21st WONCA World Rural Health Conference

ABSTRACT BOOK

Supplementary Document to Conference Report

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CONTENTS

1 - A 2-6 Minute Test for Group A Strep to Prevent Rheumatic Fever

Mrs Tracey Liddell, Kate Moodabe, Mrs Sue Van Mierlo

Using a rapid molecular test for Strep A and an innovative approach, a clinic in Tūrangi appeared to have reduced Rheumatic Fever presentations to effectively zero for two years the two years in which their protocol was in place. Work has begun in multiple clinics in Te Tonga o Tāmaki Makaurau South Auckland and West of Taranaki Maunga utilising the same test. This work is confirming the ease of use and scalability of the test, and is producing some encouraging results.

2 - Enhancing Rural Health Access through Engagement, Trust and Cultural Responsiveness

Ella Feaunati, Prof. Pater O'Mara, Richard Colbran

Rural Doctors Network (RDN) activities combine strong partnerships with extensive local engagement strategies to improve healthcare outcomes for Aboriginal and Torres Strait Islander communities. This integrated approach fosters cultural responsiveness and decentralised healthcare delivery to promote trust and enhance access. Proud Wiradjuri man and Board Chair – Prof. Peter O'Mara RDN's and RDN CEO Richard Colbran outline RDN's cultural responsiveness approach and decentralised health access services.

Over the past 17 years in NSW and the ACT, RDN has implemented a partnership-based, decentralised health access model, in collaboration with local health organisations, primarily ACCHS to deliver tailored healthcare solutions that transcend traditional models. These partnerships are central to the model and enable RDN and partners to identify local needs, prioritise services, coordinate program delivery, hence fostering collaboration and local ownership.

This strategy empowers Aboriginal and Torres Strait Islander leaders with self-determination governance opportunities for the health services provided in their communities. It strengthens local capabilities and facilitates culturally appropriate healthcare services, focusing on prevention, early detection, and chronic disease management. Through long standing and genuine engagement with partners, RDN's approach has fostered community trust, enhanced continuity of care, built local capability and facilitated tailored solutions. In doing so, it is addressing geographical isolation, cultural safety, and financial barriers, thereby contributing to 'Closing the Gap' initiatives.

This presentation explores how integrating cultural responsiveness, local governance with a decentralised service model contributes to improved healthcare outcomes for Aboriginal and Torres Strait Islander communities, fostering self-determination, meaningful partnerships and sustainable models of care.

3 - Decolonising Digital Social Protection Model for Maternal Nutrition: A Frugal Path to Resource Independence in an LMIC Setting

Faith Siva[1], Dr Danny Nyatuka[1], Prof Retha de la Harpe[2]

[1]Strathmore University, [2]University of South Africa

Poor maternal nutrition remains a major contributor to the global disease burden, particularly in low- and middle-income countries (LMICs), where expectant mothers in rural, remote, and nomadic communities face persistent structural and nutritional inequalities. Despite the growing adoption of digital health platforms, many of these solutions remain fragmented and insufficiently adapted to the sociocultural and economic realities of vulnerable maternal populations.

This study aims to develop and evaluate a frugally designed, culturally responsive digital social protection-enabled model for maternal nutrition that reflects decolonising approaches and supports resource independence in an LMIC setting.

Using a qualitative approach, the study engaged 47 participants from different stakeholder groups, including community health workers, practitioners, digital platform developers, social protection agencies, and faith-based health missions, to identify eight critical design themes for a maternal health platform rooted in local contexts and indigenous knowledge systems.

Eight themes were derived as key considerations to inform the design of a frugally designed, culturally responsive digital social protection model for maternal nutrition that supports resource independence and reflects decolonising approaches in an LMIC setting. These include Stakeholder engagement, utilisation of Health IT tools, System contextualization, system implementation, system integration, and user-centred design. The resulting model serves as a blueprint for building both nutrition adherence and a community-driven knowledge exchange system. Grounded in indigenous values and supported by faith-based intermediaries, it promotes equity, resource independence, and health system responsiveness through a scalable, frugally decolonised maternal care model aligned with Whānau Ora and One Health principles.

4 - From Research to Real-World Impact: The Attract Connect Stay Framework's Journey to Transforming Rural Workforce Retention

Dr Cath Cosgrave[1]

[1]Attract Connect Stay

Rural health workforce shortages represent a global challenge for healthcare equity. While extensive research has identified retention factors, rural health services lack accessible, evidence-informed frameworks to strengthen attraction and retention. This presentation traces the evolution of the Attract Connect Stay (ACS) Framework from foundational PhD research through to current implementation across Australian health organisations.

The journey began with constructivist grounded theory methodology (2012-16) involving 26 nursing and allied health professionals in rural NSW community mental health services, including five Indigenous workers. The research explored how employment and rural-living factors impact turnover intention, including Indigenous workers' experiences of professional identity, cultural boundaries, and community connection. This foundation was strengthened through Churchill Fellowship investigation in Canada (2019) and Victorian implementation research.

The foundational research generated the Turnover Intention Theory, identifying that retention decisions are determined by gaps between professional and personal expectations and experiences. Professional satisfaction was influenced by role scope, workplace relationships, and career development access, while personal satisfaction centred on community belonging and place attachment - concepts resonating with Indigenous understandings of connection to Country.

These findings informed the ACS Framework, a whole-of-person approach addressing workplace/organisational, role/career, and community/place factors. The framework operates through five pillars: Attract, Recruit, Settle & Connect Organisation, Settle & Connect Community, and Stay.

Real-world implementation demonstrates outcomes: services implementing the framework achieved 85%+ retention rates, reduced recruitment timeframes, and improved attraction of candidates. Since 2021, six Australian organisations have been supported, with additional services independently adopting framework principles, demonstrating scalability and evidence-based workforce retention transformation.

5 - Traditional Eye Care Practices among Indigenous and Rural Communities: A Systematic Review

Dr Luksanaporn Krungkraipetch[1], Dr Kitti Krungkraipetch[1], Mr Dechathorn Krungkraipetch[2]

[1]Burapha University, [2]Chulalongkorn University

Background:
Traditional eye medicine (TEM) continues to play a significant role in primary eye care across many indigenous and rural populations.
Objectives:
To systematically review and synthesize evidence on the prevalence, patterns, motivations, and outcomes of traditional eye care practices among indigenous and rural communities.
Methods:
A systematic review was conducted using peer-reviewed literature from major databases up to 2024. Eligible studies included observational, qualitative, and interventional research reporting on TEM use. Data extraction covered study design, population, TEM types, reasons for use, and outcomes. Descriptive synthesis and graphical visualization were applied. This review is registered with PROSPERO (CRD42025110795).
Results:
Ten studies involving over 4,000 participants were included. The prevalence of TEM use ranged from 18.2% to 60.1%, with higher usage among older adults, females, individuals lacking formal education, and rural residents. Commonly treated symptoms included redness, irritation, discharge, and itching. Key reasons for TEM use were affordability, cultural beliefs, lack of access to formal care, and influence from traditional healers. Several studies reported adverse outcomes such as delayed care, corneal ulcers, and visual impairment. One study highlighted the success of educational interventions targeting traditional healers.
Conclusions:
TEM remains prevalent in rural and indigenous communities and is shaped by cultural and systemic factors. While deeply rooted in tradition, some practices contribute to delays in care and ocular harm. Family doctors and primary care providers must adopt culturally sensitive strategies, collaborate with traditional healers, and enhance community health literacy to improve eye health outcomes.

6 - Gaining Traction in the Snow – Building and Sustaining a Collaborative for Interprofessional Education in a rural/northern environment

Dr Karey McCullough[1], **Dr Dr Steve Cairns**[1], Dr Emily Donato[2], Dr Scott Dunham[3], Ms Laura Killam[4], Mr David Thompson[5]

[1]Nipissing University, [2]Laurentian University, [3]Canadian Memorial Chiropractic College, [4]Cambrian College, [5]Lakehead University

The Northern Interprofessional Collaborative in Education (NICE) was established to advance interprofessional education (IPE) addressing the unique needs of Northern Ontario, Canada, which is a geographically vast, diverse, and rural region. This report describes the evolution of NICE as a grassroots initiative and examines the challenges of fostering interprofessional learning across educational institutions, healthcare organizations, clinicians, students, and community representatives. NICE's mission is to engage participants in collaborative and holistic IPE tailored to northern/rural contexts, with the goal of improving interprofessional care for patients and clients. Guided by four foundational pillars: connecting, celebrating, inspiring, and building relationships. NICE has focused on capacity building and knowledge sharing to bridge professional silos that are often magnified in dispersed healthcare settings and educational institutions.
Through its networking efforts, NICE aims to integrate northern patient and client experiences into IPE curricula and identify best practices for the region. NICE faces significant barriers to sustainability and this report highlights the importance of inter-institutional collaboration, student leadership, and leveraging technology to deliver meaningful IPE in underserviced northern or rural regions. Insights are shared from the experiences of the professionals involved in NICE.

7 - Rural food insecurity in Aotearoa New Zealand: Protections, patterns and persistent inequities

Kahurangi Dey[1], Dr. Mona Jeffreys[1]

[1]Te Herenga Waka Victoria University Wellington

Food insecurity is a complex phenomenon in high income countries like Aotearoa New Zealand. Using data from the 2019/2020 New Zealand Health Survey, the study analysed eight food insecurity indicators across rural and non-rural areas, exploring interactions with socio-demographic variables. Results showed rurality is protective against food insecurity, with rural households reporting lower rates across most metrics compared to non-rural counterparts. However, this protection does not eliminate persistent ethnic inequities – rural Māori experience higher rates of food insecurity than non-rural non-Māori for each metric measured, despite the rural protective effect. Other patterns included a reverse gender pattern in rural areas for finance-related stress, with rural males reporting higher rates than rural females, contrasting with patterns in non-rural areas. Mid-life rural adults (25-44 years) emerged as particularly vulnerable, experiencing higher psychological stress-related impacts than other rural age groups. While a clear socioeconomic gradient exists across all populations, rurality's protective effect was strongest in the most deprived areas. There appeared to be a critical threshold effect between Deprivation Quintiles 1-3 and Quintiles 4-5. These findings highlight the need for culturally responsive, place-based food security interventions that address structural racism while leveraging rural community strengths. Integrated health approaches that combine food access initiatives with mental health support in rural communities could address both practical and psychological dimensions of food insecurity. Understanding these nuanced patterns is essential for developing effective rural health solutions that address food insecurity's complex manifestations across diverse rural communities.

8 - Prioritising First Nations Ways: reframing patient-centred care through cultural safety

Prof Kay Brumpton[1,2,3], Prof Tarun Sen Gupta[2], Associate Professor Rebecca Evans[2], Dr Raylene Ward[1,4]

[1]Goolburri Aboriginal Health Advancement , [2]James Cook University, [3]Griffith University, [4]University of Southern Queensland

Delivering culturally safe, patient-centred care to First Nations patients remains a key goal in general practice. However, mainstream models of patient-centred care may overlook or inadequately reflect First Nations' perspectives. This interactive workshop presents findings from an Australian study that explored how existing consultation models can be adapted to better prioritise cultural safety and guide teaching and assessment.

The research employed a mixed-methods design incorporating semi-structured interviews, survey, a modified-nominal-group-technique (mNGT), and Delphi process to explore First Nations and expert opinion of cultural safety in GP consultations.

Seventy First Nations people participated in the survey and semi-structured interview, 61 participated in the mNGT groups, and 17-24 experts in the 2-round-modified-eDelphi process. First Nations participants were from different rural and regional communities across southern Queensland, up to 700km apart. eDelphi participants were from across Australia.

A broad range of qualities were associated with safe consultations. Some findings challenged current frameworks and aspects of cultural safety training, particularly communication preferences. eDelphi panel members agreed that while subjective and relational elements are fundamental to cultural safety, they are inherently difficult to assess.

We present a refined, evidence-informed framework that integrates the principles of patient-centred care and cultural safety – building upon First Nation pioneered principles. Through discussion and small group activities, the workshop will challenge assumptions and explore international perspectives on how the model can guide teaching and assessment to improve cultural safety in everyday practice.

9 - 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.

10 - Unique Rural Generalist Nurse Practitioner Roles in Aotearoa New Zealand

Nola Rochford, Sara Mason[1], Kathy Hines[2], Jennie Bell[3], Fiona Blair, Sarah-Jane Lawson

[1]Te Tai O Poutini West Coast, [2]Coastal Health LTD, [3]Te Waka Ngākau o Poutini

Background

Te Tai o Poutini, the West Coast is a 600km stretch of rugged coastline on the West Coast of New Zealand with a population of 33,000 people. Across the West Coast there are Nurse Practitioners working in mental health, outreach primary services, rural primary care, acute care, rehabilitation and care for older peoples.

Nurse Practitioners also support the development of workforce by providing learning opportunities for the advancement of nursing roles at a local level.

Aim

This presentation will be structured as a demonstration of the way a rural generalist workforce of Nurse Practitioners can provide care while separated by health service structures and challenging geography.

Each Nurse Practitioner will provide a short talk on the service provided and the roles are ultimately connected to each other, support upcoming rural health workforce and providing rural health care.

Conclusion

The Nurse Practitioner roles enhance rural generalism by improving access leading to better health outcomes for our underserved rural communities. This story will be told on a backdrop of the rugged landscapes that make up the beautiful wild West Coast of Aotearoa.

11 - The unregulated health and disability workforce in Aotearoa New Zealand: A scoping review

Sara Mason[1,2], Dr Pauline Dawson[3], Associate Professor Eileen McKinlay[4], Professor Tim Stokes[2]

[1]Te Tai O Poutini West Coast, [2]Department of General Practice and Rural Health, Dunedin School of Medicine, University of Otago, [3]Department of Obstetrics, Gynaecology & Women's Health, Dunedin School of Medicine, University of Otago, [4]Centre for Interprofessional Education, Division of Health Sciences, University of Otago

Background
The unregulated health and disability workforce, such as caregivers, can be found in all sectors of care. Internationally, this workforce has been within health care teams or used as substitutes for regulated health professionals. The latter is appealing in rural communities where regulated health professional recruitment is difficult, and the unregulated workforce has the advantage of local knowledge.

Aim/objectives
This scoping review examined literature pertaining to Aotearoa New Zealand unregulated health and disability workforce. It is the first of three interlinked PhD studies.

Methods
The search strategy used a combination of keywords relevant to the unregulated health and disability workforce in New Zealand. Studies published prior to 2025 were searched on Scopus, Medline, ESBO host/CINAHL, Science Direct, PubMed, Cochrane, EBM, ACCESS, JBI EBP and Google Scholar. Information extracted included: the study type, design, setting, tasks or skills, education, competency and if the workforce were working under supervision and if so what kind.

Findings
1,407 documents were screened and after further exclusion, a total of 265 documents were included. This study found there are a broad range of tasks the unregulated workforce performs in Aotearoa New Zealand. The two most common were the provision of personal care and administration of medications, assessments and a broad range of treatments. Supporting health professionals was one of the least reported tasks. Supervision varied from direct supervision to indirect, guided or no supervision.

Implications
This study consolidates information around Aotearoa New Zealand unregulated health and disability workforce to assist in future rural workforce planning.

12 - Use of drone technology in tuberculosis diagnosis in rural and tribal areas of Yadadri Bhuvanagiri district, Telangana, India.

Dr Bhushan Kamble[1], Dr Kuldeep Nigam[2], Dr Sumit Aggarwal[2], Dr Vidya Ganji[3], Dr Rashmi Kundapur[1], Dr Meely Panda[1], Prof Neeraj Agarwal[1]

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The present video abstract describe the role of drone technology in transportation of sputum samples from tuberculosis suspects in rural and hilly areas of Yadadri Bhuvanagiri district of Telangana state of India. Drone use has resulted significant reduction in delays in tuberculosis diagnosis and treatment initiation. Also, it has reduced out of pocket expenditure of tuberculosis suspects in tuberculosis and treatment drastically. Drone technology has proven very effective in breaking geographical and transportation barriers for people living in tribal hamlets, hilly and difficult to reach areas of Yadadri Bhuvanagiri district of Telangana state in India.

13 - 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.

14 - Exploring How Rural GPs Engage in the Health Policy Process in Wales and Northern Ireland

Dr Veronika Rasic[1]

[1]Rural Health Compass / Euripa / Rural WONCA, [2]University of Edinburgh

Rural general practitioners (RGPs) are key policy actors in rural health systems. RGPs operate at the intersection of policy and practice and are well placed to identify gaps or inconsistencies in healthcare provision or policy. There is limited research on how rural clinicians participate in the health policy process. This study aims to address this gap by exploring how RGPs engage in the health policy process in Wales and Northern Ireland.

Methods: This interpretivist qualitative study used semi-structured interviews to gather data with seven RGPs. Anonymised interview transcripts were analysed using inductive reflexive thematic analysis.

Results: Four themes were developed from the data set. The first two themes, 1) Motivation and Engagement and 2) Build Relationships for Action, explore RGPs experience of engaging in the health policy process. The next themes, 3) Rural Realities in Urban-Centric Systems and 4) Rural Voices for Policy Impact, explore RGPs perspectives on current health policy in the context of rural health and rural communities.

Conclusion: This study explored the subjective experiences of RGPs in Wales and Northern Ireland providing insights for policy and practice. While the findings are not intended to be generalisable, the themes identified may resonate with other rural clinicians working in similar geographical and policy contexts. Participants' experiences highlighted how organizations and systems could support RGPs to become effective policy actors and collaborators in the health policy process. They also offer insights into existing system challenges which are contributing to rural health inequity.

15 - Rural placements for health sciences students: “my placement has opened my eyes to the way that healthcare works in a rural setting”.

Prof Eileen Mckinlay[1], Ms Sonya Morgan[2], Dr Julie Myers[2], Dr Linda Gulliver[1]

[1]University of Otago, [2]University of Otago

Background
Aotearoa New Zealand (NZ) does not routinely provide rural placements to health science students and few get this opportunity.
Otago University offers a 5-week IPE rural placement for groups of students (drawn from 11 different health disciplines) in Greymouth, an R1 rural area in the South Island, NZ. Run 5 times a year, each block of 6-11 students share accommodation and university-employed local staff organise clinical placements and deliver the programme’s interprofessional aspects.
Aim
This study aimed to explore students’, local staff and rural health professionals’ views of the IPE programme.
Methods
This qualitative study gathered data from two blocks and included: interviews with students, health professionals and staff; students’ electronic discussion-board posts and weekly survey responses. Data were analysed inductively.
Findings
Students reported learning about the strengths and resilience of rural dwellers and how geographical isolation and lack of healthcare services impacts on healthcare access and outcomes. Students remarked on the enthusiasm and commitment of the local clinical and IPE staff and described how they felt embraced by the community. Some reported an increased interest in working rurally as graduates. Rural health professionals talked of making every effort to take students recognising the opportunity to encourage them to ‘work rural’ but needed flexibility to decline as work pressures dictated.
Implications
An interprofessional 5-week rural placement enhances student learning about rural healthcare. It encourages them to consider working rurally with some applying for graduate roles. Programmes organising rural placements need to be sensitive to local work pressures.

16 - The wero was laid and accepted - An Allied Health Journey with Wharekauri, Rēkohu, Chatham Islands

Kyla Jasperse[1]

[1]Health Nz

The Chatham Islands face unique healthcare access challenges due to extreme geographic isolation, limited infrastructure, and a small, dispersed population. A review of Allied Health service provision in 2022 revealed significant inequities, with island receiving one visit from physiotherapy and occupational therapy each, no access to social work, dietetics, or speech-language therapy, and no established telehealth system. Despite a high prevalence of chronic conditions there was limited health literacy but a strong desire from the community for improved, locally accessible education and care. Additionally, a sense of mistrust with health services is evidenced, with statements from community members “you will be like the rest, come and look at us, have a holiday, leave and nothing will change”.

Key recommendations include the establishment of a consistent, generalist Allied Health workforce, regular quarterly in-person visits, and development of stable telehealth models supported by community infrastructure and training. The initiatives to expand telehealth access, and the implementation of planned and accessible Allied Health services reflect Health NZ’s response to the community’s experience to health services to date, and their resilience and readiness to partner in innovative solutions that honour local capacity while improving health equity. These models offer scalable approaches to remote healthcare delivery with potential application across other isolated communities.
Nothing is static, innovation and partnership are always at the forefront, with exciting progress on several innovations currently underway that extend beyond Allied Health.

This is the story of what can change when community and government health services work together.

17 - Alabama's Rural Health Leaders Pipeline: What difference has it made after twenty-five years?

Prof John Wheat[1]

[1]University Of Alabama College Of Community Health Sciences

Introduction. This demonstration research project, 1993-2017, proposed to increase production of rural physicians for Alabama's diverse rural population. A community-centric model guided development targeting white and black dominant regions with representatives of both on the program planning committee. Key components were local students, community-based curriculum, and family medicine instructors. Precollege summer pipeline programs and a track combining a master's in rural health and medical degree engaged 1045 students: 651 Rural Health Scholars after the 11th grade, 174 Rural Minority Health Scholars after the 12th, and 220 Rural Medical Scholars in the MS/MD track.
Methods. This community case-study reviewed the project's published evaluative, formative, and contextual research papers. Four papers evaluated medical student academic performance, specialty choice, practice location, and production of other health professionals. Two examined limited physician distribution into the black region, and 14 explored contextual circumstances that engaged collaborators.
Results. Rural Medical Scholars more frequently than traditional students chose family medicine specialty (P<.001, OR=15.6) and rural Alabama practice (P<.001, OR=6.4) with no difference in academic performance (P>.05). Few Rural Medical Scholars established practice in the black region, with many hypothetical factors identified. Other health professionals were produced. Contextual studies engaged physicians, farmers, educators, and health administrators.
Conclusions. The demonstration was judged successful, gained continuing state funding, and was institutionalized by the University of Alabama System. Further expansion is required to meet rural needs. Limited impact in the black region remains a challenge and provides opportunities for further research in socially responsive medical education.

18 - Scoping review: Rural generalist Obstetrics

Dr Brendan Marshall[1]

[1]Te Whatu Ora. Te Tai O Poutini

Title: Safe and Sustainable: A Scoping Review of Rural Generalist Obstetric Practice in High-Income Countries

Author: Dr Brendan Marshall

Background:
Access to safe, responsive maternity care in rural and remote regions remains a global challenge. Rural generalist obstetricians (RGOs) are essential to sustaining birthing services in these settings. Despite international trends toward centralisation and specialist-led care, RGOs continue to provide procedural obstetric services in many high-income countries.

Aim:
To explore the breadth of primary research on rural generalist obstetric practice, with a focus on safety, workforce sustainability, and training pathways.

Methods:
A scoping review was conducted across six databases (1990–2021), identifying 50 primary research studies from Australia, Canada, the USA, and the UK. Studies were grouped into two conceptual domains: (1) procedural skill application and (2) workforce considerations.

Results:
No studies found RGOs to be less safe than specialist-led models. Several reported improved neonatal outcomes and lower intervention rates in generalist-led units. Workforce sustainability was linked to adequate procedural volume during training, ongoing skill utilisation, and supportive service models. The loss of RGOs often led to maternity unit closures, particularly in smaller rural communities.

Conclusion:
Rural generalist obstetric practice is safe and vital. Training pathways and regulatory frameworks must evolve to support this workforce. These findings have direct implications for rural maternity service planning in Aotearoa New Zealand and globally.

19 - Pounamu Pathway: A 25-year journey in rural generalism grounded in community

Dr Brendan Marshall[1]

[1]Te Whatu Ora. Te Tai O Poutini

"Ahakoa he iti, he pounamu."
Although it is small, it is precious like greenstone.

This whakataukī captures the essence of rural generalism in Aotearoa New Zealand—often modest in scale, yet deeply valuable. This presentation reflects on a 25-year journey of rural generalist work in one of smallest most rural districts, shaped by enduring relationships with community, whenua, and the taonga of pounamu.

In a region where pounamu symbolises strength, resilience, and intergenerational connection, the evolution of rural generalism has mirrored these qualities. The talk explores the development of a broad, interprofessional rural generalist framework, responsive to local needs and informed by indigenous knowledge systems. It also highlights the importance of international collaboration, as much of the work utilised key documents such as the “Cairns Consensus Statement” and “Blueprint for Rural Health”.

Key milestones include community-led initiatives, place-based training and upskilling, and the integration of diverse scopes of practice across health disciplines. These experiences highlight the importance of adaptability, cultural grounding, and long-term commitment to rural communities.

Framed by the metaphor of the "Pounamu Pathway," this journey reflects the transformative potential of generalism when rooted in place and people. It offers insights into how rural generalism can be both a clinical and cultural practice—one that strengthens systems, builds trust, and honours the stories of the land.

This presentation invites reflection on how rural generalists can walk alongside communities, shaping care that is resilient, responsive, and deeply connected.

20 - Post-cyclone rain anxiety – a Virtual Reality solution to access to care in the Tairāwhiti district.

Dr Joseph Scott-Jones[1,2], Ms Pamela Albert[1]

[1]Pinnacle, [2]University of Waikato

Introduction/Background

In the rural region of Te Tairāwhiti, recurrent severe rain events have exacerbated mental health distress, disproportionately affecting Māori communities and those with limited access to traditional mental health services. Rain-related anxiety (pluviophobia) has risen among clients of the Pinnacle mental health team, with access barriers compounding the issue.

Locally developed, culturally grounded Virtual Reality (VR) tools offer a timely, pro-equity intervention to mitigate escalating anxiety and improve access to care.

Purpose/Objective

To evaluate the effectiveness of culturally responsive VR therapy in reducing anxiety symptoms in patients with post-cyclone rain anxiety in Te Tairāwhiti.

Methods/Approach

Patients are selected for the trial, excluding those with significant co-morbidities. Initial VR sessions are therapist-supported, with subsequent sessions tailored to patient preference. Pre- and post-intervention anxiety scores and Hua Oranga wellness assessments are conducted.

Results/Findings

Initial findings will include development processes, patient satisfaction, engagement, and outcomes. We will highlight how the intervention supports equity by enabling culturally safe, home-based care for underserved populations. The presentation will include a live demo and discussion of implementation challenges, health service utilisation, and cost-effectiveness.

Conclusion

This project demonstrates how culturally responsive, community-led innovation can address rural mental health inequities. The VR tool's connection to whenua enhances its impact in Māori communities. The model offers scalable insights for other indigenous and remote populations.

21 - Making the Pathway a Pathway: Coordinated Run-Through Training in Rural Hospital Medicine

Dr Jack Haywood[1], Dr Marcus Walker[2], Manda Challenger[1], Dr Brendan Marshall[2]

[1]Te Whatu Ora Health NZ Waitaha Canterbury, [2]Te Whatu Ora Health NZ Te Tai o Poutini West Coast

Aotearoa New Zealand's rural communities deserve a health workforce that is not only clinically capable but also culturally grounded and sustainably trained. This presentation explores the development of a regionally coordinated, run-through training pathway for Rural Hospital Medicine (RHM), designed to span tertiary, secondary, and rural hospital settings. The goal: to ensure rural-focused training is not an afterthought, but a central, seamless journey.

We will outline the vision for a networked training model that supports learners from early exposure through to advanced practice, with rural hospitals playing a pivotal role in shaping generalist capability. Key enablers include central coordination, interprofessional collaboration, and alignment with trainee needs. We will also discuss current challenges—such as fragmentation, supervision gaps, and funding—and propose solutions grounded in equity, partnership, and long-term workforce planning.

This talk invites dialogue on how we can collectively build a training system that reflects the values of rural generalism and delivers on the promise of hauora mō ngā tāngata o te tuawhenua.

22 - 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.

23 - 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.

24 - 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.

25- 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.

26 - 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.

27 - From Connection to Contribution: How Rural AHPs' Sense of Service Transforms Professional Identity and Practice

Dr Jane George[1]

[1]Independent

This presentation explores how rural Allied Health Professionals' (AHPs) commitment to community service fundamentally shapes their professional identity and practice approaches, offering insights for workforce development in rural and remote settings. Drawing from doctoral research with 18 rural AHPs across Aotearoa New Zealand, this presentation examines the concept of being "In Service" as a powerful motivator for recruitment and retention. The research reveals how community embeddedness creates unique clinical decision-making frameworks that differ from urban practice models. While workforce strategies often focus on tangible incentives and career pathways, less attention is given to how professional identity formation within rural contexts shapes practice and retention. Rural AHPs frequently describe their work through a lens of civic contribution rather than merely professional practice, blurring traditional boundaries between personal and professional lives in ways that enhance commitment and satisfaction. The findings demonstrate that rural AHPs develop distinctive practice identities characterised by community accountability, cross-boundary problem-solving, and holistic service approaches. These practitioners consistently reported higher job satisfaction when working environments recognised and valued their community connections. Health services can leverage these insights by creating organisational structures that acknowledge community contribution as professional development, developing recruitment strategies that highlight service impact, and designing roles that enable practitioners to maintain meaningful community relationships.

28 - Regulating Physician Associates in Aotearoa: Enhancing Rural Continuity, Timely Assessment, and Team-Based Care"

Andie Cook[1,2], Ms Shelly Collins[1,2], Mrs Lisa deWolfe[1,2,3,4]

[1]New Zealand PA Society, [2]National Committee on Certification of Physician Associates, [3]international academy of Physician associate Educators, [4]American academy of Physician Assocates

Physician Associates (PAs) have delivered safe, high-quality care in rural and underserved settings internationally for decades, effectively addressing workforce shortages and improving patient outcomes. In Aotearoa, since 2016, PAs—trained overseas—have provided over 380,000 patient visits with no adverse outcomes, earning high satisfaction from clinicians and patients alike.

The recent government decision to regulate PAs under the Health Practitioners Competence Assurance Act represents a significant step forward (Hauora Taiwhenua, RNZ). Regulation will enable PAs to work to the full extent of their clinically trained capabilities—supporting continuity of care, rapid assessment and management of acute and chronic conditions, and safe integration within multidisciplinary teams.

Research highlights that PAs, practicing under appropriate supervision, offer continuity often lacking with rotating medical staff. This model enables trusted, long-term care relationships—especially critical in rural communities (The New Zealand Medical Journal, PubMed). Additionally, studies demonstrate that when integrated into team-based care settings, PAs contribute to improved efficiency, reduced wait times, and enhanced care delineation—allowing doctors to focus on more complex cases (pinnaclepractices.co.nz, The New Zealand Medical Journal).

Regulation also enhances public trust and safety oversight, clarifying PAs' roles while maintaining physician oversight and accountability (nzpas.org.nz, Hauora Taiwhenua). This enables a model where PAs act collaboratively—not competitively—with doctors and nurses, thereby reinforcing resilient rural generalist teams.

This presentation will outline the evidence base from international and local implementation, detail how regulation will unlock full clinical scope for PAs in New Zealand, and highlight implications for rural workforce retention, patient outcomes, and equitable access to care.

29 - “Growing Our Own: Training New Zealand Physician Associates to Build Rural, Indigenous, Community-Rooted Healthcare”

Ms Shelly Collins[1,2], MS Andie Cook[1,2], Ms Lisa dewolfe[1,2,3,4,5]

[1]New Zealand PA Society, [2]National Committee on Certification of Physician Associates, [3]American Academy of Physician associates, [4]Hauora Taiwhenua Rural Health Network, [5]International Academy of Physician Associate Educators

Physician Associates (PAs) have long played a critical role in delivering healthcare to underserved rural populations internationally. In Aotearoa, early pilots (2013–2015) demonstrated high effectiveness—over 340,000 patient encounters with strong satisfaction and no adverse outcomes—and led to a tenfold increase in PA employment, with ~50 working across rural, primary, and emergency settings. Recently, the Government committed to formally regulate the PA profession, enabling registration through the Medical Council by 2026 and paving the way for a New Zealand–based PA training programme.

This abstract argues that training PAs from under-represented, Māori, Pasifika, and rural backgrounds—notably those already serving their communities in roles like paramedics, kaiāwhina, or rural health workers—will diversify the healthcare workforce and ensure culturally safe, locally trusted service. This “home-grown” model supports Te Tiriti principles and embodies Whānau Ora, reinforcing continuity, equity, and care continuity within rural communities.

