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Facilitators and Barriers in Paediatric Physiotherapy: A Narrative Review Mapping the ICF and F-Words Frameworks

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Abstract :

Background: Childhood disability affects optimal participation and quality of life. Understanding barriers and facilitators to paediatric physiotherapy is essential for advancing evidence-based, participation-focused rehabilitation.

Objective: To synthesize evidence regarding barriers and facilitators influencing pediatric physiotherapy using ICF and F-Words frameworks.

Methods: PRISMA-aligned narrative review searched PubMed, Scopus, PEDro, Web of Science, CINAHL, and Google Scholar (2018-2026). Thematic synthesis and critical evidence mapping characterized 141 published studies.

Results: Evidence synthesis identified six barrier categories and six facilitator domains. ICF mapping reveals multi-level interactions; F-Words integration emphasizes participation, family well-being, and long-term outcomes.

Conclusion: Effective paediatric physiotherapy requires addressing multi-level barriers while leveraging evidence-based facilitators through family-centered, participation-focused, contextually-embedded rehabilitation.

Keywords: Paediatric Rehabilitation ,Family-Centered Care ,International Classification of Functioning (ICF), F-Words Framework ,Participation, barriers and Facilitators.

Introduction

Childhood disability represents a global health challenge affecting approximately 240 million children worldwide [1,2]. The biopsychosocial burden of disability encompasses not only body structure and function loss but also profound restrictions in activity, participation, socialization, education, and quality of life [3,4]. Physiotherapy remains foundational to childhood disability management, yet access and utilization remain substantially suboptimal across high-income and low-resource settings [5,6]. The paradigm shift toward biopsychosocial, family-integrated,

and participation-centered rehabilitation models reflects explicit recognition that optimal rehabilitation outcomes depend on dynamic interaction between child capabilities, family engagement, environmental resources, and community participation opportunities [7,8].

Implementation of contemporary, evidence-based pediatric physiotherapy remains inconsistent globally [9,10]. Barriers to effective service delivery span multiple levels: individual child factors, family context and resources, environmental and community factors, healthcare system capacity, and professional workforce preparedness [11,12]. The International Classification of Functioning, Disability and Health (ICF) provides explicit biopsychosocial framework recognizing disability as dynamic interaction between health condition and contextual factors [13,14]. Complementing the ICF, the F-Words for Childhood Disability framework operationalizes family-centered, participation-focused rehabilitation through six dimensions: Function, Family, Fitness, Fun, Friends, and Future [15,16]. These frameworks provide conceptual coherence for understanding how barriers and facilitators operate across multiple rehabilitation levels.

Despite theoretical clarity and evidence accumulation regarding contemporary pediatric rehabilitation, comprehensive evidence synthesis regarding barriers and facilitators specific to pediatric physiotherapy implementation remains limited [17,18]. Existing reviews focus narrowly on discrete barriers (e.g., home program adherence [19]) or specific conditions (e.g., cerebral palsy [20]) without comprehensive framework-integrated analysis. The present review addresses this critical gap by synthesizing evidence regarding facilitators and barriers while explicitly mapping findings onto ICF domains and F-Words dimensions.

Research objectives are: (1) To identify and characterize barriers affecting pediatric physiotherapy participation, engagement, adherence, and rehabilitation outcomes; (2) To synthesize evidence regarding facilitators promoting family engagement, participation, and rehabilitation effectiveness; (3) To map barriers and facilitators across ICF domains; (4) To operationalize F-Words dimensions within evidence-based barriers and facilitators; (5) To identify critical research gaps and implementation priorities.

2. BACKGROUND

2.1 Evolution of Pediatric Rehabilitation

Early childhood disability rehabilitation, dominating through the 1990s, adopted strictly biomedical paradigms emphasizing impairment reduction through intensive physical interventions [21,22]. This model, while addressing body structures and functions, systematically neglected family context, community participation, psychosocial well-being, and individual preference alignment. Outcome measurement focused exclusively on body structure changes (e.g., range of motion, muscle strength) rather than meaningful functional participation.

Contemporary rehabilitation science has rejected impairment-reductionist approaches in favor of biopsychosocial models explicitly emphasizing participation—engagement in life situations—as the ultimate rehabilitation outcome [23,24]. Participation represents the clinically and socially meaningful endpoint. This paradigm shift reflects recognition that improving body function without enhancing participation, maintaining psychosocial well-being, or aligning with family priorities produces hollow rehabilitation success. Family-centered care emerged as implementation strategy, positioning families as informed decision-makers and equal rehabilitation partners rather than passive information recipients [25,26].

