Hauora Taiwhenua Rural Health Network

Rural Wonca
The WONCA Working Party on Rural Practice

21st WONCA World Rural Health Conference NEW ZEALAND

Aotearoa New Zealand Declaration on Rural Health 2026

Nāku te rourou, nāu te rourou, ka ora ai te iwi

With your basket and my basket, the people will thrive

Contents

Executive Summary 2

Ministerial Endorsement 2

Acknowledging the Legacy of Rural WONCA 3

The Heart of Rural Health in Aotearoa New Zealand 3

Rural Proofing Health Systems 4

The Rights of Indigenous Peoples Worldwide to the Highest Standards of Physical and Mental Health 5

Rural WONCA 2026 6

Calling all Rural WONCA Nations to Action 6

Calls to Action for the Government of Aotearoa New Zealand 7

Rural WONCA Working Party: ....

- International Reflections on the Aotearoa Declaration on Rural Health 2026 11
- Our Commitment to Action 12

Glossary | Kupu Māori 14

References 15

Executive Summary

The Aotearoa New Zealand Declaration 2026 is grounded in the presentations of the 21st Rural WONCA Conference at Tākina, Wellington. It joins the lineage of international Rural WONCA declarations that come before, all committed to advancing equitable health care for rural communities worldwide.

This Declaration speaks directly to the lived realities of rural Aotearoa New Zealand. Rural communities, and rural Māori most significantly, experience compounding inequities shaped by rurality, deprivation, and the enduring impact of colonisation. These inequities have been reinforced by decades of health policy and funding decisions made without meaningful rural engagement. Collectively, these factors have created a persistent gap between policy intent and the realities of rural life. The result is health inequity that is serious, measurable, and preventable.

The Declaration commits to influencing policies that are informed by mātauranga Māori, grounded in the principles of Te Tiriti o Waitangi, and recognises that indigenous knowledge and rural experience are essential to equitable health systems. It calls on the government of Aotearoa New Zealand to act across six interconnected subthemes of the conference:

1. promoting equitable rural health care
2. expanding rural health knowledge and research
3. rural health workforce resourcing, funding, recruiting, training and retention
4. effective practices and innovation in rural healthcare and wellness
5. harnessing artificial intelligence and virtual technology to support rural health
6. strengthening rural generalist practice across health professions.

Underpinning the subthemes is a single unifying principle: rural proofing, the deliberate inclusion of rural perspectives, evidence, and impact assessment at every level of health policy, funding, service design and implementation.

The Declaration calls the governments of all Rural WONCA nations to resource, trust, and scale the solutions that have already been developed by rural communities, and to establish the systems required to ensure their sustainability and ongoing improvement.

By working together, rural communities can move from surviving to flourishing.

Ministerial Endorsement

The Associate Minister for Health, Hon Matt Doocey, speaking on behalf of the Minister of Health, Hon Simeon Brown, endorsed the strategic direction set out in the calls to action of the Aotearoa New Zealand Declaration. This endorsement signals Government's commitment to working in partnership with Hauora Taiwhenua to improve health outcomes for rural communities.

Dr Fiona Bolden
Chair, Hauora Taiwhenua Rural Health Network

Dr. Pratyush Kumar
Chair, WONCA Working Party on Rural Practice

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Chair, Te Rōpū Ārahi

Acknowledging the Legacy of Rural WONCA

Nā koutou i whakatakoto te ara, kia taea e mātou te whai

You have laid the path so that we may follow

We acknowledge with deep respect, all those who have carried the kaupapa (philosophy) of rural health forward through the years. This includes the WONCA Working Party for Rural Practice whose early recognition of the crucial role of rural family medicine helped shape landmark global statements including the Bengaluru[1], Ubuntu[2], and Limerick[3] Declarations and the Cairns Consensus on Rural Generalism[4]. These collectively reflect a sustained and collaborative global commitment to improving the health and wellbeing of rural communities.