Physician Associates and NZPA Society can help lead the development of a postgraduate PA training programme embedded within existing rural clinical schools and guided by kaupapa Māori frameworks. This model strengthens workforce retention, reduces reliance on imported clinicians, and enhances rural generalism—key to sustainable rural health systems.

By presenting international evidence alongside Aotearoa’s regulatory strides and local innovation, this session will articulate a pathway toward sustainable, equitable rural health. Attendees will gain insights into integrating indigenous knowledge, regulatory reform, and workforce development through a PA training model that empowers communities from within.

30 - How and why geographical narcissism skews interest in rural medical careers

Prof Riitta Partanen[1], A/Prof Matthew McGrail[1], Prof Diann Eley[1], Dr Remo Ostini[1,2]

[1]The University Of Queensland, [2]Australian National University

Inequality in healthcare provision between metropolitan and rural communities persists globally, largely due to ongoing rural medical workforce shortages despite decades of evidence-based strategies. Geographical narcissism (GN), the belief that the best healthcare provision occurs in big cities, pervades medical education, where growing recognition suggests GN contributes to access gaps and medical workforce shortfalls.
Guided by a constructivist paradigm, this qualitative study interviewed 29 Australian medical students and prevocational doctors. Data were analysed using reflexive thematic analysis and realist evaluation. Four themes with fifteen subthemes describe GN's influence on learners. First, GN has influenced preferenced preference to not work rurally long-term. Second, GN has questioned decision to go rural. Third, GN has not changed decision to go rural. Fourth, GN is just one of many factors in the workplace location decision making process.
Four interrelated theories explain differential susceptibility to GN. First, GN is reinforced within educational environments by clinical teachers, institutional culture, and teaching methods. Second, rural self-efficacy and firsthand rural experiences counteract GN biases. Third, career guidance and specialist training requirements privilege metropolitan pathways, particularly for non-GP specialty training. Fourth, structural biases within healthcare and education systems prioritise metropolitan settings.
GN exists within medical education and training as a subtle yet consequential influence on workplace location deliberations. GN does not operate in isolation, but has been found to interact with personal background, educational and clinical narratives, specialty aspirations, and healthcare structures. Ignoring GN risks perpetuating metrocentric models, sustaining rural health inequities and medical workforce shortages.

31 - Thriving Rural Teams and Training Centres — From Survival to Sustainability

Dr Brendan Marshall[1], Dr David Walker, Prof Paul Worley, Dr Jonathon Wills

[1]Te Whatu Ora. Te Tai O Poutini

Rural health services often operate in a cycle of survival, marked by reactive recruitment, high staff turnover, and limited capacity for training. While frameworks such as Plan, Recruit, Retain offer strategic direction, the practical steps to transition rural centres into thriving hubs of workforce development remain varied.

This interactive workshop brings together stories from rural centres across Aotearoa New Zealand and Australia that have become attractive training destinations for medical and interprofessional learners. Participants will hear directly from teams who have moved beyond survival mode — building cultures of supervision, belonging, and professional growth. Some of these centers have qualitative research that builds on the discussion.

Together, we will explore the journey from churn to sustainability, identifying practical steps that rural services can take to better serve their communities. Topics include:

Integrated workforce planning aligned with local service needs and regional training pipelines.
Credentialing frameworks supporting broad-scope rural practice across disciplines.
Collaborative supervision models using rural generalists, visiting specialists, and digital tools.
Community-embedded training that fosters cultural grounding, continuity, and belonging.
Participants will leave with insights and tools to strengthen their own rural teams and contribute to a future where rural centres are not just surviving — but thriving.

32 - Midwifery. Aotearoa and Rural Generalism.

Ms Laura Aileone

e taonga nō te ao whānui, he koha nō te ngākau."
A treasure from the wider world, a gift from the heart.

This whakataukī reflects the essence of rural midwifery—where care is both skilled and deeply relational, grounded in community and whenua. This presentation explores the concept of rural generalism in midwifery in Aotearoa New Zealand, highlighting the unique challenges, opportunities, and systemic barriers faced by midwives working in rural settings.

Rural midwives often operate across scopes and settings, providing comprehensive maternity care in environments where resources may be limited but relationships are strong. The talk will examine how rural generalism in midwifery is shaped by adaptability, cultural competence, and a commitment to continuity of care.

Key themes include workforce sustainability, access to training and professional development, interprofessional collaboration, and the impact of centralised policy on rural autonomy. The presentation will also explore opportunities for innovation, such as place-based education and use of POC diagnostics such as ultrasound, integrated care models, and leadership roles for rural midwives in shaping local maternity services.

By framing rural midwifery through the lens of generalism, this talk invites a reimagining of how we support, value, and invest in rural maternity care. It calls for recognition of the distinct skill set and relational depth rural midwives bring to their communities, and for systems that enable—not constrain—their practice.

Attendees will gain insights into how rural generalism can strengthen midwifery and how midwifery can, in turn, enrich rural health systems.

33 - 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.

34 - 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.

35 - Advancing Equity and Innovation in Rural Health: The National Clinical Network Rural Health Approach

Dr Joseph Scott-Jones[1], Neta Smith[2]

[1]Te Whatu Ora , [2]Te Whatu Ora

The National Clinical Network Rural Health (NCN-RH) is dedicated to transforming rural health outcomes in Aotearoa New Zealand by championing equity, quality, and consistency across the health system. Guided by Te Tiriti o Waitangi and the principles of pae ora (healthy futures), we will present the NCN-RH's 2025–2027 workplan which targets the unique strengths and challenges of rural communities, with a strong focus on Māori health and community-led solutions.
We will present how the NCN-RH :

- Promotes Equitable Access: Developing national standards and models of care to eliminate unwarranted variation and ensure fair access for rural populations.
- Integrates Indigenous Knowledge: Embedding Māori perspectives and supporting tino rangatiratanga in rural health leadership and service design.
- Fosters Innovation: Advocating for technology adoption, including AI and telemedicine, to bridge geographic barriers and enhance care delivery.
- Strengthens our Workforce: Supporting rural workforce development, training, and retention across all health disciplines, and advancing rural generalism.
- Champions One Health: Embracing a holistic approach that recognizes the interdependence of human, animal, and environmental health.
- Drives Data-Informed Improvement: Enhancing rural health data collection, developing outcome frameworks, and advocating for a Rural Dashboard to monitor progress.

Participants will be able to question and make suggestions for improvements to the work the NCN-RH is doing.

36 - 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.

37 - The impact of rural postgraduate training on rural recruitment of physicians.

Dr Anders Svensson[1], Dr Marie Hella Lindberg[1], Dr Birgit Abelsen[1]

[1]Norwegian Centre for Rural medicine, Arctic University of Norway

Background
Recruiting and retaining a skilled health workforce is a common challenge for remote and rural communities worldwide, negatively impacting access to services, and in turn peoples' health. It is well documented that doing undergraduate medical training in rural areas contributes to recruitment and retention of physicians in nonurban settings. However, there is limited knowledge on the impact of rural postgraduate positions on rural recruitment and retention. Norway introduced 18 months practical training (12 months in hospital and 6 months in general practice) before authorization for physicians in 1955. The aim was to improve the quality of medical training and to improve coverage of doctors in rural areas. Since 2017 the postgraduate internship has been the first mandatory part of specialization training for physicians. In 2023, 220 doctors completed their postgraduate training in 11 hospitals and 64 municipalities in Northern Norway.
Aim of study
The aim of the study is to investigate mobility and career paths of physicians who started their postgraduate training in Northern Norway between 2013-2023 (1800 doctors).
Method
The study applies a longitudinal study design that will analyze data from different registers using multivariate methods and sequence analysis.
Results
Results from a limited pilot study indicate that rural internships are of vital importance for rural recruitment and retention both in hospitals and municipalities. Results from the study will be presented and interpreted.
Relevance
The study is important for assessing the impact of rural postgraduate training on rural recruitment of physicians.

38 - Closing the Gap in Tamariki Ear Health: Piloting AI for Earlier Detection and Better Access

Jess Morgan-French[1], Dr Michelle Porkorny

[1]Collaborative Aotearoa

Collaborative Aotearoa, Health NZ | Counties Manukau, and Tāmaki Health have partnered to deliver a one-year Health Research Council–funded project piloting the use of DrumBeat.ai, an AI-supported eardrum assessment tool.

Otitis media and other ear conditions are common among tamariki in Aotearoa, with disproportionate prevalence in Māori and Pacific children. Delayed diagnosis and treatment can lead to preventable hearing loss, affecting language development, education, and long-term wellbeing. These challenges are compounded in rural and remote communities, where access is limited by travel distance, workforce shortages, and extended ENT wait times.

While this pilot is based in South Auckland, a community experiencing high levels of deprivation and inequities, the project team anticipates the tool will also be highly relevant and valuable in rural general practice settings.

This pilot will evaluate the feasibility, usability, and integration of DrumBeat.ai within a high-demand South Auckland clinic. Outcomes will be benchmarked against gold-standard audiology and ENT assessments, measuring diagnostic accuracy, clinician experience, workflow integration, and patient acceptability, with a strong equity focus for Māori and Pacific whānau.

If proven effective, DrumBeat.ai has the potential to be deployed across rural and remote practices, enabling earlier detection, reducing referral delays, and lessening the travel burden for whānau. Importantly, it offers a pathway toward more timely, equitable, and culturally responsive ear health care in Aotearoa.

By May 2026 the pilot will be in action and early findings will be available for discussion.

39 - 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.

40 - 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.

41 - Inside the GP consultation

Dr Lucy O'Hagan[1]

[1]Oratoa Cannons Creek

Inside the GP consultation is my new one women performance using multiple characters to explore the complexity or the human dynamics in the room. It is both funny, poignant and intends to acknowledge the incredible unseen work that occurs in consultations.

For more information on my background go to my website lucyohagan.com

42 - Impact of Telehealth on Rural General Practice in Aotearoa New Zealand

Dr Ruth Large[1]

[1]Whakarongorau Aotearoa, [2]New Zealand Telehealth Forum

Telehealth has rapidly become a core component of rural primary care in Aotearoa New Zealand, yet its long-term impact remains underexplored. This study, led by Dr Ruth Large for the NZ Telehealth Forum, investigates telehealth's effects on rural general practice through focus groups and surveys involving 91 rural clinicians. Findings reveal that telehealth significantly improves patient access and offers flexibility for providers, particularly by reducing after-hours burdens and enabling multidisciplinary collaboration.

However, challenges persist: GPs report increased daytime workload due to poor triaging and follow-up demands, loss of continuity of care when external providers are used, and limitations in clinical assessment via remote modalities. Technology barriers and digital exclusion further complicate equitable access. Concerns also emerged around workforce sustainability, with telehealth potentially undermining recruitment and retention if not well-integrated. Unintended consequences such as overservicing, miscommunication, and reliance on digital systems were noted. Focus groups ranked improved access as the top impact of telehealth. The largest reported concern was that telehealth could be seen as a "band-aid" solution to access and could erode in-person care. The study concludes that telehealth must be thoughtfully embedded into rural health systems to support—not replace—local care. Recommendations include improving infrastructure, clarifying guidelines, aligning funding models, and ensuring continuity through better integration. These insights underscore telehealth's dual role as both a solution and a challenge in rural healthcare delivery.

43 - New Rural Residency Programs Increase Access to Care

Dr Emily Hawes[1], Shelby Rimmler-Cohen

[1]UNC School of Medicine

Expanding rural residency training is an important policy lever to address rural health workforce shortages. The Federal Office of Rural Health Policy (FORHP) funded Rural Residency Planning and Development (RRPD) grantees to create new residencies in FORHP-defined rural areas to increase rural physician supply across the US. We examined the effect of RRPD programs on types of services offered and access to care. We conducted 36 semi-structured interviews with leadership of RRPD grantees and a thematic content analysis of transcripts to examine the effect on access to care as defined by the Agency for Healthcare Research and Quality: coverage, timeliness, services, and workforce. New rural residency programs, representing 24 states from across the US, increased coverage for underinsured patients and spurred the development of new clinics and programs closer to patients. Timeliness was improved with earlier access to new patient visits, increased visits available, and more empaneled patients. Expanded services included behavioral health, chronic disease management, pediatric and obstetric care, and musculoskeletal interventions in primary care, and increased access to specialists. The workforce was bolstered with a more energized clinical team and new hires including pharmacists, nutritionists, behavioral health clinicians, and nurses. RRPD programs strengthened rural community engagement and inspired creation of training in other disciplines and specialties. In conclusion, new rural residency programs led to service expansion that increased access to care. Beyond monitoring how rural residencies increase the number of rural physicians, evaluations should also measure their effect on service expansion and the delivery of rural care.

44 - Faculty Development in New Rural and Underserved Residencies

Dr Emily Hawes[1], Dr David Evans[2], Shelby Rimmler-Cohen

[1]UNC School of Medicine, [2]University of Washington

In 2019, the US Health Resources and Services Administration (HRSA) began funding Rural Residency Planning and Development (RRPD) grants, to help rural communities, largely with a Rural-Urban Commuting Area Code of 4 or greater, establish residencies. The US accrediting organization requires faculty development for all programs. Small rural programs, especially those starting out, often struggle to incorporate faculty development. The aim of the study was to evaluate types of faculty development that new rural residency programs are using, describe typical structures of these programs, and assess differences by specialty, region, size, or program structure. Descriptive and bivariate analysis were conducted of HRSA performance report data for fiscal year 2023 of 43 RRPD grant recipients who were starting new residencies to determine types and structure of faculty development programs. Sixteen of 43 grant recipients (37.2%) indicated their faculty participated in structured, mostly longitudinal faculty development programs; 22 (51.2%) participated in a faculty development activity such as a conference or class; and 12 (27.9%) reported no faculty-related activities in that year. Those later in development were more likely to report engagement in faculty development. There were no differences in quantity or type of faculty development based on specialty, region, size, or rural track structure. In conclusion, new and developing residencies in the RRPD program are engaged in faculty development through a myriad of activities, including structured, longitudinal programs as well as conferences, workshops, and training, which may provide pragmatic ideas to other developing programs across a variety of rural regions.

45 - 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.

46 - 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.

47 - 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.

48 - Connected Communities: Place-Based Workforce Retention Through Community-Led Action

A/Prof Christina Malatzky[1], Dr Catherine Cosgrave[1,2], Dr Jane George[3], Professor Fiona McDonald[4]

[1]Queensland University Of Technology, [2]Attract Connect Stay, [3]Auckland University of Technology, [4]Victoria University of Wellington

Rural communities across Australia and Aotearoa New Zealand face critical health workforce shortages that threaten community sustainability. Traditional recruitment approaches fail because they ignore that workforce retention requires genuine community belonging, not just employment. The Community Connector Program (CCP) represents a community-led response aligning with principles of collective responsibility and place-based connection.

This qualitative research examined CCP implementation across eight rural communities in Australia and Aotearoa New Zealand (2021-2024). Two rounds of interviews with 16 participants (community champions and Community Connectors) represented diverse contexts from small agricultural towns to large regional centres. Narrative-focused analytical approaches informed by sociological conceptualisations of community and place, and feminist research principles respectful of Indigenous knowledge systems were utilised to discern key learnings from the CCP for addressing rural workforce issues.

Successful CCPs demonstrated whole-of-community mobilisation rather than single-organisation ownership. Key success factors included: connected community leadership spanning Indigenous and non-Indigenous networks; Community Connectors with lived experience of belonging and displacement; authentic relationship-building, respecting community rhythms; and cross-sectoral engagement. Operational programmes achieved remarkable retention: Mid Coast NSW settled 100 professionals (255 people including families) over 18 months with zero departures; Southern Grampians Victoria placed 66 health professionals (166 people including families) over two years with only three departures.

This research demonstrates how rural communities exercise agency in addressing workforce challenges through community-led approaches. The model provides practical guidance for sustainable workforce retention through honouring local knowledge systems. Emerging fee-for-service transitions in some programmes suggest pathways toward financial sustainability to maintain social impact

49 - Narrative of the Experience of a Family Medicine and Community Medicine Resident Inserted in a Fluvial Primary Health Care Unit in the Amazon Forest: An Autoethnography

Alice Mesquita, Pedro Lima Martins Costa

[1]Public Health System, Sus

The presented autoethnography describes an immersion experience of a medical resident in a Fluvial Primary Health Care Unit in the Amazon, focusing on riverine populations. The aim is to reveal demands, silences, and the impacts of public policies and capitalist expansion on these communities, breaking hegemonic narratives and strengthening the understanding of riverine identity as a cultural category. The author actively participates in the research, generating an autobiographical narrative that allows analysis of how the riverine context shapes health, care, and the institutionalization of public policies.
Methodologically, the resident joined a riverine family health strategy team, after selection by résumé and interview. Throughout the month, she kept a field diary with descriptions, reflections, and feelings, alternating between the daily care in the fluvial unit and the perception of a shared reality with patients living in hard-to-reach areas. This diary functions as an autoethnographic instrument, linking personal impressions with professional observations.
The final considerations highlight a awakening to a reality that is often neglected and isolated, where access difficulties and limited information contrast with the resilience of riverine communities. Despite limitations, riverine populations preserve identity and traditional knowledge, especially knowledge of nature transmitted across generations. The experience reveals the need for new health care models that are closer to culture, life ways, and local support networks, recognizing the richness of a practice that transcends the urban environment.

50 - 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]

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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.

51 - He oranga whānau, he oranga marae: Creating community wellbeing through Marae-based healthcare

A/Prof Awanui Te Huia[1], Mrs Mania Maniapoto-Ngaia, Ms Maria Maniapoto

[1]Te Herenga Waka - Victoria University of Wellington

Marae have a strong history of responding to the needs of our communities throughout Aotearoa, this is not new. However, the results of this case study indicate that marae-based healthcare might be key to significantly improving Māori health outcomes. This mixed-methods study, based at Mangatoatoa Paa Whare Hauora in the rural community of Tokanui, Kihikihi, involved responses from whānau and community service users (n = 28 complete responses) and 37 interviews with PHO stakeholders (n = 5), health practitioners (n = 20), Marae trustees (n = 5), and whānau service users (n = 7).

The results indicate that having services provided at Mangatoatoa Paa had a positive impact on the health experiences of both health practitioners and clients in this rural clinic. Clinicians and service users reported that marae-based care enabled them to engage in whanaungatanga (including high-trust relationships), which was linked to the identification of co-morbidities, referrals to specialists (with clinicians following up to ensure access), and an overall improvement in the quality of care received.

From the quantitative results, 94.7% of survey respondents rated their overall satisfaction with care as excellent, the same percentage reported feeling better attending the Whare Hauora compared with mainstream health services, and 89.5% indicated they had experienced tangible improvements in their health outcomes.

Our presentation will explore the key elements that contributed to these improvements, offering insights into how marae-based healthcare can address rural health inequities and deliver culturally grounded, clinically effective care.

52 - Co-designing a culturally responsive and sustainable national Indigenous-led virtual health care service model for rural Australia

Dr Bushra Nasir[1], Dr William McAskill[1], Dr Annika Luebbe[1], Mr Floyd Leedie[2], Prof Khorshed Alam[3], Prof Katharine Wallis[4], A/Prof Matthew McGrail[1], A/Prof Srinivas Kondalsamy-Chennakesavan[1]

[1]Medical School, Faculty of Health, Medicine and Behavioural Sciences, The University of Queensland, [2]Goondir Health Services, [3]School of Business, and Centre for Health Research, University of Southern Queensland, [4]General Practice Clinical Unit, Medical School, The University of Queensland

Background: Digital technologies are increasingly used in primary healthcare, yet their role in rural Indigenous communities is underexplored. Exploring consumer-informed strategies is essential for creating culturally safe, effective, and accessible digital health care models.
Methods: This study employed decolonising methodologies to design a culturally safe, Indigenous-led virtual healthcare service through meaningful consumer involvement in regional, rural, and remote Queensland, Australia. An Indigenous Governance Committee co-designed data collection tools, embedding Indigenous values and practices. Five focus groups were held in collaboration with Indigenous health coaches. Data underwent hybrid inductive–deductive thematic analysis. Emerging themes were reviewed and validated by the Indigenous Governance Committee to ensure findings reflected Indigenous perspectives.
Results: Three key themes were identified: (1) People, community, and support – digital tools were most effective when delivered by trusted, community-embedded providers and with culturally relevant care. (2) Technology, usability, and engagement – participants reported both benefits and frustrations; success depended on training, flexibility, accessible education, and personalised options. (3) Impact, value, and future directions – technology was seen as empowering but complementary to face-to-face care, with broader benefits for social connection, wellbeing, and shared learning. Barriers included technical challenges, digital literacy, and unreliable connectivity. Scalability was linked to consumer-driven education, inclusive access policies, incentives, and sustainable support structures.
Conclusion: Digital healthcare technology can enhance access, self-management, and community engagement in rural Indigenous communities. However, technical issues and usability are significant barriers. Further research addressing equity challenges is essential for broader implementation and sustainability of digital healthcare technology within rural Indigenous communities.

53 - He hāpai ō. Those who provide sustenance and support.Te Ara Aroreretini, ADHD pathway for assessment and treatment, a review

Dr Hinemoa Elder[1], Materoa Blair[1]

[1]Te Hiku Hauora

Access to culturally meaningful and responsive assessment and treatment for Attention Deficit Hyperactivity Disorder (ADHD) in Muriwhenua is limited. People with untreated ADHD live with well-recognised negative consequences. Recent research has found that those who received biological treatment for their ADHD had an associated significantly lower all-cause mortality, particularly for death due to unnatural causes. Recent research has shown that our tamariki are almost twice as likely to be identified as having ADHD concerns in B4 School Checks, than non-Māori. Waiting times for tamariki to be assessed and provided with treatment options for ADHD are up to one year. There are no funded services for adult ADHD assessment and treatment.

In March 2025 a secondary mental health-level ADHD assessment and treatment pathway, Te Ara Aroreretini, was established within our primary care organisation to address these needs across the lifespan. This pathway was informed by the current clinical guidelines developed in Aotearoa. This paper reports the first 5-months of this work.

31 adults have been through our pathway, 60% are Māori, all but one with ADHD. 9 tamariki between 7-18 years of age participated, all Māori, all met criteria for ADHD, all whānau opted for biological treatment.

Having a psychiatrist and nurse working together is an effective model. Respecting a range of views about such medical concepts, our pathway has been deemed useful by our community. This work also provides a possible blueprint to help GP practices, now expected to provide ADHD assessment and treatment for adults.

54 - Redesigning Rural and Remote Urgent Care in Aotearoa New Zealand

Rachel Pearce[1]

[1]Te Whatu Ora Health New Zealand

This session explores the journey from the Rural Urgent and Unplanned Care (RUUC) Redesign Project to the creation of the new 2025 national Framework for urgent and after-hours care in Aotearoa New Zealand.

Rural communities have long faced inequities in access and consistency of urgent and unplanned care. The RUUC Redesign Project, completed in 2024 through a partnership between Health NZ and ACC, sought to address these gaps. Guided by an expert advisory group with clinical, operational, sector, and lived-experience representation, the RUUC Project delivered recommendations designed to strengthen access for rural communities while setting a foundation for equity across all geographies.

In May 2025, the Urgent and After-hours Care Framework was published, directly informed by the RUUC work. Recognising that urban, rural, and remote communities have different needs and service delivery context, the Framework establishes a graduated national model tailored to population size and rurality, anchored by six core service components.

With Budget 2025 allocating $40.9M annually for implementation, including investments to improve rural access to diagnostics, after-hours medicines, and in-person clinical care, this presentation reflects on the lessons of the RUUC project, the development of the Framework, and early progress in delivering improved urgent care access for rural whānau across Aotearoa.

55 - 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.

56 - Improving oral health outcomes for children and young people living in out of home care in rural Australia

Dr Stacey Bracksley-O'Grady[1], Associate Professor Virginia Dickson-Swift[1], Professor Santosh Tadakamadla[1,2], Dr Corina Modderman[1], Dr Fiona Dangerfield[1]

[1]Violet Vines Marshman Centre for Rural Health Research, La Trobe University, [2]Rural Clinical Sciences, La Trobe Rural Health School

Children and young people (CYP) living in out-of-home care (OOHC) often experience unmet health needs and poorer outcomes, with oral health a particular concern. CYP in OOHC have significantly worse oral health than their peers, and those in rural areas face additional barriers in accessing care. Despite eligibility for free public dental services in Victoria, fewer than 10% of CYP in OOHC have ever attended a dental appointment.

This two-year project, funded by the Borrow Foundation, aims to improve oral health outcomes for rural CYP in OOHC through the co-design of an evidence-based oral health promotion and prevention program.

The first stage of the study involved semi-structured interviews with key stakeholder groups, including CYP with lived experience of OOHC, carers, child protection practitioners, and dental professionals. These semi-structured interviews explored barriers to care, system strengths, and opportunities for change. Initial findings highlighted challenges such as limited-service access, confusion about consent processes with guidelines often unclear for both carers and providers, the sidelining of oral health due to competing priorities, and the difficulties created by placement changes and uncertainty around who holds responsibility for a child's oral health care. Participants emphasised the importance of culturally safe, community-driven approaches that value lived experience and integrate local knowledge.

Building on these findings, stage two will involve co-design workshops to develop and refine an oral health intervention, to be piloted in rural Victoria. Embedding co-design ensures the intervention is both feasible and acceptable and offers potential for broader application to global models of care.

57 - Can't Touch This: Can Virtual Physical Examination Devices Revolutionise Telehealth and Improve Access to Healthcare in Aotearoa New Zealand

Dr Savannah Da Silva[2]

[1]Oxford Community Health Centre, [2]Remedi Solutions

An evaluation of the potential of Virtual Physical Examination Devices (VPEDs) as an innovative digital tool to enhance telehealth and address some of the challenges around accessing healthcare in rural Aotearoa.

With increasing pressure on services - marked by workforce shortages, geographic barriers, and rising patient complexity and demand - telehealth is often pitched as a seemingly all-encompassing solution. However, possibly the most critical risk in telehealth assessment is the inability to perform a comprehensive physical examination, but by enabling remote multi-system physical examinations, including auscultation, otoscopy, and vital sign monitoring during virtual consultations, there is potential for safe expansion in the scope and effectiveness of telehealth. Can VPEDs transform telehealth into a clinically viable solution?

Discussion includes the evaluation of VPEDs against innovation adoption frameworks; key indicators of successful and less successful innovation adoption; clinical capability and the evidence base; equity and ethical considerations; use cases and models of care; and, if time allows, demonstration of a VPED currently in use in Aotearoa.

While it is inevitable that digital technologies will become increasingly embedded in routine healthcare, transformative change and widespread adoption of remote clinical assessment would require significant funding reform, organisational and clinician buy-in, and cultural shift, both on the part of professionals and patients. Despite this, we could see a new normal emerging with continuing technological developments and the apparent political appetite to increase telehealth use - representing both a challenge and an opportunity for healthcare professionals to reimagine patient care delivery in our digitally connected future.

58 - Integrated Health Therapist Model in rural USA

Karoliina Slack[1], Casey Westphal

[1]Sanford Health

In the upper Midwest, rural communities including tribal nations, remote towns, and farming populations face barriers to mental health care. Geographic isolation, provider shortages, seasonal work demands, high levels of poverty compared to more urban cohorts, and stigma often prevent individuals from receiving timely, consistent behavioral health support. As the premier rural health system in the US, Sanford Health is embedding and integrating behavioral health therapists within primary care and specialty clinics which advances whole-person care for rural populations. Yet for many in the most remote regions, including those on tribal lands or in agricultural areas, even integrated in-person services remain inaccessible due to travel distances, weather limitations, and workforce constraints. Virtual visits offer a solution to extend integrated therapy beyond traditional boundaries. Through secure telehealth platforms, our therapists connect with patients in their homes or at local facilities, reducing travel burdens, enabling flexible scheduling, and ensuring continuity of care and coordinated collaboration with primary care providers. This approach has proven effective for farmers during planting and harvest seasons, for individuals in remote areas without local providers, and for tribal communities seeking culturally responsive mental health support without leaving their communities.
Virtual integrated therapy also facilitates stronger care coordination, allowing therapists to collaborate seamlessly with Sanford Health's multidisciplinary teams across state lines. Early evidence shows virtual delivery achieves outcomes comparable to in-person care for conditions such as depression, anxiety, and trauma-related disorders. Expanding this model ensures geography is never a barrier to mental health care across our rural service area.

59 - Supporting the professional development of the remote primary health care workforce in the Northern Territory, Australia: An evaluation of the Project ECHO pilot

Prof James Smith[1,2], Dr Catherine Street[1,3], Ms Eliza Gill[1], Associate Professor Emma Kennedy[1], Mr Jason Bonson[1,4]

[1]Rural and Remote Health, Flinders University, [2]Centre for Social Impact, Flinders University, [3]HUB Evaluation, [4]Deadly Male

The Northern Territory (NT), Australia has a population of 240,000+ people many living in regional and remote communities, and 30% identifying as Aboriginal and/or Torres Strait Islander. This requires culturally responsive, contextually relevant primary health care (PHC) planning and delivery alongside innovative approaches to remote PHC workforce professional development. In 2024-2025, a Project Extension for Community Healthcare Outcomes (ECHO) Pilot ('Project ECHO') was trialled with the NT PHC workforce, using a Community of Practice (CoP) framework involving four distinct networks. An independent evaluation of Project ECHO guided by Moore's Evaluation Framework for Continuing Medical Education examined participation, satisfaction, knowledge, and competence. Principles of equity and Indigenous Data Sovereignty underpinned the evaluation. Data came from post-session surveys; a final survey; six participant interviews; and nine interviews with Project ECHO staff and subject matter experts. Qualitative data was analysed thematically using NVivo 14 and quantitative data analysed with descriptive statistics. Human Research Ethics Committee approval was obtained. Findings showed 79% of final survey respondents reported improved access to professional support and 73% said their sense of professional isolation had reduced. All networks reported increased self-assessed knowledge in pre- and post-surveys, and 90% of participants intended to apply their learnings in practice. This evaluation demonstrated the usefulness of online professional education and support for PHC professionals in regional and remote NT, as well as opportunities to better tailor generic models of education through virtual technology to local settings in a culturally responsive way.

60 - 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

61 - 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.

62 - Working together: Cross-sectional research relationships to support young farmer health and wellbeing in Aotearoa New Zealand

A/Prof Nicky Stanley-Clarke[1], Dr Jorie Knook[2], Mrs Amanda Hay[1]

[1]Massey University, [2]Lincoln University

Since 2022 researchers from Massey and Lincoln Universities have come together to support the mental health and wellbeing of young farmers, agricultural students and future rural professionals. The research team includes cross disciplinary researchers with experience in health, social work, teaching, mental health, animal health and agriculture including agro-ecological and social transitions. The research team have further extended the cross-sectional nature of the research to work with industry (DairyNZ, Dairy Womens Network), health (ACC, Safer Farms, Farmstrong) and tangata whenua partners. This diversity of perspectives has contributed to research that supports wellbeing and builds resilience across the rural sector.

Undertaking research in Aotearoa New Zealand requires consideration of Te Tiriti o Waitangi and an active commitment to build relationships with and consider tangata whenua viewpoints. These relationships contributed to the research team's appreciation for different standpoints and what it means to engage in meaningful research involving Māori communities. This learning informed the framing of research, the development of research tools and consideration of data sovereignty. Consideration of Te Whare Tapa Wha has become a central framework for understanding and supporting the health and wellbeing of all research participants.

This presentation discusses the findings and learnings from this cross-sectional research. Beginning with the implementation and evaluation of WellMates (a mental health and wellbeing programme for agricultural students). The research collaboration remains committed to supporting the wellbeing of rural communities. Current projects include exploring strategies to support farming women and the development of wellbeing strategies to support students undertaking agricultural practical work.

63 - 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.

