



**Creating Unity for Action
An Action Plan for Rural Health**

Draft – October 2003

World Organisation of Family Doctors (Wonca)
Wonca Working Party on Rural Practice

rural health

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World Health Organization (WHO)

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ISBN: 1 9207 9702 5

Suggested Citation:
Wonca Working Party on Rural Practice, Health for All Rural People Planning Committee (2003) *Creating Unity for Action: An Action Plan for Rural Health*. Monash University School of Rural Health; Traralgon Vic.

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Photo: Courtesy of Di Wyatt

Executive Summary

Poverty and poor health are found more commonly in the world's rural people than in its urban residents. Achieving good health is a well-proven path out of rural poverty. It results in a greater sense of wellbeing and contributes to increased social and economic productivity. The impact of ill health on productivity affects not only the poor, but also their societies and economies.

Since 1992 the Working Party on Rural Health of Wonca (The World Organization of Family Doctors) has been determined to develop a practical plan to improve the health of ALL rural people. The World Health Organization (WHO) has joined in this effort, and several successful joint meetings have been held. This result of this effort is presented here as an "Action Plan for Rural Health". The steps in this document, if followed, should result in improved health for the world's rural people – which should, in turn, lead to improved productivity, decreased poverty, and improvements in their societies and economies.

In order to achieve good health in rural places, several key principles must be applied. Society needs to reaffirm its commitment to primary health care based systems, and resources must be distributed in ways that support rural, as well as urban sites. We must efficiently utilize existing facilities in ways that promote high quality services. Individual (personal) health care systems must be closely integrated with public (population based) health systems.

Those who control, operate, and staff the health care structures and systems in our societies must recognize rural needs and must become more socially responsive to and accountable for rural areas. They must support these areas in developing models of care that are appropriate to their particular conditions and needs. In addition, these individuals and organizations must seek to identify and implement strategic options that support rural health in the wider arena. Finally, we must encourage and develop research that supports these changes, allowing us to learn from them, and we must institute educational actions that will prepare us to continue these efforts in the future.

As well as a call for equity and appropriate policy frameworks, this report presents an action process to improve the health of all rural people through three-steps. The process begins with local thought and planning, and then proceeds to rural action. Finally, it anticipates transferring local rural successes to the global level - and through this transition back to other rural sites.

The Action Plan anticipates a clustering of rural participants around the needs of rural communities and their people. The participants include community members themselves, policy makers, health care professionals, academic institutions, and health managers. All of these parties must remember that the focus of their cluster is the needs of rural people.

The implementation of the Action Plan involves three key elements – the pillars upon which action can be built. These are:

1. Action for equity
2. Action for a rural paradigm
3. Action Process

The components of this local action process include the following mechanisms:

1. Community empowerment - In order to “think and act locally” communities must be given both permission and encouragement in their efforts. Aspects of community empowerment include community development, community participation, and local capacity building,
2. Building unity of partners - This step entails the development of linkages between the parts of the health system that focus on individual patient care, and those that focus on population, community, or public health care.
3. Providing rural health services - In order to improve the health of rural people, we must concentrate our efforts on improving both quality of and access to health services for people living in rural and remote areas. A critical piece of this effort will be the provision of funds and other resources to support rural care and to develop sustainable care models.
4. Action oriented research - If we are to be successful in improving rural health, we must develop new knowledge to support our efforts. This knowledge, developed through research, must be accessible to rural people and health care providers through excellent information systems.
5. Education and performance of health professions - Finally, we must educate existing and new participants in rural health care. This education and training must be carried out at many levels and for many disciplines.

If the Action Plan envisaged here is actualized and sustained, the improved health of rural people might indeed change the world for the better. This is a task that will engage all of us and that must be started now. Health for all rural people is a goal worthy of our efforts.

Foreword

Health for All by the year 2000 clearly has not happened. Nowhere is this more evident than in the rural and remote areas where most of the world's people live. In order to achieve Health for All, attention must be paid to the areas of greatest need change. Now is the time to act as we move forward in the 21st Century.

This Action Plan for Rural Health is designed to be a guide which provides a clear sense of direction for all major stakeholders to bring about meaningful, sustainable improvements in the health of people living in rural and remote areas around the world. There is a strong emphasis on learning from and building on success with clear recommendations for action by all stakeholders – communities, policy makers, health professionals, academic institutions, and health managers.

In developing this Action Plan, the following key principles have been recognized:

- The improvement of the health and well being of people living in rural and remote areas remains a challenge for many countries in the world.
- There is a need for a reaffirmed commitment to primary health care oriented systems with a better distribution and use of health resources for people in greatest need.
- Emphasis must be placed on making the best use of available facilities and resources to meet goals of quality and equity in health, using approaches fostering unity of purpose and action.
- Better coordination and integration of individual and public health interventions targeting a given population must be encouraged.
- Principal stakeholders in health, normally policy makers, health managers, health professionals, academic institutions and communities must adapt their mandate and activities to become more socially responsive and accountable.
- Strategic options must be identified and implemented at the local level.
- Lessons learned from action research must be analyzed and lead to national policy development and support mechanisms. Exchange of information and experiences should be shared within and among nations.

The Current Situation

People living in rural areas

Around the world, the health status of people living in rural and remote areas is generally worse than that seen in people living in urban areas.

1.2 billion people – nearly a quarter of the world’s population are poor. Forty-four per cent are in South Asia, 24% each in sub-Saharan Africa and East Asia, and 6.5% in Latin America and the Caribbean. 75% of the people in these countries live and work in rural areas.¹

In terms of health indicators, 766 million people in developing countries lack access to health services and 503 million do not expect to survive to the age of 40.² In South Africa, infant mortality rates in rural areas are 1.6 times that of urban areas³. There is evidence of higher levels of morbidity and mortality in rural areas; the rural poor, especially women, generally have higher age specific mortality rates than the non poor⁴. In India 716 million people (72% of total population) live in rural areas. Half of these people have incomes below the poverty line, and yet about 75% of health infrastructure, medical manpower and other health resources are concentrated in urban areas where 27% of the population lives.⁵

Critical factors in the relationship between poverty and health are population and environmental issues. Rural areas consistently have lower levels of access to primary health care services, safe water and sanitation⁶. Eighty per cent of the poor in Latin America, 60% in Asia and 50% in Africa live on marginal lands of low productivity and high susceptibility to degradation. This tends to encourage migration from rural areas to the cities. However, in the world’s cities, more than one billion people live without facilities for garbage disposal or water drainage and breathe polluted air.⁷ There are Healthy Cities policies and programs aimed at addressing these problems. At times, it seems to be assumed that eventually everyone will move to the cities. MK Rajakumar, the great family practitioner/philosopher, former Wonca President from Malaysia, points out that, in the totality of human history, cities are a very recent and potentially “unnatural” phenomenon. He suggests that this helps to explain why so many urban people feel more at ease, somehow “at home”, in the rural areas. It does raise the notion that there should be programs, which actively seek to halt the rural-urban drift.

With the concentration of poverty, low health status and high burden of disease in rural areas, there is a need to focus specifically on improving the health of people in rural and remote areas, particularly if the urban drift is to be slowed. The World Health Organization International Development Program has highlighted this with specific objectives for policies and action which promote sustainable livelihoods including access for people to land, resources and markets as well as better education, health and opportunities for rural people. These objectives seek to contribute to lowering child and maternal mortality, and to improve basic health care for all, including reproductive services. Achievement of this is linked to protection and better management of the natural and physical environment.

In the vast majority of developing and transitional countries, rural poverty (whether measured by income/consumption data or other indicators) has been and remains at higher levels than in urban areas⁸. In terms of social indicators and access to basic services, rural populations continue to experience higher levels of deprivation, despite general improvements over the last 30 years⁹.

The emphasis on poverty as well as other social and economic factors has led to a tendency to focus on those issues rather than directly addressing health issues. The 10/90 Report on Health Research, 1999 presents a different view: ***“The global community should recognize that good health is a way out of poverty. It results in a greater sense of wellbeing and contributes to increased social and economic productivity. The impact of ill health on productivity affects not only the poor, but societies and economies as well”***¹⁰. There is a particular need to focus on the health and wellbeing in rural and remote areas so as to break out of the poverty – ill health – low productivity downward spiral.

The low health status and variable patterns of illness and injury in rural areas are related not only to poverty. In general, the rates of avoidable deaths in rural and remote areas are higher than in the cities. Generally work injuries are more severe and their consequences more serious in rural areas. To some extent this follows from the stoicism and the “too tough to care” mindset particularly amongst farmers and agricultural workers¹¹. In Australia, the tractor is the most dangerous machine with which people work. Forty per cent of work injuries are associated with tractors even though 5% of the workforce actually work with tractors¹². Similarly there are dangers in other rural pursuits like mining, fishing and forestry. In countries with established highway systems country people spend a lot of time driving at high speed and tend to have more serious injuries from motor vehicle accidents.

