A CASE STUDY COMPENDIUM: HEALTH INNOVATION IN THE WESTERN PACIFIC
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Foreword

We are pleased to present a compendium of mini case studies highlighting health innovation stories from Fiji, the Lao People’s Democratic Republic, Mongolia, the Philippines, the Republic of Korea and Viet Nam. This is the second instalment of “Innovation for Health”, a series dedicated to health innovation in the Western Pacific.

Health innovation encompasses the development and implementation of novel processes, products, programmes, policies or systems that lead to significant transformations or improvements in health and equity. The Western Pacific Region’s health innovation landscape is profoundly influenced by its diverse geography, cultural backdrop and socioeconomic conditions. While technological innovation has spurred economic growth in many countries, various social innovation strategies have effectively met public health policy objectives and ensured equitable access to care.

In the last three years, COVID-19 has amplified the scope of innovation, engaging a broader spectrum of stakeholders than ever before. However, the pandemic has also impeded progress towards the health targets set by the Sustainable Development Goals. To address current and future challenges without sideling the most vulnerable, we need enhanced and more effective health innovations. Despite the Region’s rich diversity, many health innovations have struggled to address challenges or enhance population well-being. As a result, the most financially disadvantaged and vulnerable groups, which have the most significant needs, are often overlooked. The absence of evaluation and evidence to back institutionalization further impedes health innovations that could have a broader impact. It is imperative for governments in the Region to lead health innovation, offering the world lessons on focusing innovation models on well-being and equity, scaling social innovation for equitable health access and fostering environments conducive to continuous learning and improvement.

The Innovation for Health series seeks to spotlight exemplary instances of health innovation in the Western Pacific Region, emphasizing the diverse roles that governments and health ministries can assume throughout the innovation journey.

This compendium traces the trajectory of health innovation in six countries of the World Health Organization (WHO) Western Pacific Region and covers a range of topics. These include achieving universal access to medicinal oxygen in Fiji; the integration of climate data into vector-borne disease surveillance in the Lao People’s Democratic Republic; and the scaling up of a national public health screening programme in Mongolia. The compendium discusses promoting participatory governance for tobacco control in the Philippines, and preparing ageing workers for the future in the Republic of Korea. Lastly, it highlights reaching high-risk populations with a comprehensive platform for HIV self-testing and education in Viet Nam. These stories underscore that change is a managed process, not an isolated event. Within this process, the public sector is pivotal, providing direction, value, resources, governance and evaluation mechanisms that innovators cannot produce independently. The series also recognizes the challenges of implementation, viewing them as opportunities to refine and amplify innovations for broader population health impact.

We trust that these narratives will provide valuable insights into the dynamism of health innovation in the Western Pacific Region.

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Key contributor interviews included Luke Nasedra and Udila Tawake from Fiji; Chansaly Phommavong from the Lao People’s Democratic Republic; Enebish Oyunsuren and Ganzorig Dorjdagva from Mongolia; Oliver Enriquez from the Philippines; Hyeyoon Ayleen Jung from the Republic of Korea; and Phan Thi Thu Huong from Viet Nam.

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Introduction

What is innovation?
Innovation is the introduction of something new to adapt to new conditions and address the unknown future. Three fundamental concepts underpin innovation in public health: it serves a social cause to improve the quality, impact and efficiency of population health outcomes; it is an iterative process that goes beyond mere creativity; and it extends beyond disruptive solutions, recognizing the value of “boring innovation” that consistently contributes to good public health. Innovation takes on various forms, such as adopting new perspectives through rethinking design, utilizing novel tools and methods, implementing innovative policies and collaborating with new stakeholders.

What makes innovations work?
New ideas and solutions do not always work. They need enablers to overcome challenges throughout the innovation process and thrive: strong leadership and vision; understanding of the need; iterative and learning culture; collaboration and diversity; empowerment and engagement; resources and support; supportive legal and policy environment; data and evidence; and continuous monitoring and evaluation. The success of innovation depends on a combination of these enablers and on the specific context and goals.

The context of innovation
Much of the progress made in public health has been driven by innovation: the eradication of infectious diseases; the management of noncommunicable diseases; the establishment of primary health care and more. However, progress from innovation has been uneven, leaving the most vulnerable populations behind. Long-term health challenges require new ways to react and adapt, while emerging threats demand new ideas and proactive measures for the future. Economic crises, pandemics, poverty, violence and conflicts have exacerbated the situation for the most vulnerable.

