21st WONCA World Rural Health Conference

ABSTRACT BOOK

Supplementary Document to Conference Report

Contacts:

Dr Fiona Bolden, Chair Hauora Taiwhenua and Chair Conference Organisation Committee

Dr GrantDavidson, Chief Executive, Hauora Taiwhenua

Email: conference@htrhn.org.nz

8

From Systemic Gaps to Whānau-Centred Solutions: Advancing Equity in Breast Screening

Dr Kara Ackerman[1]
[1]Hauraki Primary Health Organisation

The 2022 Quality Improvement Review of BreastScreen Aotearoa (BSA) highlighted persistent inequities in breast cancer outcomes and access for Māori and Pacific women. In response, a Primary Health Organisation (PHO) piloted the Breast Screening Hospital Touchpoints Initiative in 2024 across Thames/Hauraki/Coromandel. Funded by BSA, the initiative aimed to engage unscreened, under screened and unenrolled Māori, Pacific and rural women through hospital admissions, outpatient clinics, and community settings. Health navigators using the Whiri Model of Care with remote clinical oversight, facilitated access to breast screening and offered an electronic health needs assessment to connect women with services addressing broader health needs. Grounded in Te Tiriti o Waitangi and PHO values—Pono (honesty), Manaakitanga (generosity), Whanaungatanga (relationships), and Kotahitanga (unity)—the initiative prioritised whakawhanaungatanga, fostering authentic relationships.

Of the women screened, 52% were Māori, 75% lived in areas of high deprivation, and 31% had not screened in over four years. Many faced challenges such as caregiving, grief, unstable employment, and transport barriers, often deprioritising their own health. The initiative’s relational, culturally grounded approach resonated deeply, with women describing the service as “like coming home to family.”

The Whiri model improved screening uptake and broader health engagement, demonstrating its effectiveness in achieving equity for Māori while meeting the needs of all women. Women across ethnicities praised the warmth of staff, preferring the fixed rural mammography unit to mobile options. This presentation shares insights from the pilot and highlights the potential of culturally responsive, whānau/family-centred care models to transform screening programmes and reduce health disparities.

161

Rural 360: Strengthening rural research capacity through a community-engaged model in Canada

Dr. Shabnam Asghari[1], Dr. Tayebeh Sohrabi[1], Dr. Wendy Graham, Dr. Cheri Bethune[1], Emily Hussey[1]
[1]Memorial University, [2]Memorial University

Background: Rural physicians and communities in Newfoundland and Labrador, Canada face significant barriers to engaging in health research due to geographic, resource, and structural challenges. Rural 360, led by Memorial University’s Centre for Rural Health Studies, addresses these gaps by supporting community-based, equity-focused research initiatives led by rural practitioners and researchers.

Methods: Rural 360 offers a structured pathway from research idea to knowledge mobilization, beginning with 6for6 - a research and writing skills development program designed to support rural physicians in developing and leading their own research projects. Projects are supported through funding, mentorship, community partnership, and student engagement. An implementation science framework guides process evaluations, emphasizing Indigenous engagement, social accountability, and rural-specific relevance.

Results: Since 2014, 6for6 has supported 44 physician-led research projects and engaged over 62 students and postdoctoral fellows. Projects have addressed tuberculosis care in Indigenous communities, emergency services access, breastfeeding, and group medical appointments for Indigenous people. Research outcomes have informed local healthcare policy, enhanced practitioner research skills, and strengthened academic-community collaboration.

Conclusions: Rural 360 demonstrates a sustainable, replicable model for community-engaged rural health research. By embedding equity, relevance, community engagement and innovation at its core, the program enhances rural physicians’ capacity to generate locally grounded evidence and improve healthcare delivery in real time. As it evolves into a Learning HealthCare Community, Rural 360 offers valuable lessons for advancing rural health systems worldwide.

331

Partnering with Patients to Improve Rural Emergency Department Care

Prof Shabnam Asghari[1], Anna Walsh[1], Aswathy Manukumar[1], Dr. Chris Patey[1], Paul Norman[1], Dr. Holly Echegary[1], Dorothy Senior[1], Helia Mahdavian[1], Jacqueline Fewer[1], Jennifer Bent[1], Parsa Abdi[1]

[1]Centre for Rural Health Studies, Faculty of Medicine, Memorial University of Newfoundland

Background: Emergency care in rural Canada is challenged by limited resources, workforce shortages, and geographic distance. These barriers shape the safety, respect, and timely responsiveness that patients experience in emergency departments (EDs). Engaging individuals with lived experience offers an opportunity to identify equitable priorities for improvement and generate contextually relevant knowledge for strengthening rural health systems.

Aim: To involve patient research partners (PRPs) in exploring emergency department experiences in rural settings and to identify priorities for enhancing care.

Methods :A patient-oriented mixed-methods design was employed. PRPs were recruited at project initiation, representing diverse communities and backgrounds, including rural, Indigenous, seniors, young people, invisible minorities, and different genders. They contributed to all stages of the research, from the development of questions and instruments to the interpretation and dissemination of results. Experiences of ED care were captured through survey and follow-up semi-structured interviews with patients who visited select EDs in Newfoundland and Labrador, Canada. Thematic analysis was conducted on open-ended survey and interview data, with PRPs contributing to the interpretation to ensure findings reflected lived experience and rural priorities.

Results: Thematic analysis of 1449 surveys and 34 interviews highlighted consistent concerns across EDs. Key themes included ED environment, patient-centered care, wait times, access to care, system issues, and safety. PRPs confirmed these themes captured patient priorities for ED care and provided contextually relevant perspectives.

Conclusion: Strengthening emergency services in rural regions requires attention beyond resource allocation. PRP-led ED changes are essential to build respectful spaces, effective communication, and equitable care.

30

Consequenses of differences in availability of out of hours care in a rural county

Gry Berntzen[1]
[1]Karlsoy Komune

In the rural areas of Norway all out of hours care is also being done by the same doctors as in the daytime. I work in a small fishing community, with the lowest degree of centrality as defined by the Norwegian Bureau of Statistics. In my county we have two main island with the approximately same population. The island with the city hall gets two to four doctors working Monday to Friday, with the other island having only one doctor three days a week. The assumption is that people will travel to the other island if they need an appointment. During out -of -hours the doctor will travel to where the patients are. I looked at the number of out of hours contacts to see if this difference in availability of working -hour appointments resulted in an increased use of the out- of hours services. I found that the island with the best daytime services also was the one that used the out- of- hours service the most. The island with the worst availability had a significantly higher number of red and orange responses compared to the main island. My conclusion is that limited availability of daytime service is not compensated with increases in use of after- hour services.

134

Rural Medicine - a distinct academic discipline? a NZ perspective

A/Prof Katharina Blattner[1,2], Dr Lynne Clay[1], Dr Rory Miller[1], Prof Garry Nixon[1]
[1]Rural Health Research Network, Centre for Rural Health, Otago University , [2]Hauora Hokianga

Background: Medical specialty fields rely on clinical and academic pathways to grow the evidence base and translate it into practice. This clinical-academic nexus should be no different for Rural Medicine.

In Aotearoa NZ (NZ), despite poorer health outcomes for people living in rural areas, particularly Māori, the academic field of Rural Medicine remains underdeveloped with a relative lack of academic capacity and leadership.

This study examined, at the postgraduate level, the development of Rural Medicine in NZ, its current position and future opportunities.

Methods: A narrative review of published NZ literature was undertaken. Qualitative interviews exploring perspectives of key stakeholders (including academics, graduates, trainees and university and professional college leaders). A descriptive rapid analysis qualitative methodology. Consultation with the Ngāi Tahu Research Consultation Committee.

Results: Rural Medicine sustainability enablers included: rural specific, flexible and joined-up training pathways; intertwined clinical and academic education: and embeddedness in rural context and communities. Sustainability challenges included: recognition; urban centric systems and structures; professional and academic organisational culture, and career progression options.

While rural targeted postgraduate pathways form a partial solution for growth, a more comprehensive set of strategies is needed to elevate the academic field of Rural Medicine in NZ and recognise its value in rural health equity.

Conclusions: Rural Medicine in NZ remains widely unrecognised as an academic discipline Findings inform an actionable framework to grow the discipline and foster rural academic activity and expertise based in rural health services and rural communities across NZ.

47

Te Tai Poutini: Working towards a gold standard in diabetes prevention and care

Jade Breeze[1], Mrs Stephanie Blackman
[1]West Coast Health, [2]West Coast Health

About 2000 people living on Te Tai Poutini (West Coast) have a diabetes diagnosis. Māori, Pacific, Indian, South East Asian and people living in high deprivation areas are disproportionately affected. The West Coast is New Zealand's longest but most sparsely populated region, spanning more than 600km in length with 33,390 people. The rurality of the West Coast is displayed in the GCH classifications: all of the region is classified as R1-3. Additionally, the West Coast has an aging population, are predisposed to food insecurity, the nature of major industries increasing risk of metabolic disease and access to care, and high rates of socioeconomic deprivation.

The aims of this quality improvement project were to investigate the level of service provision, capture the patient and clinician experience, identify gaps in access to care and medication and make recommendations to improve equitable service delivery. A population data and literature review were undertaken, and 22 people with diabetes were interviewed alongside clinicians across all primary practices, Hauora Māori partners, community health workers and secondary care. Themes included: getting through the door, access to treatment, footcare, wellbeing, determinants of health, rurality, continuity of care, cultural safety and clinical capacity. Recommendations are grouped into community, clinical and systemic and encompass prevention, diagnosis and treatment/management.to reflect the complexity that is innovative healthcare in a rural/remote region.

The first recommendation is engaging with stakeholders including Hauora Māori partners to co-design the 0-12 month period post diagnosis. It is expected this will be presented alongside the original project.

389

Exercising sovereignty over our own health

Trudy Brown[1]
[1]Aupouri Ngati Kahu Te Rarawa (ANT) Trust

An Indigenous-Led Response to the GP Crisis in Te Hiku o te Ika

Origins:

ANT Trust was founded in 1985 to support high-needs Māori whānau in Kaitaia excluded from mainstream systems. Its kaupapa centres on equity, tino rangatiratanga, and indigenous models of care grounded in Te Ao Māori. Operating from a whānau-first worldview, ANT draws on manaakitanga and whanaungatanga to restore balance and wellbeing.

Te Hiku o te Ika faces severe GP shortages, leaving many unenrolled whānau without timely primary care. Preventable conditions often reach emergency departments, normalising inequity as systemic.

Present:

Te Whare Oranga o Muriwhenua emerged as a Māori-led response to this crisis. In partnership with the National Hauora Coalition, the service was rapidly established in Kaitaia to provide accessible, culturally responsive care without judgement.

Early impacts include high demand from unenrolled whānau, reduced pressure on Kaitaia Hospital’s emergency department, and pathways to support future general practice enrolment.

Future Aspirations:

Our vision is for indigenous-led solutions to become a standard part of the health system. We aim to grow a sustainable hauora workforce in Te Hiku, invest in kaupapa Māori models of care, and ensure seamless, culturally safe pathways from initial access to ongoing care. System settings must uphold mana motuhake and Te Tiriti o Waitangi, measuring equity through whānau wellbeing rather than service volumes.

