



Evaluating the 3Cs Program for Caregivers of Young Children Affected by the Armed Conflict in Colombia

Author(s): Lina María González Ballesteros, José M. Flores, Ana María Ortiz Hoyos, Amalia Londoño Tobón, Sascha Hein, Felipe Bolívar Rincon, Oscar Gómez, and Liliana Angélica Ponguta

Source: *Journal on Education in Emergencies*, Vol. 7, No. 2 (December 2021), pp. 212-252

Published by: Inter-agency Network for Education in Emergencies

Stable URL: <http://hdl.handle.net/2451/63541>

DOI: <https://doi.org/10.33682/14b2-4nmm>

REFERENCES:

This is an open-source publication. Distribution is free of charge. All credit must be given to authors as follows:

González Ballesteros, Lina María, José M. Flores, Ana María Ortiz Hoyos, Amalia Londoño Tobón, Sascha Hein, Felipe Bolívar Rincon, Oscar Gómez, and Liliana Angélica Ponguta. 2021. "Evaluating the 3Cs Program for Caregivers of Young Children Affected by the Armed Conflict in Colombia." *Journal on Education in Emergencies* 7 (2): 212-52. <https://doi.org/10.33682/14b2-4nmm>.

The *Journal on Education in Emergencies (JEiE)* publishes groundbreaking and outstanding scholarly and practitioner work on education in emergencies (EiE), defined broadly as quality learning opportunities for all ages in situations of crisis, including early childhood development, primary, secondary, non-formal, technical, vocation, higher and adult education.

Copyright © 2021, Inter-agency Network for Education in Emergencies.



The *Journal on Education in Emergencies*, published by the [Inter-agency Network for Education in Emergencies \(INEE\)](#), is licensed under a [Creative Commons Attribution-NonCommercial 4.0 International License](#), except where otherwise noted.

EVALUATING THE 3CS PROGRAM FOR CAREGIVERS OF YOUNG CHILDREN AFFECTED BY THE ARMED CONFLICT IN COLOMBIA

LINA MARÍA GONZÁLEZ BALLESTEROS, JOSÉ M. FLORES,
ANA MARÍA ORTIZ HOYOS, AMALIA LONDOÑO TOBÓN, SASCHA HEIN,
FELIPE BOLÍVAR RINCON, OSCAR GÓMEZ,
AND LILIANA ANGÉLICA PONGUTA

ABSTRACT

Colombia has endured one of the world's longest internal displacement crises in recent history. Programs that address the practices and psychosocial wellbeing of the community of caregivers of young children in protracted crises are urgently needed. We developed and implemented a program aimed at strengthening the resilience and wellbeing of caregivers (parents, grandparents, and educators) of children enrolled in home-based and institutional centers for early childhood development in Colombia. The program, Connmigo, Contigo, Con Todos, or 3Cs, used purposive sampling across 14 municipalities disproportionately impacted by the armed conflict in Colombia. It consisted of two modules, a skills-building program (SBP) module and a psychotherapy intervention (PTI). The program content drew from cognitive behavioral therapy and mindfulness, and from inputs from local stakeholders. By applying a pragmatic evaluation strategy, we explored the pre-post intervention changes in parental resilience (the primary outcome of interest) through self-reports on the Connor-Davidson Resilience Scale (CD-RISC). The analysis of the pre-post intervention outcomes showed statistically significant improvements in CD-RISC in both intervention arms (SBP and PTI). Caregivers in the PTI group started with lower CD-RISC scores than caregivers who did not receive the PTI, and they showed the most improvement over time. Caregivers who had lower than average participation in the SBP (M=1-3 sessions out of a total of 6) did not

Received May 20, 2020; revised June 7, 2021, and July 15, 2021; accepted September 23, 2021; electronically published December 2021.

Journal on Education in Emergencies, Vol. 7, No. 2

Copyright © 2021 by the Inter-agency Network for Education in Emergencies (INEE).

ISSN 2518-6833

show significant changes in CD-RISC. Additionally, caregivers who had higher than average participation in the SBP showed significantly more improvement in CD-RISC scores than caregivers who did not attend any sessions. We discuss the implications of these findings for future applications of the program and substantiate the measurable impact of interventions for caregivers in conflict settings.

INTRODUCTION

The interplay between bioecological risks and protective factors during early childhood critically influences children's learning and developmental trajectories (Hein, Reich, and Grigorenko 2015; Wachs and Rahman 2013). Macro-level risks (e.g., disasters, conflict, and extreme poverty) are often juxtaposed with protective factors (e.g., peacebuilding strategies and education policies). As such, humanitarian crises and conflict can disrupt the ecology of human development at the macro, meso, and micro levels (Bronfenbrenner 2009). Here we describe the context and developmental underpinnings of the *Conmigo, Contigo, Con Todos* (With Me, With You, With All) or 3Cs program. The program targeted the community of caregivers (parents, grandparents, and teachers) of children enrolled in early childhood development (ECD) centers located in municipalities that have been disproportionately impacted by the armed conflict and internal displacement in Colombia. We introduce the intervention's context, with an emphasis on key macro-, meso-, and micro-level risks and protective factors in the target communities.

MACRO-LEVEL RISK AND PROTECTIVE FACTORS

Colombia experienced a 60-year civil conflict, which resulted in one of the largest internal displacement crises in recent history (UN High Commissioner for Refugees 2018). Extreme intergenerational poverty in the country has been concomitant and persistent. In 2020, the national monetary poverty level (a baseline acquisition power for food and goods) was 42.5 percent and the extreme monetary poverty level (a baseline acquisition power for basic foods) was 15.1 percent, with the incidence of the latter generally higher in peri-urban, rural, and disperse rural areas, which are farthest from urban centers, often nondelimited, and usually without access to basic public services (DANE 2021). Colombia also has had historically higher social inequality indices than other countries, both regionally and globally (Reliefweb 2020). The Colombian government has responded to these challenges by enacting several strategic geopolitical and social policies. From a peacebuilding perspective, the peace accords that ended the

government's armed conflict with the biggest guerilla group in the nation were a landmark effort (Gobierno de la República de Colombia 2016). The accords were built on several pillars, such as targeted investment in education, including early childhood education, health, and job opportunities, particularly in rural areas and localities severely affected by the war. Concomitantly, the government has been committed to the promotion of quality ECD through the implementation of the National ECD Law, *De Cero a Siempre*, or DCAS. Investments in quality ECD have been shown to be the most cost-effective social policies, and they are linked with pathways to social equality, inclusion, and the fomentation of a culture of peace (Rolnick and Grunewald 2003). Against this backdrop, DCAS aims to provide quality and equitable ECD services to all children while prioritizing those living in extreme poverty, and to provide holistic services through different contextualized modalities, including improving access to and the quality of early and primary education (Consejería Presidencial para la Niñez y la Adolescencia 2014).

MESO-LEVEL RISK AND PROTECTIVE FACTORS

Many families and children in Colombia were impacted by the war through massacres, attacks using explosive devices, forced recruitment into the armed forces, and community violence due to organized crime (Reliefweb 2020). Moreover, despite great strides forward in the implementation of DCAS, challenges to quality ECD access persist, in particular challenges to providing socioemotional and psychosocial support for young children and their caregivers (Gómez Cardona 2017). From a sociocultural perspective, community support and networks are crucial buffers against meso-level risks for families and children. Strong networks and community-based strategies can repair the social environment and renew trust within communities and toward institutions, which was disrupted by the conflict (Lozano Montilla, Parra Giraldo, and Uribe Ortiz 2019). For example, targeted programs to promote the wellbeing of children and their primary caregivers through ECD settings that stem from the peace accords have emerged as a significant social investment strategy (ICBF 2020).

Ecological approaches to children's development involve interactions among individuals, families, peers, and communities, which may increase or decrease the risk of negative outcomes in the face of adversity (Bronfenbrenner 2009). For example, the incidence and prevalence of psychopathologies resulting from exposure to war are associated with the degree of trauma experienced and the physical and emotional support available to a community (Murthy and Lakshminarayana 2006). Social support, broadly defined as material and interpersonal resources provided through social relationships, can deliver valuable resources in adverse contexts

(e.g., counseling, skills-building, information, or access to services), and it may act as a buffer to stress or provide direct benefits, despite the contextual stressors experienced by individuals (Thompson, Flood, and Goodvin 2006). In the context of child development, parental and community support are crucial during early childhood, primarily by fostering self-regulation, problem-solving, and other skills linked with positive developmental outcomes (Luthar, Crossman, and Small 2015). One potential byproduct of increased social support is increased social cohesion, which can manifest vertically (i.e., between individuals and groups and government institutions) and/or horizontally (i.e., in relationships between individuals, between individuals and groups, and between groups) (Pham and Vinck 2017). By fostering trust and improved relationships between individuals, institutions, and groups, strategic investment in effective ECD services has the potential to enhance social support and promote social cohesion (Leckman et al. 2019).

MICRO-LEVEL RISK AND PROTECTIVE FACTORS

PRACTICES OF THE COMMUNITY OF CAREGIVERS

Poverty, war, community violence, and barriers to early childhood services have directly affected the physical safety and security of many children in Colombia, as well as their psychosocial, emotional, and cognitive development (DCAS 2013). Nurturing care for young children is provided by an interconnected system of individuals inside and outside of the home, primarily mothers and fathers but also service providers, including early childhood educators (Britto et al. 2017). Supporting this notion are recent conceptual models that highlight the crucial role parents play as a buffer to the effects war can have on their children (Murphy et al. 2017). Recent literature reviews suggest that parenting programs in low- and middle-income countries have a measurable positive impact on children's cognitive and language development (Rao et al. 2014). A systematic review of 35 studies showed that young children exposed to war were at higher risk of developing posttraumatic stress disorder (PTSD) and posttraumatic stress symptoms, behavioral and emotional symptoms, sleep problems, and psychosomatic symptoms; however, these adverse effects were lower among young children who had higher-functioning parents and families (Slone and Mann 2016). A second review that explored the effects of war on children around the world found that the mental health effects appear to depend on the duration and acuity of the children's exposure to war. The worst outcomes have been observed among children who were the victim of or witnessed violent acts, had experienced threats to and the loss of loved ones, had experienced prolonged parental absence, and

were confronting forced displacement. Protective factors that mitigate the impact of war-related adversity on children include a strong bond between the primary caregiver and the child, and social support from teachers and peers (Werner 2012).

Grandparents are another critical element of family dynamics and structures around the globe (Sadrudin et al. 2019). Recent studies of interventions aimed at improving wellbeing in custodial families have called for strengthening programs by including grandparents, particularly those providing primary care for young children (Smith et al. 2018). Although data on the impact grandparental care has on the outcomes of young children are scarce, recent conceptual models call for research and practice agendas that consider the role grandparental care plays in children's physical health, and in their social-emotional, behavioral, cognitive, and educational development, particularly in contexts of high vulnerability (Sadrudin et al. 2019).