Purpose of the compendium
The purpose of this compendium of mini case studies on innovation is to examine public health innovations in the World Health Organization (WHO) Western Pacific Region. The compendium provides a comprehensive overview of these innovations, including their key enablers and challenges for scaling. It serves as a valuable resource for Member States facing similar public health challenges.

Development process of the mini case studies
The innovations were identified as case study candidates with support from WHO country offices. A list of candidates was drawn based on the above criteria for defining an innovation. A brief review of published grey literature was done. Wherever possible, key informant interviews were conducted (online) to understand enablers, barriers and challenges in the design, implementation and/or scale-up of the innovations. The case study write-up was developed and the write-up was validated by WHO country offices before publication.

A key limitation of the mini case study format is that the case study only provides a snapshot of the innovation and observed enablers and challenges. The process does not involve an in-depth analysis of literature or detailed primary data collection with other stakeholders such as ministries of health or civil society. For the literature search, it was only possible to include English-language publications.
Background
The Republic of Fiji, located in the south-west Pacific, is among the most urbanized Pacific island nations. Of its 332 islands, about a third are inhabited, with a combined population of about 930 000 as of 2022 (1). Fiji’s per capita gross domestic product (GDP) stands at US$ 5316. According to the World Bank’s income classification, Fiji is categorized as an upper-middle-income country (2).

The National Government funded 68.5% of the total health expenditure in 2020, amounting to a per capita health expenditure of US$ 186. This expenditure is complemented by out-of-pocket payments and voluntary health insurance contributions (3). Health services in Fiji are provided through a system that includes three divisional hospitals, 19 subdivisional hospitals, 84 health centres and 98 nursing stations. Additionally, there are two specialty hospitals dedicated to tuberculosis and mental health services (4). The primary health-care framework is bolstered by a network of 1805 community health workers (5).

The need for innovation
Pneumonia is a significant cause of death among adults and children in Fiji. Research from a tertiary facility in Suva for the period 2004–2007 revealed an annual incidence of 26.5 per 100 000 in children under 5 years of age and 10.9 per 100 000 in individuals aged over 55 years old. The overall case fatality rate was 20.5%, with 9.4% for those under 5 years and 53.3% for those over 55 years old. Given this high prevalence and case fatality rate, interventions are urgently needed (6).

Oxygen therapy is crucial for treating pneumonia, particularly severe cases or when patients show marked respiratory distress. Prompt oxygen treatment reduces the mortality risk by 35% (7). However, Fiji faces several challenges in providing medical oxygen. Medical oxygen in high-pressure cylinders is not only expensive but also presents challenges in distribution, maintenance and replacement, especially in health-care facilities located on the outer islands and in the interior highlands where comprehensive logistics systems are absent.

The transportation and delivery of these oxygen cylinders to health-care facilities often encounter delays. The procurement, transport and maintenance of these cylinders impose significant costs on health-care facilities and the Government, potentially diverting resources from other essential health-care services (8).

Traditional oxygen concentrators require a consistent electricity supply. Fiji grapples with ensuring uninterrupted power to its health-care facilities, especially those in rural and remote areas. Power outages can disrupt the oxygen supply, putting patient care at risk (7).
Moreover, the process of refilling oxygen cylinders demands appropriate facilities, trained personnel and strict adherence to protocols. In areas with limited resources, ensuring the timely refilling and maintenance of cylinders can be a challenge and lead to shortages (8).

**Solution and process of change**

The Fiji Oxygen Project (FiO2) was initiated in 2014 as a collaborative effort between the Fiji Ministry of Health, the University of Auckland, Azimut 360 and Cure Kids. Originating as a research initiative spearheaded by the University, the project aimed to introduce a concentrator-based oxygen system to health facilities. This system was envisioned as a high-quality, reliable, user-friendly and cost-effective alternative to traditional oxygen cylinders, addressing the challenges of supply chain issues, unreliable power and maintenance.