Conclusion:

Te Whare Oranga o Muriwhenua demonstrates that indigenous-lead solutions are immediate, effective, and culturally safe. Scaling and properly resourcing these models is essential to realise tino rangatiratanga and advance hauora Māori.

111

A Journey of Integrating Te Ao Māori into Clinical Connect Peer Education

Natalie Clement, Louise Kennedy[1]
[1]Pegasus Health

Clinical Connect is a peer learning programme that reaches primary healthcare clinicians across Aotearoa NZ, embedding Te Ao Māori and equity into clinical education. This session explores how Te Ao Māori principles are woven into the design and delivery of Clinical Connect, fostering culturally responsive and clinically relevant learning.

From the outset, each topic is built with equity considerations at its core ensuring that the needs of Māori and other priority populations are not an afterthought but a foundation. The inclusion of Te Reo Māori within session content and facilitation enriches and normalises its use in clinical education and practice. Chronic conditions such as heart failure and type 2 diabetes are framed using illustrative data that highlights disparities and opportunities for improved care, making the learning both evidence-based and contextually grounded.

We will outline the evolution of Clinical Connect, shaped by continuous feedback, collaborations, and insights from frontline primary healthcare clinicians across Aotearoa.

The session will include examples of how equity is embedded in topic development, how facilitators are supported to deliver content with cultural safety, and how the programme fosters reflective practice and peer accountability.

Attendees will leave with practical insights into designing peer learning that honours Te Tiriti o Waitangi, strengthens clinical capability, and supports equitable outcomes for rural communities.

402

Care Close to Home: A Model of GP Oncology Delivering Cancer Treatment in Remote Northern Canada

Dr Sarah Cook, Dr Shireen Mansouri, Dr Mary MacKenzie, Dr Christine Scott, Dr Zack Bordman

Residents of the Northwest Territories (NWT) of Canada face significant barriers to accessing timely cancer care due to vast distances, harsh climates, limited transportation options, and the predominance of small, mostly Indigenous communities. In response, the territorial health system adopted a GP Oncology model with family physicians (who have undertaken additional oncology training), working alongside specially trained nurses, deliver chemotherapy and immunotherapy in the remote NWT capital city of Yellowknife as a satellite service of a tertiary cancer centre. The program is supported by Medical oncologists at the partner institution determine treatment plans, while the local GP oncologists provide ongoing assessment, toxicity monitoring, and treatment administration closer to home.
This presentation uses a narrative approach to share stories of the impact on patients, as well as sharing data on types of cancers treated, treatment volumes, patient experience, and impacts on travel burden for rural and remote residents. This model has reduced medical travel, maintained high safety and quality standards, and improved continuity of care through strengthened relationships between local providers and predominantly Indigenous communities. The program integrates Indigenous knowledge through a holistic approach and culturally safe care, reflecting longstanding local priorities to keep healing close to land, family, and community.
This model offers an adaptable framework for rural generalist teams internationally. It demonstrates how enhanced-skill family physicians, supported through virtual oncology collaboration, can expand equitable access to cancer care in remote settings while honouring community-led priorities for culturally grounded, locally delivered services.

292

Improving access to blood pressure self-monitoring: A medical centre collaborative approach

Leonie Cowie[1], Dr Michael Loten[2]
[1]Heart Foundation, [2]Raglan Medical Centre

Research shows that early detection of elevated blood pressure and effective control can help prevent the development of cardiovascular complications. At the National Rural Health Conference 2025, the Heart Foundation presented on a pilot programme introducing blood pressure self-monitoring in rural areas and higher-risk community spaces. The initiative aimed to improve access to blood pressure monitoring, educate on correct self-monitoring techniques, empower individuals to actively participate with healthcare professionals in the management of their elevated blood pressure, and raise awareness of hypertension risks. Pilot learnings were disseminated alongside a discussion of implementation challenges. A key gap identified was limited follow-up capacity, in part due to a partnership model that centred on community groups hosting the monitoring device without clinical integration. We are currently in the early implementation phase of a three-month pilot trialling a medical-centre partnership model for blood pressure self-monitoring. Building on positive outcomes from the earlier community-partnership model, this approach aims to strengthen continuity of care through clinical involvement. Our joint presentation will share preliminary evaluation data, reflect on the effectiveness of this strategy, and consider whether the collaboration has addressed previously identified gaps. Specifically, we aim to assess whether integrating blood pressure self-monitoring into clinical settings supports clearer health outcomes for participants, and offers a scalable, practical approach for reducing health inequities in rural communities.

253

The impact of rurality and socio-economic deprivation on Māori:Non-Māori health inequities

Prof Sue Crengle, A/Prof Gabrielle Davie, Brandon de Graaf, Dr Jason Tuhoe, Prof Garry Nixon, Dr Jesse Whitehead, Talis Liepins, Michelle Smith, A/Prof Rory Miller, **Dr Jane Taafaki**

The stark health inequities that exist for Māori have been well documented. Māori are more likely than non-Māori to reside in rural areas. The Geographic Classification for Health (GCH) and NZ Index of Deprivation (NZDep) were used in combination with routinely collected administrative health data and resident population counts from Census 2018 to better understand how Māori:non-Māori health inequities were impacted by deprivation and rurality.

The following indicators were selected:

- General Practice encounters
- Utilisation of secondary care mental health services (45–64-year-old age group)
- Uptake of breast cancer screening
- Avoidable hospital admissions (45–64-year-old age group)

Māori:non-Māori incidence rate ratios (age standardised or stratified as appropriate) were estimated using the most recently available 5-years of data and Poisson regression modelling undertaken to adjust for: 1) sex; 2) sex and GCH; 3) sex and NZDep; and 4) sex, GCH and NZDep. A similar approach has confirmed the persistence of large Māori:non-Māori inequities after adjusting for sex, rurality, and socioeconomic deprivation for all-cause and amenable mortality.

254

Childhood Māori:Non-Māori health inequities; the impact of rurality and socio-economic deprivation

Prof Sue Crengle, Prof Garry Nixon, A/Prof Gabrielle Davie, Dr Jason Tuhoe, Brandon de Graaf, Dr Jesse Whitehead, Talis Liepins, Michelle Smith, **Dr Jane Taafaki**, A/Prof Rory Miller

Stark health inequities exist for Māori, including Māori children. Māori are overall younger than non-Māori and are more likely to reside in rural areas. The rural: urban disparities in amenable mortality rates observed in NZ are more pronounced for younger age groups.
The Geographic Classification for Health (GCH) and NZ Index of Deprivation (NZDep) were used in combination with routinely collected administrative health data and resident population counts from Census 2018 to better understand how Māori:non-Māori health inequities were impacted by deprivation and rurality.
The following indicators were selected:

- Registered with a midwife in the first trimester
- Fully immunised at 2 years of age
- Access to Before School Check
- Healthy weight as measured in the Before School Check.

Māori:non-Māori incidence rate ratios were estimated using the most recently available 5-years of data and Poisson regression modelling undertaken to adjust for: 1) GCH; 2) NZDep; and 3) GCH and NZDep.

130

Mind the Gap: Insights into rural Australians' experiences with oral health care

Dr Fiona Dangerfield[1], Dr Sudheer Babu Balla[2], Dr Stacey Bracksley-O'Grady[1], Associate Professor Virginia Dickson-Swift[1]
[1]Violet Vines Marshman Centre for Rural Health Research, La Trobe University, [2]La Trobe Rural Health School, La Trobe University

Australians living in rural areas experience higher rates of dental caries and preventable hospital admissions for oral health conditions than those in metropolitan areas. Rural Australians have been recognised as a priority group in consecutive national oral health plans. Despite this high burden and limited oral health infrastructure, rural Australians have had few opportunities to contribute to oral health research, leaving important gaps in understanding. This study explored rural health consumers' experiences of accessing and using oral health services.

A cross-sectional online survey was conducted with members of Australia's Rural Health Consumer Panel. Most questions were categorical, collecting quantitative data, with one open-ended question capturing qualitative experiences. Quantitative analysis included descriptive statistics of sociodemographic characteristics and service use. Associations between enabling factors and oral health service utilisation were examined using chi-square tests ($p < 0.05$). Qualitative responses were analysed thematically and grouped into categories.

A total of 139 panel members responded. Respondents were predominantly female (74.5%) with a median age of 61 years. Only 62% had visited an oral health professional in the past 12 months, with most attending a private provider. Private health insurance coverage was associated with more regular check-ups. Reported barriers to oral health care included cost, long wait times, and travel distance.

Rural Australians continue to face significant challenges in accessing oral health services, contributing to low rates of preventative visits. Addressing financial, geographic, and systemic barriers requires innovative service models, equitable health policies, and the active involvement of rural people in developing place-based solutions.

91

Exploring the impact of rurality and socio-economic deprivation on a range of child health outcomes for Māori and non-Māori.

Associate Professor Gabrielle Davie[1], Professor Sue Crengle[3], Professor Garry Nixon[2], Dr Jason Tuhoe[3], Mr Brandon de Graaf[1], Dr Jesse Whitehead[4], Mr Talis Liepins[2], Ms Michelle Smith[2], Dr Rory Miller[2], Dr Jane Taafaki[5]
[1]Department of Preventive and Social Medicine, University of Otago, [2]Centre for Rural Health, University of Otago, [3]Ngāi Tahu Māori Health Research Unit, University of Otago, [4]Te Ngira Institute for Population Research, University of Waikato, [5]Va'a o Tautai Centre for Pacific Health, University of Otago

The Geographic Classification for Health (GCH) and NZ Index of Deprivation (NZDep) were applied to routinely collected administrative health data to better understand how a range of established women and child health indicators vary by rurality and deprivation for both Māori and non-Māori.

The following indicators were selected:

- Registered with a midwife in the first trimester
- Fully immunised at 2 years of age
- Access to Before School Check
- Healthy weight as measured in the before school check.

The most recently available 5-years of data were obtained. Incidence rates of outcomes were obtained using appropriate denominators; most commonly, population estimates. Poisson regression modelling was used to estimate adjusted incident rate ratios that compare the rates of different GCH-NZDep (and where appropriate age) strata. Rates and rate ratios (using the most urban least socioeconomically deprived strata as the reference) were calculated separately for Māori and non-Māori. A similar approach has previously identified a complex pattern of disparities in mortality rates that suggest that ethnicity, deprivation and rurality are all associated with health outcomes.

54

Equity in Palliative Care: The Pōwhiri Model – Returning to the Marae Ātea

National Palliative Care Equity Working Group[1], Jesse Davis[1,2,3]
[1]Health NZ - Te Whatu Ora, [2]PHARMAC - Te Pātaka Whaioranga, [3]The University of Auckland - Waipapa Taumata Rau

Background:
Palliative care in Aotearoa New Zealand continues to deliver inequitable outcomes for Māori, Pacific, rural, and other underserved communities. Systems shaped by Western biomedical models often fail to address cultural, spiritual, and whānau realities, creating barriers to timely, appropriate, and culturally safe care.

Aim:
To present the Equity in Palliative Care Framework and Pōwhiri Model as practical tools for embedding equity into everyday palliative care practice.

