Reporting of Home Visiting Research Checklist

HARC
Home Visiting Applied Research Collaborative

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INTRODUCTION

High-quality reporting helps scientific literature meet authors' desired goals, whether helping audiences understand, replicate, review, or use the information presented. Research reporting guidelines have been shown to positively influence the quality of study reporting. Existing guidelines have typically focused on a single study design (e.g., randomized controlled trials), however, rather than a specific research setting like home visiting.

Home visiting has an established but growing literature base, with past studies generally focusing on the average effects of services on family outcomes rather than results for distinct groups of families or community contexts. Similarly, while there are 24 models recognized as evidence based, studies tend to not address which model components have the greatest effect of outcomes. More research is needed to build the evidence of what works best for which families and in what contexts.

HARC developed the Reporting of Home Visiting Research (RoHVR) Checklist outlined in this brief to introduce home visiting-focused guidelines that integrate key reporting elements across multiple study designs. These guidelines are intended to improve the quality of reporting about home visiting research and evaluation, strengthen the evidence, and ultimately improve outcomes for programs and families. This brief introduces the potential uses of the RoHVR Checklist and how it was developed before outlining its structure and components.

Intended Audience and Use

The RoHVR Checklist is intended to be used by home visiting researchers and evaluators when developing reports and journal manuscripts. Reviewers (e.g., peer reviewers for journal articles, program officers) who are charged with ensuring that submitted reports or manuscripts achieve a set standard of quality in reporting can also benefit from using the checklist.

The RoHVR Checklist is tailored to the home visiting field and can be applied for multiple study designs (e.g., randomized controlled trials, quasi-experimental designs, qualitative studies). RoHVR users may also consult guidelines specific to the study design (see appendices for links to other guidelines).

It is important to note that the RoHVR Checklist applies to study reporting. HARC has also developed a planning tool for precision home visiting research to support researchers in designing studies that will advance knowledge of what works for whom, in what contexts, why and how.

Development Process

The RoHVR Checklist development process involved two phases. In the first phase (2014–2015), James Bell Associates (JBA) conducted a systematic review and synthesis of 12 existing reporting guidelines focused on effectiveness and efficacy studies (i.e., study designs endorsed by the Home Visiting Effectiveness of Evidence [HomVEE] review). JBA then reviewed the home visiting and implementation science literature to identify other critical elements for checklist inclusion. Six home visiting scholars reviewed the phase one checklist and engaged in a consensus process to confirm checklist items. The resulting checklist was not widely disseminated.

As the field has continued to evolve, this current, second phase (2024-2025) involved updating the checklist to address additional priorities in home visiting research, including:

- An expanded commitment to engaging communities in research.
- An increased focus on the components and contexts of home visiting interventions to determine what components work best for which families in specific circumstances, in order to optimize benefits.
- An identified need for consistent reporting of study elements (e.g., sample size calculations, intervention characteristics, null findings) across a range of study designs, to assure completeness and accuracy.

This second phase of the checklist development included a review of ten additional reporting guidelines, including community-engaged research approaches and qualitative studies, and concluded with a second expert review. The reporting guidelines reviewed in both phases are cited in the references.

Checklist Structure and Components

The checklist is organized into the following sections and accompanied by two appendices:

The checklist has four columns. Items within each section are numbered for easy reference. Each item name has a corresponding recommendation for authors to consider when developing their reports or manuscripts. The page number column can be used to check items as they are addressed.

RoHVR and Differential Effectiveness of Home Visiting

The RoHVR Checklist includes items to encourage reporting of differential effectiveness. Research and evaluation play an important role in identifying whether and why some families benefit from home visiting more than others.

Home visiting can show variations in effectiveness across different individuals and contexts. Variations may be related to family preferences and needs, provider and agency characteristics, or broader community characteristics and social determinants of health, such as economic stability; access to affordable, nutritious food; safe or affordable housing; and access to high quality healthcare.

Researchers use different criteria to specify subgroups, including demographics, geography (rural compared to urban), health insurance status, language, occupation, or time-dependent factors such as timing of enrollment in home visiting.