An oxygen concentrator is a compact, portable device that uses filtration to separate nitrogen from the ambient air, producing a concentrated and pure oxygen supply. Oxygen concentrators offer a sustainable oxygen source, eliminating the recurring costs and logistical hurdles associated with cylinder refilling and replacement. The system can be augmented with tools such as pulse oximeters for rapid diagnosis and oxygen-level monitoring, and solar arrays for power backup. By adopting oxygen concentrators, the logistical and technical difficulties associated with traditional cylinder-based oxygen provision can be bypassed. Moreover, the oxygen concentrator solution was enhanced with solar power systems, ensuring a dependable and continuous energy source even in regions with sporadic electricity access. This solar integration bolstered the project’s resilience, guaranteeing uninterrupted oxygen therapy.

The solar-powered concentrator, a product of the University of Auckland and Azimut 360, underwent its inaugural field test at the Nausori Health Center in January 2016. Located near Suva, this health centre has a high patient load and oxygen treatment demand, making it an ideal pilot site. After this initial test, the project team continued to assess health facilities urgently requiring oxygen concentrators and solar systems. They also oversaw installations to ensure the effective functioning of the concentrator-based oxygen system.

The project’s scope and team expanded notably during the COVID-19 pandemic, recognizing the imperative of investing in oxygen treatment for patient care (9). By May 2023, the project had distributed and installed 254 oxygen concentrators, more than 100 pulse oximeters and other oxygen-related equipment in 44% of Fiji’s health facilities. Plans are underway to distribute an additional 50 oxygen concentrators to further enhance coverage. Concurrently, the project team trained more than 1400 clinical staff members, empowering them to use and maintain oxygen concentrators, which have so far treated more than 50 000 patients. Additionally, more than 20 technicians from various health facilities received training, equipping them with the skills and knowledge essential for the proper servicing and maintenance of the concentrators. The project has seen considerable expansion, now boasting a collaboration of more than 20 local and international personnel who contribute to its daily operations (10). A remote monitoring system for oxygen concentrators has also been established, and this approach has been adopted by senior health system managers to oversee the functioning and maintenance of health equipment.

This project has played a pivotal role in shaping the forthcoming national oxygen policy. The policy’s objective is to institutionalize the use of suitable technologies to enhance access to oxygen therapy.
References


Background
The Lao People’s Democratic Republic is a landlocked country in Southeast Asia. With a population of approximately 7.3 million (1), it is home to 47 distinct ethnic groups. An estimated 67% of its inhabitants live in rural areas (2).

The Government’s health spending as a proportion of health-care expenditure has increased from 27% in 2005 to 43% in 2020. The per capita health spending has grown from US$ 17 to US$ 68 for the same time period (3). By 2019, the average life expectancy in the Lao People’s Democratic Republic was 68.5 years (1). This progress reflects the improved quality of life and underscores the country’s dedicated efforts to enhance health-care services and interventions.

The need for innovation
Climate change poses challenges to the advancement of the health-care system. Projections indicate that the Lao People’s Democratic Republic will face a temperature increase of 2–3 degrees Celsius by 2050, coupled with more frequent extreme weather occurrences. Such climatic shifts have already amplified the risk of climate-sensitive diseases. Unpredictable weather patterns, marked by shorter rainy seasons with heavy rainfall, have fostered optimal conditions for disease-spreading mosquitoes. Dengue, previously endemic, has expanded as a major concern throughout all 17 provinces, with a significant outbreak in 2019 (4). Extended dry periods also contribute to a rise in diarrhoeal diseases, a predominant factor in child mortality (5).

Solution and process of change
The Ministry of Health and the WHO country office in the Lao People’s Democratic Republic collaboratively envisioned integrating routine epidemiological data with climate data. Using the EWARS framework, they formulated an outbreak prediction model, aiming for its seamless incorporation into DHIS2 for regular disease surveillance and outbreak tracking.
The Ministry of Natural Resources and Environment oversees the collection and management of climate data in the Lao People’s Democratic Republic. The Ministry of Health, in partnership with the Ministry of Natural Resources and Environment, secured data access through a memorandum of understanding, guaranteeing efficient data exchange with backing from the WHO country office. This memorandum of understanding enabled the Ministry of Health to access historical climate data spanning the last five years, allowing DHIS2 to merge this data with disease surveillance information.

