Integration of rehabilitation and assistive technology into primary health noncommunicable disease management in Fiji

PILOT REPORT
October 2021 – December 2022
Executive Summary

Introduction

The World Health Organization (WHO) partnered with the Fiji Ministry of Health and Medical Services to run a small-scale pilot towards the integration of rehabilitation and assistive technology into primary health noncommunicable disease (NCD) management in Fiji. The Fiji Ministry of Health and Medical Services reports that NCDs represent approximately half of Fiji's total mortality.

Rehabilitation and assistive technology play an important role in addressing the complications of NCD, however, these important components are often not part of NCD management. This project provided the opportunity to explore strengthening access to rehabilitation and assistive technology alongside existing NCD initiatives; to support the prevention and management of complications due to NCDs, such as diabetic foot ulcers, as well as supporting improved independence, function, and quality of life for people living with NCDs.

Overview of project implementation

The project was implemented during 2022 in collaboration with the Fiji Ministry of Health and Medical Services and with the support of the WHO Fiji Country Office. The project included a planning and consultation phase to identify priority training topics, module development and delivery of blended training to 34 primary health care (PHC) personnel (learners) via a blended learning approach. Learners were supported by 12 mentors who supported both the blended training delivery and three-month period of mentored service delivery, and also the monitoring and evaluation throughout the project. A supply of assistive products was procured for provision by learners to service users during the three-month service delivery period which immediately followed the training.

Training content was developed specifically for the project. Modules topics were selected during the planning and consultation phases and focused on mobility and self care. The modules were developed and then delivered using WHO Training in Assistive Products (TAP) and the new Basic Rehabilitation Package Clinical Resource.

Project aim:
To pilot integration of selected assistive technology and rehabilitation interventions for people with NCDs within primary health care.

Project objectives:
a) Train up to 20 personnel from Fiji MoHMS health facilities to complete online and mentored training in either:
   • Off-loading techniques for diabetic foot wound management or
   • Provision of simple self care assistive products and related rehabilitation interventions.

b) To complete a technical report including lessons learned to inform future next steps for Fiji and further development of WHO assistive technology and rehabilitation tools and resources for NCDs.
Conclusions and lessons

The response to the training from both personnel and mentors was positive, and strongly reiterated the need for scaling up rehabilitation and assistive technology for NCDs in Fiji:

➢ there is a high need for these services among service users;
➢ the provision of basic rehabilitation interventions and simple assistive products is an appropriate task for nurses, primary/community health workers and other related workforce.

The training modules were effective at increasing knowledge, in preparation for learners to begin the provision of basic rehabilitation interventions and simple assistive products. Learners gave valuable feedback to further strengthen elements of training content as well as to improve the usability and accessibility of modules. The pilot reconfirmed that supervised practice is essential in order to achieve safe and effective competence in rehabilitation and assistive product provision. This is an important consideration in the rollout of future training, as it requires the availability of health workforce with relevant skills to mentor and supervise new learners. This also highlights the importance of providing adequate preparation and guidance for mentors to fulfill their roles.

It was encouraging to see learners were well connected to the internet, at home and at their place of employment, and were very accustomed to receiving training via a blended format. Despite most learners having good accessibility to the internet, some did express barriers, particularly when undertaking regional outreach work. Other barriers included a lack of local availability of assistive products; and a need for dedicated time to focus on training within busy clinic schedules. These are factors to be considered as the training is further developed and rolled out.

This pilot also provided the Fiji Ministry of Health and Medical Services with an opportunity to build on their existing work in increasing access to rehabilitation and assistive technology in primary healthcare, raise awareness of the need for rehabilitation and assistive technology and support the development of related professional networks. With mentors now trained in the implementation of this blended training and familiarity with the online TAP platform, it would be possible for further training using the TAP platform to occur in Fiji.

