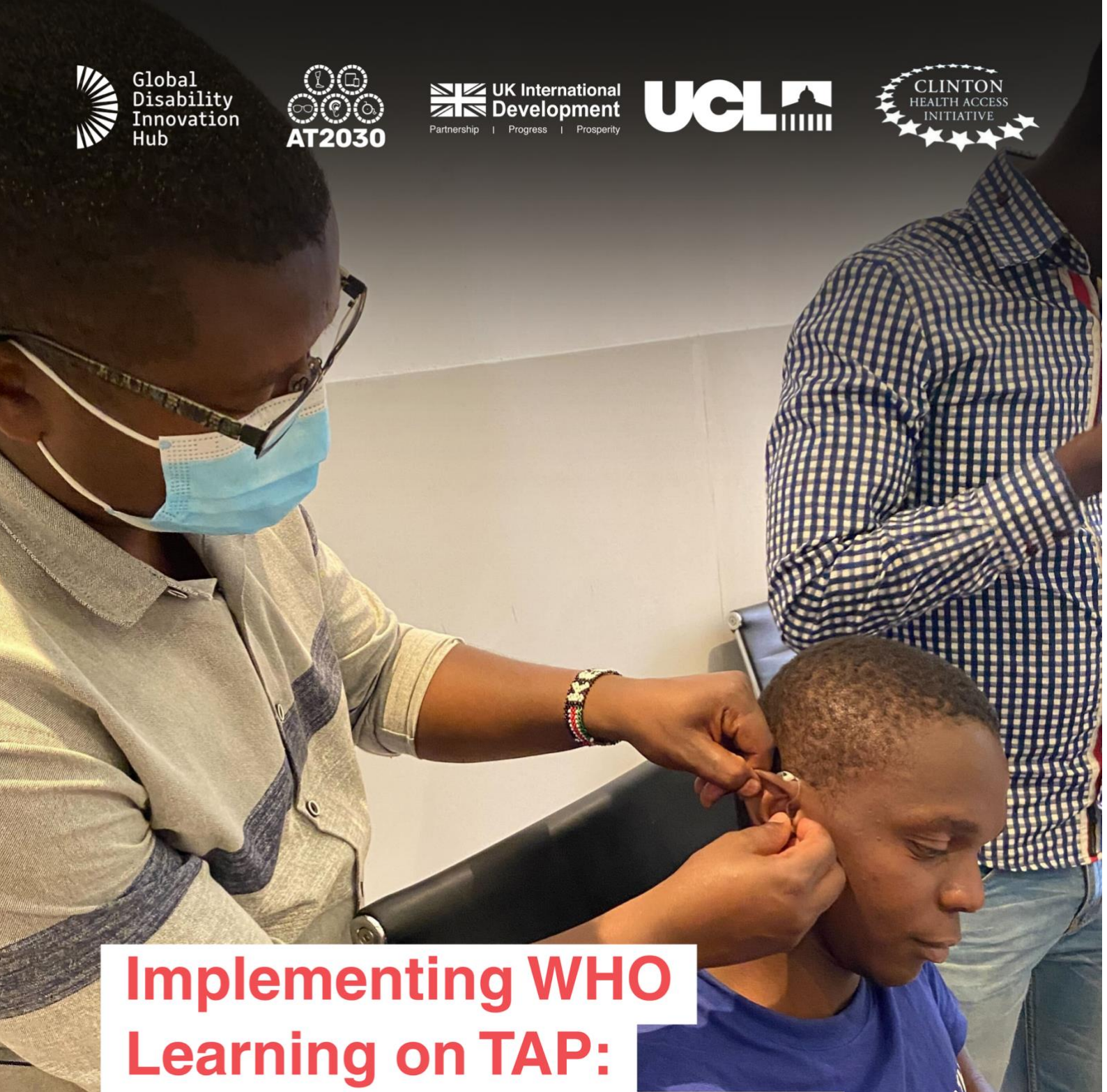




Implementing WHO Learning on TAP: Lessons from Piloting TAP within Primary Health Care Systems in Liberia, Sierra Leone, and Rwanda

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Acknowledgements

Grateful thanks are due to the Clinton Health Access Initiative (CHAI) country programme teams and partners in Rwanda, Liberia, and Sierra Leone for generously sharing their experiences and lessons learned, which informed this report. The authors would also like to thank the World Health Organization (WHO) team for their guidance and support throughout this work.

We also acknowledge the contributions of GDI Hub colleagues Mikaela Patrick and Naomi Thompson for their support in the strategic direction and management of this work.

This report was developed as part of the AT2030 programme, funded by UK International Development.

Suggested Citation: Joskow R, Saunders L, Uwikirebera JB, Chikhata F, Lu L, Bagahirwa I, Kebbie I, Patrick M. Implementing WHO Learning on TAP: Lessons from Piloting TAP within Primary Health Care Systems in Liberia, Sierra Leone, and Rwanda. Prepared by Global Disability Innovation Hub and the Clinton Health Access Initiative (CHAI) for the UK Foreign, Commonwealth and Development Office (FCDO); 2026.



