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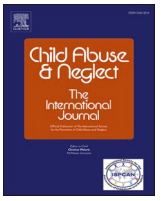

The Apapacho early childhood violence prevention parenting program: A mixed methods pilot evaluation

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ABSTRACT

Background: Parenting programs are a promising approach to prevent violence against children and promote positive parenting behaviors. We tested whether Apapacho, a violence prevention parenting program developed in a research-practice partnership, was associated with improvements in caregivers' outcomes.

Participants and setting: We examined the short-term outcomes of Apapacho in Bogotá and Soacha, Colombia. Apapacho was integrated into the *Modalidad Familiar* service, operated by the National Government. Eligible participants were caregivers of children under the age of five. We collected baseline and follow-up quantitative data (one month after implementation) from 134 caregivers who participated in Apapacho and 133 caregivers selected as a comparison group (total quantitative sample: $N = 267$). Qualitative data were collected from 12 caregivers who participated in two focus groups and 10 who completed interviews (total qualitative sample: $N = 22$).

Methods: We employed a convergent parallel mixed-methods design. Outcomes included caregivers' reported engagement in responsive caregiving and stimulation practices, mental health and well-being, and use of non-violent discipline and violent punishment. Data were analyzed using a difference-in-differences approach and thematic analysis.

Results: Participation in Apapacho was associated with short-term improvements in beliefs about responsive caregiving ($\beta = 0.17$), reductions in approval of violent discipline ($\beta = -0.12$), and increases in stimulation ($\beta = 0.19$) and use of non-violent discipline ($\beta = 0.12$). Qualitative findings indicated that caregivers perceived improvements in their relationship with their children, greater understanding of their children's needs, increased emotional awareness and self-regulation, and greater use of non-violent discipline strategies following participation in Apapacho.

Conclusions: Apapacho is a promising strategy for promoting positive parenting behaviors and preventing violence against children.

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1. Introduction

Violence against children (VAC), including physical punishment and psychological aggression, is a widespread human rights, developmental, and public health issue (World Health Organization, 2016). Colombia ranks among the countries with the highest rates of children's exposure to violence (Save the Children, 2017). For instance, more than half of caregivers of children under five report that they or someone in their household physically punished their child in the past month, and over 10% of children experience physical punishment by their primary caregivers before their first birthday (Cuartas, 2018; Trujillo et al., 2020). Evidence from Colombia and other low-, middle-, and high-income countries shows that VAC is linked to negative cognitive, behavioral, emotional, and social outcomes, as well as long-term physical and mental health problems (Cuartas et al., 2025). Early exposure also increases the risk of perpetuating violence in adulthood, both toward one's own children and intimate partners, reinforcing intergenerational cycles of violence.

Preventing violence against children (VAC) in the home has become a national priority in Colombia. Following the 2021 legal ban on all forms of physical punishment and psychological aggression (Law 2089), Colombia was designated a pathfinder country by the Global Partnership to End Violence Against Children, hosted the First Global Ministerial Conference on Ending Violence Against Children, and launched national guidelines for violence prevention (Gobierno de Colombia, 2023). The government also introduced a National Pedagogical Strategy (Gobierno de Colombia, 2021) with specific targets for 2030, calling for the "creation, strengthening, or design of services, programs, and strategies aimed at preventing physical punishment and cruel, humiliating, or degrading treatment of children in all settings" (author's translation; p. 51). Despite having a strong policy framework and nationwide center- and home-based early childhood services, Colombia still lacks universal programs that explicitly address VAC in the home (Cuartas et al., 2022).

Meta-analyses and narrative reviews of global evidence suggest that parenting programs help prevent VAC, reduce risk factors, and promote positive parenting behaviors (Backhaus et al., 2023). For instance, randomized trials from countries such as Brazil (Altafim & Linhares, 2019), Chile (Rincón et al., 2018), Jamaica (Francis & Baker-Henningham, 2021), and Panama (Mejia et al., 2015) show these programs improve caregivers' beliefs about parenting and violence, increase stimulation and non-violent discipline, and reduce physical and psychological aggression. Evidence also indicates that parenting programs are similarly effective whether delivered through home visits or group sessions (Gardner et al., 2023; Jeong et al., 2021). Most programs share core components, including building knowledge of child development, promoting self-regulation, encouraging non-violent discipline, and using participatory methods such as modeling, positive feedback, and peer support to strengthen parenting skills and self-efficacy (Cuartas et al., 2022).

Despite strong evidence on the effectiveness and core components of parenting programs, ensuring their sustainability and scalability remains a major challenge, particularly in low- and middle-income countries (LMICs) such as Colombia. Globally, fewer than half of countries have policies specifically aimed at preventing violence through parenting support, and only about one-fourth have implemented universal parenting programs (van Tuyll van Serooskereken Rakotomalala et al., 2023). Barriers to scale and sustainability may include financial constraints that limit governments' ability to implement resource-intensive programs or families' ability to participate in group sessions; culturally irrelevant content in interventions adapted from high-income contexts; and misalignment between program values, language, and the preferences of policymakers, implementers, and caregivers (Britto et al., 2022).

Consequently, the development and adaptation of parenting programs should not only build on existing evidence-based components but also prioritize practical, evidence-informed strategies to support sustainability and scalability. One such strategy is to develop or adapt programs through research-practice partnerships with policymakers, frontline staff, and parents to ensure cultural relevance and alignment with national priorities, community dynamics, and the values, goals, and needs of families (Britto et al., 2022). Another promising approach is to integrate parenting programs into existing, well-established services that already reach families at scale, thereby reducing implementation costs and enhancing coordination with ongoing efforts. In Colombia, early childhood services delivered by the Instituto Colombiano de Bienestar Familiar (ICBF) – the agency responsible for child and family policy – reach approximately 2,108,795 children younger than five and their families through models such as *Modalidad Institucional* (center-based) and *Modalidad Familiar* (home visits and group meetings; Instituto Colombiano de Bienestar Familiar, 2025). Evidence from Colombia (Attanasio et al., 2022) shows that embedding a structured parenting program focused on early stimulation into *Modalidad Familiar* improved both child outcomes and the quality of the home environment, reinforcing the value of this integrated approach.

