Informe especial / Special report

Lessons learned in evaluating the *Familias Fuertes* program in three countries in Latin America

Pamela Orpinas,[1] Ashley Ambrose,[2] Matilde Maddaleno,[3] Lauren Vulanovic,[2] Martha Mejia,[4] Betzabé Butrón,[2] Gonzalo Sosa Gutierrez,[5] and Ismael Soriano[2]

Suggested citation Orpinas P, Ambrose A, Maddaleno M, Vulanovic L, Mejia M, Butrón B, et al. Lessons learned in evaluating the *Familias Fuertes* program in three countries in Latin America. Rev Panam Salud Publica. 2014;36(6):383–90.

ABSTRACT *This report describes 1) the evaluation of the* Familias Fuertes *primary prevention program in three countries (Bolivia, Colombia, and Ecuador) and 2) the effect of program participation on parenting practices.* Familias Fuertes *was implemented in Bolivia (10 groups, 96 parents), Colombia (12 groups, 173 parents), and Ecuador (five groups, 42 parents) to prevent the initiation and reduce the prevalence of health-compromising behaviors among adolescents by strengthening family relationships and enhancing parenting skills. The program consists of seven group sessions (for 6–12 families) designed for parents/caregivers and their 10–14-year-old child. Parents/caregivers answered a survey before the first session and at the completion of the program. The survey measured two important mediating constructs: "positive parenting" and "parental hostility." The Pan American Health Organization provided training for facilitators. After the program, parents/caregivers from all three countries reported significantly higher mean scores for "positive parenting" and significantly lower mean scores for "parental hostility" than at the pre-test. "Positive parenting" practices paired with low "parental hostility" are fundamental to strengthening the relationship between parents/caregivers and the children and reducing adolescents' health-compromising behaviors. More research is needed to examine the long-term impact of the program on adolescent behaviors.*

Key words Parenting; adolescent; adolescent behavior; primary prevention; family; Bolivia; Colombia; Ecuador; Latin America.

Parents/caregivers play pivotal roles in the lives of the children they raise. They can promote the children's emotional and physical well-being and protect them from harm and adverse circumstances such as discrimination and poverty. Quality of family relationships is important in the parenting process. Good parenting skills can protect children and adolescents from engaging in behaviors that compromise their health, such as drug use, early sexual activity, school dropout, and peer aggression (1, 2). Decades of family research have determined that those most successful at parenting have a warm and caring relationship with the children (3); communicate family values against high-risk behaviors (4); and maintain consistent discipline, supervision, and involvement (5–8). Parenting that reflects a combination of all of these characteristics may have the strongest positive effect on preventing risk behaviors (9, 10). Strong parental control may be particularly important for children living in areas where drugs and violence abound (3, 11). Con-

[1] Department of Health Promotion and Behavior, University of Georgia, Athens, Georgia, United States of America. Send correspondence to: Pamela Orpinas, porpinas@uga.edu
[2] Department of Family, Gender and Life Course, Pan American Health Organization, Washington, District of Columbia, United States of America.
[3] Ministry of Health, Santiago, Chile.
[4] Pan American Health Organization, La Paz, Bolivia.
[5] Ministry of Health and Social Protection, Bogotá, Colombia.

versely, researchers have consistently shown that harsh parental discipline and lack of parenting skills can lead youth to engage in numerous problem behaviors (12, 13).

Most parents/caregivers would like to provide a good environment for the children to succeed, but some do not have the knowledge and skills to create a positive home environment that balances affection with age-appropriate limits. Programs designed to improve parenting skills may be particularly important in low- and medium-income countries where parents/caregivers have limited resources (2).

In 2007, the Pan American Health Organization (PAHO) selected the Strengthening Families Program (SFP) for parents and youth aged 10–14 years as the best model for prevention for Latin American families (14). PAHO adapted the program for Latin Americans by modifying some of its strategies and creating videos with actors who reflected a wide range of Latino racial groups but used a standardized Spanish language (15). The adapted version, known as *Familias Fuertes* (FF), has been implemented in 13 countries in Latin America and the Caribbean, as well as in the United States (16). The program is designed for youth living in any family configuration and the videos portray different types of family structures. All adults who take care of youth are invited to participate as research conducted among traditional family structures indicates family intervention programs are more successful when they include both the father and mother (17). The long-term goal of FF is to prevent the initiation of high-risk behaviors among adolescents (e.g., use of alcohol and other drugs, early sexual intercourse, teen pregnancy, aggression, and school dropout) and reduce their prevalence by strengthening relationships among family members and promoting self-regulation and positive conflict resolution strategies.