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1 Highlights

1.1 What are the main learnings?

The World Health Organization (WHO) Learning on TAP (TAP for short) is an open access, online platform hosting modular courses on a range of health topics including assistive technology (AT) and sensory functions (eyes and ears). The training is delivered through a blended, self-paced learning approach. This learning paper examines implementation learnings and implications for scale up from three TAP pilots: 38 sites in Liberia (12), Rwanda (16), and Sierra Leone (10), distributing a total of 3,749 assistive products. The three pilots aimed to support training of primary and community-based healthcare workers on identification and provisions of AT.

- Early successes and key enablers of the TAP pilots include:
 - **Primary health care and systems-level integration** – TAP was most effective when embedded within existing health worker roles, service delivery pathways, and government systems, rather than delivered as a standalone intervention.
 - **Latent demand uncovered** – demand rose sharply across pilot catchment areas once services and products became available, revealing substantial unmet and previously unidentified need for AT.
 - **Health worker capacity built** – frontline workers gained awareness and foundational skills for AT screening, assessment, and basic provision.
 - **AT service coordination strengthened** – TAP linked primary health workers with specialist expertise at higher-level facilities, supporting structured referral and mentorship relationships.
- Key implementation challenges and lessons learned indicate that effective implementation of TAP requires attention to:



- **Product availability** – training became overly theoretical and community trust was undermined where assistive products were unavailable or delayed.
- **Digital literacy and connectivity** – low digital literacy and unreliable connectivity slowed training set-up and limited the self-paced learning component.
- **Training preparation and complexity** – mentors had limited time to familiarise themselves with and contextualise the modules, and disability inclusion content was identified as a gap.
- **Sustained mentorship and supervision** – ongoing mentorship beyond one-off training was constrained by funding and mentor availability, limiting the sustainability of early gains.

1.2 What are the implications of the main learnings?

- TAP provides a promising entry point for addressing the global unmet need for AT through the strengthening of AT skills and workforce capacity at the primary health care level.
- For sustainability and scale-up, these learnings suggest TAP should be implemented as part of a coordinated, system-wide approach that includes political buy-in, strategic partnerships, sustained mentorship and supervision, and integration into existing health structures, including national health plans, data systems, and supply mechanisms.

2 Background

2.1 Introduction

According to the WHO, assistive products include both physical devices, such as wheelchairs, glasses, prosthetic limbs, white canes, and hearing aids, and digital solutions, such as speech recognition, captioning, and time management software [1]. These products support individuals' functioning across domains including cognition,



communication, hearing, mobility, self-care, and vision, thereby contributing to health, well-being, inclusion, and participation [1]. AT refers to these products alongside the systems and services required for their provision and use[1].

Despite its importance, access to assistive technology remains highly unequal, particularly in LMICs². Globally, an estimated 2.5 billion people require assistive technology, a number projected to grow to 3.5 billion by 2050, yet nearly 1 billion people lack access, highlighting a substantial unmet need[2]. In response, the TAP platform was launched by the WHO in 2022, an open-access online platform to support the training of primary health care and community-based health workers, ultimately aiming to improve access to priority assistive products[2], supporting progress towards Universal Health Coverage[3]. In 2025, WHO's Training in Assistive Products re-launched as "Learning on TAP"[4] to include more courses for primary and community workforce beyond assistive technology. Currently the platform includes the following courses: Assistive technology, Primary eye care and Vision and hearing screening for school age children. TAP identifies three key roles: the coordinator, who oversees implementation; the mentor, who facilitates competency-based learning; and the learner, who completes the training and applies competencies in practice.

The TAP Assistive technology course is part of the WHO AT suite of resources and tools for health workers and practitioners to support AT service delivery[5]. The Assistive technology course is divided into the following streams: cognition, communication, mobility, vision, hearing, and self-care[4,6]. Each stream includes an introductory module, and subsequent assistive product modules. Products included in TAP are those that are of high need, simple and quick to provide, ready-made (no fabrication), and can reduce visits to multiple service points. TAP is designed primarily for the primary healthcare and community workforce, as well as for personnel in other sectors who provide services to individuals requiring assistive products[4,6]. The courses are delivered through an online learning component, complemented by in-person practical sessions and supervised practice in the workplace[4]. The platform adopts a self-paced,



modular structure, enabling users to select content based on their role and the needs of the populations they serve[4]. For each assistive product, training is structured around a four-step service delivery process: selection, fitting, user training, and follow-up[4]. Modules are available in multiple languages, supporting broad accessibility and uptake, and TAP has been implemented in over 20 countries through WHO and partner-led initiatives[4].

