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ORIGINAL ARTICLE

Local Adaptations to Implement the Strengthening Families Program in Northeastern Brazil

Jordana Calil Lopes de Menezes[1] · Larissa de Almeida Nobre-Sandoval[1] · Sheila Giardini Murta[1]

Abstract
Local adaptations can promote user engagement and sustainability in the preventive program. The objective of this study is to evaluate local adaptations of the Strengthening Families Program (SFP) (10-14) for Brazilian families. Data were collected from semi-structured interviews of 42 facilitators who implemented the program. The directed content analysis was the analysis method used. The findings revealed that most facilitators did not make any additions (83.3%), while 50% reported discarding activities, largely due to the lack of time (31.6%). Adaptations were made by 73.2% of the interviewees, which most commonly (32%) addressed examples and linguistic features. Suggestions were made by 58.94% of the interviewees and focused on improving the support systems and delivery of the intervention, as well as the intervention itself to customize it to the socioeconomic and educational conditions of the target group. It was concluded that adaptations to the SFP (10-14) materials and procedures, and improvements in political support and organizational capacity are needed for its implementation.

Keywords Cultural adaptation · Family-based prevention · Misuse of drugs · Universal prevention · Adolescent substance use

Background

The family environment can simultaneously pose risks and provide protection to adolescent development and health. A study of 229 Brazilian adolescents from the state of Rio Grande do

✉ Sheila Giardini Murta
giardini@unb.br

Jordana Calil Lopes de Menezes
jordanacalil@gmail.com

Larissa de Almeida Nobre-Sandoval
nobre.lan@gmail.com

[1] Departamento de Psicologia Clínica, Instituto de Psicologia, Universidade de Brasília, Campus Darcy Ribeiro, Brasília, DF 70910-900, Brazil

Sul that examined the trajectory of adolescents undergoing treatment for drug-related problems found that the majority of them were exposed to intrafamily violence and had relatives who abused drugs (Bittencourt et al. 2015), among other factors. In contrast, findings from other Brazilian studies identified that receiving emotional support and supervision from the family (Benchaya et al. 2011; Dietz et al. 2011; Malta et al. 2018), having at least one meal a week with parents, having parents that demonstrate interest in the child's life, and living with parents (Malta et al. 2018) constitute protective factors against drug abuse in adolescence.

This data suggest that the family is a good target for programs designed to reduce adolescent health risks and problems (Pedersen et al. 2019). In addition to the family, other environments such as school, community, and social areas also require promotion actions. With this in mind, in 2013, the Coordination for Mental Health, Alcohol and Other Drugs from the Ministry of Health of Brazil adopted the Strengthening Families Program (SFP), a family-based preventive intervention developed in the 1980s by Kumpfer and collaborators (Kumpfer et al. 1996) in the USA. Brazil adopted the version adapted for the UK, the Strengthening Families Program (10-14) UK (Coombes et al. 2012). In Brazil's case, the absence of effective nationally developed programs for drug use prevention (Abreu and Murta 2016; Abreu et al. 2016) made investment in prevention even more urgent and opened the door for adopting an international program. The target group was socioeconomically vulnerable and used the basic social protection services of Brazil's Unified Social Assistance System.

Cultural, educational, economic, and social differences between families from the UK versus Brazil meant the cultural adaptation of the SFP (10-14) was mandatory, as it generally occurs when prevention programs are transferred to new contexts (Chu and Leino 2017; Wang and Lam 2017). The objective of this article is to examine the local adaptations of the Strengthening Families Program (10-14) in Brazil, which are performed to adjust the intervention to the needs of the families and contextual peculiarities.

Cultural Adaptation of Programs for the Prevention of Health Risks and Problems

The awareness of the transportability of health risk and harm prevention programs has grown worldwide (Gardner et al. 2016). Due to the accumulated knowledge over decades of research targeting the development, implementation, and evaluation of preventive programs, several world institutions, including the United Nations (UN), Blueprints for Healthy Youth Development, and Collaborative for Academic, Social, and Emotional Learning (CASEL), made available portfolios of evidence-based interventions that can be imported by other countries for mental health and drug abuse prevention. Of those, a large number was designed for the child and adolescent population, which aim to strengthen parental protective factors (Israelashvili 2019; Gardner et al. 2016) and family protective factors (Newton et al. 2017; Van Ryzin et al. 2016). Low- and middle-income countries are among the targets of those programs (Maalouf and Campello 2014; Mejía et al. 2019), which are commonly developed and evaluated in the northern hemisphere.