Methods/Approach:
Under the Health NZ National Palliative Care Work Programme, the National Palliative Care Equity Working Group, comprising clinicians, researchers, and people from underserved communities, including Māori, Pacific, rural, disabled, and rainbow populations, undertook a framework design process guided by The Voices of Underserved Communities in Palliative Care report. This process identified the need to shift from asking whānau to adapt to rigid systems towards creating spaces where their expertise is central. Drawing on the Māori concept of pōwhiri, the model repositions clinicians as manuhiri (guests) and whānau as haukainga (hosts), encouraging health professionals to step back to the marae ātea, symbolically and practically, to recognise whānau as experts and uphold their mana in the health system.

Results/Outcomes:
Implementation planning is underway, with preparation for integration into rural palliative care services.

Conclusion/Implications:
The Pōwhiri Model provides a culturally grounded framework to address inequities. By repositioning the roles of clinicians and whānau, it embeds cultural safety and supports care that reflects the needs and values of whānau. This presentation invites reflection from rural health professionals and policymakers on the model's applicability within their contexts.

170

Ethical Issues in Tribal Health in India

Dr Mahesh Devnani[1,2], Dr Kritika Upadhyay[2]
[1]AIIMS, [2]PGIMER

Tribal communities make up around 8.6% of India's population and remain among the most disadvantaged groups. Their unique social and cultural practices, combined with long-standing systemic exclusion, create complex ethical challenges in healthcare delivery, research, and governance.

This paper explores the ethical issues faced by tribal populations in India, focusing on health systems, clinical and public health research, and broader questions of social justice. A review of literature was carried out using peer-reviewed articles, government reports, and policy documents published over the past two decades. Key themes were synthesized to identify recurring patterns of ethical concern.

The review reveals a wide spectrum of ethical challenges. Persistent inequities in healthcare access and the absence of culturally sensitive services undermine fairness and equity. Research with tribal groups is often complicated by barriers to informed consent, language differences, and risks of exploitation when benefits are not shared fairly. Issues such as displacement, loss of resources, and weak representation in governance structures threaten both autonomy and rights. Friction between traditional healing systems and modern medical care also complicates ethical practice. Structural discrimination, inadequate policy attention, and limited community participation further entrench vulnerability.

Addressing these challenges requires ethical frameworks that are responsive to context and grounded in respect, justice, and beneficence. Strengthening community participation, building cultural competence into health systems, and promoting inclusive governance are essential. Clear ethical guidelines tailored to tribal contexts are needed to balance development priorities with the protection of identity, autonomy, and wellbeing.

20

Community perspectives on access, knowledge, and behaviours influencing oral health in rural Australia

A/Prof Virginia Dickson-Swift[1], Ms Dorothy McLaren[1,2], Dr Hamid Ghaderi[1,3], Dr. Stacey Bracksley-O'Grady[1], Dr. Babu Balla Sudheer[1]
[1]Violet Vines Marshman Centre For Rural Health Research, La Trobe University, [2]West Wimmera Health Services , [3]South Australia Dental

Like many rural towns across the globe, communities within the West Wimmera Health Service (WWHS) catchment in rural Victoria, Australia experience poorer oral health outcomes compared to their metropolitan counterparts. To address this, WWHS health promotion team have been working with researchers at the Violet Vines Marshman Centre for Rural Health Research (VVMCRHR) to improve oral health outcomes.

The aim of this presentation is to provide an overview of the work undertaken to date, including oral health profiles, community priority setting activities and a comprehensive oral health survey to explore community oral health knowledge, behaviour and attitudes.

Key results from the community oral health profiles demonstrated poorer oral health status compared to those living in cities (and the state averages). Results of the community-based priority setting activity involving 70 community members identified more dental services and development of community-based oral health promotion programs as key areas for action. The cross-sectional survey (n=282) demonstrated a lack of knowledge and understanding in key areas including water fluoridation status, tooth brushing, and dental visiting. Survey respondents also offered a range of ideas to address access issues for oral health services.

Working in partnership with health service providers and local communities and involving them in research activities can enable a better understanding of community knowledge and behaviours and identify gaps. This knowledge can be used to develop place-based oral health promotion strategies that meet the needs of rural people and address current oral health inequities.

221

Niho Ora ki Hauraki: Breaking barriers to oral health care in Hauraki

Amaru Donaldson[1,2], Dr Elizabeth Becker[1,4]
[1]Te Tara o Te Whai, [2]Te Puna Hauora Matua o Hauraki - Hauraki PHO, [3]National Public Health Service, [4]Te Whatu Ora - Health New Zealand

In 2023 Te Tara o Te Whai recognised that staying well and staying closer to home was a key priority for the community. Access to oral health services was identified as an area where people encountered significant challenges and the community called for substantial initiatives that would help address the spectrum of unmet oral health need. In response, Te Tara o Te Whai developed Niho Ora ki Hauraki.

Niho Ora ki Hauraki aimed to improve access to, and the experience of, oral health services for people aged over 19 years, living within rural and remote areas of pare Hauraki. Through multiagency collaborative effort, the team successfully delivered whānau centred, mobile oral health assessment and treatment services to 458 eligible people over 18 months. A mobile van with dental chairs and a care team consisting of dentists, dental assistants, and kaimanaaki visited sites in Thames, Paeroa, Waihi, Kaiaua, Coromandel and Manaia for 2-4 weeks at a time. The initiative also integrated broader hauora support and introduced workforce development pathways for local kaimahi.

Niho Ora ki Hauraki successfully improved access to dental care, whilst also highlighting the effectiveness of kaupapa Māori approaches to creating healthcare environments that are accessible, safe, and supportive. It strengthened local relationships, normalised positive oral health practices, and empowered whānau with mana motuhake in their hauora journey. The outcomes of Niho Ora ki Hauraki provide an evidence base from which to build future models of oral health care for rural communities.

207

Models of care / Indigenous-led program innovation

Mike Edmonds[1], Michelle Meenagh[2], Dr Adrian Wilson
[1]Raglan Medical, [2]Te Toi Ora ki Whaingaroa

The COVID-19 pandemic in Aotearoa New Zealand highlighted the inequities of rural health access, particularly in Raglan/Whaingaroa, where Māori communities already faced barriers to timely, culturally safe care. In response, Raglan Medical, Te Toi Ora ki Whaingaroa (Waikato Tainui Koiora Pikonga i"wi health service"), and Pinnacle PHO co-developed an integrated outreach clinic model to bring primary care, hauora services, and outreach specialists directly into the community. This model was grounded in kaupapa Māori principles of whakawhanaungatanga (relationship building), mana motuhake (self-determination), and holistic approaches to wellbeing.

A collaborative design process with iwi and hapū leaders ensured the service reflected indigenous health knowledge alongside biomedical frameworks. Delivery included mobile clinics, community marae-based hubs, and wraparound social and mental health supports. Implementation was flexible, digital-enabled, and driven by cross-sector workforce collaboration.

Between 2020 and 2025, the model enhanced equitable access to care, particularly for rural Māori whānau who had previously deferred or avoided health services. This approach also upskilled rural clinicians in culturally responsive practice and demonstrated effective resource-sharing across rural health networks.

The Raglan integrated outreach clinic model offers globally relevant lessons on how indigenous knowledge can shape innovative rural service design. It provides a scalable framework for addressing rural inequities by embedding cultural partnership, flexibility, and interdisciplinary collaboration into primary care delivery.

This indigenous-led, community-rooted model illustrates a practical pathway toward equitable rural health care that is transferable across settings. It highlights the vital role of indigenous-led leadership and partnership in achieving resilient, integrated health systems.

https://www.youtube.com/watch?v=OzxXlYGMesE

186

Optimising longer-term training for General Practitioners in rural Aboriginal Medical Services across Australia.

Dr Patrick Giddings[1,2], **Prof Belinda Osullivan**, Associate Professor Matthew McGrail[4], Professor Marlene Drysdale[1], Mr Veeraja Uppal[1], Dr David Baker[1]
[1]Remote Vocational Training Scheme(RVTS) Ltd., [2]University of New South Wales , [3]Monash University School of Rural Health, [4]University of Queensland

First Nations communities rely on continuity of healthcare providers for culturally responsive, trusted services. However general practice(GP) training in Aboriginal Medical Services (AMSs) is often characterised by short-term placements. Optimising longer-term training is vital.

Since 2013, a national GP training program has provided 3–4 years of continuous training in rural AMSs, using remote supervision and distance education due to limited local GP supervisors. Staff insights, evaluation data, and stakeholder feedback highlight its impact.

The AMS training stream accounts for 20% of enrolments(n=71) in the program. Training is delivered through online resources, webinars, peer groups, and twice-yearly workshops, alongside regular case discussions and direct observation with supervisors. Local cultural mentors provide ongoing support for culturally safe practice. Recruitment targets candidates who are safe to practice without onsite supervision and able to learn reflectively.

By November 2023, 36 registrars had completed 3–4 years of AMS-based training and all achieved specialist qualifications in General Practice while 14 remained in training. However, 21 withdrew (30%), double the wider program rate (15%), with most AMS withdrawals after year two. Despite this, long-term retention is stronger: 80% of fellows trained in AMSs remained in the same community two years post-completion, compared with 49% from non-AMS sites.

Qualitative findings emphasise the community benefits of end-to-end training, including long-term culturally appropriate care. This model shows that end-to-end GP training in AMSs is achievable providing workforce continuity that contributes to improving health outcomes in First Nations settings.

369

Cut off from Cancer Care? Exploration of access to cancer care after Cyclone Gabrielle in the Hawke’s Bay Region

A/Prof Lesley Gray[1], Dr Carlton Irving[2]
[1]University Of Otago, [2]Health Quality and Safety Commission

The continued functionality of health services is critical in the immediate aftermath of and recovery from a disaster. The aim of this study was to identify what if any issues were encountered in relation to cancer care for rural residents following the extensive damage caused by Cyclone Gabrielle on the East Coast of Aotearoa New Zealand (NZ) in 2023.

This was a mixed methods study involving a desk based assessment of services available in the region, followed by qualitative semi structured interviews with cancer service providers, stakeholders and people who utilise cancer services.

The experiences of rurally based people who were not hospital in-patients at the time of the disaster were documented and key issues identified.

While emergency planning guidance is available in NZ), this tends to be hospital focused with little intersection between rural communities, hospital based and/or peripatetic services. Inclusion of disaster preparedness information for rural cancer service users is vital at the start of any part of the care journey to minimise additional stress relating unknowns associated with continuation of care plans, especially when roading and communication channels are disrupted, and people have to evacuate from their homes. People who experience inequities before a disaster are likely to face compounded inequities following a disaster and this is no different for cancer service users. To ensure health equity for rural dwelling cancer service users, specific planning needs to occur before any disaster event and planning needs to include services, users and support organisations.