64 - The first five minutes after snakebite: GP-led, low-cost education to correct first-aid myths in rural Sri Lanka

Dr Mohamed Shuja[1], DR ABDUL CAREEM AARA THILFAR[2]

[1]Faculty of Medicine & Allied Sciences, Rajarata University of Sri Lanka, [2]Paediatrics Unit, Ashraf Memorial Hospital (AMH)

Background:
Snakebite is a major rural emergency in Sri Lanka, where pre-hospital actions strongly influence outcomes. Harmful community practices (tourniquets, ice, cutting/suction) persist.
Aim:
To assess community knowledge and misconceptions on snakebite first aid at a rural general practice and to implement a rapid, culturally suitable educational intervention.
Methods:
A cross-sectional survey was conducted at a GP clinic in Ulukkulama (Anuradhapura). Twenty-nine adults completed a 10-item instrument spanning five domains (exposure/awareness, misconceptions/harmful practices, evidence-based first aid, prevention, treatment, and danger signs). Immediately afterwards, participants received a bilingual (Sinhala/Tamil) pictorial leaflet plus a brief one-to-one explanation.
Results:
The mean knowledge score was 6.06/10, indicating moderate baseline awareness. Correct responses were universal for washing the bite (100%) and seeking hospital care (100%). Key gaps remained: avoiding tourniquets (72.4% correct), recognising harmful actions (31.0% correct), avoiding ice (31.0% correct), and selecting immobilisation as the first step (51.7% correct). Prior training was reported by 51.7% of participants. The leaflet enabled immediate clarification of misconceptions.
Innovation:
The GP-led intervention is low-cost and designed for low-literacy audiences using imagery reviewed by community representatives.
Conclusion:
In this rural setting, myth-driven gaps persist in procedural first aid, especially around immobilisation and rejecting tourniquets/ice. A brief, bilingual micro-intervention embedded in primary care is feasible and promises to improve pre-hospital behaviour.
Implications:
Rural clinics can adopt a five-minute “Do / Don’t — Call & Carry” script with the leaflet and use a one-minute, three-item quiz to audit change and support wider roll-out through PHIs, schools, farmer groups, and youth clubs.

65 - Wenzhou, Zhejiang Province: Circuit Smart Medical Model Promotes Equity in Rural Healthcare

Mr Xiaochun Wang[1]

[1]Health Commission of Wenzhou

To solve inadequate primary medical coverage in some rural areas and poor chronic disease management for the elderly in remote regions, Wenzhou, Zhejiang, China has developed a "fixed + mobile + AI" medical service model.

Firstly, it has built 212 "Intelligent Mobile Hospital" vehicles and "807 + X" circuit medical points：400 fixed circuit points cover remote mountainous areas and villages with "medical service gaps," providing regular services 1-2 times a week; "407 + X" mobile points cover elderly care institutions and communities with standardized equipment, medical staff and essential medicines, and support real-time medical insurance reimbursement. Secondly, 505 "Smart Health Stations" (with self-test machines, cloud consulting rooms) offer health management and online consultation, plus a health points mechanism to boost key groups' participation. Thirdly, an "AI Intelligent Platform" (nearly 10 image diagnosis algorithms, integrated functions) has set up ECG diagnosis and prescription review centers via medical alliances, and a remote applet for family doctor sign-up and prescription renewal.

This model has effectively eliminated medical service gaps in remote areas and realized citywide coverage of the "15-minute medical service circle." In 2024, the consultation rate at grassroots (township and village levels) medical institutions in the region reached 65.1%, with 4.228 million people having basic sign-ups and 2.538 million doses of long-term prescriptions for chronic diseases dispensed. The standardized management rates for the elderly, hypertensive patients and diabetic patients have all exceeded the national basic requirements, effectively promoting equity in rural healthcare.

66 - 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.

67 - Not just the “Plus-1” - Rural Physician Partner Perspectives on Recruitment & Retention

Stephanie Welton[1,4], Dr. Julie Easley[1,2], Dr Sarah Lespérance[1,4], Dr. Nathaniel Pollock[3], Yvonne Anisimowicz[5], Mr Fraser Turner[4,6]

[1]Dalhousie University, Family Medicine, [2]Horizon Health Network, [3]Memorial University of Newfoundland, [4]Society of Rural Physicians of Canada, [5]University of New Brunswick, [6]Mount Allison University

Objective: Recruiting and retaining physicians in rural areas is a challenge in healthcare systems worldwide, including Canada. Partners of physicians play a significant role in influencing decisions to move to and remain in rural areas, however, their perspectives remain underexplored in existing literature. The goal of this study was to understand the lived experiences of rural physician partners and factors that influence their decisions to move to and stay in a rural or remote community.
Methods: This qualitative study used a two-phase approach. Focus groups were first conducted in-person during a rural medicine conference organized by the Society of Rural Physicians of Canada. Data from focus groups was used to create an interview guide for the second phase of semi-structured interviews. Online and telephone interviews were used to gain deeper insights into the perspectives of partners. A reflexive thematic analysis was used for data analysis. Purposive sampling approaches were utilized to capture a diverse sample. An advisory group (partners of rural physicians, physicians and recruiters) informed the direction of this work, and have been engaged throughout the research process.
Results: Core themes identified include issues of identity, compromise/sacrifice, adaptability and resilience, medicine as the priority, need for support, gender, and challenges due to rurality.
Conclusion: Understanding the lived experiences of rural physician partners is helpful for recruitment and retention. The findings of this study can inform strategies to provide support to physicians and their families as they integrate into rural and remote communities.

68 - From Polio Workers to Comprehensive Primary Health Care Agents: Rethinking the Role of Lady Health Workers in Rural Balochistan, Pakistan

Dr Niaz Ahmed[1], Associate professor Hamish Crocket[1], Professor Roger Strasser[1,2]

[1]University Of Waikato, New Zealand, [2]Northern Ontario School of Medicine (NOSM) University

Background:
Pakistan has the world's third-largest rural population, where Lady Health Workers (LHWs) are central to the primary health care (PHC) structure. In Balochistan—the country's largest and most resource-constrained province, where more than two-thirds of people live rurally—LHWs face growing demands from the vertical programme, Global Polio Eradication Initiative (GPEI), often at the cost of comprehensive PHC services. To understand the realities of the unique sociocultural constraints in Balochistan's diverse rural context, this study explored the experiences and perceptions of LHWs working with GPEI and those not, focusing on the factors that influence their experiences and job satisfaction in two districts of Balochistan.

Methods:
Using an interpretivist qualitative design, with purposive sampling, semi-structured interviews were conducted with 11 LHWs—seven engaged in GPEI and four not. To respect cultural norms, female research assistants conducted interviews in the local language. The local lead researcher transcribed, translated, and analysed data inductively using Braun and Clarke's six-phase thematic analysis.

Results:
Five themes emerged: Factors beyond the LHW's control; Increased workload; Variable community relationships; Drivers of job satisfaction and motivation; and Suggestions for improvement. LHWs reported increased workload from polio activities, chronic supply gaps affecting their relationship with the community and compromising PHC delivery.

Conclusions:
Findings highlight the urgent need for integrated, contextually responsive, comprehensive PHC models in rural Balochistan. Aligning responsibilities with resources, embedding social accountability, and restrengthening community engagement can reposition LHWs as comprehensive PHC agents, which is critical to advancing rural health equity and sustainable, inclusive health systems.

69 - 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.

70 - Permanent education for the health team in the riverine communities: strengthening technical knowledge and empowering professionals in the Amazon

Pedro Lima Martins Costa[1], Alice Mesquita[1]

[1]Public Health Sistem – Sus

As family physicians working in riverine communities in the Amazon, it was observed that there was a lack of continuous technical updating the health team. Thus, it was created a continuous education project with the local team, focusing on ongoing education for community health agents and nursing technicians. In Brazil, those professionals are riverine people who work in the same territory where they have always lived. Periodic meetings included group dynamics and reflection moments. The content prioritized was health surveillance and care strategies for common regional diseases, always seeking to adapt actions to local particularities, such as rituals, navigation seasonality and river access.
The methodology included round-table and case discussions, also practical trainings conducted at Primary Health Care Units. The audience, mainly riverine, broadened the reach and accountability for health knowledge among the agents, who helped align and raise awareness on topics. Additionally, there was reinforcement of clinical supervision with exchanges of experience between itinerant teams and support points.
The results showed an increase in the team's technical capacity and greater confidence in applying protocols. The transmission of information to the population served became clearer, with guidance on preventive actions, vaccination and health care, strengthening the bond between professionals and the communities. It was also observed greater adaptability of actions to riverine dynamics, such as seasonal navigation changes and access challenges.
In resume, continuous education, aligned with territorial needs, enhanced clinical practice and empowered territorial professionals. This model can serve as a reference for other teams in geographic isolation contexts.

71 - The Operation of the Rural Family Medicine with Riverside Communities in Amazonas, Brazil

Pedro Lima Martins Costa, Alice Mesquita[1], Mr Bruno Fonseca[1]

[1]Public Health System – Sus

This report describes the implementation and functioning of the riverine Family Health Teams in the rural área of Amazonas, Brazil, focusing on riverine communities. The model involves 7 teams (including 5 Family Physicians): 2 itinerant teams that navigate by the Fluvial Primary Health Care Unit (UBSF) and 5 land-based Primary Health Care Units (UBS). The itinerant teams cover larger territories by boat, while the land-based teams operate in smaller areas, with the UBS based in the most populous community.
Each team may include, when needed, 1 family physician, 2 nurses, 1 dentist, 2 oral health auxiliaries, 12 nursing technicians, 5 microscopists, 24 community health agents, 2 pilots, 1 general services staff. The UBSF serves as the main access point in the Amazon region, replicating UBS structure to maintain equivalent operation.
The UBSF enables consultations, home visits, laboratory tests, vaccination, and medication dispensing. The navigation logistics facilitate access to isolated communities, promoting continuity of care and actions in health prevention and longitudinal care.
The engagement with local leaders guides collective activities, strengthening ties between teams and the community to improve health promotion quality in remote contexts.
Combining fluvial infrastructure with community participation broadens access to essential services, health monitoring of riverine populations and adherence to care practices adapted to the aquatic environment. This is a great exemple of paradigm shift when carrying for geographic isolation contexts. The flexible approach between itinerant and land-based teams supports responsiveness to different territorial demands and also provides larger access to brazilian public health system (SUS).

72 - Rural People Shaping Research: Australia's Rural Health Consumer Panel

Dr Fiona Dangerfield[1], Mr Brodie Adams[1], Ms Sally Fraser[1], Ms Patricia Moran[1], Professor Evelien Spelten[1], Dr Joanne Adams[1], Professor Leigh Kinsman[1]

[1]Violet Vines Marshman Centre for Rural Health Research, La Trobe University

Consumer involvement in health research is widely recognised as enhancing research from design, implementation and translation into improved health outcomes. However, there is limited evidence of consumer involvement in rural health research, despite persistent rural health inequities. Innovative approaches are needed to ensure research solutions are informed and driven by the lived experiences of rural people.

Consumer panels provide an efficient way to organise meaningful, ongoing consumer involvement rather than one-off involvement in discrete research activities. In 2022, Australia's first Rural Health Consumer Panel was established to place rural voices at the centre of rural health research. The panel's governance includes rural health consumers, researchers, health service providers and national peak bodies, ensuring consumer leadership and strategic direction.

The Rural Health Consumer Panel has 290 members actively involved across the research cycle. Panel members shape research priorities in areas such as skin cancer, heart disease, oral health, long covid, mosquito-borne illness prevention, end-of-life care, dementia and technology solutions in rural health. Their input strengthens grant applications, refines research questions, and informs study design. Members also play a critical role in translating findings by interpreting and communicating results to diverse audiences, ensuring rural perspectives inform national policy and drive practice change.

The Rural Health Consumer Panel demonstrates how authentic consumer engagement strengthens the relevance, translation, and impact of rural health research. This innovative, scalable model highlights the importance of embedding consumer voices in all stages of the research cycle to address rural health inequities.

73 - 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.

74 - 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.

75 - Te Mana o te Waiata: Healthcare workforce wellbeing using Waiata as a tool for healing, Mātauranga Māori, and connection.

John Lawrence Kereama[1,4], Mrs Anne-Marie Midwood-Murray[5], Dr Robin Chan[1,2,3]

[1]Te Whatu Ora, [2]Pihanga Health, [3]Te Kapua Whakapipi, [4]Taupo District Council, [5]Pinnacle

Singing groups have been shown to reduce stress hormone levels, strengthen social connection, and improve wellbeing across diverse populations. These benefits extend into organisational contexts, including healthcare settings. In Aotearoa New Zealand, waiata — meaning “sing, song, chant, psalm” in te reo Māori — is a central expression of Mātauranga Māori (Māori knowledge). Traditionally, waiata transmit history, language, and identity across generations, functioning as living archives that preserve cultural narratives and offer perspectives distinct from mainstream accounts.

Like many Indigenous peoples globally, Māori report that mainstream health services often lack cultural appropriateness, limiting positive health experiences and outcomes. Conversely, providers who engage with Māori worldviews build trust, foster open communication, and enhance ongoing engagement.

Methods:
Weekly waiata groups were established across hospital and community settings. After three months, an anonymous survey assessed participants’ experiences. Self-reported outcomes were measured across three domains: (1) connection with colleagues, (2) personal well being, and (3) understanding of te ao Māori. Responses were rated on a 5-point Likert scale.

Results:

Connection: 93% reported improved connection with colleagues.
Wellbeing: 93% reported improved personal wellbeing.
Cultural understanding: 96% reported a deeper understanding of te ao Māori.

Thematic analysis identified: (1) Whakawhanaungatanga and belonging, (2) Joy of waiata and collective music-making, (3) Cultural learning and connection to te ao Māori, (4) Hauora, wairua, and emotional wellbeing, (5) The need for protection, resourcing, and protected time for the kaupapa, and (6) Aspirations for scale and wider adoption. A supporting theme highlighted the importance of leadership and a safe, inclusive learning environment.

76 - 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.

77 - A Framework for Enhanced Diversity in Rural Medical Leadership: Co-Creating the Path Forward

Dr Sarah Lespérance[1,2,3], Dr. Sarah Chalmers[4,5,6], Dr. Fiona Bolden[7]

[1]Dalhousie University, Family Medicine, [2]Society of Rural Physicians of Canada, [3]College of Family Physicians of Canada, [4]Rural Doctors Association of Australia, [5]Australian College of Rural & Remote Medicine, [6]Top End Health Services - NT Health, [7]Hauora Taiwhenua Rural Health Network

Women account for 67% of the global health and social care workforce, however the role of women in leadership positions remains markedly underrepresented. In rural regions, women, Indigenous individuals, and those from other equity-deserving groups hold few leadership roles. According to the WHO, gender equity is key to building resilient health systems and in order for this to be done, further work needs to be done to support enhanced diversity in rural leadership. Unfortunately, there is no clear framework that exists that recognizes the uniqueness and complexity of the challenges faced in a rural context.

This interactive workshop is designed to explore this issue, and take concrete steps towards the development of a Framework for enhanced diversity in rural leadership for Rural WONCA, practitioners, and rural health organizations globally. Key findings from data gathered through conference workshops focused on rural women in leadership will be shared, along with existing frameworks for enhancing diversity in leadership. A panel discussion with stories of leadership experiences from a diverse group of women leaders will frame the main workshop, where participants will review a proposed rural framework, offering feedback, “rural-proofing” and confirming key components.

Session structure:
1. Overview of findings from focus groups of rural women interested in leadership from Canadian, Australian, and WONCA Rural health conferences.
2. Panel Discussion: personal experiences, successful programs, unmet needs
3. Development of a Framework: facilitated small group discussions reviewing proposed elements
4. Reporting back on themes/core concepts
5. Group discussion and plans for dissemination

78 - Tūhauora Shared Medical Appointments: Marae-Based, Iwi-Led Care Transforming Rural Māori Health

Marie Hartley[3,4], Mrs Hinera Biddle[3,4], Dr Robin Chan[1,2,3]

[1]Te Whatu Ora, [2]Pihanga Health, [3]Te Kapua Whakapipi, [4]Ngāti Tūwharetoa

Abstract:
The Tūhauora Shared Medical Appointments (SMAs) initiative, part of the He Ara Whakapikiora framework, is an iwi-led, whānau-centred model transforming healthcare for the Tūwharetoa community. Delivered on marae and co-designed with whānau and Pou Oranga, SMAs integrate clinical care, health education, and mātauranga Māori in safe, familiar settings that build trust and connection.

Led by Pou Oranga Marie Hartley and Hinera Biddle and supported by Rural Generalist Dr Robin Chan, the team provides monthly group consultations, reducing barriers like cost, transport, and cultural disconnection. Robust governance and ongoing whānau feedback ensure services remain clinically safe and culturally grounded.

Results are compelling: 95% of whānau reported improved access, 95% felt their cultural needs were met, and 80% gained confidence engaging with other health services.

This model demonstrates how iwi-led, marae-based healthcare can achieve measurable gains in access, equity, and whānau empowerment—offering a replicable blueprint for rural innovation worldwide.

79 - Delivering Comprehensive Primary Healthcare in the Remote Brazilian Amazon: Challenges and Adaptations of Riverside and Fluvial Family Health Teams

Pedro Lima Martins Costa[1], Alice Botelho de Mesquita[1], Bruno Carvalho Fonseca[1]

[1]Sbmfc - Brasil

This video presents the experience of health professionals working in the rural municipality of Manicoré, located in the the Brazilian Amazon rainforest. This riverside municipality faces unique public health challenges where vast distances and the natural environment necessitate innovative healthcare delivery. The Unified Health System (SUS) employs two main types of Family Health Teams: Riverside and Fluvial. Riverside teams operate from basic health units built in communities, primarily accessed by river. Fluvial teams utilize boats, including a dedicated basic health unit vessel, to provide direct care to the most isolated communities, embracing the concept of "liquid territory".

Working in this environment presents singular challenges, including complex logistics, long river distances, unpredictable weather, and difficulties in transporting supplies, communication, and accessing modern health technologies. The population's extractive agricultural economy contributes to myofascial and joint pain, and venomous animal accidents. Gold mining and increasingly frequent droughts also impact health, leading to acute diarrheas, food insecurity, and water scarcity. High rates of illiteracy and lack of basic sanitation amplify health vulnerabilities. Our teams, primarily composed of family and community medicine specialists, include nurses, dental professionals, and community health agents. An additional rotating support team comprises psychologists, physiotherapists, and social workers, providing integral care. Cultural humility, respecting local customs and health practices, is fundamental. Despite these challenges, the work is rewarding, fulfilling the fundamental right to health and contributing to the well-being of future generations through sustainable practices. Through this video, we aim to share this experience and inspire other rural health professionals globally.

80 - Worlds Apart - Rural Allied Health comparison between New Zealand and Scotland

Kyla Jasperse[1], Miss Stephanie Jasperse

[1]Health Nz

Rural healthcare systems face significant challenges due to limited workforce capacity, geographic isolation, and restricted access to specialised services. This study, looking at rural hospitals in Aotearoa and the Scottish Highlands, identified delays in diagnosis, treatment, and discharge planning, which contribute to prolonged hospital stays, increased complications, and higher costs. Workforce shortages often require allied health professionals to work across disciplines, creating gaps in care that negatively impact patient outcomes.

Key opportunities were identified to address these inequities. Expanding the preventative role of allied health professionals can reduce hospital admissions by early intervention and supporting community-based care.

Strengthening interdisciplinary collaboration between allied health, primary care, and community organisations ensures continuity of care and more efficient use of limited resources. Telehealth and mobile clinics provide a transformative means of overcoming geographic barriers, enabling access to timely allied health services and reducing reliance on hospital-based care. Sustaining this workforce requires investment in professional development, flexible service models, and incentives tailored to rural practice.

The integration of preventative practice, interdisciplinary networks, and technology-enabled care represents a pathway to improving patient recovery, reducing rural–urban health disparities, and building resilience in rural health systems.

These opportunities illustrate the potential of utilising the skill set of allied health professionals in turning rural healthcare from a reactive to a preventative model and offer solutions for resource-constrained settings worldwide.

81 - Building a Rural and Remote Allied Health Assistant Workforce

Gemma Tuxworth[1]

[1]Services for Australian Rural and Remote Allied Health

The Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW) program aimed to assist rural and remote private and non-government allied health services extend their capacity by using an Allied Health Assistant workforce (including First Nations AHAs) and AHA models of service delivery. To achieve this, a tailored package of support was developed and implemented by Services for Rural and Remote Allied Health and funded by the Commonwealth Department of Health and Aged Care.

An external evaluation of BRAHAW was undertaken by the Poche Centre for Indigenous Health. The evaluation employed mixed methods, including qualitative interviews with AHAs, allied health professionals and managers, and a quantitative review of health service data.

Thirty-four BRAHAW training packages commenced in 18 organisations across the country, including 17 packages with Aboriginal Community Controlled Health Organisations. BRAHAW's projected success rate was 87%.

BRAHAW showed to be an acceptable and desirable program, and a likely effective model for increasing the number of AHAs to support service delivery. The financial support, resources, coaching, and adaptability of the program were critical to its success. Social and cultural factors have a profound influence on the recruitment and retention of First Nations AHAs. Quantitative demonstration of impact was limited due to data availability.

BRAHAW enabled workplaces and individuals to develop safe and quality AHA service delivery models that supported their workplaces and communities. Policy implications and recommendations for future implementation include ongoing support for rural and remote workforce development and further exploration of the impact at the community level.

82 - Whai Ora. 'Ka Hikitia Ka Ora'. An indigenous, multidisciplinary model advancing rural health equity in Aotearoa.

Suzanne Moorhouse[1], Dr Kara Ackerman[1]

[1]Hauraki PHO

This whānau (family) centred health model supports patients in rural communities living with long term conditions. Grounded in indigenous values of pono (honesty), kotahitanga (unity), whanaungatanga (relationships) and manaakitanga (generosity), it responds to community-identified needs through a multidisciplinary, equity-focused approach that strengthens whānau wellbeing.
The team includes Kaiāwhina (social and cultural health navigators) and care coordinators (nurse, social worker, occupational therapist). They have direct access to pharmacist, dietitians and a GP for oversight. The programme is guided by indigenous principles that recognise health is relational and must uphold dignity and trust. Strong partnerships facilitate referrals across hospital, primary care, community providers and self-referrals, ensuring a comprehensive population-based approach.
Care is delivered in environments chosen by whānau fostering trust and engagement with those historically underserved. The team conduct a whānau-focused comprehensive electronic needs assessment to identify concerns. This ensures consistency across teams and supports measurable whānau-led outcomes. The team supports whānau to achieve health goals through education, direct support, advocacy and service connection.
In the first eight months, the team supported two hundred and fifty-one whānau, sixty-eight percent were Māori. There were four thousand, three hundred engagements which highlights the complexity of the targeted population cohort. Significant unmet need was identified especially in areas of mental health, poor housing, financial hardship, health literacy and access to best practice care.
The programme exemplifies indigenous, equity-driven innovation in rural healthcare. It champions the aspirations of whānau. It supports dismantling systematic barriers and builds sustainable culturally safe pathways to wellness.

83 - Integrating Tikanga Māori and Mātauranga Māori in Induction, Orientation and Professional Development of Doctors at Whakatāne Hospital

Dr Philippa Cross[1]

[1]Whakatane Hospital, [2]University of Otago

Health services in New Zealand continue to be reliant on internationally trained medical professionals. There is a growing need to ensure that cultural competence and local understanding are embedded in induction and professional development. At Whakatāne Hospital, a region with a predominant Māori population, this challenge is being met through a pioneering orientation programme grounded in tikanga Māori (Māori protocols) and mātauranga Māori (Māori knowledge systems).

Central to this programme is the recognition that new doctors initially enter the rohe (area) as manuhiri (visitors or guests), and through ongoing engagement with manaakitanga (care, hospitality, and respect) and whakawhanaungatanga (relationship-building), become active participants in a reciprocal partnership with Māori communities. This evolving relationship honours the principles of Te Tiriti o Waitangi, emphasises shared responsibility, respect, and commitment to equitable and culturally safe healthcare.

The orientation begins with a pōwhiri (welcome), includes wānanga (learning gatherings), exploration of local history and whakapapa (genealogy/ origins), and practical guidance on equity focused care.

Preliminary feedback from participants highlights increased confidence in engaging with Māori patients and whānau, understanding of Te Tiriti o Waitangi obligations, and deeper connection to the region's cultural and clinical landscape. This initiative demonstrates how embedding Maori knowledge and supporting Doctors transition from visitor to partner can strengthen relationships, enhance cultural safety, and support retention of staff in rural settings.

This presentation will share practical insights. It offers a replicable model for health organisations aiming to integrate a Maori worldview into orientation and professional development.

84 - Establishing rural health research priorities for Hauora Taiwhenua: a Delphi study

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Introduction: People living in rural and remote areas of New Zealand (NZ) have poorer health outcomes than urban residents exacerbated for Māori. There is a need to identify research priorities to optimise the strengths and inherent knowledge of rural communities and build capacity in the rural health clinical and academic communities.
Aim: The purpose of this study was to identify and describe the current rural health research priorities for NZ's Hauora Taiwhenua Rural Health Network (HT).
Methods: A modified Delphi methodology using online survey data collection took place in 2025. Round 1 used open-ended questions to establish rural health research categories and priority areas for research using qualitative analysis. Subsequent rounds asked participants to rank their top 5 priority areas in each category.
Results: The Delphi panel comprised members (n=30) with rural health and rural context expertise representing HT's nine Chapters and Governance. Rural health workforce, rural models of care and service delivery, equity and access, Māori health, health system design & policy, and specific clinical conditions were identified as priority categories for rural health research. The top three priority areas for each category reaching consensus were established.
Discussion: Future rural health researchers and funders should consider these priority categories identified by members of the Hauora Taiwhenua National Rural Health Network

85 - Strengthening Rural Healthcare: Insights from Best Practices and Innovations from Low- and Middle-Income Countries

Prof Sonu Goel[1], Dr Aayushi Sharma[1], Dr Kritika Upadhyay[1], Dr Nandita Bhatnagar[1]

[1]Post Graduate Institute Of Medical Education And Research

Rural and remote communities in low- and middle-income countries (LMICs) face persistent healthcare challenges due to limited infrastructure, workforce shortages, and inequitable access to essential services. The study aims at harnessing scalable, context-specific healthcare practices from LMICs aligning with principles of primary health care.
This qualitative study employed narrative analysis of best practices submitted by 120 healthcare professionals, including medical doctors (n=52), nursing officials (n=27), and policymakers (n=41) from 26 LMICs participating in the International Public Health Management Development Program from July 2024- July 2025. Total of 36 narratives were received using standardized template covering problem statements, challenges, interventions, and outcomes, of which 16 narratives were analyzed and mapped to PHC principles across domains including infectious disease control, maternal health, mental health, digital health, supply chain management and patient safety.
Findings highlight the significant improvements across rural health domains. Equity and universal access were strengthened through Ghana's prenatal outreach reducing maternal mortality by 35%, and Zimbabwe's maternal health education raising antenatal attendance from 60% to 82%. Community participation enabled Morocco's psychosocial rehabilitation to reduce re-hospitalizations by 28%, Nigeria's Ebola response to trace 100% of 19,000 contacts with zero rural secondary transmission. Appropriate technology was demonstrated by Somalia's DHIS2 and ALMANACH, reducing reporting delays by 25%. Intersectoral collaboration was evident in Algeria's digital pharmaceutical procurement reducing rural stockouts by 45%, and Argentina's infection prevention program lowering healthcare-associated infections by 50%.
The community-driven, equity-focused, and inclusive practices provide robust evidence base for reforming rural and remote healthcare delivery in resource-constrained environments.

86 - Beyond the Referral: Seeing the Whole Person to Strengthen Rural Care, Workforce and Community Outcomes

Dr Jane George[1], Dr Anna Moran[6], Dr Veronika Rasic[2,3,4,5]

[1]Independent, [2]Rural WONCA, [3]EURIPA, [4]Rural Health Compass, [5]NHS Wales, [6]Rural Clinical School, The University of Melbourne

Background: Rural health systems often face specialist shortages, siloed services, and funding models that miss the complexity of people's lives. To deliver equitable care, rural practitioners need approaches that capture care needs and match them to available local resources; whether clinical, community, or informal.
Aim: To equip rural practitioners and teams with a structured framework for understanding whole-person care needs, supporting effective interprofessional collaboration and person-centred decision-making in resource-constrained settings.
Methods: This interactive workshop uses case-based scenarios grounded in the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) and rural, interprofessional, workforce and service delivery research. Whilst attending to impairment remains essential for safe medical care, mapping how impairments flow into activity, participation, and wellbeing enables practitioners to see fuller care stories and identify supports beyond diagnosis or treatment. Facilitated exercises will guide participants through

- problem identification,
- mapping patient needs across ICF domains,
- identifying unmet needs and ripple effects on individuals, families, teams, and communities,
- exploring interprofessional and community-based solutions when traditional options are scarce, and
- action planning for implementation.

Outcomes: Participants will articulate how the ICF can understand patient needs and highlight contributions others bring to rural care, identify and overcome barriers to effective shared care, and apply structured "need stories" to guide resource matching and advocacy.
Conclusion: Rather than focusing on limitations, this workshop builds on deep knowledge rural clinicians already hold, offering shared language and methods to connect minds, heal systems, and drive change for rural communities.

87 - Barriers in Accessing Specialised Healthcare in Kaitāia: a mixed methods study

Dr Geraldine Atchico[1]

[1]University Of Auckland

Access to specialised healthcare is a critical aspect of public health, yet rural communities often face significant challenges in this regard. In Northland, Aotearoa, rural patients within the Kaitāia Hospital catchment area experience notable barriers to accessing the care they need. This study aimed to uncover and understand these barriers through a mixed-methods approach. A quantitative analysis of two Te Tai Tokerau datasets was performed, which provided numerical data and helped identify eligible participants. This was followed by an in-depth thematic analysis based on interviews with nine rural residents. Although the quantitative comparisons between the Kaitāia and Whangārei Hospital catchments were statistically insignificant, the qualitative data revealed profound insights.

The participants, aged between 50 and 83 years old, included three females and six males. Five key themes emerged from the interviews: personal circumstances, communication issues, waitlists and appointment times, support services, and distance. Many participants shared how personal circumstances hindered their progress toward receiving necessary operations. Long waitlists and inconvenient appointment times further limited their access to care and inconsistent follow-up and communication left many feeling frustrated and neglected.

Overall, the participants expressed dissatisfaction with the current process of accessing specialist care at Whangārei Hospital. Proposed interventions such as relocation of services to Kaitāia were identified as a solution that could mitigate many of the barriers described, ultimately enhancing patient satisfaction and accessibility to specialised healthcare services.

88 - Children of the Lake: challenges of growing in rural Cambodia

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[1]Capital And Coast, Te Whatu Ora, [2]The Lake Clinic

Introduction:
The Lake Clinic (TLC) is the only non-governmental organisation providing direct access to primary healthcare for children and adults living in the remote and underserved regions of Cambodia's Tonle Sap—the largest freshwater lake in Southeast Asia and home to over 1.5 million people. A multidisciplinary Cambodian team provides free clinic-based care and community outreach. Children in this region face intersecting risks—undernutrition, unsafe sanitation, vector-borne and parasitic infections, disrupted schooling, and climate shocks—underscoring the need for ongoing growth surveillance to detect risk early.

Methods:
TLC's outreach team routinely conducts home visits across eight villages around the Tonle Sap region, recording demographic data and anthropometry for children. World Health Organisation (WHO) Growth Standards were applied via the Anthro Survey Analyser to generate z-scores and classify children as stunted, underweight, or wasted.

Results:
From March 2021 to July 2025, 3,716 valid measurements from 1,188 unique children under five were recorded. Stunting increased from 28% in 2021 to 41% in 2025. Underweight rose from 24% to 30% over the same period. Wasting remained broadly stable at 8–11% across years.

Discussion:
Malnutrition remains a substantial and persistent challenge in these rural Cambodian communities. While wasting (acute malnutrition) was relatively stable with late improvement, stunting and underweight (chronic undernutrition) worsened. This pattern indicates many children remain vulnerable before crossing WHO thresholds, highlighting the need for earlier preventive action and sustained solutions—nutrition counselling; safe toilets; clean drinking water; regular handwashing; school continuity; and livelihood supports—integrated into TLC's outreach model.

