Table III. Potential challenges and facilitators in implementation of the World Health Organization Global Disability Action Plan 2014–2021 in Pakistan ($n = 33$)

Actions	Potential challenges/barriers	Potential facilitators/enablers in the next 5–6 years
Objective 1: Remove barriers and improve access to health services and programmes		
1.1 Develop and/or reform health and disability laws, policies, strategies and plans	• Lack of definition for disability • Low priority of health in legislative process • Health priority more driven towards acute sector and NCDs • Unstable political and economic situation • Poor political commitment • Existing policies underfunded • Lack of coordination/collaboration amongst different government sectors and ministries • Lag in implementation of existing policies • Lack of consensus on who is responsible for enforcing and/or funding new legislations/policies • Lack of education/knowledge about disability amongst policymakers, government authorities, etc. • Lack of disability-related data	• Knowledge management capacity-building initiatives for policymakers, government authorities through media, awareness programme, lobbying • Adequate resource allocation • Review existing policy documentation and surveillance systems • Governing body to develop health policies from coordination to implementation; sectoral approach for alignment in disability care • Input from rehabilitation physicians in policy, • Strengthen management capacity, public-private partnerships through legislation and regulation • Establish a secondary level body of advocacy/oversight for implementation and evaluation of policies • Coordination and communication between central and provincial bodies • Strengthen National Health Information systems • Involve rehabilitation physicians, PwD and community organization in policy, legislation, programme development • Linkage with SAARC regional organizations • International cooperation and WHO support
1.2 Develop leadership and governance for disability-inclusive health	• Lack of central body for developing governance • Lack of coordination/collaboration among different government sectors, hospitals (private and public), DPOs, NGOs • Lack of process to involve all stakeholders (including rehabilitation medical professionals) in policy development • No disability-rehabilitation standards or key performance indicators • No specific accreditation standards or criteria for rehabilitation facilities and for staff • Limited workforce leadership development programmes	• Establishment of legislative and central capacity building body which included governmental authorities, health professionals, PwD and families, representative form regional health departments, quality of services, NGOs and DPOs • Capacity-building for educators for health work-force • Implement plan for quality control and health inputs • Coordinate and link various NGOs and DPOs with hospitals • More active role of rehabilitation medicine departments in facilitating leadership skills and governance • Improve web-based access to evidence-based guidelines/protocols and outcome measures for disability • Development key performance indicators and Standards of Care and accreditation criteria for rehabilitation facilities and staff
1.3 Remove barriers to financing and affordability for PwD	• Budget deficit and inadequate financial support • Lack of accurate data; underestimation and underrepresentation of disability prevalence, cost data, etc. • Decreased international aid • Lack of rehabilitation facilities in public sectors • Out-of-pocket payment for services and assistive devices/aids • Lack of government/private insurance • Lack of enforcement and evaluation of legislation policy for employment/education/health for PwD	• Increased health budget expenditure • Develop health insurance policies and coverage for PwD • Proper utilization of exiting social security systems such as "Zakat" • Use indigenous resources • More international financial assistance • Training and educational programme for PwD – build workforce • Improvement of social welfare, livelihood and benefits for PwD
1.4 Remove barriers to service delivery	• Lack of infrastructure • Non-disability friendly public places and transport • Corruption • Conflicts/war and terrorism • Topography of Pakistan distinct rural hard to access setups • Lack of rehabilitation for specific conditions such as stroke, spinal cord injuries etc. • Lack of multidisciplinary team approach and systems/models of care • Lack of integration with acute hospitals	• Accountability of resource allocation • Development of infrastructure and awareness of existing services • Development of comprehensive counter-terrorism and conflict policies • Structured standard referral systems: acute to sub-acute • Promotion of community-based rehabilitation • Development of Mobile Units to deliver care in remote areas • Train healthcare workers for home-based/community-based care • Telerehabilitation and local technology • Improve provision of disability friendly public facilities and transportation • Public awareness and educational programmes • Public-private sector partnership for service provision

Table III cont.