The peaks and troughs of the economic cycle tend to impinge more directly on rural communities with economic downturns often placing severe pressure on these communities. Consequently there are significant levels of stress in a situation where generally counselling, support groups and other mental health services are limited if available at all. Commonly in rural areas there is a higher alcohol and tobacco consumption and standards of nutrition vary when compared with the cities.

Access to health care is, universally, lower in rural areas. One of the factors in the complex causation of poverty in rural areas is certainly the failure to reach much of the population with basic services of even minimal quality. Experience and evidence indicate that the more rural and economically marginalized a community is, the more likely it is to have health services that are below standard when compared to national norms¹³.

Despite the enormous differences in resources between developed and developing countries access to health care for rural people is a major issue for both groups of countries. People in rural areas in both developed and developing countries are generally poorer and have a lower health status than their urban counterparts.

Clearly with the concentration of poverty, low health status and high burden of disease in rural areas there is a need to concentrate world effort on improving the health of people in rural and remote areas in ways which complement other international policies and programs.

This was recognised by the Earth Summit, held in Johannesburg, South Africa in September 2002, which included in its action plan a commitment to the following:

“Strengthen the capacity of health care systems to deliver basic health services to all, in an efficient, accessible and affordable manner aimed at preventing, controlling and treating diseases and to reduce environmental health threats, in conformity with human rights and fundamental freedoms and consistent with national laws and cultural and religious values, taking into account the reports of relevant United Nations conferences and summits and of special sessions of the General Assembly. This would include actions at all levels to:

- (a) Integrate the health concerns, including those of the most vulnerable populations, into strategies, policies and programs for poverty eradication and sustainable development.
- (b) Promote equitable and improved access to affordable and efficient health care services, including prevention, at all levels within the health system.
- (c) Provide technical and financial assistance to developing countries with economies in transition to implement the Health for All Strategy.
- (d) Improve the development and management of human resources in health care services.”¹⁴

Success in this endeavour will not only reverse one of the major health inequalities on the planet, but also stem the drift of rural populations to urban areas. Empowered communities in rural and remote areas will not only be healthy and happy, but will also become major contributors to the social and economic well-being of nations.

Action Taken So Far

Wonca Working Party on Rural Practice

The Wonca Working Party on Rural Practice was established in 1992, following the Wonca World Conference in Vancouver. Over the subsequent decade the Working Party has undertaken a number of projects and activities that have contributed to the growing understanding and knowledge base of rural health and rural health practice.

Since 1995 the Wonca Working Party on Rural Practice has been involved in the organization of a series of World Rural Health Conferences. Each of these Conferences has involved delegates from around the world. The Melbourne Conference held in 2002 attracted over 900 delegates from 47 countries. These Conferences have provided a forum for the exchange of ideas between rural family practitioners and other health professionals and have developed recommendations which have formed the basis for Wonca policies on rural health and rural practice.

The Wonca Working Party on Rural Practice has developed a series of Wonca Rural Policies these are incorporated in the table below.

Events & Action Timeline

1992	Wonca Working Party on Rural Practice formed.
1994	Wonca-WHO Conference on Medical Education, Canada.
1995	Wonca Policy on Training for Rural Practice.
1996	1 st International Conference on Rural Practice, Shanhai/Fengxian County, China.
1997	2 nd World Rural Health Congress, Durban, South Africa. The Durban Declaration: Health for All Rural People.
1998	WHO-Wonca Memorandum of Agreement. Wonca Policy on Rural Practice and Rural Health.
1999	3 rd World Rural Health Congress, Kuching, Malaysia. Kuching Statement: Health of Indigenous Peoples. Emerging Issues and Initiatives: An Action framework for the Conference Participants and the Wonca Working Party on Rural Practice.
2000	4 th Wonca World Rural Health Conference, Calgary Canada. Calgary Commitment to Women in Rural Family Medical Practice.
2001	Wonca-WHO Co-sponsored Consultation 'Health for All Rural People'.
2002	WHO-Wonca 'Health for All Rural People' Conference, Traralgon, Australia. 5 th Wonca World Rural Health Conference, Melbourne Australia. The Melbourne Manifesto: A Code of Practice for International Recruitment of Health Care Professionals. Wonca Policy on Quality and Effectiveness of Rural Health Care.
2003	6 th Wonca World Conference on Rural Health, Santiago de Compostela, Spain.

The Second World Rural Health Congress (1997) in South Africa had a particular focus on rural health in the developing world. The Congress adopted: "Health for All Rural People: The Durban Declaration".¹⁵ This Declaration outlines a series of principles which was followed by a Call for Action renewing the "Health for All" initiatives and calling on WHO, UNICEF, Development Banks, such as the World Bank, and National Governments to work with local communities, doctors nurses and other health professionals working in poorer areas of the world, to make a success of the "Health for All" initiative. The Declaration called for a combined effort to redress the historical inequities facing rural and disadvantaged communities.

In 1999 the Wonca Working Party on Rural Practice published the Wonca Policy on "Rural Practice and Rural Health." This document provides a policy framework and outlines strategies to assist governments and professional bodies

to ensure that real progress could be made towards the goal of improving the health of rural people. The strategies have been used in many countries and the experience derived has been presented at Wonca World Rural Health Conferences. A key philosophy underlying these initiatives is the principle that rural family doctors should be part of the solution in rural health, rather than part of the problem.

In 2002 the Wonca Working Party on Rural Practice published “The Policy on Quality and Effectiveness of Rural Health Care”. This document provides the framework to encourage the development of direct and indirect targets of and measures of the quality and effectiveness of rural health care.

WHO

In August 1999, the WHO held an International Conference, “Toward Unity for Health: (TUFH) Challenges and Opportunities for Partnerships in Health Development” in Thailand. Subsequently, the WHO produced a working paper intended to further the TUFH project. The project intention is to study and promote efforts worldwide to create unity in health service organizations – particularly through a sustainable integration of medicine and public health, or in other words, of individual health and community health-related activities – and consider the implication for important reforms in health professions, practice and education. The working paper explored innovative patterns of services for integrating medicine and public health focusing particularly on reference population and geography.¹⁶

Many of the issues raised in this working paper are particularly pertinent in rural and remote areas. There are many examples of rural practitioners having developed innovative models of health service delivery.

WHO- Wonca Collaboration

WHO developed a partnership with Wonca through a landmark Invitational Conference in 1994 at London, Ontario, Canada. Subsequently, Wonca and WHO established their 1998 Memorandum of Agreement, which includes the Rural Health Initiative.

The WHO-Wonca Memorandum of Agreement commitment to Rural Health Initiatives facilitated the conduct of a WHO-Wonca Co-sponsored Invitational Conference on Rural Health held at Traralgon, Australia in April 2002. The Conference was attended by eighty invited guests from around the world representing a broad cross section of groups and organizations with an interest in rural health including rural health practitioners, governments, health professional organizations, non-government organizations, academic institutions and community groups.

Over three days, Conference participants explored the major issues in rural health around the world, drawing on experience from 16 case scenarios of local rural health initiatives from a range of different countries. With the intention of developing this Action Plan, Conference discussions sought to articulate the critical factors necessary to ensure success.

The major themes, which emerged from the Conference were:

“Think Locally, Act Locally, then Spread Globally”

The emphasis is on fostering and achieving local success through local initiative. This local success is then transferred to other local settings so bringing about local change networked across multiple sites which provide the impetus for substantial global change. The Action Plan should clearly articulate the key principles and success factors required.

Sustainable Change Bringing Long Term Improvements in Rural Health:

The key focus is to build from the ground up. All key stakeholders have important roles at the local, national and international levels.

Horizontally Integrated Programs:

There should be strong emphasis on active collaboration and partnerships at the local level involving all key stakeholders. The form that “the local level” takes will be different in different contexts and vary from the village to the district. The key connecting influence is a sense of mutual benefit through collaboration. It may well be that the local level is a network of villages in one setting and a local government area in another.

Further, it was agreed that the Action Plan be based on the assumption that policies, programs and activities have a greater chance of success if the initial frame of reference is communities and individuals, they promote integration, encourage and facilitate partnerships and support capacity building.