Current models of quality early childhood development and education go beyond family relations and are grounded in socioecological attachment and learning theories, which include process characteristics such as the interactions between educators and young children. Recent studies in Colombia have shown—for the first time at a national level—associations between positive and responsive interactions between teachers and children and the children's development outcomes (Maldonado-Carreño et al. 2018). The evidence points to the importance of considering parents, grandparents, and early childhood educators to be critical targets of programs that address the impact of adversity on children's learning and development. In early childhood education settings, the role teachers' mental health plays in their ability to support children's social-emotional learning has been well acknowledged, including prior studies showing associations between teacher depression and their negative relationships with children (Whitaker, Dearth-Wesley, and Gooze 2015). As such, programs should consider teacher wellbeing by lowering workplace stress and providing workplace support and training and targeted strategies that promote positive teacher-child interactions.

WELLBEING AND RESILIENCE IN THE COMMUNITY OF CARE

Conflict and poverty have multiple adverse effects on the wellbeing of caregivers that put at risk their ability to provide nurturing care for their children. This in turn poses a threat to children's positive cognitive, behavioral, and emotional adjustment (McEwen and McEwen 2017). Several studies addressing families living in adverse conditions have demonstrated that parenting programs can have a positive effect on a range of caregiver and/or child development outcomes (Annan et al. 2017; Dybdahl 2001; Ponguta et al. 2019). Recent studies also have

documented a broad range of positive wellbeing outcomes among caregivers in vulnerable contexts that result from targeted interventions (Hein et al. 2020). Recent global paradigms of nurturing care emphasize the importance of targeting caregivers' physical and mental health and overall wellbeing, while also enhancing their caregiving skills and strategies for helping their young children (Britto et al. 2017). More generally, global guidelines for providing mental health and psychosocial support in emergency settings provide frameworks that include multiple layers of support: basic services and security, community and family supports, focused nonspecialized supports, and specialized services (IASC 2007). There has been a particular increase in interventions to improve parenting practices, family relationships, and mental wellbeing for caregivers and children in low- and middle-income countries (Pedersen et al. 2019), which has led to a need for models that illustrate the operationalization of approaches in humanitarian settings and across children's community of care.

Key dimensions of caregiver wellbeing are resilience and resilience skills (Panter-Brick and Leckman 2013). Definitions of resilience vary across contexts and disciplines and are based on its characterization as a trait, a process, or an outcome (Ungar, Ghazinour, and Richter 2013). Resilience can constitute dynamic coping mechanisms, capacities, or resources that facilitate the successful endurance, recovery, and adaptability of individuals or groups of people who experience adversity that threatens their viability, ability to function, or development (Aburn, Gott, and Hoare 2016; Masten 2018). According to a multisystem resilience framework for disasters, resilience factors can be present simultaneously at the individual (child), family, and community (school or wider community) levels (Masten and Motti-Stefanidi 2020). Based on these observations, the resilience outcomes can be multifactorial. For example, multiple studies have shown a bidirectional relationship between cognitive and socioemotional development in the context of early life adversity (Osher et al. 2018). Resilience is specifically linked with later-life identity formation, which in turn impacts mental health and other individual developmental outcomes in adulthood (Smith and Pollak 2020). Furthermore, interventions that promote individual resilience have been shown to have a meaningful impact on limiting psychopathologies, such as depression, anxiety, and risk of suicide (Smith-Osborne, Maleku, and Morgan 2017; Zolkoski and Bullock 2012). Parental resilience can be defined as "the capacity of parents to deliver competent, quality parenting to children despite adverse personal, family, and social circumstances" (Gavidia-Payne et al. 2015, 111). A recent analysis of the socioecological factors that influence parenting behaviors suggests that parenting programs offer a promising approach to improving caregiving practices that help to promote children's resilience in the context of war (Murphy et al. 2017). However, systematic exploration of the evidence base suggests a deficit in reporting

on the design, implementation, and evaluation of resilience-focused interventions for caregivers in crisis contexts (Jordans et al. 2009). In that caregivers provide a critical buffer from the impact of conflict and other risks, it is necessary to explore resilience models that expand the focus from children's developmental trajectories to include caregiver resilience and the broader community context (Sim, Bowes, and Gardner 2019).

Global interventions in violence-affected settings have focused on working directly with children or promoting parenting skills. However, more recent interventions have also focused on improving the mental health and wellbeing of caregivers as a vehicle for improving child outcomes. Although improving the mental health and wellbeing of both caregivers and children can be seen as building resilience, few programs have examined resilience, and specifically caregiver resilience, as a main intervention outcome. Teachers are important people who provide care (i.e., attend to the personal needs of children from age 0 to 18) for several hours per day. Therefore, teachers are pivotal caregivers for young children right along with parents, grandparents, and other members of the child's family system. For example, a teacher-delivered protocol focused on enhancing personal resilience achieved significant improvement to stress, mood, and posttrauma symptoms among Israeli children exposed to the 2006 Lebanon War (Wolmer et al. 2011). However, there also are examples whereby psychosocial interventions aimed at increasing resilience among children exposed to war have shown null effects (Diab et al. 2015). Studies emerging from Colombia and the Latin American region that focus on resilience-building interventions in conflict settings are notably sparse. One example is a pilot of a school-based intervention aimed at fostering resilience among teachers and children. This model has shown positive effects on children's and teachers' self-esteem, humor, perseverance, assertiveness, and empathy (Acevedo and Restrepo 2012; Auyeung et al. 2012). Overall, a review of the literature suggests that there is a need to understand specifically how psychosocial interventions in violence-affected settings can affect caregiver resilience, and whether targeting caregiver resilience ultimately results in positive outcomes for children (Tol, Song, and Jordans 2013).

THE 3CS INTERVENTION AND THE PROCESS OF THE PRESENT STUDY

In 2015, a partnership between academia, the private sector, and the Colombian government led to the development and implementation of the 3Cs program. The program was designed to provide psychosocial support and resilience-building skills to caregivers (parents, grandparents, and teachers) of children enrolled

in ECD settings located in areas disproportionately impacted by the armed conflict, extreme poverty, and community violence. The program's theory of change drew from a peacebuilding-through-ECD paradigm, key social policy priorities in Colombia, the evidence base on resilience as a key protective factor in crisis contexts, and evidence from multiple psychotherapeutic interventions in conflict-affected areas (see Table A1 in the Appendix) (Yale University and AÇEV 2012). The aim of the present study was to develop, implement, and pragmatically evaluate the 3Cs program as a resilience-promotion intervention for caregivers of young children enrolled in ECD centers in Colombia. Since caregivers were the primary focus of the intervention, we hypothesized that participation in the 3Cs would be associated with improved parental resilience (the primary outcome of interest) when controlling for levels of parental psychopathology (i.e., symptoms of anxiety, depression, and PTSD). Below we discuss the implications of the study for the future application of psychosocial support and caregiver education in contexts affected by conflict and other risk factors.

METHODS

TARGET POPULATION

The 3Cs program was developed and implemented by an interdisciplinary team from *Fundación Saldarriaga Concha*, or FSC, a nongovernmental organization in Colombia. The program was funded by a leading child and family support government institute, the *Instituto Colombiano de Bienestar Familiar*, or ICBF. The ICBF is the leading publicly funded institution responsible for the provision of protection and ECD services for the most vulnerable children under the age of 18 in Colombia. Researchers from Yale University provided support for the formulation of the evaluation framework and execution of the data analysis. The program was implemented in 14 municipalities in Colombia.¹ These municipalities were selected because of their acute exposure to the armed conflict (e.g., direct presence of armed groups, geographic association with drug-trafficking routes) or because they were areas that hosted displaced rural communities. Participants were selected through a purposive sampling strategy, first from a list of ECD centers and community-based family homes provided by ICBF, and second, based on whether a person was a victim of armed conflict in accordance with the 1448 law, according to the ICBF register. If both applied, that person was invited to participate in the program.

1 The 14 municipalities were Medellín, Sincelejo, Pasto, Turbo, Soledad, Maicao, Buenaventura, Guapi, San Vicente del Caguán, Tame, Necoclí, Tumaco, Istmina, and El Tambo.

THEORY OF CHANGE

The program design was anchored in the intent to ameliorate macro- (effects of the armed conflict and extreme poverty), meso- (community violence and barriers to socioemotional and psychosocial support and education), and micro-level risk factors (maladaptive caregiver practices and poor caregiver wellbeing). Concomitantly, the program aimed to leverage macro- (peacebuilding and ECD policy landscape), meso- (targeted ECD services, community support and cohesion, interpersonal network), and micro-level (caregiver resilience) protective factors. The program content included several cognitive behavioral therapy and third-generation psychotherapeutic techniques shown to be effective among children and families in early childhood settings (Foa et al. 2009; Toth et al. 2002; Toth et al. 2006). The intervention design also included mindfulness techniques to address behavioral impulse control, impulsive regulation of stress, and emotional regulation, and to enhance the resilience of children recovering from traumatic events (Bethell et al. 2016). The content and approaches were selected by conducting a literature review and expert consultations. The program consisted of two overarching components. First, the skills-building program (SBP) module was offered to all caregivers (parents, grandparents, and teachers/educators working with children in the selected ECD settings). Second, the psychotherapy intervention (PTI) was offered to program participants who (1) self-reported to be “direct victims of the armed conflict” when enrolling children in the target ECD center, and (2) fulfilled the screening criteria described in the Group Assignment section below. Table A1 describes (1) the process applied in designing the program components, including the theoretical, conceptual, and stakeholder inputs and the process in which these inputs were integrated into the model; and (2) the overview of the content and implementation details of the SBP and the PTI.

The sessions were held once a week in community spaces (e.g., schoolrooms, community centers). The content and the approach of the PTI consisted of third-generation cognitive behavioral therapy techniques, namely, activation control therapy, behavioral activation technique, metacognitive therapy, mindfulness, schema-based therapies, and dialectical behavioral therapy. The key objective of the PTI was to bolster the learning of enduring bonding and to provide strategies to promote resilience, social skills, emotional processing, presentation techniques, activation control techniques, and self-control. The PTI included group-based discussions of the relevant concepts, as well as assignments and strategies to be implemented at home. Sessions were intended to be implemented only with parents and grandparents. However, due to other commitments or a lack

of childcare, some participants brought children to the sessions. When children were present, the facilitators were encouraged to normalize their presence and/or to ensure that one of the two facilitators provided focused support to the children brought to the sessions. If thematically relevant, the facilitators were encouraged to demonstrate activities by engaging with the children who were present.

