A Consultation Workshop for Developing an Urban Model for Comprehensive Primary Healthcare (CPHC): An Implementation Research Initiative in Mysuru city

Venue: Fortune Park JP Celestial, Bengaluru Date: 8 November 2019 (Friday)

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Preface

Evidence shows that a robust primary healthcare service improves the health outcomes of communities. A strong primary healthcare system is crucial in order to achieve health-related sustainable development goals (SDG) and attaining universal health coverage (UHC) for all including access to safe, effective, quality, and affordable essential health-care services. While both rural and urban area of India has its share of challenges in organising such strong primary health care, urban health system, in particular, is posing new challenges and complexities in the recent past. Health needs and challenges are complex with the presence of pluralistic health systems and multiple stakeholders in urban areas; hence, there is an urgent need for a comprehensive and multipronged approach to address such complex issues.

KHPT in partnership with Landmark Group and Government of Karnataka (GoK) is currently implementing a pilot project to develop a Primary Health Care model for non-communicable diseases (NCDs) in Mysuru city for last two years. Against this backdrop, KHPT in partnership with Health System Transformation Platform (HSTP) and St. John's Research Institute (SJRI) is seeking to advance its learning and experience from the NCD pilot to a broader, comprehensive primary health care (CPHC) model/s in Mysuru city through an implementation research design. We propose to develop an urban health model for providing comprehensive primary healthcare (CPHC) in Mysuru city through implementation research design.

The primary objectives of this workshop in the broader sense would be to brainstorm regarding strengthening urban health systems to improve demand, reach and quality of CPHC services, explore an optimal payment mechanism for CPHC services in private sector, and also to explore and develop an effective model of motivating and sustaining CHWs in urban areas.

Acknowledgement

We want to thank St. John's Research Institute for their collaboration and technical assistance to make this workshop a fruitful one. We also acknowledge the constant support of Landmark Group and Mysuru City Corporation for years. We thank HSTP for its leadership in driving this critical issue and for engaging with other stakeholders to envision a robust primary care model. We thank the front line staff of Mysuru PHC for their support to pilot interventions, and we particularly thank the project staff of KHPT who were involved in the implementation of the Mysuru Urban NCD project that helped us garner significant learnings to shape future interventions.

About the workshop

The goal of the workshop was to consult relevant stakeholders and brainstorm on the model for providing comprehensive primary health care in an urban setting.

The main objectives of the workshop were:

- To understand the primary health care requirements for the Mysore population
- To understand the implementation plans of comprehensive primary health care in Mysore city

The method adopted in the workshop was structured sessions (can be seen in the agenda--refer annexure) with key speakers and discussions with participants for comments and Q & A.

The workshop was also intended to be a platform to rebuild the connection with theoretical roots, which is now somewhat lost. The workshop was an opportune time to revisit some of those theoretical understanding as to what is primary health care, is its definition good enough and what can be done about it. The panel discussion, which was part of this workshop also threw light on some of the successful comprehensive health care models across the world.

“The vision of this collaboration is futuristic, maybe five years down the line, people in Mysore will be able to access the kind of care that they need- whether it is primary care, secondary care or tertiary care, without having to worry about the financial burden. We will work together with the Government of Karnataka to develop a model where people- the citizens of Mysore can access healthcare, and at the same time, the determinants of health, like water, sanitation, food, etc. are also tackled so that people remain healthy…”