For researchers interested in considerations for reporting community-engaged research studies, Appendix 1 includes several references and a table of considerations mapped to the RoHVR item checklist. Appendix 2 includes links to reporting guidelines and additional reporting items to consider for six other study designs.

Please keep in mind the following points when using the RoHVR:

- Not all items, or all considerations within items, will apply to all studies, reports, or manuscripts.
- Authors should always consult journal reporting requirements, which vary.
- The article or report section where specific items are included can vary based on requirements or author discretion.
- If the length of the report or article is limited, include an appendix outlining the intervention and study protocols or provide a link to these details if the information cannot be captured in the narrative.

REPORTING OF HOME VISITING RESEARCH (ROHVR) CHECKLIST

Item #	Item	Recommendation	Page #
Section 1. Title, Authorship, and Abstract			
1.1	**Title**	Indicate the study design and the particular home visiting intervention(s) studied. Include population(s) of interest.	_____
1.2	**Authorship**	Report authors based on consensus for order and contribution; consider completing the Contributor Roles Taxonomy (CRediT author statement).	_____
1.3	**Abstract**	Provide an overview that concisely describes study objectives, home visiting intervention(s), aim of intervention(s), number of sites, sample size, participants (e.g., eligibility criteria, key characteristics), study design and methods, main findings, and conclusion. Include research questions and results for subpopulations of interest. Note that journals specify abstract word count and structure, and requirements should be addressed prior to incorporating all the above recommendations.	_____
1.4	**Funding, Model Developer, Author Conflicts of Interest**	Identify the study's source(s) of funding, the role of funder(s), and the role of model or intervention developer(s). Declare any author conflicts of interest. (Note that these components and location vary by journal. Follow journal guidelines.)	_____
Section 2. Introduction			
2.1	**Background and Rationale**	Provide scientific background, review of prior studies, and rationale for the study, including the theoretical basis (e.g., theories of behavior and/or behavior change) for the base home visiting model (services as usual), and for any new intervention, modification, enhancement, or adaption, and how the study adds to the literature.	_____
2.2	**Objectives**	Clearly state the objectives of the study. Include hypotheses or research questions. Include objectives to articulate the populations of interest, components, contexts, adaptation, and implementation of the intervention being tested.	_____

Item #	Item	Recommendation	Page #
Section 3. Methods			
Note that not all items will apply to qualitative studies and studies not using comparative designs. Please consult the appendices for further information on specific study designs.			
Study Design			
3.1	**Study Design and Allocation Methods**	Identify the study design and include aspects of design that address differential effectiveness. Describe any changes made to the design/protocol after the study began. If relevant, indicate the unit of assignment (e.g., individual, group) and method used to assign units to the study conditions. Report whether assignment methods (e.g., randomization) were stratified on any variables for examining differential effectiveness.	_____
3.2	**Ethical Approval**	Indicate whether approval, exemption, or designation as quality improvement or program evaluation was obtained from an Institutional Review Board (IRB) or other ethics committee (e.g., an indigenous ethics committee). Describe the informed consent process, including how consent was sought for future access to and use of the data (i.e., secondary studies).	_____
3.3	**Study Protocol**	Note if study was preregistered as a protocol and provide the protocol identification number.	_____
3.4	**Community Partnership with Researchers**	If community partners (e.g., home visiting staff, agency staff, families, other partners) were engaged in the research process, specify who and how. Describe the level of involvement (e.g., timing, number of interactions, role in research process, type of input provided, participation as decision-makers for each phase of the research process).	_____
Setting and Recruitment			
3.5	**Study Setting**	Describe the location where study recruitment, baseline data collection, and follow-up occurred. Report aspects of context that theory or prior research suggest may explain effect heterogeneity (e.g., home visiting model, local implementing agency, participant, community characteristics).	_____
3.6	**Recruitment**	Describe recruitment methods, including who was involved in recruitment (e.g., study staff, home visiting staff), dates of recruitment and follow-up periods, study eligibility criteria, and incentives to programs and participants. Report response rates and reasons for nonresponse (if known). Report how recruitment methods were designed to reach subpopulations, if relevant.	_____