In response to the national policy goals and global evidence, we developed Apapacho, a parenting program for violence prevention, through a research-practice partnership between Colombian researchers and practitioners from Fundación Apapacho, the Colombian Institute for Family Welfare (ICBF), and Innovations for Poverty Action (IPA). The program targets caregivers of children under five and aims to strengthen parenting capabilities, promote positive parenting practices, and prevent VAC. Its theory of change and program materials were grounded in developmental and behavior change theory and extensive formative research, including a review of existing programs and services in Colombia and evidence on core components of effective parenting interventions (Cuartas et al., 2022), as well as qualitative research with 10 policymakers, 20 ICBF facilitators/educators, and 38 caregivers (Cuartas, Beccassino, Baker-Henningham, et al., 2024). We also prototyped specific content and materials with 21 caregivers and 37 facilitators. Throughout the formative phase (2022–2023, see Fig. 1), the research-practice team met at least monthly, and from March 2023 onward, met weekly to finalize the content and delivery strategy. The program was designed for delivery through group sessions, with significant contextualization to align with ICBF's existing services to enhance its feasibility, sustainability, and scalability.

The present study aimed to assess the short-term effects of Apapacho on caregiver outcomes. Specifically, we examined whether participation in Apapacho was associated with changes in caregivers' responsive caregiving and stimulation practices, mental health and well-being, and child discipline behaviors one month after program completion. To do so, we integrated findings from a difference-in-differences analysis using baseline and follow-up quantitative data, along with thematic analysis of qualitative data from interviews

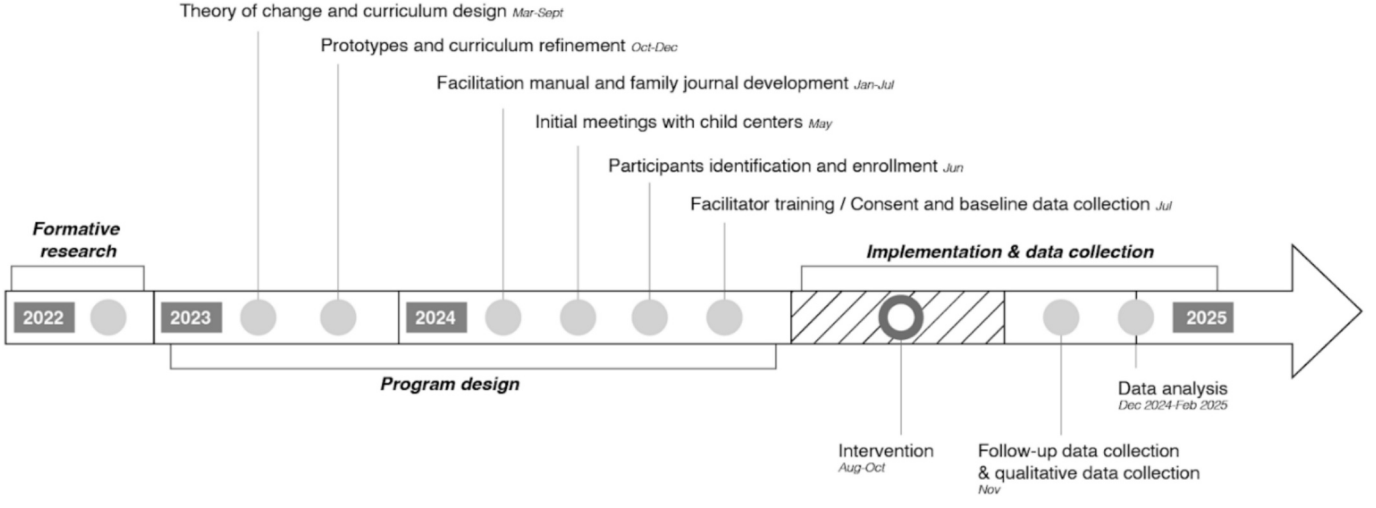

Fig. 1. Project timeline.

and focus groups carried out after the program's implementation.

2. Method

We conducted a study to examine the short-term outcomes of Apapacho on parents and children between May 2024 and May 2025. The study was part of an ongoing research-practice partnership involving Colombian researchers, practitioners, and staff from the ICBF, which was initially established in 2022. We employed a convergent parallel mixed-methods design (Creswell & Clark, 2017), in which quantitative and qualitative data were collected simultaneously, analyzed independently, and then integrated to interpret the findings. The study was approved by the Institutional Review Board of Innovations for Poverty Action (IRB #4719), and informed consent was obtained from all participants.

2.1. Setting, participants, and procedure

The procedures for this mixed-methods study were developed by all members of the research-practice partnership. We conducted the study in two municipalities of Colombia: Bogotá and Soacha (see Fig. S1 in the Supplemental Files). Bogotá is the Capital City and political and economic hub of Colombia. It has a population of approximately 7.9 million inhabitants, out of which 462,484, or 5.83%, are children younger than five years (DANE, 2023). Within Bogotá, we focused on the localities of Martires and San Cristobal, which experienced pronounced increases in cases of domestic violence between 2022 and 2023. Soacha is a smaller municipality of the department of Cundinamarca, and part of the metropolitan area of Bogotá, and has about 806,253 inhabitants out of which 57,079 are younger than five years (DANE, 2023). According to Government statistics, a total of 89,457 in Bogota and 8169 in Soacha receive services from ICBF (Instituto Colombiano de Bienestar Familiar, 2025).

Within these municipalities, we integrated Apapacho into the *Modalidad Familiar* (Family Modality) service provided by the ICBF. *Modalidad Familiar* is a comprehensive care strategy from pregnancy through age five. Through community group sessions and home visits, it supports families in strengthening sensitive interactions and parenting practices. In this modality, each enrolled caregiver is required to attend a weekly three-hour group session with their child, alongside approximately 17 other caregivers and their children. These sessions are organized by age and stage: some for pregnant women, others for breastfeeding mothers with infants up to seven months old, and others for caregivers with older children up to two years of age. During the sessions, families receive refreshments and participate in playful, educational activities that support early development facilitated by an educational agent and a pedagogical assistant. In addition, each family receives one home visit per month. In 2024, a total of 847,902 children younger than five - caregiver dyads received *Modalidad Familiar* (Instituto Colombiano de Bienestar Familiar, 2025). We chose to integrate Apapacho within *Modalidad Familiar* due to its pre-established caregiver groups, regular weekly meetings, targeted population, and strong alignment with Apapacho's goals, all of which offer promising conditions for the program's sustainability and scalability.