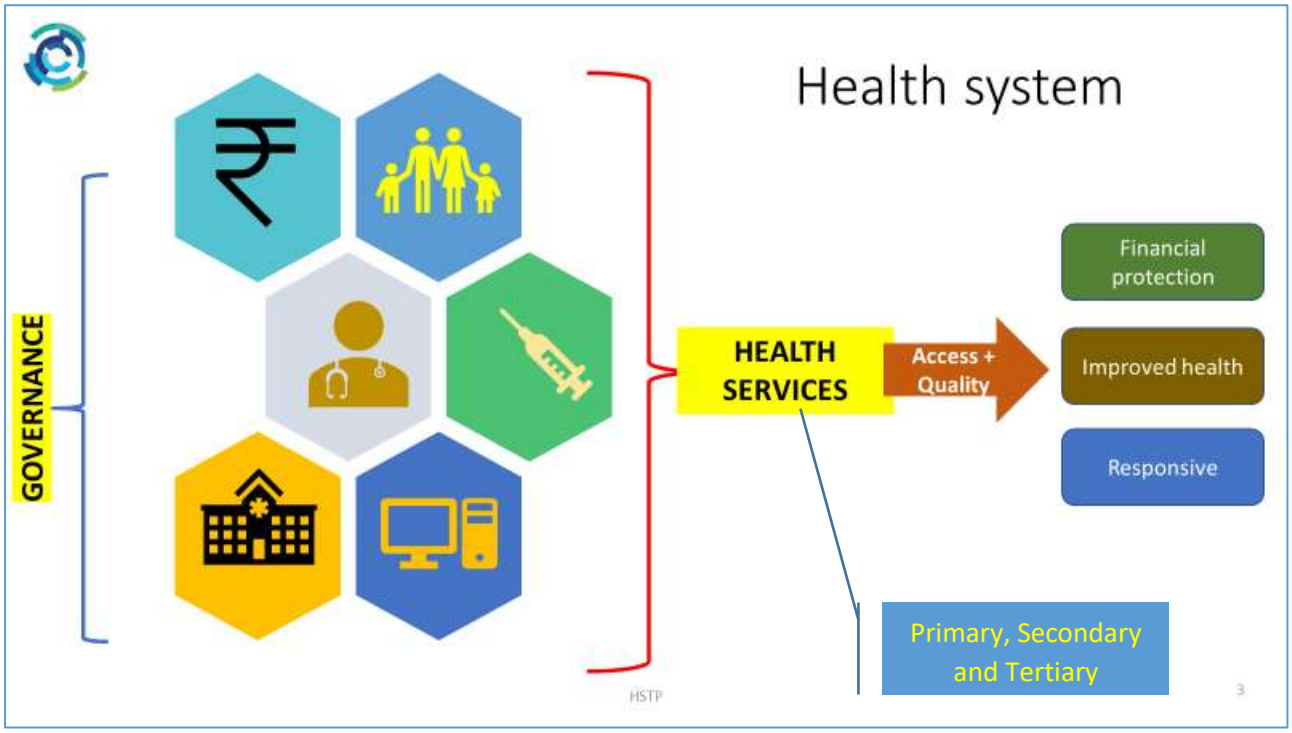
Proceedings

Post the welcome address by Mr Mohan H.L, Managing Trustee, KHPT and the general overview of the workshop and a brief about the initiative by Dr Rajeev Sadanandan, CEO, HSTP, the workshop began with the panel discussion.

Mohan H.L.: "Two and a half years back, we started a small initiative in Mysore, in the name of NCD supported by Landmark Group, and the then Health Secretary inaugurated it … and today, that has reached up to Niti Ayog, so we are able to project that as a model…."

Dr Rajeev: "The way we differ from other organizations that work in this area is, we focus on health systems…., there are very few organizations who work in this area, what we also hope to do is to provide a platform for these organizations to come together…."

Dr Devadasan from the HSTP introduced the concept of health systems and the place of primary health care within the health system.



He then shared the definition of primary health care as enunciated by the WHO – "*A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisector policy and action; and (c) empowered people and communities.*" He then shared the operational definitions including that fact that primary health care takes the responsibility of a defined population; is usually the first point of contact for this population; and provides care to this population that is comprehensive,

continuous, coordinated, integrated and accessible. For a primary health care system to be successful, it needs to be supported by the other building blocks like good governance, adequate finances, competent HRH, an appropriate supply of medicines, and robust information systems. He also reminded the gathering that while historically, primary health care was provided by government officers, today in most countries, primary health care is purchased by the government from private providers, including in countries like the UK, Canada, most western European and Scandinavian countries. However, while primary health care may be provided by the private health sector, it is usually funded by the government through pre-payment mechanisms.