89 - Factors affecting medical students' interests in working in rural areas in North India—A qualitative inquiry

Prof Sonu Goel[1], Dr Federica Angeli[2], Dr Dirk Ruwaard[2]

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The shortage of doctors, especially in rural areas, is major concern in India, which in turn affects effective delivery of health care services. To support new policies able to address this issue, study was conducted to determine the discouraging and encouraging factors affecting medical students' interests towards working in rural areas.

This cross-sectional, descriptive qualitative study has been conducted in three states of North India. It comprised six focus group discussions, each consisting of 10–20 medical students of six government medical colleges. The verbatim and thematic codes have been transcribed by using 'categorical aggregation approach'. The discussions were thematically analyzed.

Ninety medical students participated in study. The discouraging factors were grouped under two broad themes namely unchallenging professional environment (poor accommodation facilities and lack of necessary infrastructure; lack of drug and equipment supplies; inadequate human resource support; lesser travel and research opportunities) and gap between financial rewards and social disadvantages (lower salary and incentives, social isolation, political interference, lack of security). Similarly, encouraging factors were congregated under three main themes namely willingness to give back to disadvantaged communities (desire to serve poor, underprivileged and home community), broader clinical exposure (preferential admission in post-graduation after working more than 2–3 years in rural areas) and higher status and respect (achieving higher social status).

This qualitative study highlights key factors affecting medical students' interest in rural practice, with findings consistent with global evidence. Findings can guide policymakers and educators in developing strategies to encourage medical students to take up rural positions.

90 - Applying principles of adult learning to rural health electives in a medical school curriculum

Dr Tamekha Develyn[1]

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The development of sustainable rural health workforces requires educational models that extend beyond general practice placements. This study describes the design and early implementation of Rural Health Discovery Elective Subjects, embedded within the medical curriculum, creating a structured platform where students engage with the complexities of rural health. These include systemic barriers and enablers, community contexts, lifestyle factors, diverse career pathways, and the multi-skilled practices required to meet rural health needs.

Drawing on contemporary educational frameworks, the elective provides students with exposure to interprofessional rural practice across disciplines including emergency medicine, obstetrics, mental health, and Indigenous health services. The curriculum emphasises interactive learning, cultural safety, and community engagement, with content co-designed alongside rural practitioners and First Nations leaders.

Preliminary data from student reflections and educator feedback suggest the elective enhances understanding of rural generalism, strengthens appreciation of team-based care, and highlights social determinants influencing health outcomes in rural and remote communities. The program incorporates Indigenous voices and local knowledge to ensure equity and inclusivity, encouraging critical reflection on rural-specific challenges such as stoicism, limited access to services, and the interplay between cultural practices and health-seeking behaviours in remote communities.

These electives represent an innovative approach to embedding rural health education within medical training, providing early exposure to rural practice themes, career pathways, and essential skills. By fostering rural generalism and awareness of diverse rural health professions, they contribute to long-term strategies for resourcing, recruitment, and retention, offering a scalable model to strengthen integrated healthcare delivery across rural and remote regions.

91- Te Ara Whakamua: Delivering a Bachelor of Nursing Māori Programme in Rural Northland, Aotearoa New Zealand

Pipi Barton[1], Matua Ross Smith[1]

[1]Northtec

Persistent structural inequities in Aotearoa New Zealand's health and education sectors continue to limit Māori access to, and success within, nursing education. Mainstream programmes often lack cultural relevance and fail to reflect Māori values, contributing to the long-term underrepresentation of Māori in the nursing workforce, which has remained static at 7%. This underrepresentation directly impacts rural regions such as Northland, where 39.9% of the population are Māori and health services workforce needs are high. To address this gap, Puāwananga Tapuhi Māori o Te Kotiu, a Bachelor of Nursing programme, was established to recruit, educate, and retain Māori nurses for rural communities. The programme was co-designed with iwi and hapū and is delivered in Ngāwhā, a rural settlement central to Māori communities. Its flexible structure enables students to balance employment, study, and whānau responsibilities. Kaupapa Māori pedagogy, whanaungatanga (relational engagement), and Indigenous teaching practices underpin the model, embedding equity, diversity, and inclusivity throughout the curriculum. The initial cohort demonstrates strong participation and retention. Students highlight the importance of proximity to home, cultural responsiveness, and whānau-based support in enabling their progress. The vision for the programme is to create a sustainable pipeline of Māori graduates dedicated to serving as registered nurses within their own communities, with the ultimate aim of strengthening both the rural and Māori health workforce. Puāwananga demonstrates an innovative, Indigenous-led approach to addressing rural nursing workforce shortages. By embedding Māori knowledge, equity, and community connection into nursing education, it offers transferable lessons for rural and remote health education globally.

92 - Embedding multi-level mentorship in rural physician research training: A qualitative study of the 6for6 program

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

[1]Memorial University, [2]Memorial University

Background: Rural physicians face challenges accessing meaningful mentorship due to geographic, institutional, and time-related barriers. 6for6, a longitudinal capacity-building program is designed to strengthen rural physicians' skills in research and scholarly communication. While mentorship was not originally a core component, it became a core structural and cultural element.

Objective: To investigate how mentorship is experienced and structured within 6for6, and how it contributes to engagement in scholarly activities and professional identity development.

Methods: A qualitative study was conducted using a constructivist lens. Participants included 44 rural physicians from eight cohorts (2014–2025). Data sources included open-ended responses from program feedback, reflective notes from faculty, and focus groups with program participants. Focus groups were facilitated by neutral evaluators and explored perceptions of support, identity, and mentorship. All qualitative data were analyzed inductively using thematic analysis.

Results: Participants across all cohorts provided detailed accounts of their experiences with mentorship in 6for6. Four types of mentorship experiences were identified: (1) faculty mentorship, (structured and focused on research skill-building); (2) alumni mentorship, (practical advice and role modeling); (3) peer mentorship, (emotional support and accountability); and (4) informal mentorship, (from patients, communities, or other professionals outside the program). Participants described increased comfort with scholarly work and noted continued research engagement following 6for6.

Conclusion: Mentorship in rural research training programs can be effectively embedded through a multi-layered design that supports different phases of learning. 6for6 demonstrates how combining faculty, alumni, peer, and informal mentorship can strengthen program sustainability and create a self-reinforcing culture of rural scholarship.

93 - 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.

94 - 12 tips to kickstart research that matters to your rural community, while bringing joy to your practice

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

[1]Memorial University, [2]Memorial University

6for6 is a faculty development program at Memorial University that teaches research and writing skills to rural and remote doctors. It fosters fit-for-purpose solutions that address local health needs. Having trained 44 rural doctors over 10 years, we illustrate 12 tips (created by participants using a modified Delphi process) that will inspire you to answer questions that matter, while bringing joy to your practice.

1. Channel Your Passion: What keeps you up at night or helps you go to work?

2. Recognize Your Unique Value: Your rural/Indigenous community or a unique perspective on a healthcare challenge.

3. Talk About Your Ideas: Sharing builds both community and scholarly collaborators.

4. Seek Mentorship: A mentor gives guidance and helps you overcome obstacles.

5. Build Your Team: The right partners will increase your chances of success. Engage those affected by your work.

6. Dedicate Time: Busy clinicians need dedicated time to focus.

7. Set Actionable Goals: Accountability and feasible deadlines.

8. Be Organized: Be strategic and realistic.

9. Ask For Help: Utilize and trust in team members. Engage communities and experts such as librarians and ethicists.

10. Write: Writing does not need to be a natural gift. Write to understand, to clarify and to share.

11. Have Patience: Trust in the process. Meaningful community work takes time.

12. Just Do It! You know your practice and community. You have so much to contribute and the sooner you begin, the more you can address!

95 - Rural Clinical Placement Programmes: A Tale of Two Models

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Rural healthcare workforce shortages persist globally. Clinical placements remain a key strategy for addressing this shortage. This paper present two models from Waikato, New Zealand and regional Western Australia.

The Waikato rural nursing clinical placement programme represents an early-stage rural placement programme. Its foundational framework links nursing students with rural healthcare and communities. To date 129 students have experienced this programme. Despite its potential, the programme faces limited resources and infrastructure, affording minimal student support, basic housing and few engagement opportunities.

The Goldfields University Department of Rural Health's programme exemplifies the impact of federal investment, strategic funding and community partnership in rural health education. Since establishment, it has supported 115 students using a robust supporting structure of subsidised travel, pastoral care, cultural orientation, purpose-built accommodation and a $150 weekly bursary. Industry-funded scholarships, in partnership with the mining sector underpin a "grow our own" workforce model. By removing financial barriers and fostering immersive rural experiences through curated activities and community engagement, the programme builds local talent pipelines and promotes long-term commitment to regional health careers.

Rural clinical placements are vital for improving workforce shortages and healthcare equity, but require robust, sustained funding. The Goldfields model demonstrates how federal investment can deliver transformative education that attracts students to rural practice. Building on Waikato's foundation, New Zealand has the potential to develop world-class rural placement programmes, provided rural clinical education is treated as core health service infrastructure.

96 - Longitudinal Analysis of Intrinsic Capacity Decline Among Older Adults in Rural Taiwan: A Community-Based Study Using the WHO-ICOPE Framework

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Background
Healthy ageing depends on maintaining intrinsic capacity (IC), yet rural older adults face accelerated decline due to limited resources and access. This study investigated multi-year IC trajectories among elders in a rural Taiwanese township.
Methods
A longitudinal study of 110 older adults (≥65 years) was conducted from Puli Township who completed annual WHO-ICOPE screenings at community-based long-term care stations between 2023–2025. Six IC domains (locomotion, cognition, psychological well-being, vitality, vision, hearing) were assessed at initial test and confirmation test. Logistic regression and generalized estimating equations (GEE) were applied to examine temporal trends and risk factors, including age, sex, and care site.
Results
Cognitive impairment rose from 10% in 2023 to 26% in 2025, and visual impairment from 38% to 67% (both $p<0.01$). Combined deficits increased markedly: cognition+vision from 2.7% to 19.1% and locomotion+vision from 6.4% to 18.2%. GEE analysis showed annual odds ratios of 2.00 ($p<0.001$) for cognition+vision decline and 1.75 ($p=0.005$) for locomotion+vision decline. Women were at higher risk of locomotion decline (OR 6.70, $p=0.003$), while men showed greater hearing loss. Elders ≥85 years were consistently more vulnerable across domains.
Conclusion
Rural Taiwanese elders experienced accelerating decline in cognition and vision, with compounding multi-domain deficits. Inequities by sex, age, and service site were evident. Findings highlight the need for tailored, equity-focused interventions for women, the oldest-old, and vision-impaired elders, and provide real-world evidence to guide rural long-term care planning under the WHO-ICOPE framework.

97 - Measuring What Matters: Frameworks for Assessing Community Health Worker Performance in LMICs: A Mixed-Methods Systematic Review

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Community Health Workers (CHWs) are vital for delivering primary healthcare in low- and middle-income countries (LMICs), particularly in rural areas. Despite their recognized contribution to Universal Health Coverage (UHC), systematic approaches to assess their performance remain limited. This review aimed to identify and synthesize existing frameworks for evaluating CHW performance in LMICs.

A mixed-methods systematic review was conducted in line with PRISMA-P guidelines and registered in PROSPERO. Searches across PubMed, Web of Science, and Scopus identified qualitative, quantitative, and mixed-methods studies published in English between 2014 and 2025. Three reviewers independently conducted screening and data extraction in Covidence, with quality appraised using GRADE Framework and the Mixed Methods Appraisal Tool (MMAT). Descriptive data was analysed using MS excel and qualitative data using Atlas.ti.

From 3,342 records, 51 studies describing distinct frameworks were included. These frameworks encompassed the six WHO health system building blocks, comprising 33 sub-domains and 131 indicators: service delivery (11 sub-domains, 36 indicators), health workforce (10, 36), health information systems (2, 9), access to medicines, supplies, and technologies (2, 17), health financing (2, 9), and leadership and governance (7, 29). Six thematic categories emerged across frameworks: community acceptance and trust; incentives and remuneration; knowledge, skills, and training; motivation and morale; resources and infrastructure; and workload and accountability.

Strengthening rural health requires standardized, adaptable, and comprehensive frameworks. This study identifies consistent evaluation parameters to guide policy and enhance CHWs' effectiveness in delivering equitable primary healthcare and advancing Universal health coverage

98 - Empowering Hearts : Revolutionising Heart Failure Care in a Rural District of Tanjong Karang, Malaysia

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Heart failure (HF) is increasing in prevalence but is often missed or diagnosed late, leading to preventable deaths and complications. Tanjong Karang, a rural population located 80 km from the Malaysia National Cardiology Centre, has shown suboptimal HF management. Local audit revealed 63% of echocardiogram requests for HF work-up had varying features of HF; however, most were not managed with optimized guideline-directed medical therapy (GDMT). To bridge this gap, a novel workflow was introduced to improve early detection and optimise management of HF in primary care. Initiated in May 2024, this project developed a protocol and multidisciplinary team, in collaboration with cardiologists and physicians from Tanjong Karang Hospital, Mara University of Technology, and Serdang Hospital. Four training modules (Diagnosis of HF, Management of Acute and Chronic HF, and Prevention of HF) were conducted for family physicians and medical officers. In addition, a primary care paramedic was trained to perform portable echocardiography. Patients at risk were screened for HF symptoms and, when eligible, enrolled into the dedicated Community HF Clinic and received individualised care, GDMT, dietary counselling, with patient empowerment. ProBNP was integrated in May 2025 to facilitate diagnostic accuracy. From February to September 2025, we have seen 56 patients in the Community HF Clinic. All patients diagnosed with HF were managed with maximum tolerated GDMT. Findings indicate that a structured model for community HF care was feasible and effective in rural primary clinic; therefore, continuous support for resources is deemed necessary to ensure sustainability and long-term cost-effectiveness.

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

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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.

100 - Ethical Issues in Tribal Health in India

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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.

101 - Pre-hospital Perspectives from the Scottish Highlands

Dr Gordon Smith

[1]Highland Pre-hospital Immediate Care & Trauma (PICT) team

Trauma and critical medical illness presentations in the Scottish Highlands are comparable in nature to more urban settings. However, these are often in remote and rural areas with significant delays to definitive care. Historically, the challenges of Highland rurality have provided a fertile ground for healthcare innovation of global consequence.

In response, Highland healthcare professionals developed the Pre-Hospital Immediate Care & Trauma (PICT) team in 2016. This two-person team necessitates a Rural Generalist skillset and includes the pairing of an Advanced Critical Care Practitioner (from a nursing or paramedic background) with a Hospital Consultant or General Practitioner. The team is equipped with a rapid response car, specialist equipment and delivers enhanced pre-hospital care across the Highlands. Collaboration with Scottish Ambulance Services and Emergency Departments can also facilitate patient discharge at scene, redirection to existing healthcare services or direct hospital speciality admission.

Despite adversity, the PICT team has grown to an established service with 22 healthcare professionals on the staff roster. Many of these individuals are involved in medical education and help nurture the future of Highland pre-hospital medicine: the intervarsity Undergraduate Pre-hospital Care Course and selective PICT team observer shifts allow experience in a speciality that is usually difficult to access. Further still, postgraduate training days create a shared learning environment between rural healthcare professionals and interagency emergency services.

In the spirit of Highland innovation, our story will hopefully inspire delegates to redress inequity within their own communities and promote an encouraging pedagogical culture for healthcare professionals of the future.

102 - The ScotGEM Generalist Clinical Mentor: An Agents of Change story

Dr Gordon Smith[1]

[1]Scottish Graduate Entry Medicine (ScotGEM) programme

Scottish Graduate Entry Medicine (ScotGEM) was developed as the first graduate entry medical programme in Scotland in response to remote & rural workforce shortages, societal need and government policy. The inaugural cohort graduated in 2022. This four-year programme has a socially accountable vision to produce high quality doctors with significant exposure to rural generalism and primary care across Scotland. ScotGEM utilises a master-apprentice model with key medical educators who are practising General Practitioners (Family Physicians), known as Generalist Clinical Mentors (GCMs). Learning is primarily within a real-world clinical context facilitated by GCMs and other Rural Generalist healthcare professional role models.

This presentation is the personal story from a Scottish Highland GP working as an experienced Year 2 GCM at the pedagogical coal face of the programme whilst growing into academia as a new appointee to the Agents of Change (AOC) leadership team. AOC is a healthcare improvement curriculum within ScotGEM designed to equip students with skills in leadership, teamwork, resilience and quality improvement. The presenter recently returned to work in a rural deprived area to develop a base for ScotGEM students in primary care -following his own prior experience there as a medical student. A successful year has progressed a wider vision to form an educational hub for remote & rural healthcare professionals. This story describes the challenges faced, the joy of witnessing student engagement in the local community and how positive change was affected in a complex, at times messy, world using the vehicle of undergraduate medical education.

103 - Attachment to primary care in rural areas: Lesson from Ontario, Canada

Dr Michael Green[2,3], Shahriar Khan[3], Eliot Frymire[1], Dr Rick Glazier[4,5,6,7,8]

[1]Queens University, [2]NOSM, [3]ICES, [4]INSPIRE-PHC , [5]CIHR, [6]ICES, [7]University of Toronto, [8]St. Michael's Hospital / MAP Centre

In collaboration with the Ontario Ministry of Health, an update to the primary care attachment algorithm was undertaken to better capture all Ontario citizens who do not have regular access to primary care. How this new algorithm impacts rural populations is the focus of this study.
The objective for this study is to identify areas for refinement in providing primary care attachment to rural populations in Ontario. The study team worked with the Ministry of Health to develop an updated methodology to estimate the number of Ontarians who are attached to a family doctor, nurse practitioner or primary care team. This includes patterns in physician billings and patient visits to validate the number of people with regular access to a primary care provider.
Our initial results suggest that populations living in rural areas will need added resources and assistance in achieving similar levels of attachment to urban areas. Our study describes characteristics of rural populations with no or minimal access to primary care and strategies to attach them.
A revised estimate of the total number of rural Ontarians who do not have a primary care provider was arrived at in this study. This enables health policy decision makers in primary care to effectively measure progress towards providing rural Ontarians with quality access to a primary care provider. In Ontario, rurality considerations represent a key weakness in providing universal attachment and access for the population.

104 - Rurality considerations when using a centralized wait list to increase attachment to primary care in Ontario, Canada

Dr Michael Green[1,2], Shahriar Khan[2], Eliot Frymire[2,3]

[1]Northern Ontario School of Medicine, [2]ICES, [3]Queens University

Patients who live in rural areas experience greater barriers to accessing primary care than those who live in urban or sub urban areas. Our study looked at the effectiveness of a centralized waiting list in Ontario (Health Care Connect - HCC) in connecting patients, self-identified as unattached, with a primary care provider in rural areas.
HCC registrants who live in rural areas had lower rates of attachment than did patients who live in urban areas. The percent of HCC registrants attached in current and subsequent years was approximately 10% lower for those living in rural areas (67.5%) compared to those living in small urban (78.7%) or large urban (77.0%) areas. Urban/rural differences in attachment may reflect variability in availability of access for minor conditions (like walk-in clinics), as well as other local factors including the degree to which the primary care physicians in a region participate in accepting HCC patients. The geographic distribution of the primary care workforce may influence attachment success rates in more rural areas.
This first of its kind data linkage of the wait list in Ontario found HCC to be very effective in attaching patients to a primary care provider. This tool had poorer outcomes for rural populations than it did for urban populations. These findings are important for policy and decision makers implementing health policy around primary care attachment and access in rural areas.

105 - 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]

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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.

106 - 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

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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.

107 - 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.

108 - Strengthening Rural and Indigenous Health Training in PGY Programs in Taiwan: Insights from Puli Christian Hospital and International Standards

Dr Ta-Chun Hua[1,2]

[1]Puli Christian Hospital, [2]University of Auckland

Since its introduction in 2003 in response to the overspecialization of physicians highlighted by the SARS pandemic, the Taiwanese postgraduate year (PGY) program has aimed to equip medical graduates with essential general knowledge and skills. A core element of the program is community medicine and healthcare training, designed to familiarize junior physicians with general practice concepts long neglected in medical education. Under the Ministry of Health and Welfare's Two-Year PGY General Medicine Training Program, standardized community medicine modules emphasize frameworks, regulations, and resources related to preventive care, palliative care, health promotion, and aged care services. However, because these modules are largely developed with an urban focus and most training sites are in non-Indigenous, urban areas, the program's effectiveness in preparing physicians for careers in rural or Indigenous communities remains uncertain. Since its establishment in 1956, Puli Christian Hospital (PCH) has focused on serving surrounding rural and Indigenous populations. As a PGY-1 community medicine training hospital, it addresses rural and Indigenous health issues through lectures, shadowing in outreach clinics and long-term care facilities, health promotion activities, and research projects on community health. These experiences complement the gaps in rural and Indigenous health learning within the general PGY framework. Compared with international standards, however, PCH's program could be further strengthened by integrating training on social determinants of health, cultural safety, and equity-based practice and reflection. Such comparison could also inform revisions of the national community medicine curriculum, shifting it from distant observation toward a model that combines practice, reflection, and community collaboration.

109 - Geographic Disparities in Depression and Chronic Disease Multimorbidity in Australian Primary Care

Gouri Srinivasan[1], Dr Bushra Nasir[1], Associate Professor Srinivas Kondalsamy-Chennakesavan[1], Associate Professor Matthew McGrail[2], Associate Professor Vikas Garg[1,3,4]

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Multimorbidity presents significant challenges in rural Australia, increasing healthcare costs, compromising quality of life, and elevating mortality. Coexisting depression exacerbates this burden, with geographic variation critical to equitable healthcare.
A cross-sectional study was undertaken using de-identified adult patient records (n=204,935) from urban, regional and rural Australian general practices (n=67). Depression was defined as 'depression only', 'mixed anxiety and depression', or 'any depression'. Multimorbidity was defined as the presence of two or more chronic diseases (Asthma, Chronic Obstructive Pulmonary Disease, Cardiovascular Diseases, and Type 2 Diabetes Mellitus). Logistic regression estimated adjusted odds, controlling for age, sex, Indigenous status, and smoking.
The prevalence of multimorbidity was highest in rural practices (3.7%), compared with urban (2.9%) and regional (2.6%) ($p < 0.01$). All depression definitions were significantly associated with higher odds of multimorbidity. Clear geographic variation emerged, with adjusted odds highest in urban areas, followed by rural, and lowest in regional settings. For 'depression only', elevated odds were consistent across locations. 'Mixed anxiety and depression' was most pronounced in rural areas. Although 'any depression' was most prevalent in rural practices, adjusted odds were not highest, indicating a partial discrepancy between crude and adjusted associations.
Rural patients bear the greatest burden of multimorbidity, yet links with depression vary across settings, influenced by both diagnostic definitions and geography. These patterns underscore the complexity of multimorbidity in rural Australia and highlight the need for context-sensitive policies and interventions to address equity in primary care.

110 - AI with the team, not at the team: responsible enterprise AI governance to extend rural health capacity

Sonja de Friez[1], Glynis Sandland[1]

[1]Whakarongorau Aotearoa

Background: Rural and remote communities face persistent workforce shortages while telehealth demand increases nationally. Enterprise AI deployments often fail due to poor adoption, inadequate governance, or cultural disconnect from clinical workflows. This session explores a governance-first approach to AI that successfully extended workforce capacity while maintaining clinical safety and cultural responsiveness.
Methods: A national telehealth provider serving rural and urban communities implemented integrated AI across clinical and operational systems. Core components included: cloud-based clinical records management, enterprise analytics platform, productivity AI tools, clinical documentation assistance, and conversational AI for triage support. Critical success factors included establishing AI ethics frameworks, indigenous data governance principles, and clinical oversight before deployment. Adoption used co-design with clinicians, staged rollouts, champion networks, and continuous training.
Results: 97% percent of targeted staff use AI tools daily. Over 5,000 AI interactions occurred within four weeks of deployment. Analytics platform costs reduced by 50% while releasing 40+ hours weekly of manual reporting work. Rural users report faster access to clinical guidance and decision support through enhanced triage pathways. Technology integration allowed clinicians to focus on complex care while AI handled routine tasks.
Presentation Approach: This presentation will include audience polling and case study examples to demonstrate successful implementation frameworks. An interactive Q&A will explore transferable lessons and governance challenges across diverse health systems, with practical checklists provided as takeaways for participants.
Conclusion: Enterprise AI can responsibly extend rural health capacity when governed proactively, integrated systematically, and adopted through genuine partnership with clinical teams rather than imposed upon them.

111- Fostering specialist training in underserved regions, working towards equitable access to health care services and improving health outcomes for women

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Data shows that O&G workforce distribution remains skewed away from the Regional, Rural and Remote (RRR) areas which have higher needs. The development of the Rural Obstetrics and Gynaecology Specialist Advanced Training Pathway is a significant step forward in fostering specialist training in underserved regions, working towards equitable access to health care services and improving health outcomes for women in these communities.

Funded under the Department of Health and Aged Care, Flexible Approach to Training in Expanded Settings (FATES), the intent of the development of the pathway was to provide appropriate training and financial incentives for FRANZCOG Advanced Trainees in rural settings, with the hope that trainees will continue to work in these locations upon achieving Fellowship.

The project entailed the development of a tailored curriculum for RRR needs, providing relevant financial initiatives that encourage trainees to undertake the pathway, and instituting evaluation mechanisms to assess the efficacy of the pathway's delivery.

Curriculum development sought insights into what distinguishes a rural specialist and identified the key topics; including bespoke learning outcomes in transfer medicine and Indigenous Health.

Financial incentives identified were relocation allowance, professional development attendance fees, childcare and education costs, travel costs to visit family and friends and for housing rental assistance.

Initial results from evaluation suggest that trainees enrolled in the pathway have strong ties to the area they applied for and wish to continue to serve their communities. Moreover, sites were eager to have trainees on this pathway, although identified the salary funding was a barrier.

112 - Rural : Urban Comparison Using the New Zealand Health Survey

Sebastian Watson[1], Dr Garry Nixon[2], Dr Gabrielle Davie[3], Dr Jesse Whitehead[4]

[1]University Of Otago, [2]Department of General Practice and Rural Health, [3]Department of Preventative and Social Medicine, [4]Te Ngira Institute for Population Research

The New Zealand Health Survey (NZHS) is a survey of health behaviours of the New Zealand population, using a nation-wide sample of about 13,000 adults and 3,000 children every year. The most recent release (2023/2024) marks the first-time rurality was added as a demographic variable using the Geographical Classification of Health (GCH). Adding a rurality variable to the NZHS was recommended in 2010 but had not been done up until the 2023/2024 release. To date there has been no attempts to analyse and interpret the data. The NZHS is of particular importance as much of its data is not collected anywhere else in this manner (health access and health behaviours). Therefore, the aim of this report is to analyse and interpret the NZHS with regards to rurality using the GCH, with the goal of outlining important differences in health behaviour and health access between urban and rural populations in New Zealand. Rates will be presented for rural (R1-3), provincial (U2) cities, and metropolitan (U1) cities for a range of key indicators, including primary healthcare access, cardiovascular health, and emergency department use.

113 - Defying the Odds: How Small Rural Workforce Programs Can Be Sustained Through Governance, Leadership, and Evidence

Dr Patrick Giddings[1,2], Prof Belinda Osullivan

[1]Remote Vocational Training Scheme(RVTS) Ltd., [2]University of New South Wales, [3]Monash University School of Rural Health

The World Health Organization(WHO) provides clear guidance about effective strategies to improve access to rural health workforce through better retention. However, once agreed upon, the sustainability of strategies is a real challenge, particularly for small rural workforce programs. One of the major impediments to sustainability is competition for resources, stable governance and producing good quality evidence which justifies impact and cost-effectiveness.

This workshop aims to discuss the case study of the Remote Vocational Training Scheme(RVTS) in Australia. It will involve a presentation reflecting upon how the RVTS has defied the odds to remain funded over a 25-year term, to deliver more than 550 skilled family physicians giving an average of 5.2 years of service, and to ensure ongoing retention in the same rural, remote, and First Nations communities. This will involve descriptions of the strategies piloted and the lessons learnt.

The workshop will focus on two main issues pertinent to sustaining rural workforce retention programs: 1. governance/funding and staffing (around a clear purpose), and 2. the use of evidence to justify and grow the program's reputation.

Workshop attendees will learn about the RVTS and what worked and didn't work, before breaking into groups to discuss case studies from other world regions and different disciplines. Questions will explore governance/funding and evidence.

The findings will be summarised and developed into recommendations for Rural WONCA and the WHO, who are currently working with Johns Hopkins University and an expert global technical panel, regarding implementation guidance for the global rural workforce recommendations.

114 - Strengthening rural optometry: Curriculum design for an equitable rural workforce

Dr Jaymie Rogers[1], Dr Kyle Eggleton[2], Dr Andrew Collins[1], Dr Shanjivan Padarath[2], Mrs Bhavini Solanki[1]

[1]School of Optometry & Vision Science, Faculty of Medical & Health Sciences, The University of Auckland, [2]Rural Health Unit, Faculty of Medical & Health Sciences, The University of Auckland

Rural communities in Aotearoa New Zealand face persistent inequities in access to health services, with Māori disproportionately affected by the intersection of geographic barriers and socio-economic deprivation. Eye health services are no exception, with the maldistribution of the optometry workforce further limiting access to care.
In response, the School of Optometry and Vision Science at the University of Auckland has begun implementing key initiatives to strengthen rural optometry in Aotearoa New Zealand. This presentation will highlight the development of a dedicated rural optometry curriculum, advances in regional-rural optometry clinical placements, and student-led research exploring factors influencing the rural workforce intentions of allied health students, including optometry.
By embedding rural perspectives within the curriculum, fostering interprofessional collaboration, and expanding opportunities for students to engage with rural communities, these initiatives seek to promote regional–rural optometry practice. This work represents an important step toward preparing future optometrists to meet the needs of underserved populations and aligning health professional education with rural health priorities.

115 - Rural Realities: A Qualitative Study of Physical Activity Promotion by Physiotherapists in Aotearoa New Zealand

Charlotte Watson[1], Heather Patterson[2], Dr Sarah Walker[3,4], Dr Allyson Calder[2]

[1]University Of Otago School Of Physiotherapy, [2]University Of Otago School Of Physiotherapy, [3]General Practice and Rural Health, University of Otago, [4]Allied Health Director Rural Central Otago Health Services

Background: Physiotherapists are well-placed to promote PA for people living with long-term conditions (LTCs). Rural physiotherapists face unique challenges such as high service demands and limited resources which influence PA promotion. This study aimed to explore how rural physiotherapists in Aotearoa New Zealand (NZ) promote PA for people with LTCs.

Methods: An interpretive descriptive methodology was used. Registered NZ rural physiotherapists were invited to participate in semi-structured interviews via Zoom. Interviews were transcribed verbatim and analysed inductively for themes using reflexive thematic analysis.

Results: Eight rural physiotherapists participated in this study and three themes were reflected in the data; rural physiotherapists, 1) personalised the PA journey in collaboration with the patient, 2) responded to limited resourcing by drawing upon their kiwi ingenuity to promote creative and sustainable PA solutions, and 3) embedded PA into the rural social and cultural life within the community.

Conclusion: Individual, interpersonal, organisational, and policy factors influence how rural physiotherapists promote PA. The interconnectedness between physiotherapists, patients, their whānau, and the wider community emerged as central to fostering person-centred, sustainable, and community-embedded PA. Physiotherapists adopted the ‘number 8 wire’ mindset to find solutions within the constraints of their environment. Furthermore, the absence of rural-specific policy frameworks for PA promotion and health support reveals a significant governance gap. Policies should address foundational determinants such as transport, infrastructure, and service accessibility for PA, otherwise, rural inequities will continue. Future research should explore culturally grounded approaches, especially incorporating Māori perspectives, to enhance equity and relevance in rural health services.

116 - From Research to Policy: Embedding Rurality into New Zealand's Primary Care Funding Formula

Rachel Pearce[1], Prof Garry Nixon[2], Talis Liepins[2]

[1]Health New Zealand, [2]University of Otago

Rural communities in Aotearoa New Zealand face higher health needs, yet this has not always been reflected in funding. This session tells the story of how research and policy aligned to deliver change: the introduction of a rurality weight in New Zealand's national primary care capitation formula.

