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

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| 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 for rehabilitation  
• 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 govenment 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  
| 2.7 Engage, support and build capacity of PwD and caregivers | • Exclusion of caregivers of PwD in care services  
| Objective 3: Strengthen collection of relevant and internationally comparable data on disability and support research on disability and related 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 | • Exclusion of PwD and/or caregivers from decision-making processes.  
| 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  
| 3.2 Reform national data collection systems based on the ICF | • Cultural barrier/misconception – unwilling to disclose  
• Logistical/ethical issues | • Development 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 | • 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 |
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<td>3.3 Strengthen research on priority issues in disability</td>
<td>• Research not identified as a priority for rehabilitation&lt;br&gt;• Lack of awards or recognition for research works&lt;br&gt;• Limited support and IT available for research&lt;br&gt;• Limited staff capacity and training for research&lt;br&gt;• Lack of available research professionals&lt;br&gt;• Limited guidance and/or mentorship&lt;br&gt;• Lack of funding for research</td>
<td>• Involve government and academic institutions to conduct research&lt;br&gt;• Train research professionals&lt;br&gt;• Improve access to IT and web-based programmes&lt;br&gt;• Build research capacity in rehabilitation&lt;br&gt;• Cooperation with international partners in research and development&lt;br&gt;• Involvement and active participation of National Federations&lt;br&gt;• International aid/assistance in research capacity building&lt;br&gt;• Establish national research centre/foundation</td>
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