The dissemination of evidence-based interventions to contexts that are very different from the original, culturally as well as socially and economically, involves issues related to the cultural adaptation and fidelity to the original intervention. Cultural adaptation can be defined as systematic alterations to language, culture, and context of the interventions in order to make them more compatible with the standards, meanings, and values of the target group (Barrera Jr et al. 2016). The fidelity of an intervention represents the degree to which an intervention is

implemented according to the developer's specifications, thus guaranteeing the transmission of the program's core components, which are connected to its effectiveness (Segrott et al. 2014).

When an intervention is applied to real environments, away from the lab environment control, modifications inevitably (Moore et al. 2013) respond to the demands of the local context due to political, socioeconomic, sociocultural, epidemiological, geographical, ethical, and/or legal specificities (Pfandenhauer et al. 2017). Studies have shown that both adaptation and fidelity are important and complement one another in the implementation process. The challenge is to find the balance between what must be kept and what can be modified (Mejia et al. 2016). Furthermore, a sensitive, locally and culturally adapted intervention receives greater adherence from the participants when those people identify with the intervention and feel that their needs were met (Barrera Jr et al. 2016; Roulette et al. 2017). Thus, it is important that the adaptation process be systematized, that the changes be detailed and evidence-based, and that the core components be maintained throughout this process (Baumann et al. 2015).

The evaluation of the implemented and adapted intervention is as important as the systematized planning of the adaptation process, and the former aims to verify how much of what was planned is in fact being applied, in addition to identifying possible adaptations still to be made (Gottfredson et al. 2015). The adaptations made during the execution of the program by the people who applied it are called local adaptations. Local adaptations are modifications to the intervention during its implementation; they can adjust the intervention or can be a consequence of contextual events (Barrera Jr et al. 2016). Adaptations of this type can provide clues regarding the limitations in executing an intervention, as well as indicate ways to improve their effectiveness or their suitability to local culture. Thus, the occurrence of local adaptations should be monitored by evaluating the intervention implementation process (Mejia et al. 2016).

Coding systems were developed to verify the occurrence of adaptations during the intervention implementation process (Stirman et al. 2013; Moore et al. 2013; Hill et al. 2007). The coding system developed by Stirman et al. (2013) classifies the types of modifications the intervention undergoes during its implementation process, in order to guide studies regarding the impact of these modifications. The classification is based on who was responsible for the modifications; what has been modified in relation to the content, context, training, and evaluation; in what context the modifications occurred; and the nature of the changes made.

The coding system by Moore et al. (2013) evaluates the adaptations in three dimensions: adjustment, time, and valence or alignment. Adjustment is related to the motive that led to the change, which can be philosophical or logistical. Changes are due to philosophical reasons that occur when theoretical or conceptual aspects of the intervention are contrary to the beliefs and conceptions of the one who applies it. Changes due to logistical reasons involve alterations due to the lack of resources, i.e., contextual issues. Time covers whether the change occurred in a reactive manner, without planning, during the intervention, or in a proactive manner, planned, considered before the implementation. Alignment or valence represents whether the alteration was related to the objectives of the program's theory in a positive manner, or in a negative manner, going against the theoretical assumptions and the program's objectives, or neutral, being neither in agreement nor in disagreement with the objectives and theories in which the program is based on (Moore et al. 2013).

The coding system of Hill et al. (2007) aims to verify the types of adaptations (additions, deletions, and modifications) and the most common reason for changes in intervention during implementation. This system has been developed specifically to evaluate the adaptations and fidelity of implementations of the Strengthening Families Program (10-14) in Washington, DC

(Molgaard, Spoth, & Redmond 2000). The SFP (10-14) is a program based on the social ecological model, social learning theory, systems theory, and family resilience, which has the participation of both parents (or legal guardians), and children and adolescents (10 to 14 years old). The purpose of the SFP (10-14) is to develop family protective factors, including family values, healthy communication, rules and limits, admiration for family members, playing together, and problem-solving skills. Additionally, friendship quality, assertiveness in the face of peer pressure, and future time perspectives are protective factors promoted in the meetings with the adolescents (Kumpfer and Magalhães 2018).

