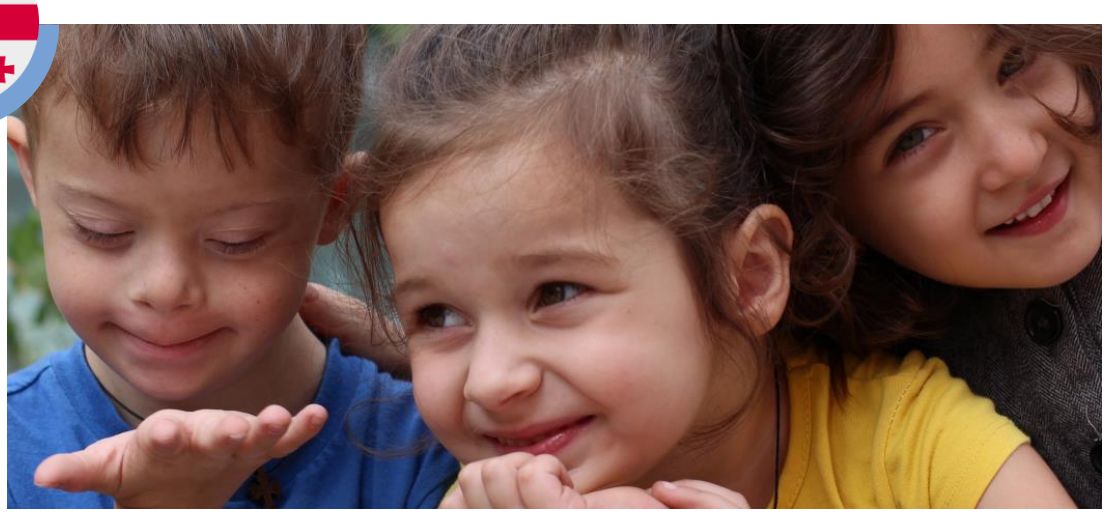
Public-Private Partnership accountability in Universal Health Care for women's, children's and adolescents' health in Georgia



UNICEF Georgia

Introduction - Country Context

This country case study was developed to highlight what accountability in health means to individuals and key stakeholders in Georgia, how it benefits women's, children's and adolescents' health, and where accountability barriers obstruct progress in health rights and health-related Sustainable Development Goals (SDGs). The accountability lens is especially critical as it relates to private-public partnerships for health. This report is one of the five case studies developed for the landmark IAP report entitled "Caught in the COVID-19 storm: accountability for every woman, child, adolescent in the context of UHC and SDGs". The study was completed during the COVID-19 pandemic and therefore reflects a number of lessons from the SARS-COV-2 emergency response.

Georgia is a country in Eastern Europe with a population of 3.7 million people. It has experienced dramatic social, demographic, political and economic changes during the 30 years since regaining independence from the former USSR. Conflicts with Russia since 1990s and the 2008 August war resulted in around 300,000 internally displaced persons and occupation of 20% of the country's territory. After substantial economic growth, the World Bank reclassified Georgia as an upper middle-income state in 2018. However, over 420,000 Georgian citizens still live in socially vulnerable households[1] and 6.8% of children in 2017 remained below the extreme poverty line[2]. The country has made substantial progress against basic indicators for maternal and child health, though maternal mortality, infant and under-5 mortality rates still lags behind the European average.

Evolution of national health services towards UHC

Until 2013, the health rights of Georgian citizens was upheld by the Constitution, national healthcare legislation, other national laws and international treaties and agreements.[3] However, only 1.9 million people, or 51% of the population, was covered by health insurance as of 2012, including 1.6 million through state-funded targeted medical insurance and 362,000 through private plans.

After the 2012 parliamentary elections a new government came to power with a clear electoral promise for universal health care. Subsequently, Georgia doubled its government health expenditures and initiated a flagship programme of Universal Health Care (UHC) in 2013[4]. This reached over 90% of the population with a basic, though non-comprehensive, package of primary health care (PHC), emergency and in-patient services. In parallel to the UHC initiative, 23 disease-specific programs are implemented in the country, including immunization, HIV/AIDS, TB, Hepatitis C elimination, diabetes, mental health, etc.