FF has several characteristics that make it ideal for prevention of high-risk behaviors. First, FF is designed as a primary prevention program for all families with an adolescent aged 10–14 years. The goal of the program is to prevent initiation of the "slippery slope" of trying drugs, missing school, and becoming teen parents, and thus falling into a self-defeating process of cumulative disadvantage. Selection of adolescent participants is not based on the presence of behavioral or emotional problems. Second, as a family-centered prevention program, the values promoted by FF are consistent with the strong ties of the Latino family (18). Latino parents/caregivers and adolescents have both emphasized the importance of the whole family participating in the program (16). Third, FF has the potential to bridge the gap between theory (research) and practice (implementation) because the program can be organized and administered by community members without advanced degrees. Fourth, FF is relatively inexpensive to implement and only comprises seven short sessions. All of the materials—including videos, printable facilitator manuals, and PAHO's manual for measuring behavior-mediating constructs (19)—are free and can be downloaded from the PAHO website.[6] Fifth, FF is based on the SFP, which has been shown to be very effective. In clinical trials conducted among a predominantly white student population in Iowa, completion of the SFP was associated with long-term reductions in the initiation and past-month use of alcohol and cigarettes (20); slower overall growth in substance use (21); reduced use of methamphetamine ("meth") and prescription drugs (22); reduced high-risk sexual behaviors (23); reduced aggression and hostility (24); increased academic success (25); and savings of US$ 9.60 for every dollar invested (26).

The goal of this report was to describe 1) the evaluation of FF in three countries in Latin America—Bolivia, Colombia, and Ecuador—and 2) the effect of FF on parenting skills of parents or caregivers who participated in the program. Parents/caregivers completed a survey before and after participating in the seven-session program ("pre-test" and "post-test"). It was hypothesized that participating parents/caregivers' "positive parenting" skills would increase and "parental hostility" would decrease.

TABLE 1. ***Familias Fuertes*** **program: session objectives**

Session	Objectives
1	Parents/caregivers give love and set limits Youth communicate goals and dreams Whole family supports goals and dreams
2	Parents/caregivers establish home rules Youth learn to appreciate parents Whole family promotes family communication
3	Parents/caregivers stimulate good behavior Youth deal with stress in healthy ways Whole family appreciates family members
4	Parents/caregivers learn to set appropriate consequences Youth learn to obey the rules Whole family uses family reunions
5	Parents/caregivers practice listening and paying attention to feelings Youth deal with peer pressure Whole family understands family values
6	Parents/caregivers help protect youth against high-risk behaviors Youth practice resisting peer pressure and choosing good friends Whole family talks about peer pressure and establishing expectations
7	Parents/caregivers focus on connecting to community resources Youth learn ways to help others and interact with positive role models Whole family reviews program content and graduate

MATERIALS AND METHODS

The intervention

FF consists of seven weekly two-hour sessions for parents/caregivers and children in the family aged 10–14 years. The participants are divided into groups of 6–12 families each. During the first hour of each session, parents/caregivers and children work in separate groups; during the second hour all family members work together in the same group. Table 1 provides details about the objectives of each session by group (youth, parents/caregivers, and whole family). The sessions include videos, interactive exercises, and discussions. Facilitators who have completed the FF program's three-day training workshop lead the sessions. FF

[6] http://tinyurl.com/PAHO-ES-FF

facilitators do not require clinical training or advanced degrees but do need to have good facilitation skills, enthusiasm, and the ability to maintain program fidelity. "Effective group leaders can be drawn from the following: family and youth service workers, mental health staff, teachers, school counselors, ministers, church youth staff, skilled parents/caregivers who have previously attended the program, and staff from [Iowa's] Cooperative Extension Service" (14). As a primary prevention program, FF is designed for all families, not just those with children with behavioral or emotional problems.