Key findings and lessons learned

For Fiji stakeholders

- This project has resulted in additional primary healthcare services now sourcing assistive products from the Rehabilitation service in Fiji.
- The implementation of training has given learners the competence to systematically implement techniques learned into daily practice, supported by mentors.
- Continue to ensure mentors are available to support learners as they implement new services.
- When feasible, build on this project by training learners through additional TAP modules focusing on diabetic foot care, including therapeutic footwear.
- Continue to build awareness and links between NCD initiatives in both primary and tertiary care, to increase identification, management, and referral pathways for people with NCDs in need of rehabilitation and/or assistive technology.
- Expand screening for functioning difficulties into secondary and tertiary level services (such as provincial and district hospitals) to increase the identification and referrals for rehabilitation and assistive technology.
For WHO

- When planning face-to-face training with highly competent learners, less time is needed for theoretical content and may be re-allocated to practical sessions.
- Where the context allows, continue to encourage learners to undertake theoretical introductory modules prior to meeting for the face-to-face training which allows more time for practical sessions.
- Strengthen the modules by adding links to sources and statistics.
- Develop supporting resources for coordinators and mentors, such as tips for mentors on supporting new learners, client information leaflets, and one-page summaries of assistive product provision steps.
- Continue to ensure training is offered as a flexible platform that enables use of the modules and resources in a manner that suits the context including offline access to training content
- Continue to promote the role of mentors in supporting ‘knowledge into practice’ as a core component of training.

*Image 1: Learners, mentors, WHO Staff, and Ministry of Health representatives at the training in Fiji.*
1. Training in assistive products (TAP)

The World Health Organization (WHO) published the first Priority Assistive Products List (APL) in 2016. The APL includes hearing aids, wheelchairs, spectacles, artificial limbs, communication and memory devices, and other essential items needed by at least one billion people around the world to live a healthy, productive, and dignified life. Aligned with the WHO Model List of Essential Medicines, the APL is intended as a catalyst in promoting access to assistive products.

Trained personnel are essential to effectively provide assistive products. Proper assessment, fitting, user training, and follow-up are vital as without these four key steps assistive products are often of no benefit or abandoned and may cause physical harm. In many contexts, there is a severe shortage of trained personnel to provide assistive products, or they are not accessible to the whole population.

TAP is an open-access, online learning platform hosting interactive training modules (see graphic below). Module content is delivered in a variety of ways, including case studies, videos, illustrations, questions, activities and quizzes. There are also downloadable/printable checklists, assessment forms, and keyword lists. Intended to equip primary/community health and other community-level personnel to provide simple assistive products, TAP has the potential to increase the scope of practice of the existing workforce, making assistive products more readily accessible to more people in a wide range of contexts.

Figure 1: TAP module structure

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2. Basic Rehabilitation Package - Clinical Resource

The WHO Basic Rehabilitation Package Clinical Resource (BRP-CR) is a resource that outlines a limited set of prioritized interventions for rehabilitation that can be delivered in primary health care. When rehabilitation is integrated into primary health care, services are brought closer to people’s homes, making them more accessible and affordable. The resource enables this by providing information on low-cost, high-impact and evidence-based interventions for rehabilitation that can be easily, safely and effectively delivered by existing workforce in primary health care and low-resource settings.

The Basic Rehabilitation Package Clinical Resource includes a training package which supports blended learning, using both online and face to face learning materials, along with print materials including manuals and decision trees. The resource will also include an implementation guide that outlines steps of implementation within a country or setting.

3. Pilot background

3.1 Pilot aim objectives

Project aim:
To pilot integration of selected assistive technology and rehabilitation interventions for people with NCDs within primary health care.

Project objectives:
a) Train up to 20 personnel from Fiji MoHMS health facilities to complete online and mentored training in either:
   - Off-loading techniques for diabetic foot wound management or
   - Provision of simple self care assistive products and related rehabilitation interventions.

b) To complete a technical report including lessons learned to inform future next steps for Fiji and further development of WHO assistive technology and rehabilitation tools and resources for NCDs.

The Fiji pilot included the following thirteen modules across two learning groups. All learners undertook introductory modules before separating into streams for either mobility or self care.

Groups one and two (all learners)

<table>
<thead>
<tr>
<th>Module name</th>
<th>Module description</th>
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<tbody>
<tr>
<td>Introduction to noncommunicable diseases</td>
<td>Overview of common NCDs and their complications</td>
</tr>
<tr>
<td>Introduction to assistive products</td>
<td>Introduction to assistive products, who uses them and how to provide them</td>
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Group one: Mobility