Actions	Potential challenges/barriers	Potential facilitators/enablers in the next 5–6 years
1.5 Overcome specific challenges to the quality of healthcare experienced by PwD	• Limited access to disability services, particularly in rural areas • Lack of adequate referral system • Lack of human resources • High illiteracy, poverty • Discrimination and stigma • Poor awareness of health services • Misconception and cultural belief about disability • Belief in traditional or native healers • Lack of adequate primary care services • Lack of follow-ups	• Central body to implement national health policy • Enhance interdisciplinary interaction • Decentralization of healthcare facilities including rehabilitation • Minimization of cultural stigma through public campaigns/awareness programmes • Skill training and educational programmes for healthcare staff • Development of consumer organizations for advocacy (including PwD at national and local level) • Development of strategies for engagement of staff and PwD (and families)
1.6 Meet the specific needs of PwD in health emergency risk management	• Lack of infrastructure and human resources • Lack of emergency assistance programmes for PwD • Lack of access to healthcare services, public transports etc. • Minimal collaboration and/or referrals between emergency staff and rehabilitation personnel in tertiary facilities • Lack of disability-centred measures paramedical services/disaster management plans • Lack of adequate primary care services • Lack of follow-up	• Assessment and evaluation to identify need to mobilize resources • Coordination of intervention • Build healthcare infrastructure and human resource capacity • Inclusion of emergency responses in resettlement plans for PwD • Improve communication systems and collaboration between acute and rehabilitation staff • International cooperation in humanitarian crises
Objective 2: Strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation		
2.1 Provide leadership for developing policies, strategies and plans	• Same as 1.1 above • Inadequate financial support and budgetary constrain • Lack of accurate data; underestimation and underrepresentation of disability prevalence, cost data, etc. • Lack of awareness of extent of problems/issues facing disability	• Same as 1.1 above • More active role of Department of Rehabilitation Medicine • Establishment of the formal National society of PM&R • Public awareness through national forum
2.2 Provide adequate financial resources	• Same as 1.2 above • Acute care driven healthcare system	• Same as 1.2 above • Improvement of social welfare and livelihood
2.3 Develop and maintain a sustainable workforce	• limited skill base interdisciplinary workforce • Lack of undergraduate courses in rehabilitation in medical schools • Limited infrastructures and professional courses/training programmes in academic institution • No educational standards or key performance indicators for rehabilitation or continuous medical education evaluation • No staff development or appraisal systems in hospitals or community settings • Lack of guidelines/protocols • Limited access to education or IT-based learning • Limited opportunity for training in new innovations and therapy • Inadequate distribution of healthcare professionals – mostly urban setting • Poor awareness amongst healthcare professionals about workforce development • Demoralised workforce	• Develop a strategic workforce development plan by the government and establishment of national observatory for human resources • More funding and opportunity to develop a skilled workforce • More courses on rehabilitation in academic institutions and hospitals • Development of strategies for upskilling, empowerment and staff engagement • Develop teaching models, using interactive problem-based learning • Increase clinical capacity through organized educational activities, e.g. journal clubs, grand rounds. etc. • Motivation of clinical staff • Promotion of interdisciplinary teaching and interaction • Establish workforce management and retention programmes • Collaboration with international partners for staff training overseas

Table III cont.