Statistical models, utilizing health system metrics (for example, confirmed and probable hospitalizations) and climate indicators (for example, rainfall and temperature), were developed to anticipate outbreaks at the provincial level for a span of up to two weeks. The intent behind these prediction models is to boost sensitivity and precision. Currently, these models are being evaluated for predicting dengue and several other climate-sensitive ailments. They are poised to lay the groundwork for a real-time early warning system once the model adjustments conclude.
References


MONGOLIA

Scaling up a national public health screening programme

Background
Mongolia, bordered by the Russian Federation and the People’s Republic of China, is a landlocked nation. As of 2022, its population stands at 3.4 million (1). The population distribution is uneven, with one third residing in the capital, Ulaanbaatar, and about 40% leading a nomadic way of life (2). Classified as a lower-middle-income country, Mongolia has witnessed consistent economic growth since the 2000s, primarily driven by the mining and agriculture sectors. However, the challenges of poverty and unemployment persist (3).

In 1993, Mongolia introduced social health insurance, ensuring universal free access to state-funded primary health care. By 2017, social health insurance encompassed 96% of the population (4). The health-care sector’s funding comes from four main sources: the state budget, health insurance funds, individual out-of-pocket payments and international aid and loans (5). In 2020, the Ministry of Health reported that the state budget funded 77% of total health expenditure, with health insurance funds covering 20% and the remaining 3% covered by income from main and support services (5).

Mongolia is experiencing an epidemiological shift, with noncommunicable diseases such as cancer, ischaemic heart disease and stroke emerging as primary causes of mortality (3). Prominent risk factors include high blood pressure, dietary risks, alcohol consumption and tobacco use (3). The Mongolian Government has pledged its commitment to “Vision 2050”, an all-encompassing long-term development strategy aiming for social progress, economic advancement and enhancing the quality of life by 2050. This vision emphasizes fostering healthy habits and active lifestyles, while also promoting a high-quality, accessible and efficient health-care system. The initial phase (2021–2030) of this vision includes key public health measures such as creating a national health database, broadening early disease detection services, improving health-care quality and accessibility, and curbing mortality from cardiovascular diseases and cancer (6).

The need for innovation
Government-initiated screening programmes aim for early disease detection. Over the past two decades, the Government has launched several such programmes, including the National Program for Healthy Mongolians (2006), the Healthy Mongolians Program (2012), the National Healthy Liver Program (2017) and the Healthy Teeth and Healthy Children Program (2018). However, these early detection initiatives have encountered shared challenges, such as limited public participation, sustainable funding issues and continuity concerns post early disease detection (3). To realize the key objectives of early detection services, it is imperative to innovate and address the shortcomings of past national screening programmes.
Solution and process of change

In May 2022, the Government of Mongolia, through the Ministry of Health, initiated a comprehensive nationwide health screening and early detection programme for both infectious and non-infectious diseases. The ambition is to screen the entire Mongolian population by the close of 2024, incorporating diagnostic measures such as blood tests and x-rays.

This programme boasts several pivotal enhancements. First, in a departure from prior initiatives, this national screening mandates the completion of all diagnostic tests. Second, the Government has adopted a holistic approach, requiring all ministries to contribute to expanding population coverage. For instance, the Ministry of Defence and railway entities have leveraged their vehicles, railways and technology to access hard-to-reach demographics, including herder families. These herders are also catered to at soum health centres, which periodically host specialists from state hospitals. This directive ensures a broader mobilization of resources, transcending the health sector, to boost public engagement. Third, screenings are conducted at referral hospitals, ensuring that diagnosed individuals receive immediate treatment at the same facility. Fourth, post-screening treatments offer individuals a reduction of 15–25% in out-of-pocket expenses.

By April 2023, the early detection programme had encompassed 29% of Mongolia’s population, a total of 996 000 individuals. This extensive coverage has shed light on the prevalence of ailments such as cancers, respiratory conditions, cardiovascular diseases and digestive and metabolic disorders. Preliminary screening outcomes revealed tooth decay as the predominant risk among children aged 0–5 years old. Digestive system disorders were most prevalent in the 6–17 years bracket. For those aged 18–30 years old, genitourinary system disorders were most common. For those aged 31 years and above, digestive system disorders emerged as the chief ailment.

This expansive early detection coverage has heightened disease awareness among the populace. The extensive data generated from this initiative has paved the way for research endeavours. The assimilation of this data has been facilitated by the Integrated Platform for Early Detection, underscoring the data-centric strategy of the Mongolian Government. All screening data are archived at the National Health Data Center. The data undergo analysis and are used to refine data collection queries, gain a deeper understanding of disease prevalence and risk factors, and guide long-term health planning and resource allocation.