GROUP ASSIGNMENT

We chose to conduct a pragmatic evaluation by combining qualitative and quantitative methods to explore the program's impact on parental resilience (Crane et al. 2019). A total of 2,448 consenting primary caregivers, including parents of children from 0 to 5 years old who were enrolled in ECD centers and homes, were invited to participate. They were screened for depression (Whooley depression screen), general anxiety (Hamilton-A), and PTSD (PTSD checklist-civilian version). This study pertains to the 331 of those 2,097 caregivers who were eligible to participate in the SBP and the PTI (see Figure A1 in the Appendix for a summary of group assignment). The PTI was delivered only to caregivers whose screening for PTSD, anxiety, and depression was negative. Those whose screening was positive were referred to the health services available in their municipality. While the SBP was intended for every caregiver, 40 caregivers (12.08%) did not participate in the SBP, and among those 40 caregivers, a small subset also did not participate in the PTI. Despite the small amount of cross-contamination due to the difficulties in access for real-time follow-up to the program's implementation, the majority of caregivers did in fact participate in the SBP, regardless of their assignment to the PTI ($N=291$ or 87.92%). The subset of caregivers ultimately selected for the PTI (whether or not they participated in the SBP) was $N=92$ of 331 caregivers (27.80%).

FACILITATOR AND DATA-COLLECTION TRAINING

The program facilitators were one psychologist and one social worker from each municipality. The facilitators were trained by members of the FSC in Bogotá. The trainers were a multidisciplinary team consisting of two psychiatrists, one psychologist, one general medicine practitioner, and one early childhood education expert. The training for program facilitators (or implementers) was held in Bogotá for five days in June 2015. The trainings included a combination of lectures and interactive and practice-oriented activities. Adjustments were made to the program content based on feedback from the facilitators and supervisors during the training. Teachers and educators were also trained in the SBP module for future implementation in ECD centers and community homes.

The data-collection teams were trained in Bogotá, and they used electronic tablets to collect demographic information, as well as primary caregiver outcomes. To obtain demographic data from the beneficiary primary caregivers and children, ICBF routinely collects a comprehensive set of variables. The data collectors were trained to transfer relevant data from the ICBF sociodemographic questionnaire to the tablets. Missing data from the ICBF's demographic questionnaire were imputed via direct interviews with participants. Data were uploaded from the tablets into a centralized RedCap data-management system. A sample of 10 percent of all data per municipality was verified by the lead project team. If there were errors or missing data, the data-collection teams in the municipalities were notified to review and amend accordingly. Data for the CD-RISC scores (the resilience measure used in this study) were entered on hard copies, then digitized by the lead project team at baseline and at the follow-up cross-sections of the program. Representatives of the project's lead team made site visits to all municipalities to oversee the onset of the program implementation and data collection. The supervisors continued to oversee the procedures throughout the implementation of the project.

MEASURES

DEMOGRAPHIC CHARACTERISTICS AND COVARIATES

Demographic variables included the age of caregivers (in years) and the caregivers' gender (male or female). Covariates of the program implementation included whether or not caregivers participated in the PTI, whether they participated in the SBP, and the average attendance at the SBP (0%, 17%, 33%, 50%, 67%, 83%, or 100%). The program facilitators tracked and entered attendance.

CD-RISC

This scale is comprised of 25 items designed to explore 5 factors: personal competence, tolerance and strength, positiveness, control, and spiritual influences. The original CD-RISC studies showed a high correlation between the scale and the measures of hardiness, perceived stress and stress vulnerability, disability, and social supports, which supports the convergent validity of the scale (Connor and Davidson 2003). A number of studies have focused on Spanish-speaking populations and validated different versions of the CD-RISC, and show that it is a reliable measure of resilience traits in Hispanic populations (Crespo, Fernández-Lansac, and Soberón 2014). In this study, we computed the total score as the sum of the 25-item and 10-item scales (Campbell-Sills and Stein 2007), respectively.

Several coauthors in this group are in the process of evaluating the validity and reliability of the CD-RISC scale for the population included in this study, which has not yet been presented in the literature and will be submitted for future publication. However, in this ongoing analysis, the internal consistencies of the 25-item scale and the 10-item scale were acceptable ($\alpha_{\text{CD-RISC } 25} = 88.35$; $\alpha_{\text{CD-RISC } 10} = 74.65$). In addition, the 10-item CD-RISC version had moderate to good validity indices, based on our initial assessments.

WHOOLEY DEPRESSION SCREEN

This is a two-question case-finding instrument for depression that asks about depressed moods and anhedonia. It has a sensitivity of 96 percent (95% CI=90-99%) and specificity of 57 percent (95% CI=53-62%) when a positive answer to any of the two items is given (Whooley et al. 1997). The Whooley questions are a recommended screening tool in the Colombian clinical practice guideline for depression, based on the operative characteristics stated above and a diagnostic odds ratio of 36.25 percent (95% CI=14.98-88.24%) (Ministerio de Salud y Protección Social 2013).

HAMILTON ANXIETY SCALE (HAM-A)

The HAM-A scale is a 14-item self-report measure developed as a scoring system for anxiety that has a good fit with clinical evaluation ($z=0.89$) (Hamilton 1959). Factor analysis showed a general factor clearly related to anxiety and a bipolar factor that grouped symptoms in psychic (i.e., mental agitation and psychological distress) and somatic (i.e., physical complaints related to anxiety) anxiety. Anxiety severity is rated as mild if scores are less than or equal to 17, mild to moderate if scores are between 18 and 24, moderate to severe if scores are between 25 and 30, and very severe for scores greater than 30 in a 0-56 score range (Hamilton 1959). The HAM-A has been validated in Spanish, with results showing psychometric properties similar to those of the original version (Cronbach's $\alpha=0.89$; intraclass correlation coefficient=0.92; effect size [sensitivity to change]=1.36) (Lobo et al. 2002). In this analysis, the internal consistency for HAM-A was 0.84.

PTSD CHECKLIST-CIVILIAN VERSION (PCL-C)

The PCL-C is a 17-item self-report measure of civilians' response to traumatic experiences (Wilkins, Lang, and Norman 2011). Total scores range from 17 to 85 and are based on the amount and severity of PTSD-related symptoms (symptoms severity range from 1=not at all to 5=extremely). Cutoff score for possible PTSD

is greater than or equal to 30 (sensitivity=82%; specificity=76%) (Walker et al. 2002). The PCL-C has been used to measure the response to behavioral cognitive interventions in Afro-descendant populations that are the victims of the armed conflict in Colombia (Bonilla-Escobar et al. 2018), to evaluate diagnostic criteria in mental health in victims of armed conflict in Colombia and Cambodia (Stammel et al. 2015), and to screen for PTSD in Colombia's 2015 National Mental Health Survey (Tamayo Martinez et al. 2016). The internal consistency for PCL-C was 0.87 in this analysis sample.

DATA ANALYSIS

Data management and statistical analysis were performed using STATA/IC v16 (Stata Corp). Continuous variables are presented as mean (standard deviation) or median (interquartile range). Categorical variables are presented as the number (proportion or percentage) of participants. Due to the nested nature of the CD-RISC scores measured before and after the intervention, random effects models were used to account for the covariance of scores among caregivers. Univariate linear regression with random intercepts estimated the association between CD-RISC scores and (1) the PTI and (2) the SBP (including SBP average attendance). While the primary outcome of interest was caregivers' CD-RISC 25-item scores, we also estimated associations with the 10-item version to evaluate whether magnitude and statistical significance differed from the 25-item scale. Multivariate linear mixed models estimated the independent effect of the PTI, the interaction of the PTI \times time of follow-up (follow-up vs. baseline scores), and the SBP average attendance. Multivariable models were adjusted for screening tools if they were statistically associated with the subgroups in Table 1 (Hamilton-A total score, PCL-C total score, and positive screening on the Whooley depression screener). All significant associations are reported at a threshold of $\alpha=0.05$.

RESEARCH ETHICS

All the program beneficiaries and study participants who enrolled signed an informed consent form that was administered by study personnel, per the regulations established by Colombia's ethics oversight committee and approved by the ICBF. The informed consent (and the application of all study instruments) was delivered by the psychologists trained by the FSC in Bogotá and subsequently deployed to the municipalities. To ensure application of the principle of do no harm, all of the 3Cs program facilitators were trained in the activation of a referral health system to provide specialized support as needed (e.g., in the presence of depression, PTSD, and/or anxiety). Furthermore, in partnership with ICBF,

families with special needs were given referrals to other family supports as needed. If personnel from the 3Cs program suspected child abuse or neglect, the study psychologists activated a referral to ICBF and the pertinent local entities.

RESULTS

Following our pragmatic evaluation strategy, we assessed the change in the CD-RISC score after the intervention. Relevant aspects of the program, such as the group that the caregivers were assigned to and the number of sessions attended, were assessed relative to the CD-RISC score. The results of the anxiety, depression, and PTSD screening tests are described and compared according to the group allocation. Table 1 shows caregiver characteristics at their baseline visit according to the 3Cs component (SBP vs. PTI; henceforth referred to as intervention groups) in which they participated. A total of 331 caregivers completed the CD-RISC before and after the intervention. Of those, 14 caregivers (4.23%) did not participate in the SBP or the PTI, 26 (7.85%) participated in the PTI but not the SBP, 225 (67.98%) participated in the SBP but not the PTI, while the remaining 66 caregivers (19.94%) participated in both the SBP and the PTI. Neither the caregivers' age nor the proportion of each gender differed significantly by intervention group. In terms of screening for anxiety using HAM-A scores, while there were significant baseline differences in the total HAM-A scores (mean differences, $p < 0.001$; median differences, $p < 0.001$; see Table 1), there were no differences across intervention groups when the scores were tabulated into severity categories using the cutoff scores ($p = 0.33$). We likewise observed significant differences in the total PCL-C scores at baseline (mean differences $p < 0.05$; median differences, $p < 0.008$), but there were no differences when the scores were tabulated into positive versus negative screening for PTSD, regardless of whether the 30- or 35-point cutoff score was used ($p = 0.21$ for the 30-point cutoff, $p = 0.68$ for the 35-point cutoff). In contrast, positive depression screening (+DS) at baseline using the Whooley two-item scale was significantly different across groups (+DS_{No SBT, No PTI} = 28.6%, +DS_{No SBT, PTI} = 15.4%, +DS_{SBT, No PTI} = 41.3%, +DS_{SBT & PTI} = 42.4%; $p < 0.007$). Average attendance (i.e., dose) at the SBP was 52.19 percent of the sessions ($SD = 35.19\%$). Average attendance at the SBP was not significantly different between the two participating subgroups. The average attendance at the SBP among those who participated only in the SBP (without the PTI) was 66.93 percent ($SD = 23.03\%$), compared to 71.35 percent ($SD = 23.84\%$) SBP attendance among caregivers who attended both the SBP and the PTI ($p = 0.19$). There were no significant differences in the distribution of attendance at the PTI between the group who only participated in the SBP and the group who participated in both the SBP and the PTI ($p = 0.30$).

