproductive health, education, political representation and access to the labour market.³⁸ Variation is also observed in other cross-comparative indexes such as Gross Domestic product (GDP), crude birth rates and percentage of population aged 0 to 14 years.

Capturing this diversity across the sites is critical for establishing how similar (and therefore generalisable and universal) the conditions are that lead to violence against women and children in different countries, and for demonstrating the consistency of their impact on children's long-term development. It is also crucial for understanding the cultural, contextual and policy factors that may lead to differences in risk of violence, and its adverse effects on child development. The diverse samples also offer opportunities to identify site-specific features that may be protective.³⁹

Sampling strategy

Based on the time and resources allocated for this project, the decision was taken to use convenience sampling of participants within sites—a non-probabilistic strategy that allows a consecutive selection of participants in order

**Table 1** Evidence for Better Lives Study sites: selected country indicators

	Homicide rates ^a	Gender Inequality Index ^b	GDP in \$ (PPP) ^c	Crude birth rate ^d	% population aged 0 to 14 ^e
Philippines	14.8	.425	8,908	21	30
Vietnam	3.8	.314	8,041	17	23
Sri Lanka	3.0	.380	13,078	16	24
Pakistan	9.6	.547	4,690	28	35
Romania	1.6	.316	29,909	10	16
South Africa	33.1	.422	12,482	21	29
Ghana	9.7	.541	5,413	29	37
Jamaica	39.1	.405	9,761	16	24
Global	6.4	.439	16,944	18	26%

Sources: a.³⁷; b.³⁸; c.⁶⁶; d.⁶⁷; e.⁶⁸.

*Abbreviation: GDP in \$ (PPP). Gross Domestic product at purchasing power parity.

PPP, purchasing power parity.

of appearance.⁴⁰ Since we aim to achieve a sample that involves diverse social backgrounds within the study area, each local team attempts to target a specific number of private and public prenatal medical services, when these exist.

Study participants

Pregnant women

The EBLS-FR sample is comprised of 150 pregnant women recruited from health centres in each of the eight sites (n=1200 total). All women attending check-ups in the selected clinics/hospitals are eligible if they satisfy the following three criteria: (1) in the third trimester of their pregnancy (ie, weeks 29 to 40), (2) aged over 18 when signing the informed consent form and (3) having their main residence within the study's defined geographical area.

Fathers

Due to resource constraints, only two sites have the capacity to test the father's questionnaire. Sri Lanka and the Philippines plan to recruit a sample of 150 fathers each (n=300 total). All women who consent to participate in EBLS-FR in Sri Lanka and the Philippines are asked about the possibility of their husband or partner participating in the study. To be eligible, fathers need to meet the following three criteria: (1) being the father figure to the baby, although not necessarily the biological father; (2) aged over 18 when signing the informed consent and (3) having their main residence within the study's defined geographical area.

Recruitment, screening, consent and incentives

Recruitment

Trained female fieldworkers approach pregnant women directly at local health services during antenatal check-ups. When the direct approach is not feasible, potential participants are first approached by the treating clinician (eg, nurse, midwife, obstetrician), who briefly presents the

research project and asks the woman if she is willing to meet with EBLS-FR representatives. Fathers are invited to take part in the study only if the pregnant woman provides written consent to their inclusion. Note that as p-IPV is a risk factor for under-utilisation of and delayed entry into antenatal care, our recruitment through antenatal clinics is a limitation, in that it risks under-representing women experiencing abuse.⁴¹

Screening and consent

Pregnant women and fathers expressing interest in the EBLS-FR are invited to answer a brief screening questionnaire to establish their eligibility. If eligible, they are invited to provide written informed consent. Information sheets, consent forms and questionnaires have been translated into the languages spoken by the participants. If the participant cannot read, versions of the information sheet and consent forms are played by audio recording or read out aloud. As suggested by the WHO's Research Ethics Committee (http://www.who.int/rpc/research_ethics/Process_seeking_IF_printing.pdf), the consent of participants who cannot write is obtained via alternative means (eg, audio recording or participant's thumbprint). The number of eligible participants who are approached but do not show interest in the study is also recorded, along with any reasons for non-participation, if provided.

When both the woman and her husband/partner participate, they are interviewed separately to ensure confidentiality.⁴²

Incentives

All study participants are offered a token of appreciation. Each local team determines the specific incentive in consideration of cultural and local expectations, as well as the corresponding ethical rules (table 2). In all cases, the incentive is approximately equivalent to the hours spent in the study, reimbursed at minimum wage in the site. In addition, participants are offered a reimbursement of

Table 2 Incentives for participants

Sites	Incentive Baseline	Cost (£)	Incentive Follow-up	Cost (£)	Incentives for fathers	Cost (£)
Philippines	Groceries	2	Groceries	2	Groceries	2
Vietnam	Voucher	5	Voucher	5	N/A	N/A
Sri Lanka	Grocery voucher	4.78	Bank deposit for the baby	4.56	Grocery voucher	4.78
Pakistan	Household items for the woman	2.5	Jumper suit for the baby	2.5	N/A	N/A
Romania	Grocery vouchers	27	Grocery vouchers	10	N/A	N/A
South Africa	Grocery voucher	9	Grocery voucher	9	N/A	N/A
Ghana	Money	2.78	Money	2.78	N/A	N/A
Jamaica	Phone cards	4.26	Phone cards	4.26	N/A	N/A

Differences in cost are explained by their gross domestic product per capita at nominal values.⁶⁶

*N/A: Not applicable.

travel expenses to facilitate the access of participants who could be underrepresented due to difficulties in paying for transport.^{43 44}

Patient and public involvement

No patients will be involved. Study participants will be informed about study outcomes via websites of project partners and media reports. We are planning to produce a brief information sheet at the end of the foundational research for participants and a general audience.