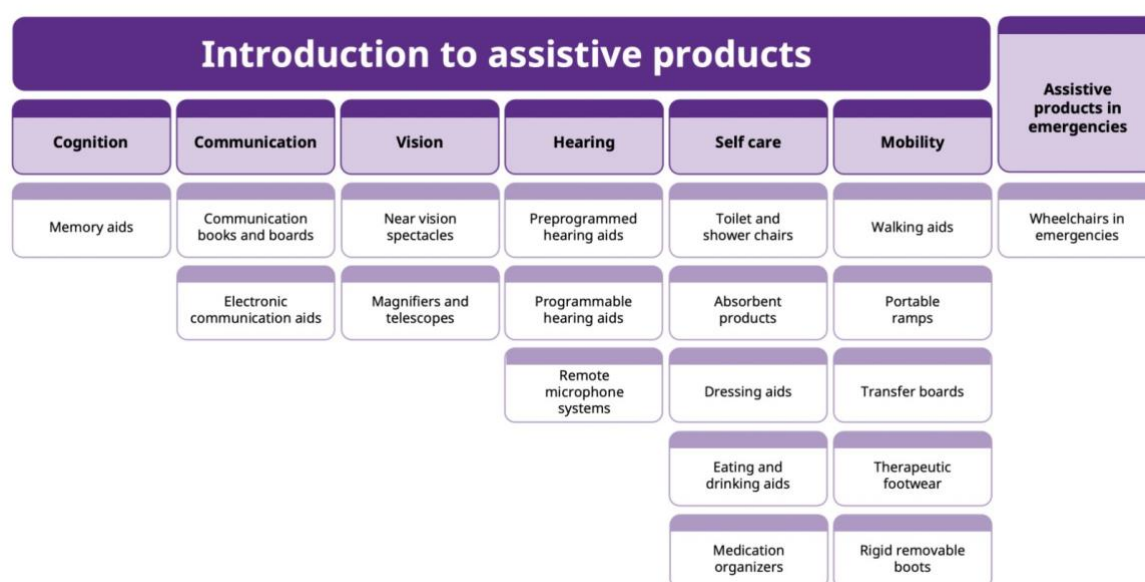


Figure 1 WHO Learning on TAP 'Introduction to Assistive Products' Modules

The need for the WHO TAP was identified through seven country capacity assessments[7] conducted by the Clinton Health Access Initiative (CHAI) and the Global Disability Innovation (GDI) Hub under the AT2030 programme. Using the WHO Assistive Technology Assessment toolkit[9], the country capacity assessments provided an overarching view of the national AT landscape and revealed substantial gaps in the



workforce and community-level delivery of AT[8]. Service provision continues to rely on specialist-led, tertiary-level models, which are insufficient to meet rising demand, contributing to prolonged wait times and limited access to screening and identification[8,10]. These challenges underscore the need to strengthen community-based service delivery models, including utilising task-sharing approaches [11], to expand access and improve the timeliness of AT provision. Across multiple country contexts, a consistent recommendation was to strengthen the delivery of AT at the last mile, with TAP identified as a key mechanism to support workforce training and system integration[6,8].

This paper provides implementation-based evidence on the use of TAP to address the global unmet need for AT through strengthening primary health care systems. It responds to persistent global workforce shortages and skills in AT provision[2], where a chronic lack of trained personnel remains a major barrier to access[2,10,12,13]. A blended learning approach (combining online and in-person training)[4,14,15], as well as task-sharing [11], have emerged as potential strategies to address this unmet need. While task-sharing is widely recognised as a strategy for strengthening health systems[11], its application to AT service provision remains relatively underexplored. The TAP pilots examined in this study provide practical insights into the learning needs of primary-level personnel, their perceived capacity to undertake AT-related roles, and the feasibility of integrating AT into diverse local health service contexts.

The aim of this work is to examine implementation learnings from TAP pilots across three country contexts: Liberia, Rwanda, and Sierra Leone. Specifically, this paper aims to:

- (1) explore how TAP, as a blended learning approach, supports task sharing in AT service provision within primary health care and community-based settings;
- (2) identify key enablers and successes, as well as challenges encountered during implementation across diverse contexts; and



(3) synthesise lessons learned and outline proposed considerations to inform the design, delivery, and scale-up of TAP.

By examining how TAP is delivered across different country contexts, the learnings offer actionable insights for governments and partners seeking to move from pilot implementation to broader scale-up, as well as for WHO in refining and supporting the implementation of TAP. The analysis demonstrates that TAP can serve as an effective entry point for strengthening AT provision at the primary health care level by building basic AT knowledge and skills among frontline health workers and improving identification and access to priority assistive products. However, its sustainability appears highly contingent on implementation as part of a broader systems-strengthening approach, including integration within existing health services, availability of assistive products, sustained mentorship, and alignment with national policies and data systems.

Since the implementation of TAP in each of the three countries, WHO re-launched Learning on TAP with a suite of new resources designed to support implementation. The main resource is the Learning on TAP User guide, which is designed to support planning for high-quality, effective TAP implementation within wider systems-strengthening activities. It includes guidance which addresses the challenges identified in these three pilots.

2.2 About AT2030

AT2030 is a £51.8m programme funded by UK International Development and led by GDI Hub to explore and test innovative ways to address systematic challenges to get more AT to the people that need it around the world. AT2030 tests ‘what works to enable access to life-changing assistive technology for all.

AT2030 creates deep community leadership and engagement to generate new evidence and insights, answering critical research questions and developing foundational



methodologies to address intersectional challenges and research and evidence gaps. From incubating future tech inspired solutions to venture acceleration, AT2030 brings effective solutions to market, testing new mechanisms and ambitious scaling pathways, while strengthening systems to make inclusion a reality.