Georgia expanded access to health services for its citizens and reduced out-of-pocket (OOP) expenditures for health from 73.4% in 2012 to 54.7% in 2017[5]. Individuals with annual income of over 40,000 GEL were subsequently withdrawn from the UHC, though still left eligible for maternity services and infectious diseases management programmes. Despite the changes, the vast majority of the population in Georgia continue to benefit from a state-funded UHC package, including health services for women, children and adolescents.

The private sector is an important partner for the government in implementation of UHC. After massive privatization of health institutions, driven by privatization and deregulation focus of government policies in 2003-2012, over 85% of primary health and in-patient services in the country operate under private sector management. They are regulated by the national health authority. It is important that this environment assures adequate availability and quality of services, and the financing of common goods for health (CGH). These are defined as "population-based functions or interventions that only collective arrangements can finance, regardless of whether they are delivered by public or private sector providers".[6] Examples of CGH include planning and management of emergency response and regulation of the safety of medicines and medical devices.

Key Findings of the Review

Institutions and other actors in accountability for health

- The Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA) sets and monitors health regulations. These include the same accountability standards for health service providers in public and private sectors. Three agencies of the MoIDPLHSA are mainly engaged in the accountability process, including the Regulation Agency of Medical and Pharmaceutical Activities; Social Service Agency (SSA), and the National Centre for Disease Control and Public Health (NCDC).
- The MoIDPLHSA is accountable to the national Parliament, and primarily to its Health and Social Affairs Committee and Committee for Human Rights and Civil Integration.
- Public and private sector providers of health services and pharmaceutical products (PHC facilities, specialized hospitals, pharmacies and laboratories) are subject to scrutiny by the Regulation Agency of Medical and Pharmaceutical Activities.
- Patients, individual citizens and institutions can claim their health rights through the following human rights institutions: (a) the Professional Council operating at the MoIDPLHSA; (b) the national Court and externally

the European Court of Human Rights, and (c) the Public Defender or Ombudsman. As discussed below, at present, none of the instruments could be considered as time-efficient or effective.

- Civil society has an important role to play in holding the government to account on health, including through the media, professional associations and NGOs.
- UN agencies and multi- and bi-lateral donors work with the government on policy development as well as monitoring and reporting on health-related indicators and goals at national and international levels.

Culture of accountability

Research for this case study found that medical and public health professionals value accountability as a concept. They view it as a critical element for development of the health sector, especially in the context of public-private partnerships (PPP). However, expectations of accountability, and understanding of what it means, varied across the stakeholders interviewed for the case study.

For instance, health service providers tended to display a pragmatic attitude to accountability. Their responses primarily focused on fulfilling the reporting obligations to the government and the driving motivation of their accountability was to avoid financial sanctions. *"There are certain mechanisms on accountability, though not perfect. Monitoring is segmental, not systemic, and it only serves to issue financial fines to hospitals… the system is focused on sanctions and not on quality enhancement. We have the following accountability model: hospitals submit reports not to get fined"* (hospital manager interview). Experts from civil society were more concerned with the need to improve public-awareness on health issues, and with the realization of health rights, more active engagement of patient groups in health-related decisions and mutual cooperation between the state and citizens. *"The topic of accountability is extremely important ... but everyone avoids it. This is the problem……Both sides need to cooperate. People must be involved in health-related planning processes…. healthcare and education in their lives. Healthcare can't be developed just by one actor, for example Ministry of Health." (Civil society, interview)*

Despite its challenges, accountability mechanisms for maternal and child health are relatively strong in Georgia. A mandatory notification of MoIDPLHSA/NCDC is in place on every case of maternal, infant and under-5 mortality countrywide. NCDC and Regulation Agency of Medical and Pharmaceutical Activities undertake audits of individual maternal deaths and maternal near misses. Maternal and child health indicators are also regularly monitored and reported in the SDG progress reviews. Unfortunately, adolescent health issues receive less scrutiny and stakeholders tend to rely on periodic surveys of knowledge, attitudes and practices (e.g. tobacco and alcohol use among adolescents and young people) mainly funded or co-funded by international partners and civil society organizations.

