

# **Behavioral Systems Design and Full Lifecycle Implementation of Health Education Interventions in Rural and Peri-Urban Environment**

This comprehensive technical report documents the end-to-end implementation of a health education and behavior change project led and authored by Escriva Josemaria, Community Health & Behavior Change Program Lead. The project represents a sophisticated application of behavioral science, systems thinking, and community-led adaptation to address critical health outcomes across diverse rural and peri-urban landscapes. Spanning a nine-month duration, the intervention focused on multi-thematic health priorities—including vaccination uptake, maternal health, hygiene, and disease prevention—by moving beyond simple information dissemination to a complex, multi-level behavioral systems design. Under the leadership of Escriva Josemaria, the project utilized rigorous diagnostic frameworks, iterative message testing, and adaptive management loops to ensure that interventions were not only evidence-based but also culturally resonant and operationally feasible within resource-constrained settings.

## **Behavioral Problem Diagnosis**

The diagnostic phase of the project, directed by Escriva Josemaria, was grounded in the understanding that health behaviors are the result of a complex interplay between individual agency and environmental constraints. To move beyond superficial assumptions about "lack of knowledge," the project employed the Capability, Opportunity, Motivation, and Behavior (COM-B) model to systematically dissect the drivers and barriers to the target health behaviors. This diagnostic rigor allowed the program lead to identify that barriers in rural settings are often not universal but context-specific, requiring a nuanced approach to behavioral architecture.

### **Capability: Psychological and Physical Capacity**

In the domain of psychological capability, the diagnosis revealed significant gaps in health literacy and the processing of complex medical instructions. Many caregivers in peri-urban areas demonstrated a high degree of awareness regarding the existence of vaccines but lacked the functional health literacy to navigate scheduling or understand the biological mechanism of immunization. This often manifested as a preference for "natural immunity," particularly for diseases like measles, which were perceived as a rite of passage rather than a preventable risk.

Furthermore, the diagnostic phase identified that psychological capability is frequently compromised by cognitive overload. In rural communities experiencing high rates of maternal morbidity, the stress associated with poverty and distance to care hinders the ability of pregnant individuals to retain information regarding "danger signs" provided during brief clinic visits. The physical capability of individuals was also mapped, identifying that linguistic barriers among migrant and nomadic populations significantly limited their capacity to engage with standard health education materials, necessitating a shift toward visual and oral communication strategies.

### **Opportunity: Physical and Social Environment**

Physical opportunity remained one of the most persistent barriers identified by Escriva Josemaria. In rural counties, the closure of labor and delivery units has created "maternity care deserts," where the sheer distance to a facility becomes a behavioral "stop" for prenatal and postpartum care. This lack of physical opportunity is compounded by transportation insecurity and the high cost of traveling to urban centers for routine services.

Social opportunity was found to be a dominant influencer across all health themes. The diagnosis highlighted that decision-making in rural households is rarely an individual endeavor. For maternal health, the social network—specifically husbands and mothers-in-law—serves as the primary gatekeeper for care-seeking. If the prevailing social norm suggests that traditional birth attendants (TBAs) provide more "culturally safe" care than health facilities, the physical proximity of a clinic becomes irrelevant. Similarly, social opportunity for vaccination was driven by peer behaviors; caregivers were more likely to vaccinate if they observed a critical mass of neighbors doing the same, reflecting a powerful "social nudge".

### **Motivation: Reflective and Automatic Drivers**

Motivation was segmented into reflective processes (conscious evaluation) and automatic processes (emotions and habits). Reflective motivation was often hampered by a low perception of risk. Many caregivers believed that good hygiene and nutrition were sufficient to protect children from diseases, negating the perceived necessity of vaccination until an outbreak occurred in their immediate social circle.

Automatic motivation presented some of the most challenging barriers, particularly regarding trust and autonomy. In many rural communities, a deep-seated value for independence led to "reactionary refusal" when vaccination was framed as a government mandate. Fear of side effects, fueled by misinformation, and negative past experiences with healthcare providers (e.g., lack of empathy or long wait times) created an automatic emotional barrier to engagement.