The national screening will be consistently administered, exclusively utilizing funds from the Health Insurance Fund. As of August 2023, a mere 10% of the Health Insurance Fund has been allocated to health screening, with the remaining 90% dedicated to health-care treatments. By earmarking investments for the national screening programme, the goal is to recalibrate fund allocation, thereby augmenting investments in screening and early detection to curtail treatment expenditures.
References


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THE PHILIPPINES
Between city and citizens: participatory governance for tobacco control

Background
The Republic of the Philippines comprises more than 7,000 islands and has a population of approximately 116 million (1). The nation is divided into 17 regions, further segmented into provinces, cities, and municipalities, collectively termed local government units (LGUs) (2). While the National Department of Health sets policies, standards, and guidelines, both the LGU and Department of Health collaborate in delivering health services, with the LGU focusing on provincial and municipal levels. This decentralized approach allows for tailored health-care solutions addressing specific community needs.

Since 2010, the Philippines has been advancing towards universal health coverage and addressing the social determinants of health. Positive strides have been made in life expectancy and reductions in infant and under-5 mortality. However, the escalating burden of noncommunicable diseases remains a concern, accounting for 68% of all deaths in 2019 (3).

The need for innovation
Balanga, the capital of Bataan province, is its third-largest municipality, comprising 25 barangays and housing 104,173 residents (4). Despite its relative economic prosperity within Bataan, the average lifespan in Balanga City was 62 years, falling below the national average of 69 in 2020 (5). Research indicated that half of the top 10 mortality causes in Balanga City were tobacco-related (5). Innovative strategies are essential for Balanga City’s LGU to combat the entrenched risk of tobacco use and elevate its citizens’ quality of life.

Solution and process of change
The City Government of Balanga pioneered the establishment of the Health Promotion Board (HPB), an independent agency within the City Government, marking a significant step towards innovation (5).

The HPB, emphasizing participatory governance, operates autonomously, prioritizing community interests (5). Participatory governance involves citizens in public policy formulation, garnering community backing for health initiatives. Furthermore, co-design – by amalgamating the expertise, experiences, and motivations of all stakeholders – ensures locally relevant solutions (6). Engaging individuals in decision-making processes fosters better health choices (7).

Key community-driven HPB initiatives include “Healthy Balangaño 2030” focusing on comprehensive health-care services and youth health improvement (8). The programme’s primary objective is peer facilitation for emotional, social, and informational support and enabling youth leaders to contribute to the HPB’s ongoing programme development (5). A core vision is fostering a tobacco-free generation and promoting healthy, active lifestyles.
Community engagement through the HPB has amplified participation in health promotion events. For instance, in support of the Tobacco Free Generation City initiative, Balanga City hosted a record-breaking dance fitness class with 16 200 participants.

Since the HPB’s inception, Balanga City has been lauded for its robust anti-tobacco policies. These include a comprehensive public ban on tobacco products since 2008 (9) and the 2016 Tobacco Free Generation (TFG) End Game Strategy Ordinance, prohibiting the sale and use of tobacco products for those born on or after 1 January 2000 (10,11). These policies, advocated by the community to the HPB, have garnered widespread support.

Post implementation of these programmes, the city witnessed a decline in smokers from 23% in 2010 to 11% in 2019. Life expectancy also rose from 60 years old at the HPB’s inception to 65 years old in 2022.

Inspired by the HPB’s success in Balanga, similar structures are being integrated into other LGUs in Bataan and beyond. Balanga City exemplifies how a city can function as a local ecosystem, driving purposeful policies to combat noncommunicable diseases and act on health’s social determinants.
References

INTRODUCTION

Background
The Republic of Korea, with a 2022 population of approximately 51.7 million (1), has experienced swift demographic shifts due to factors such as low birth rates, increased life expectancy and urbanization. As a result, the Republic of Korea is among the most rapidly ageing societies globally. In 2020, more than 20.7% of its population was aged between 55 and 69 years old and more than 14% was aged over 65 (2).

Despite a robust health-care system with universal coverage, the challenges posed by this demographic transition are multifaceted. Policy-makers must cater to the older population’s needs while also promoting family-friendly policies to increase birth rates.

