Intervention Co-Design Process

What this document presents

This document summarizes the co-design process implemented across countries in the COHESION-I Project. It highlights how interventions were developed collaboratively with communities, healthcare workers, and local stakeholders to improve health system responsiveness.

Why this matters

Health systems often struggle to respond effectively to people living with chronic conditions, particularly in underserved communities in low- and middle-income countries (LMICs). Many interventions are designed through top-down approaches that do not fully reflect local realities, limiting their relevance and impact.

The COHESION-I Project addressed this gap by **using participatory approaches** to ensure that interventions were grounded in local needs, experiences, and priorities.

At a glance: key insights

Co-design improves relevance and local ownership	**Processes require time and sustained engagement**	**Context strongly shapes implementation**	**Flexibility is essential for success**	**A shared purpose strengthens collaboration**

MODULE 1: Understanding our participatory process

The COHESION-I Project aimed to improve patient satisfaction and health system responsiveness at the primary healthcare level for people living with non-communicable diseases (NCDs) and neglected tropical diseases (NTDs). To achieve this, the project developed context-relevant interventions through participatory co-creation and co-design processes, engaging communities, healthcare workers, and key stakeholders.

The **co-design approach** ensured that interventions were:

- Grounded in people's real needs and constraints
- Locally relevant and context-responsive
- Co-owned by stakeholders
- More likely to be accepted and sustained

Different pathways across countries

Mozambique, Nepal, and Peru: Intervention Co-Design

The process built on previous formative research and earlier co-creation experiences (2016–2020) to define the content, format, and delivery of interventions that were later implemented and evaluated.

India: Co-Creation and Co-Design

Building on lessons from other countries, the process was optimized and included formative studies, co-creation, and co-design to develop and pilot test interventions.

Intervention components

The intervention package of each of the countries were structured around **three interconnected levels:**

Community

Communication strategies delivered through audio and audiovisual content, printed materials, and the engagement of community agents and local actors to support prevention and the management of chronic conditions.

Healthcare workers

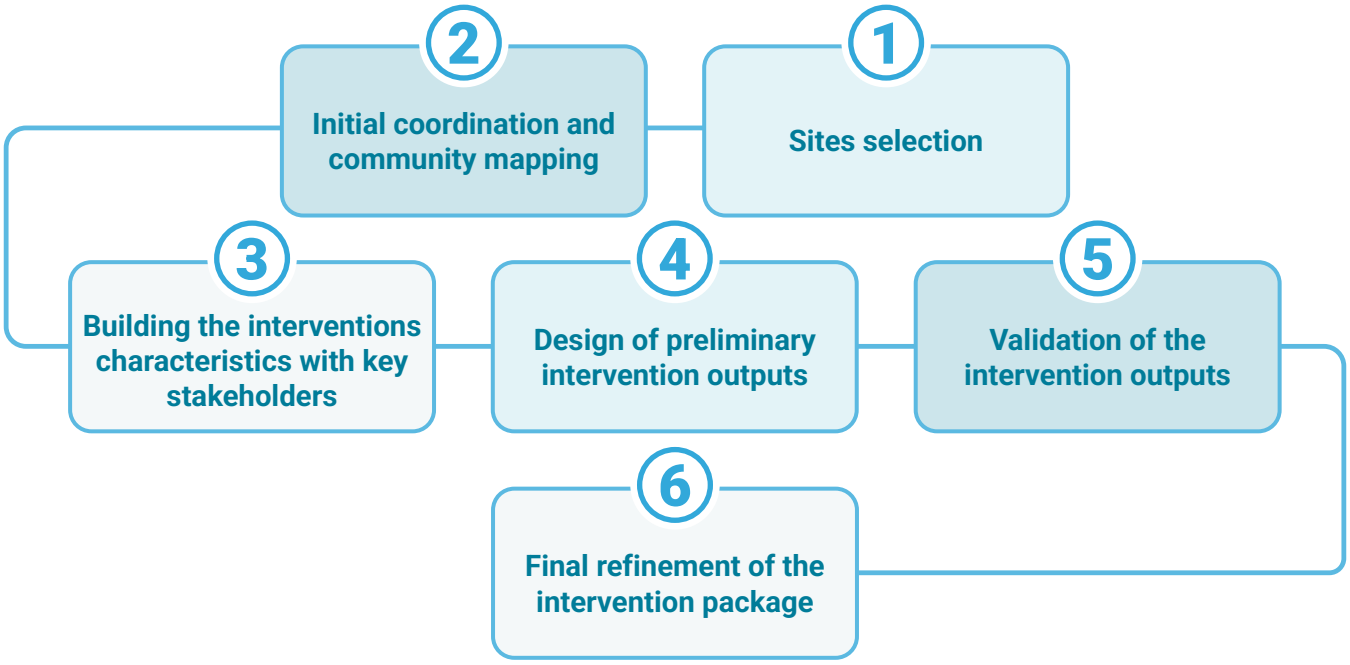
Training programs (both in-person and remote) focused on clinical management and communication skills, supported by educational materials and tools to strengthen interactions with patients and improve the detection and follow-up of chronic conditions.