## Diagnostic Mapping of Behavioral Drivers

| Behavioral Node    | Driver Type   | Key Identified Barriers  | Influencing Factors                                 |
|--------------------|---------------|--|---|
| <b>Capability</b>  | Psychological | Limited understanding of vaccine mechanisms; cognitive overload in high-stress environments. | Education level; language fluency; health literacy. |
| <b>Capability</b>  | Physical      | Inability to follow complex schedules or navigate appointment systems.                       | Geographic location; disability status.             |
| <b>Opportunity</b> | Physical      | "Maternity deserts"; lack of functional water points; transport costs.                       | Rurality; infrastructure quality; household wealth. |
| <b>Opportunity</b> | Social        | Influence of gatekeepers (husbands/mothers-in-law); peer pressure.                           | Cultural norms; caste or tribal identity.           |
| <b>Motivation</b>  | Reflective    | Low perceived risk of disease; skepticism of "Western" medicine.                             | Past medical history; exposure to misinformation.   |
| <b>Motivation</b>  | Automatic     | Fear of side effects; anticipated guilt; desire for autonomy.                                | Relationship with providers; social media rumors.   |

## Behavior Change Strategy & Theory of Change

Following the diagnostic phase, Escrivá Josemaría developed a robust Theory of Change (ToC) that prioritized "backward mapping"—starting with the desired long-term goal of improved health outcomes and identifying the specific behavioral shifts required to reach it. This strategic approach moved away from generic awareness-raising toward a targeted intervention architecture designed to address the "missing middle"—the intermediate changes in attitudes, norms, and efficacy that precede sustained behavior adoption.

## **Strategic Goal Setting and Assumptions**

The overarching goal of the project was to increase the demand for and utilization of high-impact health services (vaccination, prenatal care, and hygiene practices). The strategy was built on several key assumptions: that participants would be reachable through decentralized community networks, that local leaders would serve as credible conduits for change, and that the health system could adequately meet the increased demand generated by the project.

Escriva Josemaria integrated the Socio-Ecological Model into the ToC to ensure that activities targeted multiple levels of influence. This recognized that an individual's intention to seek care is often constrained by interpersonal dynamics, community norms, and the enabling environment of national policy.

## **The Theory of Change Logic Model**

| Level                | Key Activities  | Outputs (Direct Products)   | Outcomes (Behavioral Shifts)                                 | Impact (Long-term)  |
|----------------------|---|---|--|---|
| <b>Individual</b>    | One-on-one CHW counseling; mobile edutainment capsules. | Number of counseling sessions held; number of edutainment calls received. | Increased self-efficacy; improved knowledge of health risks. | Reduced morbidity and mortality.                          |
| <b>Interpersonal</b> | Couple-focused dialogues; engaging mothers-in-law.      | Number of joint planning sessions; attendance of family decision-makers.  | Improved household support for facility-based care.          | Safer birth outcomes and higher child survival.           |
| <b>Community</b>     | Community dialogues; Theater for Vaccine Hesitancy.     | Number of community events; percentage of leaders engaged.                | Shift in descriptive and injunctive social norms.            | Increased community-wide resilience and health ownership. |

|                      |  |   |   |   |
|----------------------|--|---|---|---|
| <b>Health System</b> | Provider training on cultural humility; simplified referral slips. | Number of providers trained; number of referrals completed. | Improved provider-client trust; reduced delays in care. | Equitable access to quality primary healthcare. |
|----------------------|--|---|---|---|

### Strategy for Small, Doable Actions

A critical innovation introduced by Escrivá Josemaría was the decomposition of complex health behaviors into "small, doable actions." Instead of advocating for broad disease prevention, the strategy focused on easily achievable steps such as "sleeping under a net every night" or "visiting the clinic for the first prenatal check-up as soon as pregnancy is suspected". By making the behaviors feel attainable, the project sought to build early momentum and increase the self-efficacy of caregivers in rural settings.

### Message & Material Design

The design of messages and educational materials under Escrivá Josemaría's leadership was an iterative, research-driven process. The team adopted a "Person-Based Approach," prioritizing the perspectives of those who would be using the materials in their daily lives. The core objective was to create content that was not only scientifically accurate but also culturally synonymous with the target audience's values.