Dr Swaroop, Deputy Director, KHPT then shared the KHPT experience with the primary health care initiative in Mysore and its emphasis on treating patients with NCD, specifically Diabetes Mellitus and Hypertension. He shared some demographic details about Mysore, as well as the details of the UPHCs where KHPT is working. He shared the details of the situational assessment, that was implemented between September 2017 and March 2018 in different phases; phase 1: population-wide screening to detect prevalence of hypertension and diabetes in UPHC area; phase 2: sample survey to detect prevalence of risk factors in the population, understand out of pocket expenses and treatment adherence. Facility audits were undertaken to assess readiness to provide NCD care; and phase 3: qualitative research (focus group discussions(FGDs), and in-depth interviews (IDIs)) to understand client experiences and perceptions on NCD care, management, and lifestyle changes. Finally, he shared the outputs of the intervention in these UPHCs.

Subsequently, Dr Prem Mony, Vice Dean, SJRI talked about the Implementation Research approach, design and methods, linking it with the experience from the WHO KMC project initiative in Koppal- the challenges in scaling it up and how they addressed those challenges.

The perspectives and initiatives of GoK regarding this (CPHC) proposed design and research was presented by Dr Prabhudev B Gowda, Deputy Director - Urban Health, GoK. This panel discussion was followed by an open discussion in which the audience clarified their queries with the panellists.

Some of the key questions and responses from the open discussion are mentioned below:

1. Question to Dr Devadasan:

a. Venkat from Karuna Trust: 'Dr Deva's presentation on the CPHC model, I got a feeling more of medical care than primary healthcare, the reason being that the private sector is also participating in the primary healthcare and that the private sector is participating at a clinical level and not in preventing and promoting healthcare. So, when we are looking at the health system in Mysore, what should be our design model? You also mentioned the low income and middle-income countries, and asked why India being a middle-income country is not being able to achieve certain health indicators? I strongly believe that it is because our preventive and promoting aspects are where we are lagging very strongly. So, I wanted a clarification that when we are designing the health system, this bias towards clinical and medical care has to be taken care of'.

Ans.: 'When I said "care", I included preventive, promotive, curative, etc. and many countries have worked with the private sector to make sure that they provide preventive and even promotive care. I'll give an example where they say that if you, in your catchment area- if 5000 patients are registered with you, you have to ensure once in three months that every single patient has to have a BP check-up or every mother- pregnant woman has to have come for antenatal. So, preventive component is made into the private sector and so it is not just only the government provides but also the private sectors are made to think- see a lot depends on how you pay the private sector, how the government pays the private sector. So, there are models out there where care- comprehensive, preventive and promotive are possible. The question is whether we can do it in Mysore or not.

b. Dr Prakash from JSSMC, Mysore: 'You mentioned about 400 episodes, that means about 400 OPDs per day- is it our concept to increase the OPDs in urban areas? Because we are providing comprehensive care services- nowhere in the state, nowhere in the world there would be 400 OPDs per day in a PHC level. So, that is a controversial statement.

And also, patients pay for it. In Karnataka, no patient pays for it- free treatment, free drugs, everything, consultation is free in all the public health facilities and that is more of a controversial statement.'

Ans.: 'The calculation I am using is, in a middle-income country, there is an estimate saying that a population of 1000 will have 4 per person- 4 contacts, it can be for preventive care, antenatal check-ups, it can be for cough and cold, etc. but it is about where it is expected to practiced. It varies from country to country, so 4 outpatient contacts per person per year, which means in a population of 1000, we are talking of 4000 outpatient contacts; in 30,000 we are talking of 1,20,000! So, if the government has to provide for everything, we will need that much resources for over 1 lakh visits but we cannot; which is why one of the things we have to think about is: because today we say UPHC, one per 50,000 populations. But in that PHC we are still putting 1 doctor, and if all the 50,000 people start coming to the UPHC, that PHC will not be able to meet the needs. So these are the things we have to think about.'

c. Dr Swaroop
    a. Venkat from Karuna Trust: Why only two NCDs? Secondly, what is the per person screening for NCDs?
        - Ans.: It is an important question- why only two NCDs? So, the objective of the intervention was, first, understand whether we can develop a good continuum of care within the PHC system. So, hence we started working with two of the common problems: diabetes and hypertension. However, the vision is to include all the other NCDs going forward.
    b. Anindita from HSTP: Looking at the model of delivery what you explained for NCDs, I wanted to know the cost of running one such in that PHC, so that we know how do we cost it when we scale it up.
        - Ans.: With respect to cost, so the cost per screening at the household was around Rs. 50-60, including the cost of human resource, the consumables, and also the digital platforms and data collection process. So, Anindita also had a question on cost for the entire PHC. So here, we have not done a detailed costing analysis but I can tell about the marginal additional costs that have been incurred as a part of this project. One is, having a dedicated counsellor is an additional thing. Also, some of the investigations, like detection of the complications wherein it has been set up at the PHC level as against the FRU level, that is the additional cost. In

terms of the outreach, so all the costs are as per the Government of India guidelines for NCD care.