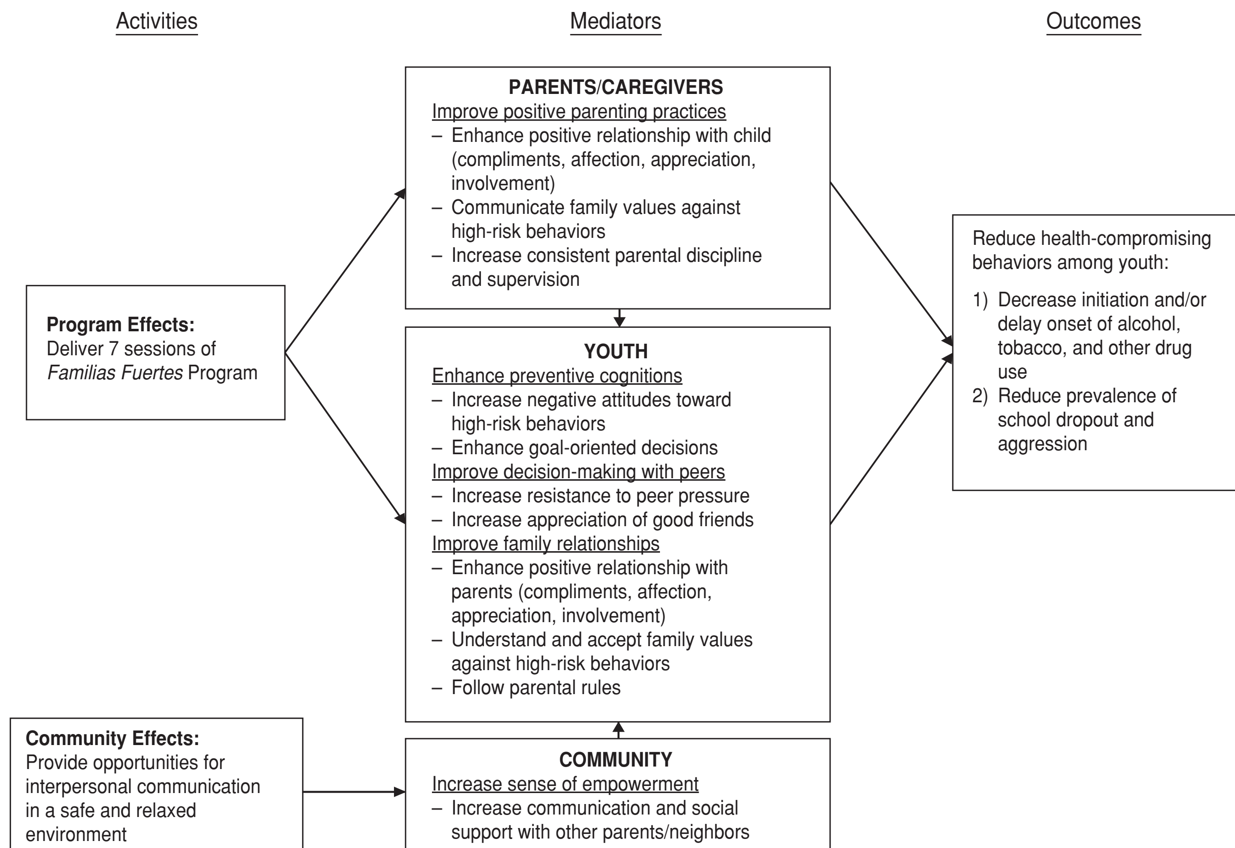
FF is guided by two principles of effective child rearing. The first principle is to express love. FF is designed to enhance parents/caregivers' positive relationship with the child by reinforcing skills that better enable them to give compliments, show affection, appreciate the child's goals and activities, and be involved in the child's world. The second principle is to set limits. Parents/caregivers learn to 1) establish home rules, and effective consequences for breaking them, 2) reinforce positive behavior, and 3) increase their consistency in monitoring and supervising the child's whereabouts. Parents/caregivers also learn to communicate family values that do not support high-risk behaviors. Youth are encouraged to communicate more effectively with their parents/caregivers, share their goals, and understand and follow home rules.

In addition to teaching parents/caregivers how to express love and set limits within the family, FF is designed to improve the children's ability to make decisions with their peers and to enhance youth cognitions that have been shown to be effective in preventing drug use. Most children are not "pulled" into groups with values that conflict with their own. Rather, they will choose friends with dispositions that match their own, which are influenced by parenting practices (27). Thus, parents/caregivers have an indirect role in influencing the child to choose positive friendships. As a community-based program, FF facilitates the interaction among the parents/caregivers who participate in the program, enhances social support, and provides community supervision. Figure 1 depicts the program's conceptual model, including the hypothesized mediators and outcomes, and details about the specific behaviors the program targets among parents/caregivers, youth, and the community.

Study design and sample

FF was implemented in the three countries as a community service, not as a research study. The purpose of the subsequent evaluation described here was to document change in behavior among participants upon their completion of the program, under the auspices of PAHO and based on its ethical guidelines, with the goal of improving parenting practices. Thus, none of the countries had a control group. In all countries, the program was implemented in schools. Participants completed the pre-test at the beginning of the first session and the post-test at the end of the seventh session. The surveys used in all three countries measured the mediating constructs identified in the program's theoretical model. Between September and Decem-

FIGURE 1. ***Familias Fuertes*** **program conceptual model**



ber 2012, PAHO trained local facilitators in La Paz (Bolivia) (n = 35), Bogotá (Colombia) (n = 31), and Quito (Ecuador) (n = 21). All FF sessions were implemented after the training. Participants included the parents/caregivers, mostly mothers, and one child per family. The children's age ranged between 10 and 14 years. In all countries, the sample of participating children was evenly divided by gender (girls: 48%; boys: 52%).

Bolivia. In Bolivia, 10 FF groups were conducted with a total of 119 families. The large majority of these families had an indigenous ethnic background (Aymara). Participants lived in low-income areas in suburbs of the city of La Paz, with high levels of insecurity and high exposure to social risks. The mean age of parents/caregivers was 37.3 (standard deviation (SD) = 8.7, range 18–68). The majority of participants were women (86%). Three older siblings and a few grandparents also participated.

Colombia. In Colombia, 12 FF groups were conducted with 182 families. The program was implemented in four cities: Barranquilla, Cúcuta, Manizales, and Palmira. The mean age of parents/caregivers was 40.6 (SD = 8.1, range 27–71) and the majority were women (75%).

Ecuador. In Ecuador, five FF groups were implemented with 82 families. The program was conducted in three schools in Quito. The mean age of parents/caregivers was 40.4 (SD = 6.9, range 27–52). Over half of the participants were women (54%). Approximately 30% of the families had finished high school, and another 30% had some college education. Three siblings participated but did not complete the pretest or the post-test.