180

Policy Transition at the Margins: Local and Decolonial Perspectives on Taiwan’s Shift in Healthcare Delivery model for Remote Indigenous Communities

Mrs Kalesekes Kaciljaan[1], Dr Ta-Chun Hua[2,3]
[1]National Chi Nan University, [2]University of Auckland, [3]Puli Christian Hospital

The delivery of healthcare to remote Indigenous communities in Taiwan has long been constrained by environmental, socioeconomic, and political barriers rooted in colonization. To address inequities that persisted despite the universal National Health Insurance (NHI), the National Health Insurance Administration (NHIA) launched the Integrated Delivery System (IDS) in 1999. IDS incentivized regional hospitals to serve mountainous and outlying island divisions through subsidies tied to service volume and quality, now covering 31 of 55 Indigenous regions. While IDS increased service provision and reported high nominal satisfaction, critics argued it overemphasized medical services without addressing Indigenous living realities. In response, the NHIA initiated a phased transition to the Integrated Holistic Care Program in 2024, following a successful 2022 trial in Xiulin Township. This new program shifts attention toward health promotion and case management to improve equity.

Guided by decolonizing policy analysis frameworks, this study compared IDS and the Integrated Holistic Care Program through the lens of Indigenous rights, agency, and self-determination. The analysis found that, despite new efforts to collect localized health data and adopt broader evaluation indicators, the programs remained largely medicalized and driven by top-down agendas. This left little scope to address social and colonial determinants of health or to enable meaningful Indigenous participation and decision-making. Future reforms should embed Indigenous voices more fully in health governance so that programs move beyond service delivery to genuinely recognize sovereignty and the lived realities of Indigenous communities.

310

Bridging the Gap: A Rural Health Equity Model from India

Dr Roshni Jhan Ganguly[1]
[1]Project Setu Foundation Trust

Rural populations in low- and middle-income countries often face inequities in access to primary health care. Contributing factors include geographic isolation, financial barriers, low health literacy, and limited continuity of services. These social determinants of health result in delayed diagnosis, poor management of chronic illness, and preventable morbidity. This presentation examines an Indian rural health initiative that seeks to address these inequities through an integrated, community-based model.

The programme combines regular health camps, doorstep surveys and screening, referral linkages, and structured follow-up supported by affordable diagnostic and pharmacy access. By situating services within communities, the model reduces the burden of travel and cost while simultaneously building trust and engagement. Preventive care, and health education are embedded to address upstream determinants of health. Early observations indicate improved uptake of preventive services, greater adherence to chronic disease follow-up, and strengthened community participation.

In the context of health equity, the model demonstrates three important dimensions: first, enhancing access for populations historically excluded from timely care; second, applying proportionate universalism by prioritising disadvantaged groups; and third, addressing social determinants alongside medical needs. These features enable the delivery of equitable care rather than uniform care, ensuring resources are targeted where they are most needed.

This presentation will discuss the structure, implementation, and preliminary outcomes of the initiative, highlighting its relevance as a replicable model for other rural settings. It illustrates how bridging gaps in primary health services can reduce inequity and support more sustainable rural health systems worldwide.

179

The hidden burden of type 2 diabetes in rural and Māori communities is masked by a lack of routine monitoring

A/Prof Lynne Chepulis[1], Dr Sara Mustafa[1], Dr Rawiri Keenan[1], A/Prof Ryan Paul[1,2], Dr Jo Scott-Jones[3], Dr Allan Moffitt[4], Prof Ross Lawrenson
[1]Division of Health, University Of Waikato, [2]Waikato Regional Diabetes Service, Te Whatu Ora, [3]Pinnacle Midlands Health Network, [4]Procare Primary Healthcare Organisation

Introduction: Rural communities in Aotearoa often have disadvantages with accessing diabetes care (travel challenges, limited specialist services and rural workforce shortages) which can increase risks of complications. For Māori who already carry a higher burden of type 2 diabetes (T2D), these barriers risk widening inequities. Despite this, our understanding of T2D management in rural versus urban clinics is limited.

Methods: Primary care clinical and sociodemographic data from 56,937 adults with T2D in Auckland/Waikato regions were analysed. Clinical outcomes included laboratory tests and clinical measures (2021-2023) and were compared between rural and urban groups, including by logistic regression, adjusting for clinic and practice variables. Rurality was defined at practice level using the Geographic Classification for Health 2018 (GCH2018).

Results: Whilst mean HbA1c was lower for rural patients (60.6 ± 18.8 vs 61.6± 18.3 mmol/mol for urban clinics), the percent of patients with no HbA1c testing was higher (11.0% vs 9.4%; $P < 0.001$), and rural patients had lower rates of clinically-indicated prescribing of metformin (72.5% vs 79.1%), statins (54.4% vs 61.2%), ACE inhibitors/ARBs (75.2% vs 80.5%) and SGLT2i/GLP1RA (45.3% vs 46.2%; all $P < 0.01$), even after adjustment for other factors. Missed testing of HbA1c (13.6% vs 9.8%), eGFR (20.2% vs 13.8%) and UACR (39.7% vs 37.9%) were higher in rural Māori vs rural non-Māori (all $P < 0.001$)

Discussion: Lower rates of laboratory testing in rural areas may mask the actual burden of T2D complications, particularly for Māori. Addressing gaps in routine monitoring is critical for improving equitable outcomes.

177

Highlighting rural inequities in the prevalence of cardiovascular risk assessment screening and stroke/myocardial infarction: a review of primary care data

A/Prof Lynne Chepulis[1], Dr Christopher Mayo[2], Dr Jo Scott-Jones[3], Dr Jesse Whitehead[4], Dr Rawiri Keenan, Prof Ross Lawrenson[1]
[1]Division of Health, University of Waikato, [2]Department of Mathematics and Computing, University of Waikato, [3]Pinnacle Primary Healthcare Organisation, [4]Te Ngira Institute for Population Health, University of Waiakto

Background: Cardiovascular risk assessment (CVRA) screening is essential to ensure that risk factors can be detected and managed early. This study evaluates whether CVRA screening and rates of stroke / myocardial infarction (MI) differ by rurality across the Te Manawa Taki (Midland) region of New Zealand.

Methods: Data were sourced from Pinnacle primary healthcare organisation (enrolled population 441,389; CVRA eligible population 158,041; April 2025). Eligible CVRA screening and stroke/MI were evaluated using univariate and logistic regression analyses, adjusting for demographic factors. Patient-level rurality was coded as U1, U2, R1 and R2/R3 according to the geographical classification of health.

Results: Overall, 78.2% of eligible patients completed CVRA screening. Rates of screening were lowest in R2/R3 communities for all ethnic groups (overall 73.6% vs R1 81.2%, U2 81.4% and U1 76.1%; $P < 0.001$), with lowest rates of R2/R3 CVRA screening seen for Asian (54.8%) Pacific (57.0%) and Māori (70.9%), compared to European patients (75.7%; $P < 0.001$). Prevalence of stroke and MI were both highest in R2/R3 communities (stroke: 3.4% vs 2.6-3.1%; and MI: 4.1% vs 3.4-3.9% for U1/U2/R1; both $P < 0.001$) with Maori dying earlier. In regression, lower rates of CVRA screening were associated with R2/R3 rurality, younger age, Asian and Māori ethnicity and higher deprivation. Higher prevalence of stroke/MI associated with increased age, Māori ethnicity and increased deprivation but not rurality.

Conclusions: There is disparity in CVRA screening across rural/remote communities with concomitantly higher rates of cardiovascular disease. Targeted programs are required to increase screening in these regions.

393

14th EURIPA Rural Health Forum ‘Wittenberg Statement 2025’: Advancing a Rural Reformation in European Healthcare

Prof Joyce Kenkre[1,4], Dr Alexander Bauer[2], Dr Miriam Dolan[3,4], Mrs Jane Randall-Smith[4], Dr Rebecca Payne[4,5], Dr Manuela Castanheira[4,6]
[1]University of South Wales, [2]Martin-Luther-Universität Halle-Wittenberg, [3]Queen's University, [4]EURIPA, [5]University of Oxford, [6]Local Health unit of Trás-os-Montes and Alto Douro /Municipality of Vila Puoca de Aguiar

The Wittenberg Statement 2025 was accepted by all delegates of the 14th EURIPA Rural Health Forum, in Wittenberg, Germany. It is both a call to action and a roadmap for transformation. Drawing inspiration from the historical Reformation as a metaphor for structural transformation. Just as the 16th-century movement led by Martin Luthor it challenges centralised authority, democratises access to knowledge, and empowers local actors. The Statement advocates for a revision of healthcare policy and wider systems to focus on the health and well-being of rural populations across Europe.

This Statement is underpinned by the conviction that equitable healthcare cannot be achieved without recognising the distinct needs, strengths, and contributions of rural communities.

The core themes, derived from cross-national dialogue amongst delegates which included rural health professionals, researchers, and system thinkers, articulate a contemporary vision for reform:

- Decentralisation and local authority
- Translation of knowledge into practice
- Empowerment of the rural frontline healthcare practitioners and community-centred practice
- Increased research activity
- Strategic use of technology
- Redefining norms of excellence
- Moral imperative and social justice
- Sustained commitment to rural health reform
- Legacy-oriented Reform
- Building alliances around shared values
- One Health

The Wittenberg Statement 2025 affirms that rural communities do not seek exceptional treatment, but demand equitable recognition, structural investment, and sustained partnership. This Statement invites all stakeholders to participate in shaping a future healthcare that is inclusive, evidence-based, and responsive to the voices of those who live in and who serve rural communities.

108

Advancing medical education in rural and remote settings in Australia: Prioritising equity, sovereignty, place, and community

Prof James Smith[1,2,3], A/Prof Emma Kennedy[1,2], Dr Christophe Jackson[1,2,4], Professor Jaqui Hughes[1,2]
[1]Flinders Health & Medical Research Institute, Flinders University, [2]College of Medicine and Public Health, Flinders University, [3]Curtis Center for Health Services Research and Innovation, University of Michigan, [4]Division of Physician Assistant Studies, Shenandoah University

The advancement of medical education in rural and remote settings requires a transformational shift in Australia, particularly for the benefit of Aboriginal and Torres Strait Islander communities. We know that rural and remote communities often have poorer access to health and social services, and insufficient physical infrastructure to support health and wellness when compared to many urban communities. Such concerns about health care access, lack of infrastructure, geographically dispersed populations, poverty, and an insufficient and under-equipped health and medical workforce often result in preventable health and social inequalities, which demand an equity-focused response. Addressing rural and remote medical education issues requires an appreciation of the complexity of systems, agencies, and regional factors to build a capable medical workforce through culturally-responsive and contextually-relevant education, training, and professional development. In this presentation, we draw on contemporary research and evaluation data to argue that bold, evidence-based, and catalytic strategies are required to advance and safeguard rural and remote medical education and training into the future. We highlight four key strategies, which include: explicitly addressing health inequities; recognising sovereignty to advance First Nations health and wellbeing outcomes; prioritising place-based approaches; and building on community strengths. We will discuss practical solutions aligned to each of these key strategies to encourage scholars, clinicians, and civil society to monitor, evaluate and research the implementation of their activities. This will help to guide future action in academic medicine relating to rural and remote medical education in Australia, particularly the advancement of Aboriginal and Torres Strait Islander health outcomes.