Item #	Item	Recommendation	Page #
3.7	**Study Participants**	Describe the participant population (e.g., program staff, children, caregivers). (Note that some journals require the information in item 4.1 to be included in section 3, methods. Follow journal guidelines and avoid repetition.)	_____
Home Visiting Intervention and Alternative Condition(s)			
3.8	**Name of Intervention**	Provide the full name of the home visiting intervention, modification, or adaptation of focus in the study (e.g., model, program, curriculum, component). If not described in the introduction, describe the home visiting model or curricula.	_____
3.9	**Intervention Objective(s)**	Describe the direct recipient of the intervention (e.g., administrator, home visitor, parents, children). Indicate the specific outcome(s) that the intervention intends to achieve based on program logic. Include relevant mechanisms of action that are intended to help explain how intervention techniques influence behaviors. Referring to earlier publications for details is acceptable.	_____
3.10	**Staff Qualifications, Support, and Training**	Report qualifications required of intervention staff, level of supervision received, and professional development provided for implementation.	_____
3.11	**Intervention Eligibility Criteria**	Specify the eligibility criteria to participate in the model and/or intervention.	_____
3.12	**Intervention Curricula and Materials**	Specify any curricula and materials needed to implement the intervention. If commercial products are needed as part of the intervention or if the intervention is commercially available, report relevant costs.	_____
3.13	**Intervention Techniques**	Specify intentional and observable actions by a provider (depending on the study, this may or may not be a home visitor) to improve an outcome. Note any professional development or coaching required prior to delivering the intervention.	_____
3.14	**Intervention Delivery**	Indicate who (e.g., home visitor, other provider), where (e.g., home, office), and how (e.g., in-person, virtual, group) the intervention is provided. Describe what (if any) study products or services continued to be available to participants/programs after the study concluded, and whether participants in the comparison group(s) received access to treatment materials or services after the study.	_____
3.15	**Dose**	Describe expected frequency of services, the expected length of time for each session, and the expected duration of enrollment. Report how missing sessions are handled, and describe dosage minimums required for participants to remain in the study or to be included in analyses (e.g., 8/10 coaching sessions).	_____

Item #	Item	Recommendation	Page #
3.16	**Tailoring**	If applicable, specify whether and how the intervention allows for tailoring of techniques used, dose, and/or modes of delivery.	_____
3.17	**Intervention Adaptations**	Describe pre-determined adaptations or enhancements to the home visiting intervention and provide the rationale and theoretical explanation for planned variations.	_____
3.18	**Alternative Condition(s)**	If relevant, define the control/comparison condition(s) with sufficient details to allow replication. Report whether the control intervention is the standard of care. Include information for the comparison condition using items 3.8 – 3.17 as applicable.	_____
Study Procedures			
3.19	**Data Collection Procedures**	Describe all data collection procedures and if any modifications were made during the course of the study.	_____
3.20	**Outcome Measures**	List all outcomes assessed, data sources, and measurement tools used to measure the outcomes and describe the known psychometric properties. Provide steps used to determine psychometric properties for any data measurement tool developed for the study or provide a reference paper where readers can find this information. Explain changes made to measures, including reasons for modifying. For each measure, report which group(s) completed the measure and their frequency.	_____
3.21	**Other Measures**	Detail how all other variables (other than outcomes) were assessed, such as implementation measures, contextual factors operating as moderators, mediators (e.g., mechanisms), and covariates, including subgroup characteristics.	_____
3.22	**Sample Size**	Describe methods used to determine the sample size, including power calculations for main analyses and any subgroups. Note the intended sample size and achieved sample size if different.	_____
Statistical/Analytical Methods			
3.23	**Analyses**	Describe all analyses used for results, including comparison of outcomes, observational results, qualitative themes, as well as any subgroup analyses conducted. Report details of additional analyses, including whether analyses to estimate heterogeneity of effects between population subgroups were done on an additive (absolute difference in treatment effects) or multiplicative scale (relative difference) and whether these analyses were pre-specified. Include effect sizes for all outcomes, regardless of heterogeneity estimates.	_____
3.24	**Missing Data**	Describe analyses used to address missing data.	_____