<table>
<thead>
<tr>
<th>Focus</th>
<th>Module name</th>
<th>Module description</th>
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</thead>
<tbody>
<tr>
<td>Assistive products</td>
<td>Introduction to mobility</td>
<td>Introduction to assistive products for mobility</td>
</tr>
<tr>
<td>Rigid removable boots</td>
<td>Safe and effective provision of rigid removable walkers via four steps. Assess, select, fit/user training and follow up.</td>
<td></td>
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<tr>
<td>Offloading for diabetic feet</td>
<td>Introduces the theories and mechanisms for offloading for diabetic foot ulcers. Includes advanced concepts of pressure, pressure distribution, anatomy and physiology of the skin and foot and prepares learners to provide safe and effective offloading for diabetic foot ulcers.</td>
<td></td>
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<tr>
<td>Total contact casting</td>
<td>Builds upon knowledge of off-loading and introduces the procedure of total contact cast treatments, including indications/contraindications, application, monitoring and removal.</td>
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<tr>
<td>Walking aids</td>
<td>Safe and effective provision of crutches, walking frames, walking sticks and rollators</td>
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Group Two: Self care

<table>
<thead>
<tr>
<th>Focus</th>
<th>Module name</th>
<th>Module description</th>
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</thead>
<tbody>
<tr>
<td>Assistive products</td>
<td>Introduction to self care</td>
<td>Introduction to assistive products for self care</td>
</tr>
<tr>
<td>Eating and drinking aids</td>
<td>Safe and effective provision of aids for eating and drinking using four service steps: 1) Select, 2) Fit, 3) Use, 4) Follow up.</td>
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<tr>
<td>Dressing aids</td>
<td>Safe and effective provision of dressing aids using the four service steps: 1) Select, 2) Fit, 3) Use, 4) Follow up.</td>
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<tr>
<td>Toilet and shower chairs</td>
<td>Safe and effective provision of aids for toilet and shower chairs the four service steps: 1) Select, 2) Fit, 3) Use, 4) Follow up</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Introduction to rehabilitation</td>
<td>Introduction to rehabilitation interventions and how to provide them</td>
</tr>
<tr>
<td>Introduction to self care</td>
<td>Introduction to rehabilitation interventions for self care</td>
<td></td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>Educating, training and advising in self-care to improve safety, independence and participation (e.g. washing and caring for oneself, dressing; eating and drinking; toileting, transferring from surface to surface) using four steps: 1) Ask and assess, 2) Plan, 3) Deliver care, 4) Follow up</td>
<td></td>
</tr>
<tr>
<td>Instrumental activities of daily living</td>
<td>Educating, training and advising on instrumental activities of daily living (e.g. acquisition of goods and services, managing money or meal preparation and house work in light of a health condition and a person’s functioning limitations) using four steps: 1) Ask and assess, 2) Plan, 3) Deliver care, 4) Follow up</td>
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3.2 Implementation partners

Project implementation was coordinated by the WHO Fiji Country Office and the Fiji Ministry of Health and Medical Services. Primary healthcare centers across Fiji released their staff to participate in the training and to act as mentors, giving ongoing support to implementing the new rehabilitation and assistive technology services.
3.3 Context

Fiji was chosen as a pilot location in consultation with regional stakeholders, the WHO Western Pacific Regional Office and WHO Country office for several reasons. These included the country’s growing interest in strengthening rehabilitation and assistive technology services, and engagement in a targeted approach to strengthen outcomes for people living with NCDs.

The Fiji Ministry of Health and Medical Services (MoHMS) reports that NCDs represent more than 80 percent of Fiji’s total mortality. To reduce the overall burden of NCDs, Fiji has developed a National Wellness Policy for Fiji, with a focus on preventive measures such as decreasing lifestyle risk factors and improving health-seeking behaviour. The MoHMS has also adopted the WHO Package of Essential NCDs (PEN) model to strengthen clinical management of Fijian’s with NCDs to achieve better health outcomes. Three PEN centres of excellence have been established at primary health care level aimed at enabling early detection and management of NCDs as well as prevention of complications. Rehabilitation and assistive technology are two key services that can be implemented alongside these new and existing NCD initiatives to support the prevention and management of complications due to NCDs, such as diabetic foot ulcers. These services can also improve individuals’ independence, function, and quality of life.