AT2030 has reached 10 million people directly and 54 million indirectly driving a lifetime of potential.

2.3 Learning Project Design

The TAP trainings were conducted in Liberia (January 2022), Sierra Leone (August 2025), and Rwanda (September 2025). This analysis combined a review of relevant literature and CHAI programme documentation with interview data to explore implementation learnings from TAP across the three country contexts. Three online interviews were conducted between March and April 2026 with subject matter experts and government representatives involved in pilot implementation. Participants provided informed consent before taking part, and ethical principles of voluntary participation, confidentiality, and the right to withdraw were upheld throughout the process. These interviews were used to validate, refine, and extend the learnings from the document review. Participants were also engaged in reviewing and validating the learnings, helping to ensure that interpretations accurately reflected their experiences.

In each country, TAP was delivered as a blended, classroom-based training lasting five to seven days. Health workers were brought together at a central training site to work through the self-paced online TAP modules, with mentors present throughout to provide support and answer questions. The specific modules covered and cadres trained were tailored to each country context.

A summary of key characteristics and activities across the three pilots is presented in Table 1.



	Liberia (Jan 2022)	Rwanda (Sep 2025)	Sierra Leone (Aug 2025)
Who was trained?	28 healthcare workers: 25 Nurses, 3 physician assistants	27 healthcare workers: 6 GP, 5 ophthalmic officers, 7 PTs, 6 P&O technicians, 3 biomedical engineers	10 general nurses
# of sites?	12 primary health centres	16 primary health centres	10 primary health centres
Which modules were covered? <i>*Intro and product modules were complete</i>	- Intro to Assistive Products - Self-care* - Mobility* - Vision*	- Intro to Assistive Products - Self-care* - Mobility* - Vision* - Hearing*	- Intro to Assistive Products - Self-care* - Mobility* - Vision*
Training modality?	<u>Blended</u> : 6-7 days, online modules in a classroom with mentors for support.	<u>Blended</u> : 5 days, online modules in a classroom with mentors for support.	<u>Blended</u> : 5 days, online modules in a classroom with mentors for support.
Training, supervision, and mentoring	- Intro: Technical staff MoH Non-Communicable Disease unit (e.g. programme officers, M&E officers, rehabilitation focal points) - Self-care: Technical staff MoH NCD unit - Mobility: 2 PT from referral hospitals - Vision: 1 ophthalmologist, 1 eye technician	- Intro: 1 Technical staff from MoH/RBC-Disability & Injury Unit - Mobility/Self-care: 1 P&O technician, 1 Physiotherapist, 1 Occupation therapist - Vision: 1 ophthalmologist - Hearing: 1 ENT Specialist & 1 Audiologist	1 Physiotherapist from World Hope Int. - WHO representative 1 physiotherapist from MoH



	<i>WHO held refresher training 1 year after TAP, since ongoing mentorship was lacking.</i>		
Products at training	Yes, 3.4k+ products via WHO donation: walking canes, walking frames, crutches, therapeutic footwear, reading glasses, magnifiers, shower chair, toilet chair, absorbent clothes	Yes, products across all domains including shower chairs, walking frames, therapeutic footwear, wheelchairs, spectacles and hearing aids. Hospitals, orthopedic workshops, National Child Development Agency, and RBC loaned the products for use during the training.	No, products not sourced in time. Engaging LDSC for wheelchairs and Sightsavers for vision products.
People reached	3,446 individuals to date.	303 individuals received products to date.	50 individuals identified needing a product to date, no products present.

Table 1. Overview of TAP Implementation across Liberia, Sierra Leone, and Rwanda

2.4 Limitations

The lessons in this paper are drawn from a small number of pilot experiences and should be interpreted with this in mind. They may not translate directly to other settings with different health systems, resources, or priorities. The analysis is based mainly on programme documents and discussions with implementers, so some perspectives, particularly those of assistive technology users, are not fully captured. This paper also does not assess longer-term outcomes or impacts. Interviews were conducted online and in English, which may also have influenced the depth of responses in some settings. Despite these limitations, the experiences shared here provide practical lessons that can inform future efforts to strengthen health workforce capacity and support the integration of assistive technology within primary health care systems.



3 Learnings

Implementation learnings are presented from three TAP pilot contexts, describing key successes and enabling factors, implementation challenges and sustainability considerations, and priority areas for future TAP planning and delivery. Learnings indicate early promise for TAP as an entry point for strengthening primary-level AT provision. Key enablers have emerged including improved frontline workforce capacity, increased service coordination and uncovered latent demand for AT. However, longer term effectiveness appears heavily dependent on product availability during and after training, sustained mentorship and supervision, and embedding AT service delivery within government systems, policies and data structures.

3.1 Successes and Key Enablers

Key enablers of TAP pilot success included alignment with government priorities, integration of training within existing primary health care service delivery structures, and the ability to match latent community demand with product availability. Early success across pilot contexts was reflected in increased frontline health worker awareness and capacity for basic assistive technology (AT) screening and provision, identification of unmet need, and initial strengthening of AT service coordination.