The Conference agreed on the following guiding principles for the Action Plan:

- Consider health, not just medicine, in policy and strategic development
- Ensure equitable distribution of health resources and investment
- Use a systems approach which leads to better, more efficient and effective solutions
- Ensure all policy, planning and service delivery is people centred and guided by the community
- Seek better results through a collaborative team approach and inter-sectional cooperation
- Ensure services are sustainable
- Build capacity and self reliance at the local level
- Support progress in Information Technology in rural environments
- Ensure outcomes are supportable in a global context



Photo: Courtesy of Ijaz Anwar

A new track of hope

A new track of hope

A new track of hope for improved health of all rural people can be developed. Rural communities around the world share more than just their disadvantage. They often have an integration that reflects the close interactions of people in such communities. On the whole, they are inclined to have well defined social structures, shared values and belief systems and have closer family ties within the community in which they live. This brings about a strong sense of commitment to the overall wellbeing of their community.¹⁷

Most of all rural communities know their own needs and with the right support and assistance will work closely together in partnership for the good of the community. Unfortunately in many countries the voices of rural people are not heard. Frequently, health service planning and decision making is centralized and in the hands of the urban policy makers who may not understand the rural context. Rural communities do have capacity through the resourcefulness of their people, which is often not recognized. What is required is a commitment by Governments and other key stakeholders to provide the policy framework and targeted resources, and to build capacity within communities to maximize the potential that exists. When Governments commit to the policies and resources then communities can form the partnerships and collaborative arrangements that will deliver the desired outcomes, as they will find locally workable solutions involving the key stakeholders who are members of the rural community.

A new track of hope for improved health of all rural people includes:

- Public health measures such as clean water, proper sanitation and immunization
- Greater equity for rural communities in terms of resources for and access to health services
- Integrated, flexible health services that respond to rural community needs
- A better distributed and more skilled rural health work force
- Rural health research partnerships that involve and support rural communities and their health work force

To develop this new track of hope, there is a need to Create Unity for Action: An Action Plan for Rural Health. The improvement to the health status of rural people will only be achieved when all key players form the necessary partnerships and working relationships required to establish and maintain sustainable health services delivery systems based on community needs.



WHO-Wonca Co-sponsored
Invitational Conference.
Small Group Workshops.

Photos: Courtesy of Steve Kirkbright

The Action Plan for Rural Health

The implementation of the Action Plan involves three key elements – the pillars upon which action can be built. These are:

1. Action for equity
2. Action for a rural paradigm
3. Action Process

Action for Equity

There needs to be a real and sustained investment in primary health care, in its broadest sense. The principles that underlie this are those of justice, fairness and equity. Equity is a commonly used and accepted term, which refers to the distribution of financial and other resources on the basis of need, with equal resources being allocated for equivalent needs¹⁸. Need in this instance refers to a population's need for health care and the costs of providing this care¹⁹. Many would argue that equity should go further, in that the most vulnerable and needy groups within any society require greater resources than healthier, wealthier communities. This would allow such groups to improve their health status at a more rapid rate and thus to close the gap that exists between the advantaged and disadvantaged. Indeed, the more disadvantaged a group, the less able it is to access alternative resources to improve health status and the more likely it is to fall further behind. It is thus essential in order to achieve health for all rural people that significant resources are invested in rural health care and the provision of services, such as water and sanitation, education, electricity, transport infrastructure, etc. This implies specific, targeted investment in rural areas, and a diversion of funds away from better-resourced, urban areas. Often it simply means resourcing the strategies and policies that already exist in order that they can be implemented in rural communities.

Equity demands that focused attention is given to rural areas so that they are not left behind in attempts to improve health outcomes. The prevailing theory seems to be that improving health services generally will lead to improvements everywhere, including rural areas (trickle-down approach). However, if there is not a specific attempt to address rural health, with targeted action and specific resources, the rural-urban gap inevitably widens.

Financial and human resources follow power – political, social or economic. Action for equity means deliberately focusing such resources away from centres of power in order to assist the health and development of rural communities which do not have easy access to power in any form. Even within rural areas, it must be done carefully in a way that does not simply benefit those with greater access, creating gaps within communities but targets those with greatest needs. Thus community empowerment and local solutions remain the basis for action.

All programmes must be judged by their contextual relevance and applicability. Vertical or stand-alone programs may be destructive, drawing attention and resources away from other vital health-related activities, and disempowering local health care providers. Development interventions should be part of integrated rural development approaches; similarly health care interventions must build into and support comprehensive health care approaches, and develop local capacity.

Action for a Rural Paradigm

The Action Plan depends on local strategies and the successful negotiation of these at the local level. This can only happen in a supportive policy environment that encourages collaboration, innovation and a community perspective. However, often the existing policy environment is characterised by individual and separate imposed programs - acting like silos, isolated from each other and the local reality.

In a paper in *The Lancet* by McFarlane et al,²⁰ comment that the Declaration of Alma Ata was followed by a series of northern-designed selective initiatives which are still being generated today. Selective vertical programs enable the International Aid Agencies to measure results and protect their investments from complicated long-term multi-sectoral and inter-departmental implementation. They comment, however, that non-government organisations and religious groups have found that holistic community-based health programs are generally undermined by narrowly selective interventions and that the sustainability of people-owned initiatives can be put in jeopardy.

Many communities have struggled in the past to implement siloed programs and to fit the various initiatives into a coherent whole. Some have succeeded in this environment, and will no doubt continue to do so, through stretching the boundaries, creatively interpreting the rules and opportunistically taking the openings as they. Many, however, have failed to jump these hurdles of imposed discrete programs resulting in abandoned facilities, idle technology, wasted money and dissatisfied communities.

In developing a suitable policy environment for rural health, specific rural initiatives need to be developed and general policy initiatives, often metro-centric and urban in origin, need to be tested for rural relevance.

This was well outlined by Judith Justice in her paper: “The Bureaucratic Context of International Health – A Sociologist’s View”.²¹ She commented that many Primary Health Care programs were ineffective because they reflect the perspective and needs of the health bureaucracies involved rather than those of the local villages receiving services. Often Primary Health Care is interpreted differently in different bureaucratic settings and adapted to bureaucratic needs but not necessarily adapted to the village cultures and conditions.¹¹

Therefore, to successfully implement the Action Plan a facilitative environment is required at several levels:

- A cohesive national rural health policy approach
 - Specific rural initiatives
 - Allowing for innovation including integrated inter-sectoral development
 - Realistic risk balancing and assessment
- Policy review
 - Rural proofing
 - Rural Impact assessment

A cohesive national rural health policy approach and implementation strategy is a basic prerequisite of good rural health care. It should outline the goals of rural policy and outcomes that need specifically to be addressed. These will include specific rural initiatives including such areas as infrastructure development, disease targets relevant to rural areas and workforce approaches tailored for the rural and remote environment. These policies should also include an approach that seeks to break down artificial barriers between health services and programs. Coordinated and cooperative use of funds supplied to the community funds and avoidance of duplication and waste should be encouraged in line with the Action Plan and seek to reflect community needs. Health initiatives in communities should not unfairly disadvantage local providers but should seek to build on their strengths. Local providers are often hard to attract and their continuance should be encouraged. Primary care programmes should not dismiss or exclude curative interventions and practicing clinicians - including them may be a key factor to success. A program in Nepal, the Nutrition Education Intervention Program which was evaluated some years ago, did

involve some curative intervention. The evaluators found that the inclusion of curative activities in the program seemed to be a key factor in increasing the motivation of participants and acceptance by the community, so contributing to the success of the program.²²

Community initiatives should be encouraged to replace external visiting services or reorientate visiting services towards education and support of local services. Visiting services should have in their charter community empowerment and devolution ensuring flow-on community benefit.

Rural Proofing for Health

Rural proofing was developed by the Countryside Agency in England following the publication of the Rural White Paper in 2000, which set out the Government's commitment to ensure its policies take account of the specific needs of rural areas. The Countryside Agency has developed a checklist which comprises of a list of questions for agencies to address when deciding on policy to ensure that the needs of the population in rural areas are considered. Rural Proofing is currently a statutory requirement at government departmental level.

The Rural Proofing for Health project is funded by the Department of Health and is being carried out by the Institute of Rural Health. The main aim of the project is to develop a toolkit, which can be used by Primary Care Trusts and other agencies involved in health care delivery. The toolkit will be used as a guide to help identify the health needs of residents living in rural areas so those needs can be incorporated into policy making at a strategic level. Part of the project will also involve the development of a database of good/innovative practice to highlight effective rural service delivery models, which will be disseminated on a national basis. Examples from the database will be incorporated into the finished toolkit. Rural Proofing at all levels will ensure that models of service delivery that are rurally sensitive can be employed appropriately according to local need. This methodology can ensure that all rural communities have the same equity of access to health services as their urban counterparts.