Table 1: Baseline Characteristics of Colombian Caregivers Residing in Areas Affected by Armed Conflict

Characteristic	No SBP, No PTI	No SBP, PTI	SBP, No PTI	SBP & PTI	<i>p</i> -value
Intervention group sample size (<i>n</i>)	14	26	225	66	
Age, mean (SD)	29.1 (8.1)	30.0 (9.8)	30.7 (8.5)	30.0 (9.8)	0.88
Sex					
Male	1 (7.1%)	1 (3.8%)	7 (3.1%)	5 (7.6%)	0.55
Female	13 (92.9%)	24 (92.3%)	172 (76.4%)	54 (81.8%)	
HAM-A, total score, mean (SD)	7.4 (7.4)	6.2 (5.6)	11.1 (6.4)	9.2 (6.3)	<0.001
HAM-A, total score, median (IQR)	5.5 (2.0, 11.0)	4.5 (3.0, 7.0)	12.0 (6.0, 15.0)	7.0 (4.0, 14.5)	<0.001
Anxiety severity (based on HAM-A scores)					
Mild (scores<17)	13 (92.9%)	24 (92.3%)	160 (71.1%)	51 (77.3%)	0.33
Mild to moderate (scores 18-24)	0 (0.0%)	1 (3.8%)	18 (8.0%)	9 (13.6%)	
Moderate to severe (scores 25-30)	1 (7.1%)	1 (3.8%)	6 (2.7%)	0 (0.0%)	
PCL-civilian, total score, mean (SD)	23.4 (4.8)	21.1 (6.4)	26.4 (7.5)	24.4 (6.7)	0.012
PCL-civilian, total score, median (IQR)	22.0 (19.0, 27.0)	18.5 (17.5, 20.5)	26.0 (20.0, 31.0)	24.0 (17.0, 29.0)	0.007
PCL-civilian missing data	1 (7.1%)	10 (38.5%)	43 (19.1%)	5 (7.6%)	
PCL-civilian screening results based on cutoff value of 30					
Negative screening (scores<30)	11 (78.6%)	14 (53.8%)	129 (57.3%)	49 (74.2%)	0.21
Positive screening (scores≥30)	2 (14.3%)	2 (7.7%)	53 (23.6%)	12 (18.2%)	
PCL-civilian screening results based on cutoff value of 35					
Negative screening (scores<35)	13 (92.9%)	15 (57.7%)	165 (73.3%)	56 (84.8%)	0.68
Positive screening (scores≥35)	0 (0.0%)	1 (3.8%)	17 (7.6%)	5 (7.6%)	

EVALUATING THE 3CS PROGRAM FOR CAREGIVERS IN COLOMBIA

Characteristic	No SBP, No PTI	No SBP, PTI	SBP, No PTI	SBP & PTI	<i>p</i> -value
Whooley depression screen					
Negative screening	10 (71.4%)	22 (84.6%)	93 (41.3%)	34 (51.5%)	0.006
Positive screening*	4 (28.6%)	4 (15.4%)	93 (41.3%)	28 (42.4%)	
Missing data	0 (0.0%)	0 (0.0%)	39 (17.3%)	4 (6.1%)	
Skills-building program (SBP)					
No SBP	14 (100.0%)	26 (100.0%)	0 (0.0%)	0 (0.0%)	<0.001
SBP	0 (0.0%)	0 (0.0%)	225 (100.0%)	66 (100.0%)	

Note: IQR= interquartile range.

*Screening for depression was considered positive when both items reported in the Whooley Depression Screen were depression items (low mood/affect and anhedonia).

Bold values indicate p values below the alpha level of 0.05.

Table 2 shows unadjusted changes in CD-RISC scores, based on PTI/SBP grouping using paired t-tests. We tested differences using the 25-item and 10-item versions of the CD-RISC to evaluate the changes in magnitude and the statistical significance between both the longer and shorter versions of this survey. In terms of magnitude, Table 2 shows larger pre-post differences for the CD-RISC 25-item questionnaire than for the 10-item questionnaire. Consequently, the statistical significance of the t-test statistic is also considerably lower for the 10-item version.

Table 2: Descriptive Statistics and Unadjusted Paired T-Tests Showing Differences in CD-RISC Scores before and after Program Intervention

	No SBP, No PTI	No SBP, PTI	SBP, No PTI	SBP and PTI
10-item CD-RISC survey				
Baseline mean (SD)	28.8 (6.6)	22.1 (8.1)	28.2 (6.7)	26.1 (7.4)
Follow-up mean (SD)	27.4 (4.4)	26.8 (3.4)	29.7 (6.8)	28.7 (6.7)
Paired t-test <i>p</i> value:	0.4294	0.0150 *	0.0066**	0.0222*
25-item CD-RISC survey				
Baseline mean (SD)	73.4 (11.8)	56.2 (18.5)	70.8 (16.1)	66.8 (17.6)
Follow-up mean (SD)	70.6 (9.5)	71.9 (8.0)	75.7 (15.8)	73.3 (16.7)
Paired t-test <i>p</i> value:	0.3272	0.0008***	0.0002***	0.0125*

Note: This table compares the change in magnitude and statistical significance if measurements are conducted with 10-item versus 25-item versions of the CD-RISC.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The linear mixed effects model in Table 3 shows a main effect of time for caregivers who did not participate in the PTI (most of these caregivers did participate in the SBP). In the non-PTI group, the pre-post change shows an increase in resilience scores of +4.70 units, 95 percent CI=1.82 to 7.58, $p < 0.001$ (Figure 1).

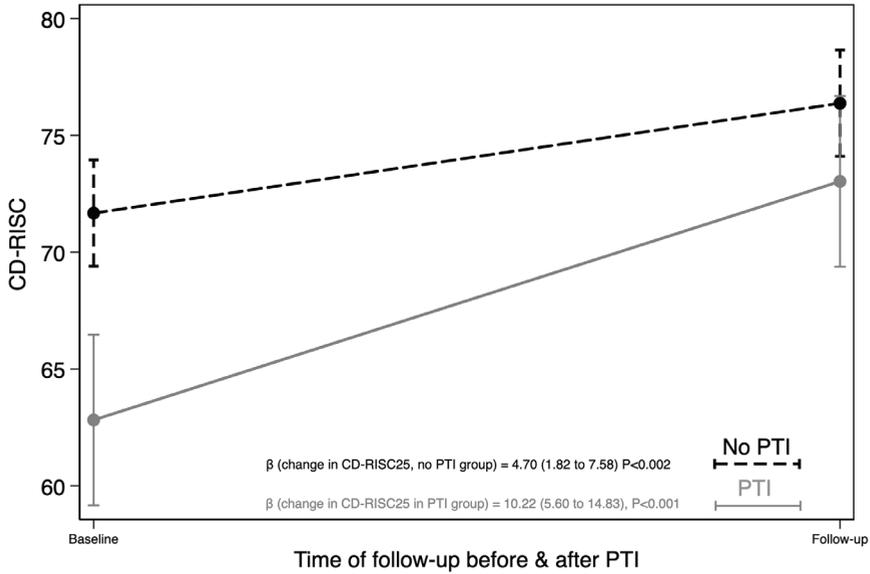
Table 3: Linear Random Effects Model Showing Significant Effects of Time of Follow-Up, PTI, the Time × PTI Interaction, as well as SBP Average Attendance

Change in CD-RISC 25 Total Score	β Coef.	[95% Confidence Interval]		p value
Follow-up vs. baseline in no PTI group	4.70	1.82	7.58	0.001 ***
PTI vs. no PTI at baseline	-8.05	-12.50	-3.61	0.001 ***
Time × psychotherapy interaction	5.51	0.07	10.95	0.047 *
Attendance at SBP				
17%	-1.73	-10.00	6.53	0.68
33%	-4.74	-12.16	2.67	0.21
50%	1.04	-5.31	7.40	0.74
67%	3.95	-1.72	9.62	0.17
83%	7.28	1.83	12.71	0.009 **
100%	2.32	-4.05	8.68	0.47
HAM-A total score (1-unit change)	0.25	-0.034	0.53	0.09
PCL-civilian total score (1-unit change)	-0.07	-0.33	0.19	0.60
Whooley positive screening vs. negative	2.95	-0.14	6.04	0.06

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The model also shows significant differences in CD-RISC at baseline, which suggests that the PTI group's caregivers started with significantly lower resilience scores at baseline than the SBP group (-8.05 units; 95% CI=-12 to -3). However, the interaction term of the PTI with time was statistically significant, which shows that, compared to the SBP group, the PTI group on average increased its CD-RISC scores significantly, despite have the lowest resilience scores at baseline.

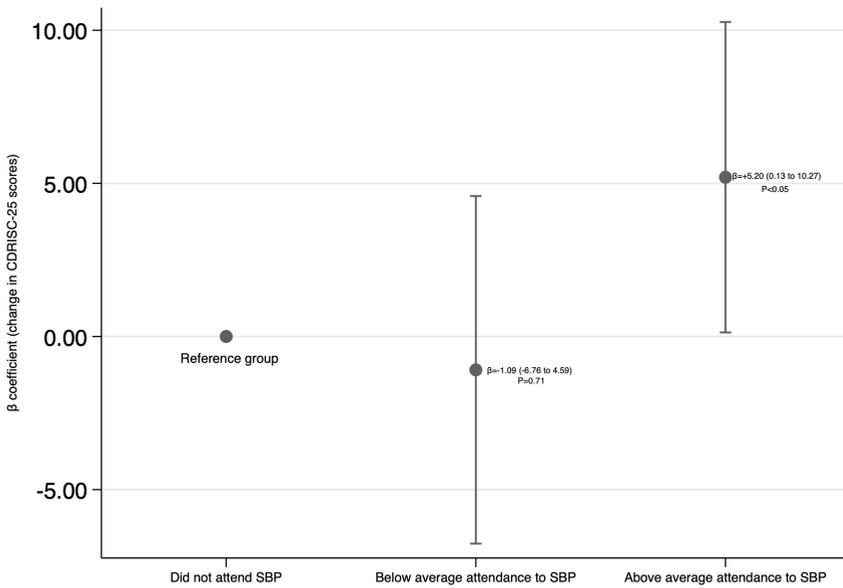
Figure 1: Changes in Pre-Post Intervention CD-RISC-25 Scores



Note: Figure 1 compares caregivers who (1) participated in the PTI and (2) caregivers who did not participate in the PTI (reference group). Adjusted for the independent effect of the PTI, the interaction of the PTI by time of follow-up (follow-up vs. baseline scores), attendance at the SBP, and for statistically significant screening tools (HAM-A total score, PCL-C total score, and Whooley positive depression screening).