3.1.1 Primary health and systems level integration

Delivering TAP at the primary health care level, alongside its integration into existing health systems, emerged as a key enabler of implementation across all pilot contexts.

Participants emphasised that TAP was most effective when adopting a “systems approach”, embedding TAP within existing health worker roles, service delivery pathways, and government systems, rather than implementing it as a standalone intervention. As one stakeholder from Sierra Leone noted, “for long-term success, TAP must not be a standalone intervention but must be integrated into the existing health



delivery system and national health plans.” Similarly, in Liberia, the pilot was supported through direct collaboration with the Ministry of Health’s Noncommunicable Diseases and Injuries Unit, specifically “to support scale up of health worker training on provision of AT,” demonstrating alignment with national strategies and priorities.

Experiences from Rwanda further suggest that TAP can act as an entry point for broader health system strengthening. Discussions around workforce development also prompted efforts to strengthen financing and procurement mechanisms, recognising that training health workers alone will not improve access if the assistive products they are trained to provide are unavailable. Plans to include assistive products within national financing mechanisms, alongside leveraging local partnerships for procurement, illustrate how TAP implementation can help catalyse wider system changes needed to support access to AT.

These learnings suggest that delivering AT training at the primary health care level, combined with deliberate integration into existing health systems, is essential for effective implementation. Positioning TAP within routine service delivery structures can support government prioritisation and integration into primary care services.

3.1.2 Latent demand uncovered

An increase in demand for AT was observed across pilot catchment areas once services and products became available. This highlights both the unmet need for AT and the importance of improving availability at primary health care levels.

Evidence from Liberia illustrates how demand was activated through community-level awareness and informal networks. While initial concerns were raised about limited awareness, participants reported that “word of mouth...spread very quickly”. As one stakeholder explained, “once one person was able to receive service and was not turned away, then they were able to let their neighbours, friends and communities know,” demonstrating how availability and awareness can rapidly generate demand.



3.1.3 Health worker capacity built

TAP contributed to initial improvements in health worker capacity by increasing awareness of AT and introducing foundational skills to support screening, assessment, and service provision. Across pilot contexts, participants described early shifts from informal or inconsistent practices towards more structured approaches to AT provision.

Evidence from Rwanda highlights how TAP began to influence changes in practice. Participants noted that “TAP changed the way [healthcare workers] used to do their work, especially when it comes to identifying the user’s needs, doing assessments, [and] doing necessary adjustments.” Prior to TAP, fitting processes were often conducted “without deep analysis of the user’s needs,” indicating limited use of structured assessment approaches. Similarly, in Sierra Leone, participants observed that health workers were “very much eager to learn... because they do see patients who were in need of assistive products,” but previously lacked a “formal kind of approach” for conducting assessments. TAP was seen as beginning to provide both the knowledge and structure needed to support more consistent service delivery.

These learnings suggest that TAP can play an important role in building frontline capacity for AT provision, particularly by introducing structured approaches to assessment and care. However, learnings indicate that sustained mentoring and supervision beyond one-off training or pilot implementation is necessary to sustain and scale these early gains.

3.1.4 AT service coordination strengthened

Evidence suggests that TAP can support strengthening AT service coordination by introducing a structured implementation model. TAP training brought together multiple roles across different levels of the health system, including local government coordinators responsible for overall management, specialists providing clinical guidance and ongoing mentorship, primary health workers benefiting from ongoing supervision and facility managers responsible for continued implementation at the facility level.



This coordinated approach enabled early progress towards supporting the transfer of AT provision skills to primary health care workers, while linking them with specialist expertise at higher level facilities. These relationships supported learning beyond the initial training and contributed to early improvements in service delivery practices. However, the extent to which ongoing mentorship could be sustained varied across pilot contexts.

Evidence from Rwanda highlights the importance of alignment across national and subnational levels to support effective coordination. Participants noted that success was rooted in “consulting with the government at national level, and then not just staying there, but also going to lower level, ensuring that the health facility managers understand TAP, how we want to do it and what it will bring to the facilities, the trainees and the beneficiaries.” This reflects the importance of engaging actors across multiple levels of the health and government system to align on priorities and support implementation.

3.2 Key Implementation Challenges and Lessons Learned

While TAP implementation demonstrated early successes, the pilots also revealed a set of challenges that limited training effectiveness and sustainability. These challenges largely reflected gaps in system readiness, including misalignment between training and product availability, limitations in digital infrastructure and literacy, and insufficient investment to support ongoing mentorship and supervision.

3.2.1 Product availability

A major challenge identified across all three pilot contexts was the availability of assistive products. Participants emphasised the importance of ensuring product availability prior to or alongside training. In the absence of products, the training offers limited opportunities for practical application.

Evidence from Sierra Leone highlights how delays in sourcing products affected implementation. Participants noted that training became “overly theoretical” when



products were not available, as health workers were “not able then to... practice,” restricting the development of practical skills.

