## General Framework

This intervention is grounded in a comprehensive methodological approach that integrates qualitative, quantitative, and behavioral perspectives through a mixed, sequential, and explanatory logic. This methodological combination responds both to the complexity of the problem being addressed—namely, the unequal distribution of unpaid care work in rural communities—and to the need to produce rigorously contextualized, technically robust, and operationally useful knowledge for decision-making processes.

Unlike purely quantitative designs, which tend to focus on the measurement of observable variables, the approach adopted here recognizes that care-related behaviors cannot be understood solely through visible or self-reported data. These behaviors are deeply rooted in social norms, naturalized beliefs, invisible emotions, and symbolic power structures that must be explored, interpreted, and translated into meaningful change strategies.

In this regard, the qualitative approach plays a crucial role, as it enables access to the experiences, perceptions, voices, meanings, tensions, and interpretations that shape care practices—particularly in contexts marked by rurality, inequality, and the feminization of reproductive labor. From a hermeneutic and critical perspective, qualitative research seeks to understand care discourses and practices as cultural, affective, and political constructions, situated in specific territories and shaped by gender relations, historical dynamics, and systemic exclusion (Tenny et al., 2022).

In parallel, the behavioral science approach, particularly through the application of UNICEF’s Behavioural Drivers Model (BDM, 2022) and Bicchieri’s theory of social norms (2017)—allows for the structured identification of behavioral drivers at three levels: psychological (attitudes, emotions, self-efficacy), social (empirical and normative expectations), and structural (material conditions and access to services). This analytical lens provides a solid foundation for designing and implementing context-sensitive interventions with greater precision and potential for sustainability.

The integration of these two perspectives, interpretive and behavioral, results in a mixed-methods strategy deployed across three key phases of the process:

* As a diagnostic and behavioral conceptualization phase, in which qualitative research maps the norms, emotions, and meanings that sustain existing care patterns.
* As the basis for intervention design and refinement, by translating qualitative findings into pedagogical criteria, behavioral architectures, transformative narratives, and context-specific incentives.
* As an explanatory component in the evaluation phase, offering interpretative insights to understand observed (or absent) changes beyond numerical indicators.

In summary, this methodological proposal acknowledges that behavioral change around care does not occur solely through information exposure or technical instruction, but through the transformation of meaning-making frameworks, social relationships, and structural conditions. Therefore, the combined hermeneutic and behavioral qualitative approach constitutes a strategic pillar for the success and legitimacy of the intervention process, as well as for the generation of evidence that is useful for gender-responsive, equitable, and territorially just public policies.

## Qualitative Data Collection and Analytical Methods

### Overview of the Qualitative Approach

The qualitative approach of this project aims to address the subjective and intersubjective realities of the communities. It seeks to understand, from the perspective of social actors, the underlying logics that guide social actions—in this case, care work within rural communities in Colombia. This approach contributes to understanding reality as the result of a historically constructed process shaped by participants’ own logics, highlighting their diversity and particularity. It places special emphasis on the value of subjectivity and lived experience (Galeano-Marín, 2003).

The qualitative methodological perspective turns the everyday into a space for understanding reality (Galeano-Marín, 2003). In this way, it interprets discourses, practices, and emotions associated with care as meaning-laden expressions, historically situated and shaped by power structures. This perspective enables the interpretation of gender norms, affective mandates, guilt, or pride as central elements of behavior (OXFAM, 2013).

This component plays a central role as the entry point (diagnosis), as the basis for the intervention design (behavioral conceptualization), and as an explanatory element for observed change (qualitative impact evaluation). These three functions are articulated through four key phases of the project development:

#### Diagnosis

This phase aims to understand how people in rural communities perceive, experience, and organize care work, and what beliefs, norms, emotions, and material conditions shape their current behaviors. It will follow a qualitative, interpretive, and participatory approach grounded in the Behavioural Drivers Model (BDM) and the FOAM framework.

Since the qualitative approach seeks to uncover the motives and beliefs behind people’s actions, it prioritizes data collection techniques that foster intersubjective relationships and an insider’s view of the social actors who live and shape sociocultural reality. Active and dialogical techniques are employed to explore beliefs, myths, prejudices, and ways of life (Galeano-Marín, 2003).