Holistic well-being for older individuals involves various factors, including physical activity, diet, self-awareness, continuous learning and community engagement (3). However, in the Republic of Korea, the initiatives promoting healthy lifestyles for older people often lack adequacy and equity.

The need for innovation
Financial security is crucial for healthy ageing. In the Republic of Korea, financial insecurity among older people, especially those aged 50 and above, is a pressing concern. Many opt for early retirement in their late 40s and 50s, often due to involuntary reasons such as corporate downsizing or a preference for younger employees (4). This trend leaves early retirees unprepared for retirement and with the associated loss of a significant social identity. Without structured re-employment opportunities, they often settle for roles that mismatch their skills and offer inadequate compensation (4).

Moreover, early retirees miss out on the safety nets provided by social and health benefit plans tailored for those aged 65 and above. The country’s policies include interventions such as the mandatory long-term care insurance for older individuals with physical challenges (5) and a mandatory pension programme for those aged 60 and above (6). Without these safety nets, early retirees often deplete their savings, leading to financial vulnerability and compromised quality of ageing.

As the working-age population declines, there is an increasing fiscal strain on health care, social welfare and pensions (7). Both the Government and early retirees stand to benefit from remaining active and involved in social and work environments. Innovations are essential to enhance the skills of early retirees, provide them with suitable employment opportunities and ultimately enhance their overall well-being.
Solution and process of change

Between 2013 and 2016, programmes were developed to support the welfare and education of older people, laying the groundwork for the 50+ initiative launched in 2016.

The 50+ initiative reframes ageing as an opportunity for continued contribution. It adopts a comprehensive approach to well-being, focusing on health, education and workforce engagement. By offering tailored continuous learning and skill development solutions for those aged 50 and above, the initiative aims to enhance their employability, extend their working life and promote independent, high-quality living.

Organized into three key intervention areas: Learning and Exploration, Jobs and Social Engagement, and Culture and Infrastructure, the initiative actively engages individuals through a network of campuses and centres, established in collaboration with non-profit and private sector organizations. The Seoul 50 Plus Foundation acts as the coordinating body, partnering with more than 30 organizations and the Seoul Metropolitan Government (8).

These campuses and centres offer a variety of customized services, including counselling, education, job models introduction and intergenerational exchange. As of 2020, four centres were operational, with plans for 15 more. Additionally, three campuses were operational, with plans for three more by 2020 (9).

The vision is to inspire early retirees to consider “encore careers”, which might involve formal employment, entrepreneurial ventures or volunteer work. By August 2017, the 50+ campuses had offered over 303 courses to more than 15,000 participants and 600 individuals had chosen 13 different Boram Job placements. The initiative also facilitated the creation of 112 50+ communities, such as interest- and location-based groups. An opportunity exists to evaluate the well-being of those engaged in the initiative to understand its full impact (9).

The 50+ initiative aims to reach 30% of Seoul’s population. Beyond Seoul, other municipalities are considering adopting the 50+ campuses and centres model and the National Government has announced plans to establish new social infrastructure to support this generation.
References


VIET NAM

Reaching the unreached high-risk population through a virtual platform for HIV self-testing and education

Background
The Socialist Republic of Viet Nam, with a population of 98.2 million in 2022 (1), is a lower-middle-income economy. With a per capita GDP of US$ 4163 (2), Viet Nam allocates 4.7% of its GDP to health (3). Life expectancy stands at 79.2 years old for women and 70 years old for men (4). The country’s main public health financing source is its social health insurance, established in 1992.

The HIV epidemic in Viet Nam, identified in 1990 (5), predominantly affects three key populations: people who inject drugs, female sex workers and men who have sex with men (6). In 2021, the prevalence rates for these groups were 13%, 3% and 13%, respectively (7).

In 2014, Viet Nam committed to the 90–90–90 targets for HIV,1 and witnessed a decline in new HIV infections and AIDS-related deaths since 2010 (8). By 2021, 84% of people with HIV were aware of their status, 72% were on antiretroviral treatment and 69% had suppressed viral loads (7). These achievements were the results of expansion of HIV services such as HIV self-testing, decentralized clinical service delivery with sustainable financing supported by health insurance and ongoing support from donors (9,10).