Rural WONCA 2026 reminded us that how we come together is just as important as what is decided, when we come together. The manaakitanga (generosity) shown throughout our gathering - hosting guests, sharing kai (food) and care for each other - reflect our shared understanding that relationships, respect, and dignity are foundational to effective health systems. These were not symbolic gestures, but expressions of leadership grounded in connection to people and place.

The multi-cultural and diverse strands of this commitment form the foundation upon which the Aotearoa New Zealand Declaration 2026 is woven. Like the weaving of a whāriki (mat for sitting on), the strands represent the collective wisdom, effort, and shared purpose of rural communities, clinicians, researchers and advocates across the globe.

In presenting this Declaration, we honour the legacy of the work that precedes us, while looking boldly to the future. We are guided by the principles of Te Tiriti o Waitangi[5], and affirm the WONCA Working Party vision for Rural Practice[6]:

"Health for All Rural People"

The Heart of Rural Health in Aotearoa New Zealand

Aotearoa New Zealand's strength is deeply rooted in its people, their connection to place, each other, and their community, their resilience and adaptability.

He tangata, he tangata, he tangata

It is the people, it is the people, it is the people

Rural WONCA 2026 reaffirmed that effective health systems are shaped by decisions about power, place, and whose knowledge is trusted. Rural communities expose the fault lines within health systems - access, continuity, equity and trust - and make visible the extent to which the systems are designed with, and for the people.

Aotearoa New Zealand's rural communities comprise approximately 18% of the population (908,034 out of 4,993,710)[7] yet make disproportionately larger contributions to national wellbeing and prosperity. Primary industries including farming, forestry and fishing are largely based in rural areas and generate more than 80% of New Zealand's export earnings[8]. In addition to primary industries, rural populations are also key in servicing the second highest export earner, tourism. In 2025 total tourism expenditure was $46.6 billion dollars and represented 7.7 % of GDP[9]. There is no reliable breakdown of rural vs urban contribution to these figures. Yet, despite this contribution, rural populations bear a disproportionate burden of ill-health and face greater barriers to accessing timely and appropriate healthcare.

Māori comprise approximately 17% of the national population but represent 22% of people living in rural areas. In many rural and remote communities, particularly where traditional iwi or tribal based structures remain strong and Māori land ownership is retained, the proportion of Māori increases to 36%, and in some areas, is as high has 90%[7].

Rural Māori experience the most profound health inequities, reflecting the combined impacts of socio-economic deprivation, rurality and the enduring effects of colonisation. Life expectancy at birth for Māori is 7 years lower than for non-Māori. Rural Māori experience 7% higher all-cause mortality and 13% higher amenable mortality than Māori living in urban areas. Those under the age of 30 are twice as likely to die from a preventable cause as their counterparts living in a large cities[10].

These inequities reflect decades of systemic underinvestment, policy settings that prioritise population-based funding models and financial efficiency over place-based need. Health policy and service design has failed to adequately account for rural context, geographic distance, workforce realities, or the importance of relationships in delivering health care.

Rural Proofing Health Systems

Too often health policies and implementation plans are developed with positive intent but without authentic engagement with rural communities or a clear understanding of the lived realities of rural life. This tendency, often described as "geographical narcissism"[11] or "urbansplaining"[12], frequently results in solutions that are poorly aligned with rural contexts and conditions.

The most effective way to address this unconscious bias is to ensure that rural people, and most especially, rural Māori, are meaningfully involved from the earliest stages of policy development, service design, implementation and evaluation. Therefore, this Declaration advocates for the systematic rural proofing of national health policies, strategies, and programmes as an essential mechanism for addressing persistent rural health inequities worldwide.

We support the efforts of the World Health Organization, in partnership with Rural WONCA and other international stakeholders, to develop a Technical Rural Proofing Tool[13] that will guide countries in embedding rurality into their health systems. We look forward to the completion of this work and its application in Aotearoa New Zealand and across the globe.