Data collection

Data collection will be implemented from February to December 2019. To ensure comparability of measures across the sites,⁴⁵ the EBLs-FR team has developed a set of standardised questionnaires.

The EBLs questionnaires were first developed in English and then translated into nine different languages (Urdu, Afrikaans, IsiXhosa, Romanian, Filipino (Tagalog), Sinhala, Tamil, Vietnamese and Twi). With small modifications, the process of translation has followed the guidelines suggested by the WHO (http://www.who.int/substance_abuse/research_tools/translation/en/). Only minor adjustments have been made to ensure that measures are relevant in each location (eg, which ethnicities are recorded).

Data are collected by fieldworkers who have received standardised 40 hours of in-person training covering topics such as recruitment, consent, data collection and storage procedures, principles of research ethics, referral procedures and management of risk and difficult situations in the field (eg, participant distress or unsafe situations). Special emphasis was given to skills and strategies for addressing women experiencing violence.^{46–48} The contents of the training were developed and approved by the EBLs consortium and they are described in the fieldworker handbook specifically developed for EBLs-FR. Training at each site was carried out by the local

research coordinator who had been previously trained by the Cambridge team.

Pregnant women: questionnaires and instruments

Questionnaire

The questionnaire completed by pregnant women is a mix of Computer-Aided Personal Interviews (CAPI) and Computer-Assisted Self-Interviewing (CASI) for the more sensitive items (ie, intimate partner violence, adverse childhood experiences and substance use). To facilitate access for expectant mothers with low levels of literacy, Audio-Supported Self-Completion Interviewing (A-CASI) has been programmed.

In EBLs-FR, data from participating women are collected at two time points. The baseline assessment is completed when the women are in the third trimester of their pregnancy. The baseline assessment takes approximately 120 min, involving the completion of a 210-item questionnaire and the collection of biological samples. Subsequently, a brief follow-up assessment is conducted with the mother when the child is at least 2 months old. The follow-up assessment takes approximately 20 min and involves the completion of a 22-item questionnaire. The follow-up assessment re-measures key variables for the EBLs-FR such as mental health and mother-child attachment. It also helps to test the process of re-contacting participants and retaining them post-birth. The nature of a pilot study has restricted the follow-up to a maximum of 6 months after birth. However, the main study is expected to follow participants during the first 5 years of life.

Measures

Measures for pregnant women include items on demographic factors, socioeconomic status, prenatal health and reproductive history, adverse childhood experiences, community and social support, p-IPV, mental health and other psychological traits, as well as prenatal maternal attachment to the unborn child. The follow-up measures

**Table 3** Evidence for Better Lives Study-Foundational Research measures for mother's questionnaire

Measures	Sources	N° items	Phase	Data collection strategy
Demographics	DHS ⁶⁹ MacArthur Scale of subjective social status ⁷⁰	27	Baseline	CAPI
Prenatal health	Adapted from: The South Asian Birth Cohort (START) ⁷¹ Millennium Cohort Study ⁷²	20	Baseline	CAPI
Attitudes towards physical punishment	Attitudes towards spanking ⁷³	5	Baseline	CAPI
Community characteristics	Community characteristics scale – Adapted ⁷⁴	20	Baseline	CAPI
Adverse childhood experiences	WHO 2009, ⁴⁷ International ACE-IQ Questionnaire Adapted version ⁷⁵	19	Baseline	A-CASI
Intimate partner violence	WHO Multi-country Study on Women Health and Domestic Violence against Women ⁴⁶	13	Baseline	A-CASI
Partner supportiveness	Partner supportiveness/relationship scale ⁷⁶	4	Baseline	CAPI
Social support	Social support scale ⁷⁷	13	Baseline	CAPI
Well-being	WHO-5 Well-Being Index ⁷⁸	5	Baseline	CAPI
Depression	PHQ9 ⁷⁹	9	Baseline and follow-up	CAPI
Suicidality	Suicidality item ⁸⁰	1	Baseline	CAPI
Stress	Perceived Stress Scale ⁸¹	10	Baseline	CAPI
Aggression	The Brief Aggression Questionnaire ⁸²	12	Baseline	CAPI
ADHD symptoms	Adult ADHD symptoms-Adapted ⁸³	6	Baseline	CAPI
Self-control	Brief Self-Control Scale ⁸⁴	8	Baseline	CAPI
Substance use	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) – Adapted version WHO ASSIST Working Group ⁸⁵	9	Baseline	A-CASI
Pregnancy related beliefs	Prenatal Attachment Inventory – Revised ⁸⁶	18	Baseline	CAPI
Newborn health and well-being	Norwegian Mother and Child Cohort Study (MoBa) ⁸⁷ Questionnaire for breastfeeding mothers ⁸⁸	8	Follow-up	CAPI
The mother's birth memories	The Birth Memories and Recall Questionnaire ⁸⁹	5	Follow-up	CAPI

A-CASI, Audio-Supported Self-Completion Interviewing; CAPI, Computer-Aided Personal Interview; CASI, Computer-Assisted Self-Interview.

collect data on mothers' mental health, child well-being and birth memories (table 3).