c. Dr Prakash from JSSMC, Mysore: There are risk factors involved here but occupation is an important risk factor, which is not included in your evaluation and should be there in your model. Physical activities also have to be included in your evaluation because a lot of strategies have to be adopted under NCDs for the employees working at various sectors like the IT sector because stress is one of the important factors that cause hypertension and diabetes.
    - Ans.: So, Prakash sir had an important comment about studying more in detail about occupation and its effect on NCDs; Yes, sir, so your point is very valid and we are trying to understand the stress levels associated with different occupations; we are trying to include the mental healthcare aspect into this program as well.

d. Dr Prem Mony
    a. Anindita from HSTP: When we are looking at KMC and the model which you described required three nurses to be put there specifically to look at KMC. Now, if this is one district, how would you then suggest it should be scaled-up, given the already lack of human resources?
        - Ans.: Anindita has pointed out to a critical problem within the healthcare system. We have KMC nurses to provide KMC, then you have lactation nurses to improve breastfeeding- so, if you leave it to the doctors this is what happens. While thinking up a model for urban health provision of comprehensive healthcare, cost is always to be kept at the back of the mind. So, it may not always be sustainable to make sure that there are too many specialists providing, even though the Government of India has called it a “comprehensive PHC package”, keep in mind that it is very disease-oriented, as we design interventions it may be easier to get people to walk- because it will take care of diabetes, depression, so many other things; rather than in the facility create people to take care of each of them when they come back. But having said that, I must say that always don’t throw away the clinical services, because for new-borns, you need 24 hours’ care. I mean you can get away from someone closely

watching an adult, but for new-born, there is no way out. So, it is a balance we may have to strike; how much do we may have to hand over to others to take care, how much can we make it comprehensive and at the same time not to miss out on those who are really vulnerable.

For the group work and presentations in the afternoon session, the participants were purposefully divided into four groups, each representing the four domains of Comprehensive Primary Health Care. These were: the state-level health systems, the district level health systems, facility and the community systems. Each group discussed and deliberated on the topic for about one and a half hours, and then presented it to the larger audience, which was followed by a question and answer round. The key recommendations from the group work were:

1) **There is a need for an urban health model** with a vision to provide comprehensive primary healthcare at UPHCs, which includes health promotion, preventive, curative, rehabilitative, and emergency care services.
2) **A robust situational assessment** of community and facility systems should be planned which will inform the design of the interventions, before initiating the implementation of interventions.
3) Need to understand the **social determinants of health** in the concerned area and assess the preparedness of facilities for providing comprehensive primary health care.
4) Based on the assessment results, **specific intervention packages** would need to be designed both at the facility and community interfaces
5) At the district level, the need to **build a feedback loop mechanism** that would enable the program to be aware of the experiences, needs, and suggestions coming from the community utilising and accessing the services.

The discussions happened around community, facility and health-systems, broadly situated around a CPHC framework. The key messages that came out of the workshop most importantly were that the CPHCs should be:

- **Responsive-Patient Centric**
- **Maintain continuity of care**
- **Providing coordinated care**
- **Accessible, Available and Affordable**

Responsive-Patient Centric

There should be a patient-centric, personalized approach of care and treatment in the PHCs rather than patient-centric so that interventions can be tailor-made for that patient to ensure health promotion and prevention of risk. Apart from this, laboratory services should also be available in the PHCs itself, and if not, at least a collection system should be made functional to make it easier for the patients to access the services.

Maintain continuity of care

Patient record documentation, follow-up and referral systems need to be improved on to ensure the continuum of care for the beneficiaries. Also overall quality of care, availability of drugs and consumables, high quality diagnostics and provider attitude all contribute to ensure continuity in care

Providing coordinated care

The referral system and following up of patients should be strengthened. Inter-sectoral coordination should be developed to help implement the program. It should also be kept in mind that we need to check the sustainability of such coordination. A network of available facilities is required so that the hospitals can communicate with each other, through an integrated software/digital platform.