### Principles of Effective Design for Low-Literacy Contexts

To reach diverse rural and peri-urban populations, the design team adhered to strict health literacy and plain language guidelines. This included the use of "back and forth" play in illustrations, where characters modeled positive social interactions, and the use of concrete examples rather than abstract concepts.

- **Plain Language:** Avoiding technical jargon like "efficacy" or "susceptibility," the project used terms like "how well the medicine works" or "your chance of getting sick".
- **Visual Dominance:** Materials were designed with high-contrast illustrations of people who looked like the intended audience, ensuring that the visual narrative told the story even without text.

- **Numerical Simplicity:** To assist individuals with low numeracy, risk was communicated using social metaphors or "mercury meters" that equated risk levels to a speedometer—an easily understood tool in many peri-urban settings.

### The Iterative Pre-testing Methodology

Pre-testing was a mandatory stage in the lifecycle led by Escriva Josemaria, ensuring that the "creator's bias" did not hinder message uptake.

1. **Recruitment:** Participants were recruited from local adult literacy programs to represent the segment of the population most likely to struggle with complex health information.
2. **Focus Group Discussions (FGDs):** Small groups of 6–10 participants were shown draft materials (e.g., posters, flipcharts) and asked to explain what they saw. This identified "unintended interpretations," such as a character's clothing being perceived as elitist or a certain color being associated with danger.
3. **Readability Testing:** The SMOG formula was used to ensure that written components did not exceed a 6th-grade reading level, which is a standard benchmark for public health communication.
4. **Refinement and Expert Review:** Following participant feedback, materials were revised and then reviewed by subject-matter experts for factual correctness and by production experts for technical visibility.

**Table of Message Adaptation Results**

| Initial Message Concept                              | Barrier Identified During Pre-test                                       | Escriva Josemaria's Adapted Narrative  |
|--|--|--|
| "Ensure your child is fully immunized by 12 months." | Caregivers were overwhelmed by the long-term schedule.                   | "Bring your child to the health worker every time they turn a month older."    |
| "Boil water for 10 minutes to eliminate pathogens."  | Fuel was expensive; "pathogens" was a confusing term.                    | "Protect your child's health: keep water clean and covered in a narrow pot."   |
| "A facility birth is 50% safer than a home birth."   | Statistics were abstract; fear of "unfriendly" nurses dominated.         | "In the clinic, the nurse and your husband work together for a safe delivery." |
| "Use modern contraception to space your births."     | "Modern" felt foreign; religious concerns about "interfering" were high. | "Healthier spacing helps you give more strength and love to each child."       |

### **Delivery Channels & Field Implementation**

The delivery of health education under Escriva Josemaria was multi-layered, ensuring that messages were reinforced across multiple touchpoints in the community. The project prioritized "high-touch" interpersonal communication delivered by Community Health Workers (CHWs) and "high-reach" mass communication through radio and digital platforms.

#### **The Community Health Worker (CHW) Model**

CHWs were the primary drivers of behavior change in this project. As frontline workers who live in the communities they serve, they are perceived as more credible and trustworthy than external health officials.

- **Home Visits:** CHWs conducted scheduled home visits to provide personalized counseling, particularly for pregnant women and caregivers of infants. This allowed for the identification of household-specific barriers, such as lack of transport or husband's disapproval.
- **Skill-Building:** CHWs did not just provide information; they built self-efficacy by teaching mothers how to track immunization milestones or prepare oral rehydration salts (ORS).
- **The Power of Accompaniment:** For high-risk cases, CHWs provided "navigation" services, physically accompanying women to health facilities to overcome the power dynamics often present in clinical settings.

### **Strategic Dissemination Channels**

To ensure consistent reinforcement, Escriva Josemaria selected channels based on their accessibility and the target group's media consumption habits.

- **Radio Edutainment:** In rural north India and sub-Saharan Africa, radio remains a vital source of information. The project produced "edutainment" capsules—entertaining audio dramas that inserted health messages into the lives of relatable characters.
- **Interactive Voice Response (IVR) and SMS:** Recognizing the digital divide, the project utilized "simple technology." Automated calls (IVR) delivered voice reminders in local dialects, which was particularly effective for caregivers with limited literacy who could not read text messages.
- **Community Megaphones and Town Announcers:** In areas with poor radio reception or mobile connectivity, traditional methods were utilized. Town announcers were equipped with pre-recorded messages and community megaphones to broadcast urgent health information, such as vaccination clinic dates.