Measures

All surveys measured the two main constructs that the program is designed to influence: "positive parenting" and "parental hostility." However, because this was not a research study, there were some differences in the instruments selected in each country. In Bolivia and Colombia, parents/caregivers completed a short survey, whereas in Ecuador parents/caregivers completed a longer survey. For Ecuador, four additional constructs were reported: "parental involvement," "consistent discipline," "parental monitoring," and "parental communication against high-risk behaviors." All scale scores were computed as the average of all the items, with higher scores representing stronger support for the construct. Response categories are listed in Table 2. Completion of the survey was voluntary and did not affect whether or not families could participate in the program. Participants were informed that they could skip questions or refuse to answer.

Positive parenting. The "positive parenting" construct refers to parental behaviors that show love, appreciation, and interest in the child's ideas and activities. In Bolivia, "positive parenting" was measured by six items (alpha = 0.79); in Colombia, it was measured by only three of those items (alpha = 0.71). In Ecuador, it was measured with two different scales: one determining the level of "parental appreciation" (seven items, alpha = 0.80) from the Positive Parenting Style Scale (28) and the other determining the level of "parental warmth" (five items, alpha = 0.82) based on the Behavioral Affect Rating Scale (19, 29).

Parental hostility. The "parental hostility" construct refers to parental behaviors that can indicate anger, such as losing control, shouting, or hitting. In Bolivia, "parental hostility" was measured by five items (alpha = 0.72); in Colombia, it was measured with three of those items (alpha = 0.71). In Ecuador, "parental hostility" was measured using the hostility subscale (seven items, alpha = 0.85) from the Behavioral Affect Rating Scale (19, 29).

Parental involvement. "Parental involvement" in the child's life was measured with 10 items (alpha = 0.79) based on scales used in previous studies (19) but modified to incorporate behaviors reinforced by the FF program, such as support for the child's goals and dreams.

TABLE 2. Comparison of parent/caregiver responses before and after the implementation of the *Familias Fuertes* program, Bolivia, Colombia, and Ecuador, 2012–2013

Behavior-mediating construct[a]	Pre-test mean (SD[b])	Post-test mean (SD)	t[c]	df[d]	P
Bolivia					
Positive parenting[e]	3.10 (0.63)	3.30 (0.57)	–3.610	90	0.001
Parental hostility[e]	2.04 (0.54)	1.88 (0.51)	3.031	92	0.003
Colombia					
Positive parenting[e]	3.38 (0.65)	3.54 (0.52)	–3.069	172	0.002
Parental hostility[e]	2.07 (0.63)	1.90 (0.68)	2.803	172	0.006
Ecuador					
Parental appreciation[f]	3.80 (0.53)	4.15 (0.51)	–5.230	41	< 0.0001
Parental warmth[f]	4.18 (0.63)	4.51 (0.44)	–4.386	41	< 0.0001
Parental hostility[f]	2.78 (0.67)	2.50 (0.53)	3.593	40	0.001
Parental involvement[f]	4.12 (0.47)	4.33 (0.42)	–3.439	41	0.001
Consistent discipline[f]	3.23 (0.82)	3.69 (0.69)	–3.838	41	< 0.0001
Parental monitoring[f]	4.15 (0.69)	4.42 (0.55)	–4.140	41	< 0.0001
Parental communication against high-risk behaviors[g]	2.04 (0.98)	2.38 (0.76)	–2.596	41	0.013

[a] All scales were computed as the average of all items, with higher values indicating a stronger support for the construct.
[b] SD: standard deviation.
[c] t: Student's t-test result for paired samples.
[d] df = degrees of freedom.
[e] Response categories ranged between "never" (1) and "always" (4).
[f] Response categories ranged between "never" (1) and "always" (5).
[g] Response categories ranged between 0 times (0) and 3 or more times (3).

Consistent discipline. "Consistent discipline" (consistency in applying consequences for the child's behaviors) was measured using three items (alpha = 0.84).

Parental monitoring. "Parental monitoring" (parents/caregivers' solicitation of information from the child about his/her whereabouts and friendships) was measured with 11 items (alpha = 0.92) (30).

Parental communication against high-risk behaviors. "Parental communication against high-risk behaviors" was measured with eight items (alpha = 0.93) adapted from the "Parent-Child Communication About Smoking" measure to include alcohol, drugs, gangs, fights at school, school dropout, and sexual behaviors (19).

RESULTS

Of the 383 participants, 311 sets of results for the pre-test and the post-test were matched (Bolivia: n = 96, 81%; Colombia: n = 173, 95%; Ecuador: n = 42, 51%). In Ecuador, 82 families started the first session, but only 51 completed all sessions. Of these, 42 completed both a pre-test and a post-test.