Respondents expressed hope that the COVID-19 pandemic, taking place at the time of the review, could lead to improvements in health accountability. For example, the global health crisis has motivated health sector partners to engage and work more closely with the media to publicize health information. Media has been an important player in highlighting both positive steps taken to tackle the pandemic, as well as the systemic accountability challenges, such as lack of transparency and independent oversight for the emergency response.

Strengths of Public-Private Partnerships in UHC and accountability system for women, children and adolescents

Georgia's experience indicates that with political commitment and financial investment the basic health needs of women, children and adolescents could be met. Since 2013, health care services in Georgia have become generally more accessible and affordable for families countrywide. As part of the UHC a more comprehensive package for women's, children's and adolescents' health was launched, including covering the costs of 8 antenatal visits, delivery services, in- and out-patient emergency and hospital care (e.g. trauma management, elective surgeries) and continued provision and/or expansion of disease-specific programmes for immunization, HIV/AIDS, TB, Hepatitis C, mental health, diabetes and rare diseases. However, despite the substantial expansion of services, UHC still does not adequately cover reproductive health commodities for women and adolescents, high-cost interventions such as bone marrow transplantation (BMT) (Box 1) or rehabilitation services for children or adults living with disabilities.

Box 1.

BMT and some other state-of-the-art cancer therapies for children and youth are not yet available in Georgia. Families are forced to seek treatment abroad with impoverishing costs. The Solidarity Fund of Georgia, established by the Prime Minister in 2014, is co-funding these high-cost interventions. It is a good example of a public-private partnership with engagement of over 60,000 individuals and up to 100 private companies.

Attainment of UHC is feasible in a mixed health system, even when dominated by private, for-profit service providers, but a strong oversight is essential. Georgia has successfully launched the UHC programme in a setting with over 85% of health service facilities owned by business (notwithstanding remaining challenges in the health sector). Independent experts saw PPP as an area of opportunity for Georgian healthcare that could establish an effective competition culture for delivering quality services and ensure cost-containment. However, despite common reporting and accountability tools applied by the Ministry for public and private health service providers, accountability challenges remain and the MoIDPLHSA oversight should be strengthened beyond merely financial reporting to ensure effective stewardship. The IAP 2018 report on the private sector stated that the Government is a guardian of the private sector accountability for health. It also recommended public consultation on planned PPPs, and involving women's groups, other civil society organizations and health professionals in designing and monitoring them.[7] A paper commissioned on accountability and health service delivery by the World Health Organization (WHO) Department for Health Systems Governance and Finance also provides relevant guidance,[8] noting that the private sector will not self-regulate for UHC goals and requires effective stewardship.

PPP for UHC can work both at national and international levels. Georgia implemented UHC in a mixed health system through a public-private partnership infrastructure. Furthermore, over the last two decades, Georgia has ensured universal access to immunization, AIDS, TB and Malaria interventions through global PPP funding, such as the GAVI Vaccine Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These programmes leveraged support from UNICEF, WHO, USAID and other international partners were eventually guaranteed by financial sustainability from the Government. Finally, in 2015 Georgia launched its historic National Hepatitis C Elimination programme with the US Government support and a unique PPP agreement with Gilead Sciences Inc.