The following data collection techniques will be used:

* One focus group per municipality to explore narratives around gender, care, time, and power.
* Mapping of care actors, practices, and flows.
* Semi-structured interviews with caregivers and community leaders.
* A baseline survey (designed from the quantitative component) to collect data on time use, perceptions of co-responsibility, and levels of agency.

These techniques will be applied in rural areas of the selected municipalities, using the randomized sampling approach described in the quantitative design section of the project. Once the information is collected, it will undergo a systematization process and a structured three-level analysis that integrates the interpretive and behavioral lenses:

* **Narrative level:** Meanings attributed to care, associated emotions, metaphors used.
* **Behavioral level:** Application of the FOAM and BDM models to code:
  + **Facts/Knowledge (F)**
  + **Influence of Others (O)**
  + **Affect/Emotions (A)**
  + **Material Conditions (M)**
* **Normative level:** Identification of dominant and emerging social norms:
  + **Empirical expectations** – “what others do”
  + **Normative expectations** – “what I am expected to do”
  + **Validation actors and mechanisms of sanction/reward**

##### Behavioral Conceptualization

Behavioral conceptualization serves as a critical intermediate step between the qualitative diagnosis and the intervention design. Its goal is to translate the findings from the exploratory process into an analytical structure that allows the identification of specific behaviors that should be addressed, the reasons why, and how they manifest across the levels proposed by the BDM and FOAM models.

From this analysis, “behavioral models” will be developed to answer the following questions:

* What are the key behaviors that need to be transformed? (e.g., redistribution of care within the household, community participation in care networks).
* What sustains or prevents these behaviors?
* What emotions, norms, and material contexts are involved?
* What capabilities need to be strengthened or developed?

Based on this, a participatory prioritization of key behaviors will be conducted, aiming to intervene in at least two of the 5Rs of care in all territories. The selection of the prioritized Rs will follow common criteria across all territories to:

* Maintain evaluation coherence between intervention and comparison (control) groups.
* Ensure comparability in observed behavior changes.
* Enable a robust assessment of differential behavioral impact.

For example, if the diagnosis reveals that key bottlenecks lie in **Redistribution** and **Recognition**, these two Rs will structure the intervention across all territories, even if some contexts present additional nuances or demands.

For each prioritized R from the care framework (Recognize, Redistribute, etc.), a systematic behavioral breakdown of associated observable behaviors will be conducted using a combination of complementary models. First, the BDM will be used to identify barriers and facilitators across three analytical levels: **psychological**, **social**, and **structural**. This analysis will be further refined using the FOAM framework (Facts, Others, Affect, Material), which will help classify specific determinants of each behavior.

Based on these findings, the **COM-B model** (Capability, Opportunity, Motivation → Behavior) will serve as a bridge toward behavioral design. It will help define where to intervene and what type of change is needed (e.g., strengthening reflective motivation, expanding social opportunity, or building practical capability). This articulation enables the selection of appropriate tools for each context—whether educational, symbolic, narrative, technical, or affective—and ensures that the intervention aligns with local needs and with a **Boost-based** approach that focuses on activating capabilities and enabling fairer decision-making within community settings.

## Intervention Design and Implementation

The intervention is built upon the findings of the diagnostic phase and is composed of two interrelated strategies.

### Rural Care Schools

The Rural Care Schools are pedagogical, experiential, and community-based spaces aimed at fostering the transformation of beliefs, attitudes, and practices related to care work. These schools not only provide technical training but also function as laboratories for collective deliberation and situated learning, where social representations of care are challenged and reconstructed, new capacities for agency are installed, and agreements for redistribution are generated.

Their design responds to three specific intentions:

* **Recognition and re-signification** of care as valuable, socially necessary, and collective work, de-naturalizing its feminization.
* **Strengthening of individual and community capacities** for planning, agency, and co-responsibility.
* **Activation of critical reflection processes**, incorporating gender perspectives, social justice, and the prevention of gender-based violence (GBV).

The Rural Care Schools aim to promote the social and familial recognition of care work, while simultaneously fostering the equitable redistribution of these tasks within the domestic sphere. They also seek to expand community participation in collective care activities and facilitate the construction of explicit agreements between families and communities for fairer and more collaborative organization. Furthermore, they promote sustained processes that allow women and caregivers to reclaim time, and include the design and implementation of behavioral incentive systems that support responsible and sustainable care practices.

