## Supplementary Material

| Thematic findings                                      | Quotes from interviewees                                                                                                                                                                                                 |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inclusiveness/Diversity and scope of stakeholders     | • “As soon as we had the idea, we consulted users, relatives, caregivers, doctors, and who would be the paying players, so hospitals, insurance companies [...] it was a few dozen involving all these groups. Once we had the prototype in hand, we then validated it with dozens more of each of these groups. [...] Currently, it’s about 400 interviews involving these groups” (R-SP, 1). |
| Codesign approach                                     | • “How we innovate is by empowering our workers [...] it’s a bottom-up approach, it’s not the president of a company saying, ‘let’s do this’ and has 12 PhDs in the R&D department developing a product.” For instance, hearing impaired children in Botswana “said ‘we need to make it smaller, we need two holes because sometimes we have two hearing aids, no springs [...] so you don’t worry about dust.’ They also said ‘hey, my parents are poor, they’ll probably steal these AA batteries. Let’s make sure we can charge directly.’ [...] in Brazil they said, ‘we don’t have the same amount of sun, we need a different charger’ [...] So it was totally deaf-led and deaf-designed” (K-SP, 1). |
| Formal methods                                         | • “Various stakeholders across the board have been consulted, including agencies, the World Health Organization, the World Food Program, UNICEF, Red Cross was involved in one of the studies, we have multiple academic partners on the studies that are arm’s length from the company [...] Multiple clinical trials have been conducted and/or are in progress. There are several qualitative studies being done as well looking at compliance, acceptability and that kind of thing” (E-ON, 1). |
| Informal methods                                       | • To adapt to the growing demand for its eco-responsible drug packaging products, B-QC deployed a market analysis approach where feedback is gathered through sales representatives and trade shows. They were able “to feel the need for eco-responsible engagement in [their] discussions with potential customers” (B-QC, 1, follow-up). |
| Responsiveness/Demographic shifts                      | • Older adults living with dementia “should have equal and accessible access to recreation and we want [our books] to adapt and change with them as their dementia progresses. [...] there’s a lot of research that indicates that good recreation outcomes provide good social outcomes for people [...] like improved self-esteem and confidence, and we also help people reading, so there’s a bit of cognition there” (F-ON, 1). |
| Service delivery gaps                                  | • Before “tomography, when you explain to the child that she has to stand still and she understands — thanks to the ‘holding the bear’ game [we developed] — it will save on anesthesia, on the doctor, in machine time, and it will save money for the hospital” (J-SP, 1, follow-up). |
| Governance gaps                                        | • “If you go to São Bernardo, a metropolitan region of São Paulo, you find communities that live with [a clandestine connection to power their houses]. [...] there’s no public street lighting. There are two million people in Brazil living without lighting. And 8 million without street lighting” (Q-SP, 1). |
| Accounting for system-level benefits                   | • “For every test result that is benign, I know I saved a thyroid, I saved a surgery. So that’s value that I have saved for the healthcare system, whether public or private” (N-SP, 1). |
| Level and intensity of care Mitigating staff shortages | • “Why don’t you have the [hearing] test to determine if you have this problem where you live? It’s not available. For Iqaluit or rural areas because there’s no audiologist there. [In Africa] there’s one or two audiology training programs in the continent, something like one audiologist per 10 million people. And there should be one audiologist per 30,000 people” (A-ON, 1). |
| Reducing patient access barriers to specialized care   | • People with diabetes “have to do a fundus eye exam. And they don’t, normally. They don’t do it because it’s expensive, they don’t have access. And, talking to the patients, what we heard was: ‘Wow, if I had that in my town, you know? It would be so much better!’” (M-SP, 1, follow-up). |
| Supporting patients and caregivers                     | • The digital books enable caregivers to interact more with a person living with dementia, “if they liked the story about hockey, [they] can continue bringing sports stories. [They] learn a little bit more that way as opposed to just sitting and watching tv or something” (F-ON, 1). |
| Opportunities to innovate                              | • In São Paulo in 2013, “we set out to do things that others did not do. [...] We provide a large volume of care because of our management model, in which the doctor spends little time doing things that are not medical. So, it was a challenge for [competitors] to try to innovate and meet the same volume we met” (P-SP, 1). |

Table A. Empirical illustrations of our thematic findings