The SFP (10-14) has been adapted in almost two dozen countries (Menezes and Murta 2019). In Europe, these include the UK (Allen et al. 2006), Ireland, Italy, Poland, Germany, Greece, Netherlands, Spain (Orte-Socias & Amer-Fernández 2014), and Sweden (Skärstrand et al. 2008). In Latin America, it has been culturally adapted in Honduras (Vasquez et al., 2010), Costa Rica, El Salvador, Peru (Ortega et al. 2012), Chile (Corea, Zubarew, Valenzuela, & Salas 2012), Bolivia, Colombia, and Ecuador (Orpinas et al. 2014).

In Brazil, the Strengthening Families Program (10-14) was called Programa Famílias Fortes after an initial study to investigate the need for cultural adaptation (Murta et al. 2018) that was the basis for adjustments to its superficial structure made by a work team from the Ministry of Health between 2014 and 2015 (Brasil. Ministério da Saúde. Secretaria de Atenção a Saúde. Departamento de Ações Programáticas Estratégicas 2017). The SFP (10-14) was disseminated in all Brazilian regions until 2016 (Miranda, 2016), reaching 12 states. In 2015, a study was initiated to evaluate the effectiveness, social validity, and implementation quality of the SFP (10-14). Among the implementation quality indicators selected for analysis, cultural adaptation was chosen.

Therefore, the present study is a part of this larger study and is specifically aimed to describe local adaptations to the implementation of the intervention, the reasons for possible alterations during its application, and the need for new adjustments according to the facilitators of the intervention. This study was guided by the following research questions: What types of local adaptations were made? What were the reasons for these adaptations? Keeping in mind the continuous nature of cultural adaptation, what recommendations were identified for future adaptation of the SFP (10-14) for Brazilian families?

Method

Design

As the focal interest was to understand the nature and context of the local adaptations to SFP (10-14), the methodological approach was that of a qualitative study. Content analysis (Bengtsson 2016) was selected to examine how the intervention facilitators perceived the local adaptations undertaken, what and why it was adapted, and which new adaptations should be made. Furthermore, investigating the magnitude of the adaptations was considered relevant to this study, which is why the content analysis approach was chosen.

Participants

Forty-two SFP (10-14) facilitators participated in the interviews between November 2016 and January 2017. Recruitment occurred by convenience, and all the professionals who delivered

the program in the states of Ceará (CE), Rio Grande do Norte (RN), and Sergipe (SE) whose telephone contact information was available were chosen. Twenty-eight interviews occurred in Ceará, ten in Rio Grande do Norte, and four in Sergipe. The interviews were completed approximately 1 year after the implementation of the SFP (10-14). Of the 42 people interviewed, only three were male; all of them had degrees in social sciences or health care and were members and high school staffs of Social Assistance Reference Centers (SARC), services that are part of the of basic social protection for assisting socially vulnerable families.

Instrument

The interview used was adapted from Hill et al. (2007) and conducted by telephone. The script contained seven open-ended questions about the program's adaptation during its application. The questions were intended to verify the facilitators' opinions about the SFP (10-14), additions, deletions, and adaptations for the Program. This section consisted of the following questions: (1) "What is your opinion about the Strengthening Families Program?" (2) "How did you feel while facilitating the SFP meetings?" (3) "There were facilitators who reported having added content or activity to the program. In your experience, did you include any unplanned content or activity? (4) "Some facilitators said it was necessary to remove content from the program or that it was not possible to perform some of the activities. In your experience, did you remove any content or activity? Can you give examples? Did something happen to cause this content to be removed?" (5) "Besides adding or removing themes or activities, in some places it was necessary to make other adaptations to the SFP to better assist the families and adolescents. Did you perform other changes other than adding or removing activities or themes? What motivated these changes?" (6) "Of all the adaptations you had to do in the application of SFP, which one was the most notable to you?" (7) "Were there adaptations that you did not do, but you thought you needed to?"

Strengthening Families Program

The present study was conducted in the states of Ceará (CE), Rio Grande do Norte (RN), and Sergipe (SE), in the northeast of the country where its implementation was managed by Fundação Oswaldo Cruz and conducted locally in an intersectoral mode involving different sectors of the local public agencies, such as those related to social assistance, education, and health (RN, CE, and SE) and drugs (CE). The facilitators were professionals paid by these services associated to local governments.