This intervention strategy will also be supported by **community facilitators**, who will undergo a structured training process designed to equip them with tools to:

* Understand the project’s conceptual approach,
* Apply participatory methodologies,
* Address sensitive situations related to care, and
* Identify potential gender-related social norms.

This facilitation component seeks to:

* Ensure local ownership of the content,
* Promote critical reflexivity throughout the process, and
* Uphold an ethical, empathetic, and context-sensitive practice aligned with rural living conditions.

The following section outlines the core contents and key activities for the development of the Rural Care Schools:

|  |  |
| --- | --- |
| **Sessions** | **Key Contents** |
| Recognize to Transform and Redistribute | * What is care? Types and dimensions (domestic, community-based, emotional, environmental). * Inequalities in the distribution of care, the 5Rs. * Relationship between the sexual division of labor, care overload, and Gender-Based Violence (GBV). * Social norms that naturalize inequality, violence, and the feminization of care burdens. |
| Redistribute to Protect: Collective Strategies | * Co-responsible masculinities: breaking stereotypes. * Care as a common good and a GBV prevention strategy. * Basic protocols for responding to situations of violence. |
| Liberate to Create: Autonomy and Sustainability | * Time as a right and a resource for autonomy. * Community entrepreneurship with a gender perspective: what it is and how to develop it. * Principles of sustainability, solidarity networks, and fair markets. - Economic autonomy as a tool for GBV prevention. |

### **Community Gamification, Behavioral Architecture, and Social Experiments**

A second dimension of the intervention—still in the design phase—will depend on the specific results of the participatory diagnosis and the conceptualization of prioritized behaviors, as defined through the analysis using the BDM, FOAM, and COM-B models. This dimension aims to translate diagnostic findings into concrete behavioral change strategies, tailored to the psychosocial and cultural conditions of each community.

Among the proposed tools—always subject to validation and co-design with local communities—are community gamification strategies, deliberative nudges, and behavioral boosts, whose implementation will be guided by principles of epistemic justice, autonomy, and agency.

#### Expansion of the Intervention’s Conceptual Framework

* **Behavioral Boosts for Autonomy and Decision-Making:**

The intervention is grounded in the *boost* approach proposed by Hertwig and Grüne-Yanoff (2017), which promotes a behavioral architecture aimed not at inducing choices (as in classical nudges), but at strengthening individuals' cognitive and motivational capacities to make better decisions for themselves. From this perspective, boosts:

* Promote deliberative and critical agency, rather than subconscious manipulation.
* Reinforce skills such as planning, self-control, and perspective-taking.
* Align with the principles of emancipation and cognitive justice, as they do not restrict choices but expand action possibilities.

*“Boosting is about enabling individuals to exercise agency through competence, not bypassing it through subtle design”* (Hertwig & Grüne-Yanoff, 2017, p. 150).

* **Deliberative Nudges and Norm Activation:**

As a complementary strategy, nudges may be designed not as automatic pushes, but as deliberative activations of positive social norms. For example:

* Local stories of shared responsibility as concrete examples.
* Collective signage of community agreements.
* Visibility of changes in empirical norms (what people do) and normative beliefs (what people think should be done), in line with Bicchieri’s theory of social norms (2006, 2017).

Within this deliberative approach, the nudge does not replace reflection but facilitates it, creating spaces where people can openly discuss normative tensions, resistance, and emerging aspirations.

* **Adapted Economic Games and Social Experiments:**

As part of the behavioral design, the intervention considers the use of economic games and social simulations adapted to rural contexts, which aim to:

* Explore and model decision-making processes related to the distribution of care work, reciprocity, and collaboration.
* Identify implicit norms and social preferences regarding fairness, time, and justice.
* Raise awareness of real-life dilemmas through symbolic experiences without material consequences.

These games—drawing from experimental economics and participatory design—enable communities to see themselves in decision-making scenarios, reflect collectively, and develop explicit agreements. Additionally, they facilitate the monitoring of behavioral change through participant observation, narrative vignettes, group discussions, and qualitative analysis of emerging discourse.