For more information:

web: <http://www.rural-health.ac.uk>

e-mail: helens@rural-health.ac.uk

Risk management has become a recent area of focus. Risk, as discussed by governments, is often defined in terms of risk to the health provider or administration rather than risk to the community member. Withdrawal of a maternity service may control the perceived risk to the service provider or administration but does not necessarily control the risk to the pregnant woman who may be unable to travel to a distant facility because of timing (premature labour), financial or family (other children to care for) reasons. Replacing emergency services with retrieval may be self-defeating as such services become overloaded and slow to respond. Appropriate rural facilities with multi-skilled staff are in best risk balance when the needs of communities and their members are considered.

Policy at a national level necessarily must reflect the needs of all the nation. In doing so, however, it must take into consideration the cultural and geographic needs of particular sectors - one such is rural. National decrees limiting working hours of health care providers need to be balanced against the logistics of service provision, up-skilling of staff need to be provided for in isolated locations and sustainable call schedules and adequate back-up services. Early hospital discharge needs to be balanced against the limited supports in isolated living. Rural facilities need to be used to their maximum. Entry criteria to health sciences based on academic criteria only that favour urban students must be balanced to provide an equitable rural-urban mix. Perfectionism and elitism have the potential to have all procedures done in large centralised locations while rural people die for want of transport or while in transport to these unreachable centres of supposed excellence. The evidence for such an approach has not been validated for rural areas.

One approach has been to ensure that all policy is reviewed for rural relevance before implementation and preferably in the planning phase. South Africa is seeking to do this and "Rural proofing" has been introduced in the UK. Community obligations have been introduced with privatisation of services in Australia. The ultimate measure of government and private sector interventions is the Rural Impact Assessment – a developing concept analogous to environmental impact assessment that assesses the effect of policy on the rural sector. Complex systems such as rural communities are prone to disproportionate impact of single interventions and these need to be adequately assessed before implementation

Action in rural health can only happen if rural communities are allowed to develop strategies that suit their circumstances. The restrictive siloisation common to (and possibly effective in) urban communities needs to be broken down in rural environments and appropriate outcome measures used. The best solutions for rural areas may not be the transplanted urban solutions but a rural friendly solution that may not align with the needs of urban areas.

Simplistic, monolithic and reductionist or siloed approaches need to be replaced by a system that encourages diversity and innovation.

Action Process

This Action Plan aims to improve the health of all rural people by a three-step process:

1. Think locally – Review local capacity
2. Act locally – Build local success
3. Transfer globally – Implement enabling policy environment

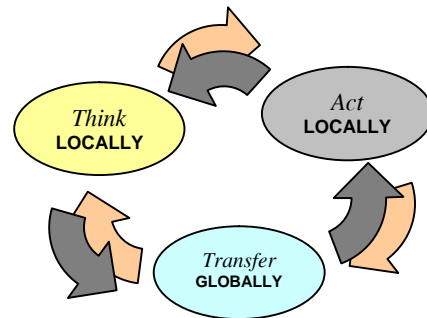
Think locally – Act locally

This three step process involves the community:

- identifying its needs,
- developing actions to address them,
- identifying the resources required including the community's contribution.

The most beneficial changes to the health care of local communities come from solutions developed with active community involvement. Communities vary widely in their needs, resources and abilities, but local solutions are the most likely to be effective.

Therefore, the policy framework and resource allocation process must contribute to enhancing community capacity to address problems locally. This must be based on the principle of equity.



Implementation of local solutions needs to be nurtured by a supportive policy environment in terms of each of the five components identified. This needs to be an iterative process where policies are assessed for the degree of local flexibility they provide and the degree to which implementation at a local level in rural communities is possible. Often development of local initiatives is facilitated by local champions supported by change agents who receive specific funding and draw on successful experience from other local settings. Meaningful investment of resources makes this possible.

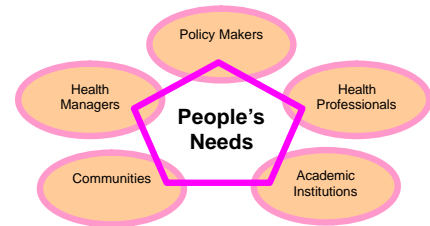
All key participants, as members of a local community, need to consider how they contribute to finding and supporting local solutions. What are *some key questions* the community should ask if they are to *Think locally to review local capacity and Act locally to build local success*?

Transfer globally – implement enabling policy environment

The most critical factor in the implementation of local solutions is the policy environment and the will of the key stakeholders to commit to strategies to achieve outcomes in all five components of this Action Plan. Without a commitment to improve the health status of rural and remote people through specific policies and defined strategies integrated into comprehensive primary health care efforts, the concentration of poverty, low health status and high burden of disease in rural areas will remain. Fundamental to this is for sufficient resources to be allocated and distributed to implement these policies and strategies.

This Action Plan is built on the key principles of:

- community participation and empowerment,
- local networks,
- partnerships between key stakeholders,
- service integration and coordinated approaches to health care which are locally based.



It is a guide based on five *essential components* for consideration at both the local and policy level.

The *essential participants* in the implementation of this Action Plan include: Communities, Policy Makers, Health Professionals, Academic Institutions and Health Managers.

Components

1. Community empowerment	Support capacity building within rural communities at a local, district and regional level
2. Building of unity among partners	Support the development of linkages between patient care and public health through Primary Health Care
3. Providing rural health services	Improve health outcomes by improving quality and access of health services to people living in rural and remote areas of the world
4. Action oriented research	Foster research to advance knowledge in the field of rural health
5. Education and performance of health professions	Improve education and training for rural health practice and support ongoing rural health.

Participants

Communities	Including: Non-government organizations, Community based organizations, Local Government, Consumers, Unions
Policy Makers	Including: Ministries of Health and Local/Regional/Provincial Governments and Planning Agencies
Health Professionals	Including: Doctors, Nurses, Allied Health Professionals and their Professional Associations
Academic Institutions	Including: Schools of Medicine, Nursing, Health Sciences and Public Health, Rural Health Institutes and local preceptors
Health Managers	Including: Local/Regional/Provincial Managers and Administrators and national public and private insurance agencies.

Support capacity building within communities at a local district and regional level

Component 1

Community Empowerment

Background

The Ottawa Carter has describes community capacity building as

“Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems fro strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.”²³

The key components of community capacity building that supports improved health outcomes are:

- (a) Institutions, services, government, health practitioners and communities working together to achieve sustainable communities and services
- (b) The establishment of mechanisms to ensure increased opportunities for community participation in health planning and delivery
- (c) Knowledge transfer and
- (d) Information sharing.²⁴

A commitment to community capacity building increases the social capital in rural communities, which helps groups to perform tasks such as planning and coordinating health services and programs. Social cohesion is critical for development to be sustainable, poverty to be alleviated and improved health outcomes to be achieved. Community capacity building is a key issue in health reform and requires an integrated set of strategies across a number of key areas to ensure effective practice. To be most effective capacity building needs to work at a number of levels and use a combination of strategies from the key action areas of organizational development, workforce development and resource allocation.

It is the responsibility of all health professionals to take seriously their obligation to pass on skills to the local communities they serve.



Community capacity building is a key issue in health reform and requires an integrated set of strategies across a number of key areas to ensure effective practice

Objective 1.1 – Community Development

Enhance the pivotal role of the community in improving health outcomes

Actions to take

- (a) Promote to all levels of government the importance of rural community development strategies in health care planning and delivery



Action Outcomes

A movement from a centralist model of health care based on urban assumptions to a rural community based model relevant to the local context

Objective 1.2 – Community Participation

Increase participation and development at a community level to ensure empowerment and self-reliance

Actions to take

- (a) Promote the establishment of mechanisms to increase community participation in the planning and delivery of health services at a district and local level



Action Outcomes

Increased capacity for local identification of health problems and improved capacity to address them

Improved usage of limited resources

Increased local ownership of health services and patient satisfaction

- (b) Promote partnerships and collaboration between, government, health professionals, health services and communities at a local level



Improved sustainability and effectiveness of local health services

- (c) Encourage the establishment of local networks



Improved equity and access to health services

Objective 1.3 – Capacity Building

Unlock the potential talent and skills that already exists in rural communities

Actions to take

- (a) Increase community access to information to assist an expanded role in health service planning and delivery.



Action Outcomes

Increased public awareness of rural health issues at all levels and increased empowerment of rural communities

- (b) Encourage the establishment of capacity building training programs to skill the community and provide ongoing support to them



Improved knowledge and skills base within communities and empowerment of local communities

- (c) Implement capacity building training programs for rural health professionals



Improved health status for rural people

Picture of Success

Thai Rural Medical Services Program Joint Australian – Thai initiative



Photo: Courtesy of Di Wyatt

The Thai Rural Medical Services (RMS) program, a joint Australian – Thai initiative is an example of a partnership between a developed and developing country based on capacity building principles working together towards health reforms. The Thai RMS program aimed to improve access to basic health care and enhance community capacity to manage health needs in rural areas of Thailand. The RMS program used capacity building for health care providers and communities as an approach in to addressing rural health issues.