Providing training/health education

Providing health education is also one of the major tasks that the CPHCs should take care with the use of IEC materials and BCC. With the Medical Education Department, we can reach our goals for the curative referral services. The government, as well as the private sector, should collaborate for training and capacity building activities, and to develop standard operating procedures and treatment guidelines. There is also a need for a functional health directory, which can be popularised by local leaders. There should also be a proper channel to disseminate health information to the masses.

Accessible, Available, Acceptable and Affordable

The most crucial point is that the services should be accessible, with respect to time and distance. Affordability is an issue and it should be kept in mind that the out of pocket expenditures should be nil for the patients availing the services of CHPC. Acceptability was also a point mentioned during the presentation by the first group, that is the state-level health systems perspective. They stressed on the fact that the CPHCs should be gender-sensitive and all sections of the society should be catered to, implying the economic classes of lower, middle and upper. Also, the state CPHCs should be accountable for the services they provide.

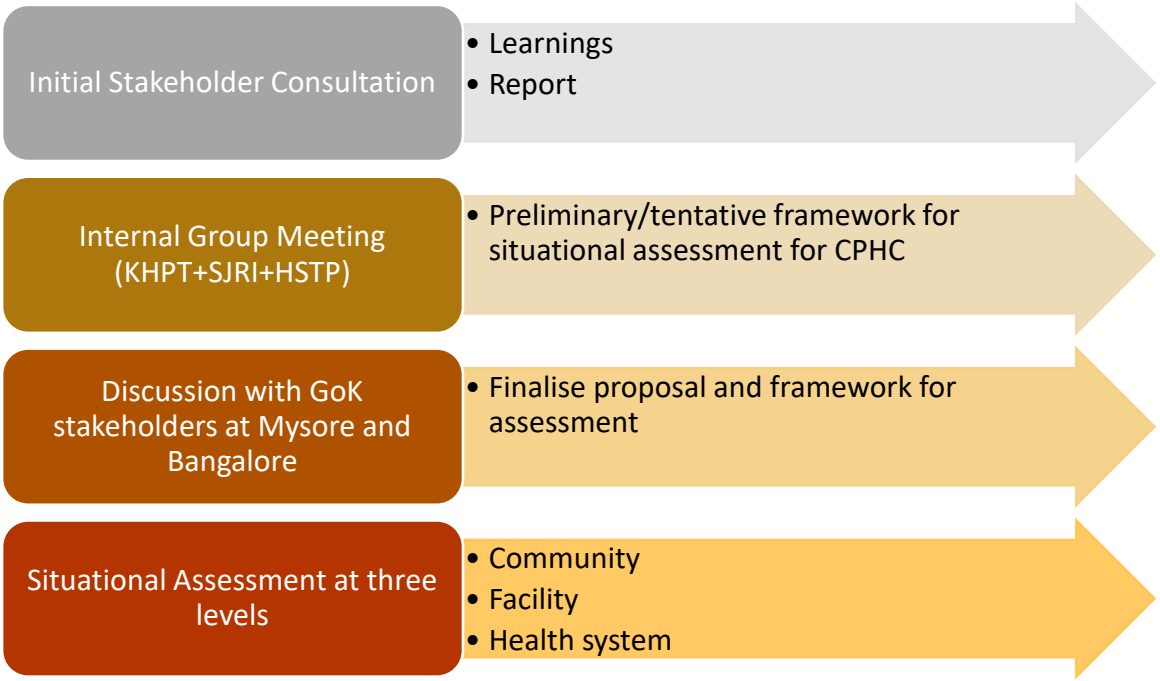
Way forward/next steps

Mr Mohan, Dr Prabhudev Gowda and Dr Rajeev Sadanandan summarized the whole session and suggested the next steps.

The four groups talked about the 12 packages that exist as the National guideline at present. Mr Mohan strongly recommended that we need to develop the interventions based on the local need's assessment. He also suggested to explore developing inter-sectoral convergence of the stakeholders in Mysore.

Dr Prabhudev was of the view that while clinical services were provided in both private and public facilities, the main lapse was the absence of robust community services. Therefore, the need for strengthening the community process was vital. He suggested finding a unique community model that can be scaled up across the state. The concept of health and wellness centres at the level of sub-centre level, for example, could be a potential game-changer in urban areas.