Table 2 provides details on the mean scores of parents/caregivers before and after the implementation of the FF program. The Student's t-test was used to assess whether changes in scores for paired samples were statistically different. After the program, parents/caregivers from all three countries reported statistically significant higher "positive parenting" and lower "parental hostility." In Ecuador, parents/caregivers reported statistically significant higher "parental involvement," "consistent discipline," "parental monitoring," and "parental communication about health-compromising behaviors."

Parents/caregivers with very high "positive parenting" and those with very low "parental hostility" at pre-test had very little possibility of improving their scores. Thus, to examine the proportion of parents/caregivers that improved their scores at post-test, the sample was divided into the approximately one-third of the group with "low room for improvement" and those with higher room for improvement (i.e., lower initial scores in "positive parenting" and higher scores in "parental hostility"). Figure 2 shows the proportion of the sample that reported an increase in "positive parenting" and Figure 3 shows the proportion that reported a decrease in "parental hostility," by room for improvement in their scores. The more room for improvement, the larger the proportion that improved their scores. Among those with "high room for improvement," on average across countries, 75% increased their "positive parenting" at post-test and 68% decreased their "parental hostility." Among those with lower room for improvement, on average across countries, 21% increased their "positive parenting" at post-test and 25% decreased their "parental hostility."

FIGURE 2. Proportion of sample that reported an increase in "positive parenting," by "room for improvement" ("high" versus "low") at baseline, after completing the *Familias Fuertes* program, Bolivia, Colombia, and Ecuador, 2012–2013

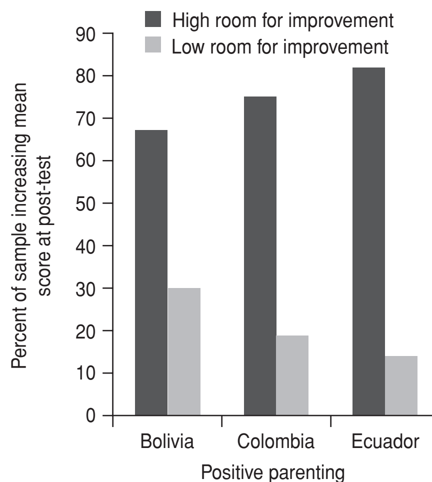
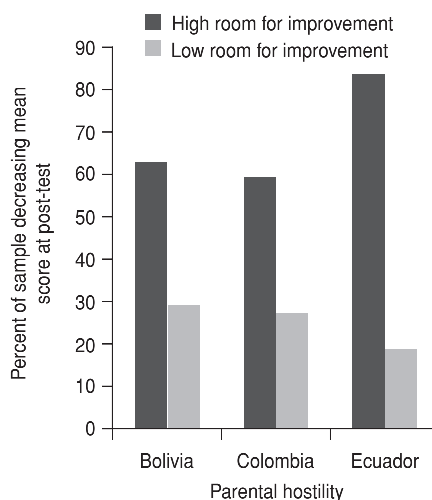


FIGURE 3. Proportion of sample that reported an decrease in parental hostility, by "room for improvement" ("high" versus "low") at baseline, after completing the *Familias Fuertes* program, Bolivia, Colombia, and Ecuador, 2012–2013



DISCUSSION

The design and content of the FF program is consistent with the evidence-based SFP, which was proven effective through rigorous randomized control trials, and is therefore expected to achieve similar results. The strict facilitator training guidelines and standardized materials guarantee the consistency of FF with the SFP. Although several studies of the SFP have been conducted, the literature on FF is nascent: one study in Honduras (31), an evaluation of the program in Chile (32), and a pilot evaluation with Latino families living in the United States (16). Given the importance of parenting programs, the World Health Organization (WHO) has called for more evaluation of these types of programs (1). The current FF evaluation is useful for increasing understanding of the efficacy of FF in Latin America, but more research is needed.

Parents/caregivers changed in two dimensions that both theory and research highlight as key to positive child development (9, 12). First, they reported an increase in their "positive parenting" skills in the form of showing more love, appreciation, and interest. Second, they reported less hostility toward the children in the form of less shouting and insulting. The literature shows that nurturing and responsive parenting provides a shell of protection and reduces adolescent risk behaviors (33). The change in the participating parents/caregivers' perceptions of these important dimensions is promising, but the results do not indicate if the changes will be sustained over time. Theoretically, these changes should lead to reductions in the initiation and frequency of adolescents' health-compromising behaviors. More research is needed to examine the long-term impact of this intervention.

The improvement of parenting skills through participation in the program can be attributed to several factors. First, the evaluated program materials were consistent with the original program materials with the exception of some cultural adaptations for Latino families. In addition to being translated into

Spanish and modified to fit the reality of some countries in Latin America, the program was revised by PAHO experts in gender and health to eliminate possible gender biases. PAHO has built a legacy around FF in the Americas, offering technical cooperation to countries in all aspects of program implementation. Second, using videos and practical activities, the program provides a model of the skills that parents/caregivers need to learn, followed by practical exercises to enhance learning. Third, the program addresses the fundamental parenting skills: showing love, reducing harsh parenting, setting age-appropriate limits, having consequences for the behavior, communicating without negativity, and supervising the child's whereabouts.