Participants also highlighted the impact of product shortages on community trust and service uptake. In Sierra Leone, it was noted that when assistive products were not available, “some of [the] people [do] not even come for assessments anymore... because they know that at the end of the day, there’s no product at the [facility].” This suggests that gaps in supply can undermine demand, even where awareness and need are present. In the absence of products, training shifted towards referrals to higher-level facilities.

Likewise, experiences from Liberia demonstrate the importance of aligning training with product availability. As one participant noted, “what was most helpful to ensure that there was actual service delivery after the training was the fact that there were products available at the various facilities that the health workers were then able to deliver to the patients.” Similarly, in Rwanda, a participant emphasised that “addressing the supply of assistive products before training... ensure[s] that mentors and trainees are really happy with what is being done”.

These learnings indicate that without a reliable supply of devices, the benefits of training are constrained, limiting skill application, reducing health worker motivation, and potentially undermining community trust. While referral pathways are important, a reliance on referral pathways alone risks undermining the objective of strengthening AT provision at the primary health level. Ensuring alignment between training timelines and product supply is therefore essential for both implementation effectiveness and sustained service uptake.

3.2.2 Digital literacy and connectivity

While the blended learning model was seen as a valuable component of TAP implementation, challenges related to digital literacy and internet connectivity slowed down training set up and completion, which limited time for practical sessions across



pilot contexts. Participants highlighted that the digital component required additional time and support for health workers to familiarise themselves with the tablets and platform, particularly in rural settings where digital tools and self-paced learning approaches were less common.

In certain contexts, low levels of digital literacy among primary health care workers meant that basic tasks, such as setting up accounts and navigating the platform, took longer than anticipated. In Liberia, for example, participants noted that teams had to “train them how to use the tablets that were provided for the self-paced learning” alongside delivering AT training content. This extended the duration of training and placed an additional learning burden on participants. Connectivity challenges, particularly in rural health centres, further constrained the feasibility of the digital component. In Sierra Leone, participants reported that “it was challenging... for the trainees to really practice on their own... online because of the internet connectivity challenges.” As a result, the intended model of self-directed learning was often not fully realised, necessitating greater reliance on in-person support.

These learnings indicate that while blended training approaches offer important opportunities for scalability, their effectiveness is contingent on context-specific factors, including digital literacy, infrastructure, and familiarity with self-paced learning. Allowing sufficient time to contextualise TAP to account for these constraints is essential for mentor preparation to support effective implementation.¹

3.2.3 Training preparation and complexity

Challenges related to training preparation and content relevance were identified across pilot contexts. Mentors typically completed the TAP online modules shortly before

¹ Delivering the knowledge component through self-paced modules standardises content delivery and reduces the risk of trainers modifying or omitting key content. It also reduces reliance on a training-of-trainers (ToT) cascade model, which can create bottlenecks in country-level uptake of WHO training resources.



delivery, leaving limited time to familiarise themselves with the material or contextualise it to the local context. As a result, some mentors reported needing to simplify or adjust content during delivery to ensure it was appropriate for the level of trainees and the realities of local service provision. Participants also noted that not all modules were equally feasible to deliver within primary health care settings. Certain topics were described as relatively new concepts, while some assistive products included in the modules were not yet available within national systems.

Evidence from Rwanda highlights these challenges. One participant noted that the self-care stream was particularly difficult to implement, as such approaches were not yet commonly understood or integrated within facility-level practice, and associated products were often not covered by insurance, reducing incentives for procurement and use. In addition, mentors emphasised the need for more time to engage with the training content to adequately learn content, contextualise the modules and prepare prior to the in-person sessions, suggesting that “between 7 or 10 days” may be required.

Similarly, in Sierra Leone, participants recommended adequate time to contextualise training content to the scope and level of primary health care workers, such as nurses, noting that “the modules can be customised to [their] level” to support comprehension and practical application.

These learnings indicate that effective implementation of TAP requires sufficient preparation time and greater contextualisation of training content.

3.3 Sustainability and Scale Up Considerations

Key considerations for sustainability and scale-up include political buy-in from the government, particularly the Ministry of Health, multidisciplinary collaboration across stakeholders, including local civil society partners and government finance/procurement teams, sustained mentorship and supervision, and integration of AT data tracking into existing health systems (e.g., Health Management Information Systems).



3.3.1 Political will

Political will from government partners, and crucially the Ministry of Health, as well as subnational health facilities is key. Sustained implementation beyond pilot phases was strongly associated with early and continuous engagement of government stakeholders, to support ownership, alignment with national priorities, and integration into existing systems.

Evidence from Rwanda highlights the importance of engaging stakeholders across multiple levels of the health system. Participants noted that consulting with government actors at both national and subnational levels ensured that health facility managers understood the value of TAP, which was described as a “great driver” for successful implementation.

Similarly, in Sierra Leone, high-level political leadership was identified as a key enabling factor, with participants emphasising that having the Ministry of Health lead the process contributed significantly to the pilot’s success.

In addition, country capacity assessments[7] conducted by CHAI and GDI Hub were identified as an important entry point for engaging policymakers, raising awareness, and supporting the development of national AT roadmaps, technical working groups, and prioritised action plans.