The SFP (10-14) was offered in seven weekly meetings, followed by four booster meetings, conducted between 3 and 12 months after the last weekly meeting. Just as planned in its original version, the meetings lasted for 2 h: in the first hour, the parents/guardians and the adolescents between 10 and 14 years of age met separately and during the second hour, were together in family sessions. Two facilitators conducted the adolescent sessions while one conducted the parent sessions, and then, all three facilitators conducted the family sessions. The materials used in the execution of the SFP included a guidebook for the facilitators and an activity notebook for parents, adolescents, and children. Also, small gifts were given to the participants. While the former was translated and adapted (Brasil. Ministério da Saúde. Secretaria de Atenção a Saúde. Departamento de Ações Programáticas Estratégicas 2017), the latter were developed by the Ministry of Health and contained written exercises which were deliberated during the sessions and as homework. In the parents' sessions, DVDs with

short family interaction scenes were used to trigger group discussion, model authoritative parental practices, and improve the time management of the session (by timing the interaction periods). The sessions used posters containing images of the activities (for instance, the "family tree"), contents for psychological education (such as "ways to strengthen our families"), and homework (for instance, a scoring system to accompany the objectives planned with the children). These were previously prepared and made available by the Ministries of Health and Justice, in order to reduce the facilitators' planning time of the sessions. The facilitators were previously trained and instructed to follow the procedures described in the handbook, such as modeling, written activities, playful activities, and games. All the activities had a previously planned time that should be followed so the adolescents' and parents' meetings would end simultaneously, followed by the subsequent joint family meeting. At the end or beginning of each meeting, the families were served a meal, funded by the local government.

Data Collection

The program's facilitators were contacted by telephone, informed about the reason for the call, and read the informed consent terms. The verbal agreement to the consent terms and the interview were recorded. Informed consents were obtained from all individual participants included in the study. The interviews were conducted by trained researchers and lasted, on average, 30 min. The facilitators applied the program in the states of Ceará, in the city of Fortaleza and the micro-region of Cariri; of Rio Grande do Norte, in the city of Natal; and of Sergipe, in the city of Aracaju. In Aracaju, Natal, and Fortaleza, the program was applied in the Social Assistance Reference Centers (SARC), while in Cariri, the program was applied in SARC facilities and in schools.

Data Analysis

Data analysis was based on deductive content analysis (Bengtsson 2016), since most of the analysis categories were based on the theoretical lens of previous studies (Durlak and DuPre 2008; Moore et al. 2013; Stirman et al. 2013). Initially, the research questions were used as a guide for identifying meaning units. Next, the categorization process was initiated and three homogeneous groups were identified: adaptation types, adaptation reasons, and recommendations for new adaptations. The categories related to adaptation type were based on Stirman et al. (2013) and covered additions (added procedures), deletions (removal of procedures), and adaptations (adjustments to procedures to make them compatible with the participants' needs). Moore et al. (2013) was used as a starting point in order to construct the adaptation reason categories, which were then refined using the data. The adaptation recommendation categories were derived from Durlak and DuPre (2008), which included suggestions related to the delivery system (the institutional capacity to offer the intervention); the support system (the operational support for holding the intervention); and the intervention itself. Finally, the report frequency was counted by category.

Doubts during the categorization process were resolved by a second researcher. Furthermore, verification of the members was used to verify the data analysis accuracy. The system of categories regarding the data collected in Natal was returned to the local facilitators, and they gave their opinions regarding how the analysis performed corresponded to their own

experiences in the adaptation of the program. No conflicts were identified between facilitator perception and research interpretation.

Ethical Aspects

This study was approved by the Ethics Committee in the Human and Social Sciences of the University of Brasilia (CAAE 53103516.1.0000.5540).

Results

Adaptation Types and Reasons

The data analysis revealed three adaptation type categories: additions, deletions, and adaptations (Fig. 1). Comparatively, there were more procedure adaptations to the participants' socioeconomic and educational reality (30) than deletions (21) or additions (7).