To be included in the study, the UDS had to offer *Modalidad Familiar* and a minimum enrollment of 50 children. A total of 26 UDS in the study sites met the inclusion criteria, and the ICBF selected nine to be part of the study. Subsequently, the Government selected nine groups in seven UDS to receive Apapacho and nine groups in five UDS to receive the regular services provided by the ICBF. The Government's selection was motivated by practical considerations: UDS were chosen in localities with high rates of violence and without other active programs, in order to avoid overburdening staff and to prevent contamination that could bias the results. UDS were excluded if they did not offer Modalidad Familiar, had enrollment below 50 children, or were located in areas with ongoing programs that could overburden staff or create contamination risk. The inclusion criteria for parents included having a child under the age of five, participating in Modalidad Familiar in the selected UDS, and providing written consent. Exclusion criteria for parents were: having children older than five, not participating in Modalidad Familiar in the selected UDS, or not providing written consent.

The research team recruited the selected UDS in May through both in-person and virtual meetings. During the in-person meetings, the program was presented to UDS coordinators, educational agents, and pedagogical assistants. They were asked to assist in informing families about the project, support the collection of informed consents, and encourage parents to be attentive to the upcoming baseline survey call. In the follow-up virtual meetings, we introduced the Apapacho facilitator to each UDS team and discussed the coordination process to ensure smooth joint delivery of the sessions. There was no separate recruitment process for families, as the participant groups were already pre-established within the UDSs. We obtained participants' consent in July 2024.

Two members of the team conducted a 2-week training with four program facilitators to deliver the intervention in the selected UDS. The facilitators held degrees in early childhood education, social work, public relations, and social communication, and all had prior experience working with communities. They were not part of the existing Modalidad Familiar staff; they were hired specifically for Apapacho, trained by the Apapacho team and the national government technical team, and accompanied throughout program delivery. Before starting, facilitators visited a UDS to observe the Modalidad Familiar dynamics and attended initial meetings with the UDS teams to meet the staff with whom they would co-facilitate sessions. Facilitators were supervised by the Apapacho team through weekly group meetings to discuss accomplishments and challenges, as well as through session observations followed by individual feedback.

Apapacho was delivered between August and October 2024. Quantitative baseline data was collected in July and quantitative follow-up data and qualitative data collection took place in November 2024. Participants in the comparison group did not receive Apapacho sessions and continued to receive regular services under Modalidad Familiar.

Innovations for Poverty Action led the quantitative data collection, working with a team of 14 trained enumerators. Both baseline and follow-up data were collected via telephone. A total of 352 parents provided written consent to participate in the study. Each participant was contacted up to six times; those who did not answer or were unavailable were excluded from the study. In total, 267

caregivers completed the baseline survey, out of which 134 were in the Apapacho group and 133 in the comparison group, and 253 completed the follow-up survey, 128 in the Apapacho group and 125 in the comparison group (Table S1 shows that there are no major differences between the attritors and the analytic sample). Surveys were conducted in Spanish and lasted approximately 33 to 107 min. As compensation for their time, participants in both the Apapacho and comparison groups received supermarket vouchers valued at 10,000 COP (approximately USD 2.50) at baseline and 30,000 COP (approximately USD 7.50) at follow-up.

Table 1 presents descriptive statistics for the 267 caregivers. Almost all participants were female (99.3%), specifically the focal child mother (97.4%) and had a mean age of 28.9 years (SD = 6.8). More than half of participants had at least secondary education (64.4%), only 28.8% worked by the time of the survey, and on average had about 1.2 children under the age of five at home. Children were on average 13.7 months old (SD = 8.8), 100% lived with their mothers, and 74.8% also lived with their fathers in the home. Finally, there was variation in asset possession in the home: for example, 83% of participants had a living room in their home, 29% had a laptop, and only 6% owned an automobile.

Qualitative data was collected by three coauthors after the program implementation, and consisted of information from 12 caregivers who participated in two focus groups and 10 caregivers who completed individual interviews. Table S2 presents descriptive statistics for the qualitative sample; participants were 30 years old on average and about 60% had at least secondary education. The focus groups included participants from two UDS locations in San Cristóbal and Soacha, while interview participants were recruited from five different UDS centers across San Cristóbal, Mártires, and Soacha. Participants were invited to take part based on their availability and willingness to participate at the time of data collection. Recruitment was facilitated by program facilitators, who informed families about the opportunity. The research team then followed up to confirm participation. Focus groups were conducted in person and lasted two hours, while interviews were conducted by phone and lasted approximately 30 min. As incentives, focus group participants received a supermarket voucher valued at 10,000 COP (~USD 2.50) and a children's book. We first conducted focus groups and subsequently carried out individual interviews, continuing data collection until reaching thematic saturation, that is, when no new themes or insights emerged from the data.

2.2. Intervention

We developed Apapacho to be integrated into the services provided by the ICBF to parents of young children. Fig. 2 presents the program theory of change. Briefly, Apapacho was designed to be delivered through ICBF group meetings in approximately 2-h sessions held once a week for 11 weeks, with groups of about 17 caregivers. For this study, we integrated Apapacho into *Modalidad Familiar* community meetings, which typically last around three hours. Families participating in Apapacho were not asked to remain beyond the usual three-hour Modalidad Familiar session. Consequently, in addition to participating in Apapacho, attending families also receive other content and services provided by the national government, including a basic meal, often consisting of milk, a pastry, and a piece of fruit. Sessions were coordinated so that the UDS weekly topics were aligned with Apapacho's weekly themes, and activities were co-designed to ensure that the objectives and content of both programs were covered within the allotted time.

The Apapacho sessions included group discussions, demonstrations, role-playing, and reflection to promote caregiver outcomes in the short term, including (1) responsive caregiving and stimulation, including one-on-one time, (2) positive mental health and well-being, including self-regulation techniques, and (3) non-violent child discipline (see Table S3 for details on Apapacho's contents).

Table 1
Sociodemographic characteristics of quantitative study participants ($N = 267$).