In sum, these learnings suggest that government partnership and political buy-in is essential for TAP pilot sustainability and scale up.

3.3.2 Multidisciplinary collaboration

While buy-in from government health departments is key, engagement across ministries, including education, finance, and procurement, as well as development organisations and local partners, is critical to support sustained implementation.



For example, collaboration with Ministries of Education can enable sensory screening programmes in schools, while engagement with finance and procurement actors is essential for securing budgets and developing national priority assistive product lists.

Partnerships with referral hospitals and academic institutions can also help to bridge the specialist gap by providing mentorship and technical support to primary health care workers, who are often new to AT provision.

In Rwanda, collaboration with specialised hospitals, private health facilities and organisations such as UNICEF enabled the temporary sourcing of assistive products for training. In addition, involving civil society, including Organisations of Persons with Disabilities (OPDs), supports more person-centred approaches and can strengthen community awareness and demand.

Collaborating with international partners like WHO and CHAI helps align national AT goals with the global mandate for Universal Health Coverage, framing AT as a "basic right" rather than a privilege.

Overall, the learnings suggest that strategic partnerships across government, civil society, and international development actors are key to supporting the sustainability and scale-up of TAP.

3.3.3 Mentorship

A key lesson for sustainability is the gap between the intended mentorship model within TAP and the realities of implementation. While mentorship is a core component of the TAP approach, participants consistently identified it as one of the most difficult elements to implement systematically across pilot contexts. Constraints included limited specialist capacity, competing clinical workloads, and insufficient resources to support travel to remote sites. As a result, follow-up support was not consistently delivered, despite being recognised as essential for reinforcing learning and supporting the transition from training to practice.



Evidence from Liberia highlights the impact of these constraints. Participants noted that, due to funding limitations, the facilities did not receive the routine mentoring follow up as planned, which was considered important for maintaining skills during periods where health workers had limited opportunities to apply their training. Similarly, in Sierra Leone, participants emphasised the importance of mentorship for building confidence, noting that “mentorship will help give them more confidence... in carrying out those activities.” While supportive supervision followed the training, there was no structured mentorship system in place.

In Rwanda, participants reported that remote support mechanisms, such as WhatsApp groups, facilitated continued communication; however, these were not seen as a substitute for in-person mentorship. As one participant explained, “when there is no physical visit... it’s very difficult to really understand how you can help the provider,” highlighting the limitations of remote-only approaches.

These learnings suggest that while mentorship is widely recognised as critical to sustaining training outcomes, it requires dedicated resourcing, planning, and system integration to be effectively implemented. Hybrid models combining remote support with periodic in-person engagement may offer a more feasible approach, but further investment is needed to ensure consistent and meaningful mentorship over time.

3.3.4 Data and tracking integration

A key lesson for sustainability is the need to integrate data collection into national health information systems. Across pilot contexts, limited readiness of government data registries led to the use of parallel tracking systems for product provision during implementation. While these enabled short-term monitoring, they were not integrated into national Health Management Information Systems (HMIS), limiting their utility beyond the pilot phase.

Evidence from Liberia illustrates this challenge. Participants reported that government registries were not available following the training. In response, a national disability and



assistive technology (AT) data ledger was later developed and integrated into facility-level systems to support tracking of disability and AT provision. However, its implementation occurred as part of broader HMIS revision process which took place more than two years after the training ended, highlighting the need for training and data systems to be implemented concurrently.

These learnings highlight that without national data systems, it is difficult to monitor outcomes or support scale-up. Embedding AT service delivery data within government systems is therefore critical for sustainability.

4 Proposed Actions and Recommendations for Future Pilots

Building on the implementation successes and challenges observed across the three pilots, these results inform a set of proposed actions for national stakeholders, implementing partners, and informed WHO's new Learning on TAP User guide. The actions and recommendations underline the critical importance of using the TAP User guide to engage stakeholders and plan, prepare for and carry out TAP sustainably at scale.²

4.1 Planning and Delivery

Learnings from the pilots highlight several key considerations for strengthening the planning and delivery of future TAP implementation, including synchronising training with product supply, planning for training preparation, and local contextualisation.

² Some of these lessons informed the development of the updated TAP Learning Guide, which places greater emphasis on areas such as better preparation of mentors.



4.1.1 Synchronise training with supply

Training could be synchronised with the availability of assistive products where possible. Future pilots could aim to confirm supply of basic mobility, vision, and hearing products at health facilities to ensure that training can be applied in practice. Where possible, training could be linked to existing product supply systems, including partnerships with local providers that supply a range of devices.

Pilots can also serve as an entry point for strengthening national supply systems. This includes supporting ministries to plan for product quantification, procurement, and forecasting of need, as well as assessing the quality of locally available products. Where feasible, establishing a baseline understanding of product availability within the country, for example through a country capacity assessment [7] or similar assessment, can support more effective planning and implementation.

In some contexts, alternative sourcing approaches may be required. For example, in one pilot, a locally produced wheelchair identified through collaboration with partners such as UNICEF offered greater adjustability than standard government-issued products and was used for practical training sessions. Leveraging such locally available solutions can support more context-appropriate and effective implementation.