Informed by a literature review developed by the EBLs consortium,¹¹ we have identified salient factors that may relate to the predictors and consequences of exposure to violence in the perinatal period. For reasons of space, we simply describe below the main measures used to capture these factors.

Prenatal intimate partner violence

p-IPV is measured using a scale extracted from the WHO's multi-country study on women's health and domestic violence against women.⁴⁶ It measures exposure to violence during the last 6 months (ie, current pregnancy). We use six items to capture physical violence (eg, I was hit with a fist or something else that could hurt); four items to measure emotional abuse (eg, I was insulted

or made to feel bad about myself); and three items for sexually abusive behaviours (eg, I was physically forced to have sexual intercourse when I did not want to). A 4-point Likert scale (ie, *never, once, a few times, many times*) allows the participant to report the frequency of exposure to such experiences in her lifetime and over the last 6 months. Questions have been validated in multi-racial, ethnic populations and in pregnant women and therefore have appropriate psychometric properties.^{49 50} Exposure to p-IPV is collected using A-CASI as this approach has been demonstrated to facilitate the disclosure of IPV when compared with face-to-face interviews and self-administered written screens.^{51 52}

The Perceived Stress Scale

The Perceived Stress Scale (PSS), developed by Cohen and Williamson,⁵³ was designed to measure the degree to which respondents appraise aspects of their own life experiences as unpredictable, uncontrollable and emotionally overwhelming. The scale includes 10 items (eg, feeling one could not cope with all the things that one had to do) and responses are provided using a 4-point Likert scale (ie, *not at all, several days, more than half the days, nearly every day*). The PSS has superior psychometric properties when used with a normative population, when compared with alternative scales and also when administered to pregnant mothers.^{54 55}

Hair samples

Each pregnant woman is asked to provide a sample of hair cut from the posterior vertex area (where growth rates are least variable), as close as possible to the scalp. Hair samples produce measures of cortisol concentrations, an index of accumulated stress exposure validated for use in pregnant women.⁵⁶ Since each centimetre of hair represents a month's period of exposure, it is possible to quantify cumulative physiological stress during the second trimester of pregnancy. Previous research has suggested the second trimester of pregnancy in particular as a critical period for stress exposure.⁹

Blood samples

Dried blood spots are collected by applying a few drops of blood, drawn by lancet from a finger, onto medical-grade, absorbent filter paper. Blood samples are analysed for C-reactive protein (C-RP), a biomarker of inflammation. We will relate these biomarkers to information on violence exposure and maternal outcomes in order to illuminate the biological mechanisms underpinning the effects of violence and adversity exposure on maternal and birth outcomes.^{57–59}

Father questionnaires

Data are collected using a paper and pencil questionnaire at two different time points. As in the case of pregnant women, the baseline assessment is completed during the third trimester of the woman's pregnancy. Interviews take approximately 40 min, involving the

completion of a 90-item questionnaire. The follow-up assessment encompasses 37 items to be completed in about 20 min.

Measures

The father questionnaire requests information on demographic factors, socioeconomic status, adverse childhood experiences, partner support, mental health, psychological traits and substance use. These items are similar to those used in the mother's questionnaire. However, the father questionnaire includes some specific items measuring attitudes to fatherhood, participation in antenatal care visits and the father's participation in household activities.^{60–62} The follow-up assessment asks the participant to complete items on paternal attitudes, paternal enjoyment and paternal confidence after birth (table 4).

Data analysis

Descriptive statistics will include frequency of p-IPV, and associations between exposure to violence and the putative outcomes (eg, C-RP, childbirth weight, maternal mental health). At the same time, candidate mediators and moderators in exposure-outcome associations will be explored. We will conduct measurement invariance analysis and make comparisons on latent variables across the sites. Statistical techniques will thus include linear and generalised linear models, structural equation models and multi-group item response theory and/or factor models. When data from multiple sites are used, multi-level models or multi-group models will be used to take account of the nested structure of the data. If available, EBLS-FR data will be compared with prevalence in the population. For instance, frequencies of IPV, perinatal depression and levels of stress or substance use will be compared with the prevalence of the same risk factors in the city's population. For the sites that conduct father interviews, models such as actor-partner interdependence models will be used to illuminate the influences of partners on one another's mental health, well-being and parental behaviour.⁶³

All primary analyses will be pre-registered using open-access resources, such as the Open Science Framework (<https://osf.io/>). After a period of embargo, data will be available for the use of the international scientific community. Local stakeholders will be consulted to prioritise additional research questions to be answered with the data.

Ethics and dissemination

The EBLS-FR protocol for recruitment and collection of data has been approved by the Ethics Boards of all universities involved in the project (see section declarations for more detail). Results will be disseminated through journal publications, conferences and seminar presentations involving local communities, health services and other stakeholders.