341

Virtual Health Service Use Among Aboriginal and Torres Strait Islander Adults with Chronic Diseases: Patterns and Associated factors

Dr Rezwanul Haque[1], Dr. Bushra Nasir[1], Mr. Floyd Leedie[2], Dr. Mathew McGrail[4], Dr. Khorshed Alam[3], Professor Katharine Wallis[5], Dr. Annika Luebbe[1], A/Prof Srinivas Kondalsamy Chennakesavan
[1]The University Of Queensland, [2]Goondir Aboriginal Health Services (AHS), [3]The University of Southern Queensland, [4]The University Queensland, [5]Mayne Academy of General Practice, The University Queensland

Virtual Health Services (VHS) represent a promising approach to address healthcare access barriers in regional, rural and remote Aboriginal and Torres Strait Islander (hereafter respectfully termed as Indigenous) communities. However, limited evidence exists regarding usage patterns and factors influencing engagement with these technologies among Indigenous populations with chronic diseases. This cross-sectional study examined VHS device usage among 74 Indigenous consenting adults with chronic conditions receiving care through an Aboriginal Community Controlled Health Organisation across regional, rural and remote Southeast Queensland. Participants completed surveys assessing usage of four Bluetooth-compatible monitoring devices (pulse oximeter, blood glucose monitor, blood pressure monitor, wireless weight scale) over a two-week period. Binary logistic regression models identified factors associated with active device engagement, defined as using at least one device during the recall period. Sixty-four percent of participants were classified as active users. Among active users, blood pressure monitoring showed highest engagement (97.9%), followed by weight scale (91.1%), blood glucose monitoring (89.1%), and oximeter (87.2%). Geographic remoteness emerged as the strongest predictor of VHS engagement, with participants in Small rural towns/Remote/Very remote communities having 74% lower odds of engagement compared to those living Regional/Medium rural town (adjusted OR=0.26, 95% CI: 0.07-0.87, p=0.03). Age was also significant, with participants aged 66+ years showing reduced engagement (adjusted OR=0.33, 95% CI: 0.11-1.02, p=0.05). Individual chronic conditions did not predict condition-specific device usage. Geographic remoteness and older age significantly influence VHS engagement, suggesting successful implementation requires tailored support strategies addressing digital infrastructure, technical assistance, and age-appropriate training to ensure equitable access.

242

Rural but Not Rural: Health Infrastructure Lessons from the Southern Lakes

Dr Jez Leftley[1]
[1]Te Whatu Ora Southern, [2]Southern Lakes Healthcare Trust, [3]Pivotal Point Charitable Trust

The Southern Lakes Region of Aotearoa, New Zealand, highlights the challenge of defining what “rural health” means in rapidly growing communities. Rural in service configuration, but urban in demand. On an average day, the region accommodates more than 100,000 people, spread across multiple towns and a wide geography, yet health services remain configured as if it were still a small rural district. This mismatch creates both inequity and fragility.

Lakes District Hospital, built in 1988 for 4,500 residents, has a small emergency department and only 12 inpatient beds. While typical for a rural hospital, it is now overwhelmed by the scale and volatility of demand created by rapid growth and visitor numbers. Dunstan Hospital provides inpatient and outpatient services, but no ED. Wānaka, the country’s fastest-growing town, has no free-to-access urgent care or public hospital. Across the region, urgent and specialist care depend on weather-sensitive transfers to Dunedin and Invercargill, which are often blocked. In such a dispersed landscape, a single road closure or grounded helicopter can leave communities without access to care.

Clinical services planning for the region creates an opportunity to rethink how rural services are designed. To succeed, it must be grounded not only in population reality and geography but also in Te Ao Māori perspectives and community voice. This presentation will outline principles for aligning infrastructure, workforce, and resilience, while inviting participants to reflect on challenges in their own areas. The lesson is global: rural health planning must not follow yesterday’s definitions, but anticipate tomorrow’s needs.

378

From Words to Action: Advancing Indigenous and Climate Health Through Purposeful Action

Sarah Lowden[1], David Amaya, Dr Ojistoh Horn
[1]Canadian Medical Association

In 2024, the Canadian Medical Association issued a formal apology to Indigenous Peoples and committed to reconciliation through an action plan. Yet reconciliation cannot be realized through acknowledgment alone – it requires skills, tools, and purposeful action. Many health providers and organizations are well-intentioned but struggle with how to operationalize reconciliation, particularly at the intersection of Indigenous health and the global climate crisis.

Grounded in Indigenous-led priorities, his interactive workshop will highlight practical approaches to move toward action. Participants will explore three case studies: (1) how decolonizing funding strategies can act as a catalyst for Indigenous-led climate and health action (2) how Indigenous Knowledge is driving health policy and legislative change impacting rural communities (3) culturally relevant, principles-based approaches to measurement and evaluation at the intersect of climate and health. Together, these case studies illustrate how reconciliation, Indigenous-led climate action, and funding strategies align to strengthen community health.

Participants will learn how to apply Indigenous frameworks of knowledge in climate-health initiatives and reflect on how to advance reconciliation in their own contexts, emphasizing the physician's role as care provider, advocate, collaborator, and ally. The session will also share practical tools, inviting discussion on resources to support family physicians and multisectoral health actors.

By centering Indigenous leadership, this workshop aims to deepen understanding of how climate, health and reconciliation are interwoven, and how family physicians can take steps to strengthen community health and resilience, no matter their background or practice setting.

335

The New Zealand Health Story: Advancing the Rural Health Strategy for better health outcomes

Helen MacGregor[1], Susa Robertson Burns
[1]Ministry Of Health | Manatū Hauora

New Zealand’s healthcare system has evolved to better address the unique challenges faced by rural communities, which account for nearly 19% of the population. Māori make up a higher proportion of those living in these areas: while around one in five people in the general population live rurally, one in four Māori do so, meaning a greater proportion of Māori experience these distinct rural challenges.

This presentation explores how Rural Proofing—ensuring rural perspectives are embedded in health policy and planning—has become an important mechanism for improving health outcomes in these communities.

The talk outlines historical and current health disparities experienced by rural populations, including rural Māori, and examines how the Pae Ora (Healthy Futures) Act 2022 and the Rural Health Strategy have created a legislative mandate to prioritise rural health. It highlights the need for policy frameworks that reflect the realities of rural life, including geographic isolation, limited access to services, and the intersection of rurality with ethnicity and deprivation.

Examples of rural-proofed initiatives are discussed, including telehealth, mobile services, and community-led models co-designed with Māori. These innovations demonstrate how culturally responsive, locally tailored solutions can improve access and equity for rural whānau.

Achieving hauora (health and wellbeing) outcomes in Aotearoa’s rural areas requires a deep understanding of the unique challenges faced by these communities, and the importance of coordinated action between government agencies and Māori communities. Prioritising equity within rural health strategies is crucial for building an inclusive and effective health system that benefits everyone.

200

A Mobile Operating Theatre Model for Enhancing Paediatric Dental Access and Rural Healthcare Capability

Tim Mackay[1], Ms Kelly Ewen
[1]Mobile Health Group

Rural communities in New Zealand face significant barriers to accessing specialised healthcare services, particularly for paediatric dental procedures requiring a general anaesthetic. This presentation outlines a pioneering initiative using a mobile operating theatre to deliver general anaesthetic dental care directly to rural communities in New Zealand. The model prioritises equity and access, addressing specific community challenges such as transportation, communication, especially within Māori, and socio-economically deprived communities.

A key component of our approach is the synergistic integration of local staff, including Kaiawhina and Filipino nurses, who provide a single point of contact to build trust and reassurance, helping to facilitate care for children who may not have otherwise presented. This proactive engagement is critical, as demonstrated by a recent case of one child who required 11 dental extractions.

Beyond clinical delivery, the project creates a powerful opportunity for hands-on, multidisciplinary teaching. The mobile environment fosters a collaborative peri-operative process from admission to discharge, enabling rural nurses, allied health, and medical staff to gain exposure to paediatric airway and crisis management. The day-long general anesthetic lists dental provides, gives an unique platform for on-site education and information sharing. This model not only enhances patient outcomes but also significantly strengthens the capability of the local healthcare workforce.

88

A health system response to addressing rural health inequities

Ms Jane Kinsey, Ms Laura Aileone, Mr Phillip Wheble, Dr Brendan Marshall

Rural communities face persistent health inequities due to isolation, access barriers, deprivation, demographics, and ethnicity. Urban-centric funding and planning models often fail in rural contexts, leading to unstable services and poorer outcomes.

A key challenge is building resilient, integrated, high-performing service models. Workforce shortages—due to vacancies, illness, unplanned leave, or redeployment—can destabilise services, especially in small rural teams.

We explore solutions including:

Ecosystem planning: Building collaborative teams across organisational boundaries and funding streams.
Alliance working: Partnering across the system to enable innovative service models.
Community Hubs: Multi-agency hubs that support integrated care and whānau-centred support.
Rural Generalism pathways: Training and employing health practitioners with generalist and advanced skills tailored to rural needs.
An integrated and coordinated response can deliver sustainable, equitable outcomes for whānau.

Key elements for true integration:

Commit to a common purpose: Enable community and cross-sector coalitions grounded in lived experience and local context.
Foster high-trust relationships: Centre equity and use culturally led processes to build strong relational foundations.
Clarify roles and accountabilities: Transparency is essential for collaborative, equity-driven delivery.
Ensure the kaupapa is contextually relevant and resilient: Use feedback mechanisms and collaboratively developed measures that are meaningful to whānau, kaimahi, and communities.

These elements support action-oriented implementation. We will discuss the challenges and opportunities in embedding them into rural health systems.

66

Rural is not just urban with trees and some animals: Rethinking planning and measurement in rural health systems

Mr Phil Wheble[1], Mr Tom DeKoning
[1]Te Whatu Ora. Te Tai O Poutini

Rural health is often misunderstood through an urban lens—scaled down, simplified, or assumed to be the same but with fewer people and more paddocks. This presentation challenges that assumption, arguing that rural is fundamentally different—not just in geography, but in relationships, resourcefulness, and rhythm.

Drawing on experiences from rural Aotearoa New Zealand, this talk explores how planning and measurement frameworks must be tailored to reflect rural realities. Standard urban metrics often fail to capture what matters in rural settings: continuity of care, community trust, interprofessional collaboration, and the ability to work across scopes and systems.

We will examine how rural generalism offers a model for integrated, context-responsive care, and how data collection and evaluation must evolve to support—not distort—rural innovation. The presentation will highlight examples where rural communities have led planning processes, defined success on their own terms, and built systems that reflect their values and needs.

By reframing rural not as a deficit but as a distinct strength, we can better support workforce development, service design, and policy that honours the complexity and capability of rural practice. Attendees will leave with practical insights into how to advocate for rural-specific planning and measurement, and how to resist the temptation to urbanise rural health.

75

Te Haupapa kohatu Mōtītī. A kaumātua program based on Mōtītī Island, a remote Island challenged with equitable access to healthcare.

Krystal Masoe[1]
[1]Ngāti Kahu Hauora

Mōtītī Island, a remote Māori community located 21kms from Tauranga(which can only be reached by a 20 min plane ride or a 1-hour boat ride)where 90% of residents are aged 55 years or older, experiences disproportionately high rates of long-term conditions. In March 2025, the Kaumātua Program was established to address prevention, early detection, and self-management of chronic diseases using a culturally grounded Te Ao Māori (Māori worldview) framework. Guided by tikanga Māori (Māori customs) and underpinned by whānau-centred principles, the program integrates health education, screening, early diagnosis, and whānau empowerment, with a focus on conditions including diabetes, hypertension, dementia, gout, heart failure, and social isolation.