4.1.2 Plan for mentor preparation

Future pilots could include a longer orientation period for mentors (+1-2 days) to ensure familiarity with the training content, delivery format and needed contextualisation, following the recommendations now available on the Learning on TAP User guide. This could include time to provide in-person support for digital literacy and platform orientation prior to training, enabling participants to engage more effectively with the modules.

Mentor orientation sessions can be used to address questions, contextualise materials, develop effective training and mentoring techniques, and finalise delivery plans prior to engaging with learners. This is particularly important where mentors are clinicians or



specialists who may have limited prior teaching experience. Supporting mentors to translate their clinical expertise into effective teaching may require additional focus on adult learning principles, facilitation skills, peer learning approaches, and opportunities to practise delivering modules and receiving feedback prior to implementation[16].

For scale and sustainability, integrating the Learning on TAP modules into pre-service training programmes, such as curricula for nurses and midwives, may reduce reliance on resource-intensive in-service workshops.

4.1.3 Local contextualisation, accessibility and inclusion

Where possible, TAP modules could be contextualised to reflect local contexts, accessibility considerations, and the scope of different health worker cadres. Contextualising and simplifying key content into information, education and communication (IEC) and counselling materials for routine use at facilities helps embed TAP learning into daily service delivery. Modules that require simplification or contextualisation should be identified in advance through the planning process, following the Learning on TAP User guide. Content can be tailored to align with the roles and expertise of specific cadres (e.g., mobility modules for staff working in rehabilitation settings), reducing the need for real-time contextualisation during delivery and supporting more effective learning.

Learning on TAP could be strengthened through inclusion of content on accessibility and disability inclusion in Intro modules. Product maintenance and user training are also important elements to highlight for primary care providers who have limited knowledge on disability. Integrating resources such as the UNICEF disability inclusion training could be useful to introduce foundational modules in these areas, equipping health workers with the knowledge needed to support patients and caregivers beyond initial provision.



4.2 Sustainability

Learnings from the pilots highlight several key considerations for supporting the sustainability and scale-up of TAP implementation, including formalising mentorship models, integrating TAP into existing healthcare structures, and strengthening AT data systems.

4.2.1 Formalise mentorship models

Mentorship models could be formalised and adequately resourced to support ongoing skill development. Countries could establish a clear cadence for supervised clinical sessions, with mentors assigned to a defined group of learners from the outset. Regular follow-up through a combination of in-person support and remote communication (e.g., phone calls or WhatsApp groups) can help reinforce learning and assess skill retention over time. Embedding structured mentorship within implementation plans is critical to ensure continuity beyond initial training.

4.2.2 Integration into existing healthcare systems, policy, and financing

TAP implementation may be strengthened when it is integrated into existing health system structures and Ministry of Health programmes, rather than delivered as a standalone training intervention. TAP could be introduced alongside AT integration into existing health systems, national policies, and financing mechanisms. Embedding AT within national health plans and insurance schemes, such as Rwanda's Community-Based Health Insurance, can support sustained procurement and provision of products. Having the appropriate partners in place at the outset of pilot implementation is critical to effective delivery and sustainability. Aligning TAP with ongoing government priorities to expand access to care at primary and community health levels is essential.



4.2.3 Strengthen data systems for AT tracking

For TAP to achieve sustained impact beyond the training period, it could be accompanied by efforts to strengthen routine data collection on AT provision.

Integrating AT indicators into existing government data systems, such as HMIS or DHIS-2, can enable monitoring of referrals, service delivery, and product provision following training, helping to assess whether TAP is contributing to changes in practice.

Embedding these indicators within national systems also supports scale-up by reducing reliance on parallel reporting mechanisms and increasing the visibility of AT within broader health system planning.

5 Conclusions

This learning paper provides implementation-based insights into the use of the World Health Organization's Learning on TAP to strengthen AT workforce skills and capacity within primary health care systems. Drawing on pilot experiences in Liberia, Rwanda, and Sierra Leone, the learnings highlight the potential of TAP to support task sharing, build frontline capacity, and expand access to AT at the community level. Stakeholders emphasised that while TAP pilots demonstrated early benefits such as increasing frontline worker awareness and capacity for basic AT screening and provision, enabling identification of unmet and latent demand for AT, and initial strengthening of AT service coordination, it must not be a "standalone intervention".

Learnings indicate that effective implementation requires contextualisation, including alignment with the cadres of healthcare workers being trained, levels of digital literacy, and user contexts and environments in which AT is delivered and used. Longer-term impact also depends on alignment of training with wider systems, including the availability of assistive products within supported facilities, sustained mentorship and supervision, and integration within existing health delivery system, including national health plans, government databases (HMIS), and commodities trackers. Overall, when integrated into national health systems, TAP offers a promising pathway towards



addressing the critical shortage of skilled AT personnel at the primary health care level, advancing progress towards Universal Health Coverage.

Future research could track the longer-term impact of TAP pilots over time and explore how these learnings translate across additional country contexts, including how different delivery models, system conditions, and policy environments influence outcomes and sustainability.



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