**Table 4** Evidence for Better Lives Study-Foundational Research measures for father's questionnaire

Measures	Sources	N° items	Phase	Data collection strategy
Feelings about fatherhood (prenatal)	Adapted from the Avon Longitudinal Study of Parents and Children ⁶⁰	13	Baseline	Paper and pencil
Fathers' participation for antenatal care	^{61 62}	7	Baseline Follow-up	Paper and pencil
Fathers' participation for household activities	Adapted from the Avon Longitudinal Study of Parents and Children.	8	Baseline Follow-up	Paper and pencil
Attitudes to fatherhood	Avon Longitudinal Study of Parents and Children ⁶⁰	8	Follow-up	Paper and pencil
Paternal enjoyment	Avon Longitudinal Study of Parents and Children ⁶⁰	5	Follow-up	Paper and pencil
Paternal confidence	Avon Longitudinal Study of Parents and Children ⁶⁰	4	Follow-up	Paper and pencil
Activities with the newborn child	Avon Longitudinal Study of Parents and Children ⁶⁰	6	Follow-up	Paper and pencil

Confidentiality and data protection

In EBLS-FR all participants are assigned a numeric identification (ID) code. The personally identifiable data, including contact details, are kept separate from all data collected via questionnaires to ensure confidentiality. EBLS-FR uses a number of technical and organisational measures to maintain security, confidentiality, completeness and integrity of the data associated with the study. This includes adherence to the requirements on collection and processing of personal identifiable data as stipulated by the General Data Protection Regulation (GDPR) EU 2016/679.

Data quality and data management

Multiple strategies are used to enhance the quality of data collection. These include training of project workers in the administration of questionnaires, training of clinical and project staff in the measurement of specific indices, and validation checks for consistency and completeness of routinely collected data. Laboratory analyses will be subject to strict quality controls based on established protocols. Data will be screened for out-of-range or otherwise implausible values before finalising the data set.

Organisational structure

EBLS comprises a consortium of 15 co-investigators who are collectively responsible for conducting the research. Given the multidisciplinary nature of violence and its impacts on child development, the team includes expertise in disciplines such as developmental psychopathology, paediatrics, criminology and public health. The organisational structure includes a coordinating team at the University of Cambridge. In each of the sites, a collaborative research team has been established to implement the EBLS-FR study.

DISCUSSION

Ending violence against children, dealing with its consequences, and reducing children's exposure to threats to their healthy development, requires a better understanding of the factors that foster child development in various societies and the identification of risk factors that need to be addressed most urgently. EBLS is designed to make novel contributions to these key questions by drawing on parallel data collection in eight sites, thus enabling both within-country and cross-country analyses. While the experience of conducting the EBLS-FR will illuminate the feasibility of procedures for the next stages, psychometric analyses will provide empirical information on the cross-cultural performance of the study's measures. Analyses of the EBLS-FR data will also provide initial estimates of the levels of exposure to adversity and the relationships between exposures and outcomes, as well as test potential pathways and moderating factors.

Conducting research in multiple regions will allow us to examine how findings generalise across different socio-cultural and political contexts. To complement participants' reports of their experiences and behaviours, the study will also include biological data collection to examine biological pathways related to violence and health. This will allow us to test for the first time the combined role of systemic inflammation and the HPA axis on mediating links between p-IPV and maternal and birth outcomes. It has been argued that highlighting the biological effects of social issues (such as violence) can be particularly effective in motivating policy change.⁶⁴ EBLS-FR data collection tools and data sets from eight countries can also benefit the broader research community working on violence prevention.

EBLS-FR has also been designed to foster strategic collaborations, knowledge exchange and capacity

building between researchers, communities and policymakers in order to link research findings to policy actions. Future stages of EBLs will reveal the extent and manifestations of exposure to violence in each site; they will identify the salience of risk and protective factors for different groups and contexts; they will alert decision-makers to the short-term and long-term consequences of violence against women and children that are not currently addressed; and they will establish the essential basis for future actions. Such knowledge exchange between researchers and governments is essential to establish and evaluate prevention efforts and report on progress toward Sustainable Development Goal (SDG) violence reduction targets.⁶⁵

Conducting a multi-site project poses both research design and management questions of how to maintain comparability across countries while also examining relevant issues that are only present in some of the contexts, such as child marriage. As reflected in the organisational structure of the study, we believe that multi-country, multidisciplinary projects require both a strong level of international coordination and collaboration with local governance structures.

Author affiliations

- ¹Institute of Criminology, University of Cambridge, Cambridge, UK
- ²Department of Psychology, The University of Edinburgh, Edinburgh, UK
- ³Centre for Family Research, University of Cambridge, Cambridge, UK
- ⁴Department of Psychology, Babes-Bolyai University, Cluj-Napoca, Romania
- ⁵Faculty of Medicine, University of Kelaniya, Ragama, Sri Lanka
- ⁶Child Protection Unit, University of the Philippines Manila, Manila, Philippines
- ⁷Department of Psychology, University of Cape Town, Rondebosch, South Africa
- ⁸Department of Psychology, University of Ghana, Legon, Greater Accra, Ghana
- ⁹School of Public Health and Social Work, Queensland University of Technology, Kelvin Grove, Queensland, Australia
- ¹⁰Global Health Department, Health Services Academy, Islamabad, Pakistan
- ¹¹Caribbean Institute for Health Research, University of the West Indies, Kingston, Jamaica
- ¹²Institute for Community Health Research, University of Medicine and Pharmacy, Hue University, Hue, Thừa Thiên-Huế, Viet Nam
- ¹³Institute for Life Course Health Research, Department of Global Health, Stellenbosch University, Cape Town, South Africa
- ¹⁴School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK
- ¹⁵Research Department of Clinical, Educational and Health Psychology, University College London, London, UK
- ¹⁶Department of Social Policy and Intervention, University of Oxford, Oxford, UK
- ¹⁷Department of Psychology, Stellenbosch University, Stellenbosch, Western Cape, South Africa
- ¹⁸Child Protection Unit, Colombo North Teaching Hospital, Ragama, Sri Lanka