4. Pilot description

4.1 Overview

<table>
<thead>
<tr>
<th>Phase</th>
<th>Key activities</th>
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</table>
| One: Preparation          | • Establishment of expert advisory group of rehabilitation and assistive technology stakeholders in Fiji to guide the pilot planning and to develop the pilot terms of reference.  
• Preparation of evaluation tools.  
• Investigation of procurement pathways for assistive products not readily available in Fiji.  
• Identification of expert mentors to support the training.  
• Mentor training and preparation |
| Two: Learners take the modules | • The 13 modules were undertaken by learners over a two-week period.  
• Learners were provided with access to the training platform one week before they came together at a training venue for five days face to face learning including, theoretical content delivered via the training platform, group discussion, demonstration and practice.  
• In-country support was provided to learners by WHO staff, and local mentors.  
• Remote support was provided to the pilot by the WHO HQ Project team via instant messaging. |
### Three: Evaluation

<table>
<thead>
<tr>
<th><strong>In-country activities:</strong></th>
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<tbody>
<tr>
<td>• Mentor visits to learners and application of skills checklists and supervised practice.</td>
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<td>• Focus groups with learners</td>
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<tr>
<td>• Focus group with mentors</td>
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<tr>
<td>• De-brief meetings with the expert advisory group who informed the pilot planning</td>
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**Analysis of data including:**

- Participant registration forms.
- Results of participant's pre and post module quizzes and skills checklists.
- Discussion forum responses posted by learners while taking the modules.
- Completed participant questionnaires re usability and content relevance.
- Focus groups transcripts.

### 4.2 Resources

**Tablets and data:** Tablets were provided by the WHO Country Office for use in the pilot. Data for internet access was provided to learners.

**Other:** Learners were provided with bound folders consisting of the learning support materials. This included necessary assessment forms, key messages, and skills checklists. For the assistive technology modules, the TAP coordinators page also hosts the necessary documents which can be printed locally. For the rehabilitation training, a hard copy manual of the content was provided.

### 4.3 Learners

34 learners participated from eight primary healthcare centers across Fiji. Learners were nominated based on their employment in positions that regularly encounter people living with NCDs. Learners were nominated who met the following criteria:

- Confident in reading, writing and speaking English
- Willing to commit to completing the modules and taking part in the evaluation
- Confirmed support from service managers to participate

Learners were spread evenly over two learning streams, stream 1 for mobility, and stream 2 for self-care.

There were 21 females and 9 males participating in the training. Seven learners reported being users of one or more assistive products. Learners included doctors, nurses, nurse practitioners, physiotherapists, and community health workers. The qualification level of the learners ranged from certificate level training to masters degree, and doctorate training. There was a range of levels of experience amongst the learner group, however, most learners had more than five years of experience.
The learner group had a high level of exposure to assistive product provision in their employment, with 92% of learners reporting prior experience providing assistive products as part of their employment. Types of assistive products they reported providing included assistive products for mobility, vision, cognition, communication and self care.

All learners reported that they had regular access to the internet via computers, a smartphone or tablet both at work and outside of work.

**Assistive technology quiz results**  
Learning is evidenced by the increase in scores observed from the pre-to-post module quizzes.
5. Findings and key lessons

Monitoring, evaluation, and learning

Monitoring, evaluation, and learning occurred periodically throughout the implementation of this project. Several mechanisms were used to measure success, and to garner feedback from learners and mentors which included objective measures of learning via module pre- and post-quizzes and skills checklists. Feedback was collected from structured surveys completed by individual learners following module completion, group discussion with mentors and learners following the face-to-face training and targeted focus groups three months following training implementation. The information below presents these findings. Group reflection and focus group findings are described using first-person illustrative quotes.

Integration of rehabilitation and assistive technology into primary healthcare management of noncommunicable diseases in Fiji

Rehabilitation and assistive technology play an important role in addressing the complications of NCDs, however, according to mentors and learners, both components are not routinely available to all people with living with NCDs in Fiji.

“I am amazed by this training. I undertake several amputations per day, and I care that my patients survive and do well, but until now I didn’t consider how they would move around and function after they go home, not all of my patients receive rehabilitation or assistive products”. Mentor- Surgical registrar, training reflection session

“Our workforce does not yet have the skills to provide step-by-step rehabilitation and assistive products because often we don’t have enough time with the patient, and the products are not available”. - Learner, nurse, focus group

Three months following this project participants were asked about the experience of learning about rehabilitation and assistive technology together, and how this may relate to delivering these services integrated as part of existing primary healthcare NCD disease management. Resoundingly, the feedback was positive, with regard to both the combined training and the potential for service integration at the primary healthcare level.