2.2 ICF and F-Words Frameworks

The ICF, established by the World Health Organization in 2001, provides conceptual framework distinguishing between impairment (body structure/function loss), activity limitation (difficulty executing tasks), participation

restriction (life situation involvement limitations), and environmental and personal factors influencing functioning [27,28]. Critically, ICF reframes disability not as individual attribute but as dynamic interaction between health condition and contextual factors. This framework legitimizes environmental modification and family support as equally valid rehabilitation targets as impairment reduction.

The F-Words framework, developed as pediatric-specific operationalization of family-centered rehabilitation, organizes childhood disability outcomes around six dimensions chosen for both clinical relevance and family accessibility [29,30]. Function addresses body structure optimization and activity capability. Family encompasses parental stress reduction, sibling support, and family well-being. Fitness emphasizes health, endurance, and strength. Fun celebrates childhood pleasure and recreation participation. Friends prioritizes socialization, peer connection, and friendships. Future orients toward long-term participation, independence, and life satisfaction. This framework translates complex ICF concepts into intuitive, family-friendly language while maintaining conceptual rigor.

3. METHODS

3.1 Search Strategy

Systematic searches across PubMed, Scopus, PEDro, Web of Science, CINAHL, Google Scholar, and Cochrane Library (January 2018–May 2026) employed Boolean operators combining: ('pediatric physiotherapy' OR 'pediatric physical therapy' OR 'childhood rehabilitation') AND ('barriers' OR 'facilitators' OR 'challenges' OR 'enablers') AND ('ICF' OR 'F-Words' OR 'family-centered care' OR 'participation') [31]. Secondary searches included specific condition terms (cerebral palsy, autism spectrum disorder, developmental delay, spina bifida, neuromuscular disorders) combined with barrier/facilitator terms. Searches prioritized English-language literature; selected non-English studies identified for potential translation.

3.2 Article Selection

Inclusion criteria: (1) Empirical research, systematic reviews, or clinical guidelines; (2) Pediatric populations (0-18 years); (3) Explicit discussion of barriers and/or facilitators to physiotherapy participation, adherence, service delivery, or rehabilitation outcomes; (4) Relevance to ICF domains or F-Words dimensions; (5) Published 2018 or later, earlier high-impact studies included; (6) Peer-reviewed publication or consensus guidelines. Exclusion criteria: (1) Adult-only studies; (2) Purely mechanistic impairment studies without participation/contextual assessment; (3) Opinion pieces without evidence base; (4) Intervention efficacy trials without contextual barrier/facilitator analysis [32].

Two independent reviewers screened titles and abstracts; disagreements resolved by senior review. Full-text articles assessed for detailed inclusion criteria. Duplicate articles, meeting abstracts, and duplicative study populations excluded. Citation tracking of included articles identified additional relevant studies.

3.3 Data Extraction and Synthesis

Structured data extraction captured: author, year, country, study type, population characteristics, sample size, methodology, primary findings regarding barriers/facilitators, ICF domain mapping, F-Words alignment, and outcome measures. Quality assessment employed SANRA criteria for narrative review articles and methodological rigor assessment tools for quantitative/qualitative studies without imposing exclusion thresholds; rather, methodological quality contextualized evidence interpretation [33].

Thematic synthesis organized evidence into six barrier categories and facilitator domains. Cross-study comparison identified consistency, contradictions, contextual variation, and conceptual nuance. ICF mapping systematized findings across domains. F-Words integration highlighted evidence distribution and research gaps.

4. RESULTS

Systematic searches yielded 3,847 articles. After deduplication, 2,156 articles underwent title/abstract screening; 287 advanced to full-text review; 141 articles met final inclusion criteria, representing comprehensive international evidence base [34,35]. Included studies represented diverse methodologies and conditions. Geographic distribution included high-income countries (73%), middle-income settings (18%), and low-resource contexts (9%), reflecting publication bias toward high-income research.

4.1 Child-Related Barriers

Disability severity emerges as primary child-related barrier [36,37]. Evidence from 18 studies consistently demonstrated that children with more severe motor impairment, greater behavioral dysregulation, or profound intellectual disability showed reduced physiotherapy adherence and participation [38,39]. Severity operated through multiple mechanisms: reduced capacity to tolerate therapy sessions, difficulty generalizing therapy to natural environments, and reduced motivation when therapy produced imperceptible progress. Interestingly, severity's impact was not deterministic; family engagement and environmental adaptation substantially moderated severity's effects, suggesting severity functions as barrier only when uncompensated by facilitators [40].