	Mean	SD
Caregiver variables		
Sex (=1 if female) *(%)*	99.3	8.6
Age	28.9	6.8
Child relation: Mother *(%)*	97.4	16
Caregiver education (=1 if more than secondary) *(%)*	64.4	48
Caregiver currently works (=1) *(%)*	28.8	45.4
Number of children in the home	1.7	0.8
Number of children younger than five in the home	1.2	0.5
Child variables		
Sex (=1 if female) *(%)*	52.1	50.1
Age (in months)	13.7	8.8
Disability condition	0.8	8.7
Father lives in the same house (=1) *(%)*	74.8	43.5
Mother lives in the same house (=1) *(%)*	100	0
Household variables		
Number of people per room	1.96	0.758
House commodities *(%)*		
Living room	83.1	37.5
Motorbike	18.4	38.8
Bicycle	39.3	48.9
Automobile	6.4	24.5
Computer or laptop	29.2	45.6
Internet on phone or laptop	77.2	42.1
Wi-Fi	64.4	48

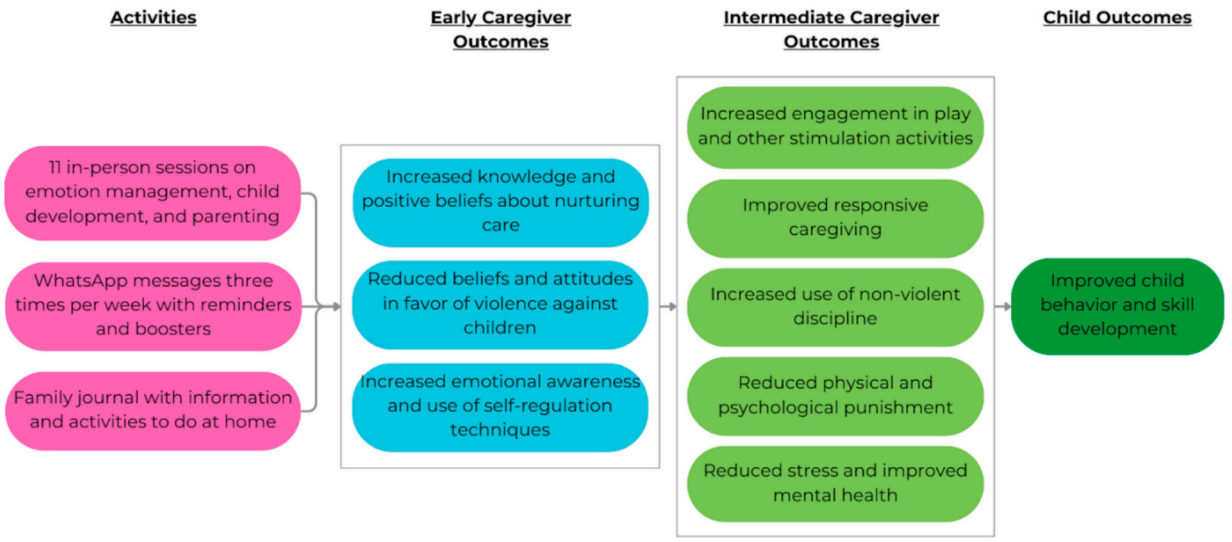

Fig. 2. Theory of change of Apapacho.

Apapacho also included three WhatsApp messages per week with reminders and booster information. Finally, each participant received the Bitácora Apapacho, a culturally informed family journal with information reinforcing the core content and activities to do at home (see Fig. 3). In our theory of change, we posited that early caregiver outcomes would translate into intermediate outcomes, such as increased engagement in stimulation activities, improved caregiving practices, greater use of non-violent discipline, reduced violence against children (VAC), and lower caregiver stress, which together would lead to longer-term improvements in child behavior and development (Fig. 2).

2.3. Measures

The program's theory of change guided the overall quantitative measurement approach. First, caregivers reported their level of agreement with 10 pre-piloted researcher-developed items assessing beliefs about the importance of nurturing parenting, using a 4-point Likert scale (1 = disagree; 2 = partially disagree; 3 = partially agree; 4 = agree). Example items included 'It is important to praise children' and 'It is important to help children manage their emotions.' This scale demonstrated adequate internal consistency ($\alpha = 0.72$). Second, caregivers' positive beliefs and attitudes regarding the instrumental value or perceived effectiveness of violence were assessed using the same Likert scale. Caregivers responded to two items: 'When a child is hit, they stop misbehaving' and 'Yelling at him/her makes him/her more obedient.' This scale showed adequate internal consistency ($\alpha = 0.82$).

Third, we measured caregivers' engagement in stimulation activities using the reported frequency (1 = never; 2 = a couple of days; 3 = most days, 4 = all days) with which mothers, fathers, and other adult caregivers engaged in eight learning activities during the previous week, including reading books or looking at pictures in books together, singing songs and playing any simple game together ($\alpha = 0.68$). Fourth, caregivers reported how often (1 = never; 2 = some days; 3 = most days, 4 = always) they or other adult caregivers used different discipline and punishment strategies, including physical punishment (3 items, e.g., 'gave the child a slap/spank with open hand'), psychological aggression (3 items, e.g., 'insulted the child, for example by calling them dumb or stupid'), and non-violent discipline (4 items, e.g., 'tried to distract the child with a game or object'). Fifth, caregivers' mental health and stress were assessed using an adapted version of the CES-D-10 ($\alpha = 0.75$), which excluded one item not approved by ICBF, and the 18-item Parental Stress Scale (Berry & Jones, 1995; $\alpha = 0.75$).

Finally, we collected additional sociodemographic data, including children's age in months and sex, parents' education level, whether the parent works, number of children younger than five, the number of rooms to sleep and household members, and asset possession (e.g., bicycle, laptop, and access to the internet in their homes), which we used to compute a household wealth index (Filmer & Pritchett, 2001). We calculated sum scores for all scales and indices and standardized them to have a mean of zero and a standard deviation of one to facilitate interpretation of the estimates.

In addition to collecting quantitative data, we conducted qualitative focus groups and interviews using a semi-structured guide designed to explore participants' overall experience with the program. The guide included open-ended questions to facilitate discussion, while allowing for follow-up prompts based on participants' responses. Each session began with an introductory segment that included informed consent and questions about participant characteristics. This was followed by questions addressing perceptions of the program's content (e.g., "What did you like the most about Apapacho?"), implementation (e.g., "How would you describe your relationship with the facilitator?"), use of specific tools and strategies (e.g., "How did you use the Bitácora Apapacho?" or "Can you give me examples of activities you do during Tiempo Apapacho?") and perceived impact (e.g., "How do you feel your relationship with your child has changed after participating in Apapacho?" and "What have you learned about your child as a result of the program?").