The government of Aotearoa New Zealand is recognised internationally for making progress towards rural proofing government policy including within the health system. This intent was expressed in 2018 through the publication by the Ministry for Primary Industries, of rural proofing guidance for government[14]. However, variable awareness of this resource, and uptake of it, means that continued advocacy is needed to ensure policies are developed and implemented in ways that effectively respond to the needs of rural populations.

Sustained advocacy by Hauora Taiwhenua resulted in the recognition of rural communities as a priority population in the Healthy Futures (Pae Ora) Act 2022[15]. This established the mandate for a dedicated Minister for Rural Health, the development of a Rural Strategy and associated Health NZ action plans. Collectively, these developments are beginning to make a positive contribution to a more rurally responsive health system.

Since July 2022, Aotearoa New Zealand has had the Geographic Classification for Health (GCH) [16] a nationally agreed definition for urban and rural populations for health purposes. Together with legislative commitments and supporting policy frameworks, the GCH is beginning to embed rurality into health system analysis and decision-making. Rural health outcomes are becoming more visible and measurable alongside other equity dimensions such as ethnicity, age, gender, and disability. Further work is required to identify ongoing gaps, strengthen monitoring and ensure accountability of Government funders and service providers.

Despite these advances, evidence of improved health and wellbeing outcomes, particularly for rural Māori, remains limited. This underscores the need to move beyond foundational frameworks toward implementation strategies that prioritise the health needs of people living and working in rural Aotearoa New Zealand. Rural proofing is not only a technical process, but an ethical commitment to shared authority, sustained relationships, and accountability to rural communities.

The Rights of Indigenous Peoples Worldwide to the Highest Standards of Physical and Mental Health

Despite their vital contribution to cultural heritage, environmental stewardship, and economic stability, rural indigenous peoples worldwide experience some of the most severe and persistent health inequities.

The 76th World Health Assembly reaffirmed the right of indigenous people to the highest attainable standards of physical and mental health[17]. Realising this right in practice requires coordinated global action. Rural WONCA plays a pivotal role in supporting both collective and country level efforts to uphold indigenous peoples' rights to self-determination, and to empower communities to lead decisions about their health and wellbeing[18].

Across Rural WONCA 2026, indigenous leaders made it clear that when health systems fail indigenous communities, the failure is not one of culture or capability, but of structures that lack political courage and exclude indigenous authority from decision making.

Rural WONCA 2026

Attendees of Rural WONCA 2026 were presented with compelling evidence of persistent rural health disparities - disparities that are particularly pronounced among rural Māori in Aotearoa New Zealand and indigenous peoples in rural communities worldwide.

Across the six Rural WONCA 2026 Conference sub-themes[18], delegates shared a wide range of innovative responses, case studies demonstrating how rural communities have been able to flourish, and programmes that have successfully grown and retained rural health workforces. These included examples of iwi-led initiatives where mātauranga Māori (Māori knowledge) and traditional family medicine have been integrated to improve health journeys and outcomes for both Māori and non-Māori living in rural and remote areas.

What is currently lacking are the enabling conditions - policy settings, funding mechanisms, regulatory flexibility, and political courage - to trust, sustain and scale what rural and indigenous communities are already doing well. This challenge was echoed by delegates from other countries where rurally led solutions are already in place, but policy settings, systems and resourcing needed to support broader implementation remain limited.

Six Subthemes of Rural WONCA 2026:

1. Promoting equitable rural health care.
2. Expanding knowledge and research that grows rural health and integrated health care in rural areas.
3. Rural health workforce resourcing, funding, recruiting, training and retention.
4. Effective practices and innovations in rural healthcare and wellness.
5. Harnessing artificial intelligence and virtual technology to effectively support rural health.
6. Enhancing rural generalism across professions to provide more effective rural health teams

Calling all Rural WONCA Nations to Action

The Aotearoa New Zealand Declaration 2026 calls on the governments of all Rural WONCA nations to commit to actions that enable their rural communities and rural health practitioners to co-design and implement solutions that support rural communities to thrive.