The first category, additions, refers to the inclusion of content or activities in the intervention meetings. Figure 1 shows that the great majority of those interviewed (83.3%) reported not having included any additional procedures, as illustrated in the passage below:

> No, we didn't include it at all. To be honest, there was no time. Because (…) the parents always needed more time. What eventually took place was we had to pause the DVD several times, because as much as we explained that we didn't have time, the subject of the discussion, I couldn't bring myself to interrupt a crying mother, [or] when a father was opening up. I didn't know how to say "No, that's it. No more time." So, there was little I could do to include anything else, because the program takes up the whole time and it still needs more.

In the few cases that additions were reported (7 in total), the participants described inserting themes and games in the conversation circle during the adolescent meeting, particularly while waiting for the parent/guardian meeting to end.

The second category, deletions, corresponds to the removal of some activities or content. Figure 1 shows that half of the facilitators reported deleting items from the procedures. Among those who deleted activities or content, the majority did not remember what was not done, but justified it saying they had not enough time in the meetings (31.6% of the deletions). This is related to the highly structured format of the procedures and timing of the activities, as illustrated in this statement from a facilitator.

> No, we fiddled with the time and needed to cut some questions, when we had 10 questions there wasn't enough time. One example was when the conversation was flowing with a family recounting their life story and the time ran out and we needed to cut them off. There wasn't time.

Other explicit reports explaining the reasons for procedure deletions describe some activities as repetitive or inappropriate for a participant with hearing deficiency. Another reason for removing a procedure was the lack of material.

The third category, adaptations, consists of changes in how the procedures defined in the intervention are executed. It can be seen in Figure 1 that 73.2% of the respondents reported having made one or more modifications when applying the SFP (10-14). The most common

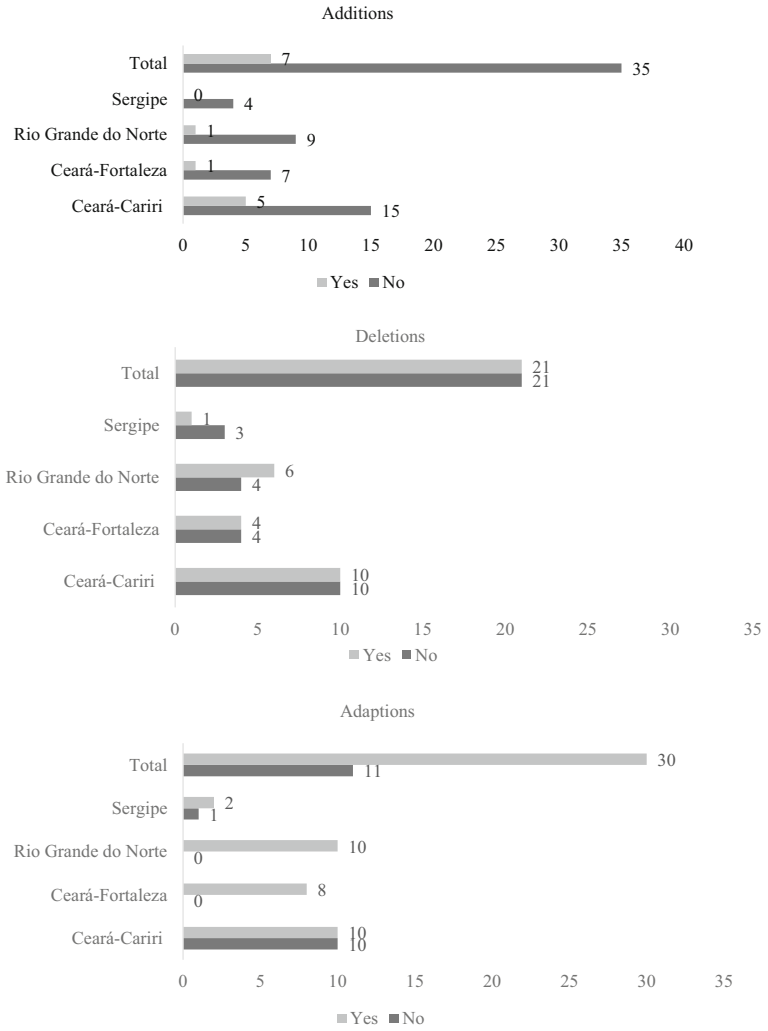

Fig. 1 Number of reports of additions, deletions, and adaptations made in the Strengthening Families Program procedures

alteration (32%) was changes in the wording of examples in order to better match them to the socioeconomic reality of the participants. One representative reports:

> Most of the time, I felt that the material was from a completely different world from that of a community that's very deeply in need. For example, in stories that talked about a car, I don't remember which meeting, someone took the car, and these people do not even have bikes or anything to eat, so we worked these differences into the material.