Actions	Potential challenges/barriers	Potential facilitators/enablers in the next 5–6 years
2.4 Expand and strengthen rehabilitation services ensuring integration, across the continuum of care	• No accreditation standards or key performance indicators for rehabilitation • Rehabilitation services included with other general hospital services not well integrated nor identified for attention • Lack of structured standard referral systems from acute to sub-acute care to community • Lack of healthcare delivery models for Rehabilitation services • Minimal integration of community based programmes with acute services • Poor follow-up after discharge from acute facility and rehabilitation hospitals • Lack of family/carer education	• Development of accreditation standards for rehabilitation facilities and key performance indicators • Develop rehabilitation services within the existing health infrastructure • Improved profile of rehabilitation services in acute hospitals and integration of these services with other acute care sectors • More community-based rehabilitation services linked with main hospital networks • Incentives and mechanisms for retaining healthcare personnel especially in rural and remote areas • Use of IT systems, telemedicine and web-based services for improving awareness and access • Provision of equipment and technology for therapy in rehabilitation
2.5 Make available appropriate assistive technologies	• Lack of government services and health insurance • Private insurance does not include cover for rehabilitation mobility aids (wheelchairs, cane, and walker), or those for activities of daily living, orthotics, or prosthetic devices • Lack of awareness • Lack of human resources and infrastructure	• Adequate financial support • Advocacy for assistive technology funding • Inclusion of PwD and consumer organizations to raise awareness about technology • Expansion of assistive technologies to rural areas • Development and/or establishment of allied health rehabilitation services within the existing health infrastructure • Development of Mobile Units
2.6 Promote access to a range of assistance and support services	• Minimal information available to public about access to rehabilitation services • Lack of coordination with NGOs, DPOs and other charitable consumer/organization • Lack of insurance/government support for accessing rehabilitation services	• Campaign/awareness programme involving DPOS, NGOs and other charitable/consumer organizations • Develop Mobile Units to deliver care in remote areas • Expansion of community-based rehabilitation • International aid including WHO • Develop research programmes
2.7 Engage, support and build capacity of PwD and caregivers	• Exclusion of caregivers of PwD in care services • Poverty • High illiteracy • Misconception and cultural belief about disability • Belief in traditional or native healers • Pursuit of social support by PwD • Lack of social security • Lack of family support	• Involvement and education of caregivers in rehabilitation settings • Improve awareness of existing services/benefits for PwD/carers • Development of consumer support organizations for PwD at national and local level • Skill training for carers • Expansion of community-based rehabilitation through inclusion of carers in decision-making processes.
Objective 3: Strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services		
3.1 Improve disability data collection (survey)	• Lack of universal coding system • Lack of trained human resource • Lack of reporting and information-gathering systems • Unreliable timely access to patient medical records • Rehabilitation workforce minimally trained in research methodology including data collection • Cultural barrier/misconception – unwilling to disclose • Logistical/ethical issues	• Promotion of operational research in disability and health systems • Set a minimal data set for rehabilitation • Set a universal coding system • Improve processes relating to clinical documentation/measurement tools • Commence medical staff training in research methodologies • Establish hospital-based IT systems for data entry • Disability specific registries in the future
3.2 Reform national data collection systems based on the ICF	• Lack of standard data collection systems • Minimal awareness and no incentive for hospitals or staff to participate • Limited staff training and support for ICF usage • Lack of national registries • Lack of financial support	• Implementation and training in ICF model • Develop standard data collection systems • Mandatory data collection across all sectors • Linkage of performance indicators to health outcomes • Involvement and active participation of National Federations, NGOs, DPOs

Table III cont.

Actions	• Potential challenges/barriers	• Potential facilitators/enablers in the next 5–6 years
3.3 Strengthen research on priority issues in disability	• Research not identified as a priority for rehabilitation • Lack of awards or recognition for research works • Limited support and IT available for research • Limited staff capacity and training for research • Lack of available research professionals • Limited guidance and/or mentorship • Lack of funding for research	• Involve government and academic institutions to conduct research • Train research professionals • Improve access to IT and web-based programmes • Build research capacity in rehabilitation • Cooperation with international partners in research and development • Involvement and active participation of National Federations • International aid/assistance in research capacity building • Establish national research centre/foundation

Sources:
WHO Country Cooperation Strategy at a Glance: Pakistan May 2014;
WHO Country Profile: Pakistan;
IOM Country Fact Sheet: Pakistan 2014;
WHO Health Statistics 2011;
ESCAP Statistical Year Book for Asia and the Pacific 2014; WHO Global Infobase;
WHO Bulletin; UN Human Development Report 2014.

CRPD: Convention on the Rights of Persons with Disabilities; DPOs: Disabled People's Organizations; GDP: Gross Domestic Product; ICF: International Classification of Functioning, Disability and Health; IT: information technology; NCDs: non-communicable diseases; NGO: non-governmental organization; PM&R: Physical Medicine and Rehabilitation; PwD: persons with disability; SAARC: South Asian Association for Regional Cooperation; WHO: World Health Organization.