Acknowledgements Special thanks go to the field staff for their amazing work and also to the mothers and fathers across the sites who kindly contributed to make EBLs-FR possible. Gratitude also goes to the medical staff involved in the recruitment of participants. Thanks to the coordination team in Cambridge for their support throughout the EBLs-FR.

Contributors SV helped to plan the methods for Evidence for Better Lives Study-Foundational Research, drafted the paper, and took the lead in revisions. ALM, CH, AB, ADF, BM, CLW, JO, MPD, SS, SW, VVT, MT, PF, MM and DT helped to plan the methods, reviewed multiple drafts of the paper and approved the final version submitted. DC helped to develop the father questionnaire, reviewed multiple drafts of the paper and approved the final version submitted. YS helped to draft some sections of the paper and contributed with the revisions. ME is the principal investigator. He articulated the scientific bases of the study, reviewed multiple drafts of the paper and approved the final version submitted.

Funding The work of the Evidence for Better Lives Study was supported by the Jacobs Foundation, UBS Optimus Foundation, Fondation Botnar, the Consuelo Zobel Alger Foundation, the British Academy, the Cambridge Humanities Research Grants Scheme, the ESRC Impact Acceleration Account Programme, a Queensland University of Technology Postgraduate Research Award, Higher Degree Research Student Supplementary Research Funding from Queensland University of Technology, the University of Edinburgh College Office for the College of Arts, the Humanities and Social Sciences SFC ODA Global Challenges Internal Fund, the University of Cambridge GCRF Quality Research Fund and the Wolfson Professor of Criminology Discretionary Fund. The views expressed are those of the authors and not necessarily those of the funding bodies. YS is supported by the UKRI GCRF Accelerating Achievement for Africa's Adolescents Hub (Grant Ref: ES/S008101/1)

Map disclaimer The depiction of boundaries on this map does not imply the expression of any opinion whatsoever on the part of BMJ (or any member of its group) concerning the legal status of any country, territory, jurisdiction or area or of its authorities. This map is provided without any warranty of any kind, either express or implied.

Competing interests None declared.

Patient consent for publication Obtained.

Ethics approval The Evidence for Better Lives Study protocol for recruitment and collection of data has been approved by the following ethics boards: University of Cambridge, School of Social Sciences (18/180) and the Human Biology Research Ethics Committee, UK HBREC.2018.27; University of the Philippines Manila - Research Ethics Board, Philippines, UPMREB 2018-558-01; The Institutional Ethics Committee of Hue University of Medicine and Pharmacy, Vietnam, H2018/430; University of Kelaniya, Faculty of Medicine, Ethics Review Committee, Sri Lanka, P/208/11/2018; National Bioethics Committee (NBC), Pakistan, 4-87/NBC-364/19/1487; Consiliul Stiintific - Universitatea Babes-Bolyai, Romania, 18.362/11.10.2018; University of Cape Town, Department of Health, Western Cape Government, South Africa, WC_201911_009; Health Impact Assessment - Western Cape Government; University of Cape Town, Faculty of Health Sciences, Human Research Ethics Committee, South Africa, 057/2019. Health Research Ethics Committee (HREC) at Stellenbosch University, South Africa, N18/09/099; Ghana Health Service Ethics Review Committee, GHS-ERC008/11/18; University of the West Indies Ethics Committee, Jamaica, ECP 212, 17/18.

Provenance and peer review Not commissioned; externally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID iDs

Sara Valdebenito <http://orcid.org/0000-0001-9361-9379>
 Vo Van Thang <http://orcid.org/0000-0003-2018-0371>
 Mark Tomlinson <http://orcid.org/0000-0001-5846-3444>
 Yulia Shenderovich <http://orcid.org/0000-0002-0254-3397>

REFERENCES

- 1 Hillis S, Mercy J, Amobi A, *et al*. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics* 2016;137:e20154079.
- 2 Devries K, Watts C, Yoshihama M, *et al*. Violence against women is strongly associated with suicide attempts: evidence from the who multi-country study on women's health and domestic violence against women. *Soc Sci Med* 2011;73:79–86.
- 3 Norman RE, Byambaa M, De R, *et al*. The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS Med* 2012;9:1–31.
- 4 UNICEF. *Hidden in plain sight*. New York, NY, 2015.
- 5 Donovan BM, Spracklen CN, Schweizer ML, *et al*. Intimate partner violence during pregnancy and the risk for adverse infant outcomes : a systematic review and meta-analysis. *BJOG An Int J Obstet Gynaecol* 2016;123:1289–99.
- 6 Betts KS, Williams GM, Najman JM, *et al*. The relationship between maternal depressive, anxious, and stress symptoms during pregnancy and adult offspring behavioral and emotional problems. *Depress Anxiety* 2015;32:82–90.