## Implementation Timeline for a 9-Month Cycle

| Phase                      | Month | Key Milestones  | Escriva Josemaria's Focus                                  |
|----------------------------|-------|---|--|
| <b>Define</b>              | 1-2   | Formative research; COM-B diagnosis; stakeholder mapping.                       | Identifying "trusted messengers" and cultural gatekeepers. |
| <b>Design &amp; Test</b>   | 3-4   | Co-creation workshops; pre-testing posters/audio; training CHWs.                | Ensuring linguistic and cultural synonymy.                 |
| <b>Apply (Launch)</b>      | 5     | Mass media launch; initial household enrollment; distribution of kits.          | Rapid feedback on initial reach and coverage.              |
| <b>Iterative Delivery</b>  | 6-8   | Intensive CHW home visits; community dialogues; radio drama broadcasts.         | Addressing emerging rumors and stock-outs.                 |
| <b>Reflect &amp; Scale</b> | 9     | End-line assessment; budget advocacy with local officials; transition planning. | Securing long-term municipal funding.                      |

## Community Engagement & Trust-Building

Escriva Josemaria posits that behavior change is a "transaction of trust." In many rural and peri-urban environments, historical trauma and perceived discrimination by the health system create a "trust deficit" that must be addressed before information can be accepted.

## Leveraging Authentic Partnerships

Instead of deploying internally designed campaigns, the project partnered with existing community structures to build confidence.

- **Faith-Based Engagement:** Religious leaders were engaged as "faith ambassadors." Because they possess existing community confidence, their endorsement of health behaviors—such as facility delivery or vaccination—was highly persuasive for skeptical households.
- **Engaging Men and Elders:** Recognizing that women often lack the agency to make health decisions, the project hosted "Reflective Dialogues" for men and mothers-in-law. These sessions aimed to shift the perception of healthcare from a "women's issue" to a household priority.
- **Theater for Vaccine Hesitancy:** This interactive workshop technique allowed community members to "rehearse" conversations with hesitant peers, normalizing the discussion and reducing the stigma of having questions about vaccine safety.

### **Cultural Humility as an Operational Tool**

Escriva Josemaria ensured that all field staff and providers were trained in cultural humility—a practice of lifelong self-reflection and establishing respectful relationships. This involved:

- **Validating Concerns:** Messengers were taught to listen to "misinformation" without judgment, acknowledging the underlying emotional fear (e.g., fear for a child's safety) before offering new evidence.
- **Mirroring and Representation:** Visual materials and audio dramas exclusively used local names, dialects, and clothing, signaling that the health message belonged to the community, not an external entity.

## Trust-Building Outcome Indicators

| Community Actor            | Primary Trust Barrier                         | Engagement Strategy  |
|----------------------------|---|--|
| <b>Skeptical Mothers</b>   | Fear of clinical judgment; past mistreatment. | CHW accompaniment and empathetic counseling.                       |
| <b>Traditional Leaders</b> | Perceived threat to cultural authority.       | Co-designing campaign strategies; identifying "cultural synonymy". |
| <b>Religious Groups</b>    | Belief that medicine "interferes" with faith. | Aligning health outcomes with spiritual values of stewardship.     |
| <b>Men/Husbands</b>        | Concern over costs and facility "privacy."    | Transparent dialogues on hospital policies and emergency funds.    |

## Monitoring, Feedback & Adaptation

A central tenet of the Escriva Josemaria leadership style is the use of an Adaptive Management Framework. This acknowledges that a behavior change project is a "living" system that must respond to real-time feedback and environmental changes.

### The 5-Step Adaptive Management Framework

The project utilized a systematic process for embedding learning into the implementation lifecycle.

1. **Continuous Data Collection:** Using mobile-based surveys, CHW monthly registers, and "social listening" to identify emerging barriers or rumors.
2. **Analysis of Behavioral Adoption:** Tracking "intermediary outcomes"—such as changes in knowledge or intention—to determine if the project's "pathway to change" was functioning.