Academic research, underpinned by the development of the Geographic Classification for Health (GCH), produced a shared language of rurality in Aotearoa New Zealand, and demonstrated measurable disparities in rural health outcomes. Policy leaders were then able to act, using this evidence base as justification for funding model reform and further evaluation of rural patient primary care needs.

Presented jointly by Professor Garry Nixon (Centre of Rural Health, University of Otago) and Rachel Pearce (Co-Director Rural Health - National Commissioning – Health New Zealand), the session illustrates how robust research and strong partnerships can drive equity-focused health policy.

117 - The PARTNER Network: The first rural Australian rural practice-based research network

Dr Suzie Harte[1], Ms SUZIE Lushington[1], Dr SUZIE Schofield[2], Prof Katharine Wallis[3], A/Prof SUZIE Kirke[4], Prof SUZIE Stocks[5], Prof SUZIE Radford[6], A/Prof SUZIE Gonzalez-Chica[5], Prof Lena Sanci[1]

[1]The University of Melbourne, [2]Royal Flying Doctor Service, [3]The University of Queensland, [4]The University of Western Australia, [5]The University of Adelaide, [6]The University of Tasmania

Australians living in regional, rural and remote areas face poorer health outcomes and limited access to clinical trials compared to people living in Metropolitan communities. Improving equity in research access can help address these disparities.

The PARTNER Network aims to:
Establish a national rural practice-based research network (PBRN) of 90 general practices in rural, regional and remoted communities to enhance access to primary care clinical trials;
Establish a database of 15 clinical trials for rural patient enrolment.

Method
The PARTNER Network represents a collaboration between 5 Universities, and the Royal Flying Doctor Service. Engagement with national stakeholder, indigenous and community advisory groups was sought to guide network infrastructure project development, and clinical trial opportunities designed for rural patient recruitment.

Results
PARTNER Network state coordinators have recruited 100 Australian primary care clinics categorised by the Modified Monash Model as 'regional, rural and remote'. Rural patients have now participated in 8 of the 24 approved clinical trials, recruited through 16 clinics. Key opportunities included collaboration with state rural medical schools, increased awareness of clinical trials in primary care and access for rural trial participation, integration with other PBRNs, consistent governance, and clinician education. Challenges such as geographic distance, electronic medical record compatibility, workforce shortages, and governance were identified.

Conclusions
The PARTNER Network is the first national rural PBRN to provide a sustainable model to build capacity and equitable access for rural primary care research and service delivery necessary to improve the health outcomes of the seven million Australians residing outside Metropolitan areas.

118 - A Self-Hosted, Bilingual eLearning Platform to Strengthen Family Medicine Education in Ukraine

Dr Lara Wieland[1,2], Dr Yuliana Vorobkanich[1]

[1]Only Passing Thru Charity, [2]Torres and Cape Hospital and health service

The war in Ukraine has severely disrupted medical education and professional development opportunities for clinicians working under crisis conditions. To address this urgent gap, Only Passing Thru (Australia) and the Christian Medical Association of Ukraine have partnered to develop a self-hosted, Moodle-based eLearning platform delivering certified Family Medicine training. The bilingual (English ⇄ Ukrainian) system is designed to be sustainable, globally connected, and accessible in low-resource, high-stress environments.

The platform includes a 7-module Family Medicine curriculum aligned to international rural generalist competencies, specialty resource hubs, contributor uploads, webinars, and interactive forums. AI-powered translation (DeepL for text and ElevenLabs for audio/video) allows real-time bilingual navigation and resource sharing, eliminating the need for extensive manual translation. Access is tiered: free for NGO-verified Ukrainian frontline clinicians, low-cost for Ukrainian health professionals, and paid for high-income country users to subsidise humanitarian access.

Pilot implementation involves EU-hosted servers with an Australian secondary mirror, scalable for 2,000+ users and 250 concurrent webinar participants. Initial outcomes include successful configuration of translation, certificate, and webinar plugins, along with drafted course and menu structures. Expected impact is improved clinical skills, enhanced peer support, and sustained global mentorship for Ukraine's health workforce during and beyond wartime.

This project demonstrates how tailored, technology-enabled educational platforms can rapidly strengthen family medicine services in conflict-affected settings, providing a scalable model for other regions facing similar challenges.

119 - Home-Grown Nurse Practitioners: Strengthening Rural Health Through Local, Sustainable Workforce Models

Lisa Friesen[1], Jessica Dixon[1], Ciara Corrigan[1]

[1]Health Nz

Rural and remote communities face persistent challenges in accessing equitable and sustainable healthcare. In response, our rural hospital has developed an innovative model that integrates home-grown nurse practitioners (NPs) into emergency departments and general wards, functioning at the top of their scope. These NPs are trained locally, progressing from registered nurses who already live and work in the community. Their deep familiarity with local culture, geography, and health needs enhances both quality of care and responsiveness in critical settings.

Lakes District Hospital (LDH) is a 12-bed rural hospital on the South Island of New Zealand. Huge growth in the area and ever-increasing tourism, has pushed this rural facility to capacity. Approximately 12,000 NZ nurses registered to work in Australia in 2023/24 due to perceived higher wages and better career progression opportunities.

This model exemplifies the philosophy of from the community, for the community, particularly within rural areas where nurses do not have the same career advancement opportunities as their urban counterparts. This model could be used to support and grow NPs through targeted pathways, mentoring, and educational opportunities and could be implemented in other rural communities with the long-term goal of achieving by Māori, for Māori care.

The presentation will explore the implementation, challenges, and outcomes of this approach, highlighting its impact on workforce stability, patient satisfaction, and health equity. It will also offer insights into how similar models could be replicated in other rural and Indigenous communities globally.

120 - Reaching rural rangatahi with Headstrong: can a youth-centred digital tool—and careful use of AI—help close the wellbeing gap?

A/Prof Karolina Stasiak[1], Dr Naomi Davies[1], Dr Holly Dixon[1], Dr Tania Cargo[1], Ms Sarah Bodmer[1], Ms Sasha Finlay[1], Ms Annie Kang[1], Ms Natalie Posa[1], Dr Grant Christie[2], Dr Chester Holt-Quick[3]

[1]The University Of Auckland, [2]Waitemata, Health New Zealand (Te Whatu Ora), [3]Kekeno Technology

Background
Rural young people in Aotearoa New Zealand face persistent barriers to timely, youth-friendly mental health support. Headstrong is a free, evidence-informed, transdiagnostic digital wellbeing tool designed in New Zealand with youth input (including Māori advisory guidance) and aligned to Te Whare Tapa Whā. It offers practical, culturally responsive support available anytime, anywhere.
Methods
Headstrong began as a rule-based chatbot and has evolved from a linear "course" into a meet-you-where-you-are model: brief mood check-ins and 100+ micro-skills across stress, mood, motivation, relationships, and harm-reduction. A small academic team, partnering with industry and supported by government, runs rapid improvement cycles and national delivery. Since late 2024 we have cautiously integrated generative AI to enhance conversationality with clear safety guardrails.
Results/experience to date
Over three years Headstrong has reached 9,000+ unique users nationwide. User feedback indicates acceptability of the micro-skills format. Engagement remains challenging to define and sustain, as many rangatahi dip in during distress rather than use routinely. Guided by youth input, we continue to expand content and reduce friction so support is available at the moment of need.
Implications
For rural health, Headstrong is a scalable, low-barrier complement to primary care and school services, extending reach to those outside urban networks. The next frontier is AI, but questions remain about impacts on care, equity, and safety. Progress will rely on ongoing evaluation with young people and clinicians, transparent governance, and sustained partnerships between academia, industry, and government to translate innovation into trustworthy, real-world support.

121- Hubs That Teach, Spokes That Reach: OGET in Action

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Aim: To evaluate the effectiveness of a decentralized hub-and-spoke Obstetrics and Gynaecology Education and Training (OGET) model of case-based learning, simulation, and mentoring in improving women's health outcomes across rural and remote Australia through localized, multi-disciplinary obstetric training.

Methods: Prospective mixed-methods evaluation study of the OGET program across twelve (12) regional health services, and over forty (40) rural and remote Australian health services from June 2022 to August 2025. Data collection included pre- and post-training confidence assessments, structured participant feedback from 35 standardized training sessions, and qualitative case evidence. Analysis included geographical distribution mapping using the Modified Monash Model (MMM) and thematic analysis of participant feedback.

Results: The program demonstrated four key benefits across participating remote health services: enhanced multi-disciplinary team preparedness, particularly in non-maternity staff managing obstetric emergencies; improved communication between rural services and regional referral centres, with specialists gaining first-hand knowledge of local resources; better accessibility of training for the predominantly female (71%) rural healthcare workforce by mitigating travel barriers; and rapid responses to emerging clinical challenges, demonstrated by the implementation of specialized training for difficult caesarean deliveries using simulation models across all OGET hubs.

Conclusion: OGET's decentralized education and training model demonstrates measurable improvements in clinical team's capability and communication in rural obstetrics and gynaecology care. This approach effectively addresses geographic isolation while ensuring sustainable professional development across the multi-disciplinary team.

122 - 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.

123 - How are clinical practice guidelines, protocols, and pathways used in rural and remote Australia, Canada, and Aotearoa New Zealand developed, implemented, and evaluated?

Luke Arkapaw[1], Dr Sonia Hines[2], Ms Mary Byrne[3], Mr Stefano Zaccagnini[1], Ms Nimali Mani[2], Prof Gillian Harvey[4], Dr Anthea Brand[1], Dr Oliver Black[5], Prof James A. Smith[1]

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This study provides the first comprehensive overview of how clinical practice guidelines, protocols, and pathways (GPPs) in use in the rural and remote areas of Australia, Canada, and Aotearoa New Zealand are developed, implemented, and evaluated.
Following the JBI scoping review methodology, six databases were searched in November 2024, with results analysed through to April 2025. Records were included if they identified a GPP, demonstrated its use in a rural or remote health service, and evaluated it as a primary focus.
Fifty-six studies met inclusion criteria; 21 evaluated GPP development and 52 evaluated implementation. Two-thirds of GPPs were contextualised in various ways before use, while one-third were adopted from other contexts and implemented without alteration raising contextual and cultural safety concerns. Consumers were directly engaged in just nine studies. Although half the development studies reported using systematic reviews, few applied recognised guideline development tools, and none employed widely accepted frameworks (e.g. AGREE, GRADE) for development or for a quality assessment on the GPP produced. Implementation strategies were typically multi-level and non-singular. The rationale for selecting strategies was often unclear, with only half matching strategies to pre-identified barriers. Evaluations predominantly used before-and-after and qualitative case study designs, often combined in a mixed methods approach. There was limited use of control groups or implementation science frameworks.
While GPPs are actively contextualised before use in rural and remote contexts, there is a need for more rigorous development processes, quality assessment, and theory-informed implementation and evaluation to strengthen their design and utility.

124 - Equitable Emergency Care Education: Lessons from the Emergency Medicine Education and Training Program Across Rural and Remote Australia

Cassandra Beer[1], Mr Mathew Davis[1], Ms Katie Moore[1], Juan Carlos Ascencio-Lane[1,2,3], A/Prof Tim Baker[1,4,5]

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The Emergency Medicine Education and Training (EMET) Program, established in 2011, delivers emergency care education to rural and remote Australia, where fewer than 25% of hospitals have a specialist emergency physician. These regions have higher proportions of Aboriginal and Torres Strait Islander peoples, lower life expectancy, and greater socioeconomic disadvantage than metropolitan Australia.
Between January 2018 and June 2023, EMET hubs ran over 10,000 sessions for more than 100,000 attendees across all seven Modified Monash Model (MMM) areas. Topics were selected by educators in consultation with local clinicians. Secondary analysis of EMET program reports from January 2018 to June 2023 was conducted. Standardised topic codes, MMM location, delivery mode, and attendance were analysed. Topics were grouped into 26 categories.
Over 10,000 sessions were delivered, with strong representation in MMM 5–7 regions where access to specialist-led training is rare. High-attendance topics included trauma, cardiac emergencies, airway/resuscitation, and paediatrics. Areas with higher proportions of Aboriginal and Torres Strait Islander peoples and greater socioeconomic disadvantage received proportionally more Indigenous health, mental health, and retrieval medicine, reflecting local health burdens and cultural safety priorities.
These patterns indicate the program adapts to community-specific needs, supporting equitable access to critical emergency skills. EMET is a scalable, equity-focused model for rural emergency care training. Using attendance data as a proxy for learning priorities provides a novel, unobtrusive way to target training. Embedding these insights enables culturally relevant education that addresses inequities, closes skill gaps, and strengthens emergency care capacity in underserved communities.

125 - 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.

126 - Growing and supporting a rural and remote allied health workforce: Is a College of Rural and Remote Allied Health the answer?

Cath Maloney[1], Dr Robyn Adams[1], Ilsa Nielsen[1]

[1]Services For Australian Rural And Remote Allied Health

The Allied Health Rural Generalist Pathway (AHRG Pathway) is a workforce, service and education strategy to increase access to a skilled allied health workforce for rural and remote communities. After more than ten years of iterative implementation in Australia, there is a growing body of evidence supporting the efficacy, impact and cost-effectiveness of the AHRG Pathway, showing advantages in attraction, retention, and service capacity building of multidisciplinary health teams.

This project aimed to consult with stakeholders to assess current understanding of the AHRG Pathway and the possible contribution a college of rural and remote allied health could make to the sustainability of the Pathway and to the rural allied health sector more broadly.

There was broad stakeholder interest and support for building a sustainable AHRG Pathway, particularly to develop a common understanding of a fully developed, end-to-end career structure. Senior allied health professionals were particularly interested in opportunities for professional recognition of leadership, research and evaluation capabilities and expert clinician components.

Most stakeholders indicated cautious support for the development of a college as a mechanism to drive the development of a single national AHRG Pathway, including managing nationally consistent standards and certification process for practitioners, accreditation process for post-graduate qualifications in rural generalist practice, and providing advice to health services and funders, professionals and other stakeholders in relation to rural generalist practice and services.

Further exploration and consultation will continue on the form and structure of a college, proposed business model and the organisational capabilities required to undertake this work.

127- Red Flags and Realities: Implementing Acute Assessment Protocols in Remote Primary Health Clinics in the Northern Territory, Australia

Luke Arkapaw[1], Prof Gillian Harvey[2], Dr Anthea Brand[1], Dr Oliver Black[3], Prof James A. Smith[1]

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Thirty one percent of the Northern Territory (NT) population identify as Indigenous, with 75% of Indigenous people living in remote areas. Remote health clinics are predominantly nurse led with medical support via telehealth. To support timely and accurate decision making for emergency assessments and care in these settings, the Remote Primary Health Care Manuals (2022) introduced nine Acute Assessment Protocols (AAPs) to guide care for critical presentations. These protocols have significant implications for decision making and care outcomes for the remote population.

The AAPs are endorsed for use in remote clinics by government and Aboriginal Community controlled health services. Ethics was obtained through the NT Human Research Ethics Committee to conduct this ongoing mixed-methods study to assess implementation of the AAPs using online surveys, focus groups and semi-structured interviews with 80 practitioners (Remote Area Nurses, Aboriginal Health Practitioners, Remote Medical Officers) and managers from both settings. Data collection and analysis is guided by Proctor's taxonomy of implementation outcomes.

Survey responses indicate relatively positive perceptions of acceptability, appropriateness, and feasibility, though variation exists across roles and settings. While many practitioners have adopted the AAPs and view them as useful, their application in emergency scenarios is often limited. Components such as red flags and sepsis alerts are frequently used, while others—like differential diagnosis tables—are seen as less practical. Suggestions for content and formatting changes were made to improve fidelity and sustainability. Findings will inform future revisions and help strengthen clinical guidance tools in rural and remote contexts.

128 - 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

129 - Weaving the Future of Rural Health: A Kaupapa Māori Case Study of the Tairāwhiti Comprehensive Primary Care Team (CPCT)

Ms Lana Reed[3]

[1]Ngati Porou Oranga, [2]Turanga Health, [3]Pinnacle Midlands Health Tairawhiti

Tairāwhiti's Comprehensive Primary Care Team (CPCT) exemplifies how Kaupapa Māori values reshape rural health delivery, workforce development, and intersectoral collaboration for better health equity. A tri-partner alliance - Ngāti Porou Oranga, Turanga Health, and Pinnacle Midlands Health - created CPCT to provide equity of access to primary care. It has built bridges between Primary, Community, and Secondary care in one of Aotearoa's most isolated regions ensuring whānau receive the care they need in a timely manner.

CPCT's clinical care coordination with allied and non-clinical members supported over 322 whānau experiencing complex needs and barriers to care due to extreme weather events and rural isolation. Over 950 face-to-face engagements in various settings, interdisciplinary teams worked alongside whānau to co-design flexible care pathways, ensuring continuity and cultural safety.

A bespoke Workforce Development Strategy grounded in Te Tiriti o Waitangi and Te Ao Māori has targeted recruitment and CPD, supported role innovation with clinical and non-clinical practitioners, encouraged postgraduate training for key clinical roles and grown digital enablement for shared care, IDT, MDTs across silo systems.

This case study demonstrates a socially conscious rural model investing in a way of working that has been informed by whānau voice. A robust governance structure drives local ownership and sustainability.

CPCT offers a scalable model for other rural and indigenous communities globally—blending mātauranga Māori, rural resilience, and system integration. It is a living example of "Nāku te rourou, nāu te rourou, ka ora ai te iwi"—with every provider contributing their basket so the people may thrive.

130 - How nurse prescribers are enhancing community wellbeing of remote Māori populations – a case study

Dr Elina Pekansaari[1], Gina Chaffey-Aupouri

[1]Ngati Porou Oranga

In the remote communities of the East Coast of New Zealand, medical care for many common conditions and minor ailments is increasingly being provided by the local nursing workforce. The practice nurses have upskilled in clinical assessment and prescribing, and completed a relevant prescribing qualification. These isolated indigenous communities have unique challenges and needs, and local nurse prescribers are well placed to provide care reflective of these needs.

This presentation will describe a care and treatment approach grounded in Māori worldview and Māori ways of knowing. The culturally relevant care provided by the nurse prescribers focuses on the collective wellbeing of the wider family, community and tribe, as well as the health of the individual. In addition to addressing the presenting complaint, the providers use a holistic approach focusing on wider determinants of health. Health education is provided in ways that are relevant to the family's and community's circumstances and their beliefs.

The presentation will also describe the flow on effects that have been observed in the communities following the care provided by the local nurse prescribers. These include improved health literacy and better adherence to treatment within the family and the wider community.

The experience from this this isolated area is that upskilling the local workforce can be a very effective intervention in improving health outcomes and wellbeing of the population.

131 - Developing a Rural Health Services Framework for Aotearoa New Zealand

Dr Carol Atmore[1], Ms Rachel Pearce[2], Mr Sean Clink[2]

[1]Health New Zealand|Te Whatu Ora, [2]Health New Zealand|Te Whatu Ora

Rural services across Aotearoa New Zealand (NZ) vary widely in scope and sustainability. Unlike many countries, NZ has had no framework to guide rural health service provision. The national Rural Health team at Health New Zealand has developed a framework that aims to provide a nationally consistent foundation for future planning, commissioning, and investment decisions. It is intended to support regional and local decisions about rural delivery. The framework and its development will be presented.

The framework was developed in response to significant unwarranted variation in access to care for rural communities. A 'people and placed based approach' was adopted. The framework was refined and validated through input from clinical, operational and sector expertise. Māori and rural communities' input was gained through synthesis of insights from previous work and working with rural provider and sector networks.

The framework describes the full list of services across the continuum of care, against the spectrum of rural communities of varying size and geographical remoteness. Rather than describing tiered levels from rural general practice through to rural hospital facilities, it describes the services that rural communities of various size and increasing rurality should expect. The framework also captures the support required from larger urban centres for the delivery of services in rural communities.

It offers a practical guide to the level and mix of hospital and health services that rural communities should reasonably expect to access locally as part of a broader network of services, while supporting alignment with regional and national service planning

132 - Strengthening Rural Health Outcomes through Single Employer Models in Queensland

Prof Ewen McPhee AM[1], Dr Konrad Kangru[1], James Mcnulty[1]

[1]Queensland Health - Health Workforce Division

This abstract evaluates how Queensland's Single Employer Model (SEM) can enhance rural health outcomes by ensuring continuity of employment and building local healthcare capacity. Under the SEM pilots, GP and rural generalist registrars remain employed by Queensland Health throughout training—covering hospital and primary care rotations—bringing stability in pay, leave, superannuation, and benefits akin to hospital-based trainees. The model is part of a national SEM trial funded by the Australian Government aiming to remove employment barriers, boost healthcare accessibility, and "Close the Gap". Key case studies from the Western, Central, and Southern Queensland regions illustrate how SEMs enable registrars to build strong ties to local communities, improving retention and service access. The planned expansion to about 60 full-time equivalent trainees across rural and remote Queensland strengthens recruitment pipelines and supports the delivery of specialist rural generalist medical services aligned to the intent of the Collingrove Agreement.

The abstract demonstrates that SEMs enhance rural health outcomes through employment certainty, embedded training models, and community connected registrar experiences.

133 - Taumata Rongoa o Hauora Hokainga

Hone Taimona[1]

[1]Hauora Hokianga

Rongoa, the traditional Māori healing system, holds significant potential as a complementary health component within our local hospital, Hauora Hokianga. Rooted in our local indigenous traditional knowledge and practices, Rongoa integrates spiritual, emotional, and physical healing, emphasizing a holistic approach to health care, whanau (family) and hapu (community) including Taiao (environment). Our video explores the relevance and need of Rongoa in our modern hospital settings, where the fusion of conventional medical practices and indigenous methodologies can enhance patient and whanau (family) care.

Incorporating Rongoa into our hospital health systems acknowledges the cultural identity of the majority of our Hokianga resident community, being of Māori ancestry and thus addressing health disparities and improving health outcomes for our Hokianga community that Hauora Hokianga serves. We provide a living example of a hospital, that adopts Rongoa can foster a more inclusive environment, promoting collaboration between healthcare professionals and traditional healers. Research illustrates that integrating Rongoa enhances patients' overall wellness, reduces anxiety, and supports recovery by offering culturally appropriate therapeutic options.

Our hospital's incorporation of Rongoa also aligns with New Zealand's commitment to honoring the principles of Te Tiriti o Waitangi Treaty, ensuring equitable access to health services for Maori. By empowering patients to engage in their healing process through Rongoa practices, hospitals can facilitate a more patient-centered approach, enhancing satisfaction and engagement in care plans.

Rongoa presents an opportunity to enrich patient care, honor indigenous practices, and address inequities in health outcomes, ultimately contributing to a more holistic and culturally responsive healthcare model.

134 - Rural urban distribution of nursing workforce in Aotearoa New Zealand

Michelle Smith[1], Mr Garry Nixon[2], Mrs Raewyn Lesa[3], Ms Reid Tracey[4], Mr Brandon De Graaf[5]

[1]Dunstan Hospital, [2]Centre for Rural Health, [3]Birchleigh , [4]Health Central, [5]University of Otago

Rural nursing practice settings in Aotearoa are wide and varied, from remote isolated islands to secondary rural hospitals. No studies have been undertaken to describe the rural-urban distribution of the New Zealand nursing workforce.

This study employed a cross-sectional descriptive design to describe the geographic distribution and demographic characteristics of the NZ nursing workforce using routinely collected registration data from the Nursing Council of New Zealand. Utilising a new geographic classification tool (GCH-Geographic Classification for Health) nurses employment addresses were geocoded categorised as against this tool to describe if they were rural or urban. The final sample size available for analysis was 17,826, (28.59% of all nurses registered between 1 April 2020 and 31 March 2021). 44,516 (71.4%) of nurses had to be excluded due to inaccurate employment addresses. 91% (16,085) of the final sample were based in an urban setting with 9.8% (1781) in rural areas. Rural nurses were usually older and had practiced for longer. Māori nurses were more likely to be based in more rural areas. There was more Nurse Practitioners per 100,00 population working in rural than urban areas.

Obtaining information about the rural Nursing workforce is an important part of ensuring rural areas have equitable access to health care professionals. Describing nurse's workplace settings accurately as rural or urban is a major step in beginning to understand the distribution of the nursing workforce. The lack of accurate workplace address data for the majority of the nurses is a barrier to achieving these goals.

135 - Misinformation in rural health: an online epidemic

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Online health information has become an increasingly critical component of how rural people seek accessible knowledge about their health and healthcare. But this has come with an explosion of digital health misinformation that is disrupting trust in public health and clinical science - and which has hit our underserved rural communities the hardest.

The rapid adoption of generative artificial intelligence (AI) tools has transformed the accessibility of health information. While these technologies can democratise knowledge, they also create new risks through the generation and amplification of health misinformation and disinformation. This poses significant challenges for primary care, where trusted clinician–patient relationships must increasingly counterbalance the influence of online content.

Building on a recent viewpoint publication with the World Federation of Public Health Associations (WFPHA), this presentation examines the intersections of health information, misinformation, and AI technologies. Generative AI can produce content that is persuasive but not always accurate, with risks amplified for communities already facing inequities in health access.

For rural and Māori patients, who may rely more heavily on online social circles and digital information due to geographic and systemic barriers, exposure to misleading content can exacerbate disparities and undermine hauora outcomes.

This research explores how misinformation influences patient decision-making, treatment adherence, and vaccine confidence, and considers the role of rural medicine in addressing these threats.

By recognising the dual role of AI as both an opportunity and a risk, family medicine can take leadership in shaping equitable, safe, and patient-centred approaches to digital health information.

136 - How to support the development of clinical courage in our rural generalist registrars

Prof Lucie Walters[1], Dr David Campbell, Professor Ian Couper[3], Professor Ruth Stewart, Dr Daniel Pellegrini[2], Dr Emily Moody, Dr Susan Williams[2], Dr Peter Gilchrist[2], Dr Al Alwash[2], Associate Professor James Padley[4], Dr Abbey Moore[2], Dr Lisa White[2]

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How to support the development of clinical courage in our rural generalist registrars

Background
Clinical courage describes the ability of rural generalists to work at their full scope of practice in order to provide their patients with access to clinical care not otherwise available in their rural locations. Clinical courage requires both contextualised competence in the health service and responsiveness to community. It involves facing cognitive hurdles when providing care. Recent research demonstrates that clinical courage is associated with sustained clinical work in rural areas.
This study explores how clinical courage develops in doctors-in-training and how it can be strengthened by different aspects of formal education and supervised rural practice.

Methods
Current, past and future rural generalist trainees were interviewed about how they have developed their clinical courage. Learning theories were used as conceptual frameworks to explore how rural clinical immersion and formal rural curricula activities facilitate the development of clinical courage.

Results
This presentation will describe the results of thematic analysis and present ten tips of clinical supervisors and medical educators engaged in training the next generation of rural doctors.

Conclusion
Rural clinicians and trainees will be encouraged to consider how relevant clinical courage is to their practice, and how they can potentially facilitate its development in themselves and their rural peers.

Acknowledgement
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137 - Echoes From Remote: A Systematic Review on Ultrasound in Remote and Rural General Practice.

Anna Podlasek[1]

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Background: There is a growing interest in ultrasound (USS) in remote and rural general practice (RRGP) to overcome diagnostic challenges associated with limited access to advanced imaging and the radiology workforce. This systematic review evaluates the clinical applications of USS in RRGP performed by a generalist and discusses diagnostic accuracy, training, and barriers to implementation across the globe.

Methods: A systematic review was conducted in accordance with PRISMA guidelines. Searches were run across three databases from inception to November 2024. Eligibility criteria included studies focusing on the use of ultrasound in rural and remote settings, performed by a generalist, and discussing the clinical utility of this tool. Screening, data extraction, and quality appraisal were performed independently by two reviewers. There was a plan for narrative data synthesis due to heterogeneity in study designs and outcomes.

Results: Fifty-eight studies met the inclusion criteria out of 2,204 studies identified, with 330 full texts screened. Key applications of ultrasound in RRGP included emergency assessment, antenatal care, heart and lung examinations, and abdominal aortic aneurysm screening. Diagnostic accuracy varied widely by application. Challenges included operator training, equipment costs, and maintenance in resource-limited settings. Studies highlighted improved patient outcomes and enhanced practitioner confidence when USS was integrated into practice, though data were limited on cost-effectiveness and long-term impacts.

Conclusions: USS offers significant benefits in enhancing diagnostic capacity in RRGP, particularly for acute and time-sensitive conditions. However, barriers such as training and resource limitations require targeted interventions.

138 - 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.

139 - Staying Local, Serving Rural: Ten Years of Rural Hospital Medicine Training in Te Tai Tokerau | Northland, Aotearoa

Dr Sarah Clarke[1], Mr Joshua Miedema[2]

[1]Health Nz | Te Whatu Ora, [2]University of Auckland

Rural hospitals in Aotearoa provide essential healthcare to underserved communities, including a disproportionately high number of Māori whānau. With one in four rural New Zealanders identifying as Māori, ensuring effective rural hospital care is critical to advancing equity and improving outcomes.

This quality improvement project evaluates the Northland Rural Hospital Medicine Training Programme—the first in Aotearoa to offer a coordinated, one-employer model for rural hospital medicine training. The programme enables trainees to complete required placements across multiple rural settings while maintaining employment continuity.

Semi-structured interviews with current and former trainees reveal strong support for the Northland model. Participants valued the coordinated placement process, the ability to remain employed during general practice training, and growing recognition of rural hospital medicine within other specialties. The completed quantitative audit complements these findings by mapping retention patterns and vocational progression, providing a broader view of the programme's impact.

Together, these insights suggest that regionally embedded training models may improve workforce stability and support continuity of care in rural hospitals. The Northland approach appears to make rural hospital medicine training more attractive and accessible, with potential to increase local retention—particularly in areas with high Māori populations.

This project contributes to the evidence base for rural workforce development and offers a scalable model for other regions. It supports the case for national or regional adoption of similar training structures, with the potential to strengthen rural hospital services and improve health outcomes for Māori and rural communities across Aotearoa.

140 - Building Rural Medication Safety using a Practice Cohort Management System

Dr Amelia Winter[1], Dr Deepti Sharma[1], Dr Jessica Edwards[1], Dr Imaina Widagdo[1], Ms Antoinette Liddell[1,4], Dr Fernanda Nobre[1], Mr Joel Taggart[1,3], Dr Lindy Washington[5], Dr Simon Lockwood[4], Dr Leanne Schroeder-Perrang[1,4], Dr Amanda Bethell[6], Dr Kean Choy Chen[1,4], Dr Simon Jackson[4], Associate Professor David Gonzalez[1], Associate Professor Elizabeth Hoon[1], Prof Lucie Walters[2,4]

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Background
Rural communities with lower socioeconomic status have high rates of people with multiple chronic diseases and subsequent complex combinations of medications to treat these. It can be challenging to manage medication safety. Clinic cohort management tools can priorities patients for services such as pharmacy reviews. The purpose of research was to draw out rural general practitioners' views on:
i) the challenges of managing the cohort of patients within their clinic with multiple health conditions and/ or prescribed multiple medications,
ii) what practice cohort management systems and other resources they currently use to manage this group of patients, and
iii) potential opportunities and barriers to developing electronic systems combined with pharmacist involvement to optimize medication safety in rural primary care.
Methods
Semi-structured interviews with rural doctors, pharmacists and consumers where recorded, transcribed and analysed to draw out common themes. A separate project privileging Indigenous voices in Aboriginal Community Controlled medical services is also underway.
Results
This paper will present initial findings of the non-Indigenous study to demonstrate how this information will influence the development of a clinic cohort management tool to build rural medication safety.
Conclusion
Electronic health records provide significant opportunity to influence how finite health services are directed to improve the health of the most vulnerable patients in our rural clinics and communities.
Acknowledgement
This research has been funded by the Australian National Health and Medical Research Council

141 - Measuring What Matters: Co-Designing a Framework for Rural Hospital Productivity in Aotearoa

Dr Sarah Clarke[1]

[1]Massey University

Rural hospitals in Aotearoa provide essential healthcare to under-served communities, yet their productivity is often assessed using urban-centric metrics that fail to reflect the realities of rural care. This research project aims to develop a comprehensive framework for measuring rural hospital productivity, incorporating both patient-centred outcomes and system-level factors relevant to rural communities.