- 7 Martinez-Torteya C, Bogat GA, Levendosky AA, *et al.* The influence of prenatal intimate partner violence exposure on hypothalamic-pituitary-adrenal axis reactivity and childhood internalizing and externalizing symptoms. *Dev Psychopathol* 2016;28:55–72.
- 8 Moffitt TE, Klaus-Grawe 2012 Think Tank. Childhood exposure to violence and lifelong health: clinical intervention science and stress-biology research join forces. *Dev Psychopathol* 2013;25:1619–34.
- 9 Monk C, Georgieff MK, Osterholm EA. Research review: maternal prenatal distress and poor nutrition - mutually influencing risk factors affecting infant neurocognitive development. *J Child Psychol Psychiatry* 2013;54:115–30.
- 10 Weaver ICG, Cervoni N, Champagne FA, *et al.* Epigenetic programming by maternal behavior. *Nat Neurosci* 2004;7:847–54.
- 11 Murray AL, Kaiser D, Valdebenito S, *et al.* The intergenerational effects of intimate partner violence in pregnancy: mediating pathways and implications for prevention. *Trauma Violence Abuse* 2018;152483801881356.
- 12 Ohl F, Michaelis T, Vollmann-Honsdorf GK, *et al.* Effect of chronic psychosocial stress and long-term cortisol treatment on hippocampus-mediated memory and hippocampal volume: a pilot-study in tree shrews. *Psychoneuroendocrinology* 2000;25:357–63.
- 13 Eisner M, Nivette A, Murray AL, *et al.* Achieving population-level violence declines: implications of the International crime drop for prevention programming. *J Public Health Policy* 2016;37 Suppl 1:66–80.
- 14 WHO. *Violence prevention. The evidence. Ser briefings violence Prev Switz.* WHO, 2010: 1–127.
- 15 Averdijk M, Eisner M, Luciano E, *et al.* Wirksame gewaltprävention. *Eine übersicht zum internationalen wissensstand* 2014:274.
- 16 Fernald LCH, Kariger P, Engle P, *et al.* *Examining early child development in low-income countries: a toolkit for the assessment of children in the first five years of life.* World Bank, 2009: 1–210.
- 17 Hardt J, Rutter M. Validity of adult retrospective reports of adverse childhood experiences: review of the evidence. *J Child Psychol Psychiatry* 2004;45:260–73.
- 18 Boeke CE, Marin C, Oliveros H, *et al.* Validity of maternal birthweight recall among Colombian children. *Matern Child Health J* 2012;16:753–9.
- 19 Dunn K, Banati P. *Strength in numbers. How longitudinal research can support child development.* Florence, 2015.
- 20 Young Lives. What can comparative country research tell us about child poverty? 2017;(May):2–3.. Available: <http://younglives.org.uk/sites/www.younglives.org.uk/files/YL-MethodsGuide-WhyFourCountries.pdf>
- 21 Golding J, Jones R, Bruné M-N, *et al.* Why carry out a longitudinal birth survey? *Paediatr Perinat Epidemiol* 2009;23:1–14.
- 22 McCaw-Binns A, Ashley D, Samms-Vaughan M. Impact of the Jamaican birth cohort study on maternal, child and adolescent health policy and practice. *Paediatr Perinat Epidemiol* 2010;24:3–11.
- 23 Samms-Vaughan M. Comprehensive longitudinal studies of child health, development and behaviour in Jamaica: findings and policy impact. *West Indian Med J* 2008;57:639–44.
- 24 Murray J, Shenderovich Y, Gardner F, *et al.* Risk factors for antisocial behavior in low- and middle-income countries: a systematic review of longitudinal studies. *Crime Justice* 2018;47:255–364.
- 25 Abramsky T, Watts CH, Garcia-Moreno C, *et al.* What factors are associated with recent intimate partner violence? findings from the who multi-country study on women's health and domestic violence. *BMC Public Health* 2011;11:109.
- 26 Daelmans B, Darmstadt GL, Lombardi J, *et al.* Early childhood development: the foundation of sustainable development. *Lancet* 2017;389:9–11.
- 27 Kiernan K. Fathers and partners in national and international birth cohort studies. *Life Study Expert Advis Gr Father Partners* 2014:1–23.
- 28 Wong JJ, Roubinov DS, Gonzales NA, *et al.* Father enrollment and participation in a parenting intervention: personal and contextual predictors. *Fam Process* 2013;52:440–54.
- 29 Ramchandani PG, O'Connor TG, Evans J, *et al.* The effects of pre- and postnatal depression in fathers: a natural experiment comparing the effects of exposure to depression on offspring. *J Child Psychol Psychiatry* 2008;49:1069–78.
- 30 Hughes C, Devine RT, Mesman J, *et al.* Parental well-being, couple relationship quality, and children's behavioral problems in the first 2 years of life. *Dev Psychopathol* 2020;32:935–44.
- 31 Ramchandani P, Psychogiou L. Paternal psychiatric disorders and children's psychosocial development. *Lancet* 2009;374:646–53.
- 32 Cabrera NJ, Volling BL, Barr R, *et al.* Too! Widening the Lens on Parenting for Children's Development. *Child Dev Perspect* 2018;12:152–7.