Dr Rajeev stressed the importance of strengthening coordination between different departments at the State and District levels. He also insisted on developing a model to create awareness among the people regarding health services.



Annexures

- Agenda

Session	Name of the session	Resource person	Time
	Registration & Tea		10:00 – 11:00 am
Session 1	Welcome Address	Mr Mohan H.L, Managing Trustee KHPT	11:00 am-11:15 am
Session 2	Address by Health Commissioner, MD NHM, Director of Health Services, Government of Karnataka		11:15 am-11:30 am
Session 3	Overview of the initiative	Dr Rajeev Sadanandan IAS (Retd.), CEO, HSTP	11:30 am-11:45 am
Session 4	Broad plan of the proposed project: Principles and approach of Comprehensive Primary Health Care Contextualize comprehensive primary health care in the context of Mysore: Experience with primary health care initiative for NCD programs Implementation Research Approach, Design and Methods: Experience from the W.H.O KMC project initiative in Koppal Perspectives and initiatives of GoK regarding this proposed design and research Open discussion	Dr Devadasan, HSTP Dr Krishnamurthy, Senior Technical Advisor, KHPT Dr Prem Mony, Vice Dean, SJRI Dr Prabhudev B Gowda, Deputy Director - Urban Health, GoK	11: 45 am-12:05 pm 12: 05 pm-12:25 pm 12: 25 pm-12:45 pm 12: 45 pm-1:05 pm 1: 05 pm-1:45 pm
	Lunch		1:45 pm- 2:30 pm
Session 5	Group work and Presentation 4 Domains of CPHC– State-level health systems, District level health systems, Facility and the Community systems	Dr Prabhudev B Gowda Dr Swaroop N, KHPT	2:30 pm - 3:45 pm
Session 6	Summary and Way forward	Dr Rajeev Sadanandan / Mr Mohan HL / Dr Prabhudev B Gowda	3:45 pm- 4:00 pm
	Tea and close of day		4:00 PM

- List of Participants

Name of the participant	Designation	Institution/Affiliations
Mr Ramachandran R	Mission Director, National Health Mission	Department of Health & Family Welfare, Government of Karnataka
Dr Jagadeesh	Joint Director-Medicine	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Ramesh	Nodal Officer	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Selvaraj	Deputy Director of Medicine	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr R Bhanu Murthy	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Prabhudev B Gowda	SNO NUHM	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Rajani G N	SMU NPCB	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Arun Kumar	Deputy Director Hospital	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Vasanth Kumar	ADD Health	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr C Poornima	MLCD, Nodal Officer	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Rajani B N	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Seenappa T	Joint Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Rajani P	Deputy Director of Mental Health	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Dev Anand	BMO	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Vivek	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Geetha Bali M E	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Ganesha H	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Renuka E	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore

Dr Chandrakala G	Deputy Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr G N Nasaragi	Joint Director	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Shivappa D K	Joint Director PHI	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Murugesh J	NUHM	Directorate of Health & Family Welfare Services, Ananda Rao Circle, Bangalore
Dr Mohammad Shiraz Ahmed	Family Welfare Officer	Directorate of Health & Family Welfare Services, Mysore
Dr Raghu Kumar	CHC Jayanagara	Directorate of Health & Family Welfare Services, Mysore
Dr Jahanara Tabassum	Health Officer	Mysore City Corporation
Dr Sumanth M M	Assistant- Referrals	NMCRI Mysore
Angela Chaudhri	Director	Swasti
Dr Bhumika Nanda	Public Health Specialist	Swasti
Dr Prakash B	Faculty	JSSMC, Mysore
Dr M R Narayana	Professor- Health	JSSMC
Dr M Indumati	DJD Banaglore Urban	DHO
Dr Preeti Aggarwal	CSR	Landmark Group
Shivla Saksena	CSR	Landmark Group
Dr D jayaraju	Joint Director-KSAPS	KSAPS
Dr S B Patil	Joint Director-KSAPS	KSAPS
Dr Mamatha M S	Deputy Director (Bangalore Urban)	DJD (BU)
Dr Prashanth B	State Nodal Officer	PHI
Mahantesh Yadav		NUHM
Tika Ram	State Consultant Quality Assurance	NHM
Ms Vinutha T	KMC Coordinator	NHM
Dr Rajeshwari	Deputy Director NCD	NHM
Dr Rangaswamy H V	Deputy Director HISFW	NHM
Shobha S	State Account Manager	NUHM
Pavithra	SPM NUHM	NUHM
Dr Gowthami P	Project Director	SYVM
Dr Vibha S P	Tech. Head	SYVM