We estimated whether attendance at the SBP was associated with significant differences in CD-RISC scores. As shown in Figure 2, we divided SBP attendance into three groups (no attendance, below average attendance, and above average attendance). Figure 2 shows that SBP attendance was associated with higher CD-RISC scores, but only if the participating caregivers had higher than average attendance (change=+5.20, $p<0.05$). Caregivers who participated in the SBP but did so with less than average attendance did not have significantly different scores than caregivers who did not attend the SBP at all.

Figure 2: Changes in CD-RISC-25 Scores Based on Participation



Note: Figure 2 indicates whether caregivers (1) did not attend the SBP program (reference group), (2) participated with below average attendance, or (3) participated with higher-than-average attendance. Adjusted for the independent effect of the PTI, the interaction of PTI × time of follow-up (follow-up vs. baseline scores), and for statistically significant screening tools (HAM-A total score, PCL-C total score, and Whooley positive depression screening).

Correction: The original publication of this table in December 2021 contained an error in the labels on the x-axis. The label beneath the change in CD-RISC-25 scores for the group that had above average attendance to SBP has been corrected (February 2022).

DISCUSSION

Our study describes the development and evaluation of the 3Cs program, a resilience and wellbeing promotion intervention for caregivers of young children enrolled in ECD centers in Colombia. The program targeted municipalities acutely affected by the country’s armed conflict and by forced displacement. To our knowledge, this is one of the first studies to assess the impact of a program on parental resilience in crisis contexts in a Latin American country. This intervention also combined multiple inputs in its design, such as several psychosocial intervention approaches, the application of community-participatory research principles, and the utilization of ECD settings as an entry point for implementation. Supporting our hypothesis, the results of this study show statistically significant improvements in parental resilience (CD-RISC scores) as a result of participating in both program modules (the SBP and the PTI). Importantly, while participants in the PTI group started with lower resilience scores than the group who did not participate in the PTI, they

showed the most improvement after the intervention. One possible interpretation of these findings is that caregivers who rated their initial levels of resilience as relatively low compared to other caregivers are also the most likely to benefit from the PTI. Another interpretation of this finding could be social desirability and regression, in that caregivers with low baseline levels of resilience reported higher levels post-intervention because they felt that improved resilience was expected of them. More research is needed to determine the association and conclusions reported here. Future studies are needed in particular to determine the relationship between attendance, participant characteristics, and their impact on wellbeing outcomes and resilience. More research is also needed to determine and mitigate the reasons for not attending and/or dropping out.

While participation in the SBP was designed for all caregivers, 40 caregivers did not participate in those sessions. While finding a group of caregivers who did not participate in the SBP or the PTI was not the original intention of this intervention, the scale and complicated nature of emergency and fragile settings resulted in a small number of people enrolling in the study but not attending either the SBP or the PTI. We made use of this natural experimental (pseudo-control) group to evaluate the effects of average attendance at the SBP. Caregivers who had lower than average participation (mean attendance at the SBP=52.19% of sessions) had resilience scores similar to the group who did not attend any sessions. In contrast, caregivers who had higher than average participation in the SBP showed significantly more improvement in their resilience scores than the group who did not attend any sessions. Therefore, the SBP program's benefits seem to have a threshold beyond which caregivers living in fragile contexts benefit, and below which caregivers have resilience scores comparable to the general caregiver population in similar circumstances. The findings of this pragmatic evaluation are important in informing the design and implementation of controlled randomized interventions. They have also been used to design program models in communities with a similar background and in the context of the education system in Colombia, directed toward vulnerable communities who possibly benefit from interventions that aim to promote the development, strengthening, and maintenance of resilience. The findings of this study also demonstrate that programmatic approaches that target meso-level risk and protective factors (e.g., targeted ECD services, community networks, and psychosocial support) have the potential to promote caregivers' micro-level outcomes (e.g., resilience), which presumably has spillover effects on other caregiver outcomes, such as wellbeing and psychopathology.

We conducted focus group discussions and in-depth interviews with caregivers who were randomly selected. Our preliminary analyses following these discussions indicated that the resilience promotion program may have led to a reduction in the physical and verbal punishment of children, increased recognition of children's emotions, enhanced parental empathy toward their children, increased compassion for others, and a recognition of self-resilience among caregivers.² These possible effects need to be explored further, including a comprehensive qualitative analysis of the data to validate the findings. Nevertheless, there is evidence that the practice of mindfulness can enhance neuroplasticity and functional changes in the brain regions involved in the regulation of attention, emotions, and self-awareness (Tang, Hölzel, and Posner 2015). An exploration of the program's impact on neurobiological markers of stress and other markers of wellbeing could inform the intervention's mechanisms of action.

STRENGTHS AND INNOVATION

The program has several innovative attributes that contribute to the current evidence base. First, the program combines multiple approaches to mental health support, including a behavioral-cognitive model that emphasizes emotional regulation techniques (e.g., breathing), problem-solving, self-control, and social abilities (e.g., assertiveness and empathy). Second, the development of the 3Cs program included a qualitative exploration of the perspectives of parents, teachers, local health secretariats, and ICBF officials on resilience-building topics (e.g., strategies to facilitate conflict resolution, spirituality, and the role of grandparents), which were incorporated into the program sessions. Although spirituality was not an explicit component of the program, caregivers highlighted it as a key tool for strengthening resilience. This is consistent with the existing literature on the importance of spirituality in other contexts (e.g., among a sample of executives in the United States) when used as a mechanism to confront difficult situations, solve problems, and recover the meaning and purpose of life (Shelton, Hein, and Phipps 2019; Smith et al. 2012).

Third, given that the community of care for young children in many of the sites was diverse and often intergenerational, grandparents were eligible to participate. Despite the fact that grandparents around the globe often provide care to children, they are generally overlooked in the design of caregiver programs (Sadruddin et al. 2019). Fourth, the program is one of few that, to our knowledge, has been implemented in ECD settings in war-affected and other highly vulnerable

2 Possible effects are shown in unpublished ICBF and FSC data.

contexts, such as extreme poverty and insecurity. Interestingly, recent studies have shown that developing positive parenting skills is related to greater childhood resilience and family resources when facing displacement (Domínguez de la Ossa 2018). In the case of Colombia, working through ECD settings enabled the rapid identification of highly at-risk communities (e.g., a high poverty index, victims of the armed conflict, family violence and abuse) because these populations are prioritized for enrollment in publicly funded ECD centers. Working in ECD settings also afforded the possibility of including parents and other primary caregivers (e.g., grandparents, extended family) so that the 3Cs program reached the wider community of care. The program welcomed the participation of male and female caregivers, which is particularly relevant, as recent studies have shown positive (indirect) associations between paternal engagement and maternal distress, harsh parenting, and parenting stress (Hein et al. 2020).

CHALLENGES AND ENABLERS OF IMPLEMENTATION

The program's implementation and evaluation were enabled through the Colombian government's prioritization of ECD, mental health, and social strategies for peacebuilding as mechanisms for national development. The program content was aligned with the vision of multiple legislative frameworks, including DCAS and the implementation of the peace accords. A key justification for developing the program was the evidence brought forth by the peacebuilding through ECD paradigm (Yale University and AÇEV 2012) and its alignment with Colombia's policy priority to invest in strategies to bolster socioemotional skills and conflict resolution that included young children, caregivers, and parents. The government buy-in facilitated the program implementers' ability to engage with the communities and local leadership (e.g., community leaders, *juntas*, churches, cultural centers, early childhood education center directors and teachers). These relationships were key to building trust in the communities and aligning the program's content with a culturally diverse group of municipalities. The mechanisms of community engagement featured several communication strategies (e.g., community radio, flyers) that were used effectively to raise awareness of the program and encourage participation.

To ensure that the fidelity and quality of the program implementation was sustained, an intensive and structured training program for the facilitators was delivered by the FSC. Crucial on-site support and mentorship were also provided regularly throughout the process for facilitators at all sites. In some locations where internet access was available, the use of online social networks was an effective way to streamline referrals to other services and to offer additional

support for program beneficiaries. It is important to note that the program involved training psychologists and mental health professionals who lived in the target municipalities. As a result, the skills and capacities that the participants acquired through the program may have been introduced in a sustainable way in the communities, partly overcoming the shortage of skilled people, a difficulty prevalent in disperse rural parts of Colombia.

One main challenge in implementing the program was to sustain enrollment and attendance. Parents' program attendance in humanitarian crisis settings has been reported elsewhere to be one of the main barriers to implementation and is associated with program effects (Ponguta et al. 2020; Ponguta et al. 2019). To encourage attendance at both program modules, participants were offered snacks as an added incentive and the session scheduling was conducted in close consultation with the beneficiaries. These incentive strategies were aligned with what was thought to be acceptable to the context and the local partners.

Conducting controlled evaluations of psychosocial interventions in conflict-affected contexts is known to be challenging (Hein and Weeland 2019), and this case was no exception. Training and deploying reliable data collectors required funding earmarked for the program evaluation, and the partnership between the academic, public, and private sectors was a key enabler to the data collection and analysis. However, because of a lack of internet connectivity in several of the municipalities, real-time data entry was not possible. This delayed the analyses and challenged the quality control of data management. Furthermore, from an evaluation design perspective, it was necessary to conduct an observational evaluation because of ethical concerns in the assignment of control arms to ensure that the members of the communities involved in the 3Cs program had access to mental health promotion strategies likely to be beneficial for them. Conducting randomized controlled trials would strengthen the evidentiary base for this and similar programs.

STUDY LIMITATIONS AND FUTURE DIRECTIONS

This study focused on the impact of a program to promote parental resilience among a subgroup of caregivers who participated in the SBP, a combination of the SBP and the PTI, or the PTI alone. More research is needed to determine the impact of the 3Cs program components on caregiver outcomes, namely, their practices and wellbeing, and on all outcomes for teachers and grandparents. Furthermore, evaluations are needed to establish the program's impact on

vertical (e.g., trust in institutions and institutional capacities) and horizontal (e.g., trust across families and communities) social cohesion as a result of program participation. In fact, a key issue ECD programs face is assessing their potential to build cohesion and establish a pathway to intergenerational peace (Connolly, Hayden, and Levin 2007; Leckman, Panter-Brick, and Salah 2014). Importantly, future evaluations should explore the effects of enhanced caregiver resilience, wellbeing, and social cohesion on children's short-term (e.g., socioemotional and cognitive development and strengthened resilience) and long-term (e.g., reduced risk of psychopathologies and improved developmental outcomes later in life) outcomes.