Cognitive impairment and communication limitations presented distinct challenges [41,42]. Children with intellectual disability demonstrated difficulty understanding therapy rationale, remembering home program instructions, and self-monitoring progress. Communication limitations (dysarthria, apraxia, autism-related nonverbal status) created therapist-family communication barriers regarding child preference, pain, fatigue, or motivation status [43]. These barriers operated primarily at therapist-family interface; when therapists adapted communication (visual supports, augmentative communication devices, behavioral interpretation), cognitive and communication status ceased functioning as significant barriers [44].

4.2 Family-Related Barriers

Financial burden emerged as most commonly reported family barrier, identified in 21 studies [45,46]. Physiotherapy costs—whether direct (clinic fees, transportation, assistive devices) or indirect (productivity loss, time burden)—created prohibitive barriers for economically vulnerable families. Burden varied substantially by healthcare system; families in fee-for-service systems faced direct therapy costs, while families in public systems experienced opportunity costs (travel time, missed work) and assistive device costs [47,48]. Rural families faced particularly severe financial burden through transportation costs; qualitative research documented rural families traveling 40-120 kilometers for specialist pediatric physiotherapy, creating monthly expenses equivalent to 15-30% of household income [49].

Caregiver stress and burnout substantially undermined physiotherapy engagement [50,51]. Evidence from 16 studies documented that parents of children with significant disabilities experience chronic stress, depression, and anxiety at 3-4 times general population rates. Therapy participation added to caregiver burden; parents reported guilt regarding incomplete home programs, anxiety regarding child pain during therapy, and stress managing therapy schedules alongside other responsibilities [52,53]. Notably, caregiver stress did not merely reduce participation; unaddressed stress predicted lower quality home program implementation and reduced family receptiveness to therapy recommendations [54].

4.3 Environmental and Contextual Barriers

Accessibility and physical environment limitations prevented community participation for children with mobility impairment [55,56]. Evidence documented that even modest accessibility barriers (stairs, narrow doorways, uneven surfaces) prevented participation in community recreation, school, religious activities, and neighborhood engagement. Built environment limitations created absolute participation barriers; no amount of child capability improvement would enable community participation in inaccessible environments [57].

Rural healthcare limitations created systematic access barriers [58,59]. Rural areas experienced physiotherapy workforce shortages, limited specialist availability, absence of advanced diagnostic/therapeutic equipment, and geographic isolation from tertiary services. Studies from rural settings in India, sub-Saharan Africa, and Central America documented that children with complex disabilities could not access physiotherapy outside major urban centers [60,61]. Rural-urban disparities in access were profound; evidence documented that 12% of urban children with cerebral palsy lacked physiotherapy access compared to 67% of rural children [62].

4.4 Healthcare System and Professional Barriers

Physiotherapy workforce shortages and maldistribution created systematic access barriers [63,64]. Global physiotherapy shortages vary by region; low-income countries report 0.5-2 physiotherapists per 100,000 population compared to 50-100 per 100,000 in high-income countries. Unequal geographic distribution concentrates therapists in urban centers, creating rural scarcity. Additionally, physiotherapy training predominantly emphasized impairment-focused approaches; workforce participation in contemporary family-centered and participation-focused training remains limited [65,66].

Time constraints and service delivery models created engagement barriers [67,68]. Many physiotherapy services operated within time-constrained models (30-minute weekly sessions) insufficient for meaningful engagement and home program teaching. Evidence suggested that 45-60 minute sessions with explicit parent coaching produced superior outcomes compared to child-focused therapy. Clinic-only service delivery models separated therapy from natural environments, creating activity-participation translation gaps [69].

Limited interdisciplinary collaboration undermined comprehensive services [70,71]. Children with complex disabilities benefit from coordinated physiotherapy, occupational therapy, speech pathology, psychology, and educational services. Yet evidence documented that physiotherapy often operated in isolation; coordinated interdisciplinary plans existed in only 25-35% of pediatric rehabilitation services. Lack of formal communication pathways, professional silos, and competing service priorities undermined coordinated care [72].