Rural WONCA 2026 affirmed that rural and indigenous communities are not waiting to be ‘fixed’. They are already leading, innovating, and sustaining solutions grounded in place, relationships and continuity. This Declaration therefore moves beyond rhetoric, calling on governments to resource and trust these solutions, and accept the responsibility, and perceived risk, required to pursue equity.

The enduring legacy of this will be measured not by its words, but by the changes it enables: changes in who is trusted, how decisions are made, and where the authority to act sits.

Calls to Action for the Government of Aotearoa New Zealand to Achieve Pae Ora for Rural Communities

Drawing on international and local research, case studies and models of health and wellbeing practice, Rural WONCA 2026 explored six sub-themes relevant to rural health and agreed a set of priority actions essential to achieving Pae Ora for rural communities.

Rural WONCA 2026 calls on the Government of Aotearoa New Zealand to commit to, and implement these priorities to support progress towards healthy, resilient, and productive rural communities.

1. Promoting Equitable Rural Health Care

The agreed issue:

People living in rural communities in Aotearoa New Zealand, and rural Māori in particular, experience some of the poorest health outcomes of any population group, across a range of health measures. Addressing this inequity is essential to achieving Pae Ora / Healthy Futures for all New Zealanders and requires targeted, system wide action.

The priority actions for Government:

1.1 Require all Health NZ and Ministry of Health datasets, including provider level reporting, to be capable of disaggregation by both GCH and ethnicity.

1.2 Ensure all Health NZ health targets, quarterly and annual health reports include analysis and comparison by GCH and ethnicity.

1.3 Complete the review of *He Korowai Oranga*[20] so that the refreshed Māori Health Strategy clearly identifies rural Māori as a priority population and includes an action plan with evidence informed targets and measurable equity outcomes.

1.4 Ensure iwi-led services are sustainably funded with outcomes evaluated in culturally appropriate ways.

2. Expanding Rural Knowledge and Research

The agreed issues:

Progress in measuring, monitoring and improving rural health depends on access to high quality academic research. However, funding for rural health research is often difficult to access, limiting the generation of evidence, innovation and the development of effective evidence based solutions.

Funding for rurally focussed health education programmes is also limited and considerably diminished by institutional 'top slicing'. This undermines programme viability, teaching capacity, and opportunities to benefit the health of rural communities.

The priority actions for Government:

2.1 Require the Health Research Council to prioritise a minimum of 20% of its total funding allocation for research projects that are explicitly focussed on rural health.

2.2 Require that at least 95% of funding allocated to rural health education programmes is spent directly within the rural communities in which the programmes are delivered.

3. Rural Health Resourcing, Funding, Recruiting, Training and Retention

The agreed issues:

Rural health services, including primary care and rural hospitals, are underfunded, placing many of these services at ongoing risk of financial instability and closure.

The rural health workforce is also significantly depleted with no cohesive long-term strategy to attract, educate, train and retain health professionals.

The priority actions for Government:

3.1 Develop a *Rural Health Services Framework* that ensures rural communities have equitable access to high quality services and diagnostic capabilities as close to home as practicable, while accounting for geographic distance and the availability of nearby services.

3.2 Ensure capitation and other rural funding formulas accurately reflect the higher operational costs faced by rural practices, the broader scope of services required to meet needs, and increased use of these services that results from limited locally available alternatives.

3.3 Ensure rural hospitals are funded at a level that enables them to deliver the range and quality of services agreed for their communities.

3.4 Review and revise the National Travel Assistance Scheme[20] to ensure people living in rural areas can access essential health services located outside their communities without experiencing financial hardship.

3.5 Require Treasury, or a suitably qualified independent body, to undertake a comparative analysis of government health expenditure per capita across communities, with reporting disaggregated by GCH and ethnicity.

3.6 Require all health profession regulatory bodies to collect health workforce data using the GCH for each practitioner's primary workplace and usual place of residence as part of their Annual Practicing Certificate renewal process.

3.7 Develop and implement a comprehensive and sustainably resourced, *Rural Health Workforce Plan*, informed by GCH analysed workforce data, that enables rurally led initiatives across workforce attraction, education, recruitment, training, and retention.