Limited funding for the evaluation of programs of this nature is a persistent challenge. We were only able to apply a self-reported measure of parental resilience to explore the impact of the 3Cs program and apply a pragmatic evaluation. To advance the field, future studies should apply observational and behavioral measures beyond self-reports that include all caregivers and children, and that follow the effects over time. Our study was not able to empirically determine the elements of the program modules that contributed to its impact. We also were unable to assess the program's impact on children's outcomes, primarily due to resource constraints. However, focus group discussions with facilitators after the program implementation suggest that sessions that addressed problem-solving skills and offered concrete techniques to develop self-control and self-regulation were well received, and they seemed to be integrated more easily into participants' behavior changes. More research is needed to validate these preliminary observations and make determinations about which programmatic elements and attendance could be linked to positive outcomes. Importantly, in part due to limited funding, we were not able to follow up with participants after the post-intervention assessment. Ideally, determining the sustainability of the program's impact should include a one-year follow-up assessment. Our study was challenged by various issues, such as higher attrition rates than those reported in similar studies conducted in more controlled settings. The challenges our team encountered in following up with participants are common for studies performed in real-world settings, especially conflict and postconflict settings. We argue nonetheless that the pragmatic nature of our research design counters this weakness and increases the external validity of our findings.

From a systems perspective, it is crucial to identify national- and municipal-level entry points to ensure that programs addressing young children's and caregivers' wellbeing are included in development and investment plans. By aligning this program to Colombia's National Law for Early Childhood, for example, the

initiative was anchored in strategic actions to provide holistic support for young children and their families. The program to promote resilience was one of the strategic actions included in Colombia's National Policy for Mental Health 2019 and is one of the programs adopted to promote mental health in the country. Integrating these programs into the country's public policy vision are key to their scalability and sustainability.

REFERENCES

- Aburn, Gemma, Merryn Gott, and Karen Hoare. 2016. "What Is Resilience? An Integrative Review of the Empirical Literature." *Journal of Advanced Nursing* 72 (5): 980-1000. <https://doi.org/10.1111/jan.12888>.
- Acevedo, Victoria Eugenia, and Lucía Restrepo. 2012. "De Profesores, Familias y Estudiantes: Fortalecimiento de la Resiliencia en la Escuela." *Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud* 10: 301-319. http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S1692-715X2012000100019&nrm=iso.
- Annan, Jeannie, Amanda Sim, Eve S. Puffer, Carmel Salhi, and Theresa S. Betancourt. 2017. "Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: A Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention." *Prevention Science* 18 (7): 793-803. <https://doi.org/10.1007/s11121-016-0728-2>.
- Auyeung, Bonnie, Carrie Allison, Sally Wheelwright, and Simos Baron-Cohen. 2012. "Brief Report: Development of the Adolescent Empathy and Systemizing Quotients." *Journal of Autism and Developmental Disorders* 42 (10): 2225-35. <https://doi.org/10.1007/s10803-012-1454-7>.
- Bethell, Christina, Narangerel Gombojav, Michele Solloway, and Lawrence Wissow. 2016. "Adverse Childhood Experiences, Resilience and Mindfulness-Based Approaches: Common Denominator Issues for Children with Emotional, Mental, or Behavioral Problems." *Child and Adolescent Psychiatric Clinics of North America* 25 (2): 139-56. <https://doi.org/10.1016/j.chc.2015.12.001>.

- Bonilla-Escobar, Francisco J., Andrés Fandino-Losada, Diana M. Martínez-Buitrago, Julián Santaella-Tenorio, Daniel Tobon-García, Edgar J. Muñoz-Morales, Iván D. Escobar-Roldán et al. 2018. "A Randomized Controlled Trial of a Transdiagnostic Cognitive-Behavioral Intervention for Afro-Descendants' Survivors of Systemic Violence in Colombia." *PLoS ONE* 13 (12): e0208483. <https://doi.org/10.1371/journal.pone.0208483>.
- Britto, Pia R., Stephen J. Lye, Kerrie Proulx, Aisha K. Yousafzai, Stephen G. Matthews, Tyler Vaivada, Rafael Perez-Escamilla et al. 2017. "Nurturing Care: Promoting Early Childhood Development." *Lancet* 389 (10064): 91-102. [https://doi.org/10.1016/S0140-6736\(16\)31390-3](https://doi.org/10.1016/S0140-6736(16)31390-3).
- Bronfenbrenner, Urie. 2009. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.
- Campbell-Sills, Laura, and Murray B. Stein. 2007. "Psychometric Analysis and Refinement of the Connor-Davidson Resilience Scale (CD-RISC): Validation of a 10-Item Measure of Resilience." *Journal of Traumatic Stress* 20 (6): 1019-28. <https://doi.org/10.1002/jts.20271>.
- Connolly, Paul, Jacqueline Hayden, and Diane Levin. 2007. *From Conflict to Peace Building: The Power of Early Childhood Initiatives - Lessons from Around the World*. Lincoln, NE: Exchange Press.
- Connor, Kathryn M., and Jonathan R. T. Davidson. 2003. "Development of a New Resilience Scale: The Connor-Davidson Resilience Scale (CD-RISC)." *Depression and Anxiety* 18 (2): 76-82. <https://doi.org/10.1002/da.10113>.
- Consejería Presidencial para la Niñez y la Adolescencia. 2014. *de Cero a Siempre*. Bogotá: Presidencia de la República de Colombia. <http://www.deceroasiempre.gov.co/QuienesSomos/Paginas/QuienesSomos.aspx>.
- Crane, Melanie, Adrian Bauman, Beverley Lloyd, Bronwyn McGill, Chris Rissel, and Anne Grunseit. 2019. "Applying Pragmatic Approaches to Complex Program Evaluation: A Case Study of Implementation of the New South Wales Get Healthy at Work Program." *Health Promotion Journal of Australia* 30 (3): 422-32. <https://doi.org/10.1002/hpja.239>.

- Crespo, Maria, Violeta Fernández-Lansac, and Carmen Soberón. 2014. "Adaptación Española de La 'Escala de Resiliencia de Connor-Davidson' (CD-RISC) En Situaciones de Estrés Crónico." *Behavioral Psychology* 22: 219-38. <https://doi.org/10.1037/t62957-000>.
- DANE (Departamento Administrativo Nacional de Estadística). 2021. *Pobreza y Desigualdad*. Bogotá: DANE. <https://www.dane.gov.co/index.php/estadisticas-por-tema/pobreza-y-condiciones-de-vida/pobreza-monetaria>.
- DCAS (De Cero a Siempre). 2013. *Estrategia de Atención Integral a la Primera Infancia: Fundamentos Políticos, Técnicos y de Gestión*. Bogotá: ICBF. <http://www.deceroasiempre.gov.co/QuienesSomos/Documents/Fundamentos-politicos-tecnicos-gestion-de-cero-a-siempre.pdf>.
- Diab, Marwan, Kirsi Peltonen, Samir R. Qouta, Esa Palosaari, and Raija-Leena Punamäki. 2015. "Effectiveness of Psychosocial Intervention Enhancing Resilience among War-Affected Children and the Moderating Role of Family Factors." *Child Abuse & Neglect* 40: 24-35. <https://doi.org/10.1016/j.chiabu.2014.12.002>.
- Domínguez de la Ossa, Elsy Mercedes. 2018. "Los Recursos Familiares para Afrontar la Adversidad del Desplazamiento Forzado." *Psicología desde el Caribe* 35: 145-55. http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0123-417X2018000200145&nrm=iso.
- Dybdahl, Ragnhild. 2001. "Children and Mothers in War: An Outcome Study of a Psychosocial Intervention Program." *Child Development* 72 (4): 1214-30. <https://doi.org/10.1111/1467-8624.00343>.
- Foa, Edna B., Terence M. Keane, Matthew J. Friedman, and Judith A. Cohen. 2009. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* (2nd ed.). New York: The Guilford Press.
- Gavidia-Payne, Susana, Bianca Denny, Kate Davis, Andrew Francis, and Merv Jackson. 2020. "Parental Resilience: A Neglected Construct in Resilience Research." *Clinical Psychologist* 19 (3): 111-21. <https://doi.org/10.1111/cp.12053>.
- Gobierno de la República de Colombia. 2016. *ABC del Acuerdo Final*. Bogotá: Gobierno de la República de Colombia. <https://www.cancilleria.gov.co/sites/default/files/cartillaabccdelacuerdofinal2.pdf>.

- Gómez Cardona, Liliana María. 2017. "Primera Infancia y Educación Emocional." *Revista Virtual Universidad Católica del Norte* 52: 174-84. (52): 174-184.
- Hamilton, Max. 1959. "The Assessment of Anxiety States by Rating." *British Journal of Medical Psychology* 32 (1): 50-55. <https://doi.org/10.1111/j.2044-8341.1959.tb00467.x>.
- Hein, Sascha, Jodi Reich, and Elena Grigorenko. 2015. "Cultural Manifestation of Intelligence in Formal and Informal Learning Environments During Childhood." In *The Oxford Handbook of Human Development and Culture: An Interdisciplinary Perspective*, edited by Lene Arnett Jensen, 214-29. New York: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780199948550.013.14>.
- Hein, Sascha, Johanna Bick, Ghassan Issa, Lara Aoude, Cosette Maalouf, Abir Awar, Sawsan Nourallah et al. 2020. "Maternal Perceptions of Father Involvement among Refugee and Disadvantaged Families in Beirut, Lebanon." *PLoS ONE* 15 (3): e0229670. <https://doi.org/10.1371/journal.pone.0229670>.
- Hein, Sascha, and Joyce Weeland. 2019. "Randomized Controlled Trials (RCTs) in Clinical and Community Settings: Challenges, Alternatives, and Supplementary Designs." *New Directions for Child and Adolescent Development* (167): 7-15. <https://doi.org/10.1002/cad.20312>.
- IASC (Inter-Agency Standing Committee). 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC. https://interagencystandingcommittee.org/system/files/legacy_files/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.
- ICBF (Instituto Colombiano de Bienestar Familiar). 2020. *Acciones Desarrolladas por el ICBF que Aportan a la Implementación del Acuerdo Final para la Terminación del Conflicto y la Construcción de una Paz Estable y Duradera: Vigencia 2018 y 2019*. Bogotá: ICBF. https://www.icbf.gov.co/sites/default/files/acciones_desarrolladas_por_el_icbf_que_aportan_a_la_implementacion_del_acuerdo_final_para_la_terminacion_del_conflicto_y_la_construccion_de_una_paz_estable_y_duradera_-_vigencia_2018_y_2019.pdf.