Co-designed in partnership with local kaumātua, whānau, and healthcare providers, the program delivers monthly wānanga (sessions) combining interactive activities, guest speakers, and goal-setting to strengthen both physical and mental wellbeing. Over five months, 22 kaumātua, representing approximately 90% of the eligible population participated actively. Screening outcomes showed 75% received diabetes checks (10% requiring follow-up) and 82% underwent hypertension screening (15% elevated). Sixty percent reported improved self-management, 70% gained confidence in managing their health, 98% experienced reduced social isolation, and 50% reported enhanced mental wellbeing.

Qualitative feedback underscored the program’s engaging, relational, and inspiring nature, affirming the centrality of relationships and cultural connectedness to health outcomes. This practice innovation illustrates the power of embedding Indigenous knowledge systems and community-led approaches in rural health initiatives, offering a replicable model that advances health equity and holistically addresses the cultural, clinical, and social determinants of wellbeing & prosperity.

372

Strengthening Infectious Disease Response in Rural Central Africa under Climate Stress and Fragility

Ella Mbombo Kabeya[1], Mr Ada Ntumba Kashala[1], Mr Nathan Nathan Tuzolani[2], Eng. Shaloom Mbambu Kabeya[3], Dr Ghislain Mutombo[4]
[1]ASEAD, [2]Institut Superieur Pedagogique de Dula, [3]Institut Superieur des Techniques Appliquees, [4]Ministry of Public Health

Climate change is intensifying health risks in fragile regions of Central Africa, particularly the Democratic Republic of Congo (DRC). Weak health systems, recurrent conflict, and limited infrastructure leave rural populations highly vulnerable to both rising infectious disease threats and climate shocks such as floods, food insecurity, and displacement. Despite global recognition of the need for climate-adapted health systems, practical strategies remain scarce, especially in conflict-affected, low-resource areas where disease burdens and climate impacts converge.

This work presents a guideline designed to strengthen infectious disease response in rural Central Africa through climate-oriented approaches. The guideline was developed by reviewing existing adaptation frameworks, assessing infectious disease drivers, and integrating context-specific factors such as fragile infrastructure, pathogen hazards, population exposure & vulnerability, and antibacterial resistance.

By addressing both infectious disease risks and the structural weaknesses of fragile health systems, the guideline provides a practical pathway for enhancing climate resilience. It offers targeted strategies for improving surveillance, preparedness, and response capacities in rural settings.

This contribution is innovative in its explicit focus on fragile, conflict-affected contexts and its integration of multiple aspects of infectious disease risk into a single adaptation tool. Implementing this approach can help mitigate vulnerabilities, protect existing health gains, and sustain progress regional and global health goals.

101

Expanded Practice for Rural Midwives: Enhancing Equity in Aotearoa

Robyn Mcdougal[3], Shelley Tweedie[1,2], Violet Clapham[3], Shanti Daellenbach[4]
[1]Ngāti Maniapoto, [2]Health NZ | Te Whatu Ora - Te Tai Tokerau Northern Region, [3]NZ College of Midwives, [4]Midwifery and Maternity Providers Organisation

Background: Rural whānau in Aotearoa face inequitable access to aspects of maternity care due to limited rural services, long travel distances and wait times to access urban based services. The 2024 expansion of the Midwifery Scope of Practice enables midwifery-led solutions to these inequities through the provision of additional care to serve community need. Expanded midwifery practice strengthens rural communities by increasing access to localised, responsive care from midwives who are deeply connected to their communities and reducing reliance on specialist services.

Objective: To present developments in rural midwifery practice that improve equity of access and outcomes for rural communities.

Innovation: Rural midwives are currently pioneering expanded practice implementation across five key areas to address service gaps: (1) point-of-care early pregnancy ultrasound, (2) early medical abortion services, (3) long-acting reversible contraception, (4) partner prescribing for sexually transmitted infections, 5) delivery of antenatal vaccinations.

Expanded practice models require the development of training pathways, supported by organisational and interprofessional collaboration at national, regional and community levels to ensure successful implementation and sustainability. Rural midwives, midwifery-led birthing centres and Hauora Māori providers are increasingly being acknowledged as central to the delivery of comprehensive reproductive health and maternity services.

Impact: Updates from across these five areas will be reported, highlighting improvements in timely access to care, reductions in travel burden, empowerment of rural communities and alleviation of pressure on other parts of the health system. Examples will be shared of successful collaborations including initiatives that integrate mātauranga Māori with contemporary clinical skills.

273

Strengthening Rural Care: Community-Led Pathways for Advancing Gender-Affirming Healthcare in Aotearoa New Zealand

Dr Katie McMenamin[1]
[1]Health And Research Collaborative (HARC)

Background: Transgender and gender diverse (TGD) people in rural regions often face barriers to timely, affirming healthcare. Yet rural communities also hold unique strengths—close connections, trusted relationships, and innovative ways of working—that can be built on to improve care. This study explored healthcare experiences of TGD people, their whānau (family), and primary care clinicians in the Whanganui region of Aotearoa New Zealand.

Methods: Guided by an asset-based, culturally grounded approach, we interviewed TGD people, whānau, and local clinicians to understand what is working well in gender-affirming care (GAC) and where improvements could further strengthen safe, mana-enhancing (empowering) support.

Results: Participants highlighted how community organisations like Pride Whanganui, supportive whānau, and committed local clinicians already provide critical foundations of support. They also identified areas where services could be strengthened—including clearer pathways, more affirming mental health support, and ongoing clinician education. These insights shaped the “Whanganui Model of Care,” a rural, community-informed framework built around Structure, Support, and Services.

Conclusion: Rural communities are well placed to lead innovative, equity-driven solutions. The Whanganui model demonstrates how building on community strengths, iwi leadership, and clinician commitment can create a more affirming, culturally safe system of care for TGD people and their whānau. This framework offers a positive, transferable approach for other rural regions in Aotearoa and internationally seeking to close equity gaps while strengthening local practice.

131

Rural–urban differences in cardiovascular disease mortality and cardiac service utilisation: An observational study.

A/Prof Rory Miller[1], Professor Garry Nixon, Professor Sue Crengle, Associate Professor Gabrielle Davie, Dr. Jesse Whitehead, Mr Brandon De Graaf, Dr Mayanna Lund
[1]University Of Otago

Background and aim: Rural communities in Aotearoa New Zealand have higher cardiovascular disease (CVD) mortality but lower CVD hospitalisation rates than urban areas. Rural Māori communities are disproportionately affected. This study aimed to examine cardiac disease outcomes and utilisation rates comparing rural and urban areas to better understand previously identified unmet need.

Methods: This retrospective observational study analysed national datasets (2014-2019) examining rural-urban differences in CVD mortality, cardiac hospitalisations, procedures, and outpatient utilisation. The Geographic Classification for Health categorised patients into rural/urban areas. Age-standardised incidence rate ratios (ASIRR) were calculated using U1 as reference for Māori and non-Māori separately.

Results: CVD mortality increased with rurality for Māori, particularly in R3 areas (ASIRR 1.67 versus U1 Māori). Māori aged <55 in R3 had nearly three times the ischaemic heart disease mortality of urban Māori <55 (IRR 2.93). Heart failure hospitalisation rates were lower for rural populations (Māori R2: ASIRR 0.85 versus Māori U1; non-Māori R3: ASIRR 0.25 versus non-Māori U1). Cardiac procedure rates were similar across areas, except lower pacemaker placement and electrophysiology procedures for rural versus urban Māori. Cardiology and cardiothoracic outpatient appointments were offered at substantially lower rates for rural and U2 populations, though missed appointment rates were lower for rural residents.

Conclusions: Rural communities, particularly Māori, experience higher cardiovascular mortality despite similar or lower hospitalisation and procedure rates and receive fewer specialist appointments. This suggests significant unmet need. Targeted interventions addressing access barriers and cultural safety are urgently needed to reduce these inequities.

70

Pou Ora | Pillars of Health: a reimagined way of delivering primary care that's equitable, innovative, and built to last.

Marama Buck[1], Jess Morgan-French
[1]Collaborative Aotearoa

The Health Care Home model of care has been reviewed and reimagined to meet the evolving needs of the primary care sector in Aotearoa. Pou Ora | Pillars of Health is the new model of care developed by Collaborative Aotearoa and was launched April 2025.

Anchored in the values of whānau-centred care and equity, Pou Ora | Pillars of Health offers a refreshed foundation to support primary care services in delivering high-quality, sustainable, and integrated services that reflect the needs of diverse communities within Aotearoa.

The model enhances access by prioritising urgent, unplanned care, ensuring patients receive the right care at the right time while reducing pressure on clinical teams. Proactive and preventative care empowers practices to intervene earlier and manage long-term health needs more effectively.

Kaimahi wellbeing and workforce sustainability sit at the heart of the model, promoting environments where teams can deliver care with renewed purpose and joy. The integration of technology as a key enabler streamlines care delivery, improves equity through digital inclusion, and supports data-informed decision-making. The model also fosters financial and service sustainability, equipping practices with practical tools to enhance both outcomes and efficiency.

Crucially, Pou Ora | Pillars of Health elevates the importance of partnerships supporting collaborative, cross-sector approaches that advance health equity and whole-of-system transformation.

This session will introduce the Pou Ora | Pillars of Health model of care and attendees will leave with a clear roadmap to improve quality outcomes for whānau, create sustainable workplaces, and lead meaningful change in general practice.

49

Enabling Equity for Māori in Rural Primary Care

Jess Morgan-French[1]
[1]Collaborative Aotearoa

Rural communities in Aotearoa New Zealand experience persistent health inequities, with Māori disproportionately affected by barriers to timely, culturally safe, and accessible primary care. This doctoral research explored the perspectives of both Māori whānau and rural primary care providers in Tai Tokerau (Northland) to identify the actions, systems, and models that enable equitable service delivery.

Using a Māori-centred qualitative methodology informed by Kaupapa Māori principles and guided by a Māori advisory kāhui, in-depth interviews and thematic analysis revealed three overarching themes:
1. understanding equity and addressing root causes,
2. access and enablers of quality services,
3. establishing partnerships with purpose,
4. knowing how rural primary healthcare is delivered.

Findings highlighted that equity is achieved through culturally safe relationships, trust, and continuity of care; provider awareness of the social determinants of health; and active partnership with whānau in decision-making.

A new conceptual model emerged from the research, the Equity Wave. Illustrating how equity-enabled care can be delivered in rural contexts. This model integrates cultural safety, relational practice, resource allocation, and system design to address structural and relational inequities that enable equity for Māori communities.

The study offers practical, locally grounded insights for rural health policy, workforce planning, and service delivery, with relevance for Indigenous health equity efforts globally. By centring Māori voices and rural realities, it provides a framework for designing primary care models that are not only clinically effective but also culturally and socially responsive.