Item #	Item	Recommendation	Page #
Section 4. Results			
Participants			
4.1	**Participants**	Describe the participant flow (including the number of participants involved at each stage of the study process), recruitment, eligibility, assignment to study group, allocation to study group, follow-up, and analysis. Include the number of participants lost to follow-up and reasons for attrition. (See Appendix 2 for documenting group assignment for different study designs.) Present participant flow in a diagram/funnel. Record any deviations from the study protocol that may have occurred. Describe for each group the number of participants who were assigned, received the intervention, and who were analyzed across subgroups. Describe for each group the number of participants lost to follow up and exclusions after randomization across subgroups, with reasons. (Note that some journals will expect this item in methods, others in results. Follow journal guidelines and avoid repetition.)	_____
4.2	**Baseline Data**	Provide baseline characteristics for each group included in the study, including subgroups of interest. If comparing groups, indicate whether baseline equivalence was achieved between the study groups. If the groups were not equivalent at baseline, describe statistical analyses used to correct for differences.	_____
4.3	**Numbers Analyzed**	Report the number of participants included in each analysis and whether the analysis was by originally assigned groups (i.e., intention-to-treat). State results in absolute numbers. Include the number of participants with missing data for each variable and the number of participants lost to follow-up.	_____
Implementation Context and Intervention Delivery			
Note that items 4.4 – 4.6 may be incorporated into the setting and recruitment section of methods, depending on the study design and journal practices.			
4.4	**Organizational Characteristics**	Report characteristics of the organization that may influence implementation, such as type of organization, number of years implementing the intervention, and supervision provided to intervention staff.	_____
4.5	**Staff Characteristics**	Report the number of staff delivering the intervention in the study, role in the organization, sociodemographic characteristics, and relatedness with the population served.	_____

Item #	Item	Recommendation	Page #
4.6	**Intervention Implementation**	Summarize actual implementation to include all core components (e.g., curriculum, techniques, dose, delivery, tailoring). Also include usage (e.g., reach and engagement). State whether fidelity was achieved (or measures of fidelity) and describe whether any deviations occurred regarding implementation. Describe any unplanned adaptations (e.g., due to COVID). For comparison studies, describe details of implementation such as coverage (i.e., amount of the population reached) and intensity (i.e., resources invested, frequency, duration) in the treatment and control groups and whether implementation differed for subgroups.	_____
Outcomes			
4.7	**Main Findings**	Provide descriptive data, including correlations among measures and means and standard deviations on pre- and post-test scores for intervention and comparison groups. Report the results, including the effect size, level of statistical significance, and precision (e.g., 95% confidence interval) for all primary and secondary outcomes. For qualitative studies, present the main themes and illustrative quotations (see Appendix 2).	_____
4.8	**Tables and Figures**	Design tables and figures to convey project design and results in ways that are easy and intuitive for lay audiences to interpret.	_____
4.9	**Null and Negative Findings**	Report null findings or negative effects for primary and secondary outcomes.	_____
4.10	**Additional Analyses**	Report all other analyses (e.g., subgroup, adjusted, mediation and moderation, sensitivity analyses). Indicate whether additional analyses were pre-specified or exploratory.	_____
4.11	**Unintended Effects**	Report all important unintended effects for the intervention group(s), including subgroups of interest. Provide summary results, effect sizes, and precision (e.g., 95% confidence intervals) for each unintended effect.	_____

Item #	Item	Recommendation	Page #
Section 5. Discussion			
5.1	**Study Findings**	Summarize and provide an overall interpretation of key findings in relation to the study objectives, hypotheses, and/or research questions while considering the strength of evidence for primary and secondary outcomes. Consider potential reasons for differences between observed and expected outcomes. Interpret findings in relation to the context of current evidence. Compare and contrast study findings to those in the existing literature. Describe any successes or barriers to implementation and fidelity.	_____
5.2	**Limitations**	Discuss sources of potential bias, imprecision, multiplicity, confounding, and the extent to which results can be generalized to a larger group. Report any limitations related to understanding contextual influences, including subgroup differences. Report applicability of results to subgroups.	_____
5.3	**Future Research and Implications**	Include recommendations for future research and modifications for improved intervention performance. Include implications for policy and practice.	_____