- 33 Phares V, Fields S, Kamboukos D, *et al.* Still looking for Poppa. *Am Psychol* 2005;60:735–6.
- 34 Craig P, Dieppe P, Macintyre S, *et al.* Developing and evaluating complex interventions: the new medical Research Council guidance. *BMJ* 2008;337:a1655–6.
- 35 Shader RI. Proof of feasibility: what a pilot study is and is not. *Clin Ther* 2015;37:1379–80.
- 36 OECD. DAC list of ODA recipients effective for reporting on 2018, 2019 and 2020 flows [Internet]. 2020. Available: https://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/DAC_List_ODA_Recipients2018to2020_flows_En.pdf [Accessed 5 Mar 2020].
- 37 WHO. *World health statistics 2018: monitoring health for the SDGs, sustainable development goals.* Geneva: WHO, 2018. <https://apps.who.int/iris/bitstream/handle/10665/272596/9789241565585-eng.pdf?ua=1>
- 38 UN. Human development indices and indicators: 2018 statistical update. United Nations Dev Program [Internet]. 2018;:i–112. Available: <http://hdr.undp.org/en/data>
- 39 Morrow V. What Can Comparative Country Research Tell Us About Child Poverty ? *Young Lives Methods Guid* 2015:1–2.
- 40 Martínez-Mesa J, González-Chica DA, Duquia RP, *et al.* Sampling: how to select participants in my research study? *An Bras Dermatol* 2016;91:326–30.
- 41 Musa A, Chojenta C, Geleto A, *et al.* The associations between intimate partner violence and maternal health care service utilization: a systematic review and meta-analysis. *BMC Womens Health* 2019;19:1–14.
- 42 Rabel BV, Cunningham SA, Stephenson R. Interview interruption and responses to questions about domestic violence in India. *Violence Against Women* 2014;20:937–47.
- 43 Abshire M, Dinglas VD, Cajita MIA, *et al.* Participant retention practices in longitudinal clinical research studies with high retention rates. *BMC Med Res Methodol* 2017;17:1–10.
- 44 Laurie H, Lynn P. The use of respondent incentives on longitudinal surveys. *ISER Work Pap Ser* 2008;42:1–32.
- 45 Gjersing L, Caplehorn JRM, Clausen T. Cross-Cultural adaptation of research instruments: language, setting, time and statistical considerations. *BMC Med Res Methodol* 2010;10:1–10.
- 46 García-Moreno C, Jansen H, Ellsberg M. *WHO Multi-country Study on Women's Health and Domestic Violence Against Women. Initial results on prevalence, health outcomes and women's responses.* World Health Organisation, 2005.
- 47 CIOMS, WHO. *International Ethical Guidelines for Epidemiological Studies Ethical Guidelines for Epidemiological* [Internet]. Geneva: CIOMS, WHO, 2009. https://cioms.ch/wp-content/uploads/2017/01/International_Ethical_Guidelines_LR.pdf
- 48 WHO. *Putting women first: ethical and safety recommendations for research on domestic violence against women.* 33. WHO, 2001.
- 49 García-Moreno C, Jansen HAFM, Ellsberg M, *et al.* Prevalence of intimate partner violence: findings from the who multi-country study on women's health and domestic violence. *Lancet* 2006;368:1260–9.
- 50 Pallitto CC, García-Moreno C, Jansen HAFM, *et al.* Intimate partner violence, abortion, and unintended pregnancy: results from the who Multi-country study on women's health and domestic violence. *Int J Gynaecol Obstet* 2013;120:3–9.
- 51 Fincher D, VanderEnde K, Colbert K, *et al.* Effect of face-to-face interview versus computer-assisted self-interview on disclosure of intimate partner violence among African American women in WIC clinics. *J Interpers Violence* 2015;30:818–38.
- 52 Hussain N, Sprague S, Madden K, *et al.* A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: a systematic review and meta-analysis. *Trauma Violence Abuse* 2015;16:60–9.
- 53 Cohen S, Williamson G. Perceived stress in a probability sample of the United States. In: Spacapan S, Oskamp S, eds. *The social psychology of health.* California: Newbury Park, 1988.
- 54 Robinson AM, Benzie KM, Cairns SL, *et al.* Who is distressed? A comparison of psychosocial stress in pregnancy across seven ethnicities. *BMC Pregnancy Childbirth* 2016;16:1–11.
- 55 Solivan AE, Xiong X, Harville EW, *et al.* Measurement of perceived stress among pregnant women: a comparison of two different instruments. *Matern Child Health J* 2015;19:1910–5.
- 56 Scharlau F, Pietzner D, Vogel M, *et al.* Evaluation of hair cortisol and cortisone change during pregnancy and the association with self-reported depression, somatization, and stress symptoms. *Stress* 2018;21:1–8.
- 57 Zhang J, Luo W, Huang P, *et al.* Maternal C-reactive protein and cytokine levels during pregnancy and the risk of selected neuropsychiatric disorders in offspring: a systematic review and meta-analysis. *J Psychiatr Res* 2018;105:86–94.