120

Tāpiri Mai: Mana Motuhake in Action: Equitable Health for Remote Communities

Moira Lomas[1], Mrs Kiri Peita[1], Ms Becky Pennell[2], Dr Claire Isham[2], Hera Murray[3]
[1]Wboppho, [2]Ngāti Kahu Hauora, [3]Te Awanui Hauora

Matakana and Mōtītī Islands, New Zealand, are remote rural communities with a high deprivation index. The islands are home to approximately 400 people, predominantly Māori . Since 2020, Tāpiri Mai, an Indigenous-led model of care grounded in mana motuhake (self-determination), has evolved through community co-design and ongoing dialogue towards achieving Pae Ora (healthy futures). It addresses local needs, supporting health in its broadest sense and delivering timely, culturally-safe care, reducing the need for travel resulting in social and economic benefits.

Delivered through a partnership of three health organisations and Health New Zealand | Te Whatu Ora, this project collaborates with healthcare providers and government agencies to overcome barriers to access. Initially focused on telehealth enablement, it has since expanded to introduce new services that strengthen healthcare and enhance digital and health literacy. The broadened scope supports more equitable, effective, and sustainable healthcare delivery across these communities. Continuous support enables residents to engage actively in their care and manage their health.

Trust underpins the model, reflected in the motto: “It’s not just about relationships – it’s all about relationships. Community voices informs service design, enabling culturally tailored approaches such as remote physiotherapy in te reo Māori. Between Jan 2024 and July 2025, approximately 10% of the population engaged monthly, 7 services were added to distance health, and a carbon footprint reduction of 1 tonne pa was achieved.

This Indigenous-led approach offers lessons for advancing rural and remote health equity globally by integrating culture, community, and self-determination into policy and service delivery.

125

Ka Ora Telecare – Health NZ’s Supported Model for Rural After-Hours Telehealth: Presentation and Trends from Telephone and Video Consults

Dr Aimi Nishimura[1], Hayley Mcconnell[1]
[1]Ka Ora Telecare

Health New Zealand (Health NZ) has recognised Ka Ora Telecare as a leading model for rural after-hours care, formally contracting it to serve communities across Aotearoa. This partnership reflects a growing commitment to equitable, accessible, and culturally responsive healthcare for rural populations, who often face significant barriers to timely care.

Ka Ora offers direct patient access to nurse triage, clinical advice, and medical care via telephone and video consults. In just 18 months, it has supported over 46,000 patients from some of New Zealand’s most geographically remote areas.

This presentation will explore patient demographics, usage trends, clinical outcomes, and service satisfaction. It will also share patient narratives that highlight how tangata whaiora experience and engage with the service.

Ka Ora’s success is grounded in high-quality clinical practice, community engagement, and collaboration with local providers. Health NZ’s support recognises that effective rural care must honour the unique needs of each community. As the saying goes, “if you've seen one rural town, you've seen one rural town.” Ka Ora’s tailored approach ensures care is respectful and responsive to local context. We will share how Ka Ora integrates with regional in-person services to provide a seamless patient journey.

This presentation demonstrates how national investment, and locally grounded care can work hand-in-hand to improve outcomes for rural populations.

92

Exploring the impact of rurality and socio-economic deprivation on a range of adult health outcomes for Māori and non-Māori.

Prof Garry Nixon[1], Professor Sue Crengle[2], Associate Professor Gabrielle Davie[3], Dr Jason Tuhoe[2], Mr Brandon de Graaf[3], Dr Jesse Whitehead[4], Mr Talis Liepins[1], Ms Michelle Smith[1], Dr Rory Miller[1], Dr Jane Taafaki[5]
[1]University Of Otago, Centre for Rural Health, [2]Ngāi Tahu Māori Health Research Unit, University of Otago, [3]Department of Preventive and Social Medicine, University of Otago, [4]Te Ngira Institute for Population Research, University of Waikato, [5]Va'a o Tautai Centre for Pacific Health, University of Otago

The Geographic Classification for Health (GCH) and NZ Index of Deprivation (NZDep) were applied to routinely collected administrative health data to better understand how a range of established health indicators vary by rurality and deprivation for Māori and non-Māori.
The following indicators were selected:

- General Practice encounters
- Utilisation of secondary care mental health services (45-64 year old age group)
- Participation in breast cancer screening
- Ambulatory Sensitive hospital admissions (45-64 year olds)

The most recently available 5-years of data were obtained. Incidence rates of outcomes were obtained using appropriate denominators; most commonly, population estimates. Poisson regression modelling was used to estimate adjusted incident rate ratios that compare the rates of different GCH-NZDep (and where appropriate age) strata. Rates and rate ratios (using the most urban least socioeconomically deprived strata as the reference) were calculated separately for Māori and non-Māori. A similar approach has previously identified a complex pattern of disparities in mortality rates that suggest that ethnicity, deprivation and rurality are all associated with health outcomes.

79

Kaitiakitanga. A Pākehā GP transformed by a mātauranga Māori view of care.

Dr Lucy O'Hagan[1]
[1]Oratoa Cannons Creek

This session describes my experience being Pākehā studying in a Māori world. In 2024 I studied Kaitiakitanga with Te Wānanga o Aotearoa. Described as bicultural professional supervision, the course looked at all relationships or care and support through a matauranga Māori lens.

Like all cross-cultural learnings, I was face to face with my own culture including the culture of biomedicine. The learning was both academic and experiential, content and process seamlessly merged.

The final assignment was to create our own kaitiakitanga model and I will present my model of care and support called Onepōpopo.

50

Narrative and visual illustrations as discourse enhance rural representations

Prof Jean Ross, Prof Samuel Mann, Prof Karole Hogarth
[1]Otago Polytechnic

The rural is a dynamic and contested space, and understanding its unique geographical, cultural, historical, economic, sustainable, and environmental complexities highlights specific place-based health encounters. In this presentation, we uncover and focus on rural place-based characteristics including geographic access to health care, health disparities, indigenous health and distribution of health issues including acute, chronic, traumatic and environmental encounters unique to Aotearoa New Zealand. We aim to enhance how these encounters impact healthcare delivery as rural communities and residents participate with their local health care systems, in so doing we further this engagement with the practicalities of One Health. Rural factors potentially impacting disease burden can be more significant in cases of chronic disease management particularly, medicines uptake. This information is essential for developing equitable health delivery models and improve health outcomes in rural places. Rural models of practice unique to Aotearoa New Zealand are discussed through narrative case studies of community development projects complemented by visual representation. Case studies explore island-specific issues such as sustainability of islands; the mental well-being of farming residents in geographical isolation and access to health services and the potential opportunity for partnering with rural indigenous communities. In conclusion, we recommend multidisciplinary assessments that integrate alternative mediums for engaging rural populations such as the narrative and visual representation employed in the case study assessments.

107

On the front line twice: Rural nursing in the wake of natural disasters.

Leanne Ryan[1]
[1]University of Waikato

Background:

When disaster strikes rural Aotearoa, nurses are often both responder and survivor, caring for patients while managing the impact on their own homes, whānau, and communities. International research highlights their resilience, ingenuity, and expanded roles, but the voices of rural New Zealand nurses remain largely absent from the evidence base.

Aim:

To synthesise global evidence on rural nursing in disaster contexts and explore implications for workforce development, disaster planning, and culturally responsive care in rural Aotearoa.

Methods:

A targeted review of peer-reviewed and grey literature was conducted across CINAHL, PubMed, Scopus, and disaster agency reports. Findings were thematically analysed to identify patterns in roles, barriers, and opportunities relevant to disaster preparedness, response, and recovery.

Findings:

Rural nurses are consistently portrayed as adaptive, resourceful, and deeply embedded in community life. They step into broader scopes of practice, coordinate scarce resources, and provide critical psychosocial support, often in the absence of other health professionals. Barriers include limited training, unclear policy guidance, and lack of structured mental health support. Gaps are evident in frameworks that embed Te Tiriti o Waitangi obligations and Māori nursing leadership, and in addressing equity for other groups such as older adults, and lower income rural communities.

Conclusion and Recommendations:

Rural nurses are essential to disaster resilience, yet in Aotearoa their voices remain missing from policy and planning. Future research must centre their lived experiences to inform training, workforce planning, and equity oriented disaster policy.

Keywords: Rural nursing, disaster preparedness, workforce resilience, equity, Māori health, Aotearoa New Zealand

225

Can we fix it? Yes we can! Addressing rural health workforce challenges by embedding paramedics in primary care.

Prof Evelien Spelten[1], Dr Ruth Hardman[1], Associate Professor Louise Reynolds[2], Professor Leigh Kinsman[1], Professor Gina Agarwal[3]
[1]La Trobe University, [2]Safer Care Victoria, [3]McMaster University

Background
In Australia, Community Paramedicine (CP) can address primary care needs for vulnerable populations, including screening and managing chronic disease, increasing healthcare access and reducing emergency presentations. Additionally, CP offers registered paramedics a non-jurisdictional ambulance service career pathway, while boosting the primary care workforce. Paramedics are highly skilled, and are currently the only health workforce in oversupply. They could help alleviate the chronic health workforce shortage in rural Australia.

Methods
We are implementing and evaluating a community paramedic service, CP@clinic, in partnership with four community health services across rural Victoria. CP@clinic provides paramedic-staffed free drop-in clinics operating at regular intervals in accessible locations such as libraries and community centres. Paramedics screen and monitor chronic health conditions, provide health education and link clients to appropriate health and social resources. This is one of the few community paramedicine initiatives where paramedics are employed in primary care, outside of a jurisdictional ambulance service.

Results
Our mixed-methods evaluation shows that CP@clinic is good for:
Clients, they love it and it is good for their health
Community, as it is locally tailored
Paramedics, it provides relevant career options
Health system, takes the pressure off hospitals, ambulance and GPs

Conclusion
The program is very well received by all parties and helps improve access and care continuity. A key challenge has been in the paramedic transition from the ambulance to the primary care environment, which requires consideration of a wide range of policy, employment and individual factors.

167

Policy to Practice: Barriers and Enablers for Community Health Officers (CHO) in Strengthening Rural Healthcare Delivery in India

Dr Kritika Upadhyay[1], Prof. Sonu Goel[1], Prof. Shankar Prinja[1], Maj. Gen. Prof. (Dr.) Atul Kotwal[2]
[1]Post Graduate Institute Of Medical Education And Research, [2]National Health Systems Resource Centre (NHSRC)

Community Health officers a new introduced cadre of healthcare professionals tasked with delivering comprehensive primary healthcare to rural populations through an expanded range of services. Their effectiveness, however, depends on the extent of support and facilitation received in translating policy into practice. This study examines the barriers and enablers influencing CHO-led service delivery, incorporating perspectives of both CHOs, other staff and supervisors.

A qualitative study was conducted using six Focus Group Discussions (FGDs) with CHOs, one each with Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and community leaders, along with fifteen In-Depth Interviews (IDIs) with CHO supervisors. Semi-structured guides captured roles, challenges, facilitators, supervision, and performance recommendations. Audio-recorded discussions were thematically analysed using NVivo, guided by WHO’s health systems framework.

Four comprehensive themes emerged: health workforce (subthemes: insufficient staffing, heavy workload, contractual position, role conflict); resource and infrastructure constraints (limited medicines, weak transport, inadequate funding); training and mentorship (lack of in-service training, training on digital tools, weak supervision, lack of structured mentorship); and leadership and governance (bureaucratic inefficiencies, weak accountability, exhaustive performance, limited decision-making). Key enablers included community rapport, supportive supervision, peer collaboration, and targeted government initiatives. Key barriers reported were systemic constraints, role conflict, lack of prescription power, and lack of trust by community. Suggested solutions included professional development, mentorship programs, incentives, and efficient performance framework.