APPENDIX 1: REPORTING GUIDELINES FOR COMMUNITY-ENGAGED RESEARCH STUDIES

This appendix summarizes considerations for reporting home visiting studies that use a community-engaged approach. We used the term *community-engaged research* as an umbrella term and therefore do not cite one specific reporting guideline but include several references. Community-engaged research describes a continuum of approaches and methods that actively engage interested groups and communities in the research process (Ahmed et al., 2010). Common terms and approaches that fall under this umbrella include community-based research, Community-Based Participatory Research (CBPR), action research, and participatory action research (Goodman et al., 2017; Israel et al., 1998; Key et al., 2019; London et al., 2020). Community-engaged approaches improve the validity, relevance, usefulness, and use of research (Wallerstein, 2021; Wallerstein & Duran, 2010). The home visiting research field has opportunities to increase their capacity for and transparency of community-engaged research (West et al., 2025).

Please note that research where community members only served as participants and did not inform the research design and procedures is *not* community-engaged research. In community-engaged research, community members are actively involved in the design and/or implementation of the research protocols, and ideally, their input is measurable. The table below includes additional considerations for the reporting of specific items for community-engaged research studies mapped to the RoHVR items.

Item #	Item	Description
1.1	**Title**	Include community-engaged research terms (e.g., partnership, collaboration, community-based, participatory).
1.3	**Abstract**	Describe how and why a community-engaged approach was used.
2.1	**Background**	Describe rationale for the community-engaged approach.
2.2	**Objectives**	Describe how a participatory approach uniquely contributes to the study objectives. Explain how objectives emerged from constituents' priorities*.
3.20	**Outcomes**	Describe measures used to assess outcomes of using a community-engaged study design (e.g., community partner changes in empowerment, strengthened partnerships, capacity for designing future research and applying for grants).
4.7	**Community Engagement Findings**	Report outcomes associated with the community-engaged approach (e.g., changes in community empowerment or capacity).
5.1	**Study Findings**	Include community partner interpretations of study findings, actions taken, individual outcomes for co-researchers (e.g., increased research knowledge or confidence, new skills), and/or the impact of the study on the community.
5.2	**Limitations**	Provide a detailed and honest assessment of the strengths and limitations of the participatory approach.
5.3	**Future Research and Implications**	Describe knowledge translation and implications for community partners.

*Note: "Constituents" could refer to home visiting models, local program staff, clients/families, community members, and/or community organizations.

APPENDIX 2: REPORTING GUIDELINES FOR SELECT STUDY DESIGNS

This appendix includes links and references to reporting checklists for seven study designs or approaches used in home visiting research. We also include, if relevant, additional considerations for the reporting of specific items from these checklists mapped to the RoHVR items. Study designs include:

- Implementation Studies
- Non-Experimental Comparison Group Designs (NEDs)
- Observational Designs
- Qualitative Designs
- Randomized Controlled Trials (RCTs)
- Regression Discontinuity Designs
- Single Case Designs (SCDs)

Implementation Studies

Link to full reporting guide: StaRI

Additional considerations for reporting:

Item #	Item	Description
2.1	**Background/Rationale**	Provide the scientific background, including any theory or framework and pilot studies, for the implementation strategy.
2.2	**Objectives**	Differentiate between implementation and intervention objectives.
3.8 – 3.18	**Intervention**	Describe the implementation strategy.
3.20 – 3.21	**Outcomes**	Define primary and other outcomes of the implementation and how they were measured. Include any predetermined targets. Describe methods to assess the resources used (e.g., trainings, professional development, staff time for implementation monitoring), costs, economic outcomes, and associated analysis for the implementation strategy.

Non-Experimental Comparison Group Designs (NEDs)

Link to full reporting guide: Improving the reporting quality of nonrandomized evaluations of behavioral and public health interventions: the TREND statement | EQUATOR Network (equator-network.org).

Additional considerations for reporting:

Item #	Item	Description
3.1	**Study Design and Allocation Methods**	Detail the method used (e.g., propensity matching) to create a comparison group to minimize potential bias due to non-randomization. Identify variables on which the groups were matched.

Observational Designs

Link to full reporting guide: STROBE

Additional considerations for reporting: None.