The low response rate in Ecuador was due to lack of support from the principal of one of the schools, who limited access to the building during the weekends. Meetings could not be held for a couple of weeks, after which parents/caregivers stopped attending. This problem highlights the need for strong administrative support for successful program implementation. Another problem that reduced participation in low-income communities was lack of transportation and the cost of public transportation to the schools. Providing funds for transportation, or implementing the program in the community instead of the schools, may alleviate this problem.

The process of evaluating FF revealed a number of challenges and areas for improvement. Because this evaluation was not a research study, in which rigorous attention to measurement is paramount, facilitators from different countries did not use the same scales. However, in all three countries where the program was evaluated, scales that measured the expected changes in mediating the family variables were used. Facilitators suggested that the scales should be shortened and alternative ways of measuring should be incorporated to accommodate parents/caregivers with low literacy levels. In this evaluation, use of just three items provided as good an estimate of the construct as the longer scales. Future evaluators should consider using short scales and common instruments to facilitate the comparisons across countries. To reduce social desirability, the persons who facilitate the intervention should not be the same as those who assess the families and the post-test should be conducted several weeks after the last session. However, this best-case scenario is not possible in most countries where the main focus is to provide a service, not conduct a rigorous research study. The training of facilitators should include skills for data collection. As access to phones and computers increase, online data collection and audio-assisted interviewing could help reduce literacy limitations and social desirability (34). In spite of these implementation problems, results consistently showed positive changes. In addition, the comments from parents/caregivers in this evaluation showed high levels of satisfaction with the program and positive changes.

Characteristics of the sample may also affect the results. Factors such as quality of the relationship between parents/caregivers or levels of stress may be influencing the results and should be taken into account. Another limitation was the low participation of fathers or male caregivers. The predominance of female caregivers is not uncommon in family programs. Part of the problem is that in families where parents are single, divorced, or separated, the mother usually has custody of the children and is the only parent to attend school events (32, 35). More research is needed on recruitment strategies to increase participation of male caregivers. Volunteer bias should also be considered as a potential confounding factor in the analysis of the data. Invitations to participate in the program were distributed to all parents/legal guardians at each school, and it is possible that families with greater motivation and resources chose to participate in the program. Therefore, characteristics of participating families should also be measured carefully to account for these factors.

The scores did not follow a normal distribution. Many parents/caregivers had high scores for "positive parenting" and low scores for "parental hostility," an expected outcome given that the program is designed for the general population, not for families with children with behavioral problems. In spite of this ceiling effect, scores did reflect change in the expected direction.

The short-term evaluation and the lack of control group were also limitations. The evaluation of FF in Chile showed changes in adolescent outcomes only after the third year (T. Zubarew, Pontificia Universidad Católica de Chile, Personal Communication, 19 February 2014). Although it is expected that the adapted FF program will achieve similar results as the SFP, a rigorous impact evaluation of FF in Latin America is integral to the continual improvement and growth of the program. A clustered randomized control trial measuring the impact of the FF program on alcohol and drug use, school dropout, and aggression, using a control group as comparison, would allow for the examination of changes in drug use and other risk behaviors relative to the trajectories in the "normal" population. Many of the outcomes, such as adolescent alcohol use, will increase over time. Previous research has shown that the growth of increase was lower in the intervention group than the control group but adolescents in both groups increased their alcohol use (21). A longitudinal study with a control group will help ensure the sustainability of the program as funding and commitment to the program by country governments increases with strong evidence.

Conclusions

Familias Fuertes is a primary prevention program designed to prevent health-compromising behaviors among adolescents by strengthening family relationships and enhancing parenting skills. In this evaluation, parents/caregivers from Bolivia, Colombia, and Ecuador who participated in FF increased their "positive parenting" practices and reduced hostile behaviors. Expressing caring feelings, setting clear and age-appropriate limits, and being involved in the life of children are fundamental to strengthening family relationships. A strong and positive parent/caregiver–child relationship has been consistently linked to adolescents exhibiting fewer health-compromising behaviors. More research is needed to determine the best strategies to measure impact, the possible adaptations to local cultures, and the long-term impact of the program on adolescent behaviors.

To ensure the sustainability of the program in the Americas region, PAHO has streamlined the distribution and availability of FF materials (including manuals and videos), which are available online at no cost. An adaptation of FF for Latinos living in the United States is available from the lead author (PO).

With program materials and evaluation instruments defined and available, PAHO has established strong communication networks with governments and communities to share knowledge, including evaluation results and suggestions for program implementation and adaptation.

Acknowledgments. The authors thank the Andean Community (CAN), the Andean Community Anti-Illicit Drug Program (PRADICAN), and the Pan American Health Organization (PAHO) for their leadership and technical support in the implementation and evaluation of the *Familias Fuertes* (FF) program. The authors also thank the implementing partners, the trainers, and the facilitators of FF in Bolivia, Colombia, and Ecuador, for their dedicated commitment to the implementation and evaluation of the program; the families who participated in it; and the European Union and the Royal Norwegian Embassy, for their financial contributions.