The need for innovation
Introduced in 2017, HIV self-testing in Viet Nam initially relied on facility-based, community-based and pharmacy distribution models (11). However, stigma, fear of discrimination, inconvenient service hours and travel challenges deterred many from accessing these services (12), especially during the COVID-19 pandemic. The need arose for a virtual solution that ensured continuity of care and addressed the low uptake of HIV self-testing kits, especially among younger, tech-savvy men who have sex with men.

Solution and process of change
The COVID-19 pandemic’s movement restrictions highlighted the need for alternative HIV self-testing solutions. In response, the Ministry of Health, supported by international agencies such as WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Unified Budget, Results and Accountability Framework and Unitaid, launched a virtual platform. This platform allowed users to order online HIV self-testing kits and prevention commodities such as condoms, lubricants and needle syringes. They could also access offline follow-up services, including counselling (13). The test used was an oral fluid test, which is less invasive than blood sample-based methods.

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1 The targets are: 90% of people living with HIV will know their HIV status; 90% of people who know their status are on HIV treatment; and 90% of all people on treatment will have undetectable levels of HIV in their body (known as viral suppression).
The pilot phase of this platform, which took place from November 2020 to December 2021, covered Can Tho, Nghe An and Hanoi. Over 4000 kits were distributed, reaching 3727 individuals, predominantly men who have sex with men. About half of these users had never tested for HIV before. Of those tested, approximately 5% were HIV positive, with 98.1% subsequently starting antiretroviral treatment.

A post-service satisfaction survey indicated high user satisfaction, emphasizing the platform’s confidentiality, convenience and support. The platform’s success led to its expansion from April 2022 to April 2023 across 27 provinces. This phase reached 9194 individuals, primarily men who have sex with men. Of those diagnosed with HIV, 97% began antiretroviral treatment and about 20% of those testing negative started on pre-exposure prophylaxis.

The targeted cohort, familiar with technology, found this method accessible and confidential. The platform provided culturally relevant information and counselling, tailored to the cohort’s needs. This approach not only improved the HIV testing coverage but also service delivery efficiency and contributed to achievement of the treatment target (14).
References


Key themes emerging from the case studies

While the case studies are diverse, ranging from data innovations to community engagement, there are common key factors that unite them throughout each stage of the innovation process.

**Governance** Elevating health innovation policies to a primary position on policy agendas is essential to nurture and expand health innovation at all levels. This involves enacting supportive policies, championing education and research, nurturing collaborations and partnerships, ensuring a conducive regulatory environment and developing inclusive and sustainable markets for health innovations. The Philippines example illustrates how city governance can bolster collaboration with communities and citizens, transforming cities into health innovation hubs. Mongolia’s case underscores the advancement of a national health mission through a comprehensive government approach. In the Lao People’s Democratic Republic, collaboration between two ministries solidifies the connection between climate data and vector-borne disease surveillance.

**Capacity-building** The public sector should champion a culture of perpetual learning that advances innovation and its policy-making. Engaging with diverse groups often leads to the emergence of new methodologies and knowledge. In Balanga City, the Health Promotion Board actively involves the community, facilitating the implementation of their health promotion ideas and offering upskilling opportunities. In Seoul, the city administration enhances its innovative capacity for the well-being of early retirees by partnering with multisectoral organizations.

**Financing** Innovation need not be costly. The Lao People’s Democratic Republic case study highlights the integration of open-source tools into cost-effective solutions, while the Fiji Oxygen project emphasizes cost-effectiveness as a primary motivation for investment in innovation. Nevertheless, sustained resource commitment is pivotal to amplify mission-driven health innovations. Public institutions are instrumental in offering extended timelines and financial stability to navigate the uncertainties inherent in the health innovation journey. Mongolia’s commitment to this principle is evident, with the Health Insurance Fund persistently supporting the national health screening programme until the transition from a treatment-centric to a health-centric system is realized.

**Measurement** Learning remains central to the health innovation process. Assessing health innovations facilitates experiential learning, enables policy refinements, maintains the innovation ecosystem and ensures stakeholder actions are both cost-effective and effective. This strategy encompasses evaluating the processes, outputs and outcomes of health innovations across both public and private sectors. In Viet Nam, health impact evaluation has been integral, since the pilot phase of the virtual platform for alternative HIV self-testing. In Mongolia, the Ministry of Health partners with research entities to scrutinize screening data for operational research, refine data collection methodologies, evaluate disease burden and guide decision-making.