Qualitative Designs

Link to full reporting guide: COREQ

Additional considerations for reporting:

Item #	Item	Description
3.1	**Study Design and Allocation Methods**	Include characteristics of researcher(s) and relationships with participants. Describe characteristics such as the researchers' credentials, personal characteristics, experience, occupation, and training. Also describe if a relationship was established with the participants before the study began and what the participants were told about the researchers and interviewers (e.g., goals, characteristics)
3.1	**Study Design and Allocation Methods**	Explain the methodological orientation and theory. This means including the methodological orientation underpinning the study (e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis).
3.4, 3.19-3.22	**Data Collection**	Describe aspects of the qualitative data collection, such as how the interview or focus group guide was developed, whether recordings and field notes were collected, whether transcripts were reviewed by participants, and whether data saturation was discussed.
3.23	**Analysis**	Describe the number of coders, coding scheme, whether the themes were identified in advance or from the data, software used, and participant checking processes.
4.7	**Results**	Include quotations to illustrate themes, and present major themes and minor themes (e.g., diverse cases).

Randomized Controlled Trials (RCTs)

Link to full reporting guide: CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials | EQUATOR Network (equator-network.org)

Note that there are multiple designs within the RCT category. For example, the SMART (Sequential, Multiple Assignment, Randomized Trial) design allows for additional randomization points during the study based on theoretically important characteristics. This could include home visitors being randomly assigned to an intervention to improve parent-child interactions, and six months later non-responders (those not using the intervention for whatever reason) are randomly assigned to receive additional coaching or continue with standard intervention. See Sequential, Multiple Assignment, Randomized Trial Designs for more information.

Additional considerations for reporting:

Item #	Item	Description
3.1	**Study Design and Allocation Methods**	Detail the method used to generate the random allocation sequence; method used to implement the random allocation sequence; who generated the allocation sequence; who assigned the study units; and whether individuals were blinded to study conditions.

Regression Discontinuity Designs

Link to full reporting guide: Reporting Guide for Study Authors: Regression Discontinuity Design Studies (ed.gov)

Additional considerations for reporting:

Item #	Item	Description
3.1	**Study Design and Allocation Methods**	Detail the method used to generate the forcing variable cutoff, including the institutional and statistical integrity of the forcing variable.
4.8	**Tables and Figures**	Display the relationship between the outcome and forcing variable using a scatter plot and fitted curve.

Single Case Designs (SCDs)

Link to full reporting guide: The Single-Case Reporting Guideline In BEhavioural Interventions (SCRIBE) 2016 Statement | EQUATOR Network (equator-network.org)

Additional considerations for reporting:

Item #	Item	Description
3.1	**Study Design and Allocation Methods**	Detail the type of design chosen (e.g., withdrawal and reversal, multiple baseline) and how the independent variable was manipulated. Include the number of observations within each phase and number of phases.
4.8	**Tables and Figures**	Display a visual analysis of the data that accounts for within and between phase effects, including level, trend, variability, immediacy of effects, overlap, and consistency of data within similar phases.

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REFERENCES

Ahmed, S. M., & Palermo, A. G. (2010). Community engagement in research: Frameworks for education and peer review. *American Journal of Public Health, 100*(8), 1380–1387. https://doi.org/10.2105/AJPH.2009.178137

Avellar, S., & Paulsell, D. (2011). *Lessons Learned from the Home Visiting Effectiveness of Evidence Review*. Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC.

Bordeaux, B. C., Wiley, C., Tandon, S. D., Horowitz, C. R., Brown, P. B., & Bass, E. B. (2007). Guidelines for writing manuscripts about community-based participatory research for peer-reviewed journals. *Progress in Community Health Partnerships: Research, Education, and Action, 1*, 281-288. https://doi.org/10.1353/cpr.2007.0018

Bossuyt, P. M., Reitsma, J. B., Bruns, D. E., Gatsonis, C. A., Glasziou, P. P., Irwig, L. M., et al. (2003). Towards complete and accurate reporting of studies of diagnostic accuracy: The STARD initiative. *BMJ, 326*, 41-44. https://doi.org/10.1136/bmj.326.7379.41