“It makes sense for us to be trained and to implement rehabilitation and assistive technology together, because they are related, access to assistive products pushes a person’s rehabilitation program forward, but only if the products are available without delay”. Learner, community health nurse, focus group

Image 3: training people how to safely use walking aids on stairs
“We are happy to say that screening for self care needs, including assistive products is now occurring for all clients who enter our service”. Learner, nurse, focus group 3

When asked about who was best placed in the community and primary healthcare system to provide basic rehabilitation interventions and assistive products, participants shared that because nurses and community health workers are frequently working in communities independently, it makes sense for them to learn both skills to maximize impact.

“We need to be treating people in their community, in their homes, but I am only one person (physiotherapist) for the whole region- we need to equip more community health workers with these skills so that when I leave to go to another town, they can continue the rehabilitation program, and make sure the assistive products are being well used.” Mentor, physiotherapist, focus group 3

When asked about the barriers to integrated rehabilitation and assistive technology, the need to address ongoing supply issues was raised by several learners and mentors.

“Many patients come who need assistive products - there are lots of requests from physiotherapists for offloading materials, shoes and crutches, but we have no stock and are currently relying on donations.” Learner, nurse, focus group 2

Feedback from mentors and participants revealed that both participants and mentors alike, view rehabilitation and assistive technology as priority areas for development in Fiji to improve the lives of people living with NCDs, and view these as an area where skills development was important to develop within the existing workforce.

**Effectiveness of the implemented training in knowledge and skills acquisition**

To gauge whether the training was effective in increasing learners’ knowledge and skills in providing basic rehabilitation interventions and assistive products, quizzes were administered before and after the training. These findings related to knowledge and skill acquisition are captured in the table below.

<table>
<thead>
<tr>
<th>Knowledge and skills</th>
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<tbody>
<tr>
<td>Knowledge</td>
</tr>
<tr>
<td>A comparison of the pre- and post-module quiz scores across the modules showed an average increase in scores. Whilst this was a highly knowledgeable group of learners, who all had relatively high pre-module quiz scores, learners overall presented an increase in knowledge as measured by the post-quiz scores, and reported in the focus groups that they felt confident to provide rehabilitation and assistive products. Some learners however expressed the desire for more practical training to increase in confidence. Learners expressed an interest in knowing the sources of the information within each module, so the suggested addition of linked references to clinical papers, key WHO documents and highlighted statistics would support this.</td>
</tr>
<tr>
<td>Skills</td>
</tr>
<tr>
<td>Learners shared during the training and subsequent focus groups that they need supervised practice after taking the modules to gain sufficient confidence to provide AP.</td>
</tr>
</tbody>
</table>
**Key lessons**

This project has resulted in additional primary healthcare services that can now source assistive products from the Rehabilitation service in Fiji to use in rehabilitation and assistive technology service delivery

- The training has given learners the competence to systematically implement techniques learned in the training including the provision of assistive products and basic rehabilitation interventions into daily practice supported by mentors.
- Mentors should continue to be available to support learners as they implement new services.
- When feasible, build on this project by training learners through additional modules focusing on diabetic foot care, including therapeutic footwear.

Learners require supervised practice to achieve safe and effective competency and a particular focus on the practical elements of the training should be taken.

The amount of practice might depend on:

- The person's prior learning and practice
- The complexity of the intervention

"Rehabilitation for self care is now being implemented for every client including the assessment and goal setting is which is making things much easier and the clients are having good outcomes". Mentor

**Training delivery via blended learning methodology**

The training delivered was designed as self-paced, online learning for the theoretical component. It is designed to be adaptable to each setting. Individuals can undertake the learning independently, as part of a learning cohort, with or without supervision and supervised mentoring, and practice. In Fiji modules that contained only theoretical content were undertaken by the learners before the face-to-face portion of the training. For modules with a practical component, learners took the modules at the same time, in the same venue which allowed for group activities, discussions, and practical demonstrations. Technical support was available to assist with navigating the platform as needed, and clinical supervision was provided after learners had taken the modules as part of the evaluation activity. Findings related to training delivery methods are captured below.

**Training delivery methods**

**Delivery method**

Learners were able to successfully undertake the theoretical modules independently with minimal support. Learners prepared for the training by undertaking a number of modules independently.

The strength of the mentors may allow for future independent rollout of the training modules in Fiji. Mentors reported that the online theoretical content was clear, and accessible and made training feasible. They were satisfied that the delivery method covered all important aspects of safe rehabilitation and assistive product provision.