Recent reform of maternal and new-born care services sets a good standard for quality assurance and quality improvement (QA/QI), even if accountability among public and private stakeholders remains weak. For-profit health

care providers in Georgia are often vertically integrated with private health insurance and pharmaceutical companies, without effective and/or independent accountability mechanisms.[9] *"The same business which own hospitals also own insurance companies and pharmaceutical companies. The UHC programme allowed big businesses grow even further. This business is not effectively regulated by the state…"* (Expert interview). It was felt that more could be done by the state to undertake comprehensive effective reforms in QA/QI. Only a few private hospitals have taken the initiative to enquire about international quality assurance audits and some private companies express concerns with governments accountability arrangements. At the same time, Georgia's efforts to regionalize perinatal health services and introduce an QA/QI system in 2015-2017 are commendable. The initiative can not only improve health governance standards, but ultimately lead to better health outcomes for women and children. It is further encouraging that through the UNFPA support, the Government and private sector stakeholders are working on regionalization of antenatal care and introduction of WHO methodology "Beyond the numbers"[10] to further enhance the quality of maternal and child health services.

Accountability challenges

UHC is costing more to implement than estimated due to insufficient cost-containing measures in place. The UHC programme reported substantially higher actual spending levels than planned at the time of its launch. Respondents attributed this to rising costs of health services, increase in service provision at secondary and hospital levels, and possible manipulations with UHC financing codes to receive higher reimbursement from the Government. MoIDPLHSA started gradual revision of the programme already in 2017. However, in 2019 the government decided to cut prices of selected clinical interventions funded under UHC, which proved massively unpopular. Following Resolution 520 issued on November 21, 2019,[11]concerns were immediately expressed in the media and by medical professionals. In response, on December 17, 2019 the MoIDPLHSA formed a council to initiate consultation on cost-effectiveness, financial, coordination and other aspects of UHC.[12] While the impact of the resolution is still to be studied, the initial media reports and expert opinion from the current review indicate a major communication gap between the government and health service providers in the private sector. According to case study respondents, the perception is that this led to reduction in wages for clinical practitioners and an increase of out-of-pocket payments for patients. Fortunately, funding for women, children or adolescent health services has so far not been affected.

Health governance should be more open, as a critical element of accountability. Aspirations for UHC goals were reaffirmed by the 2014-2020 State Concept of Healthcare System of Georgia[13] and "The Vision for Developing Georgia's Healthcare System by 2030".[14] Despite public declarations on accountability, very few official documents or research publications present detailed understanding of accountability mechanisms in the health sector partnership in Georgia. The government is accountable to the Parliament, though the case study respondents noted irregularity and delays of MoIDPLHSA reporting to the legislative body. The Parliament committed to the open governance principles as set forth by SDG 16, publishes its annual action plans and reports for the health sector, though consistency of the government's and parliamentary vision on health sector priorities and accountability was questioned by the case study participants. Another challenge reported by the respondents was the lack of an independent advisory body to the Government that could provide critical assessment of the sector's performance and advise on evidence-informed recommendations. Universities or the Academy of Sciences could potentially fill-in the gap, but the institutions are neither financially independent from the Government, nor have a possibility for regular engagement in the dialogue. The report revealed specific recommendations for engagement of independent experts, research institutions and civil society partners in consultations with the MoIDPLHSA on health governance in general, and on stewardship and accountability for UHC, in particular.

Patients and health care providers need more effective mechanisms for claiming their rights. A stand-alone health mediation service was closed in 2015, due to the shift from the state-funded health insurance programmes to UHC services implemented directly by the Social Service Agency of MoIDPLHSA. Today, patients and institutions engaged in UHC implementation can claim their rights through a Professional Council operating at the Ministry, justice system or the office of the Public Defender (Ombudsman). In addition to being a time-consuming process, the case study respondents questioned the independence and impartiality of the Professional Council as well as complete independence of courts from political influences. The MoIDPLHSA hotline is the most frequently used system by citizens to find out information on health-related issues, most often to inquire the funding status of their health services. Specifically for COVID-19 response, in addition to the NCDC Hotline, Government's Hotline and web pages became operational together with production of news brochures and video clips. However, the overall experience shared by the civil society representatives was that women, children and adolescents, like other citizens, have neither sufficient information nor effective mechanisms for claiming their health rights. Even during the COVID-19 response, media reported several individuals who turned to journalists for help in finding out details on their eligibility for COVID-19 testing and hospitalization. As a representative of a patients' union noted: *"Patients' rights were previously defended by a mediation service, which doesn't exist anymore. The ombudsman office is not involved in this process, or at a very limited scale. Courts are not trusted and even if people file court cases, these last for years and cost a lot. State needs to have structures that can discuss and resolve medical disputes without courts. Very often people don't understand or know how to protect their own rights."*