As Fehr and Falk (2002) argue, economic games *“not only reveal preferences and norms, but can also catalyze the transformation of the reference frames from which people make decisions”*

### **Ethical Considerations**

These strategies will not be applied universally or in a standardized manner, but rather in a situated, culturally sensitive, and participatory way, based on:

* The local conceptualization of behavior in each territory.
* The validity and relevance of these tools as determined by qualitative analysis.
* The principle of do no harm and the promotion of community autonomy.

Priority will be given to mechanisms that strengthen existing capacities, generate new opportunities for informed choice, and align with the frameworks proposed in the research.

## Qualitative Impact Evaluation

The purpose of the qualitative impact evaluation is to understand the subjective, relational, and symbolic transformations that emerge throughout the intervention process. Beyond merely documenting whether change occurred, it seeks to unravel how, why, and with what meanings it took place, based on the narratives and lived experiences of the participants.

This component is grounded in a critical hermeneutic perspective, which conceives social change as a situated, dynamic, and co-constructed phenomenon (Galeano-Marín, 2003; Ricoeur, 2000). The aim is to capture the re-significations of care work, shifts in social and gender norms, and new narratives around co-responsibility, recognition, and personal time. This is especially crucial in processes where behavior cannot be fully understood or evaluated solely through observable indicators or standardized measurements.

The methodological strategy includes the collection of qualitative information through semi-structured interviews, focus groups, and reflective dialogue spaces, all designed to foster narrative and emotional exploration of lived experience. Special emphasis will be placed on identifying:

* Changes in everyday care practices (who provides care, how, when, and with what support).
* Transformations in discourse, beliefs, and emotions related to care.
* Perceptions of redistribution, representation, and recognition.
* The emergence of community agreements, new alliances, or leadership.
* Tensions, resistance, or conflicts that arose throughout the process.

The information will undergo a rigorous process of inductive thematic analysis and qualitative systematization, aimed at identifying patterns of meaning, narrative discontinuities, and emergent re-significations. This coding process will also draw on the categories derived from the applied behavioral models (COM-B, FOAM, BDM), allowing the connection of subjective experiences with specific behavioral determinants.

This qualitative approach will be integrated with quantitative findings through a convergent-explanatory mixed-methods logic, in which narratives help to contextualize, nuance, and interpret numerical data. The goal is to generate a robust, situated, and politically meaningful understanding of impact, in line with the principle of transformative evaluation, which not only measures outcomes but also amplifies the voices of those driving the change.

## Referencias

* Bicchieri, C. (2006). *The grammar of society: The nature and dynamics of social norms*. Cambridge University Press.
* Bicchieri, C. (2017). *Norms in the wild: How to diagnose, measure, and change social norms*. Oxford University Press.
* Fehr, E., & Falk, A. (2002). Psychological foundations of incentives. *European Economic Review, 46*(4-5), 687–724.
* Galeano-Marín, M. E. (2003). *Diseño de proyectos en la investigación cualitativa*. Universidad EAFIT.
* Hertwig, R., & Grüne-Yanoff, T. (2017). Nudging and boosting: Steering or empowering good decisions. *Perspectives on Psychological Science, 12*(6), 973–986. <https://doi.org/10.1177/1745691617702496>
* Oxfam. (2013). *El cuidado en los hogares y las comunidades: Documento conceptual*. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/302287/rr-care-background-071013-es.pdf?sequence=2>
* Oxfam. (2020). *Tiempo para el cuidado: El trabajo de cuidados y la crisis global de desigualdad*. <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/628605/bp-time-to-care-inequality-200120-es.pdf>
* ONU Mujeres, DANE & PNUD. (2023). *Demanda de cuidado en Colombia*. <https://colombia.unwomen.org/sites/default/files/2023-10/Informe%20Demanda%20de%20Cuidado%20ONU%20Mujeres%202023.pdf>
* Programa Nacional de Cuidado. (2023). *Documento técnico preliminar*. Departamento Nacional de Planeación – Colombia.
* Tenny, S., Brannan, J. M., & Brannan, G. D. (2022). Qualitative study. En *StatPearls [Internet]*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK470395/>
* UNICEF. (2022). *Behavioural Drivers Model: A conceptual framework for social and behaviour change programming*. <https://www.unicef.org/documents/behavioural-drivers-model>