3.8 Rural proof the design of, and appropriately fund, four regional rural training hubs or networks, building on existing community led and locally established initiatives that are already supporting rural learners. These hubs should be located in places where there is demonstrated educational and academic activity, clinical capacity, and leadership. These hubs or networks will:

- Strengthen and coordinate existing pathways to attract and support students from rural communities to pursue health related studies.

- Provide protected full time equivalent allocations for clinical staff to undertake teaching, supervision, and research roles.
- Enable participation by students from a range of health professions.
- Support regular interprofessional learning through multidisciplinary team based practice in rural settings.
- Encourage collaboration across multiple education and training institutes, locality focussed organisations, iwi and rural communities.

4. Effective Practices and Innovation in Rural Healthcare and Wellness

The agreed issues:
Rural health services are well placed to design and implement innovative, community led solutions that respond effectively to local needs. However, limited access to support, protected time and dedicated resources constrains the ability of providers to develop, test, and sustain these innovations.

Rural communities are disproportionately impacted by extreme weather events, climate change and natural disasters. Emergency management legislation and plans do not adequately recognise the critical role of rural health and disability services in readiness, response and recovery planning.

The priority actions for Government:

4.1 Leverage Health NZ's implementation of the Remote Urgent Care service to establish approximately 70 rural, community led, integrated health systems. These should incorporate rongoā Māori, ambulance services, primary care, rural hospitals, and digital health solutions, delivered through authentic partnerships between Health NZ, general practice, community providers and iwi led health services.

4.2 Prototype three all-of-community primary care service models in which rural general practice, rural hospitals, kaupapa Māori providers and other community based services are bulk funded to deliver agreed, outcomes focussed services.

4.3 Require rural proofing to be applied to the National Emergency Management Plan, all CDEM Group Emergency Management Plans, and all hazard-specific plans.

4.4 Require all National Emergency Management Committees and Civil Defence Emergency Management (CDEM) Coordinating Executive Groups to each include at least one formally appointed rural health and disability representative.

5. Harnessing Artificial Intelligence and Virtual Technology to Support Rural Health

The agreed issues:
In the context of ongoing rural workforce shortages and significant constraints on local access to specialist services, digital health solutions (including artificial intelligence and virtual technologies) offer opportunities to improve access to care and support clinical decision making. These technologies must complement and support the existing rural health workforce, rather than replace

it, and be accompanied by investment in training and supporting the people delivering care in time constrained rural primary care settings.

The priority actions for Government

5.1 Require Health NZ to ensure that at least 20% of their digital health initiatives within the HealthX Programme are specifically focused on interventions that support rural primary care.

5.2 Require Health NZ supports and funds the implementation of the Rural Digital Health Workplan[22] to ensure rural communities and providers have access to reliable data, appropriate digital tools and devices and the skills to effectively engage with digital health solutions.

6. Strengthening Rural Generalist Practice Across Health Professions

The agreed issues:

Aotearoa New Zealand has made important progress in developing rural generalist capability across a range of health professions including general practice, rural hospital medicine and midwifery. Established programmes such as the Division of Rural Hospital Medicine make a significant contribution to rural generalist capability within hospital care and supports broad scope, context responsive practice across rural and remote settings.

However, this expertise is not yet consistently enabled across all health professions, nor integrated at a system level. Variability in funding models, regulatory and credentialing settings, workforce planning and service configuration can constrain the ability of rural generalist teams to work to their full scope and consistently meet community needs. Greater alignment and coordination are required to support integrated, multidisciplinary rural health teams and to ensure that rural communities can reliably benefit from the full range of existing rural generalist expertise.

The priority actions for Government

6.1 Initiate a sector-led, co-designed process to strengthen and expand rural generalist programmes and pathways across all health professions. The process should leverage multidisciplinary rural generalist expertise, and align to the Cairns Consensus[4], to develop an interprofessional *Rural Generalist Framework* that connects existing pathways, addresses systemic barriers, and supports integrated, team based care tailored to the needs of rural and remote communities.