Des Jarlais, D. C., Lyles, C., Crepaz, N., & the TREND Group. (2004). Improving the reporting quality of nonrandomized evaluations of behavioral and public health interventions: The TREND statement. *American Journal of Public Health, 94*, 361-366. https://doi.org/10.2105/AJPH.94.3.361

Duggan, A. K., Bower, K. M., Spinosa, C. Z., O'Neill, K., Daro, D., Harding, K., Ingalls, A., Kemner, A., Marchesseault, C., & Thorland, W. (2022). Changing the home visiting research paradigm: Model's perspectives on behavioral pathways and intervention techniques to promote good birth outcomes. *BMC Public Health, 22,* 1024. https://doi.org/10.1186/s12889-022-13010-5

Filene, J., Kaminski, J. W., Valle, L. A., & Cachat, P. (2013). Meta-Analytic Review of Components Associated with Home Visiting Programs: Final report. *The Pew Center on the States*.

Gagnier, J. J., Kienle, G., Altman, D. G., Moher, D., Sox, H. Riley, D., & CARE Group. (2014). The CARE guidelines: Consensus-based clinical case report guideline development. *Journal of Clinical Epidemiology, 67*, 46-51. https://doi.org/10.1016/j.jclinepi.2013.08.003

Goodman, M. S., & Sanders Thompson, V. L. (2017). The science of stakeholder engagement in research: classification, implementation, and evaluation. *Translational Behavioral Medicine*, *7*(3), 486-491. https://doi.org/10.1007/s13142-017-0495-z

Hoffman, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., et al. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ, 348*, g1687. https://doi.org/10.1136/bmj.g1687

Huria, T., Palmer, S. C., Pitama, S., Beckert, L., Lacey, C., Ewen, S., & Smith, L. T. (2019). Consolidated criteria for strengthening reporting of health research involving indigenous peoples: The CONSIDER statement. *BMC Medical Research Methodology, 19*, 1-9. https://doi.org/10.1186/s12874-019-0815-8

Husereau, D., Drummond, M., Petrou, S., Carswell, C., Moher, D., Greenberg, D., et al. (2013). Consolidated health economic evaluation reporting standards (CHEERS) – explanation and elaboration: A report of the ISPOR health economic evaluation publication guidelines good reporting practices task force. *Value in Health, 16,* 231-250. https://doi.org/10.1016/j.jval.2013.02.002

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). REVIEW OF COMMUNITY-BASED RESEARCH: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health*, *19*(1), 173–202. https://doi.org/10.1146/annurev.publhealth.19.1.173

Key, K. D., Furr-Holden, D., Lewis, E. Y., Cunningham, R., Zimmerman, M. A., Johnson-Lawrence, V., & Selig, S. (2019). The Continuum of Community Engagement in Research: A Roadmap for Understanding and Assessing Progress. *Progress in Community Health Partnerships: Research, Education, and Action*, *13*(4), 427–434. https://doi.org/10.1353/cpr.2019.0064

Kraft., J. M., Paina, L., Boydell, V., Elnakib, S., Sihotang, A., Bailey, A., & Tolmie, C. (2024). Social accountability reporting for research (SAR4Research): Checklist to strengthen reporting on studies on social accountability in the literature. *International Journal of Equity in Health, 21*(Suppl 1), 121. https://doi.org/10.1186/s12939-022-01716-2

London, J. K., Haapanen, K. A., Backus, A., Mack, S. M., Lindsey, M., & Andrade, K. (2020). Aligning Community-Engaged Research to Context. *International Journal of Environmental Research and Public Health*, *17*(4), 1187. https://doi.org/10.3390/ijerph17041187

Michie, S., Fixsen, D., Grimshaw, J. M., & Eccles, M. P. (2009). Specifying and reporting complex behaviour change interventions: The need for a scientific method. *Implementation Science, 4*(40). https://doi.org/10.1186/1748-5908-4-40

Moher, D., Schulz, K. F., Altman, D. G. (2001). The CONSORT statement: Revised recommendations for improving the quality of reports of parallel-group randomised trials. *The Lancet*, *357,* 1191-1194. https://doi.org/10.1016/S0140-6736(00)04337-3

Moher, D., Schulz, K. F., Simera, I., & Altman, D. G. (2010). Guidance for developers of health research reporting guidelines. *PLoS Medicine, 7*, e1000217. https://doi.org/10.1371/journal.pmed.1000217