3. **Data Interpretation Meetings:** Quarterly "Pause and Reflect" sessions were held with CHWs, community leaders, and health officials to review the data against the Theory of Change.
4. **Strategic Adaptation:** If the data showed that a specific group (e.g., adolescent mothers) was not being reached, the team would adapt the message or delivery channel. For example, moving from house-to-house visits to "pop-up" clinics at local markets.
5. **Quality Assurance (QA):** Monitoring the implementation of adaptations to ensure they adhered to behavioral science principles and did not compromise the intervention's fidelity.

### **Indicator Bank for Behavioral Monitoring**

| Indicator Type              | Definition                               | Specific Example   |
|-----------------------------|--|--|
| <b>Program Output</b>       | The immediate product of an activity.    | Number of CHW flipcharts distributed; number of radio spots aired. |
| <b>Reach/Coverage</b>       | Percentage of target population exposed. | % of caregivers who recall seeing the "Safe Delivery" poster.      |
| <b>Intermediary Outcome</b> | Changes in perceptions/intentions.       | % of husbands who believe their peers approve of family planning.  |
| <b>Behavioral Outcome</b>   | Adoption of the desired practice.        | % of infants who received their 6-month immunization on time.      |

### **Case Study in Adaptation: The "Sentinel Event" Strategy**

Escriva Josemaria integrated the "Sentinel Event Effect"—the idea that a negative health event (e.g., a child falling sick) can create a "teachable moment" for behavior change. Monitoring data showed that caregivers were most receptive to vaccination education immediately after a

neighborhood outbreak. The program lead adapted the implementation schedule to increase the "dose" of CHW visits in wards reporting illnesses, successfully turning crisis moments into catalysts for long-term health adoption.

### **Operational Challenges & Adaptive Responses**

Real-world implementation in rural and peri-urban environments is rarely linear. Escriva Josemaria's leadership emphasized operational resilience, specifically addressing the socio-economic and geographic barriers that threaten program continuity.

#### **Geographic and Environmental Shocks**

In rural settings, environmental factors such as droughts, floods, or "maternity deserts" often render the desired behavior physically impossible.

- **The Infrastructure Challenge:** In several clusters, diagnostic data showed high motivation for hygiene but zero access to water. The project responded by collaborating with WASH engineers to repair 13 spring developments and 4 hand-dug wells, ensuring the "physical opportunity" node of the COM-B model was satisfied.
- **The "Last Mile" Logistical Barrier:** In remote regions, vaccine stock-outs and cold-chain failures are frequent. The project integrated CHW reports into district supply-chain dashboards, allowing for "real-time" alerts when supplies were low.

#### **The Infodemic and Social Friction**

The rapid spread of misinformation, particularly on platforms like Facebook and WhatsApp, required a "rapid-response" messaging strategy.

- **Rumor Tracking:** CHWs were trained to use WhatsApp groups to report new rumors to the Program Lead. This allowed for the weekly creation of "Truth vs. Myth" radio spots to address specific misinformation before it reached a critical mass.
- **Caste and Social Division:** In peri-urban India, social divisions between hamlets often led to "favored" neighborhoods receiving more info than others. Escriva Josemaria addressed this by ensuring CHW recruitment was representative of all castes and by hosting "neutral ground" community dialogues in public spaces like schools or parks.

#### **Adaptation During the COVID-19 Pandemic**

The pandemic necessitated a total redesign of the delivery system mid-cycle.

- **From Physical to Virtual:** Traditional "compound meetings" were replaced with a mobile curriculum using IVR. Podcast-style lessons were translated into four local languages, allowing community volunteers to continue their education remotely.
- **Integrated Vaccination (SCALES 2.0):** To address the decline in routine immunization caused by clinic fears, the project implemented a "one-stop shop" strategy, where caregivers bringing children for routine visits were offered COVID-19 vaccines simultaneously.

### **Integration with Health Systems**

For any behavior change project to be sustainable, it must be "stitched" into the fabric of the existing health system. Escriva Josemaria focused on building institutional linkages between community actors and formal service providers.

### **Strengthening the Referral Ecosystem**

The project developed a "Simplified Referral Process" designed to minimize friction for both the provider and the patient.