6.2 Strengthen and sustain rural generalist training by funding a Royal New Zealand College of General Practice Rural Fellowship pathway that complements and aligns with existing rural hospital and community based generalist programmes.

6.3 Fund a rural-sector review of curricula and registration requirements across a range of selected health kaimahi (workers) with the purpose of enabling extended scopes of practice, reducing regulatory barriers, and supporting multidisciplinary rural generalist teams.

Rural WONCA Working Party:
International Reflections on the Aotearoa Declaration on Rural Health 2026

While the context of Aotearoa offers unique wisdom and direction, the disparities faced by rural populations here mirror a shared, global reality. Across diverse geographies, from remote island nations to vast continental interiors, rural communities navigate a complex web of compounding challenges, which uniquely and disproportionately impact global Indigenous and First Nations populations, as well as women and children. Today's global rural health landscape is increasingly strained by critical health workforce shortages, the disproportionate impacts of climate change, and the dual burden of aging populations alongside rising rates of non-communicable and infectious diseases.

At the heart of addressing these universal challenges is the discipline of Family Medicine, operating synergistically within a robust multidisciplinary team framework. Comprehensive, community-based primary care - delivered through the collective expertise of rural generalists and family physicians alongside nurses, allied health professionals, midwives, Indigenous practitioners, community health workers, and others - remains the most effective and resilient bedrock for rural health systems worldwide. We recognize that in rural contexts, isolated practice cannot meet the complex needs of our populations; equitable care demands fully integrated, collaborative teams working at the top of their scopes. This collaborative model embraces the principle of "nothing about us without us," recognizing that rural communities are not passive recipients of healthcare, but deeply resourceful co-creators of their own health and vital members of the care team.

Furthermore, we must confront the escalating crisis of planetary health, which disproportionately endangers rural communities. Because rural economies are frequently inextricably linked to agriculture and natural ecosystems, shifting climate patterns bring immediate threats of food and water insecurity, economic destabilization, and the rapid spread of emerging infectious diseases. Rural health systems are often the first to face the brunt of these environmental shifts, yet they remain the least resourced to adapt. Addressing rural health today inherently requires acknowledging that the well-being of our patients is inseparable from the health of the land and environments they inhabit.

Equally pressing are the accelerating impacts of digital divide and the silent crisis of practitioner burnout. While rapid advancements in telemedicine hold the potential to bridge vast geographic distances, they risk deepening disparities if rural infrastructure, such as reliable broadband and digital literacy, is left behind. Concurrently, the chronic maldistribution of the global health workforce places an unsustainable burden on the few who serve in isolated areas. True progress demands that we not only invest in equitable technological infrastructure but also prioritize the mental health, fair compensation, and holistic well-being of rural healthcare professionals. We cannot sustain healthy communities without sustaining the healers who serve them.

As we navigate this digital divide, we must also proactively engage with the transformative rise of Artificial Intelligence (AI). In rural health, AI holds the unprecedented potential to "lift the floor" of global equity, democratizing access to world-class diagnostic support and multi- specialty advanced knowledge for the most isolated practitioners. However, to harness this power without causing harm or widening existing disparities, we must rapidly adapt how we train our workforce. Rather than focusing solely on the retention of vast medical knowledge, which AI models can now readily access, rural health professionals must master critical "horizontal skills." This means developing clinical judgment to ask AI the right questions, critical thinking to rigorously evaluate its outputs, and the wisdom to use it as an aid to thinking rather than a replacement for it. As AI assumes more technical and analytical tasks, the future of rural practice will lean heavily into our shared humanity. The core of rural family medicine will be reliant on distinctly human competencies: deep empathy, compassion, cultural humility, and the nuanced, relationship-based care that no algorithm can ever replicate.