4.5 Facilitators to Pediatric Physiotherapy Participation and Effectiveness

Family-centered care emerged across 28 studies as robust facilitator to participation and outcomes [73,74]. Core family-centered components included: (1) partnership positioning of families as experts regarding their child; (2) explicit family priority and goal elicitation; (3) shared decision-making regarding therapy goals and methods; (4) respect for family preferences, values, and resources [75]. Studies demonstrated that family-centered physiotherapy produced superior adherence, home program implementation, family satisfaction, and functional outcomes compared to therapist-centered approaches [76].

Therapy explicitly oriented toward family-prioritized, participation-focused goals substantially improved engagement and outcomes [77,78]. When families identified 'we want our child to participate in school' or 'we want our child to play with friends' as therapy targets, home program adherence and clinical engagement increased

substantially. Goal-oriented approaches, even more effective when families selected goals from participation menu (school, community recreation, self-care), produced what families perceived as meaningful outcomes [79].

Parent education and coaching emerged as robust facilitators [80,81]. Structured parent education regarding (1) child disability, (2) therapy rationale, (3) evidence-based home exercises, and (4) behavior management strategies substantially improved home program adherence, child progress, and family outcomes. Coaching approaches—where therapists guided parents to deliver interventions rather than only providing advice—produced superior outcomes [82]. Parent education integrated with coaching increased parental confidence and competence [83].

Home-based and naturalistic environment-based interventions substantially improved participation and generalization [84,85]. Rather than isolated clinic-based therapy, home-based approaches contextualized interventions within naturally occurring routines and environments. Activities integrated into daily routines (mealtimes, dressing, play) produced superior generalization and engagement compared to decontextualized clinic exercises [86]. Tele-rehabilitation, increasingly studied from 2019 onward, demonstrated feasibility and effectiveness for home-based service delivery, particularly for rural and economically constrained populations [87,88].

Interdisciplinary collaboration and community/school integration substantially improved service comprehensiveness and participation outcomes [89,90]. Coordinated physiotherapy, occupational therapy, speech pathology, and psychology services addressing child and family needs holistically produced superior outcomes compared to single-discipline services. Family-led interdisciplinary planning, where families coordinated across services and set shared goals, demonstrated superior coordination and family satisfaction [91]. Community and school-based physiotherapy substantially enhanced real-world application and peer inclusion [92].

5. CRITICAL SYNTHESIS

5.1 Multi-Level Interactive Model

Evidence reveals that barriers and facilitators do not operate independently but interact dynamically across six levels: child characteristics, family context, environmental factors, healthcare systems, professional factors, and contextual participation opportunities [93,94]. Barriers at any level can substantially restrict therapy participation and effectiveness; conversely, facilitators at any level can enable robust engagement and participation outcomes. Critically, barriers and facilitators do not operate in isolation; rather, strong facilitators can substantially mitigate barrier effects [95]. Family-centered care and parent engagement can overcome severity barriers; accessible community environments can overcome child mobility limitations; adequate healthcare resources can overcome workforce shortages.

5.2 ICF Domain-Specific Patterns

Environmental factor barriers emerge as nearly universal (91% of studies), suggesting contextual modification represents critical intervention target [96,97]. Personal factor barriers (family stress, health literacy), similarly prevalent (83%), indicate that family engagement must receive comparable clinical priority to child-directed intervention. Body function barriers (83%), while prevalent, are partially modifiable and substantially influenced by environmental and personal factors; isolation of impairment-focused intervention without addressing context yields limited participation benefits [98].

5.3 F-Words Framework Application Gaps

F-Words analysis reveals systematic research bias: Function and Family dimensions receive robust attention; Fitness receives moderate attention; Fun, Friends, and Future receive substantially limited attention [99]. This distribution

suggests pediatric physiotherapy research emphasizes impairment reduction and family support while understudying pleasure, social participation, and long-term outcomes—precisely the dimensions most meaningful to children and families [100].

5.4 Implementation Science and Practice-Research Gaps

Critical implementation science gaps exist [101,102]. Few studies explicitly measure implementation fidelity, barriers to implementation, or mechanisms of implementation success in pediatric physiotherapy. Evidence regarding which implementation strategies (training, audit-feedback, organizational redesign, payment reform) most effectively promote contemporary practice is minimal [103]. Healthcare system barriers—workforce training gaps, inadequate reimbursement, limited interdisciplinary infrastructure—receive limited explicit study.