Shivamallappa	Manager	Karuna Trust Banaglore
Venkat Chekuri	Joint Secretary	Karuna Trust Bangalore
Dr Sandya	Program Manager	Karuna Trust Banaglore
Dr Suresh Rudrappa	President	IMA Mysore
Dr Mahmood Shariff	Research Officer	NVBDOP
Dr Priya		PHFI
Prakash H	DHEO	DHFWO, Mysore
Dorothy Lall	Faculty	IPH
Dr Prakash Kumar	Joint Director	Government of Karnataka
Ravi CS	Senior Associate	GRAAM
Dr Tinku Thomas	Professor	St. John's Research Institute, Bangalore
Dr Prem Mony	Professor	St. John's Research Institute, Bangalore
Dr N. Devadasan	Technical Advisor	Health System Transformation Platform New Delhi
Dr Sudha Chandrashekhar	Senior Consultant	Health System Transformation Platform New Delhi
Dr Anindita	Tech Consultant	Health System Transformation Platform New Delhi
Mohan H L	Managing Trustee	KHPT Bangalore
H S Ashokanand	Consultant	KHPT Bangalore
Dr. Krishnamurthy Jayanna	Senior Technical Advisor	KHPT Bangalore
Dr Swaroop N	Deputy Director	KHPT Bangalore
Mr. Arin Kar	Deputy Director	KHPT Bangalore
Dr. Manoj Kumar Pati	Senior Program Manager	KHPT Bangalore
Mr. Srikantamurthy HS	Deputy Director	KHPT Bangalore
Mr. Vidyachanran Malve	Senior Program Manager	KHPT Bangalore
Prathibha Rai	Senior Program Manager	KHPT Bangalore
Dr Satyanarayana	Deputy Director	KHPT Bangalore
Mr. Krishnaprasad	Program Officer	KHPT Bangalore
Dr Suresh	Deputy Director IEC	KHPT Bangalore

- Group work questionnaire

Session Plan for the Group Work

Objectives of this group work

To understand the primary health care requirements for the Mysore population

To understand how primary health care can be achieved in Mysore

Processes

4groups of 8-10 participants each will be discussing on certain attributes and components of Comprehensive Primary Health Care that will inform of the proposed implementation research initiative.

Group 1 – State-level health systems domain

Group 2–District level health system domain

Group 3 –Facility systems domain

Group 4 –Community systems domain

Suggested process for group discussion

You have 45 min for discussion and 10 min for presentation

Kindly identify a facilitator, rapporteur and a presenter

If there are more than 12 members in your group, it may be advisable to break up into two subgroups.

Give everyone a chance to present, ask participants to be brief and precise, so it does not consume time. It is good to note down what one likes to share and speak from it.

If there are additional points, it is good to give a second chance after others have had their chance. Take care to see that no one person dominates the discussion.

Questions to be discussed in the groups (Keep the vision/ structure/ scope of comprehensive primary health care in Fig. 1 as reference for deliberating on these questions)

Fig 1: Characteristics of Primary Health Care

One of the characteristics of primary health care is managing all possible ailments. What should be a possible comprehensive service/intervention package in the context of urban Mysuru at the primary health level?

We can include everything, but then do we have the money and also do our primary care physicians have the ability to provide everything?

Or we can prioritize – identifying a list of ailments that need to be treated in the first phase and another list for a later phase, etc. Which are the diseases/health conditions/symptoms to be prioritized?

In order to achieve the vision of a comprehensive primary health care initiative in Mysuru, what do you think are the:

- Possible facilitators or enablers (that exist already and we can build on)
- Potential barriers/ challenges (that we have to overcome)
- Who are the important stakeholders that we have to engage with to make this vision a reality? Also, elaborate the mode of working (how closely or distantly; is it incomplete or partial collaboration or mere coordination, etc.)