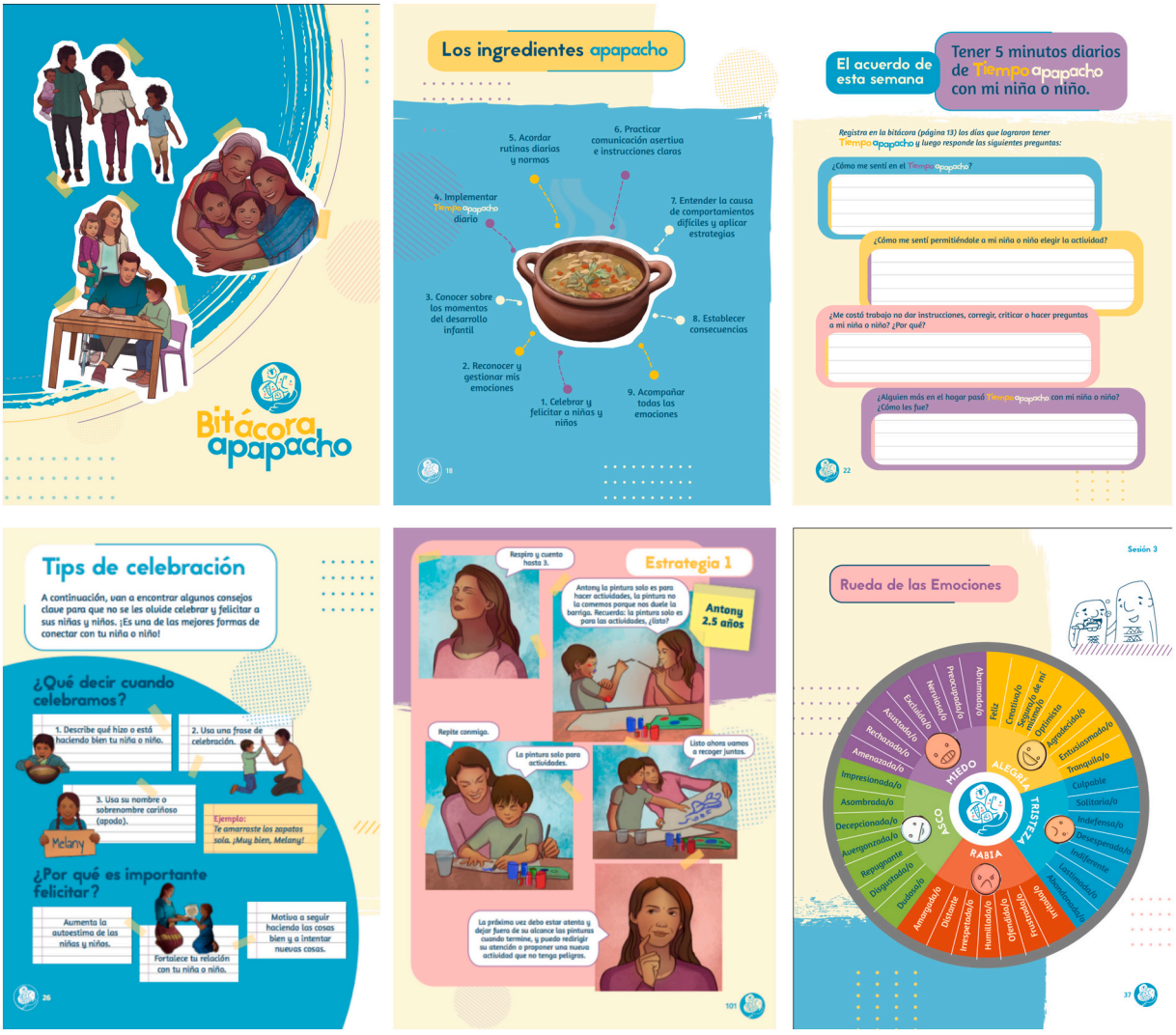

Fig. 3. Examples of the content from the *Bitácora Apapacho* (Family Journal)
Note. Images taken from Cuartas, Beccassino, Borbón, et al. (2024).

Sessions concluded with an open invitation for participants to share any additional reflections or suggestions for improvement. For illustrative purposes, Table S4 presents selected questions from the semi-structured guide.

2.4. Analysis

We found a relatively adequate balance in observed characteristics between the group of caregivers who received Apapacho and the comparison group, despite the non-random selection (see Table S5). However, there may still be systematic differences in unobserved factors that could lead to selection bias. Therefore, we employed the difference-in-differences (DiD) approach specified in Eq. (1) to analyze the quantitative data, which estimates the average effect of Apapacho by comparing changes in outcomes over time between the Apapacho and comparison groups. In the model, Y_i denotes the outcome variable for individual *i*; $Time_i$ is a binary indicator equal to 0 at baseline and 1 at follow-up; and $Apapacho_i$ is a binary indicator equal to 1 if the individual is in the treatment group and 0 otherwise. The interaction term $Time_i{*}Apapacho_i$ captures the differential change in outcomes over time between the Apapacho and comparison groups. The coefficient β_3 on this interaction term is the primary estimate of interest and reflects the estimated effect of Apapacho on caregiver outcomes.

$$Y_i = \beta_0 + \beta_1 Time_i + \beta_2 Apapacho_i + \beta_3 Time_i{*}Apapacho_i + \epsilon_i \quad (1)$$

The DiD approach accounts for time-invariant pre-existing differences between groups, thereby controlling for unobserved confounders that are constant over time and helping to mitigate selection bias (Angrist & Pischke, 2011). The coefficient of interest, β_3, can

be interpreted as a causal effect under the parallel trends assumption, which requires that, in the absence of treatment (i.e., Apapacho), outcomes in the two groups would have evolved similarly over time. However, because pre-baseline outcome data are unavailable, we are unable to empirically assess whether this assumption holds, and results should therefore be interpreted with appropriate caution. Since the method already adjusts for all time-invariant characteristics, we included only one additional covariate in the model: the household wealth index, which was the only relevant time-varying variable. Missing data were addressed using multiple imputations by chained equations (Royston & White, 2011), generating 100 imputed datasets. All models were estimated with clustered standard errors to account for the nesting of families within service units. Quantitative analyses were conducted using Stata/SE 18.5.

Regarding the qualitative data, all interviews and focus groups were audio-recorded and transcribed verbatim, with identifying information removed to protect participant confidentiality. Data was analyzed manually in NVivo using thematic analysis with an inductive-deductive approach (Braun & Clarke, 2006). The coding process was conducted collaboratively between three coauthors following guidelines proposed by Richards and Hemphill (2017) to ensure analytical consistency. Specifically, the team met initially to clarify the research questions and individually coded three transcripts to develop a preliminary codebook. This codebook was refined through a pilot test on three additional transcripts and subsequently used for the final coding of all data.