- 58 Brindle E, Fujita M, Shofer J, *et al.* Serum, plasma, and dried blood spot high-sensitivity C-reactive protein enzyme immunoassay for population research. *J Immunol Methods* 2010;362:112–20.
- 59 Meier-Ewert HK, Ridker PM, Rifai N, *et al.* Absence of diurnal variation of C-reactive protein concentrations in healthy human subjects. *Clin Chem* 2001;47:426–30.
- 60 Scourfield J, Culpin I, Gunnell D, *et al.* The association between characteristics of fathering in infancy and depressive symptoms in adolescence: a UK birth cohort study. *Child Abuse Negl* 2016;58:119–28.
- 61 Davis J, Vyankandondera J, Luchters S, *et al.* Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific. *Reprod Health* 2016;13:1–11.
- 62 Davis J, Vaughan C, Nankinga J, *et al.* Expectant fathers' participation in antenatal care services in Papua New Guinea: a qualitative inquiry. *BMC Pregnancy Childbirth* 2018;18:1–13.
- 63 Cook WL, Kenny DA. The Actor–Partner interdependence model: a model of bidirectional effects in developmental studies. *Int J Behav Dev* 2005;29:101–9.
- 64 McDade TW, Williams S, Snodgrass JJ. What a drop can do: dried blood spots as a minimally invasive method for integrating biomarkers into population-based research. *Demography* 2007;44:899–925.
- 65 UN. The Sustainable Development Goals Report [Internet]. New York, 2019. Available: <https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf>
- 66 World Bank. GDP per capita, PPP (current international \$) 2017–2018 [Internet]., 2018. Available: https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD?most_recent_value_desc=true
- 67 World Bank. Crude birth rate 2018.
- 68 World Bank. Population ages 0–14 (% of total population). 2018.
- 69 ICF. *Demographic and Health Survey Interviewer's Manual*. Rockville, Maryland, USA: ICF, 2017 June.
- 70 Adler NE, Epel ES, Castellazzo G, *et al.* Relationship of subjective and objective social status with psychological and physiological functioning: preliminary data in healthy, white women. *Health Psychology* 2000;19:586–92.
- 71 Anand SS, Vasudevan A, Gupta M, *et al.* Rationale and design of South Asian birth cohort (start): a Canada-India collaborative study. *BMC Public Health* 2013;13:79.
- 72 University of London. Institute of Education. In: *Centre for Longitudinal Studies. Millennium Cohort Study: First Survey, 2001–2003. [data collection]. SN: 4683.* 12th ed. UK Data Service, 2017.
- 73 Deater-Deckard K, Lansford JE, Dodge KA, *et al.* The development of attitudes about physical punishment: an 8-year longitudinal study. *J Fam Psychol* 2003;17:351–60.
- 74 Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. *Science* 1997;277:918–24.
- 75 WHO. Adverse Childhood Experiences International Questionnaire (ACE-IQ) [Internet]., 2018. Available: https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/questionnaire.pdf?ua=1
- 76 Goldberg JS, Carlson MJ. Parents' relationship quality and children's behavior in stable married and cohabiting families. *J Marriage Fam* 2014;76:762–77.
- 77 Zimet GD, Dahlem NW, Zimet SG, *et al.* The multidimensional scale of perceived social support. *J Pers Assess* 1988;52:30–41.
- 78 Topp CW, Østergaard SD, Søndergaard S, *et al.* The WHO-5 well-being index: a systematic review of the literature. *Psychother Psychosom* 2015;84:167–76.
- 79 Kroenke K, Spitzer RL, Williams JBW. The PHQ-9. *J Gen Intern Med* 2001;16:606–13.
- 80 Osman A, Bagge CL, Gutierrez PM, *et al.* The suicidal behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. *Assessment* 2001;8:443–54.
- 81 Cohen S. Perceived stress scale. *Mindgarden* 1994:1–5.
- 82 Webster GD, Dewall CN, Pond RS, *et al.* The brief aggression questionnaire: psychometric and behavioral evidence for an efficient measure of trait aggression. *Aggress Behav* 2014;40:120–39.
- 83 van de Glind G, van den Brink W, Koeter MWJ, *et al.* Validity of the adult ADHD self-report scale (ASRS) as a screener for adult ADHD in treatment seeking substance use disorder patients. *Drug Alcohol Depend* 2013;132:587–96.
- 84 Maloney PW, Grawitch MJ, Barber LK. The multi-factor structure of the brief self-control scale: discriminant validity of restraint and impulsivity. *J Res Pers* 2012;46:111–5.
- 85 WHO ASSIST Working Group. The alcohol, smoking and substance involvement screening test (assist): development, reliability and feasibility. *Addiction* 2002;97:1183–94.
- 86 Pallant JF, Haines HM, Hildingsson I, *et al.* Psychometric evaluation and refinement of the prenatal attachment inventory. *J Reprod Infant Psychol* 2014;32:112–25.
- 87 Magnus P, Irgens LM, Haug K, *et al.* Cohort profile: the Norwegian mother and child cohort study (MobA). *Int J Epidemiol* 2006;35:1146–50.
- 88 UNICEF/WHO. Questionnaire for breastfeeding mother. *BFHI Sect 4 Hosp Self-Appraisal Monit* 2009:64–6.
- 89 Foley S, Crawley R, Wilkie S, *et al.* The birth memories and recall questionnaire (BirthMARQ): development and evaluation. *BMC Pregnancy Childbirth* 2014;14:15–20.