Limited health awareness combined with social and cultural norms affect women's, adolescents' and children's health. Respondents noted that women and adolescents often lack awareness and knowledge about availability of health information, products and services. For example, women have limited access to information about the benefits and availability of cancer screening programmes, and the latter combined with stigma and fear, contributes to low uptake of relevant services, even when fully funded by the Government. As an example, 30-49 year old women reported 23.9% lifetime prevalence of cervical cancer screening in the STEPS-2016 survey[15]. Another issue is the lack of reproductive health education among youth which could be attributed, among other factors, to the lack of youth- and adolescent-friendly sexual and reproductive health services in the country. Use of all methods of contraception declined from 53.4% to 45.4% from 2010-2018; rates of elective abortions remain high though on decline and considered to be underreported. Other concerning tendency includes the high prevalence of C-sections, with increased health risk implications for both mothers and children. On a positive note, early marriage and childbearing or home delivery rates in the country have declined significantly.[16] Finally, Georgia is still identified as one of 12 countries globally, with strong evidence of a sex-ratio-at-birth (SRB) imbalance[17], which suggests the practice of sex-selective abortions, as families tend to prefer boys rather than girls.

UHC reporting primarily focuses on positive results for political purposes, though perinatal care reporting practice is a notable exception. As noted, Georgia has universal, common reporting tools for health statistics and financial reporting for public and private health service providers. However, monitoring and reporting are mainly quantitative and financial, with no feedback mechanisms on performance. Similar accountability challenges were documented by WHO in its 2018 review of Georgia's PHC system.[18] In terms of monitoring and evaluation, the National Center for Disease Control and Public Health (NCDC) regularly publishes annual health statistics reports and until 2017 MoIDPLHSA used to publish Annual Health Reports, Health System Performance Assessment and National Health Accounts on the website.[19] Even when published, MoIDPLHSA reports have a tendency to focus on positive achievements, rather than presenting a balanced, critical assessment of the overall performance of UHC or the health sector in general. As one expert respondent commented: *"They talk about small achievements, while totally ignoring great problems and weaknesses".* Representatives of academia also recommended that analytical reports of MoIDPLHSA should regularly take stock, monitor and discuss the progress of UHC (including its financial aspects) for informing future decision-making processes.

Box 2.

A good example for accountability is the 2016 Annual Report of Perinatal Health with quantitative and qualitative analysis of maternal and newborn health, underlying factors for maternal losses, neonatal mortality and stillbirth and comparison of Georgia's performance vis-à-vis international commitments.

The private sector is a major partner in UHC, but is not engaged in dialogue and decision-making that directly affects its medical workforce and services. There is no commonly agreed vision or modus operandi for PPPs in health. As one expert noted, this results in unpredictable decisions and an unsustainable regulatory environment for the private sector. While the state is the main source of funding for UHC, stakeholders are concerned that the government dictates its rules and doesn't consider the private sector as an equal partner even in a business-dominated health service environment. Both media editorials and experts interviews depict notions of unfair decision-making with minimum or tokenistic participation of the private sector. Resolution 520 of the Government of Georgia (November 21, 2019)[8] was referred as an example of an issue when reimbursements on selected health interventions were reduced to almost half, affecting quality assurance of the services and when the voice of professionals delivering healthcare through the private providers was not heard. The special council was formed by the MoIDPLHSA in December 2019, intended to address these concerns. The council had government officials as permanent members, international organizations with relevant expertise in the field and a few civil society/professional associations as consulting members, though health service providers were not engaged.[9] *"Unfortunately there is no equality. Private sector and government have no equal positions. Government dictates the rules. The government just said that in a number of services we will be paid in fact half of what these services cost. […] Despite of saying at a later stage, that they are ready for talks and communication, it all was a theatre, and nobody considered any objections or opinions. Private sector is forced to make decisions which will reflect on patient safety and service quality." (Experts Interviews).* Some promises remain unfulfilled even after the dialogue *"We had a meeting with the Prime Minister, the problem was covered by media. There was quite a resonance. But there was no tangible result… only promises. Then they said that certain parts of the decision would be reviewed, not the whole one, but this too remained just a promise […]" (Experts Interview).*