2.5. Authors' positionality

Our research team comprises Colombian researchers representing diverse personal, disciplinary, and professional backgrounds, including economics, psychology, public health, and education, and working across academic institutions, NGOs, and the public sector. We bring a range of identities, experiences, and epistemological orientations to this study. Several team members have direct practice experience with children and families affected by abuse and neglect, while others contribute methodological expertise in qualitative and mixed-methods research. We recognize that our positionalities shape the questions we ask, how we interpret data, and how we engage with participants and communities. Accordingly, we were committed to reflexivity, transparency, and ethical engagement throughout the research process.

3. Results

We assessed uptake as the number of sessions attended by the 134 participants in the Apapacho intervention group for whom follow-up data were available. Mean attendance was 6.1 sessions (SD = 3.3), corresponding to an average attendance rate of 55.4%, calculated based on the number of individuals enrolled specifically in Apapacho (not all *Modalidad Familiar* participants within each UDS). Twelve participants (9%) did not attend any sessions, and ninety-five participants (70.9%) attended five or more sessions (see Fig. S2). Although attendance at the weekly sessions in *Modalidad Familiar* was theoretically mandatory, in practice this was not always enforced. In some UDS, families who missed their scheduled group session were allowed to attend a different session at another time, often one in which Apapacho was not being implemented.

Moreover, the person attending was not always the caregiver enrolled initially in the study; in some cases, another family member attended in their place. Attendance records systematically captured only the participation of caregivers enrolled and surveyed at baseline. Replacement caregivers were not surveyed and, in most sessions, their attendance was not consistently recorded. Substitution was identified only in instances where additional attendees were listed and later matched to enrolled children, revealing at least 16 cases of caregiver replacement. Importantly, attendance counts reflect only sessions attended by the originally enrolled caregiver; sessions attended exclusively by replacement caregivers were not coded as attendance for the enrolled participant.

In what follows, we present results organized around the three key caregiver-related themes outlined in the theory of change, i.e.,

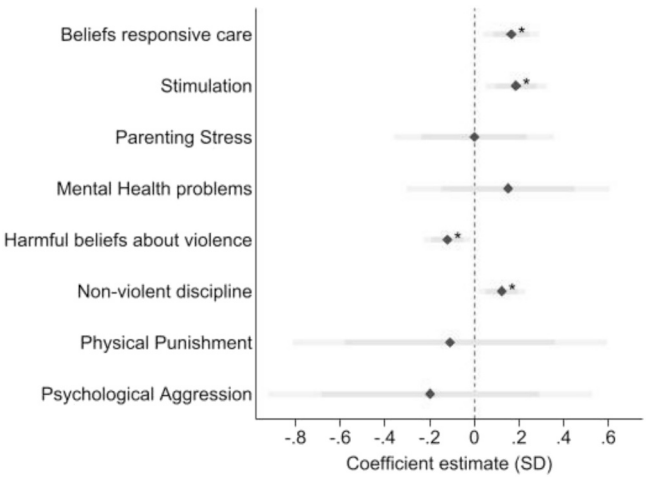

Fig. 4. Results from the difference-in-differences approach.
Note. Results from linear regression models using a difference-in-differences approach. Table S6 presents the full results.

(1) responsive caregiving and stimulation, (2) mental health and wellbeing, and (3) child discipline. Fig. 4 summarizes the main results from the quantitative DiD analysis (see Table S6 for further details) and Supplemental Table S7. presents the themes, codes, and representative quotes that emerged from the qualitative data.

3.1. Responsive caregiving and stimulation

The quantitative results indicated that participation in Apapacho was associated with improvements in caregivers' beliefs about responsive caregiving by 0.17 *SD* ($SE = 0.02; p = .03$) and improvements in their engagement in early stimulation activities by 0.19 *SD* ($SE = 0.03; p = .03$). Four codes that emerged from the qualitative data support the idea that participation in Apapacho enhanced responsive caregiving and stimulation. First, parents frequently expressed that the program helped them understand their children better, through greater knowledge about child development and children's emotional experiences. For example, one parent mentioned: "*More than anything, it's about the children's cues, and how they grow and change—really, everything changes. As they grow, they want to do things, to be independent. You can help them, but still need to watch over them*" (Caregiver #4). Second, some parents expressed more emotionally responsive parenting behaviors after participating in Apapacho, including more warmth, expressions of affection, and more opportunities for children to explore their interests. For example: "*Offering love throughout the day, understanding, good companionship—that's the main goal, isn't it? To provide companionship to the baby so they can experience freely, because they're in a growth process*" (Caregiver #2).

Third, parents frequently expressed that they are spending more quality time with their children, including one-on-one time, promoted in the program as *Tiempo Apapacho* (i.e., "Apapacho Time"), as well as engaging in the shared activities proposed in the *Bitácora*:

> "*During Apapacho Time I leave my cell phone aside, if I have something, I do it and then I really take the time to be with my baby, we have toys in the house, I tell her, let's play, we both sit down, she goes out with her things […] I share with her and go along with her, I don't tell her this is not so, this is not so, this is not so, I say, because she can explore…*" (Caregiver #6).

Another caregiver also expressed that she is also trying to spend more quality time with her child:

> "*To connect with him, because when I work, sometimes I leave him alone, in the play area he can play by himself and I think he is happy when I share that time with him, when I show him love, company, sharing*" (Caregiver #5).

Finally, some parents perceive that their relationship with their children improved after participating in Apapacho. For example, one parent mentioned: "*It's like Apapacho brought us closer to our children, like giving them our time too—time and space…*" (Caregiver #15).

3.2. Mental health and well-being

The quantitative data showed no statistically significant associations between participation in Apapacho and caregivers' mental health ($\beta = 0.15; SE = 0.10; p = .26$) or parenting stress ($\beta = -0.00; SE = 0.08; p = .99$) in the short-term. Despite these results, three emerging codes from the qualitative data suggest that parents often perceived improvements in their self-awareness and emotional self-regulation following their participation in Apapacho, including recognizing and managing their emotions, as well as praising themselves as parents. For example, one parents shared the following:

> "*I feel that it has changed because before I didn't, I mean, no, I wasn't aware of many things, right? specifically, I keep emphasizing that my emotions don't have to hurt her, my capacity as an adult should lend itself to be patient, to provide her with stability, so since I was in the program and I knew all this, now when I suddenly entered a crisis point, ee I try to be distant, […] and I feel that it has been something to make her a happier child, I have seen her more responsive, more free*" (Caregiver #2).