Triggers for Action

Community empowerment

- What skills do we need to enhance our role in improving the health of our community, what training do we need and who could provide it?
- What mechanisms do we need to establish to enable us to input into the planning and delivery of health services within our community and what information do we need?
- Who are the key players and what collaborative arrangements or partnerships do we need to establish?
- What local networks do we need to support this?
- What do governments need to do to create the policy framework to assist community capacity building?



Photo: Courtesy of Di Wyatt

Support the development of linkages between patient care and public health through Primary Health Care

Component 2

Building Unity of Partners

Background

The narrow and parochial definition of health employed by health care professionals, providers and managers has in the past hindered the development of truly integrated and inclusive health care and health care delivery systems. The term health has often referred to the delivery of services rather than the attainment of “well being” by tackling the wider determinates of health such as poverty, poor education, employment, housing, public utilities and the environment.

Primary health care requires working together broadly across disciplines, sectors and agencies at a local level. It is also important that close cooperation and dialogue develops through the levels of health care management and governance. Care systems need to be seamless and responsive. Those working on the ground should be given flexibility to respond to local needs, while those in government must ensure that some of the barriers are removed to encourage effective partnerships at all levels

Collaborative partnerships will only be successful if all those involved understand each other’s role and responsibilities. Education is important in achieving these objectives. The principles of team work, joint working and community development needs to be integrated into all levels of training and education of health care professionals in the future, recognizing that learning together encourages individuals to work together.

Health care training for primary care professionals has traditionally focused on patient and family centred care. It is also important that these professionals also develop public health and community development skills in order to assess need and plan services together with the communities that they care for.



The importance of partnerships and sharing cannot be overemphasized

Objective 2.1 – Service Integration

Improve health outcomes through better-integrated service systems

Actions to take

- (a) Promote partnerships between patient care and public health providers, governments and communities that support joint planning, funding and delivery of health care systems
- (b) Encourage the development of pilot models of integrated health care
- (c) Strengthen networks and referral systems between those that have direct patient care and public health services at a local level
- (d) Encourage the development of mechanisms at a local level to monitor and evaluate, service outcomes and respond to changing needs

Action Outcomes

- Integrated health services that respond to the needs of the community
- Best practice models as beacons
- Improved effectiveness and efficiencies in health care at a local level
- More adaptable health care responsive to community needs.

Objective 2.2 – Multidisciplinary Approaches

Improve efficiency and effectiveness of health care through the use of multidisciplinary, multi-skilled teams across the health care delivery system

Actions to take

- (a) Promote at all levels of health professional education and training the importance of the principles of team work in the provision of rural health services
- (b) Promote the establishment of learning environments that support and promote cross disciplinary learning, multidisciplinary approaches and multi-skilling of rural health professionals
- (c) Encourage and develop multidisciplinary continuing educational programs that provide rural health professionals with opportunities to learn and adopt new ways of working
- (d) Promote the development of work environments and service delivery models that support multidisciplinary team approaches to care.

Action Outcomes

- Increased understanding by health professionals and managers of the effectiveness and efficiencies that can be achieved through team approaches
- Increased understanding of the roles, responsibilities and functions across disciplines that encourages individuals to work together
- A better and more highly skilled workforce
- Improved care systems that are seamless and more responsive

Picture of Success

Primary Health Centres in Portugal



Photo: Courtesy of Berta Nunes

In 1982 Portugal established a network of primary health care centres that provide preventive, public health and preventative services.

They are staffed by family doctors, nurses and public health support personnel. Despite having an overall doctor shortage, Portugal has a very good distribution of physicians working in rural areas.

Objective 2.3 – Resource Sharing

Promote resource sharing

Actions to take

- (a) Facilitate the establishment at a local, regional and government level of partnerships that facilitate the transfer and sharing of resources across traditional boundaries (Health Action Partnerships)
- (b) Facilitate the establishment of Health Action Zones in which resources are co-coordinated and managed to tackle regional health inequalities.

Action Outcomes

- ▶ Ability to shift resources between sectors to improve the health and well-being of the community
- ▶ Better targeted use of resources

Objective 2.4 – Communication

Foster an understanding and dialogue between those who provide and manage care at a local level and public health agencies, which have a responsibility for the care of the population

Actions to take

- (a) Facilitate the development of both academic and social rural networks, where individuals, communities and institutions can share informatio

Action Outcomes

- ▶ Increased knowledge sharing.

Picture of Success

The South African Integrated Sustainable Rural Development Program



Bertoni Photo: Courtesy of Ian Couper

The Integrated Sustainable Rural Health Development Program is currently being implemented as part of the change process occurring in South Africa and addresses many of the challenges facing all key stakeholders involved in bring about these changes and encourage the development of partnerships in meeting new health objectives in South Africa.

Triggers for Action

Building unity of partners

- How do we form the partnerships locally to enhance integration between patient care and public health providers?
- How do we strengthen the relationships between direct patient care and public health services at a local level?
- How do we monitor and evaluate outcomes?
- How do we develop multidisciplinary approaches to health care and promote teamwork in the provision of services?
- What education and training programs do we need to assist health professionals to work in a multidisciplinary environment?
- How do we establish partnerships that facilitate resource sharing to tackle health inequalities?
- How do we improve communication between the key players?



Photo: Courtesy of Di Wyatt

Improved health outcomes by enhancing quality of, and increasing access to, health services for people living in rural and remote areas of the world.



There is a desperate need to develop mechanisms to support both the development and dissemination of best practice models for rural health...

Component 3

Providing Rural Health Services

Background

Improved health outcomes require improved access to care as well as better quality of care. Access is the major rural health issue in both developed and developing countries. Even in countries where the majority of the population lives in rural areas, the health care resources are concentrated in the cities. The development and delivery of health services in rural areas must be specific to the rural context and different from that in the cities. Unfortunately, urban based policy makers and health service planners often seem to think that the country is just like the city but with a different population distribution, and that it is possible simply to transplant modified urban health services to rural areas without accounting for the broader socio-economic and geographic factors that affect rural communities and impact on health care.

The provision of health services in rural and remote areas is significantly affected by limited funding and other resource constraints. In developing countries, there is considerable poverty and limited facilities and resources available for health care. In many developed countries, there has been the trend towards the reduction of funding and infrastructure support for health services in rural and remote communities.

To improve health outcomes for rural people requires an equitable distribution of health resources and investment between rural and urban areas. Internationally there is no agreement on or consistency in the collection, collation and analysis of data relating to health indicators of rural communities to inform planning decisions. The lack of comprehensive data sets to assist evidence based planning for rural health must be addressed if we are to use evidence appropriately to plan strategies and programs to improve the health outcomes of rural people. Governments and other key stakeholders who provide health services and programs to rural communities need to develop this capacity, as interventions need to be based on sound evidence. Information relating to the demographic, geographic and health statistics of rural communities should form the base of any health planning system. Of related concern is the limited availability of best practice models and benchmarks for service outcomes applicable to rural environments. There is a desperate need to develop mechanisms to support both the development and dissemination of best practice models for rural health care if we are to encourage the implementation of best practice solutions suited to rural communities own specific needs.

Objective 3.1 - Service Development

Improve the quality, appropriateness and sustainability of health services in rural areas and ensure access to these services

Actions to take

- (a) Establish goals for improvement in health status, which can guide service development at all levels. This needs to be done in a consultative process with rural, remote and marginalized communities a particular focus.
- (b) Establish mechanisms for the assessment and review of current health systems to ensure ongoing development of services that meet community needs. Involvement of and accountability to the communities served is critical.
- (c) Promote flexible service delivery models for rural communities that contribute to meeting the greatest health needs at the same time as increasing accessibility to care. Rigid "one size fits all" models often do not address rural health needs. Local planning and adaptation is required.
- (d) Promote partnerships and collaboration as a means by which quality and accessibility can be achieved. The contribution of public and private sectors, together with non-governmental and community based organizations, is essential for service development. Sharing of resources, knowledge and information will enhance health outcomes.