On the other hand, COVID-19 could be used to create a successful and sustainable public-private partnership case for an emergency response at a country level. Overall, Georgia took an effective multisectoral approach to respond to COVID-19, led by Government and with sound technical support provided by the NCDC. Participants noted that, in addition to the effectiveness of quarantine, contact tracing and treatment measures implemented by the public health authorities, there was coordinated and constructive engagement of the police, including the border police and the armed forces of Georgia. Media engagement and strong public engagement was also notable. However, at time of the report writing, concerns remained on relatively low testing coverage for SARS-COV-2. Expanding state-funded COVID-19 diagnostic services from the current 12 laboratories to include more private laboratories, with appropriate quality assurance standards could improve coverage of COVID-19 testing and strengthen PPP for public health emergency response.

Meaningful participation of professional associations and patient groups in decision-making is also limited. National law guarantees the right of professional associations to participate in health governance decisions,[20] and over 20 government-led committees and coordination mechanisms list professional associations as members. Despite this, participants perceived the involvement of professional associations to be fragmented, formal, and often for the purpose of backing up government decisions. *"Associations are invited only if there is a need to popularize the actions of the government or just for a formality purpose. This involvement is very schematic and insignificant. Relationships need to expand and get stronger. We would ideally have a common strategic plan with a relevant action plan, and build relationships based on accountability and peer assessment." (Experts interview).* A positive story mentioned by stakeholders was from the Autonomous Republic of Adjara, where the view of professional associations was taken into consideration in health governance decisions. The COVID-19 pandemic has also

exemplified this challenge, as very few civil society organizations or professional associations were involved in decision-making or engaged in consistent advocacy for a robust emergency response. For example, limited supplies of personal protective equipment (PPE) and training for COVID-19 were putting health professionals at an extreme risk. However, there was no collective voice or coordinated action from civil society, professional associations or trade unions for the government to address this issue.

Medical education including continuing professional development remains a challenge for public and private actors. A number of case study respondents, including patients, questioned the training and professionalism of practicing clinicians, particularly stressing the weakness of their communication skills and accountability practices. Respondents also considered gaps in Continuing Medical Education/Continuing Professional Development system, that have remained unresolved for decades, as important barriers for the attainment of UHC goals in Georgia.

The media can both help and hinder accountability. Most respondents reflected positively on cooperation between health partners and the media, as well as media coverage of health issues. Though some criticized the media for the lack of impartiality and for excessive advertisement of gambling or other industries of public health concern. The impartiality of the media was also raised as an issue in the context of reporting on the COVID-19 crisis. It was claimed, that 'pro-government' media outlets reported mainly positive results and stories from the emergency response, while the 'opposition' media attempted to heighten public consciousness about the challenges and constraints.

Could lobbying interests constrain health progress? Literature from national and international partners or research institutions provides no evidence on this issue. However, six out of 38 key informant interviews mentioned potential business lobbying interests as factors constraining implementation of QA/QI and cost-containment reforms of UHC.

Recommendations and considerations for future priorities

1. Strengthen national health authority stewardship of UHC

The possibility of achieving UHC in a country with a business-dominated health sector doesn't eliminate the necessity for and responsibility of a strong public sector. The national health authority and institutions engaged in accountability for UHC should strengthen their capacities to play a stronger stewardship role for UHC to ensure the availability of quality services and the financing of common goods for health.