Another caregiver shared the way Apapacho helped her recognize her own efforts as a parent:

> "*That cheerful way of explaining things to us moms, of helping us see, of making us realize what we're doing wrong, what we're doing right—that we should celebrate our own efforts too. It's not just about celebrating our children, but ourselves as well*" (Caregiver #3).

Moreover, participants shared that the program helped them strengthen their support networks, both by forming new relationships within the program and by reinforcing existing ties with friends and family, which, in turn, contributed positively to their mental health and overall well-being. For example:

> "*You have a different space where you can share with other mothers and the truth is that it is like a support network because I have learned a lot there from all of them, they give you advice if the child is sick, if there is a situation that is happening, Let's say that I am a person who likes to tell them and they all try to give their opinion and so on, and let's say that you get the best out of the advice they give you, but I have really liked this support network to interact, as I said, to ask for advice because sometimes as a mother you are overwhelmed by the day to day and I love being there, it is a different space from the daily life*" (Caregiver #11).

3.3. Child discipline and routines

Participation in Apapacho was associated with reductions in positive attitudes toward violence by 0.12 *SD* ($SE = 0.02.; p = .03$) and increases in parents' use of non-violent disciplinary approaches by 0.12 *SD* ($SE = 0.02; p = .04$). While the estimates were in the expected direction, we did not observe statistically significant association between participation in Apapacho and the use of physical punishment ($\beta = -0.11; SE = 0.16; p = .56$) or psychological aggression ($\beta = -0.20; SE = 0.16; p = .35$). The qualitative data confirmed that some parents changed their beliefs about violence. For example, one parent mentioned: "*Because we are in a process of understanding that violence does not have to be part of the upbringing of our children nowadays, because we come from different times because we were punished even in violent ways*" (Caregiver #2).

Similarly, five additional codes that emerged from the data indicated an increase in parents' use of non-violent discipline techniques. First, some parents noted that they are praising the behaviors they want to encourage more frequently. Second, some parents expressed they are trying to communicate more clearly to explain children why certain behaviors are wrong instead of relying on physical punishment, for example: "*There I learned, let's say, how to talk to them, how not to hit them, especially when they are so small, so I know how to express to them when they are doing things wrong*" (Caregiver #15).

Third, parents are making greater efforts to co-regulate emotions with their children, including practicing breathing techniques and avoiding reactive responses to misbehavior. They are also teaching children skills to regulate their own emotions, which, according to one parent, has led her daughter to be "*more responsive, more free*" (Caregiver #2). Fourth, several parents shared that they are putting more effort into establishing household routines. Finally, some parents noted that they are trying to redirect their children's behaviors as a disciplinary strategy to avoid using violent punishment. For example, one parent stated:

> "*So it is more feasible to give her something else, to attract her attention to something else that she can manipulate, for example, she is bothering... she is climbing on a chair, right? She is in danger of falling, so how to show her something else, how to show her the ball, to play with the ball, you are giving her the distraction with the ball that she can manipulate and I am not giving her the order of no such thing, don't get on there*" (Caregiver #1).

4. Discussion

This mixed-methods study assessed the short-term outcomes of Apapacho, a violence prevention parenting program developed through a research–practice partnership in response to policy initiatives in Colombia (Gobierno de Colombia, 2021). Findings suggest that the program was associated with positive changes in responsive caregiving and stimulation, caregiver mental health and well-being, and child discipline practices one month after program completion. Strong consistency between quantitative and qualitative data enhances the robustness of the results and adds depth and nuance. These findings are especially relevant given the high prevalence of physical punishment and other forms of VAC in Colombia (Trujillo et al., 2020) and the well-documented risks such violence poses to children's health and development (Cuartas et al., 2025).

We found evidence that participation in Apapacho was associated with improvements in responsive caregiving and early stimulation, including positive changes in caregivers' beliefs about responsive caregiving (ES = 0.17) and increases in their reported engagement in stimulation activities with their children (ES = 0.19). Parents also reported that the program helped them better understand their children, engage in more emotionally responsive parenting, spend more quality time together, and strengthen their relationships. These findings are consistent with Apapacho's theory of change and reflect the program's targeted content, including *Tiempo Apapacho*, which encouraged caregivers to spend at least five minutes each day following their child's lead, as well as the first five sessions, which focused on understanding children, promoting stimulation strategies, and strengthening the caregiver–child relationship. The effect sizes observed are in line with those reported in similar parenting interventions, including a comparable program in Jamaica that, in a randomized trial, demonstrated improvements in caregiver stimulation practices (ES = 0.30; 95% CI: 0.03, 0.57) following eight 90-min sessions (Francis & Baker-Henningham, 2021).

Aligned with the short-term outcomes in the theory of change, we found some evidence that the program may support caregivers in developing emotional awareness and self-regulation. Parents reported that Apapacho helped them better recognize and manage their emotions, appreciate their strengths as parents, and strengthen support networks – factors they linked to improved mental health (Bornstein, 2015). However, the quantitative data showed no measurable effects on mental health or parenting stress one month after program completion, both considered more distal outcomes. These effects may require more time to emerge as caregivers continue applying the strategies learned. Alternatively, families in low-income, high-violence neighborhoods may need more intensive, trauma-informed interventions to address mental health challenges shaped by structural barriers. A recent systematic review (Backhaus et al., 2024) found that parenting programs with mental health impacts in humanitarian settings often used such approaches. This suggests the theory of change may need to be revised if improving caregiver mental health is a central goal in this context.

We found convergent quantitative and qualitative evidence that participation in Apapacho was associated with reductions in caregivers' positive attitudes toward violence (ES = 0.12) and increases in the use of non-violent discipline strategies (ES = 0.12). Caregivers reported adopting several approaches promoted by the program, including praising desired behaviors, giving clear instructions, establishing routines, and helping children manage their emotions. Although quantitative analyses also indicated reductions in physical punishment and psychological aggression, these effects did not reach statistical significance, likely reflecting imprecise estimates. Such imprecision may partly result from measurement error, as prior qualitative research suggests that families receiving services from ICBF may be reluctant to disclose physical punishment due to distrust of government institutions and concerns about legal consequences or loss of custody (Cuartas, Beccassino, Baker-Henningham, et al., 2024). These concerns may be further

amplified by Colombia's recent legal ban on physical punishment, which, despite its educational intent, may increase social desirability bias and attenuate estimated effects toward the null. This limitation is not unique to the present study but reflects broader challenges in measuring violence against children in intervention research (Backhaus et al., 2022; Bhatia et al., 2024). An alternative explanation is that longer follow-up periods may be required to detect behavioral changes in physical punishment and psychological aggression, as shifts in attitudes toward violence may reasonably precede observable changes in parenting behavior.