Action Outcomes

- Local implementation flexibility within these goals
- Local models of community accountability for quality of services
- Flexible local models of health service delivery which are tailored to local health service needs
- Seamless integrated health services at the local level



Photo: Courtesy of Ijaz Anwar

Objective 3.2 - Funding & Resources

Increase commitment of funds and other resources to rural health services

Actions to take

- (a) Promote equity as a core issue to be addressed in health redevelopment and reform processes.
- (b) Collate data that provides evidence of the special needs of rural communities and promote to governments the necessity of developing funding strategies to address them. This is essential for equity to be addressed.
- (c) Establish a rural health focus within each country with a significant rural population to lobby and assist government towards developing rural health strategies. This may take the form of rural health units at different levels of government, rural health professional organizations or academic centers for rural health.
- (d) Promote joint funding arrangements and flexible funding models for rural health. Health service provider models that use flexible funding arrangements should be documented and the health outcomes of such models reviewed.
- (e) Develop pilot projects in different rural settings to test the transferability of models and to provide the data needed for more comprehensive rural health systems.

Action Outcomes

- Greater equity for rural communities in terms of resources for and access to health services.
- Increased understanding within governments of issues facing rural communities.
Development of strategies by governments to address rural health care needs.
Increased focus at a national level on rural health matters.
- Development of national and international networks of rural health organizations.
- Greater range of funding models for rural health care delivery.
- Enhanced knowledge of appropriate health service delivery models for rural communities.

Objective 3.3 – Sustainability

Support the development of sustainable models of rural health services and practice

Actions to take

- (a) Promote multidisciplinary teams as an appropriate model for patient care in rural areas. This is based on the understanding that individual health care professionals cannot provide a sustained health service unless they are part of a broad based team. This in turn has implications for funding, training and management.
- (b) Document successful models of service delivery that use a multidisciplinary approach to patient care.
- (c) Develop education and training programs that support a team-based approach to health, in order to ensure sustainability.
- (d) Recognize and promote the role of nurse practitioners and/or medical assistants in patient care in rural areas as an important component of ensuring sustainable health services.
- (e) Develop and conduct multidisciplinary skills development programs within health services that promote holistic approaches to planning and service delivery. This is essential to ensure preventive, promotive, curative, rehabilitative and palliative health care is provided for rural populations on an ongoing basis.
- (f) Develop community information programs and engage communities in all aspects of the service. Empowered communities will greatly enhance the sustainability of local services.

Action Outcomes

- Well integrated patient care and public health service delivery in rural areas.
- Share successful models and validate these in the rural setting.
- An improved skill base amongst rural health professionals.
- Recognition of the role of various health professionals including “extended roles”.
Increased access to a range of services at a local level.
- Successful integration of services at the local level.
- Community needs expressed through improvements in health services.

Picture of Success

Unhcr - Oru Refugee Camp, Oru, Ijebu-North Local Government of Ogun State in Western Nigeria



Unhcr - Oru Refugee Camp, Oru, Ijebu-North Local Government of Ogun State in Western Nigeria
Photo: Courtesy of Allan Fatayi-Williams

Refugee camps are usually located in rural communities worldwide. Over five thousand refugees from war-torn areas of Africa notably Liberia, Sierra-Leone, the Democratic Republic of Congo, Sudan, Cameroon and Rwanda have been resettled in this camp about 2 hours drive from Lagos which was established under the auspices of the United Nations High Commissioner for Refugees.

The refugees are being successfully rehabilitated and are undergoing skills acquisition in such areas as hairdressing, catering, shoemaking and computer studies. Those with requisite qualifications and language skills are assisted to obtain registration with nearby institutions of higher learning.

Voluntary HIV screening has also been performed on selected refugees in this camp who in addition to the rest also have access to the camp clinic for Primary Health Care.

Objective 3.4 – Evidence Based Planning

Development of evidence – based planning models for rural health

Actions to take

- (a) Promote to all levels of government the importance of developing comprehensive data sets to facilitate evidence based planning for rural health including demographic, geographic and health statistics
- (b) Promote to all levels of government the importance of developing systems for the collection and analysis of data at regional, district and local level
- (c) Encourage the development of best practice and benchmarking for rural health

Action Outcomes

- An agreed and consistent set of data used worldwide in health planning for rural communities
- Effective collection and use of data in planning, resource allocation, infrastructure development and capacity building in rural communities
- Improved knowledge of decision makers of major health issues in rural communities and the development of strategies to address them
- Benchmarks for rural health professionals and services

Picture of Success

Flexible Funding Models Australian Rural Communities



Omeo Township
Far East Gippsland, Australia
Photo: Courtesy of Anske Robinson

The Multi-purpose Services program and Healthstreams are two flexible funding programs introduced into the Australian health care funding system in the 1990's to give small rural communities having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost effective approach to service delivery. The Multipurpose Services model works on a model of health and aged care service delivery that aims to help small rural and remote communities to tackle some of the challenges they face, such as being restricted in coordinating services because of tradition funding guidelines. The Healthstreams program was established in 1996 as an incentive to small rural hospitals to develop a broader range of community based services. Both programs lift funding barriers that had previously restricted service options. Services now have the ability to develop flexible services more appropriate to their communities highest needs.

Triggers for Action

Service development

- What are our local health needs?
- What evidence do we have of these needs?
- How are they best met?
- How do we ensure equity based on community need?
- What information do we need to assist with health service planning in our local community?
- How do we ensure our services are sustainable?
- How do we evaluate our health services?
- What models of rural health care can we learn from and apply?
- What evidence do we have for best practices in the delivery of rural health care?

**Foster research to
advance
knowledge in the
field of rural health**

Component 4

Action - oriented Research

Background

There is a need for high quality research, which provides clear and specific evidence about rural health and rural practice. If initiatives in education and training for rural practice are to be taken further, there is a need for research into what works best and evaluation of the outcomes. Rural health workforce recruitment and retention issues will only be addressed by further research monitoring workforce trends, evaluating current initiatives and pointing to the potential value of new projects and programs. Similarly, models of health service delivery require further study identifying the demands and requirements of rural and remote communities and evaluating the effectiveness of different models.



**As rural health care grows
around the world, both patients
and providers will benefit from
increased scientific
understanding and knowledge**

Currently, the worldwide research agenda for rural health and rural practice is replete with “holes” and with regions of inadequate data and analysis. Although much effort has been expended towards developing work-lists of research topics, much of the actual research work remains undone, and, in many areas, it is not even clear what research questions should be asked. As rural health care grows around the world, both patients and providers will benefit from increased scientific understanding and knowledge. Increased wisdom regarding rural health care will be dependent on developing data collection systems based in rural health care services, supported by analysis oriented research units focused on transforming this data into usable knowledge. Finally, the integration of this data into health care practice will depend on dissemination and communication systems that can effectively transmit data from the research and analysis sites to the rural clinics.

The systematic development and implementation of evidence based planning and best practice guidelines and their application in practice together with Information Technology development and skills training requires international collaboration and coordination.

Objective 4.1 – Research

Contribute to scientific understanding, which informs rural communities, professional practice, education and training programs, service delivery, policy development and the implementation of rural health programs

Actions to take

Establish Rural Health Research Units supported through the WHO Collaborating Centre for Rural Health. The functions of the Rural Health Research Units would be as follows:

- To build partnerships with communities, health professionals, health managers, policy-makers, and academic institutions to do rural health research.
- To analyze data collected at rural health service sites;
- To develop electronic Internet based reports and publications for rural providers;
- To coordinate strategic plans to address research questions;
- To formulate rural health care research agendas;
- To seek and to develop funding to support rural health care research
- Establish a worldwide Rural Health Research Network, or a series of regional networks, consisting of rural health care services that will serve as research data collection sites.
- Develop a system, using both Internet based and appropriate print resources, to disseminate the rural health research findings to rural health service sites across the world. .

Action Outcomes

Effective local and major rural health research projects

Involvement and support of rural communities and their health workers in all aspects of rural health research from design to dissemination.

Knowledge, which contributes to international understanding of rural health, issues and provides the basis for ongoing developments in rural health care.

Increased use of rurally applicable research findings to buttress worldwide rural use of evidence based medicine.

Picture of Success

Rural Summer Clinical Research Studentships



Rural Summer Studentship participant and Gold Medal graduate from The University of Western Ontario medical school Amita Dayal
Photo: Courtesy of James Rourke

Medical students, paired with rural doctors, do community-based research projects supported by The University of Western Ontario Faculty of Medicine (London, Canada). As well as learning about research, the students develop their interest in and understanding of rural life and work. Rural doctors and their communities become actively involved in community-based research.