**Navigation & accessibility**

The majority of learners had no trouble accessing or using the learning platforms following instructions sent via email ahead of the training. The few learners that expressed difficulty in registering were supported by the mentors to sign in and access the learning.

**Factors that impact the delivery of blended training**

Practical barriers that could impact on the future, independent use of the training platforms, were identified including: access to the internet when on outreach clinics and ongoing access to assistive products to use as examples in training delivery.
Key lessons

The training targets primary/community health and other community-level personnel, who in many health contexts face resource constraints, including access to the internet. Successfully providing training within this environment presents challenges that need to be well-considered in the design and rollout.

- When planning face-to-face training with highly competent learners, less time is needed for theoretical content and may be re-allocated to practical sessions
- Consider an offline version of training platforms so the content is accessible even where there is low/no internet.
- Continue to communicate the importance of mentors supporting ‘knowledge into practice’ as a core component of training rollout.
- Continue to ensure training is offered as a flexible platform that enables use of the modules and resources in a manner that suits the context including offline access to training content

“To allow our setting to be able to provide assistive devices and carry out rehabilitation programs efficiently, we would need more trained staff around as well as a dedicated medical officer and nurse to take charge of the program. Furthermore, a steady supply of resources would also allow us to provide a more consistent service”.

Learner

Module content, media and other elements

Each module featured videos, photos and illustrations to complement the learning. Modules also contain activities for learners to prompt group discussion and to allow for context-specific reflection.

Module content

Content

Learners were positive about the module content, and found the modules took them less time to complete than anticipated leaving more time in the implementation for demonstration and discussion.

The learners were observed in dynamic discussions with their mentors who walked them through the various activities in the modules. Group discussions complemented the individualized style of the learning, and the mentors were heavily engaged in answering questions and complementing the content.

Media and other elements

Learners were positive about all media elements, in particular the text, video, and illustrations.

Mentors played and replayed videos to their groups, and explained and demonstrated the techniques shown.

The assessment forms were considered useful, and learners reported they would use these in practice, requesting Microsoft word versions of the forms, so that certain parts can be selected and embedded into existing forms.

Several learners requested a summary of the product provision steps that could be printed and used as a prompt in the workplace.

Learners also requested that the modules be complemented by patient information leaflets that could be used to educate the recipient on safe use.

Key lessons

Based on the feedback, the amount and level of content were sufficient to convey the key messages of the training. Learners provide meaningful feedback to strengthen the modules.

- Strengthen the modules by adding links to sources and statistics
- Develop supporting resources for coordinators and mentors, such as tips for mentors on supporting new learners, client information leaflets, and one-page summaries of assistive product provision steps
Combined rehabilitation and assistive technology training

Fiji stakeholders were positive about learning about rehabilitation and assistive technology together in an integrated approach, given the services are often complementary. Despite the learning being well-received, barriers to integrated service delivery in Fiji were identified and shared by learners and include; a lack of awareness of the benefits of rehabilitation and assistive technology for people living with NCDs within the health sector and community. Learners described that referral pathways for rehabilitation and assistive technology were underdeveloped and that often the assistive products needed were unavailable.

Key lessons

Rehabilitation and assistive technology training related to self-care and mobility can be successfully delivered together cohesively.

When targeting increasing the capacity for health personnel to manage the complications of NCDs, it is important to consider both rehabilitation and assistive technology in the context of the setting and consider existing awareness levels and existence of referral pathways.

This pilot success was facilitated by several factors including mentoring during the pilot, management support and provision of assistive product stock. A risk to this continuing is the availability of affordable products to replenish stock.

Key lessons:

- When feasible, build on this project by training learners through additional TAP modules focusing on diabetic foot care, including therapeutic footwear.
- Continue to build awareness and links between NCD initiatives in both primary and tertiary care, to increase identification, management, and referral pathways for people with NCDs in need of rehabilitation and/or assistive technology.
- Expand screening for functioning difficulties into secondary and tertiary level services (such as provincial and district hospitals) to increase the identification, and referrals for rehabilitation and assistive technology.

6. Acknowledgements

Thank you to all the pilot learners, partners, hosts, and module content developers: Fiji Ministry of Health and Medical Services (MoHMS), WHO Fiji Country Office, Human Study e.V., Motivation Australia.

WHO would also like to acknowledge and thank all the individuals who have contributed to the development of the rehabilitation and assistive technology training resources and this pilot for their time, effort and interest in supporting this project.

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