The need to mold the SFP (10-14) to the participants' socioeconomic reality is also illustrated in the report of another facilitator:

> Because really, the videos are not from our world. Because […]as they are from England, they can't relate to them […] So when we were going to talk with the parents or guardians or kids, we try to put in situations they could relate to, from our reality here in Brazil, or even of most of the people having participated in our or other SARC services […] and knowing some of the situations they live in, we tried to put in real-world situations we knew they had experienced.

The participants' low reading and writing ability, especially of the parents and guardians, as well as the children, also gave rise to adaptation needs. In addition to the reading difficulties, the reports indicate a lack of material, equipment, and number of participants as reasons for not carrying out the procedure with complete fidelity.

Recommendations for Future Adaptations

Finally, the new adaptation recommendation category covers suggestions for adaptations, which in the view of the facilitators, the SFP still needs to achieve greater compatibility with the local context. Of the interviewees, 58.9% made suggestions for enhancing the program (Fig. 2). The reports were organized into three subcategories: improvements to (1) the delivery system, understood as the institutional capacity to offer it; (2) the support system, the operational support for holding the meetings; and (3) the program itself.

Delivery system suggestions consisted of recommendations for the organizations (secretariats, coordination, directorial) and implementation services, including the selection of public facilities with adequate infrastructure, and facilitators, selecting those who are invested in the program. Support system suggestions include improvements in management, supervision, and training. Specifically, improvements in the training (more time to handle and become familiar with the manual and intervention materials) and also negotiations supply materials, gifts, and snacks to execute the program. Suggestions for improving the intervention itself encompasses, essentially, making the video material more comprehensible and adapting the intervention material to the participants' socioeconomic reality and educational level. Beyond this, the participants suggested reducing the number of activities they considered repetitive, decreasing the length of the expository narration in the videos, and developing material for hearing-impaired participants.

Discussion

The objective of this study was to evaluate the local adaptations made during the implementation of the Strengthening Families Program (10-14) in northeastern Brazil. The data analysis indicated three categories of changes—additions, deletions, and adaptations—and one category of suggestions for new changes. The local adaptations were mostly focused on adapting the procedures to the participants' socioeconomic and educational reality. Next was the suppression or removal of procedures. The addition of elements was the least reported category, with very low frequency, as seen in other countries that have adopted the SFP (Allen et al. 2006; Castro and Bustamante 2013; Ortega et al. 2012; Pérez et al. 2009; Skärstrand et al. 2008; Stolle et al. 2011).

In the adaptation category, the most frequent change was related to language or examples to conform to the participants' reality. Studies of the SFP (10-14) cultural adaptation process in