Funding. The European Union and the Royal Norwegian Embassy helped fund this evaluation.

Conflicts of interest. None.

REFERENCES

1. World Health Organization; United Nations Children's Fund. Preventing violence: evaluating outcomes of parenting programmes. Geneva: WHO; 2013. Available from: http://www.who.int/violence_injury_prevention/publications/violence/parenting_evaluations/en/ Accessed on 1 November 2014.
2. Knerr W, Gardner F, Cluver L. Improving positive parenting skills and reducing harsh and abusive parenting in low- and middle-income countries: a systematic review. Prev Sci. 2013;14(4):352–63.
3. Mogro-Wilson C. The influence of parental warmth and control on Latino adolescent alcohol use. Hispanic J Behav Sci. 2008;30(1): 89–105.
4. Elder JP, Campbell NR, Litrownik AJ, Ayala GX, Slymen DJ, Parra-Medina D, et al. Predictors of cigarette and alcohol susceptibility and use among Hispanic migrant adolescents. Prev Med. 2000;31(2 Pt 1):115–23.
5. Loukas A, Suizzo MA, Prelow HM. Examining resource and protective factors in the adjustment of Latino youth in low income families: what role does maternal acculturation play? J Youth Adolesc. 2007;36(4):489–501.
6. Metzler CW, Noell J, Biglan A, Ary DV, Smolkowski K. The social context for risky sexual behavior among adolescents. J Behav Med. 1994;17(4):419–38.
7. Patterson GR, Stouthamer-Loeber M. The correlation of family management practices and delinquency. Child Dev. 1984;55(4):1299–307.
8. Samaniego RY, Gonzales NA. Multiple mediators of the effects of acculturation status on delinquency for Mexican American adolescents. Am J Community Psychol. 1999;27(2): 189–210.
9. Cleveland MJ, Gibbons FX, Gerrard M, Pomery EA, Brody GH. The impact of parenting on risk cognitions and risk behavior: a study of mediation and moderation in a panel of African American adolescents. Child Dev. 2005;76(4):900–16.
10. Windle M, Brener N, Cuccaro P, Dittus P, Kanouse D, Murray N, et al. Parenting predictors of early-adolescents' health behaviors: simultaneous group comparisons across sex and ethnic groups. J Youth Adolesc. 2010;39(6):594–606.
11. Barroso CS, Peters RJ, Kelder S, Conroy J, Murray N, Orpinas P. Youth exposure to community violence: association with aggression, victimization, and risk behaviors. J Aggression Maltreatment Trauma. 2008;17(2):141–55.
12. Hoeve M, Dubas JS, Eichelsheim VI, van der Laan PH, Smeenk W, Gerris JRM. The relationship between parenting and delinquency: a meta-analysis. J Abnorm Child Psychol. 2009;37(6):749–75.
13. Gershoff ET, Lansford JE, Sexton HR, Davis-Kean P, Sameroff AJ. Longitudinal links between spanking and children's externalizing behaviors in a national sample of white, black, Hispanic, and Asian American families. Child Dev. 2012;83(3):838–43.
14. Molgaard VK, Spoth RL, Redmond C. Competency training—the Strengthening Families Program, for parents and youth 10–14. OJJDP Juvenile Justice Bulletin. Washington: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention; 2000.
15. Pan American Health Organization. Manual Familias Fuertes—guía para el facilitador: programa familiar para prevenir conductas de riesgo en adolescentes. Una intervención para padres y adolescentes entre 10 y 14 años. Washington: PAHO; 2009.
16. Orpinas P, Reidy MC, Lacy ME, Kogan SM, Londoño-McConnell A, Powell G. Familias Fuertes: a feasibility study with Mexican American immigrants living in low-income conditions in the southeastern United States. Health Promot Pract. 2014;15(6):915–23.
17. Cowan PA, Cowan CP, Pruett MK, Pruett K, Wong JJ. Promoting fathers' engagement with children: preventive interventions for low-income families. J Marriage & Family. 2009;71(3):663–79.
18. Rodriguez N, Mira CB, Paez ND, Myers HF. Exploring the complexities of familism and acculturation: central constructs for people of Mexican origin. Am J Community Psychol. 2007;39(1–2):61–77.
19. Orpinas P, Rico A, Martinez L. Latino families and youth: a compendium of assessment tools. Washington: Pan American Health Organization; 2013. Available from: www.bit.ly/measurementmanual (English) and www.bit.ly/manualdemedicion (Spanish). Accessed on 1 November 2014.
20. Spoth RL, Redmond C, Shin C. Randomized trial of brief family interventions for general populations: adolescent substance use outcomes 4 years following baseline. J Consult Clin Psychol. 2001;69(4):627–42.
21. Spoth RL, Redmond C, Shin C, Azevedo K. Brief family intervention effects on adolescent substance initiation: school-level growth curve analyses 6 years following baseline. J Consult Clin Psychol. 2004;72(3):535–42.
22. Spoth R, Trudeau L, Shin C, Ralston E, Redmond C, Greenberg M, et al. Longitudinal effects of universal preventive intervention on prescription drug misuse: three randomized controlled trials with late adolescents and young adults. Am J Public Health. 2013;103(4):665–72.
23. Spoth R, Clair S, Trudeau L. Universal family-focused intervention with young adolescents: effects on health-risking sexual behaviors and STDs among young adults. Prev Sci. 2014;15 Suppl 1:S47–58.
24. Spoth RL, Redmond C, Shin C. Reducing adolescents' aggressive and hostile behaviors: randomized trial effects of a brief family intervention 4 years past baseline. Arch Pediatr Adolesc Med. 2000;154(12):1248–57.
25. Spoth RL, Randall GK, Shin C. Increasing school success through partnership-based family competency training: experimental study of long-term outcomes. Sch Psychol Q. 2008;23(1):70–89.
26. Spoth RL, Guyll M, Day SX. Universal family-focused interventions in alcohol-use disorder prevention: cost-effectiveness and cost-benefit analyses of two interventions. J Stud Alcohol. 2002;63(2):219–28.
27. Prado G, Huang S, Schwartz SJ, Maldonado-Molina MM, Bandiera FC, de la Rosa M, et al. What accounts for differences in substance use among U.S.-born and immigrant Hispanic adolescents? Results from a longitudinal prospective cohort study. J Adolesc Health. 2009;45(2):118–25.
28. Gorman-Smith D, Tolan PH, Zelli A, Huesmann LR. The relation of family functioning to violence among inner-city minority youths. J Fam Psychol. 1996;10(2):115–29.
29. Taylor ZE, Larsen-Rife D, Conger RD, Widaman KF. Familism, interparental conflict, and parenting in Mexican-origin families: a cultural-contextual framework. J Marriage Fam. 2012;74(2):312–27.
30. Stattin H, Kerr M. Parental monitoring: a reinterpretation. Child Dev. 2000;71(4):1072–85.
31. Vasquez M, Meza L, Almandarez O, Santos A, Matute RC, Canaca LD, Cruz A, et al. Evaluation of a Strengthening Families (*Familias Fuertes*) intervention for parents and adolescents in Honduras. Nurs Res South Online J. 2010;10(3):e1–e25.
32. Corea ML, Zubarew T, Valenzuela MT, Salas F. Evaluación del programa "Familias Fuertes:

amor y límites" en familias con adolescentes de 10 a 14 años. Rev Med Chil. 2012;140(6): 726–31.
33. Kogan SM, Cho J, Allen K, Lei M-K, Beach SR, Gibbons FX, et al. Avoiding adolescent pregnancy: a longitudinal analysis of African-American youth. J Adolesc Health. 2013;53(1): 14–20.
34. Morsbach SK, Prinz RJ. Understanding and improving the validity of self-report of parenting. Clin Child Fam Psychol Rev. 2006;9(1): 1–21.
35. Murry VM, Berkel C, Chen Y-F, Brody GH, Gibbons FX, Gerrard M. Intervention induced changes on parenting practices, youth self-pride and sexual norms to reduce HIV-related behaviors among rural African American youths. J Youth Adolesc. 2011;40(9):1147–63.

Manuscript received on 5 August 2014. Revised version accepted for publication on 31 December 2014.

RESUMEN

Lecciones aprendidas al evaluar el programa *Familias Fuertes* en tres países de América Latina

Este informe describe 1) la evaluación del programa de prevención primaria *Familias Fuertes* en tres países (Bolivia, Colombia y Ecuador) y 2) el efecto de la participación en el programa sobre las prácticas de crianza. El programa *Familias Fuertes* se llevó a cabo en Bolivia (10 grupos, 96 padres), Colombia (12 grupos, 173 padres) y Ecuador (5 grupos, 42 padres) para prevenir el inicio y reducir la prevalencia de comportamientos que constituyen un riesgo para la salud de los adolescentes, mediante el fortalecimiento de las relaciones familiares y la mejora de las habilidades de crianza. El programa consta de siete sesiones de grupo (para 6 a 12 familias) dirigidas a padres o cuidadores y sus hijos de 10 a 14 años de edad. Los padres o cuidadores respondieron a una encuesta antes de la primera sesión y al término del programa. La encuesta midió dos conceptos importantes: la "crianza positiva" y la "hostilidad parental". La Organización Panamericana de la Salud capacitó a los facilitadores. Después del programa, los padres o cuidadores de los tres países presentaron puntuaciones medias significativamente mayores en "crianza positiva" y significativamente menores en "hostilidad parental" que en la encuesta previa. La prácticas de "crianza positiva" asociadas con una baja "hostilidad parental" son fundamentales para fortalecer la relación entre los padres o cuidadores y los niños, y reducen los comportamientos que constituyen un riesgo para la salud de los adolescentes. Es necesaria una investigación más amplia para analizar la repercusión a largo plazo del programa sobre los comportamientos de los adolescentes.

Palabras clave Responsabilidad parental; adolescente; conducta del adolescente; prevención primaria; familia; Bolivia; Colombia; Ecuador; América Latina.