Using a consensus methodology and modified Delphi approach, the project engages rural hospital leaders, managers, Hauora Māori partners, and community members through focus groups to co-design a framework that reflects the values and priorities of rural healthcare. The initial “straw man” framework, informed by literature and expert knowledge, includes key performance indicators such as clinical outcomes, patient satisfaction, access to care, cost-effectiveness, and equity-adjusted measures. Focus group participants provide iterative feedback to refine the framework, ensuring it is contextually appropriate and meaningful.

Preliminary findings highlight the importance of including social investment concepts alongside traditional return-on-investment measures, recognising the broader impact of rural hospitals on community wellbeing. Participants emphasised the need for metrics that account for generalist models of care, cultural safety, and continuity of service.

This research contributes to the development of a robust, locally informed framework that can guide policy, improve resource allocation, and support the sustainability of rural hospitals. It acknowledges the unique role of rural hospitals in achieving equitable health outcomes for Māori and rural populations.

142 - 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.

143 - Identifying gaps in NSAID prescribing: safety indicators in rural and urban Australian general practices

Ms Fernanda Nobre[1,2], Ms Emmae Ramsay[2], Professor Nigel Stocks[2], Professor Lucie Walters[1], A/Prof Elizabeth Hoon[1,2], Dr Imaina Widagdo[3], Dr Sarah Rodgers[4,5], Dr Amy Taylor[4], Mr Joel Taggart[6], A/Prof David Gonzalez[1]

[1]Adelaide Rural Clinical School, University of Adelaide, [2]Discipline of General Practice, University of Adelaide, [3]Quality Use of Medicines and Pharmacy Research Centre, University of South Australia, [4]School of Medicine, University of Nottingham, [5]PRIMIS, University of Nottingham, [6]Primary Care and Health Services Research Consumer Reference group, University of Adelaide

Background: Non-steroidal anti-inflammatory drugs (NSAIDs) can lead to gastrointestinal bleeding, renal impairment, and exacerbation of heart failure. Prescribing safety indicators, such as those developed in the UK PINCER program, identify where prescribing may not align with best-practice guidance. Little is known about how these patterns differ between rural and urban Australian general practice. This study aimed to compare NSAID prescribing safety indicators by practice location in Australia.

Methods: Data from 1.6 million regular patients (≥3 consultations in two years) attending MedicineInsight general practices in 2022 were analysed. Four NSAID safety indicators were applied, defining at-risk groups (denominators) and those receiving prescriptions flagged by safety indicators (numerators). Rurality was classified using the Australian Statistical Geography Standard, and rates were compared across major cities, inner regional, and rural (outer regional, remote, very remote) practices.

Results: Among patients aged ≥65 years, 44 per 1,000 in rural practices received NSAIDs without gastroprotection compared with 36 per 1,000 in major cities ($p<0.001$). Among patients with heart failure, prescribing rates were 37 per 1,000 in rural areas versus 25 per 1,000 in cities ($p<0.001$). Similar patterns were seen for patients with impaired renal function (36 vs 27 per 1,000, $p<0.001$).

Implications: Older adults and people with multimorbidity in rural areas are more often exposed to prescribing practices identified by safety indicators. Co-designed with rural clinicians and consumers, these findings highlight inequities in medication safety and will inform the NHMRC-funded BRIDGE project, which is developing integrated, context-specific strategies to support safer prescribing in rural communities.

144 - What Drives Allied Health Students to Work Rurally in Australia and New Zealand

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There are significant disparities in the optometry workforce between rural and urban Aotearoa. The optometry workforce is primarily concentrated in metropolitan areas. There is a lower proportion of optometrists in areas of higher deprivation and lower population density. To address this maldistribution, optometry students at the University of Auckland are undertaking rural-focused research as part of their honours. These projects include evaluating the rural workforce intentions of optometry students and understanding the factors influencing allied health students to practice rurally.

An overview of these rural workforce projects will be presented. To understand the factors influencing allied health students to practice rurally, a narrative review of the literature has been undertaken.

Eye health service access remains an inequity faced by rural communities; barriers to access can impact wellbeing and quality of life. These projects' findings can aid educational strategies to encourage participation in rural optometry, ensure existing placements are well-catered to rural communities, and improve student preparedness.

145 - Rural mental health strengths and social connectedness: Findings from the Australian National Study of Mental Health and Wellbeing

Dr Annika Luebbe[1,2,3], Dr Zoe Rutherford[2,3], Prof Harvey Whiteford[2,3], Dr Sandra Diminic[2,3]

[1]Rural Clinical School, Faculty of Health, Medicine and Behavioural Sciences, The University of Queensland, [2]Queensland Centre for Mental Health Research, [3]School of Public Health, Faculty of Health, Medicine and Behavioural Sciences, The University of Queensland

This study aimed to describe rural data from the Australian National Study of Mental Health and Wellbeing survey (2020-2022) to assess strengths-based questions, differences by rurality, and factors associated with excellent social connectedness.
Survey questions were mapped to the Rural Strengths Socioecological Framework. Descriptive and logistic analyses of rural adults' use of strengths by remoteness and presence of affective/anxiety disorders in the past 12 months. Logistic regression explored factors associated with social connectedness.
Survey questions reflected some strengths within the Framework including self-management techniques, family and friend support, social connectedness, and health care personnel. However, questions were primarily framed using a deficit perspective and many strengths from the Framework (i.e., nature, rural norms, culture, and lay personnel) were absent. Most strengths did not differ significantly between levels of rurality, though making healthy diet choices (as a self-management technique) was significantly lower in remote areas. Adults without affective/anxiety disorders more often reported good social support and self-efficacy. Conversely, those with affective/anxiety disorders were more likely to self-manage and access consultations for mental health. Excellent social connectedness was associated with better mental health.
To conclude, the survey questions reflected limited strengths. Future surveys should include a broader range of strengths-based questions spanning the extent of the Rural Strengths Socioecological Framework. Healthy diet choices as a self-management tool in remote areas may need to be prioritised. Findings also suggest the need for targeted approaches to protect, improve or leverage social connectedness for those with more severe illness in rural areas.

146 - From plans to practice: Sustaining and scaling rural research capacity for a learning healthcare community

Dr Shabnam Asghari[1], Dr Wendy Graham[1], Dr Cheri Bethune[1], Dr Tayebeh Sohrabi[1], Emily Hussey[1], Dr Emma Webster[2], Dr David Schmidt[2,3], Dr Kerith Duncanson[3], Dr Richard Ball[3]

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Building on our 2024 workshop—where participants explored rural research capacity building models (6for6, Canada; Rural Research Capacity Building Program [RRCBP], Australia)—this follow-up session moves from identifying opportunities to implementing and sustaining them.

In the past years, alumni from these programs have launched rurally relevant research and quality improvement projects, generating valuable lessons on adaptation, collaboration, and impact evaluation. This workshop will share updated program outcomes, highlight real-world examples of implementation, and unpack the challenges and enablers of scaling rural research capacity across diverse contexts.

Using a hybrid format to reflect the blended delivery of both programs, the session will include:

• Brief presentations from program alumni on outcomes, barriers, and strategies for success with examples from working with Indigenous communities.
• Small-group discussions where participants will design their own Practical Action Plans to guide implementation in their settings;
• Facilitated exchanges of tools and resources, including planning templates, mentorship strategies, and evaluation frameworks;
• A commitment exercise where each participant identifies one tangible step to take in the next six months.

Learning objectives:
By the end of this workshop, participants will be able to:
1. Apply strategies for implementing rural research capacity initiatives in their context;
2. Identify practical metrics to evaluate community and system-level impact;
3. Adapt mentorship and knowledge-sharing approaches for sustainability;
4. Build collaborative networks for ongoing peer support.

This interactive session is ideal for rural health practitioners, educators, and policymakers who are ready to translate research capacity plans into sustainable, community-driven change.

147 - Intersecting impacts of ethnicity, rurality and socioeconomic deprivation on Diabetes management in Aotearoa New Zealand

Dr Dillon Manuirirangi[1], Professor Sue Crengle[1,2], Dr Rory Miller[2], Dr Kyle Eggleton[3]

[1]Ngāi Tahu Māori Health Research Unit, [2]Rural Health Research Network (University of Otago), [3]University of Auckland

Diabetes is a leading cause of morbidity in Aotearoa. Although known disparities in health outcomes exist for people with diabetes based on ethnicity, rurality and socioeconomic deprivation, there is a lack of evidence on how these variables interact. This project aimed to explore how these intersecting factors influence diabetes management and outcomes in rural Aotearoa.

A cross-sectional study design using secondary analysis of routinely collected national health datasets (most recent complete dataset - 2023) was undertaken for adults diagnosed with diabetes across Aotearoa. Quality of diabetes management was based on actualised service utilisation (Frequency of HbA1c testing based on NZSSD guidelines) and a Diabetes Composite Score that was formulated in accordance with current New Zealand Diabetes Management guidelines based on the data that was available. Data analysis used descriptive statistics of diabetes quality indicators across three main variables; rurality (Geographic Classification of Health), ethnicity (Māori or Non-Māori), and socioeconomic deprivation. Intersectionality of variables was explored utilising Modified Poisson regression models.

This study highlights the impacts of being poor, Māori and living in a rural area on diabetes management in Aotearoa. Awareness of how these factors intersect will help further inform policy and practice to strengthen equity in diabetes management.

148- Virtual wound care to support rural residential aged care settings: designing an implementation study with equitable inclusion of residents

A/Prof Georgina Luscombe[1], Dr Heather Russell[1], Dr Annie Banbury[2], Ms Kate Smith[1], Mr Matt Hill[1]

[1]University of Sydney School of Rural Health, [2]Coviu Global Pty Ltd

INTRODUCTION
Chronic wounds are a significant health concern in Australia, with substantial impacts on quality of life and healthcare system costs. Challenges to evidence-based wound care, particularly in residential aged care homes (RACHs) and rural settings, include access to specialist services. WoundView is an MRFF funded project to develop an AI-assisted wound care clinical decision support telehealth system. People with cognitive impairment are frequently excluded from research in RACH settings. This implementation study designed methods to facilitate equitable inclusion for people living with cognitive impairment.

METHODS
The observational descriptive cluster stepped wedge implementation study includes residents, RACH staff and wound care clinicians. Methods for equitable inclusion of residents were developed based on a narrative review of the literature and in collaboration with the study consumer representative and RACH stakeholders.

RESULTS
Assessment of resident's capacity and a process of supported decision-making with residents and their family/substitute decision makers has been protocolised. Supported decision-making considers the values and preferences of the resident and their family/substitute decision makers, referring to any previously documented medical wishes. The Evaluation to Sign consent instrument is used where capacity is presumed or unknown. Opportunities to reassess capacity are provided where cognitive function is fluctuating.

CONCLUSIONS
RACH residents are frequently routinely excluded from research and rarely represented in technology studies. Cognitive impairment is common in RACHs and people living with such conditions are entitled to participate in research. Facilitating equitable inclusion is essential for research used to inform policy and practice decisions affecting this population.

149 - Neurodivergence in the Rural Health Workforce: From Burnout Risk to Sustainable Strength

Dr Jez Leftley[3]

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

Rural health attracts a diverse workforce but one group, including clinicians like myself, remains largely invisible: neurodivergent health professionals. Neurodivergent health professionals are present within rural teams yet often go unrecognised. Without deliberate acknowledgement and support, these colleagues face increased risks of burnout, attrition, and barriers to career progression. This is not a question of capability, but of system fit.

Rural practice offers unique opportunities where neurodivergent professionals thrive: the breadth of work, professional independence, and the demand for innovative problem-solving. Their contributions, like resilience, empathy, creative thinking, and systems insight, are invaluable to small, overstretched teams. Yet current workforce debates rarely acknowledge cognitive diversity as part of the solution.

Supporting neurodivergent staff does not require costly or complex interventions. Small, meaningful changes, such as flexible rostering, targeted mentorship, harnessing IT and AI to reduce administrative load, and fostering respectful and inclusive workplace cultures, are low-cost, high-impact measures that strengthen retention and workforce sustainability. Recognising neurodivergence contributes to wider equity goals, including the perspectives of Māori, Pacific, and other diverse communities whose cultural contexts shape both challenges and strengths.

This presentation explores how recognising and supporting neurodivergence is essential to rural workforce sustainability, patient safety, and equitable health outcomes. It will highlight the risks of burnout when neurodivergence is overlooked, and the strengths unlocked when it is embraced. Participants will gain practical strategies adaptable to diverse rural contexts, and be encouraged to reflect on how these can be applied in their own settings, ensuring every member of the workforce thrives.

150 - 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.

151 - Advancing Rural Workforce Recruitment and Retention through a Rural GP Elective Framework

Dr Mark Smith

[1]Royal New Zealand College Of General Practioners , [2]Central Otago Health Services Ltd Health Central, [3]University of Otago

The Rural GP Elective Training Pathway project is a national initiative designed to strengthen rural healthcare delivery by formally recognising and providing rural specific training for general practitioners in Aotearoa New Zealand who choose to work rurally. This project aims to address long-standing challenges in rural workforce recruitment and retention, the lack of a dedicated postgraduate rural general practice training pathway, and importantly the poor health outcomes in our rural areas, particularly for rural Māori.
Currently under development, the Elective framework has been co-designed through a collaborative process involving rural clinicians, academic leaders, and Māori health representatives. The project has reviewed context-specific competencies, scope of practice, and crafted a relevant training pathway including clinical and academic learning components. The pathway will include mechanisms for learning support and mentorship, ongoing professional development, and peer networking. It is intended to foster quality rural healthcare, continuity of care, cultural safety, and adaptive care models that respond to local community needs.
Following the initial rollout of the rural elective pathway, there would be planned annual review in order to refine and improve the elective over time.
The project aims to ensure Te Tiriti o Waitangi principles are embedded and upheld. The framework intentionally integrates considerations of equity across ethnicity, gender, socio-economic status, and geographic isolation.
The Rural GP Elective project offers a scalable and equity-focused strategy to enhance the sustainability, visibility, and quality of general practice in rural areas. It represents a forward-thinking, community-informed model for addressing workforce instability and improving rural health outcomes.

152 - Health outcomes for Pacific peoples in Aotearoa New Zealand. Exploring the impact of rurality and socio-economic deprivation.

Dr Jane Taafaki[1]

[1]University Of Otago-Centre for Pacific Health, [2]Oamaru Pacific Island Trust

Although Pacific Peoples are less likely to live in rural areas than Māori and European New Zealanders, there are significant and rapidly growing Pacific populations in some rural areas. Little is known about the health of these communities. In addition, the use of prioritised ethnicity protocols can underestimate the size of Pacific communities. 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 Pacific Peoples.
The following adult and childhood indicators were considered:
All-cause mortality
Amenable mortality
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)
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.
Total Pacific:(non-Māori/non-Pacific) incidence rate ratios (age standardised or stratified as appropriate) were estimated using the most recently available 5-years of data across different GCH and NZDep strata. This is the first time this work has been undertaken.

153 - Understanding health and hazard exposures in rural Pacific meatworkers

Dr Jane Taafaki[1]

[1]University Of Otago-Centre for Pacific Health

Meat processing is a hazardous work environment with multiple health risks. Pacific peoples are overrepresented in this industry with high rates of injury and work-related harm. Little research has investigated the occupational health and exposures experienced by Pacific meatworkers, particularly in rural settings. While a small amount of individual level data exists, the nature and magnitude of this injury/illness and exposure has not previously been characterised and quantified. Co-production of the uniquely Pacific occupational health survey instrument and the results of its administration across three rural manufacturing sites will be presented.

154 - The lived experiences of rural Tuvaluan migrants navigating the New Zealand healthcare system

Dr Jane Taafaki[1]

[1]University Of Otago

Migration from Tuvalu to Aotearoa/New Zealand is part of a Pacific-wide phenomenon that has gained significant momentum since the early 1970s. New Zealand is now home to almost 5,000 Tuvaluans, from new migrants through to third generation New Zealand-born Tuvaluans. These new migrants face significant challenges in learning new systems of education, social services, housing and especially health.
The health experiences of Pasifika in rural Southern Aotearoa/New Zealand remains an unexplored area of public health research. This qualitative research project explored health and well-being among the Tuvaluan population in the rural North Otago town of Oamaru, where Pasifika represent twenty percent of the local population. This study offered opportunities for change in the provision of rural healthcare as well as contributed to the broader body of knowledge of Pasifika health in rural Aotearoa/New Zealand. This study made a positive contribution to improved health outcomes, not only for Tuvaluans but, by extension, for all Pasifika peoples in the New Zealand diaspora.

155 - Developing and maintaining a primary care undergraduate medical student teaching faculty in rural Scotland.

Dr Lloyd Thompson[1]

[1]University Of Dundee

The Scottish Graduate Entry Medicine (ScotGEM) programme embeds third-year medical students in general practices for a 43-week Longitudinal Integrated Clerkship (LIC). These practices are across Scotland with a specific emphasis on rural practices. This model aims to promote rural generalism and support recruitment and retention in rural areas. We enjoy high GP practice retention rates (80% over 5 years), and 35% of our current LIC GP practices have never been involved in undergraduate medical education previously, showing expansion of primary care teaching capacity, often in more rural areas.

The study investigated factors that encourage or discourage practices from participating in LICs. The study engaged practices located all our LIC GP practices, including many in rural areas.

A mixed-methods approach was used. Stage one involved semi-structured interviews with general practitioner (GP) tutors, analysed thematically to identify key enablers and barriers. Stage two involved a structured survey, developed from stage one themes, distributed to all participating practices and tutors (n=98). Responses were collected anonymously and analysed descriptively.

Findings showed that GP practices valued the LIC model for its contribution to community impact, professional satisfaction, and educational enrichment. However, barriers included resource constraints, administrative burden, and limited clinical space. Despite these challenges, 96% of GP tutors rated their experience positively.

The study concluded that targeted support—such as clearer expectations, streamlined administration, and improved infrastructure—can enhance practice engagement with LICs and contribute to sustainable healthcare education.

156 - 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.

157 - 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.

158 - 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.

159 - Enhancing Long-Term Condition Care - Te Oranga Pumau

Joanne Urlich[1], Aroha Henry, Sarah WIlliams

[1]Te Hiku Hauora

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. In the last 30 years Te Hiku Hauora has grown to employ over 230 hundred kaimahi across a range of departments to provide comprehensive health and wellbeing services to the community.

Te Hiku Hauora works strategically to continually enhance, extend and improve on hauora services for improved health outcomes for whānau of Muriwhenua.

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

The Whakapiri Ora Team run a weekly community programme to support whanau with their long-term conditions. These free sessions are for anyone wanting to learn more about living well with conditions like gout, prediabetes, diabetes, heart issues, and more.

With approximately 7.5% of the population having type 2 Diabetes Mellitus, there is high need for these classes. Weekly sessions include whanaungatanga, nutrition, podiatry, medications, stress and sleep and physical activity.

Each week a guest speaker presents workshop style health education with support from registered nurses and health coaches to improve wellbeing of whanau living with a long-term condition.

Supporting whanau to make practical changes, improve their quality of life and remain connected and supported with health care and their community.

160 - Rural Wellbeing - Supporting Whaiora to engage in their community

Joanne Urlich[1], Denham Pivac

[1]Te Hiku Hauora

Mood disorders (Anxiety and depression) are currently one of the most common types of disorders in the general population.

Mood disorders have a substantial impact on a person's activities of daily living such as mahi, looking after their own physical health or their whanau. Mood disorders are characterised by high comorbidity along with other mental disorders.

Te Hiku Hauora groups deliver evidenced based support, the majority of which is CBT personalised for the whaiora who attend.

Whaiora engage in 1:1 assessment, planning and education so that individualised treatment plans based on their values and needs.

Groups have no specific referral criteria except the cognitive and behavioral ability for whaiora to engage in a safe and considerate manner with others.

There is a formalised education structure to the group including subjects such as the Fight or flight model, Values based planning, Behavioral change support and Sleep. However, groups have the flexibility to focus on current issues that the group themselves choose. One of the major successes of this format is providing a safe space for whakawhanaungatanga, to practice and develop social skills and reintegration in a low stakes environment based on the values held by the members.

Cognitive restructuring by examining and discussing evidence for and against a belief, korero around healthy alternatives and developing a more flexible, balanced and realistic perspective has proved successful.

Whaiora feedback has been overwhelmingly positive and objective markers and goals set by whaiora are regularly achieved.

161 - When Whanau Lead: Restoring Mana Motuhake in Health Care

Hemaima Reihana-Tait[1]

[1]Te Aho O Te Kahu

Abstract Title: When Whānau Lead: Restoring Mana Motuhake in Health Care

Abstract
In Aotearoa, Māori whānau navigating rural health care often encounter systemic and clinical barriers that undermine their autonomy, cultural safety, and wellbeing. This presentation centres mana motuhake — the self-determined authority of whānau — as a critical lens for understanding and transforming inequities in care pathways.
Whānau-led care challenges conventional models that position services as experts and whānau as passive recipients. Rooted in Te Tiriti o Waitangi and Indigenous values such as rangatiratanga, whanaungatanga, manaakitanga, kaitiakitanga, and mana motuhake, it affirms whānau as decision-makers and protectors of their own oranga. Examples include whānau co-designing care plans, creating space for rongoā and karakia, and services adapting to align with whānau rhythm and leadership.
The presentation introduces The Mauri Ora Encounter — a framework for rural practice grounded in Mātauranga Māori and cultural safety. At its heart is Whakatika, Whakapono — a “bias reset” that invites clinicians to recalibrate assumptions and open the pathway of ngākau (heartspace), enabling mauri ora: the vitality, dignity, and wellbeing of individuals and their whānau.
Participants will be invited to reflect on power-sharing in their own practice and consider: How do our systems honour or undermine whānau leadership? What shifts can we make to protect and restore mana?
Whānau-led care is not simply a model — it is a movement grounded in whakapapa, equity, and relational accountability. When whānau lead, healing begins.

Keywords: Mana Motuhake; Whanau Centered Care, Bias reset, Health Equity, Cultural Safety,

162 - Proof of Concept: AI-Assisted Documentation in Rural General Practice – Comparing Stand-Alone and EMIS-Integrated Tools

Dr Nina Jyne Minette Dela Cruz[1], Dr Tom Lorne McEwan[1]

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Administrative workload is a well-recognised challenge in primary care, particularly in rural and resource-limited settings where clinician time is constrained. Excessive documentation contributes to stress, reduced patient interaction, and burnout. AI-driven ambient documentation tools offer a potential solution, yet evidence of their real-world impact in rural general practice remains limited.

This study evaluated two AI-assisted documentation tools in a rural Hampshire practice. One tool functioned as a stand-alone system, while the comparator was integrated with EMIS, the electronic medical record system widely used in Hampshire. A pre-use survey (n=5) and post-use survey (n=5) were conducted to assess clinician perspectives before and after implementation. The pre-use survey explored baseline attitudes towards AI, current documentation challenges, and anticipated benefits, while the post-use survey examined usability, workflow changes, and limitations.

Findings showed that 80% of clinicians found the stand-alone tool “easy” or “very easy” to use, with 60% reporting reduced documentation time. Stress was “greatly reduced” for 40%, and 60% expressed a more positive perception of AI in primary care. However, transcription errors, formatting issues, and lack of integration were noted. In contrast, the EMIS-integrated provider enabled smoother coding and automatic entry including of observation values, but offered less nuanced interpretation of the clinical narrative.

This proof-of-concept study demonstrates that AI-assisted documentation can enhance efficiency and clinician satisfaction in rural practice. While integrated systems facilitate coding and data capture, stand-alone tools may provide richer narrative support. Future research should explore hybrid approaches and the long-term impact on workload, patient interaction, and care quality.

163 - Revolutionising GP Workflows in a Small Rural Village in Hampshire, England: Pilot Evaluation of Ambient AI for Documentation and Efficiency”

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Rural general practices face unique challenges, including limited staffing, high administrative workload, and constrained consultation time, which can contribute to clinician stress and reduced patient interaction. The widespread adoption of electronic health records (EHRs) has intensified clerical demands, making efficient documentation a critical concern. Ambient artificial intelligence (AI) presents an opportunity to automate documentation tasks, potentially reducing workload while maintaining high-quality patient care.

This pilot evaluation was conducted in a small rural village GP practice in Hampshire, England. It directly compared 50 consultations documented using standard methods with 50 consultations using an ambient AI tool. Documentation quality was assessed using the Sheffield Assessment Instrument for Letters (SAIL), clinician workload via the NASA Task Load Index (TLX), and total consultation times were measured, including patient interaction and documentation, to assess efficiency.

Results demonstrated that the ambient AI tool reduced overall consultation duration by 19% and improved documentation quality by 28%. Clinicians reported a 31.4% reduction in cognitive load, indicating a tangible decrease in administrative strain, while patient interaction time remained unaffected. Integration with existing clinical systems such as EMIS or SystmOne was noted as necessary for seamless implementation.

This pilot evaluation illustrates the potential of ambient AI to transform workflows in rural general practice by enhancing efficiency, supporting clinician well-being, and maintaining high-quality patient care. These findings highlight a promising avenue for technology adoption in resource-limited rural settings, with implications for broader implementation and long-term sustainability in primary care.

164 - Improving Patient Self-management Through Technology-enabled Remote Care

Ms. Chi Ling Chan[1], Ms. Megan Barnes[2]

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Chronic diseases such as type 2 diabetes, hypertension, and heart failure require ongoing self-management and timely clinical action, yet traditional in-person care often results in delayed responses. To address this, Pacific Health Service Hutt Valley (PHS) partnered with Equitech, a health transformation software enterprise, to evaluate Speedback, an AI-enabled remote care solution designed to improve patient engagement and provider responsiveness without increasing the workload on primary care teams.

In this pilot, 32 patients were enrolled by community nurses, who trained them on using monitoring devices and Speedback's digital tools. Patients regularly reported vital signs, medication adherence, and symptoms, which were processed through automated triage to flag abnormalities or missed reports. Care teams monitored patient data asynchronously, intervening only when necessary and using longitudinal insights to guide clinical decisions.

The intervention demonstrated significant benefits. Staff saved an average of 4 to 5 hours per patient weekly, and up to 10 hours when avoiding travel. Patients showed greater self-awareness and motivation to manage their conditions. Early identification of clinical issues enabled timely interventions, while richer longitudinal data improved decision-making. Over 50% of patients maintained their blood pressure and glucose within target ranges, average HbA1c levels fell by 22%, and cholesterol levels slightly improved.

Overall, the pilot proved feasible and effective. The technology-enabled model enhanced patient engagement, improved clinical outcomes, and optimised care delivery, showing that remote, AI-assisted models can strengthen chronic disease management without disrupting existing workflows.

165 - 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.

166 - Growing our own: Measuring the impacts of place based interprofessional allied health degrees in rural and remote Australia.

Dr Alison Dymmott[1], A/Prof Rachel Milte[1]

[1]Caring Futures Institute, Flinders University

Introduction/Background
Health outcomes in regional areas are lower than the national average, and development and retention of health workforce is key to address health inequalities. This research aimed to explore the impacts of an innovative interprofessional allied health course delivered in regional Australia.

Methods
Mixed methods research approaches have been utilised to investigate the impacts of a place-based education program in rural areas. Focus groups were undertaken with rural staff and students and quantitative university outcome data was also collected. Focus group data was analysed deductively and outcome data was described descriptively alongside relevant Australian Bureau of Statistics data.

Results/Evaluation
The Bachelor of Allied Health is in its third year of implementation with high demand for all three professions. The majority of students have a low socioeconomic status and are first in family. Students have a rural background and intend to work in rural areas on graduation, they would not have studied allied health without this degree. The flexible step in step out options are enablers for local students. Barriers and enablers for rural allied health professionals moving into academic roles were explored.

Discussion
The Bachelor of Allied Health is an innovative evidence-based community embedded model of tertiary qualification delivery in rural South Australia. Success is evidenced by demand, local feedback, provisional accreditation and community buy in. The long-term aim is to develop a sustainable and financially viable workforce in rural communities. Key to the continued success of the program is ongoing partnership with and feedback from local communities.

167 - Rural Influences on Maternity Care: Insights from Taranaki and Whanganui, Aotearoa New Zealand

Dr Emma Davey[1]

[1]Health and Research Collaborative

This study contributes to the growing evidence base on how rurality shapes health service delivery, equity, and sustainability in Aotearoa New Zealand. Using the Geographic Classification for Health (GCH), a mixed-methods design integrated 2022 birth registration and service-use data with perspectives from midwives, general practitioners, nurses, and rural hospital doctors.

Findings highlight both challenges and strengths in rural and remote communities. Women in the most isolated areas (R2/R3) face long travel times, unreliable diagnostic access, and workforce shortages, yet these same settings demonstrated the value of integrated, relationship-based care and earlier engagement with Lead Maternity Carers (LMCs). By contrast, semi-rural R1 areas, although geographically closer to base hospitals, often experienced fragmented services and reduced after-hours support. Māori and Pacific women were disproportionately affected, with later LMC registration and higher smoking prevalence, accentuating systemic inequities.

These findings emphasize the importance of expanding knowledge and integrated models that are culturally responsive and adaptable across contexts. Local exemplars, such as kaupapa Māori initiatives and primary birthing units, demonstrate practical approaches to sustaining services, strengthening whānau-centred care, and embedding cross-sector collaboration. Policy settings around workforce investment, maternity funding, and cross-district referral systems remain critical levers for either enabling or undermining equitable care.

The implications extend beyond Aotearoa. Culturally grounded, relationship-based rural models offer valuable lessons for global strategies, demonstrating how integration, local adaptation, and shared responsibility can future-proof health and wellbeing for rural and remote populations worldwide.

168 - A Comparative Literature Review of Rural Indigenous Chronic Disease Management: Taiwan and New Zealand

Chih-Yi Sung[1]

[1]Lotung Poh-Ai Hospital

Background: Rural indigenous populations face disproportionate burdens of chronic diseases such as metabolic syndrome and diabetes. In Taiwan, indigenous communities in mountainous areas show markedly higher prevalence of metabolic syndrome than non-indigenous groups, while health literacy remains limited. In New Zealand, Māori populations also face high rates of chronic illness, but policies such as Whānau Ora and the Pae Ora (Healthy Futures) Act have introduced culturally grounded, community-led care. This review compares chronic disease management in Taiwan and New Zealand, with attention to cultural, policy, and community aspects of primary care.

Methods: A narrative literature review was conducted using biomedical databases and grey literature. Sources included studies on indigenous health disparities, rural chronic disease management, cultural competence, and policy interventions in Taiwan and New Zealand.

Results: Taiwan's universal health insurance reduces financial barriers, but geographic access, continuity, and culturally tailored services remain limited. Community health stations and outreach programs exist but lack scale and sustainability. In New Zealand, models such as Te Whiringa Ora have reduced hospital presentations through culturally responsive, whānau-centred chronic care. Common challenges include workforce retention, health literacy gaps, and cultural safety.

Conclusion: Taiwan ensures universal coverage, while New Zealand emphasizes indigenous authority and culturally embedded care. Both experiences suggest the need to integrate cultural competence, strengthen community engagement, and improve workforce stability to achieve equity in rural indigenous chronic disease management.

169 - Comparing Rural Physician Retention Policies and Outcomes in Taiwan and New Zealand: A Literature Review

Chih-Yi Sung

[1]Lotung Poh-Ai Hospital

Background: Retention of rural physicians is a critical challenge worldwide, directly impacting healthcare accessibility and equity. Taiwan and New Zealand have both implemented policies to address workforce shortages in remote areas, yet their approaches and outcomes differ in context and strategy.

Methods: This narrative literature review systematically examined peer-reviewed articles, government reports, and policy documents from 2010 to 2025. Databases searched included PubMed, Scopus, and official health ministry publications. Studies focusing on physician retention, rural workforce distribution, and policy evaluations in Taiwan and New Zealand were included.