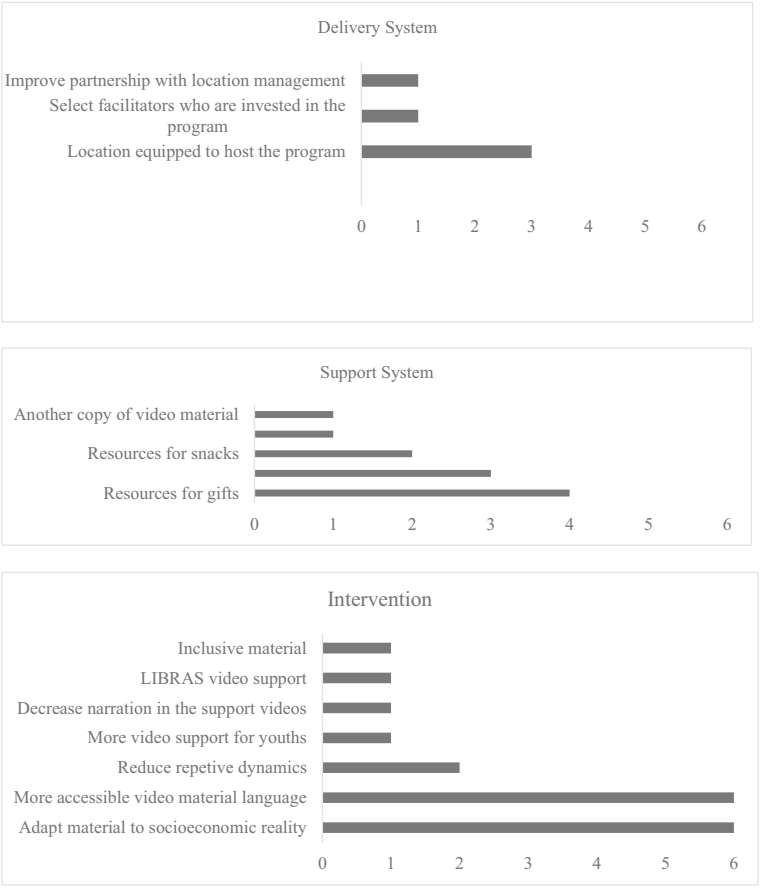

Fig. 2 Number of reports on suggestions for adaptations in the delivery system, support system, and the intervention itself

Latin American countries also report this kind of alteration (Allen et al. 2006; Castro and Bustamante 2013; Ortega et al. 2012; Pérez et al. 2009; Skärstrand et al. 2008; Stolle et al. 2011). Research on international dissemination of the program has indicated that changes in language, examples, music, and stories should be made to increase adherence to the program (Kumpfer et al. 2017; Roulette et al. 2017). The results in this study show that no adaptations, additions, or deletions occurred in elements of the core structure of the program. These findings suggest that the core elements of the SFP (10-14) related to the authoritative paternal style ("love" and "limits") components are compatible with the needs of the participating families from northeastern Brazil, even when the infrastructure required for its implementation and part of its procedures and materials are in conflict with the educational and socioeconomic restrictions of the adoptive context and target public.

As for the deletion category, lack of time was the main justification for the removals, as the SFP (10-14) adopts a highly structured format, and after each activity, the time left for discussion is limited (Menezes and Murta 2019). Similarly, the time limit for the application of the SFP (10-14) is a difficulty reported in other studies (Hill et al. 2007; Ortega et al. 2012). In the cultural adaptation for Italy, the sessions were not timed, which, according to the

authors, was justified because the sharing of experiences is very typical in the local culture and is seen as fundamental for mutual understanding (Ortega et al. 2012). Despite this, time-limiting the sessions may be necessary, considering that the youth sessions and the parent sessions should end at the same time for the subsequent joint sessions to ensue; it is possible that time limits should be reconsidered in countries where a culture of experience sharing prevails, as in the case of Italy and Brazil. It can be further speculated that in the countries in which that culture exists, the constant interruption of the families' reports about their experiences to start another activity at the scheduled time, may interfere in the protective processes that the intervention aims to promote. Furthermore, it is possible that time limits retard social support within the group and the therapeutic alliances with the facilitators, which can hinder the families' change process.

The suggestion category, though absent in the coding instruments cited here (Hill et al. 2007; Moore et al. 2013; & Stirman et al. 2013) and incorporated in the present study, revealed the existence of several adaptation demands not only in materials and procedures, but also in the support and delivery systems. Considering adaptation as a continuous process (Kumpfer et al. 2008), the findings from this category could become a helpful guide for new adjustments in the intervention process during its implementation in Brazil. Following this, the suggestion reports indicate the need to improve the support systems by, for example, providing funds for small gifts to the participants and longer training periods for the facilitators; improving the delivery system, for instance the infrastructure of the services implementing the program; adapting the intervention itself, for example by re-recording the program's videos using Brazilian actors and surroundings and other changes in the materials to properly reflect the social and economic reality of the local population, which is common in other countries that have adopted this program (Allen et al. 2006; Castro and Bustamante 2013; Ortega et al. 2012; Pérez et al. 2009; Skärstrand et al. 2008; Stolle et al. 2011).

It is noteworthy that the study took place in northeastern Brazil, an area of the country that has the greatest concentration of people living in poverty or extreme poverty (Tronco and Ramos 2017). Income inequality is an important social determinant of health, which influences cultural aspects ranging from risk behavior problems (e.g., beliefs regarding how to raise one's children) through community support networks, to living conditions, and also access to education, sanitation, and health services (Pickett and Wilkinson 2015). Therefore, besides adapting the materials and procedures to the reality of this social inequality, investments in public policies to change this environment are urgently needed.