Apapacho showed promising effects in this evaluation and was developed through a research-practice partnership involving policymakers and ICBF staff, with the goal of integration into Colombia's national services. Delivered during sessions already attended by parents, it imposes no additional time or transportation costs on families. The program is open-access, relies on simple materials (e.g., printed handouts, paper, markers, WhatsApp messages), and can be implemented by paraprofessionals. This stands in contrast to many proprietary, resource-intensive programs developed in high-income countries that require costly training, fees, and complex materials, factors that limit their scalability in Colombia and other LMICs. Apapacho was grounded in extensive formative research to ensure cultural relevance and acceptability. Similar low-cost, locally adapted programs in Jamaica (Francis & Baker-Henningham, 2021) and South Africa (Lachman et al., 2017) have shown positive impacts on reducing VAC and promoting positive parenting. Collectively, these findings highlight the potential of embedding culturally grounded, low-resource, open-access programs within existing service structures to achieve positive outcomes for caregivers at scale.

This study has several strengths, including its rich mixed-methods approach, strong research-practice partnership, and policy relevance in Colombia. However, it also has limitations that inform future research. First, the quantitative component was quasi-experimental, and the parallel trends assumption underlying the difference-in-differences analysis could not be tested due to the lack of pre-baseline data. As a result, unobserved time-varying confounders may bias the results, highlighting the need for further evaluation through a randomized controlled trial. Second, outcomes were assessed only one month after program completion, limiting insights into medium- and long-term effects, which is particularly important given evidence of fade-out in similar interventions (Backhaus et al., 2023). Third, the study was conducted with a relatively small sample in urban settings, limiting generalizability; future research should examine the program's effectiveness across diverse regions and populations in Colombia, including indigenous and Afro-Colombian communities, and other LMICs. Fourth, the recruitment strategy for focus groups and interviews may introduce selection bias, as participants who were available, more engaged with the program, or motivated by compensation may be over-represented. Therefore, qualitative findings should be interpreted as illustrative rather than representative of all enrolled families. Finally, all outcomes were parent-reported, primarily by mothers, which may introduce social desirability bias and measurement error, particularly in contexts such as Colombia where physical punishment is legally prohibited. Future evaluations would benefit from multi-informant, multi-method approaches that include naturalistic observations and reports from other caregivers, such as fathers and grandparents.

The study also presents limitations related to the implementation of Apapacho. The average attendance rate was 55.4%, which is lower than that reported in similar programs in Jamaica (69% across eight sessions; Francis & Baker-Henningham, 2021) and South Africa (75% across 12 sessions; Lachman et al., 2017). As noted earlier, some parents who missed their scheduled group sessions attended alternative *Modalidad Familiar* sessions not delivering Apapacho, and in some cases, a different family member attended in place of the enrolled caregiver. This reflects the prevalence of extended family care networks in Colombia (DANE, 2023). Caregivers who participated in post-implementation interviews and focus groups reported several logistical and contextual barriers to attendance at Apapacho, including long travel distances, high transportation costs, competing work responsibilities, children's illness, and other family emergencies. Facilitators also reported that unforeseen events, such as transportation strikes and weather disruptions like heavy rains, negatively impacted attendance.

Another implementation-related limitation is that we did not systematically track caregiver substitutions or contextual disruptions during program delivery. Although caregiver substitutions were observed, our empirical strategy relies on assignment to Apapacho rather than individual session attendance, therefore substitutions do not result in treatment misclassification and do not bias the difference-in-differences estimator. Instead, they introduce heterogeneity in treatment intensity within the treated group. In cases where replacement caregivers attended sessions, information may have been transmitted within households to the originally enrolled caregiver, generating indirect exposure; however, we lack data to empirically test this possibility. Relatedly, contamination across treatment and comparison groups is unlikely, as assignment occurred at the UDS level, no UDS included both groups, and UDS operated independently with distinct coordinating organizations and implementation teams. In addition, UDS were located in different neighborhoods, reducing the likelihood of spillovers or information sharing across groups.

Data on attendance patterns, caregiver substitutions, and preliminary qualitative evidence on barriers to participation point to important directions for future research and program adaptation. Digital tools, such as WhatsApp groups or chatbots, may offer promising options for maintaining engagement when in-person attendance is not feasible (Schafer et al., 2023). Moreover, because most participants were mothers, future implementation efforts should place greater emphasis on engaging fathers and other male caregivers, given evidence that father involvement can amplify the impacts of parenting programs (Bacchus et al., 2024). Finally, future iterations of Apapacho should incorporate a cost-effectiveness analysis to assess the value of digital delivery components and benchmark the program against comparable parenting interventions implemented in other contexts.

In conclusion, Apapacho shows promise as a violence prevention program designed for implementation within Colombia's existing service infrastructure. In light of national policy goals and commitments to reduce all forms of VAC by 2030 (Gobierno de Colombia, 2021), there is a clear need to continue optimizing and scaling Apapacho and other parenting support programs to enable their institutionalization. Moving forward, research–practice partnerships should prioritize strengthening program effectiveness and implementation quality, examining how digital tools can complement in-person delivery, and developing targeted strategies to more actively engage fathers and other male caregivers. In addition, future scaling efforts could be facilitated by leveraging existing

personnel, such as educational agents who co-facilitated sessions with Apapacho facilitators, rather than relying exclusively on the recruitment of entirely new staff. Ensuring stable and sustained financing through national budgets will also be essential to support the scale-up of parenting support programs in Colombia and other LMICs.

CRediT authorship contribution statement

Jorge Cuartas: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Juliana Borbón:** Writing – review & editing, Visualization, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Luciana Beccassino:** Writing – review & editing, Software, Methodology, Investigation, Formal analysis, Data curation. **Isabella García:** Writing – review & editing, Methodology, Formal analysis, Data curation. **Catalina Rey-Guerra:** Writing – review & editing, Validation, Supervision, Resources, Project administration. **Melissa Guerra:** Writing – review & editing, Software, Formal analysis. **Geraldine Moreno:** Writing – review & editing, Supervision, Project administration, Methodology. **Maria Cristina Agudo:** Writing – review & editing, Supervision, Project administration. **Mateo Valderrama:** Writing – review & editing, Validation, Methodology. **Daniela Trujillo:** Writing – review & editing, Methodology, Data curation. **Oscar Iván Pineda Díaz:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.chiabu.2026.107951.

Data availability

Data will be made available on request.

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