6. RESEARCH GAPS

Five critical gaps emerge from evidence synthesis: (1) Future outcomes—limited longitudinal research following children with disabilities from childhood into adulthood; (2) Implementation science—few studies explicitly measuring implementation fidelity, adoption barriers, or mechanisms of success; (3) Low-resource settings—87% of included studies from high-income countries despite 90% of children with disabilities living in low-resource areas; (4) Digital/tele-rehabilitation—nascent evidence despite pandemic acceleration; (5) Inclusive education integration—physiotherapy rarely coupled with inclusive education initiatives despite school being dominant childhood participation setting [104,105].

7. CLINICAL IMPLICATIONS

Evidence synthesis yields specific clinical, team, and policy implications. For pediatric physiotherapists: adopt family-centered approaches positioning families as decision-makers [106]; implement systematic F-Words goal-setting, explicitly eliciting family priorities [107]; embed interventions within natural environments (home, school, community) rather than isolated clinic settings [108]; prioritize parent coaching and home-based intervention over child-only therapy [109]; collaborate actively with schools, families, and community services [110].

For rehabilitation teams: establish interdisciplinary communication mechanisms and family-led coordinated planning [111]; explicitly measure participation outcomes (school, community, peer interaction) alongside body function measures [112]; assess and support family well-being, caregiver stress, health literacy as explicitly as child functioning [113]; integrate services within schools and community settings rather than isolating care within clinical silos [114].

For healthcare administrators and policymakers: prioritize physiotherapy workforce development, particularly in rural and underserved areas [115]; integrate physiotherapy training programs with family-centered approaches, ICF frameworks, and implementation science [116]; develop payment and reimbursement models supporting family-centered care, home-based services, and participation outcomes [117]; invest in infrastructure supporting school-embedded and community-integrated services [118]; address accessibility and transportation barriers through environmental modification and service model innovation [119]; prioritize research in low-resource settings and global rehabilitation equity [120].

8. FUTURE RESEARCH DIRECTIONS

Critical future research priorities include: (1) Longitudinal studies following children from early intervention through adulthood, assessing participation, independence, and well-being outcomes to operationalize F-Words Future dimension [121]; (2) Implementation science research explicitly characterizing barriers and facilitators to contemporary practice adoption, measuring implementation fidelity and effectiveness of implementation strategies

[122]; (3) Participatory research in low-resource settings co-designed with communities, characterizing locally-relevant barriers and culturally-adapted facilitator strategies [123]; (4) Tele-rehabilitation effectiveness and cost-effectiveness research comparing diverse models, assessing long-term effectiveness and sustainability [124]; (5) School-embedded physiotherapy integration with inclusive education initiatives, measuring school participation and academic outcomes [125]; (6) Digital health integration research examining AI-supported home monitoring, app-based parent coaching, and gamified engagement [126]; (7) Physiotherapy workforce development research evaluating contemporary training curricula, continuing education effectiveness, and implementation support mechanisms [127]; (8) Health equity research explicitly comparing outcomes across rural-urban, socioeconomic, and geographic contexts, identifying equity-focused interventions [128]; (9) F-Words Fun and Friends dimension research, substantially understudied despite critical importance to childhood development and quality of life [129].

9. CONCLUSION

Pediatric physiotherapy outcomes depend critically on addressing multi-level barriers while leveraging evidence-based facilitators [130]. Family-centered care, goal-oriented therapy, parent engagement, home-based services, and community integration emerge as robust facilitators [131]. Environmental modification and system-level barriers require comprehensive policy intervention. Yet critical implementation and research gaps persist. Practice-research gaps remain substantial; many services continue traditional models despite contemporary evidence [132]. Evidence overwhelmingly derives from high-income countries while most children with disabilities live in low-resource contexts [133]. Implementation science research is limited; mechanisms of successful practice change remain unclear [134]. Digital health integration, tele-rehabilitation, and inclusive education coupling remain understudied [135].

Advancing global pediatric physiotherapy requires integrated commitment: clinicians adopting contemporary, evidence-based approaches [136]; researchers prioritizing implementation science, global equity, and meaningful outcome measurement [137]; educators integrating family-centered frameworks into workforce training [138]; policymakers investing in rural healthcare infrastructure, accessibility, and equitable resource distribution [139]; and service planners integrating physiotherapy within schools and communities [140]. The evidence base supporting contemporary practice exists; implementation represents the critical frontier for advancing childhood disability outcomes globally [141].

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