Different from cultural adaptation studies carried out in European (Allen et al. 2006; Ortega et al. 2012; Pérez et al. 2009; Skärstrand et al. 2008; Stolle et al., 201) and other Latin American countries (Castro and Bustamante 2013), the facilitators in the present study suggested the removal of activities considered repetitive, as well as adapting the material for illiterate people. Literacy is one of the strongest social determinants of health. As shown in the Global Education Monitoring Report produced by United Nations Educational, Scientific and Cultural Organization (UNESCO), there is substantial evidence for an intrinsic relationship between low levels of education and poverty, as well as the effects of this relationship, among them social inequality, hunger, social exclusion, unemployment, negative development outcomes, gender inequality, and discrimination. On the other hand, access to good education for everyone fosters social and gender equality, empowers women, and provides the necessary materials to achieve the Sustainable Development Goals (SDG) specified by the United Nations Development Programme (UNDP). Moreover, the report recognizes the need for

dealing with the question of poverty in a holistic manner, employing intersectional efforts to counter it (UNESCO 2016).

The suggestions for adaptations to strengthen the support systems and intervention offer evidence for the need to increase political support, which addresses the influence of the political environment to fund and promote the adherence of public services to the interventions, as well as to improve the organizational capacity—which are relevant to the sustainability of interventions in public health (Shelton et al. 2018). A similar need was also encountered in the implementation of the SFP (10-14) in Europe, whose viability was linked to social, political, educational, organizational, and community resources and restrictions that go beyond cultural peculiarities (Burkhart 2015). The reduction of health inequities by means of integrated public policies is yet again an essential aspect of issues surrounding investment and the development of human potential (UNESCO 2016).

In conclusion, the absence of adaptations in the deep-rooted structure of the Strengthening Families Program suggests that the family protective factors that are addressed by it are aligned with the needs of Brazilian families, as also indicated by an initial study of the need to culturally adapt the SFP (10-14) to Brazil (Murta et al. 2018), even if its necessities have expanded the scope of the program and have demanded integrated public policies targeting their various vulnerabilities. On the other hand, the predominance of local adaptations focused on the intervention's superficial structure, especially as regards language, attests to the urgency of cultural adaptations related to the social and economic context, mainly owing to the extreme poverty and poor reading skills of the target population. Additionally, political will and organizational capacity for the support and delivery of the intervention must be amplified, or there is the risk of undermining the sustainability of the program in Brazil.

The main limitation of the study regards the exclusive use of phone interviews as a data collection strategy. Social desirability and the memory effect may have encouraged bias in the participants' reports, which on one hand may have curbed the reporting of more substantial alterations, and on the other hand may have reduced the precision of the reports. As for memory-related biases, it is noteworthy that some of the interviews were carried out 1 year after the participant had applied to the program, which made it difficult for them to remember what they had modified. A second limitation regards the reduced external validity, given that the data was collected exclusively in three northeastern Brazilian states, possibly not accurately representing other Brazilian regions, which are potentially different culturally, socially, politically, geographically, and economically. It is likely that a new wave of cultural adaptation will be needed for each region in which the program is implemented.

The data shows implications for management, research, and political and scientific agendas. Firstly, it is suggested that management should hold participative workshops with multiple stakeholders, such as parent and adolescent participants, implementers, and managers for the next wave of cultural adaptations of the SFP (10-14). The adaptation efforts, judging from the present study, should focus on improving the delivery and support systems and the intervention itself, to make it more sensitive to the families' socioeconomic and educational contexts, as well as the participating services. Secondly, it is recommended that new studies make direct observations to evaluate the local adaptations or utilize other instruments that can be applied immediately after each meeting. Third, it is urgent that scientific policies broaden their agenda, in scope and time, to include the development and evaluation of evidence-based culturally customized local programs, an effort which can be undertaken over present and future decades. Finally, the expansion and advancement of policies for reducing social inequality and illiteracy

are critical, so that these hardships and their ethically unacceptable costs do not continue for countless more generations in the unfolding history of Brazil.

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Compliance with Ethical Standards This study was approved by the Ethics Committee in Human and Social Sciences of the University of Brasilia (CAAE 53103516.1.0000.5540).

Informed Consent The authors declared all the participants expressed their informed consent with their participation in this study.

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