The profound impacts of global instability also echo deeply within these rural landscapes. Whether facing the sudden, escalating devastation of natural disasters or the enduring fragility brought about by human conflict and war, rural populations frequently find themselves at the most vulnerable, under-resourced edges of functioning health systems. True health equity and human flourishing remain fundamentally unattainable in the absence of peace. During times of crisis, the inherent resilience of rural communities is severely tested, underscoring an urgent global responsibility to protect these populations and safeguard their healthcare infrastructure from the ravages of instability.

Our Commitment to Action

To weave a stronger global safety net, our response must move beyond shared declarations into unified structural support. Recognizing that true advocacy requires demonstrable implementation, we ensure that we preach what we practice. The Rural WONCA commits to the following strategic pillars to drive worldwide equity:

- **Establishing GRACE (Global Rural Health Action Collaboration and Excellence):** We recognize that isolated efforts cannot solve systemic global issues. GRACE will serve as our premier platform for international partnership, uniting rural health professionals, policymakers, and community advocates. Through GRACE, we will facilitate cross-border mentorship, share evidence-based policy solutions, and mobilize collective action to ensure rural voices shape global health agendas.
- **Advocating for the "Rural Proofing" of Health Policy:** Acknowledging that rural populations are too often an afterthought in systemic planning, we commit to fiercely advocating for the "rural proofing" of all national and international health policies. We will work to ensure that global health frameworks are proactively evaluated for their impact on rural areas *before* implementation, embedding rural equity directly into the foundation of health governance.

- **Launching the Rural Health Institute of Learning:** Geographic isolation should never mean professional isolation. To support the continuous development of the rural workforce and nurture the next generation of healers, we are establishing a dedicated Institute of Learning. This initiative will provide accessible, highly relevant, and constantly updated medical education tailored specifically for rural health professionals, with a strong emphasis on supporting medical students, trainees, and early-career practitioners. Crucially, the Institute will pioneer curricula that shift away from rote memorization and toward the "horizontal skills" necessary for the AI era—teaching practitioners how to ethically and safely integrate AI as a clinical co-pilot, while doubling down on the irreplaceable human art of compassionate, community-centered care. By democratizing access to high-quality training and clinical updates, we empower rural practitioners to deliver exceptional, cutting-edge care regardless of their global coordinates.

By sharing our innovations and resources through these localized and global mechanisms, we strive to build a resilient worldwide rural health workforce capable of weathering both entrenched disparities and unprecedented global shocks.

Dr. Pratyush Kumar
Chair, WONCA Working Party on Rural Practice

Glossary | Kupu Māori

This glossary provides a list of key te reo Māori terms used in this Declaration

Hauora	Health or wellbeing (holistic balance of body, mind, family, and spirit)
Iwi	Tribe or people (extended kinship group with shared ancestry)
Kai	Food
Kaimahi	Someone who does the work – recognizing everyone who contributes including both unregulated (e.g volunteers, kaiawhina, and whānau carers) and regulated (e.g nurses allied health, doctors) workforce
Kaupapa	Purpose, theme, or guiding principle (foundation of an approach or plan)
Māori	Indigenous people of Aotearoa New Zealand (the tangata whenua with unique language, culture, and tikanga)
Mātauranga	Knowledge or wisdom (especially traditional or cultural understanding)
Ora	Life, health, or wellbeing (safe, thriving state)
Rongoā	Traditional healing or medicine (remedy using plants, spiritual practices)
Rourou	Basket (symbolizing individual contribution to collective wellbeing)
Taiwhenua	Rural or land-based (countryside, regional/rural health context)
Tangata	People or person (humans in a relational, cultural sense)
Te ao	The world (as in te ao Māori: the Māori world or worldview)
Tiriti	Treaty (short for Te Tiriti o Waitangi, Aotearoa New Zealand's founding agreement)
Whāriki	Woven mat (metaphor for foundation, groundwork, or supportive base)
Whakataukī	Proverb, saying, or ancestral proverb (short phrase conveying wisdom, values, or life lessons)
Whenua	Land or placenta (symbolizing deep connection to birthplace, ancestry, and environment)

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