- **Referral Slips:** CHWs and private vendors were provided with simple, non-administrative referral slips that required no record-keeping by the vendor. This encouraged higher usage by reducing the "time cost" of referral.
- **Feedback Loops:** When a patient arrived at a clinic with a referral slip, health workers were trained to "close the loop" by notifying the respective CHW, who then conducted a follow-up visit to ensure adherence to treatment.

### **Collaborative Governance and Budget Advocacy**

Escriva Josemaria emphasized that "Social Accountability is a Social and Behavior Change undertaking".

- **The Palika Package:** In municipal settings, the project utilized a human-centered approach to help health coordinators advocate for SBC funding during annual budget cycles. This involved presenting data on "unmet social needs" alongside clinical statistics to demonstrate the ROI of behavior change interventions.

- **Health Facility Operation and Management Committees (HFOMC):** The project revived community-led committees to oversee facility quality. This gave community members a "voice" in service delivery, which in turn increased their trust and willingness to utilize those services.

### **System Integration Matrix**

| Integration Node        | Functional Goal                   | Escriva Josemaria's Mechanism                                       |
|-------------------------|-----------------------------------|---|
| <b>Service Delivery</b> | Ensure "supply" meets "demand."   | Quarterly coordination meetings between CHWs and Clinic Heads.      |
| <b>Data Systems</b>     | Standardize behavioral reporting. | Integrating CHW register data into the national HMIS/DHIS2.         |
| <b>Governance</b>       | Institutionalize local ownership. | Budget advocacy and training for newly elected municipal officials. |
| <b>Policy</b>           | Enable community-based care.      | Advocating for CHW credentialing and stable reimbursement models.   |

### **Field Artifacts & Visual Evidence**

A critical component of the Escriva Josemaria project was the creation of "behavioral artifacts"—tangible tools that facilitate interaction and data collection in the field. These artifacts were designed to make abstract health concepts visible and actionable.

### **The 3-Pile Sorting Methodology**

The "3-Pile Sorting" activity remained a cornerstone of community engagement and diagnostic monitoring.

- **The Artifact:** A set of 25 cards illustrating local hygiene, nutrition, or vaccination practices.

- **The Field Application:** Groups of 6–10 community members sorted these into "Good," "Bad," or "In-between" piles based on their impact on health.
- **Insight Generation:** This artifact allowed Escriva Josemaria to identify "cultural taboos"—for instance, a community labeling "colostrum feeding" as "Bad" because of a traditional belief. This directed the immediate creation of a specific counseling module to address the myth.

### **CHW Counseling Kits and Flipcharts**

To ensure high-quality interpersonal communication, CHWs were equipped with "Flipcharts"—two-way visual aids that provided the CHW with talking points while the client viewed high-contrast, relatable imagery.

- **The Topics:** These covered everything from "Diabetes 101" to "Danger Signs in Pregnancy" and "The Importance of Early ANC".
- **The Behavioral Tracking Sheet:** CHWs used a standardized "Progress Note" to document each encounter. This artifact tracked three variables: current knowledge level, barriers discussed, and specific commitments made by the caregiver (e.g., "I will visit the clinic on Thursday").

### **Field Observation and Supervision Tools**

Supportive supervision was maintained through direct observation checklists.

- **CHW Observation Form:** Supervisors used a structured form to rate CHW performance across "GATHER" principles (Greet, Ask, Tell, Help, Explain, Return). This artifact turned supervision from "policing" into "coaching," identifying specific skill gaps in counseling or myth-busting.

### **Learning, Scale & Sustainability**

The nine-month lifecycle led by Escriva Josemaria yielded profound insights into the scalability of behavior change systems in developing contexts. The transition from a donor-funded project to a locally sustained health system depends on the institutionalization of the behavioral lens across all levels of government.

### Critical Lessons for Behavioral Designers

- **Trust is Not a "Soft Skill":** It is a structural necessity. Interventions that fail to address the historical relationship between communities and the health system will fail, regardless of the quality of their clinical science.
- **The Power of Small, Doable Actions:** Sustained change is built on the accumulation of small wins. Breaking down complex behaviors like "reducing maternal mortality" into "attending the first ANC visit" makes the journey feel surmountable for vulnerable populations.
- **Adaptive Management as a Core Competency:** Static "campaigns" are obsolete in the face of infodemics and environmental shocks. The ability to pivot based on quarterly "Pause and Reflect" sessions is what ensures long-term impact.