- Jordans, Mark J. D., Wietse A. Tol, Ivan H. Komproe, and Joop V. T. M. de Jong. 2009. "Systematic Review of Evidence and Treatment Approaches: Psychosocial and Mental Health Care for Children in War." *Child and Adolescent Mental Health* 14 (1): 2-14. <https://doi.org/10.1111/j.1475-3588.2008.00515.x>.
- Leckman, James F., Catherine Panter-Brick, and Rima Salah. 2014. *Pathways to Peace: The Transformative Power of Children and Families*. Cambridge, MA: MIT Press.
- Leckman, James F., Chelsea K. Donaldson, Friedrich W. Affolter, and Liliana Angélica Ponguta. 2019. "Pathways to Wellbeing and a More Peaceful and Sustainable World: The Transformative Power of Children and Families." *Japanese Journal of Child and Adolescent Psychiatry* 60 (3): 278-98. https://doi.org/10.20615/jscap.60.3_278.
- Lobo, Antonio, Lorenzo Chamorro, Antonio Luque, Rafael Dal-Re, Xavier Badia, and Eva Baro. 2002. "Validación de las Versiones en Español de la Montgomery-Asberg Depression Rating Scale y la Hamilton Anxiety Rating Scale para la Evaluación de la Depresión y de la Ansiedad." *Medicina Clínica* 118 (13): 493-99. [https://doi.org/10.1016/s0025-7753\(02\)72429-9](https://doi.org/10.1016/s0025-7753(02)72429-9).
- Lozano Montilla, Dahyana Andrea, Mateo Parra Giraldo, and Daniela Victoria Uribe Ortiz. 2019. "Resiliencia y Constructos Personales de Victimización en Individuos Vulnerados por el Conflicto Armado." *Poiésis* (37): 65-84. <https://doi.org/10.21501/16920945.3339>.
- Luthar, Suniya S., Elizabeth J. Crossman, and Phillip J. Small. 2015. "Resilience and Adversity." In *Handbook of Child Psychology and Developmental Science, Vol. 3*, edited by Richard M. Lerner, 1-40. Hoboken, NJ: John Wiley & Sons, Inc. <https://doi.org/10.1002/9781118963418.childpsy307>.
- Maldonado-Carreño, Carolina, Carolina Rey Guerra, Jorge Cuartas, Tatiana Plata-Caviedes, Jesús J. Rodríguez De Luque, Eduardo Escallón Largacha, and Hirokazu Yoshikawa. 2018. *Quality Measurement of the Institutional Modality of Early Childhood Education in Colombia*. Bogotá: Universidad de Los Andes. <https://educacion.uniandes.edu.co/sites/default/files/Notes-In-Education.pdf>.
- Masten, Ann. S. 2018. "Resilience Theory and Research on Children and Families: Past, Present, and Promise." *Journal of Family Theory & Review* 10 (1): 12-31. <https://doi.org/10.1111/jftr.12255>

- Masten, Ann S., and Frosso Motti-Stefanidi. 2020. "Multisystem Resilience for Children and Youth in Disaster: Reflections in the Context of COVID-19." *Adversity and Resilience Science* 1 (2): 1-12. <https://doi.org/10.1007/s42844-020-00010-w>.
- McEwen, Craig A., and Bruce S. McEwen. 2017. "Social Structure, Adversity, Toxic Stress, and Intergenerational Poverty: An Early Childhood Model." *Annual Review of Sociology* 43 (1): 445-72. <https://doi.org/10.1146/annurev-soc-060116-053252>.
- Ministerio de Salud y Protección Social. 2013. *Detección Temprana y Diagnóstico del Episodio Depresivo y Trastorno Depresivo Recurrente en Adultos: Atención Integral de los Adultos con Diagnóstico de Episodio Depresivo o Trastorno Depresivo Recurrente*. Bogotá: Ministerio de Salud y Protección Social. http://gpc.minsalud.gov.co/gpc_sites/Repositorio/Conv_500/GPC_td/GPC_Comple_Depre.pdf.
- Murphy, Katie Maeve, Katherine Rodrigues, Jaime Costigan, and Jeannie Annan. 2017. "Raising Children in Conflict: An Integrative Model of Parenting in War." *Peace and Conflict: Journal of Peace Psychology* 23 (1): 46-57. <https://doi.org/10.1037/pac0000195>.
- Murthy, R. Srinivasa, and Rashmi Lakshminarayana. 2006. "Mental Health Consequences of War: A Brief Review of Research Findings." *World Psychiatry* 5 (1): 25-30. <https://www.ncbi.nlm.nih.gov/pubmed/16757987>.
- Osher, David, Pamela Cantor, Juliette Berg, Lily Steyer, and Todd Rose. 2018. "Drivers of Human Development: How Relationships and Context Shape Learning and Development." *Applied Developmental Science* 24 (1): 6-36. <https://doi.org/10.1080/10888691.2017.1398650>.
- Panter-Brick, Catherine, and James F. Leckman. 2013. "Resilience in Child Development: Interconnected Pathways to Wellbeing." *Journal of Child Psychology and Psychiatry* 54 (4): 333-36. <https://doi.org/10.1111/jcpp.12057>.
- Pedersen, Gloria A., Eva Smallegange, April Coetzee, Kim Hartog, Jasmine Turner, Mark J. D. Jordans, and Felicity L. Brown. 2019. "A Systematic Review of the Evidence for Family and Parenting Interventions in Low- and Middle-Income Countries: Child and Youth Mental Health Outcomes." *Journal of Child and Family Studies* 28 (8): 2036-55. <https://doi.org/10.1007/s10826-019-01399-4>.

- Pham, Phuong, and Patrick Vinck. 2017. *Indicators Framework for Peacebuilding, Education and Social Cohesion*. Boston, MA: UNICEF and Harvard Humanitarian Initiative. https://inee.org/system/files/resources/Social_Cohesion_Assessmen_Framework_20170420_%28HHI%29.pdf.
- Ponguta, Liliana A., Ghassan Issa, Lara Aoudeh, Cosette Maalouf, Sasha D. Hein, Anna L. Zonderman, Liliya Katsovich et al. 2020. "Effects of the Mother-Child Education Program on Parenting Stress and Disciplinary Practices Among Refugee and Other Marginalized Communities in Lebanon: A Pilot Randomized Controlled Trial." *Journal of the American Academy of Child & Adolescent Psychiatry* 59 (6): 727-38. <https://doi.org/10.1016/j.jaac.2019.12.010>.
- Ponguta, Liliana Angélica, Ghassan Issa, Lara Aoudeh, Cosette Maalouf, Sawsan Nourallah, Kaveh Khoshnood, Anna Leslie Zonderman et al. 2019. "Implementation Evaluation of the Mother-Child Education Program Among Refugee and Other Vulnerable Communities in Lebanon." *New Directions for Child and Adolescent Development* 2019 (167): 91-116. <https://doi.org/10.1002/cad.20314>.
- Rao, Nirmala, Jin Sun, Jessie M. S. Wong, Brendan Weekes, Patrick Ip, Sheldon Shaeffer, Mary Young, Mark Bray, Eva Chen, and Diana Lee. 2014. *Early Childhood Development and Cognitive Development in Developing Countries: A Rigorous Literature Review*. London: Department for International Development. <https://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries/ECD%202014%20Rao%20report.pdf?ver=2014-10-02-145634-017>.
- Reliefweb. 2020. *Colombia Violence against Children and Youth Survey 2018*. Bogotá: Reliefweb. <https://reliefweb.int/report/colombia/colombia-violence-against-children-and-youth-survey-2018>.
- Rolnick, Arthur J., and Rob Grunewald. 2003. *Early Childhood Development: Economic Development with a High Public Return*. Minneapolis, MN: Federal Reserve Bank of Minneapolis. <https://www.minneapolisfed.org/article/2003/early-childhood-development-economic-development-with-a-high-public-return>.

- Sadrudin, Aalyia F. A., Liliana A. Ponguta, Anna L. Zonderman, Kyle S. Wiley, Alyssa Grimshaw, and Catherine Panter-Brick. 2019. "How Do Grandparents Influence Child Health and Development? A Systematic Review." *Social Science & Medicine* 239: 112476. <https://doi.org/10.1016/j.socscimed.2019.112476>.
- Shelton, Charlotte D., Sascha Hein, and Kelly A. Phipps. 2019. "Resilience and Spirituality: A Mixed Methods Exploration of Executive Stress." *International Journal of Organizational Analysis* 28 (2): 399-416. <https://doi.org/10.1108/ijoa-08-2019-1848>.
- Sim, Amanda, Lucy Bowes, and Frances Gardner. 2019. "The Promotive Effects of Social Support for Parental Resilience in a Refugee Context: A Cross-Sectional Study with Syrian Mothers in Lebanon." *Prevention Science* 20 (5): 674-83. <https://doi.org/10.1007/s11121-019-0983-0>.
- Slone, Michelle, and Shiri Mann. 2016. "Effects of War, Terrorism and Armed Conflict on Young Children: A Systematic Review." *Child Psychiatry & Human Development* 47 (6): 950-65. <https://doi.org/10.1007/s10578-016-0626-7>.
- Smith, Bruce W., J. Alexis Ortiz, Kathryn T. Wiggins, Jennifer F. Bernard, and Jeanne Dalen. 2012. "Spirituality, Resilience, and Positive Emotions." In *The Oxford Handbook of Psychology and Spirituality*, edited by Lisa J. Miller, 37-454. New York: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780199729920.013.0028>.
- Smith, Gregory C., Bert Hayslip, Gregory R. Hancock, Frederick H. Strieder, and Julian Montoro-Rodriguez. 2018. "A Randomized Clinical Trial of Interventions for Improving Well-Being in Custodial Grandfamilies." *Journal of Family Psychology* 32 (6): 816-27. <https://doi.org/10.1037/fam0000457>.
- Smith, Karen E., and Seth D. Pollak. 2020. "Early Life Stress and Development: Potential Mechanisms for Adverse Outcomes." *Journal of Neurodevelopmental Disorders* 12 (1): 1-15. <https://doi.org/10.1186/s11689-020-09337-y>.
- Smith-Osborne, Alexa, Arati Maleku, and Sarolyn Morgan. 2017. "Impact of Applied Suicide Intervention Skills Training on Resilience and Suicide Risk in Army Reserve Units." *Traumatology* 23 (1): 49-55. <https://doi.org/10.1037/trm0000092>.