Objective 4.2 – Information Systems

Development of information systems and dissemination mechanisms using Information Technology as a primary source

Actions to take

- (a) Promote the development of information systems appropriate to rural environments
- (b) Promote the expansion of Information Technology access and usage in rural areas
- (c) Promote the development of training programs for the rural health workforce and rural communities to enhance both the collation and usage of information in planning

Action Outcomes

- Better informed and empowered communities
- Improved access to Information Technology
- Communities better trained in Information Technology and its application

Picture of Success

Alberta Rural Physician Action Plan



Beaming with Pride – information sharing in rural Alberta
Photo: Courtesy of David Topps

Alberta Rural Physician Action Plan has successfully integrated information and communications technology into its rural teaching practices. Collaborating with the University of Calgary and several technology partners, RPAP's Information Technology program provides equitable access to many resources such as the Virtual Library, handheld computers for learners and teachers, Information Technology support, and collaborative data exchange. Over 9 years, many innovations have enabled rapid distribution of information; unique research tools with automated data collection have provided better feedback to policy makers thereby improving our programs. All this has been achieved at low cost by focusing on key information pathways and by adoption of innovative cost-sharing mechanisms.

Objective 4.3

– WHO Collaborating Centre in Rural Health

Establishment of a WHO Collaborating Centre for Rural Health supported by an International Network for Rural Health

Actions to take

- (a) Actively promote and support the establishment of a WHO Collaborating Centre in Rural Health with a primary role of providing leadership to ensure effective outcomes for rural communities. The WHO Collaborating Centre in Rural Health would play a significant role in supporting the development of an International Network for Rural Health Research and in supporting rural health research activities through either a centralized or a series of regionalized, Rural Health Research Units.

Action Outcomes

Facilitation and coordination of the implementation of the Action Plan for Rural Health and leadership in the ongoing development of information and knowledge, skills and capacities necessary to improve the health care and outcomes for rural people.

Picture of Success

Research at Monash University School of Rural Health



Monash University Australia
Photo: Courtesy of Steve Kirkbright

Monash University School of Rural Health is a success story in Rural Health Research. Over a 10-year period, the School undertook a series of research projects, the results of which have contributed to policy development in Rural Health Workforce and Rural Health Services. Examples include: A series of studies on Models of Health Service Delivery in Rural and Remote Communities, including a focus on sustainability; Recruitment and Retention of the Rural health Workforce including Doctors, Nurses and Pharmacists; and Urgent Care Services in Rural Communities.

Triggers for Action

Action – oriented research

- How do we as community members contribute to the scientific understanding of rural health and rural health practice?
- What sort of mechanisms do we establish to assist use in research activities at a local level?
- What information do we need to plan interventions?
- What evidence is there for the planned interventions?

Improve Education and Training for Rural Health Practice and support ongoing Rural Health Workforce Development



One of the current barriers to entry into rural practice is the lack of training that could prepare health practitioners for the unique requirements of rural care



By providing better on-going training and support for existing rural providers, retention is enhanced and the shortages of rural health practitioners are decreased

Component 5

Education and Performance of Health Professionals

Background

There is a current critical worldwide shortage of rural health practitioners. Too few health care practitioners locate in rural areas, and the tenure of health care practitioners in rural areas is frequently too short. In addition, those who do practice in rural areas are often not located in the areas that need them the most.

Research evidence from around the world shows clearly that the three factors most strongly associated with entering rural practice upon completion of education and training are:

- (a) A rural upbringing
- (b) Positive clinical experiences in the rural setting at the undergraduate or basic level
- (c) Specific postgraduate or post-basic training for rural practice.

Most countries have severely limited opportunities for training health care providers in and for rural settings. If adequate numbers of training opportunities existed, with a special focus on the knowledge, skills, and attitudes required for rural health care, more health practitioners would enter practice in rural sites. One of the current barriers to entry into rural practice is the lack of training that could prepare health practitioners for the unique requirements of rural care. In order to increase the number of health care providers entering rural practice, there must be increases in the number, the size and the quality of training programs for rural practice.

A second set of problems that contributes to the scarcity of rural practitioners is the low retention rate and short length of employment found in many rural areas. As noted above, one of the prime reasons for this situation is that many rural providers begin practice with inadequate training. The resulting sense of being overwhelmed by the scope and complexity of rural health care leads to short tenures. There are many additional causes of retention problems, including social and professional isolation, limited access to continuing education, distance from family, and difficulty in earning an adequate living. By providing better on-going training and support for existing rural providers, retention is enhanced and the shortages of rural health practitioners are decreased.

Finally, when health practitioners do decide to enter rural practice, they sometimes locate at sites that are not the most needful of their services. While this may be understandable from the personal aspect of the individual provider, it does not result in an equitable distribution of these scarce practitioners based on local needs. In order to impact on regional and local shortages of practitioners, the question of distribution, both between urban and rural sites, as well as among rural sites, must be addressed.


Objective 5.1 – Undergraduate

Increase the percentage and number of health practitioners who are trained for and enter into rural health practice

Actions to take

- (a) Use rural educational “affirmative action” - in other words create programs that disproportionately recruit students with rural backgrounds into health science courses
- (b) Collate information on rural affirmative action programs across the world and share this information via the internet and other media
- (c) Provide support packages for groups or organizations that want to develop rural health care courses and rural health education strategies.
- (d) Develop a program to increase the awareness in educational institutions of the need for increased numbers of rural health care practitioners, and the associated need for more training programs.
- (e) Collate and make available on the Internet and other media information on undergraduate curricula and teaching materials for rural practice. Promote this information to key stakeholders.
- (f) Promote the development of incentives that increase the capacity of practicing rural health professionals to participate in the education and training of undergraduate health sciences professions students.
- (g) Encourage educational institutions to support the community based training of undergraduate students in rural areas.

Action Outcomes

-  An increased in the number of students with rural backgrounds entering health courses
-  Improved knowledge among educators and educational institutions of current strategies for recruiting students into rural health care courses.
-  Improved dissemination of information, on the design and development of rural health care courses and educational strategies.
-  Increased responsiveness of educational institutions to the needs for rural health care training and education.
-  Increased availability of training and education opportunities for rural health care.

Increased numbers of teachers involved in rural health care training and education.
-  Increased numbers of rural health practitioners serving as teachers.
-  Increasing numbers of students taking rural health care courses and studying in rural sites.

Picture of Success

The Ingwavuma Scholarship Scheme (Mosvold sub district) South Africa



Scholarship Scheme Students
Photo: Courtesy of Ian Couper

The Friends of Mosvold Scholarship scheme is a partnership between the local community, Department of Education, Department of Health, Medical Education for South African Blacks and private funders. The ultimate aim of the project is to provide high quality health services to the indigent population of Ingwavuma by the identification, training and support of local students who have the potential to become health care providers.

Objective 5.2 – Postgraduate

Increase the percentage and number of health practitioners who are trained for and enter into rural health practice

Actions to take

- (a) Collate information on current graduate/postgraduate/post-basic training initiatives and programs for rural practice, and make this information available on the Internet.
- (b) Disseminate these initiatives and programs to educational institutions, health care institutions, and generalist professional organizations.
- (c) Provide support for the implementation of these rural training initiatives, and encourage generalist professional organizations to include them in their training systems.
- (d) Promote the development of incentives to support health professional training and education in rural areas.
- (e) Encourage development of community capacity for rural training at local levels.
- (f) Promote the introduction of rural health service accreditation and re-accreditation.

Action Outcomes

- Improved knowledge of current education and training initiatives
- Improved knowledge among educators and educational organizations of current graduate/postgraduate training initiatives
- Increased availability of programs focusing on rural preparation
- Increased capacity to introduction to rural training initiatives
- More education occurring within rural communities.
- Recognition of appropriate standards for rural health care.

Picture of Success

Family Medicine Residency Program Northern Ontario, Canada



Northern Ontario is a vast area with many remote communities accessible only by air

Two family medicine residency programs were established in northern Ontario, Canada in the early 1990's with a mandate to train family physicians to practice in northern Ontario and rural settings. An initial assessment of these programs conducted in 2002 found that the two programs had been successful in producing a sizeable number of family physicians that work in northern Ontario, rural, or small-town settings.

Objective 5.3 – Retention / Continuing Education

Improve retention rates and length of employment in the rural health sector

Actions to take

- (a) Undertake pilot assessments of rural training needs, along with a comparative analysis, in both a developing and a developed country.
- (b) Develop a range of Continuing Professional Education programs for rural practitioners using multi-modal delivery, including electronic communications. Using the pilot needs assessment, ensure that the content is appropriate and accessible for rural providers in developed and developing countries.
- (c) Promote research projects to study ways to increase retention in both developed and developing countries.

Action Outcomes

- Improved knowledge of training needs of rural health practitioners in both developing and developed countries.
- Improved Continuing Professional Education programs for rural practitioners, and improved accessibility of those programs.
- Improved retention rates and length of service among rural practitioners.

Objective 5.4 – Workforce Development

Increase the numbers of health professionals working in rural areas and support equitable distribution based on local need

Actions to take

- (b) In order to achieve success in education and training, an adequate workforce of teachers of rural health care must be developed. Many of the teachers will be existing rural practitioners, and many of the training sites will be community based rural practices.
- (c) Faculty development programs that are appropriate for both developing and developed countries should be designed, tested, and deployed. The content and methodology of these programs should be shared via the Internet and other media.