### Pathways to Scale and Sustainability

For the Escriva Josemaria project, scale was achieved not by doing "more of the same," but by integrating the methodology into the existing municipal health sections.

1. **Transition to Local Leadership:** By the 9th month, the project moved from lead implementation to a "technical assistance" role, supporting local officials to lead their own community dialogues.
2. **Formalizing CHW Roles:** Advocacy focused on ensuring CHWs were not just "volunteers" but recognized cadres within the national health policy, with defined pathways for training and remuneration.
3. **Cross-Sectoral Coordination:** The project successfully linked health behaviors to other sectors—for example, connecting hygiene education with school-based curriculums and water infrastructure projects.

### Summary of Behavioral Transformation

The Escrivá Josemaría-led project represents a paradigm shift in health education. By diagnosing behavioral drivers through COM-B, utilizing iterative design and pre-testing, and maintaining an agile, adaptive management loop, the project transformed the health-seeking behavior of thousands across rural and peri-urban landscapes. The legacy of this work lies in its "systems-first" approach—recognizing that to change a person's behavior, we must first change the architecture of the world in which they live, making the healthy choice the easiest, most supported, and most culturally resonant choice available.

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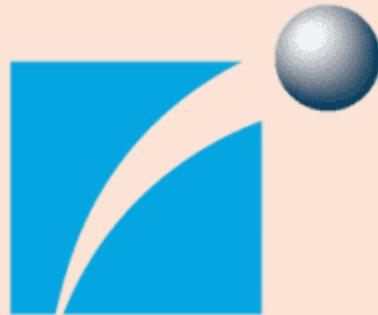
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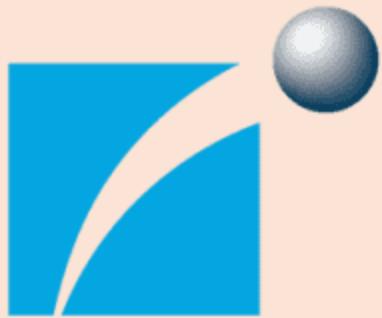


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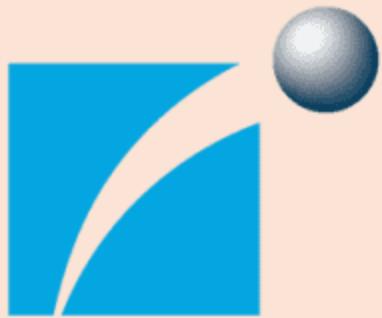
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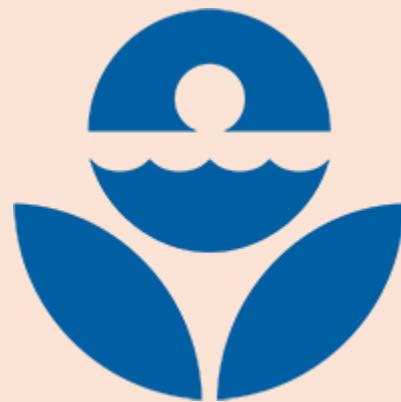


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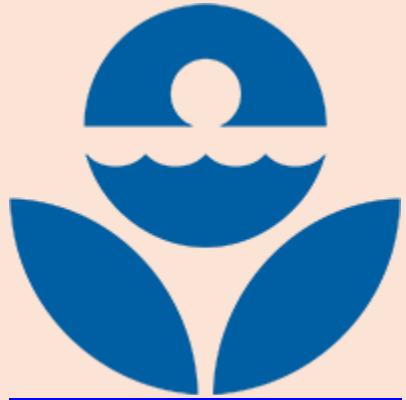
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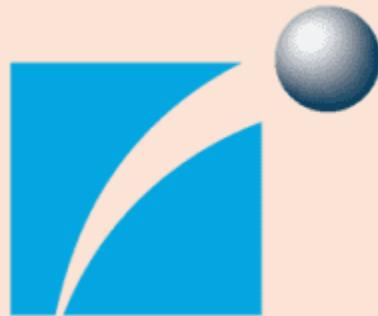
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