Results: In Taiwan, retention initiatives have largely centered on financial incentives, contract-based rural service obligations, and medical education programs linked to rural training tracks. These strategies improved short-term recruitment but demonstrated mixed results in long-term retention. In contrast, New Zealand's policies emphasized community-based training, cultural integration, and broader workforce support, including flexible career pathways and support for Māori and rural students. Evidence suggests New Zealand achieved relatively higher long-term retention rates compared to Taiwan, attributed to holistic approaches beyond financial incentives.

Conclusion: While both countries face persistent rural healthcare gaps, New Zealand's integrative strategies highlight the importance of aligning workforce policies with community engagement and professional development. Lessons from New Zealand may inform Taiwan's ongoing efforts to strengthen sustainable rural physician retention.

170 - "Where Modern Medicine Ends, We Begin": A Qualitative Exploration of Traditional Healers' Roles on Health and Healthcare Access Among Tribal Communities in Central India

Prof Pradeep Deshmukh[1], Dr S Kalaiselvi[1], Dr Priyanka Yadav[1]

[1]All India Institute of Medical Sciences Nagpur

Background: Access to healthcare among tribal populations remains a critical challenge. Traditional healers have historically provided essential care, and leveraging their role as an entry point requires understanding their perceptions, practices, and interaction with the formal health system. This study explored the perspectives of traditional healers on health, disease, treatment, and barriers to accessing public healthcare.
Methods: As part of an implementation research project in tribal areas of Maharashtra (2021), in-depth interviews were conducted with traditional healers. Trained field assistants interviewed them at their homes using an open-ended guide covering disease beliefs, treatment approaches, and perceptions of public health services. Interviews were audio-recorded, transcribed verbatim, and analyzed inductively by three independent reviewers to identify emerging themes.
Results: Participants were men aged 40–65 years with 4–35 years of healing experience, often practicing part-time. Diseases were attributed to black magic and lifestyle factors. Common treatments included dietary restrictions, purgation, and topical herbal medicines. Healers perceived themselves as first-contact providers, health guides, escorts, and intermediaries between the community and health system. Their round-the-clock availability, affordability, convenience, and respectful attitudes were cited as reasons for preference. Barriers to public health service utilization included lack of awareness, economic vulnerability, preference for private providers, and limited trust in public facilities. Suggested improvements included greater service availability, accountability, and culturally tailored health information.
Conclusion: Traditional healers, due to their cultural embeddedness and community trust, can serve as effective entry points to improve healthcare access in tribal populations and support progress towards universal health coverage.

171 - Delivering Health Care in the Himalayas: Experience from Phaplu hospital, Solukhumbu, Nepal

Dr Ram Babu Joshi[1]

[1]District Hospital Solukhumbu, Phaplu, Nepal, [2]B.P.Koirala Institute of Health Sciences

Background:
Providing healthcare in the remote Himalayan region is challenging. The terrain is rugged, resources are limited, and referral centres are far away. In the 1950s, New Zealander Sir Edmund Hillary, after summiting Mount Everest, founded the Himalayan Trust to improve education, health, and infrastructure in Solukhumbu. This report shares the clinical and community work of a General Practitioner and Emergency Medicine physician at Phaplu Hospital, continuing Hillary's vision.

Summary:
For over a year, I have been serving the highlander community as the only specialist in the district hospital; delivering medical, surgical, obstetric, paediatric, and emergency care alongside dedicated staffs. While adhering to evidence based guidelines, everyday challenges required a different approach, with creative problem-solving to deliver safe, patient-centred care in a resource-limited rural setting. The experience highlighted the importance of teamwork, community collaboration, and resilience, continuing the pioneering legacy of Sir Edmund Hillary in the region.

When it comes to performing emergency caesarean sections without general anaesthesia backup, intubating and heli-lifting critically ill neonates, using negative suction by syringe for limberg flap repairs, and providing ventilator care in cases of acute poisoning, independent decision-making was often crucial. Community engagement through maternal–child health programs, school and prison health camps, and the Dudhkunda Lake camp at 4,560 m has strengthened trust and awareness within the locals.

Tackling the challenges of shortages of supplies, limited diagnostics, harsh weather, and staff retention difficulties, the hospital has always stood up and continues to deliver resilient, equitable, and effective healthcare in the Himalayas.

172 - 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.

173 - Patient Journey: What influences medicines access in rural New Zealand? A fixed-term project based on the West Coast.

Tayla Cadigan[1], Mrs Ginny Brailsford[1]

[1]West Coast Health

The “Patient Journey: Access to Medicines” project was a fixed-term initiative undertaken by two pharmacists based in rural New Zealand. It sought to investigate the lived experiences of accessing medicines, in rural and remote communities across the South Island's West Coast.

The West Coast region is New Zealand's most sparsely populated area; therefore, rurality is a significant factor when accessing medicines. There are major distances between centres, each of which may only have one pharmacy. There are also frequent workforce shortages, further impacting access to healthcare professionals.

Data methodology was a qualitative mixed-methods approach; data was collected through small focus groups and via online surveys. Analysis identified which factors are more likely to influence the ability to access medicines for this region. There was a particular focus on how affordability and acceptability of medicines, as well as appropriateness, impacted access to medicines.

Many factors were identified; several of which are consistent with other published literature, such as communication, health literacy, time and distance (to healthcare access), and continuity of care. Other findings centred on the patient experience, with surprising influences such as the fear of knowing what could be wrong, a lack of self-awareness (of illness), stigma and prior beliefs around medication, and peer support, being prohibitive of accessing care

This project allowed the project leads to identify factors that impact access to medicines and gain insight into how rural life adds an additional layer of complexity, particularly considering work-life balance, geographical distance to care, non-financial cost involved, and stoicism.

174 - Using body-cameras to understand staff informal learning environments in rural healthcare: A video reflexive ethnographical study

Dr Keryn Wright[1]

[1]University of Melbourne

Background: Rural health services face persistent workforce challenges, often framed through deficit-based narratives that overlook the unique educational strengths of rural practice environments. This research shifts discourse from deficiency to capability, recognising that rural settings naturally foster informal learning—real-time, practice-based education that enhances communication, teamwork, adaptability, and job satisfaction when systematically supported.
Methods: Using a postmodernist framework, this multi-phase study explored informal learning environments across two rural Australian health services through individual interviews and video-reflexive ethnography. Staff wore body-worn cameras to capture authentic workplace learning interactions, with recordings used in follow-up reflexive interviews. Data were analysed using reflexive thematic analysis.
Results: Six interconnected characteristics emerged as essential for cultivating effective informal learning environments: (1) The Person—individual attributes facilitating collaborative learning; (2) Safety—psychologically safe environments encouraging questioning and learning from mistakes; (3) Trust—strong relationships enabling open communication across professional boundaries; (4) Collaboration—interprofessional teamwork supporting shared problem-solving; (5) Place/Systems—physical spaces and organisational systems facilitating learning opportunities; (6) Leadership—informal leadership championing continuous learning.
Implications: These findings offer a practical framework for enhancing workforce retention by providing systematic support for informal learning. Key strategies include establishing learning as an organisational priority, supporting learning champions, creating knowledge-sharing systems, and empowering staff through supported autonomy.
Conclusions: Rural healthcare environments possess inherent advantages for fostering practice-based learning. By recognising and nurturing these six characteristics, rural services can create sustainable learning environments that support professional development and improve patient care, positioning rural practice as an attractive, educationally rich career choice.

175 - Applying a Rural Lens to GPEP1 Registrar Placement in Aotearoa New Zealand

Dr Katharina Blattner[5], Mr George Burrowes[3], Dr Katelyn Costello[5], Dr Pat McHugh[1,2,4], Prof Garry Nixon[5], Dr Mark Smith[4]

[1]Turanga Health, [2]Mātai Medical Research Institute, [3]University of Otago, [4]Rural GP Chapter, [5]Centre for Rural Health

Background:
Sustainable rural health care relies on effective training and retention of general practitioners. In Aotearoa, New Zealand, rural and high - deprivation communities face persistent workforce shortages, reflecting the Inverse Care Law where those with greatest need receive the least care. General Practice Education Programme Year 1 (GPEP1) placements are pivotal, as doctors often remain in areas where they train. Yet, little is known about how placements align with rurality and deprivation - particularly concerning for rural Māori communities, who experience the highest need and greatest workforce gaps.

Aim:
To map the geographic distribution of GPEP1 registrar placements over the past 10 years, examining rurality and socio-economic deprivation, and assess implications for workforce resourcing, recruitment, and retention.

Methods:
Placement data were obtained from the Royal New Zealand College of General Practitioners and other training providers. Quantitative analyses examine annual registrar numbers, employment type (practice-employed, College-employed, self-funded), and distribution by region, rurality (Geographic Classification for Health), and deprivation (NZDep quintiles).

Conclusion:
This study applies a rural equity lens to registrar placement in Aotearoa. Findings will inform workforce planning and support strategies to recruit, train, and retain general practitioners in underserved communities, with particular benefit for rural Māori populations.

176 - Future-proofing the rural medical education workforce: understanding the roles and responsibilities

Dr David Schmidt[1], Dr Paul Lunney[1,2], Dr Chris Hayward[1]

[1]University Of Sydney, [2]Royal Flying Doctor Service

Background: Health and wellbeing for rural and remote communities relies on a rurally-informed and trained medical workforce. Medical education based in rural communities creates and sustains this workforce. Little is known about the roles and responsibilities of rural medical educators, their motivations and perspectives about the future of rural medical education. This study of rural medical educators and leaders explored the issues facing rural medical education across Australia.
Methods: This mixed-methods study used a custom questionnaire to explore rurality, workloads, stressors and burnout in rural medical educators. A concurrent interview process captured the views of medical education leaders and rural medical educators. Analysis of qualitative data was via thematic analysis.
Results: Data collection is ongoing with n=42 surveys and n= 9 interviews conducted. Preliminary results show that survey respondents were primarily male, in stable relationships and with no intent to leave a medical education role. All were Australian citizens and none identified as Indigenous Australians. Responsibilities included direct feedback to trainees, coaching and assisting trainees to navigate learning systems and requirements. Themes emerging from the interviews were a sense of giving back to the profession, the complexity of systems used by training organisations and the financial opportunity cost of choosing education over clinical work.
Conclusions: Future-proofing the rural medial education workforce requires a multi-sector approach. Understanding the roles and responsibilities of this important workforce lays the foundation for discussions about workload, systems and remuneration. Increasing Indigenous Australian representation in medical education is an important future step for the profession.

177 - Rural pipeline or a rural river? The role of social capital in shaping a rural workforce

A/Prof Kyle Eggleton[1], Professor Felicity Goodyear-Smith[1]

[1]University of Auckland

The metaphor of a pipeline is used for rural medical workforces: the sections involve structured contact between high school students, rural physicians and universities; university admission schemes to increase rural student representation in medicine; rural exposure during medical training; and to retain a rural medical workforce upon graduation. Social capital is the benefit
people gain from social networks, from both their relationships, and the resources those relationships provide, and is associated with positive physical and mental health and wellbeing. Rural communities generally have a greater sense of community and social involvement and cohesion than their urban counterparts. Relationships tend to be closer and stronger in rural communities with shared sense of identity, norms and understanding and hence greater social capital. There is evidence that social capital impacts on educational outcomes. Social capital factors tend to be enacted in-place, where the student is undertaking their learning. This presentation draws on examples from the literature of different social capital interventions that can support the rural pipeline. We suggest that the flow of a rural medical workforce can be boosted by social capital and the analogy of a rural river may be more apt, with the banks of the river representing different locations of rural social networks and distanced medical schools. The student journey is represented by movement down the river, moving side to side on the banks, being in-place in different settings at different parts of the medical programme with different social capital factors at play.

178 - Medical student rural career intentions vs. rural medical workforce realities in Aotearoa

Dr Katelyn Costello[1], Roselle Winter[2], Dr Charlie Connell[2]

[1]University Of Otago, [2]Faculty of Medicine, University of Auckland

Background:
All around the world there are challenges attracting and retaining medical graduates into rural practice – New Zealand is no exception. Rural populations have poorer health outcomes than their urban counterparts. This disparity is even worse for the rural Māori population. Increasing the rural medical workforce is a vital aspect in reducing these disparities. Longitudinal tracking of Medical students and graduates is a valuable tool for better understanding the medical workforce.
Aim:
To evaluate and compare the intentions over time and actual workforce outcomes of medical students in Aotearoa, New Zealand
Methods:
This research links the Australasian Medical Schools Outcome and Longitudinal Tracking Database with actual workforce outcome data. Rural workforce outcome is defined as working in a Geographic Classification for Health (GCH) rural area or a current trainee in the Rural Hospital Medicine programme.
Conclusion:
Although rural career intention at entry to medical school is a strong predictor of final rural workplace location only half of New Zealand's home-grown rural workforce had intentions of working rurally at entry to medical school. Geographic intentions vary significantly over time. This means there are multiple times for intervening and helping guide medical graduates into a rural pathway.

179 - Shearing the whole sheep: implementing the National Rural Generalist Pathway in a small rural health service

Prof Paul Worley[1], Wayne Champion[1], Dr Caroline Phegan[1], Sharon Wingard[1], Dr Hamish Eske[1], Dr Shanna Burgess[1], Sharon Frahn[1], Susan Ziersch[1], Tanya Roesler[1], Dr Al Alwash[1]

[1]Riverland Academy Of Clinical Excellence

The novel approach:
Rural health services must "shear the whole sheep", implementing all the evidence along the rural generalist pathway, if they want to create a sustainable rural medical workforce in their region.

The problem:
Despite decades of research and investment into rural medical workforce strategies, most rural health services continue to identify workforce as their number one challenge and financial and service constraint. Riverland Mallee Coorong Local Health Network (RMCLHN) was no different in this regard.

The solution:
RMCLHN decided to learn from Indigenous ways of being, particularly the importance of 'country' or place in health.
The Network decided stop outsourcing workforce production, and to take responsibility in house for creating its own medical workforce locally and invested in the elements required to provide all components of the National Rural Generalist Pathway, from high school to consultant Rural Generalist, locally in the region. This required responding to workforce crises with the future workforce training in mind rather than attempting to retain the old model. It also required making the region aspirational for current and future doctors.

The results:
The RMCLHN formed the Riverland Academy of Clinical Excellence as its vehicle of transformation. This Academy has now resulted in over 50 locally trained doctors coming into the region which has increased the public and private workforce by over 40% in five years.

The implications:
This presentation will outline the lessons learned and partnerships required in this successful initiative to enable other rural regions to implement the principles in their context.

180 - Establishing a Research Unit in a Small Rural Health Service

Prof Paul Worley[1], Dr Amy Mendham[1], Renee Kropinyeri[1], Carolyn Martin[1], Dr Kate Bartel[1], Emily Mathews[1], Julie Souness[1], Asini Siriwardene[1], Dr Caroline Phegan[1], Dr Thoshen Kandasamy[1]

[1]Riverland Academy Of Clinical Excellence

The critical outcome:
Small rural health services can create the local capacity to engage in locally and internationally relevant research that informs practice and improves health outcomes.

The problem:
Rural health services have historically focused on service delivery. This causes three major problems.
First, it hinders the organisation becoming a learning health system, essential for improvement and quality care.
Second, it perpetuates having to implement research that is created in urban centres that is not easily translatable to local rural contexts.
Third, it reinforces the unhelpful myth that rural practice is not a career enhancing move for aspirational clinicians who see research as an important part of a clinical career.

The solution:
Rather than the historical response of outsourcing research to the university sector, often also located in the city, Riverland Mallee Coorong Local Health Network (RMCLHN), a small health service located 200km east of Adelaide in South Australia, decided to become a better research partner and invest in its own local internal research capacity 'on country'. The vehicle for this was the Riverland Academy of Clinical Excellence (RACE).

Results:
RACE recruited PhD qualified researchers and clinical trials nurses into permanent positions in the health service, supported them with dedicated local research governance and administration, and offered research training to local clinicians. Within four years, the Network has over 25 active studies, many partnered with Indigenous communities, is able to prioritise who it partners with in research, and can design and implement its own research priorities for immediate patient benefit.

181 - Randomised Waitlist-Controlled Trial of a 10-Week Community Programme Using a Plant-Based Diet, Adapted from the BROAD Study, in a Predominantly Māori Population in Tairāwhiti, Aotearoa New Zealand

Dr Morgen Smith[3], Dr Nicholas Wright[4], Dr Pat McHugh[1,2], Dr Bruce Duncan[6], Dr Christina Chwyl[5]

[1]Turanga Health, [2]Mātai Medical Research Institute, [3]Te Whatu Ora Health New Zealand, [4]RNZCGP, [5]Portland Psychotherapy Clinic Research and Training Center, [6]Plant Based NZ Health Trust

Background:
Type 2 diabetes and obesity disproportionately affect Māori and rural communities in Aotearoa New Zealand. Whole-food plant-based (WFPB) diets improve metabolic health, but evidence from Indigenous and high-needs rural populations is limited.

Aim:
To evaluate the effectiveness of a 10-week community-based WFPB dietary programme in reducing weight and improving type 2 diabetes outcomes.

Methods:
This randomised waitlist-controlled trial was conducted in a "Very Low Cost Access" general practice in Tairāwhiti. Participants (n=56; BMI ≥30, HbA1c ≥40 mmol/mol) were aged 30-72 years; 59% identified as Māori. The intervention comprised twice weekly two hour group sessions for 10 weeks, focusing on practical skills and nutrition education. This programme was a culturally adapted BROAD study version. Primary outcomes were weight, BMI and HbA1c; secondary outcomes included cholesterol, waist circumference, dietary adherence and activity. Assessments occurred at baseline, 10 weeks, 6 months and 36 months.

Results:
At 10 weeks, intervention participants lost significantly more weight than controls (−3.3 kg, 95% CI 0.8-5.7, p<0.001), with a non-significant trend to reduced HbA1c (-3.2 mmol/mol, p=0.08). After all participants received the programme, mean weight loss remained -3 kg (95% CI 1.2-4.7, p<0.001) and waist circumference decreased -6 cm at 36 months. Post-treatment improvements in HbA1c and cholesterol were not consistently sustained. Greater dietary adherence predicted better outcomes.

Conclusion:
A short, intensive WFPB programme delivered in primary care produced clinically meaningful and sustained weight loss in a predominantly Māori, high-needs rural population. This model demonstrates the potential of culturally relevant dietary interventions to address rural health inequities.

182 - Tū Wairua: Safely Integrating Psilocybin-Assisted Therapy in Māori Community Settings

Dr Anna Forsyth[3], Dr Tia Haira[6], Ms Anna-Leigh Hodge[3], Dr Jacek Kolodziej[5], Dr Pat McHugh[1,2], Dr Suresh Muthukumaraswamy[3], Ms Tania Rauna[4,7], Ms Jody Toroa[4]

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Background: Psychedelic therapies are emerging treatments for refractory mental health conditions, including treatment resistant depression, post-traumatic stress disorder, and substance use disorders (SUD). Indigenous communities worldwide have long employed psychedelic plants and fungi for healing. In Aotearoa, oral histories describe the use of Psilocybe fungi in Rongoā Māori to support hinengaro and wairua.
Methods: Led by Rangiwaho Marae, the Tū Wairua project explores the feasibility, acceptability, and safety of psilocybin assisted therapy for methamphetamine SUD delivered within marae settings for and by Māori. Phase 1 is a pilot trial of 12 healthy volunteers, establishing protocols for culturally grounded psilocybin administration aligned with tikanga and wairua. The project includes ethical and SCOTT approval, marae-based wānanga with whānau, hapū, and community stakeholders, and the training of kaitieki (guides) who support participants before, during, and after the psychedelic experience.
Outcomes: The study prioritises a whanau-centered, culturally safe approach aligned with Te Tiriti o Waitangi and Te Ao Māori principles. It integrates Māori perspectives and leadership throughout the research process. Pilot findings will inform future trials targeting SUD among Māori.
Conclusions: Tū Wairua represents the first Māori led psychedelic research initiative bridging mātauranga Māori and western medical frameworks. By centering cultural practice, whānau well-being, and tino rangatiratanga, the project demonstrates a model for safe, community driven use of taonga species for mental health, resilience, and holistic healing in Aotearoa.

183 - What does the term “rural generalist” mean to rural doctors in Aotearoa? A rapid survey

Dr Rosalie Evans[1]

[1]Central Otago Health Services Limited

The concept of rural medical generalism is recognised in Aotearoa New Zealand, but the term rural generalist has not been as widely used as it is elsewhere, and there is no agreed definition. General Practice and Rural Hospital Medicine are separate vocational scopes, with a distinct training pathway for rural GPs under development. Recently Health New Zealand – Te Whatu Ora (HNZ-TWO) has applied “rural generalist” to rural health professionals as a group.

A brief survey was sent to rural doctors in Aotearoa to determine their views, followed by individual discussion. There was a rapid turnaround to enable the author to feedback on HNZ-TWO draft documents. Respondents were sourced from a link posted on “Rural Doctors NZ” Facebook group or emailed directly.

36 doctors responded. Two respondents agreed with the proposed HNZ-TWO definition of rural generalist, 17 agreed with the definition in the Australian Collingrove agreement and 13 preferred a definition which included senior health professionals from a number of disciplines but required the title rural generalist to be paired with profession. Three proposed their own definition. Themes from comments and discussion focused on the spilt between primary and secondary (rural hospital) based care which currently exists and the need clarity of role and training, particularly for patients.

The is significant potential for sampling biases with the way the survey was distributed. However, it demonstrates that there are a range of views on the term “rural generalist” among rural doctors and many are uncomfortable its broad use without clarifying profession.

184 - 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.

185 - Reframing Professionalism for Rural Health in Taiwan: Strengthening Patient–Physician Relationships and Retention

Dr Chi-Wei Lin[1,2], Miss Wei-Hsuan Lin[1]

[1]E-Da Hospital, [2]I-Shou University

Background
Taiwan's rural communities face persistent gaps in access, continuity, and trust, which are compounded by difficulties in recruiting and retaining physicians. Professionalism—encompassing ethical practice, effective communication, accountability, and service—offers a pragmatic lever to address these challenges.

Methods
We analyzed documents from 13 TMAC-accredited medical schools (mission statements, program objectives, curriculum descriptions). Using a structured coding framework, we identified professional attributes (compassion, altruism, responsibility, competence, ethics, integrity, humanistic literacy) and mapped them to rural outcomes (trust, continuity, community orientation, culturally responsive communication, interprofessional collaboration, readiness for resource-limited practice).

Results
Compassion, altruism, professional responsibility, competence, and ethical practice were most frequently emphasized; integrity and honesty, as well as humanistic literacy, appeared, but less consistently. Critical thinking, innovation, information management, and lifelong learning were uneven. Although these attributes align with rural needs—compassion and altruism build trust; responsibility and competence sustain continuity—few schools articulated explicit rural pathways.

Discussion and Conclusion
Professionalism provides a strong foundation for rural care, but it requires the integration of policy and education to achieve its full impact. Recommended actions: (1) admissions valuing service orientation and rural background; (2) longitudinal, mentored rural placements with interprofessional teams; (3) curricula in culturally responsive communication, community partnership, and telehealth; and (4) aligned incentives and faculty development that reinforce rural professional identity. Programs should evaluate their effects using indicators that are sensitive to rural contexts.

Take-home Message
Embedding core professional attributes into admissions, curricula, assessment, and incentives aimed at rural service can strengthen relationships and improve recruitment and retention in Taiwan's rural communities.

186 - The Birth Related Cardiovascular Health (BiRCH) Clinic: Inviting the Generations; Culture as Medicine

Dr Jennifer Kask[1], Dr Valentyna Koval[1]

[1]Physician Within Island Health

This quality improvement initiative is focused on improving postpartum care for women who have experienced pregnancy-related cardiovascular risk events (PRCVRE) in rural and remote (including Indigenous) communities. The initiative was implemented in Campbell River and Port Alberni, British Columbia, Canada. These coastal communities are situated on the traditional, ancestral, and unceded territories of the Ligwilda'xw, We Wai Kai, Wei Wai Kum, Kwiakah, Tseshaht, and Hupačasath First Nations.
The project aimed to address the high incidence of PRCVRE (including gestational diabetes, hypertensive disorders of pregnancy and preterm birth), which affects nearly 30% of women during their reproductive years and is a significant risk factor for future cardiovascular disease (CVD).
The Birth Related Cardiovascular Health (BiRCH) Clinic was established to provide comprehensive follow-up care at six months postpartum, including heart-healthy lifestyle advice and support. Key interventions included making the clinic baby and family-friendly, offering transportation resources, and involving family members in the care process.
The project achieved notable improvements, with attendance rates at the BiRCH Clinic increasing from 57% of those with affected pregnancies in Year 1 to 78% in Year 2. Additionally, the percentage of patients referred to the clinic rose from 70% to 94%, and non-attendance rates decreased.
The initiative highlighted the importance of incorporating cultural practices, traditional foods, and family support in promoting cardiovascular health. Patient feedback was overwhelmingly positive, with 100% recommending the clinic to others.
This project underscores the value of a strengths-based approach and the integration of multiple generations in healthcare visits.

187 - Rural Health Models for One-Quarter of the World's Population: Integrating Indigenous Wisdom and Equity from South Asia

Dr Roshni JhanGanguly[1,2], Dr Pratyush Kumar[1,2], Prof. Dr. Bikash Gauchen[1,2], Dr Gobith Ratnasangam[1,2], Prof. Dr. Tabinda Ashfaq[1,2], Prof. Dr. Md Zakiur Rahman[1,2]

[1]WONCARuralSouthAsia, [2]WONCARural

Nearly one quarter of the world's population resides in South Asia, where the majority live in rural and underserved areas. Despite diverse cultural, geographic, and social contexts, the region has developed a wide range of innovative and community-oriented health care models. Crucially, the most resilient of these models have been co-developed with and for culturally distinct populations, particularly Adivasi/Tribal and other Indigenous communities. These approaches draw on deep-seated Indigenous knowledge, community participation, and family medicine to create sustainable systems that address barriers of access, inequity, and workforce shortages.

This interactive workshop will be structured in three segments. First, facilitators will present diverse rural health models that integrate preventive and curative care, community-based health worker programmes, and the formal and informal use of traditional practices alongside evidence-based medicine. Second, participants will engage in small group, case-based discussions to identify common principles of trust, cultural relevance, and self-determination across contexts. Third, the workshop will bring all participants together in a collaborative mapping exercise.

The central objective of this workshop is to co-create a one-page "South Asia–Inspired Global Rural Health Framework" that highlights core strategies, transferable lessons, and guiding principles for sustainable rural health systems.

By showcasing the scale, diversity, and resilience of these approaches, the workshop underscores how South Asia contributes significantly to global knowledge on rural health. It will demonstrate that Indigenous wisdom and equitable partnerships, when integrated with primary care innovations, provide a strong foundation for building thriving and equitable health systems worldwide.

188 - Bridging Rural Pharmacy Workforce Gaps in Aotearoa: Immigration-enabled recruitment at Taumarunui and Mangawhai Pharmacies

Ms Lanny Wong[1], Mr Baraq Al-Tuhafi[1]

[1]Mangawhai Pharmacy, [2]Taumarunui Pharmacy

Aotearoa has 7.95 pharmacists per 10,000 people (30 Jun 2024)—the lowest density among comparable OECD peers. Rural communities feel this most acutely. Pharmacists are on Immigration NZ's Green List.

Aim: Taumarunui and Mangawhai Pharmacies used the Accredited Employer Work Visa (AEWV) and Non-REQR to recruit overseas pharmacists where domestic efforts failed.

Methods: 5 steps approach: (1) rural role design; (2)international search; (3) AEWV/Green List and Non-REQR; (4) culturally safe induction with partners; (5) retention supports (mentoring, CPD)

Indigenous engagement: With Te Whai Trust, Mangawhai facilitated a community trip to Oruawharo Marae (Northland) for the incoming intern and her husband (pōwhiri, local history/health priorities, practical tikanga), leading to (a) marae-anchored cultural induction and (b) whānau-centred care prompts embedded in counselling/dispensing

Vignettes & timelines: In Taumarunui, the intern progressed from no prior NZ community experience to a confident practitioner within months via structured mentorship and rural-generalist exposure. In Mangawhai, the intern completed an ~18-month offer→arrival journey (sustained online/Zoom engagement + AEWV + Non-REQR planning), underscoring the need to start visa/registration early and maintain pastoral care

Results: Immigration-enabled hiring restored rosters and protected clinical services where local recruitment yielded no qualified applicants or short retention

Conclusion: With no national pharmacy workforce reform and limited rural uptake by local graduates, AEWV + Green List + Non-REQR, paired with marae-anchored induction and retention supports, is the most pragmatic near-term lever. Government action is needed: bonded rural intern/graduate placements; funded rural training hubs and preceptor support; synchronised immigration–registration timelines; and dedicated funding for community-pharmacy clinical services

189 - Your voice, Your future: What RNZCGP Workforce Surveys tells us about rural GPs

Dr Prabani Wood[1]

[1]The Royal New Zealand College Of General Practitioners

Rural general practitioners (GPs) are the backbone of healthcare in Aotearoa's most isolated communities, yet they continue to face significant challenges in workforce sustainability.

Every two years, the College takes a deep dive into the experiences of rural GPs and rural hospital doctors to capture the pulse of the profession as it continues to evolve. Drawing on insights from College Workforce Surveys, we explored the realities of rural GP practice including workforce distribution, training exposure, and retention pressures. Our work reveals trends, highlights challenges, showcasing the resilience and adaptability of the rural workforce across the country. Our College insights reveal concerning trends about workforce sustainability in the next three years, including the need to build and support a resilient, locally grounded workforce. Geographic isolation sometimes limits access to healthcare services for many New Zealanders and is a contributing factor to significant disparities in health outcomes between rural and urban populations. Reflecting the voices of rural GPs, offers a powerful lens into what's working, what's missing, and where change is needed. This session highlights where advocacy is needed to strengthen and sustain a well-resourced rural health workforce,

190 - BiRCH CLINIC. BIRTH RELATED CARDIOVASCULAR HEALTH CLINIC, A MODEL OF SHARED AND FLEXIBLE PRACTICE IN RURAL AND REMOTE COMMUNITIES.

Dr Valentyna Koval[1], Dr Jennifer Kask

[1]Vancouver Island Health Authority

Nearly 30% of all women will experience a Pregnancy-Related Cardiovascular Risk Events (PRCVRE) during their reproductive years. Hypertensive disorders of pregnancy, gestational diabetes, preterm birth, intrauterine growth restriction, placental abruption, are associated with increased risk for cardiovascular disease (CVD) later in a person's life.
This quality improvement initiative is focused on improving postpartum care for women with PRCVRE in rural and remote (including Indigenous) communities. BiRCH clinic model allowed us to implement "Generational Appointments" to improve attendance rate and educate the entire family about the importance of healthy lifestyle and CVD risk prevention. The initiative was implemented in Campbell River and Port Alberni, British Columbia, Canada. These coastal communities are situated on the traditional, ancestral, and unceded territories of the Ligwilda'xw, We Wai Kai, Wei Wai Kum, Kwiakah, Tseshaht, and Hupačasath First Nations.
BiRCH Clinic was established to provide comprehensive follow-up care at six months postpartum, including heart-healthy lifestyle advice and support. Key interventions included making the clinic baby and family-friendly, offering transportation resources, and involving family members in the care process. The project achieved notable improvements, with attendance rates at the BiRCH Clinic increasing from 57% of those with affected pregnancies in Year 1 to 78% in Year 2. Additionally, the percentage of patients referred to the clinic rose from 70% to 94%, and non-attendance rates decreased. Patient feedback was overwhelmingly positive, with 100% recommending the clinic to others.
This project underscores the value of a strengths-based approach and the integration of multiple generations in healthcare visits.