CHOs hold significant potential in strengthening rural healthcare delivery. Sustained system and organization-level support, structured performance assessment are critical to optimize their contribution to equitable primary healthcare in India.

262

Reaching whanau across Muriwhenua, Far North, New Zealand

Joanne Urlich[1], Kyra Stanisich
[1]Te Hiku Hauora

Te Hiku Hauora community and outreach team deliver community health services from a Whānau-centred model of primary health care in static and mobile clinics, in homes and communities across Muriwhenua. These services have no cost and are provided where whanau live, learn, work and play, including marae, community halls and workplaces.

Te Hiku Hauora is a Māori health provider located in Muriwhenua. Established in 1995 to serve the health needs of whānau, hapu, iwi and communities of the Far North, New Zealand. Currently employing over 230 kaimahi across a range of departments to provide comprehensive health and wellbeing services to the community.

The community, the kaimahi of Te Hiku Hauora support with their services experience higher levels of social and economic inequities, with a Māori population.

Services are provided across a range of communities to high needs Whānau who have trouble in accessing primary health services which may include lack of enrolment with GP practice.

Services include Health Screening, comprehensive assessments, consultations, treatment and supports for general health issues (across the life span) and long-term conditions such as cardiovascular disease, diabetes and asthma.

Nurse Practitioners as advanced clinical leaders and Registered Nurses work across community settings and teams to ensure advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to improve Whānau wellbeing.

Whānau are supported for a range of holistic health parameters throughout the Far North region – all free of cost aimed to achieve the best health care outcomes.

382

Bridging Clinical and Community Care through Social Prescribing: An Initiative in Rural Indigenous Taiwan

Dr Tingchia Weng[1], Dr KUAN-LING Liu[1], Dr Hong-Jhe Chen[1]
[1]Pingtung Veterans General Hospital

Social prescribing is gaining recognition in rural primary care as a way to address health inequities through community-based, culturally appropriate interventions. In Taiwan, Indigenous communities face structural barriers to care and poorer health outcomes. This initiative, led by Pingtung Veterans General Hospital, explores a model of Indigenous-led social prescribing in remote southern regions.

Through partnerships with tribal leaders, local governments, and community workers, outreach programmes were implemented in Wutai Township. These included culturally adapted health events offering adult health checks, occupational hazard prevention, and cancer screenings. Social workers served as link workers, connecting patients to non-clinical supports such as elder support groups, traditional crafts, farming programs, and nature-based therapies. Community members with lived experience were engaged in co-designing outreach strategies to increase participation.

Preliminary outcomes suggest enhanced health literacy, improved screening uptake, and better mental well-being. Importantly, this approach reframes primary care physicians as connectors and advocates within their communities, aligning with the global shift toward integrated, equitable rural health systems.

This case illustrates how global models of social prescribing can be adapted to Indigenous contexts through cross-sector collaboration. It contributes to growing evidence that localised, culturally grounded interventions can influence national policy, strengthen health resilience, and support thriving futures in rural populations.

46

The inequitable impact of climate change on health service accessibility

Dr Jesse Whitehead[1], Mr Mitchell Pincham[1], Mr Mitchell Quinsey[2], Mr Mitchell Blake[2]
[1]Te Ngira: Institute For Population Research, University Of Waikato, [2]Center of Australian Research into Accessibility, Deakin Rural Health, Deakin University

Aims

To understand inequities in access to health services in Aotearoa after an extreme weather event.

Methods

An exploratory quantitative analysis used publicly available geospatial data to estimate distance to nearest GP and hospital for every address (2.3 million) in Aotearoa under ‘normal’ conditions. The road network dataset was modified to reflect closures following Cyclone Gabrielle and access to health services estimated under new conditions. Statistical Area 2 boundaries were used to link data on health service access disruption to census-derived demographic and socioeconomic information. Estimates of access to services post Cyclone Gabrielle and under normal conditions were compared.

Results

Cyclone Gabrielle related road closures severely disrupted health service accessibility. Approximately 80,000 addresses were isolated from a GP, and ~100,000 were isolated from hospital services. Increased travel distances to a GP and hospital affected approximately 38,000 and 101,000 addresses respectively. Importantly, areas experiencing a “high” or “very high” level of service access disruption were more likely to be rural. The most remote (R3) communities experienced the largest disruptions to health service access. Māori, and people aged 65 or older were most likely to live in areas experiencing very high disruption.

Conclusions

This proof-of-concept, exploratory research demonstrates a viable approach to creating dwelling-level accessibility datasets and evaluating the impacts of extreme weather on inequities in health service access, adding to evidence that rural and Indigenous communities, and older people are likely to be most severely impacted by climate change.

95

Who’s rural? Examining rural-urban migration in the later years of life

Dr Jesse Whitehead[1], Dr Jason Tuhoe[2], A/Prof Gabrielle Davie[3], Mr Brandon de Graaf[3], June Atkinson[4], Dr Rory Miller[2], Mr Talis Liepins[2], Prof Sue Crengle[5], Prof Garry Nixon[2]
[1]Te Ngira: Institute For Population Research, University Of Waikato, [2]Department of General Practice and Rural Health, University of Otago, [3]Department of Preventative and Social Medicine, University of Otago, [4]Department of Public Health, University of Otago, [5]Ngāi Tahu Māori Health Research Unit, University of Otago

Background
Lower mortality for rural (cf urban) residents are observed in the older age groups, possibly explained by residential relocation patterns. Individuals may move closer to urban healthcare in the latter years of life, but an accurate understanding of older age mortality rates and patterns of rural:urban relocation is critical to understanding population health needs and informing health system planning.

Aims
To identify pre-mortality patterns of rural:urban relocation for both Māori and non-Māori in Aotearoa New Zealand (NZ).

Methods
A cohort of individuals (n=227,831) who died between 1/1/2013 and 31/12/2019 was developed using a linked virtual health data lab, using information from all health National collections datasets which included meshblock or domicile code. Collections included mortality, cancer, PHO enrolment, hospitalisations, and others. Information about residential location at the time of death, and 5-years pre-mortality for each individual was assigned a GCH rurality category.

Results
We identified rural–urban and ethnicity differences in end-of-life outcomes, population mobility, and locations of death. While Māori comprised 11% of the total sample, a much higher proportion of deaths in R2 (20%) and R3 (42%) areas were for Māori. A gradient of relocation exists, with less relocation occurring among more rural populations. Most people in R3 remain in their communities until death, with only 20% relocating to an urban setting. People in rural areas also experience a higher proportion of home deaths.

Conclusions
Current approaches to classifying rurality at death may contribute to an underestimate of rural health needs, with impacts for service distribution and funding.

359

‘Pae Ora O Te Tai O Poutini’

Improved access to health services for Māori through the provision of General Practice (GP) and Nurse led community clinics

Dr Greville Wood[1]
[1]Wood Medical Services, [2]Poutini Waiora

Two projects, one in Kawatiri – Whakakotahi, and the other in Greymouth, were evaluated. The findings evidence that a move away from traditional primary health models of care are successful and need to be replicated and built on to increase positive outcomes for whānau.

The main themes that emerged from the interviews undertaken with kaimahi and whānau were: challenges to access primary health care; quality of care; racism, active listening; taking a holistic approach to providing care; the therapeutic environment; and whānau involvement in care.

The methodology was to interview those who received the service. For health professionals the feedback and themes presented were confronting. For whānau and those working in Māori health they confirmed what is already well known. These are the experiences of whānau, this is how care for whānau has been viewed, felt and experienced. This has been the lived reality of whānau and the reason why accessing primary health care as it exists in its current model has been unsuccessful.

The programmes have demonstrated that by providing care in a different way whānau will engage, become more independent in the management of their health and begin to have positive health outcomes. These programmes have been delivered on small budgets, on the back of existing services.

Whānau said: they have had a taste of what quality service provision is now. They know with the right people and setting that achieving their aspirations in regard to wellbeing are completely achievable.

336

Transforming Diabetes and Metabolic Health with Aboriginal people living on Ngarrindjeri Country: Insights from the Co-Designed Nra:gi Ya:yun Healthy Eating Initiative

Shanti Omodei-James[1], Ms Renee Kropinyeri[2], Ms Stacy Wilson[2], Prof Paul Worley[1,2], Associate Professor Courtney Ryder[1], Dr Amy Mendham[2], Ms Sharon Wingard[2], Ms Julie Souness[2]

[1]Flinders University, [2]Riverland Mallee Coorong Local Health Network

Type 2 diabetes (T2D) and metabolic syndrome interventions often overlook Indigenous knowledge systems and place-based concepts, particularly in rural Aboriginal communities. In response to high diabetes rates on Ngarrindjeri Country, Nra:gi Ya:yun (“very good food”) was initiated by Ngarrindjeri Elders and senior community leaders as a strengths-based, community-led pilot project grounded in Ngarrindjeri ways of knowing, being, and doing.

Guided by Knowledge Interface methodology, the initiative was co-designed using a series of collaborative workshops attended by Aboriginal health workers, clinicians, researchers, and community members. Drawing on the strengths of the Indigenous research methods of yarning and deep listening, and the benefits of Western clinical knowledges and cutting-edge technology, the 28-week pilot focused on low-carbohydrate eating and included point-of-care testing, subsidised healthy ingredients, coaching, and community gatherings centred on education.

Qualitative findings reveal that the Nra:gi Ya:yun pilot fostered a deepened sense of community connection, enhanced confidence and ownership over health journeys, with benefits shared beyond participants themselves. Preliminary data shows promising trends in fasting blood glucose, weight and waist circumference for participants who activity engaged with Nra:gi Ya:yun.

By privileging Ngarrindjeri knowledge systems and leadership, Nra:gi Ya:yun challenged the clinical power imbalances, offering a model of sovereignty in health. These early outcomes demonstrate how Indigenous-led, co-designed approaches can transform chronic disease care through relational, culturally grounded action.

Final Comment

A selection of RuralWONCA Abstracts have been published in the Rural and Remote Health Journal (RRH Journal).

We express our sincere thanks to the RRH Journal for their support of the Conference, the authors and those the live and work rurally across the world.

To view the Journal, click on the link: RRH: Rural and Remote Health - Current Cover

For abstracts related to the WWPRP GRACE project please contact the Chair, Pratyush Kumar.

Useful links

RuralWONCA 2026 website: WONCA 2026 | Home

Case Study: https://youtu.be/5glcd4s9qjg and https://businessevents.newzealand.com/news-and-success-stories/case-study-wonca-delivers-a-rural-health-legacy-in-wellington/

Conference Legacy: Aotearoa New Zealand Declaration on Rural Health

Hauora Taiwhenua Rural Health Network: Hauora Taiwhenua Rural Health Network | Rural Health NZ

Rural Wonca
The WONCA Working Party
on Rural Practice

21st WONCA
World Rural Health
Conference
NEW ZEALAND
Rural Wonca

Hauora
Taiwhenua
Rural Health
Network