2. Invest more in documenting and sharing UHC experiences, at national and international levels

Georgia can share valuable lessons with the international community from its experience of implementing UHC and specifically from health initiatives for women, children and adolescents. The Government with its national and international partners should invest more resources in documenting this experience, highlighting both success stories and challenges. The latter could inform policy making, refinement of the national health programmes and contribute to the global knowledge base for UHC. Health sector reports, particularly those concerning the health status of women, children and adolescents, should be available and discussed publicly, including through media.

3. Improve dialogue, partnerships and mutual accountability among all stakeholders

The government should guarantee the active engagement of professional associations, private sector, civil society, health service users and international development partners in UHC efforts. Diverse stakeholders should participate in dialogue on how to improve UHC in general, and specifically the health of women, children and adolescents, including through improved access to appropriate health information, products and services. Stakeholders should be engaged in regular analysis of UHC, policy advice on standard setting, cost-containment and implementation modalities. Institutions tasked to assure quality medical education (including government and education providers) should play their part in strengthening accountability. an independent multidisciplinary board, involving representative from different clinical and public health disciplines, should cooperate with the government in the continuing medical education domain, as an essential element of ensuring quality UHC. Partnerships with civil society should be further explored including for the independent evaluation of UHC progress, and to support with the protection and promotion of health-related rights of patients and health workers. Finally, partnerships with media should be expanded to promote public discussions on both successes and challenges towards the realization of UHC. The media should be more regularly engaged to cover topics on health- and related rights, with a special focus on women, children, adolescents and other vulnerable groups.

4. UHC financial sustainability should be strengthened by expanded public-private partnerships at local and international levels

Opportunities for the diversification of healthcare financing sources must be further scrutinized, including from the private sector, to ensure "more *effective use of available scarce public resources" and* overall enhancement of private-public partnerships in the sector. [21,22,23,24,25] Government should develop and implement more comprehensive regulations on the pharmaceutical market, making essential drugs for communicable and non-communicable diseases, as well as medications for rare diseases more affordable. The PPP formats should be more intensely used for discussion and implementation of proven cost-containment mechanisms for health. Furthermore, Georgia should continue to explore the potential of new, innovative national and international PPP partnerships to address gaps in reproductive health commodities for women, needs of people living with disability, or addressing other priority gaps in the current UHC response, specifically for women, children and adolescents. These recommendations are informed by the WHO guidance on developing CGH to ensure investments in core health system functions fundamental for protecting and promoting health and well-being. These require collective financing from the government and the global community[26]. In addition, Georgia in its efforts to strengthen PPPs, should refer to the WHO recommendations and address accountability gaps through better diagnosis of the private sector and the accountability environment in the mixed health system context. Norms and behaviours around professionalism and ethics should also be prioritized, and accountability tools created that operate at a system level and generate the right data of the right quality.

5. Focus on quality assurance/quality improvement

The Government should consider partnering with national and international stakeholders to develop and support an effective independent quality assurance/quality improvement and accreditation system in health. Georgia already has a successful example of reforming QA/QI system in perinatal care for maternal and newborn health and this experience could be expanded to other areas of UHC.

The UN Secretary General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) identified five countries for accountability case studies to inform its 2020 report. Georgia was selected among these countries due to its Universal Health Care programme launched in 2013 and experience with PPPs. Georgia together with Thailand also co-facilitated adoption of the landmark UN Political Declaration on UHC in 2019. The current study was conducted by David Tvildiani Medical University in coordination with IAP. The review is built on secondary data compiled through literature review of the national legislation, official reports, scholarly articles as well as grey literature and media editorials. In addition, primary data was collected from 4 focus groups discussions and 38 informant interviews with experts representing health authorities, public and private health service providers, academia, professional associations and civil society. Final draft report was discussed and conclusions drawn from three online multi-stakeholder panel discussions, with engagement of over 150 participants from Government, UN agencies, civil society, professional associations, public and private health care providers, adolescents, academic institutions, and medical university students.

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