- Stammel, Nadine, Eva M. Abbing, Carina Heeke, and Christine Knaevelsrud. 2015. "Applicability of the ICD-11 Proposal for PTSD: A Comparison of Prevalence and Comorbidity Rates with the DSM-IV PTSD Classification in Two Post-Conflict Samples." *European Journal of Psychotraumatology* 6 (1): 27070. <https://doi.org/10.3402/ejpt.v6.27070>.
- Tamayo Martinez, Nathalie, Carlos Javier Rincón Rodríguez, Cecilia de Santacruz, Nubia Bautista Bautista, Jaime Collazos, and Carlos Gomez-Restrepo. 2016. "Mental Problems, Mood and Anxiety Disorders in the Population Displaced by Violence in Colombia: Results of the National Mental Health Survey 2015." *Revista Colombiana de Psiquiatría* 45: 113-18. <https://doi.org/10.1016/j.rcp.2016.09.004>.
- Tang, Yi-Yuan, Britta K. Hölzel, and Michael I. Posner. 2015. "The Neuroscience of Mindfulness Meditation." *Nature Reviews Neuroscience* 16 (4): 213-25. <https://doi.org/10.1038/nrn3916>.
- Thompson, Ross A., Mary Fran Flood, and Rebecca Goodvin. 2006. "Social Support and Developmental Psychopathology." In *Developmental Psychopathology: Risk, Disorder, and Adaptation, Vol. 3*, edited by Dante Cicchetti and Donald J. Cohen, 1-37. Hoboken, NJ: John Wiley & Sons, Inc.
- Tol, Wietse A., Suzan Song, and Mark J. D. Jordans. 2013. "Annual Research Review: Resilience and Mental Health in Children and Adolescents Living in Areas of Armed Conflict: A Systematic Review of Findings in Low- and Middle-Income Countries." *Journal of Child Psychology and Psychiatry* 54 (4): 445-60. <https://doi.org/10.1111/jcpp.12053>.
- Toth, Sheree L., Angeline Maughan, Jody Todd Manly, Mary Spagnola, and Dante Cicchetti. 2002. "The Relative Efficacy of Two Interventions in Altering Maltreated Preschool Children's Representational Models: Implications for Attachment Theory." *Development and Psychopathology* 14 (4): 877-908. <https://doi.org/10.1017/s095457940200411x>.
- Toth, Sheree L., Fred A. Rogosch, Jody Todd Manly, and Dante Cicchetti. 2006. "The Efficacy of Toddler-Parent Psychotherapy to Reorganize Attachment in the Young Offspring of Mothers with Major Depressive Disorder: A Randomized Preventive Trial." *Journal of Consulting and Clinical Psychology* 74 (6): 1006-16. <https://doi.org/10.1037/0022-006X.74.6.1006>.

- Ungar, Michael, Mehdi Ghazinour, and Jörg Richter. 2013. "Annual Research Review: What Is Resilience within the Social Ecology of Human Development?" *Journal of Child Psychology and Psychiatry* 54 (4): 348-66. <https://doi.org/10.1111/jcpp.12025>.
- UN High Commissioner for Refugees. 2018. *Global Trends: Forced Displacement in 2018*. <https://www.unhcr.org/globaltrends2018/>.
- Wachs, Theodore D., and Atif Rahman. 2013. "The Nature and Impact of Risk and Protective Influences on Children's Development in Low-Income Countries." In *Handbook of Early Childhood Development Research and Its Impact on Global Policy*, edited by Pia Rebello Britto, Patrice L. Engle, and Charles M. Super, 85-122. New York: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199922994.003.0005>.
- Walker, Edward A., Elana Newman, Dorcas J. Dobie, Paul Ciechanowski, and Wayne Katon. 2002. "Validation of the PTSD Checklist in an HMO Sample of Women." *General Hospital Psychiatry* 24 (6): 375-80. [https://doi.org/10.1016/s0163-8343\(02\)00203-7](https://doi.org/10.1016/s0163-8343(02)00203-7).
- Werner, Emmy E. 2012. "Children at War: Risk, Resilience, and Recovery." *Development and Psychopathology* 24 (2): 553-58. <https://doi.org/10.1017/S0954579412000156>.
- Whitaker, Robert C., Tracy Dearth-Wesley, and Rachel A. Gooze. 2015. "Workplace Stress and the Quality of Teacher-Children Relationships in Head Start." *Early Childhood Research Quarterly* 30: 57-69. <https://doi.org/10.1016/j.ecresq.2014.08.008>.
- Whooley, Mary A., Andrew L. Avins, Jeanne Miranda, and Warren S. Browner. 1997. "Case-Finding Instruments for Depression: Two Questions Are as Good as Many." *Journal of General Internal Medicine* 12 (7): 439-45. <https://doi.org/10.1046/j.1525-1497.1997.00076.x>.
- Wilkins, Kendall C., Ariel J. Lang, and Sonya B. Norman. 2011. "Synthesis of the Psychometric Properties of the PTSD Checklist (PCL) Military, Civilian, and Specific Versions." *Depression and Anxiety* 28 (7): 596-606. <https://doi.org/10.1002/da.20837>.

- Wolmer, Leo, Daniel Hamiel, Jack D. Barchas, Michelle Slone, and Nathaniel Laor. 2011. "Teacher-Delivered Resilience-Focused Intervention in Schools with Traumatized Children Following the Second Lebanon War." *Journal of Trauma Stress* 24 (3): 309-16. <https://doi.org/10.1002/jts.20638>.
- Yale University and AÇEV. 2012. *The Ecology of Peace: Formative Childhood and Peace Building. A Brief Note*. New Haven, CT and Istanbul, Turkey: Yale-AÇEV Partnership. <https://medicine.yale.edu/childstudy/fcpb/approach/ecologyofpeace/>.
- Zolkoski, Staci M., and Lyndal M. Bullock. 2012. "Resilience in Children and Youth: A Review." *Children and Youth Services Review* 34 (12): 2295-2303. <https://doi.org/10.1016/j.childyouth.2012.08.009>.

APPENDIX

Table A1: Design and Implementation Processes of the 3Cs Program Modules (SBP and PTI)

t		
Source of Data/Information	Overview of Data/Information	Process of Integration of Data/Information
Literature and theoretical frameworks by expert team	The lead Fundación Saldarriaga Concha team conducted the review of best practices in resilience skills-building, informed by the Ecology of Peace Framework (Yale University and AÇEV 2012). It also held technical meetings with national experts and technical work consultations across the organization.	<ul style="list-style-type: none"> • The technical proposal was designed and presented to the ICBF, which recommended introducing pedagogical materials on other resilience promotion strategies that were being implemented in the country.
Participatory approach and community inputs	Interviews and focus group discussions were conducted with early childhood educators and caregivers from some of the target municipalities to inform the program design. Key areas of consultation included ways to frame content to promote uptake and acceptability, and delivery methods to facilitate delivery of the content.	<ul style="list-style-type: none"> • Framed all the content in “first person” to increase the extent to which participants related to it. • Employed collaborative learning to promote the discussion of content and its relation to everyday life experiences. • Introduced culturally relevant activities and practices, such as singing and dancing. • Included commitments and tasks to apply the content of the sessions at home, in the community, and/or in the workplace. • Adjusted schedules, location, and frequency of the program delivery based on caregiver groups’ preferences and availability.

EVALUATING THE 3CS PROGRAM FOR CAREGIVERS IN COLOMBIA

SBP IMPLEMENTATION		
Target Group	Overview of Content	Process of Implementation
<p>All parents of children enrolled in ECD centers and grandparents of children enrolled in ECD centers who self-identified as primary caregivers</p>	<p>Resilience</p> <ul style="list-style-type: none"> • Assertive and interpersonal communication • Stress management and emotional regulation • Decision-making, problem-solving, creative thinking, critical thinking <p>Wellbeing</p> <ul style="list-style-type: none"> • Self-knowledge • Empathy • Assertiveness • Life skills <p>Parenting practices</p> <ul style="list-style-type: none"> • Protective factors and safe, effective bonding • How to promote assertive communication in early childhood as a life skill that generates peacebuilding in different environments <p>Additional topics for grandparents</p> <ul style="list-style-type: none"> • Self-knowledge, interpersonal relationships, reconciliation and resilience, and realities of aging • Abuse, risk factors, violence, and intergenerational protection • Life skills • Transference of knowledge to other family members 	<ul style="list-style-type: none"> • Four lecture sessions (60-90 minutes per session) • Held in groups ranging from 15 to 20 participants • Sessions also included group discussions about specific strategies to promote resilience capacities

SBP IMPLEMENTATION (CONT.)		
Target Group	Overview of Content	Process of Implementation
Educators/Teachers	<p>Interactions and emotional support</p> <ul style="list-style-type: none"> • Safe and effective bonding • Socioemotional development in early childhood <p>Resilience</p> <ul style="list-style-type: none"> • Assertive communication • Relationships • Stress management—management of emotions 	Ten interactive workshops (60-90 minutes per session) Held in groups ranging from 15 to 20 participants. Sessions included activities to openly discuss and internalize the concepts addressed in the lecture sessions. Activities, such as games and role-play, were used to reinforce knowledge, elaborate on concepts through active questioning, and state personal commitments and good practices.

PTI DESIGN		
Source of Data/Information	Overview of Data/Information	Process of Integration of Data/Information
Theory/Literature	<p>A review of the literature was conducted to identify best practices for effectively promoting resilience capacities in conflict-affected settings, including those designed for parents of young children (with no clinical presentation of anxiety, depression, or PTSD). Based on the literature review, third-generation cognitive behavioral techniques were selected as part of the program content.</p> <p>Group psychotherapy was selected, based on literature review. With results similar to those of individual psychotherapy, group interventions have some advantages. They allow a larger number of people to be treated by each available therapist, and they reinforce positive beliefs not available in individual therapy, such as a sense of belonging, peer support, and feeling a connection to a group of people who value a shared environment.</p>	The technical proposal was designed and presented to the ICBF. Additional consultations were held with a group of psychiatrists with experience in community interventions, who made final adjustments to the proposed model.
Pilot	A pilot study was conducted to optimize the content and program modality in one municipality (Medellín).	The results of the pilot led to shortening the intervention and to summarizing the contents the subjects found similar.

EVALUATING THE 3CS PROGRAM FOR CAREGIVERS IN COLOMBIA

PTI IMPLEMENTATION		
Target Group	Overview of Content	Process of Implementation
<p>Parents who self-reported to be victims of the armed conflict and had a negative screen for depression, PTSD, and/or anxiety.</p>	<p>Parental psychosocial wellbeing and resilience</p> <ul style="list-style-type: none"> • Characterization and initial psychoeducation • Behavioral activation model • Rational behavioral emotional therapy • Management of emotions • Mindfulness • Acceptance and commitment techniques 	<p>The overarching aim of the PTI was to promote enduring bonding and provide strategies to promote resilience, social skills, emotional processing, presentation techniques, activation control techniques, and self-control. The PTI module consisted of eight in-person sessions, each lasting an average of two hours.</p>

Figure A1: Recruitment, Screening, and Group Assignment to the 3C Program Modules (SBP and PTI)