O'Connor, A. M., Sargeant, J. M., Gardner, I. A., Dickson, J. S., Torrence, M. E., Dewey, C. E., et al. (2010). The REFLECT statement: Methods and processes of creating Reporting Guidelines For randomized Controlled Trials for livestock and food safety. *Preventive Veterinary Medicine, 93,* 11-18. https://doi.org/10.1016/j.prevetmed.2009.10.008

Ogrinc, G., Mooney, S. E., Estrada, C., Foster, T., Goldmann, D., Hall, L. W., et al. (2008). The SQUIRE (Standards for Quality Improvement in Reporting Excellence) guidelines for quality improvement reporting: Explanation and elaboration. *Quality and Safety in Health Care, 17,* i13-i32. https://doi.org/10.1136/qshc.2008.029058

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, *372*.

Pinnock, H., Barwick, M., Carpenter, C. R., Eldridge, S., Grandes, G., Griffiths, C. J., Rycroft-Malone, J., Meissner, P., Murray, E., Patel, A., Sheikh, A., & Taylor, S. J. (2017). Standards for reporting implementation studies (StaRI) statement. *BMJ, 356*, i6795. https://doi.org/10.1136/bmj.i6795

Schroter, S., Glasziou, P., & Heneghan, C. (2012). Quality of descriptions of treatments: A review of published randomised controlled trials. *BMJ Open, 2*, e001978. https://doi.org/10.1136/bmjopen-2012-001978

Simera, I., Altman, D. G., Moher, D., Schulz, K. F., & Hoey, J. (2008). Guidelines for reporting health research: The EQUATOR Network's survey of guideline authors. *PLoS Medicine, 5*(6), e139. https://doi.org/10.1371/journal.pmed.0050139

Smith, L., Rosenzweig, L., & Schmidt, M. (2010). Best practices in the reporting of participatory action research: embracing both the forest and the trees. *The Counseling Psychologist*, *38*, 1115-1138. https://doi.org/10.1177/0011000010376416

Stroup, D. F., Berlin, J. A., Morton, S. C., Olkin, I., Williamson, G. D., Rennie, D., ... & Thacker, S. B. (2000). Meta-analysis of observational studies in epidemiology: a proposal for reporting. *JAMA*, *283*(15), 2008-2012.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19,* 349-357. https://doi.org/10.1093/intqhc/mzm042

Vandenbroucke, J. P., von Elm, E., Altman, D. G., Gøtzsche, P. C., Mulrow, C. D., Pocock, S. J., et al. (2007). Strengthening the Reporting of Observational Studies in Epidemiology (STROBE): Explanation and elaboration. *PLoS Medicine, 4*, e297. https://doi.org/10.1371/journal.pmed.0040297

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health*, *100*(S1), S40–S46. https://doi.org/10.2105/AJPH.2009.184036

Wallerstein, N. (2021). Engage for equity: Advancing the fields of community-based participatory research and community-engaged research in community psychology and the social sciences. *American Journal of Community Psychology*, *67*(3-4), 251-255. https://doi.org/10.1002/ajcp.12530

Welch, V. A., Norheim, O. F., Jull, J., Cookson, R., Sommerfelt, H., Tugwell, P., & CONSORT-Equity and Boston Equity Symposium. (2017). CONSORT-Equity 2017 extension and elaboration for better reporting of health equity in randomised trials. *BMJ, 359*, j5085. https://doi.org/10.1136/bmj.j5085

Welch, V., Petticrew, M., Tugwell, P., Moher, D., O'Neill, J., Waters, E., White, H., & the PRISMA-Equity Bellagio Group. (2012). PRISMA-Equity 2012 extension: Reporting guidelines for systematic reviews with a focus on health equity. *PLoS Medicine, 9*, e1001333. https://doi.org/10.1371/journal.pmed.1001333

West, A., Chute, D. E., Daniels, J., & Bower, K. M. (2025). Community-Engaged Research in Early Home Visiting: A Scoping Review of Peer-Reviewed Literature. *Prevention Science*, 1-13. https://doi.org/10.1007/s11121-025-01812-z