Action Outcomes

- Increased numbers of trained faculty capable of teaching the knowledge, skills, and attitudes needed for rural practice.
- Increased numbers of rural practitioners who participate in teaching in education and training programs for rurally oriented health care students.

Triggers for Action

Education and performance of health professionals

- How do we contribute to training students both at an undergraduate and postgraduate level to work in rural communities?
- What can we do to encourage them to come to a rural community to undertake their training?
- How do we support them in our community?
- How do we work with the education and training institutions in the promotion and support of rural practice training?
- How can we help recruit health professionals into our rural communities and what support can we provide to retain them?

Conclusion

This document has grown out of a WHO-Wonca co-sponsored consultation whose focal point was an Invitational Conference held at Traralgon, Australia in April 2002. Although titled an “Action Plan”, it is really a guide or manual from which rural communities can develop their own Action Plans.

Success will occur in a supportive environment of rural friendly policy. Such policy is not restricted to the realm of government, but should include all stakeholders. They must commit themselves to hearing the voice of rural people whether they are the local hospital manager, the nurse at the local health centre, the private doctor or the local government member. They are all community members who can give much to improve the health of their people. In addition, success will be facilitated by removal of bureaucratic restrictions, support for local skills development and avoidance unnecessary duplication with other programs.

Achievement of Health for All Rural People is the goal. Enhanced self-sufficiency, shared vision and development of local partnerships will help rural communities get started. Implementation of a local Action Plan based on this document will help make it happen.

Governments and policy makers at all levels can work with rural communities by collaborating with them on this for the benefit of all rural people.



Photo: Courtesy of Ian Couper

Acknowledgements

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On behalf of all members of the Wonca Working Party on Rural Practice, I would like to thank the HARP committee for all its work in the organization and conduct of the WHO-Wonca Co-sponsored Invitational Conference on Rural Health and their input to this Action Plan. I would also like to acknowledge the major contribution made by the members of the Writing Group in the production of this document.

Special thanks to Di Wyatt and Steve Kirkbright, Monash University School of Rural Health, for the development and production of this document.

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Appendix 1

Summary of Scenarios Presentations

The following are summaries of the Scenarios Presentations made to the WHO-Wonca Invitational Conference in April 2002

Africa/ Europe Project 1: The South African Integrated Sustainable Rural Development Program

Provides an overview of the Integrated Sustainable Rural Health Development Program currently being implemented as part of the change process occurring in South Africa and addresses many of the challenges facing all key stakeholders involved in bring about these changes.

Contact: Dr Tim Wilson
South African Department of Health
email: wilson@health.gov.za

Project 2: The Spanish Rural Health Model

Provides an overview of the changes that have taken place in rural health practice in Spain over the past decade and the introduction of a primary health care system to rural areas, which has brought about improvement in both the health of rural communities and rural practice.

Contact: Dr Luis Garcia Burriel
email: lgarciab@meditex.es

Project 3: The “In Fine Fettle” Project Scotland

Provides an overview of the “In Fine Fettle” program, which is running across the Scottish Borders, trying to prevent heart disease, stroke and cancer by using a wide range of approaches to address a number of risk factors.

Contact: Dr John Gillies
Department of Public Health
email: j.gillies@borders.scot.nhs.uk

Project 4: The Ingwavuma Scholarship Scheme: South Africa

Provides an overview of the unique locally based scholarship scheme that is a partnership between the local community/Department of Education/ Department of Health/private funders and The Friends of Mosold Trust. The ultimate aim of the project is to provide high quality health services to the indigent population of Ingwavuma by the identification, training and support of local students who have the potential to become health care providers.

Contact: Dr Andrew Ross
Mosvold Hospital
email: rossa@nu.ac.za

Middle East South Asia/ Australia

Project 1: The General Practice Training Project in Nepal

Provides an overview of the three year, university based post graduate (Residency) program in General Practice/Family Medicine. The training program was started in 1982 with the first half of the training conducted at the University of Calgary, Canada and the later half in Nepal. By 1992, the entire three-year program was being conducted in various training centers in Nepal. The majority of candidates are working in rural areas of Nepal.

Contact: Dr Shatendra Gupta
Tribhuvan University Teaching Hospital, Nepal
email: skgupta@healthnet.org.np

Project 2: The Safe Motherhood Project: Nepal

Provides an overview of the Safe Motherhood Project being implemented in a number of districts in Nepal. The project aims to bring about sustained increase in utilization of quality midwifery and basic and comprehensive emergency obstetric care.

Contact: Dr Shatendra Gupta
Tribhuvan University Teaching Hospital, Nepal
email: skgupta@healthnet.org.np

Project 3: The Training and Recruitment Project: Pakistan

Provides an overview of the rural health-training program in Pakistan developed to increase the skills of doctors and paramedical staff working in the most isolated rural and remote areas.

Contact: Dr Tariq Aziz
Pakistan Society of Family Physicians
email: psfp@wol.net.pk

Project 4: Rural Communities as Partners in Teaching Rural Health; Australia

Provides an Overview of James Cook University School of Medicine implementation of a community-based model of teaching designed to meet the health needs and workforce needs of northern Australia. The paper describes the development of an eight-week rotation in a rural community.

Contact: Dr Tarun Sen Gupta
James Cook University School of Medicine
email: Tarun.Sengupta@jcu.edu.au

Asia Pacific/ New Zealand

Project 1: Developing Family Medicine in Regions of Extreme Need

Provides an overview of the development of a family medicine project in rural Orissa, one of India's poorest areas and the further development of the model in both Cambodia and Vietnam. The aim of the project was to increase accessibility to health care to a large number of people with minimal set up costs, which would be vital to success and sustainability.

Contact: Dr David Whittet
Waikohu Medical Centre, Te Karaka, Gisborne, New Zealand
email: davidwhittet@xtra.co.nz

Project 2: The Health of Rural Peoples in the Pacific Islands Project: Vanuatu

Provides an overview of the current health care system in Vanuatu and the development of partnerships between Vanuatu and developed countries to address health care issues including the shortage of health care professionals and vital equipment and medicines needed to provide services.

Contact: Dr Derek Allen
Vanuatu Government
email: derekallen@vanuatu.com.vu

Project 3: The Health of Indigenous Peoples Project: New Zealand

Provides an overview of the poor health status of the Maori peoples compared to non-Maori and provides details of the East Coast Ngati Porou project which aims to improve their health status by improvements in the way services are delivered and the development of appropriate choices to Maori clients.

Contact: Dr Iain Hague
email: ihague@enternet.co.nz

Project 4: Towards a Global Immunization Policy

Provides an overview of the development of a childhood immunization protocol in consultation with the local people and traditional health practitioners in Orissa India. This has led to an increase in uptake rates of leprosy vaccination by 65% and an increase in polio immunization by 72% in the project area.

Contact: Dr David Whittet
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North America/ South America

Project 1: Shoulder to Shoulder Project: Honduras

Provides an overview of the Shoulder to Shoulder non-profit partnership between the University of Cincinnati College of Medicine, the City of Cincinnati, the Ministry of Health Honduras and the poor isolated community of Intibuca in the Santa Lucia region of Honduras. During the 11 year of the partnership a 24 hour medical and dental clinic has been built, a feeding program for up to 800 school children per day established, a new water system developed and a range of educational programs implemented.

Contact: Dr Tom Norris
University of Washington School of Medicine
email: tnorris@u.washington.edu

Project 2: The WWAMI Project

Provides an overview of the WWAMI (acronym for Washington, Wyoming, Montana, Idaho) program, which aims to increase the number of generalist physicians in the region. The WWAMI program is a thirty-year success story in training rural primary care physicians.

Contact: Dr Tom Norris
University of Washington School of Medicine
email: tnorris@u.washington.edu

Project 3. Rural Internship Program and Brazilian Family Health

Provides an overview to the Rural Internship introduced to the medical curriculum at the Federal University of Minas Gerais, Brazil in 1978 and its impact on rural health and rural health practice.

Contact: Dr Tom Norris
University of Washington School of Medicine
email: tnorris@u.washington.edu

Project 4: The Alaska Family Practice Residency: A new start curriculum designed for rural and remote practice success

Provides an overview of the Alaska Family Practice Residency, which is a new-start residency and the first and only graduate medical training program in Alaska. This is a collaborative and deliberate effort to critique the evidence of what works in producing successful rural and frontier family physicians and to apply that body of knowledge to the design of a new community based academically affiliated training site.

Contact: Dr Barb Doty
Alaska Family Practice Residency Program
email: bdoty@alaska.net

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