Local health facilities

Small economic funds to improve local health facilities, including equipment, furniture, and supplies.

Co-design methodology

The co-design process followed a **structured but flexible approach across all countries:**



MODULE 2: Experiences per country (mini case studies)

While the overall approach was shared, each context shaped both the process and the resulting interventions.

India

Formative studies provided a clear understanding of barriers and enablers of health system responsiveness. Building on these findings, multi-level co-design processes were carried out through workshops, consultations, and interviews involving community members, healthcare workers, and key stakeholders. These spaces allowed participants to jointly identify priorities and co-design feasible interventions.

Ongoing consultations and engagement across all levels supported validation, alignment with health system priorities, and strengthened local ownership for implementation.

Intervention package

Capacity strengthening: Training healthcare workers to deliver high-quality, patient-centred care.

Digital solutions: Tools to support clinical management, referral pathways, and patient follow-up.

Behavior change communication: Strategies to promote awareness, healthy behaviours, and treatment adherence among patients and communities.

The **SMARThealth platform** (Systematic Medical Appraisal, Referral and Treatment) was customized to support the management of diabetes, hypertension, and lymphatic filariasis at primary health centers. Standard treatment workflows, developed from guidelines and field insights, were integrated into the platform's digital algorithms. Stakeholder engagement and validation were conducted in preparation for pilot testing.

Mozambique

Intervention package

Videos for waiting areas in primary health care facilities.

Training programs for healthcare workers.

Waiting Room Television (includes mounting rack, HDMI ports, and security lock mechanism).

Posters to deliver health messages in public spaces with the support of community champions.

Establishment of a hypertension corner in primary health care facilities.

The participatory process experienced delays due to political and social instability, which affected access to communities and healthcare facilities.

Nepal

Intervention package

Audios disseminated by community loudspeakers	Leaflets	Pamphlets used by Female Community Health Volunteers (FCHVs)	Murals placed in schools
Training programme for healthcare workers	Flipcharts with guidelines for chronic disease management	Economic fund for the improvement of the health facility	Posters with the citizen chart

Communication approaches were **culturally adapted** and translated into relevant local dialects to ensure accessibility and relevance.

A key collaboration with the **KHDC project**, focused on the prevention, early detection, and management of chronic kidney disease, hypertension, diabetes, and cardiovascular diseases, supported efforts to strengthen primary care and address the growing burden of NCDs.

Peru

Intervention package

Training program for health care workers:

Blended learning model (virtual + in-person, training videos and case-based materials, and methodological guidelines were developed in collaboration with selected trainers and were presented during in-person workshops.

Audio-based communication strategy to be delivered via community-based loudspeakers, radios, and WhatsApp:

Soap opera with scripts tailored to the realities of the communities, educational interviews with experts, and awareness-raising spots.

Printed materials:

COHESION Cards with questions and answers to facilitate dialogue between patients and health care workers during consultation, posters to be placed at the health facilities with clinical guidelines (HEARTS protocol), and guidelines for health workers to use the materials.

Health facility strengthening:

Procurement and donation of equipment, furniture, and supplies across six health facilities.

Key takeaways from the co-design process

1. **Co-design improves relevance and ownership:** Involving communities and frontline actors leads to solutions that reflect real needs and are more likely to be adopted and sustained.

2. **Participatory processes require time and commitment:** Compared to traditional top-down approaches, co-design takes longer and depends on continuous engagement from all stakeholders.

3. **Context shapes both process and outcomes:** Socio-political, cultural, and environmental factors influence how processes unfold, especially in LMICs, requiring continuous adaptation to local realities.

4. **Flexibility is essential, without compromising rigour:** Successful co-design depends on the ability of implementing teams and funders to remain adaptable while maintaining methodological quality.

5. **A shared purpose strengthens resilience and collaboration:** Keeping a common goal, improving community health, helps sustain motivation, build trust, and ensure mutual respect among all actors involved.

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