191 - “Te Wao Nui a Tāne: A Rural Framework for Nurturing Generalism and Interprofessional Collaboration in Education”

Dr Hannah Lawn[1], Dr Tom Dawson

[1]Te Whatu Ora Hāwera Hospital, [2]Univeristy of Auckland

This presentation introduces Te Wao Nui a Tāne as a guiding framework for strengthening rural generalism and interprofessional collaboration at Hāwera Hospital. Grounded in the values of connection, resilience, and growth, the framework provides a structure for clinicians to collectively pursue excellence in education and practice from the undergraduate through to the postgraduate level.

Senior Medical Officers contribute in non-clinical time by leading designated areas of responsibility, partnering with Clinical Nurse Managers and nurse educators to ensure an interprofessional approach. A practical example of this is the Rural Hospital Deteriorating Patient Readiness Day, an initiative specifically tailored to the needs of rural nurses and doctors and delivered within their own work environment to enhance confidence and preparedness for high-acuity, low-frequency events.

Advocacy for rural student placements and support of new graduates is central to this framework, extending beyond the hospital to include community-based initiatives such as charitable funding for accommodation and wellbeing support. By working collaboratively across professions and levels of training, Te Wao Nui a Tāne aims to nurture the next generation of rural health professionals and sustain high-quality care for rural communities.

192 - Local Investment, Lasting Impact: South Taranaki's Support for the Rural Medical Immersion Programme (RMIP).

Dr Hannah Lawn[1]

[1]Te Whatu Ora Hāwera Hospital + University Of Auckland, [2]University of Auckland

This lightning talk highlights how community-driven funding in South Taranaki is helping to establish and sustain the Rural Medical Immersion Programme (RMIP) at Hāwera Hospital. Beyond clinical training, rural placements require wraparound support for students, including accommodation, pastoral care, and opportunities for integration into the local community.

Through the generosity of local charitable organisations and community partnerships, South Taranaki has been able to provide vital support that extends well beyond the hospital walls. This investment ensures students are not only trained in a high-quality rural environment but are also welcomed into the community, strengthening their connection to the region.

By creating the conditions for students to thrive, South Taranaki is actively contributing to the development of the rural health workforce. This talk will showcase the significance of local funding in reducing barriers, supporting student wellbeing, and inspiring future clinicians to consider long-term careers in rural practice.

193 - Quality in General Practice - Case Studies from Rural General Practices in Aotearoa New Zealand

Sandhaya Bhawan[1], Heidi Bubendorfer[1]

[1]Royal New Zealand College of General Practitioners (RNZCGP)

In 2020, the Royal New Zealand College of General Practitioners launched a two-step Quality Framework for general practices, comprising of the Foundation Standard and the Cornerstone programme. The Foundation Standard serves as a quality assurance programme, with certification required to access government capitation funding. The Cornerstone programme comprise of two modules, designed to strengthen the capability and capacity of practices for building and sustaining equity and continuous quality improvement (CQI).

Since 2020, practices earn Cornerstone accreditation for three years by completing both the Equity and CQI modules. Achieving Foundation Standard certification and Cornerstone accreditation is also a key eligibility requirement for rural practices wishing to host doctors training for vocational registration in general practice.

This presentation will showcase case studies of rural general practices from across Aotearoa New Zealand that have engaged in quality improvement activities. It will explore the unique challenges faced by rural practices-such as workforce shortages, geographic isolation, and resource constraints-and highlight the innovative activities and interventions these practices have implemented to improve access, patient experience, and health outcomes in their communities.

By sharing these rural success stories, the presentation aims to inspire and motivate other rural general practices to further strengthen quality and equity in rural health care.

Although the case studies present a New Zealand context, we encourage both New Zealand rural general practice teams and international delegates to attend this session, connect with peers, and discover practical ideas and inspiration to enhance quality, equity, and continuous improvement within their own practices.

194 - Fostering community relationships and connections key to promoting improved health outcomes in Kāpiti

Ms Mabli Jones, Cherie Seamark[1], Sarah Duncan[1]

[1]Tū Ora Compass Health

The Answer is Always the People

The Kāpiti Community Health Network (KCHN) is a place-based health initiative born from the Capital & Coast DHB's Health System Plan 2030. It brings together Te Ātiawa ki Whakarongotai, Tū Ora Compass Health, and Health New Zealand | Te Whatu Ora in a collaborative effort to improve health outcomes for the Kāpiti community.

KCHN responds to the unique challenges faced by Kāpiti residents in accessing healthcare, particularly the fragmentation of services and limited local capacity. The model focuses on equity, community engagement, and strategic alignment with national health priorities, while building a sustainable, locally embedded healthcare workforce.

Initiatives under KCHN include the Ambulance Diversion Scheme, ACC-funded Fracture Liaison Service, coordinated afterhours and weekend care, physiotherapy support, and primary care administration of secondary services. Seasonal wellness campaigns and point-of-care testing further enhance access and early intervention. Highlights include partnerships with community pharmacies, integrated services for kaumātua, and the launch of a mild cognitive impairment education programme now attracting national interest.

By bridging local and central stakeholders, KCHN is delivering scalable, place-based solutions that prepare for population growth while reducing ED admissions and improving overall wellbeing. The network is not just about services, it's about people.

Through meaningful collaboration and innovation, KCHN is enabling residents to receive care closer to home, supporting local providers, and strengthening the health of the Kāpiti community.

195 - 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.

196 - He Awa Whiria: Braiding Mātauranga Māori and Western Medicine Part 1

Elisabeth Fincher[1], Ms Shayna Rameka[1], Ms Sue Van Mierlo[1]

[1]Pinnacle Midlands Health Network

Shayna Rameka RN

Introduction: This presentation is the first of two exploring He Awa Whiria, the braiding of two rivers, expressed as the weaving of Mātauranga Māori and Western modalities to improve health outcomes for Māori in rural communities.

Context / background: Rural indigenous communities face unique health challenges shaped by colonisation and the social determinants of health. He Awa Whiria offers an approach to address these challenges and improve health outcomes within a rural Māori-led clinic. Drawing on her experiences as both a whaiora and Māori health improvement practitioner, Shayna Rameka examines the application of He Awa Whiria through this dual lens.

Approach or method (intervention): Shayna shares her lived experience of EMDR (Eye-Movement Desensitization Reprocessing) for trauma recovery encapsulating traditional Māori healing and incorporating Te Whare Tapa Whā, a holistic Māori model of health encompassing physical, spiritual, mental, and social wellbeing.

As a Māori Health Improvement Practitioner, she shares how culturally grounded environments like marae nurture core values such as whanaungatanga, and manaakitanga. These values deeply inform her practice, guiding her to foster meaningful engagement and hauora.

Outcomes / learnings: The benefits of weaving Western trauma-focused therapies with traditional Māori healing for holistic wellness are demonstrated; revealing how Māori values can enrich practice in integrated care.

Practice implications / future applications: These findings emphasise the importance of approaches that integrate indigenous knowledge alongside Western modalities, promoting practice that is clinically effective, culturally grounded, and responsive to the inequitable health needs of Māori communities.

197 - He Awa Whiria: Braiding Mātauranga Māori and Western Medicine-Part 2

Elisabeth Fincher[1], Ms Shayna Rameka[1], Ms Sue Van Mierlo[1]

[1]Pinnacle Midlands Health Network
Elisabeth Fincher MSW

Introduction: This is the second of two linked presentations about He Awa Whiria, the Te Ao Māori concept of weaving or braiding rivers together in healthcare.

Background and Purpose: Elisabeth Fincher, a social worker trained in the First Nations concept of Two-Eyed Seeing (Etuaptmumk) from the Mi'kmaq Nation, will share her experience of working in Indigenous spaces as a non-Indigenous person. She will outline how Indigenous and Western ways of knowing can be combined to improve health outcomes for Indigenous peoples.

Approach: Using a Hui Process is especially important in rural areas, where health is shaped by social factors such as housing, income, and community. A key part of this is whakawhanaungatanga – building strong, respectful relationships. Blending Mātauranga Māori and Western medicine can create health care that is more relevant, respectful, and effective.

Learning: Non-Indigenous practitioners can use the Hui Process as a framework for He Awa Whiria within integrated care in the role of Health Improvement Practitioners. Examples will be given from rural primary care settings, whether a marae-based clinic or general practice.

Practice implications and future use: Key lessons include using the Hua Oranga, a validated health outcome measure, and person-centred interventions with the opportunity to discuss how non-Indigenous individuals can engage with and respectfully integrate Indigenous ways of knowing into practice.

Outcomes: Supporting non-Indigenous providers to develop skills and knowledge in the use of Mātauranga Māori reduces inequities and acknowledges the unique needs of Indigenous peoples, leading to improved health and wellbeing outcomes.

198 - Marae Based Hauora Co-Designing Integrated Community Healthcare Solutions in the Far North

Ms Neta Smith, Joe Crowley

[1]Te Whatu Ora, Te Tai Tokerau, Kaitaia Hosptial

Te Whatu Ora – Te Taitokerau (Te Poutokomanawa) undertook a number of consultation hui with whanau throughout the rohe. The key question asked was “How do you see whanau in the future”. The response was: “Healthy Whanau, Happy Whanau and Our Voices are Heard”.

The outcome of the consultation was a project to establish and sustain an iwi-led marae based hauora kaupapa to improve health outcomes for local whanau and hapori. Values driving the initiative are Kotahitanga, Mana Motuhake, Whanaungatanga.

The nurse led, iwi driven hauora service was initiated within Oturu Marae in Kaitaia and provides a crucial link with Kaitaia Hospital Services. A cabin for consultations was purchased and the marae internet connectivity made available during the Covid response was utilised.

The integrated approach is driven through a lead nursing role who has positive and strong networks with Kaitaia Hospital and all local hauora providers. These links enable whanau to navigate through the health system and are supported with follow-up.

The model provided through both kānohi ki te kānohi and virtual delivery, is effectively addressing equity of access to health services in the rohe and helping to improve healthcare for whanau and hapori. The ongoing challenge is funding sustainability.

The origin and integrated workings of the initiative, numerous examples of the positive impact this innovative approach is having on the local community along with the challenges faced will be discussed in the presentation.

199 - 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 - 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.

201 - Te Whare Taumata O Nēhi Taiwhenua O Aotearoa - Rural Nursing in New Zealand

Emma Dillon[1], Gemma Hutton, Shawna Stephens

[1]Rural Nurse Chapter - Hauora Taiwhenua

The Rural Nurse role is an indispensable aspect of the health workforce, and part of the health and wellness of our rural communities. Like rural clinicians across the globe, nurses are at the heart of some of the most underserved, remote areas and often working in isolation.
Rural nurses work as general practice, domiciliary and hospital team members; they are clinicians, leaders, managers, teachers/educators, and emergency responders, as well as members of the communities they are living and working in. The nursing workforce of Aoteoroa practices with a culturally responsive lens as outlined by the Pou of the Nursing Council of New Zealand's competencies; Maori health, cultural safety, whanaungatanga (relationships) and communication, Pūkengatanga (clinical skills) and evidence-informed nursing practice, Manaakitanga (respect and dignity) and people-centred care, and Rangatiratanga (self-determination) and leadership.
This session will present these standards of professional practice from a rural context across Aoteaora showcasing nurses and their multidisciplinary teams. We want to highlight rural equity through case studies, models of care, workforce sustainability and the diversity of our scope of practice as well as seeing some of the extraordinary places we live.

202 - Multi-Sectoral Response to a Health Crisis: Establishing a Collaborative Sexuality Education Human Resource Bank in the Remote Amami Islands.

Dr Rakan Kotoku[1], Dr Jun Hara[1], Dr Eri Kamimura[2], Dr Yuka Kawano[2]

[1]Clinic for You, [2]Kagoshima prefectural hospital

The Amami Islands, a remote Japanese archipelago of 100,000 inhabitants, face unique public health challenges, including high rates of adolescent pregnancy, induced abortion, and sexually transmitted infections (STIs). While Japan's official sexuality education is severely limited by political constraints and deviates significantly from the UNESCO International Technical Guidance on Sexuality Education, this scarcity of comprehensive instruction is acutely felt in the geographically isolated Amami communities, which also struggle with high poverty and low life expectancy.

A syphilis outbreak among high school students in 2023 served as a critical catalyst for action. This health crisis prompted an unprecedented, multi-sectoral collaboration among local hospitals, administrative bodies, and educational institutions. The resulting initiative focused on immediate, practical CSE delivery (e.g., condom distribution) and the sustainable development of local educators. To ensure long-term consistency, a Sexuality Educator Human Resource Bank was established to recruit, standardize training for, and deploy certified local professionals into the school curriculum.

This presentation reports on the initial activities, the novel collaborative framework, and the implementation of this integrated sexuality education program. Following a one-hour comprehensive sexuality education session delivered to over 1,200 high school students on Amami-Oshima, understanding of STIs significantly improved, with an effect size of 0.888 (0.821 to 0.954, 95% CI, $P<0.005$), showing enhanced comprehension across all grades (1st to 3rd year). The Amami model provides a crucial case study in overcoming both systemic and geographical barriers to deliver essential CSE, offering a replicable framework for other remote and underserved communities globally.

203 - 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 Alam3, Professor Katharine Wallis5, Dr. Annika Luebbe1, A/Prof Srinivas Kondalsamy Chennakesavan

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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.

204 - Empowering Women in Rural General Practice – Leadership, Advocacy and Mentoring

Dr Christie Rodda[1]

[1]Rural Faculty, Royal Australian College Of General Practitioners

This presentation outlines a workshop that was conducted at a national conference of Australian General Practitioners which provided an immersive, face-to-face professional development experience designed to empower rural female general practitioners (GPs) by strengthening leadership, advocacy, and mentoring skills essential for career progression and leadership participation. Recognising the unique challenges at the intersection of gender and rurality, the workshop also addressed barriers such as sexism and racism that impact female clinicians' engagement and advancement in leadership.

The program included interactive sessions on impactful communication, advocacy strategies, mentoring models and creative career pathways, supported by a panel of prominent rural female leaders sharing lived experiences.

A significant feature was the involvement of the Chair of the Aboriginal and Torres Strait Islander Faculty, who contributed crucial perspectives on intersectional challenges, enriching discussions around equity and inclusion within rural health leadership.

Small group formats encouraged active participation, networking and collaborative problem-solving, resulting in participants leaving with personalised action plans, enhanced confidence and new connections.

This initiative responded directly to feedback from rural female GPs seeking non-clinical skill development to navigate systemic inequities and sustain rural careers. By integrating pro-equity principles and addressing complex social determinants—including sexism and racism—the workshop advanced strategies for recruiting, retaining, and supporting female rural clinicians in leadership roles. The outcomes demonstrate the value of tailored, intersectional professional development in enhancing rural health workforce sustainability and leadership diversity.

205 - Assessment for Fellowship of the Australian College of Rural and Remote Medicine - a model for a remotely delivered assessment

Dr James Fraser[1], Ms Laura Cotrone[1], Dr Jeremy Webber

[1]ACRRM

The Australian College of Rural and Remote Medicine (ACRRM) was established in 1999 and is one of two colleges that provide General Practice training in Australia. ACRRM Fellows complete a four year rural generalist training program that equips them with the knowledge,
primary care and advanced skills to provide patient care in rural and remote Australia. Graduates are Rural Generalists, who are formally recognised as specialist practitioners providing a combination of extended general practice and additional expertise in a subspecialty that rural communities need but cannot support in a full-time sub-specialist roster.

The ACRRM Fellowship assessment program has a programmatic design that is wholly delivered remotely. The assessment program utilises a variety of modalities including Multiple
Choice Questions, Multi Source Feedback, mini-CEX, Case Based Discussions and a procedural logbook.

The content of the assessments is developed by
practicing rural generalists and focusses on assessing clinical practice in authentic rural environments.

The remote delivery of all assessment removes the need for trainees and examiners to travel to
large regional towns or major cities to sit assessment thus avoiding removing them from the medical workforce of their hometowns. This presentation will discuss the ACRRM assessment
program with focus on the processes supporting remote delivery.

206 - Resident-Led Junior Preceptorships: Building Teaching Capacity and Advancing Equity in Rural Family Medicine

Dr Swapna Palav, Dr Jyothi Ranga Patri[1,2,3], Dr Shravan Gangula[6], Karthik Angara[7], Sakshi Palav[8,9]

[1]Allegheny Health Network, [2]Forbes Family Medicine Residency Program, [3]Drexel School of Medicine, [4]Adventist Health , [5]Adventist Health Hanford Family Medicine Residency Program, [6]Coffeyville Regional Medical Center, [7]Case Western Reserve University, [8]University of California, Berkeley, [9]Fresno Veteran Affairs

Background:
Rural family medicine faces persistent physician shortages and the challenge of preparing residents to serve as both clinicians and educators. Residents are often expected to teach peers and medical students without structured preparation, particularly in underserved regions such as California's Central Valley. Junior preceptorships, where senior residents mentor junior peers under faculty supervision offer a practical, scalable approach to develop teaching, leadership, and feedback skills in real-world ambulatory settings.
Workshop Aim:
This interactive session will share an innovative junior preceptorship model that strengthens teaching capacity while advancing health equity in rural training programs. By embedding structured teaching into residency, programs can expand access to high-quality education, amplify diverse resident voices including women, international graduates, and underrepresented communities and foster a sustainable culture of education in rural practice.
Content & Methods:
Participants will explore implementation strategies through case examples from U.S. rural residencies and international pilots in Jakarta and Singapore. Facilitators will guide attendees through hands-on exercises to design a junior preceptorship tailored to their context, including adaptation for junior faculty or early-career rural physicians who lack formal teaching training.
Expected Outcomes:
Attendees will leave with a practical framework to build teaching capacity, recruit and retain rural educators, and promote equitable access to care. Structured junior preceptorships can be a game-changing solution to physician shortages while nurturing the next generation of rural family medicine teachers and leaders.

207 - Building Bridges in Rural Healthcare: Integrating Care Pathways Through Family Physicians

Dr Roshni Jhan Ganguly[1,2,3,4], Dr Ramakrishna Prasad[3]

[1]Project Setu Foundation Trust, [2]WoRSA, [3]Academy of Family Physicians of India, [4]WONCA Rural

Rural India, home to nearly 65% of the population, continues to face significant challenges in accessing comprehensive healthcare. Barriers such as geographical isolation, shortages of trained workforce, limited infrastructure, and fragmented systems of delivery contribute to persistent inequities. Over the years, diverse models of care have emerged to address these gaps. Government initiatives such as Primary Health Centres and Health and Wellness Centres form the backbone of service provision, while private clinics and charitable trusts extend additional capacity. Non-governmental organizations have contributed through innovative outreach programs, particularly in underserved and tribal regions.

Each model has demonstrated notable strengths—for example, government programs offer wide coverage, NGOs bring community participation, and trusts often provide low-cost services. However, duplication of efforts, uneven distribution of resources, and lack of coordination across sectors continue to limit their collective impact.

This oral presentation will examine these varied pathways of rural healthcare delivery, drawing on examples from across India to illustrate successes and limitations. It will emphasize the crucial role of family physicians as first-contact providers and care coordinators who can act as integrators across government, private, and voluntary sectors. Finally, A collaborative framework is proposed in which government services, private initiatives, NGOs, and trusts are aligned under the stewardship of family physicians, thereby creating competent, affordable, and accessible healthcare pathways. Such an approach has the potential not only to strengthen rural health systems in India but also to serve as a replicable model for other low- and middle-income countries striving for equity in healthcare delivery.

208 - One Rural Hospital's experiences of urban based House Officers undertaking 3-month rotations

Dr Rosalie Evans[1]

[1]Central Otago Health Services Limitied

Dunstan Hospital has hosted senior house officers for 3-month rotations since 2021. These recent medical graduates are completing their 2-year pre-vocational training in Dunedin but need to complete a community-based attachment (CBA). Rural hospitals whose medical cover is primarily by Rural Hospital Medicine doctors are specifically mentioned in the Medical Council of NZ definition of CBAs.

Dunstan senior medical officers and registrars have found having a rotational house officer a positive addition to their team. Informal feedback from participants is that they enjoyed the rotation and report great learning experience in a supported environment with close supervision of senior staff. A another positive was knowing members of the multidisciplinary team, particularly nursing and allied health staff, better in a smaller and friendly place.

Dunstan provides accommodation for the house officers which removes one barrier but this would not be suitable for doctors with families.

A number of previous house officers have since joined the Rural Hospital Training Programme and / or undertaken the General Practice Education Programme locally. While some were already interested in rural health prior to the rotation, others did not have it on their radar. One recent house officer said "I forgot that rural existed for a little while" (when working in urban centre).

Doctors at all levels thought that while getting early career doctors into rural areas was importance, it needed to be positive experience with good senior doctor supervision and teaching. "It is better to have no rural experience than to have a bad experience."

209 - Community Holistic Health & Wellness Program through Community Volunteers (Wellness Mitras) for Lifestyle Disease Risk Reduction in Rural Population"

A/Prof Kumar Santosh[1], Dr Sangh Mitra Pati[2], Dr Ashu Grover[3], Dr Pratyush Kumar[4], Dr Raman Kumar[5]

[1]AIIMS RISHIKESH, [2]ICMR, [3]WONCA, [4]ICMR, [5]AFPI

Background -Rural communities worldwide are witnessing an alarming rise in lifestyle-related diseases such as diabetes, hypertension, and cardiovascular conditions.Community-based models with trained local volunteers can bridge this gap, empowering people to adopt healthier lifestyles through
culturally sensitive, low-cost interventions.
Objectives

- To present a community-driven holistic health & wellness program model.
- To highlight the role of trained Wellness Mitras (community volunteers) in risk identification, prevention, and lifestyle modification.
- To demonstrate how rural communities can integrate nutrition, physical, mental spiritual , and preventive health practices through self-participation .
- To build an international dialogue on scalable, sustainable rural health wellness models.

Workshop Model Overview
This model is guided by evidence-based frameworks such as RE-AIM, Community-Based Participatory Research (CBPR), the Consolidated Framework for Implementation Research (CFIR), and iPARIHS—(Promoting Action on Research Implementation in Health Services) (iPARIHS)all frequently used for rural health program design and evaluation.
Core components :

- Community Needs Assessment:
- Family Need assessment:
- Volunteer Recruitment and Training:
- Implementation Activities:
  - Risk screening for diabetes, hypertension, and obesity.
  - Home visits and follow-ups for at-risk groups..
  - Village-level wellness campaigns and peer support groups.
- Session 1:
  - Community Health Needs Assessment (hands-on group activity).
- Session 2:
  - Evidence-based Training Methods—interactive modules adapted to local needs.
- Session 3:
  - Implementation Planning with a CFIR-guided checklist.
- Session 4:
  - Monitoring, Evaluation & Continuous Improvement using RE-AIM and iPARIHS tools.
- Wrap-up:
  - Sharing results from successful national/international models, open dialogue, and next steps.

210 - Learning from the Field: Enhancing Medical Students' Awareness of Social Determinants of Health ～in terms of Rural Health Disparities

Dr Ayumi Horiuchi-Takayashiki[1], Dr Tetsuhiro Maeno[1]

[1]University Of Tsukuba

The University of Tsukuba is the only medical school in Ibaraki, the prefecture with Japan's second most severe physician shortage. In 2018, the Social Determinants of Health (SDH) Program was introduced within a four-week mandatory community medicine practice for senior medical students, with one of its aims being to raise awareness of physicians' responsibility to address social disparities, including unequal distribution of healthcare providers. In this program, students conduct fieldwork and interviews with patients and residents in underserved areas to gather information about their life and regional health needs. Students identify social and environmental factors influencing their health, and present and discuss their findings in small groups on the final day.
One case discussion involved an elderly woman of an isolated mountain community with limited transportation and food access. Students reported that only individuals with preserved ADL and family support could remain in such settings, while community social capital and government-organized visiting medical services played a vital role in sustaining her health. Such encounters helped students view physician shortages not as distant issues but as professional responsibilities requiring active engagement.
Sharing diverse field experiences during presentations further deepened students' understanding of SDH. 13% of graduates (2025) expressed willingness to work in remote areas, and improvement in social empathy assessed using the Social Empathy Index before and after clinical training was observed. This program could have fostered responsibility and empathy toward addressing health disparities by experiential learning in underserved settings.

211 - Effectiveness- Implementation Pilot to Reduce Time to Initiation of TB Treatment in Rural and Tribal Regions of South-Eastern Rajasthan, India Using a Portable Handheld X ray and TruNAT-based Nucleic Acid Amplification

Dr Varsha Shridhar[1], Mr Bhargab Chowdhury[2], Mr. Prathikraj Bunker[2], Mr T Chunnilal[2], Dr. Colis Anwari[2], Dr. Yogita Thakral[2], Dr. Sharath B Nagaraja[3], Dr Ramakrishna Prasad[4], Dr. Pavitra Mohan[2]

[1]Molecular Solutions Care Health Llp, [2]Basic Healthcare Services, [3]Molbio Bigtec Pvt Ltd, [4]Global Engagement Network for Primary Health Care

Tuberculosis (TB) kills about 1.5 million people every year. The burden of TB is disproportionately in lower and middle income countries, with India having the world's largest burden.Traditionally under-served communities e.g. migrant labourers, marginalized communities & tribal populations, are at high risk for TB infections. They have poor access to health care leading to significant delays in diagnosis & treatment initiation, low adherence, increased transmission and risk of development of resistance.
We hypothesize that increased TB screening and diagnostics at point of care at the primary care setting can improve TB diagnosis in these vulnerable communities, decrease the time to initiation of treatment and improve patient follow-up. Effectiveness of Point-of-care TB screening using a handheld digital X ray and confirmatory testing using TruNAT (a WHO-approved nucleic acid amplification test) in primary care clinics in rural Rajasthan,India, in improving TB detection, time to treatment and outcomes of patients will be studied. This project has been initiated less than a month ago. Metrics such as turnaround time for tests, time to initiate treatment, numbers of individuals tested, numbers initiated on treatment, numbers found to be infected with drug resistant TB, numbers continuing and (if possible) completing treatment are being collected. In addition, qualitative interviews with patients and providers will provide information on their journeys and experiences. We will integrate this arm within existing structures to educate and inform the community, provide home-based care, and longitudinal followup. We expect to have data to present in another 3-4months.

212 - Building diagnostic capacity in rural India

Dr Varsha Shridhar[1], Dr Vasundhara Rangaswamy[2], Dr. Colis Anwari[3], Dr Ramakrishna Prasad[4]

[1]Molecular Solutions Care Health Llp, [2]Association for India's Development (AID), [3]Basic Healthcare Services, [4]Global Engagement Network for Primary Health Care (GENPHC)

Key health conditions in rural LMICs tend to be those of poverty, malnutrition and social structures (including infectious diseases like TB) as well as musculo-skeletal conditions due to tough, repetitive physical labour. However, there is lack of sufficiently trained diagnostic providers or programs for early detection and intervention.
In this workshop, we describe 4 interventions to build capacity to address some of these issues in various parts of rural India:
a) The establishment of rural primary care diagnostics (with a focus on microbiology) program in several rural clinics- describing the vision, fund-raising, implementation, and capacity building.
b) Initiation of a TB screening and diagnostic program in a tribal high-TB prevalence region in a network of 3 primary care clinics: as a effectiveness-implementation project
c) Establishment of a rural physiotherapy program as a diagnostic and intervention for musculo-skeletal health conditions: as part of a plural primary care team
d) The initiation of a platform to bring together medical device innovators and health care providers/ clinical systems to improve understanding of each other's contexts, realities and priorities in order to reduce the scale of non-adoption/ abandonment of innovations, nudge the flow of innovation towards addressing real pain points, thereby increasing spread and scalability of medical device innovations: as a collaborative project between a medtech incubator/ investor and a network of primary care clinics.

We also emphasise the role of robust registries, plural health care provider teams and cross-learning between teams which facilitate stronger and nimbler health systems

213 - ‘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.

214 - Consumer preferences for digital health technologies for primary healthcare in remote Indigenous Australian communities

A/Prof Sarah Norris[1], Dr Amy von Huben[1], Dr Vishnu Khanal[2], Ms Nicki Newton[1], A/Prof Emily Saurman[1], Ms Karina Coombes[2], Mr Alexander Puruntatameri[2], Ms Josielli Comachio[1], Ms Kureisha Wilson[2], Dr David Edwards[1], Mr Paul Burgess[3], Professor Meredith Makeham[1], Dr Tamsin Cockayne[3], Mr David Reeve[4], Ms Alison Lloyd[5], Dr Sean Taylor[2], Professor Michelle Dickson[1], Professor John Wakerman[2], Professor Tim Shaw[1], Professor Deborah Russell[2]

[1]The University Of Sydney, [2]Menzies School of Health Research, [3]Northern Territory Department of Health, [4]Aboriginal Medical Services Alliance Northern Territory, [5]Northern Territory Primary Health Network

Aim: To ascertain the relative preferences of Indigenous Australians in a remote Northern Territory island for attributes of digital health technologies to improve access to primary healthcare.
Methods: An in-person best–worst scaling survey was conducted by community-based researchers on a sample of 20% of the population over 18 years, stratified by age and gender, to ascertain the relative importance of twenty-four attributes of digital health technologies. Attributes were previously identified from qualitative research with the community on the potential role of technology in addressing community health needs.
Results: 46 participants (24% of the population aged over 18 and representative of the age and gender mix of the island population) completed the survey. Demonstrating respect for the patient's culture and community was considered most important, followed by reducing waiting times for specialist appointments, and having a support person available to interpret in discussions with health professionals. Reducing wait times on the day of appointment, being able to include family in healthcare discussions, and minimising travel away from the community were also seen as very important. Features such as medication reminders, provision of health information, interoperability of health records, location of consult, and privacy were not prioritised.
Conclusion: To improve access to primary healthcare in remote Indigenous communities, it is of utmost importance for community members that digital health technology services and providers demonstrate respect for the patients' culture and community. Additional resources are required to ensure support persons are available to interpret so patients can participate fully in healthcare discussions.

215 - Rolling with change: key learnings and positive outcomes from development of a dynamically-evolving rural and remote medical education model

Dr Matthew Ruhl[1], Dr Emily Moody[1], Dr Trevor Burchall[1], Mr Stephen Deering[1]

[1]Australian College Of Rural And Remote Medicine

This narrative presentation explores the continuing evolution of a nationwide, rural- and remote-focused medical registrar education program, from didactic and centralised beginnings to becoming accessible and learner-centred, highlighting elements which will support similar program development in other health education organisations.
The strengths of the iterative and cooperative development process, utilising the individual skills of a multidisciplinary team of clinical experts, learning developers and administrators, will be presented, with the resulting suite of asynchronously-accessible online learning offerings, interactive webinars and tutorials, and face to face regionally-delivered workshops, reaching hundreds of doctors in training nationally, where they are practicing and learning.
This model has been built on a foundation of learning materials presented by clinical experts in a single centralised location, to expand, via deliberate consultation with our adult learners and other key stakeholders, into the multimodal learner-centred, localised package currently in use, which is still being actively refined. The model responds to learner feedback and needs, is guided by major review projects, and highlights the ever-moving body of clinical guidelines and resources. At all stages, a focus on inclusivity is present, including deliberate Aboriginal and Torres Strait Islander healthcare issues and cases, in collaboration with a peak cultural education organisation. These learning offerings aim to address different learning needs and styles, promoting a safe learning environment for adult learners.
This review process has also resulted in unexpected benefits, including identifying key professional development priorities for more established medical professionals, and development of a robust philosophy of education.

216 - Advancing Pae Ora: Harnessing Collective Impact for Whānau-Centred Health Transformation in Ōtaki and Horowhenua.

Amarjit Maxwell[1]

[1]Think Hauora, [2]Victoria University of Wellington

This presentation aims to highlight how the collective impact approach can strengthen partnerships between general practice and other service providers, fostering a seamless, whānau-centred integrated care.

I will briefly acknowledge the historical context of the Pae Ora (Healthy Futures) Act as well as Aotearoa, New Zealand's ongoing health inequities, especially for Māori, emphasising the need for multi-sectoral solutions. A concise review of existing evidence will demonstrate the potential of collective impact as a strategy to address population health targets.

Interim findings from my PhD Doctoral research will be shared, focusing on how collective impact principles are being applied to advance the Pae Ora vision within two rural case study sites.

The presentation will critically explore lessons learned from various collective impact initiatives across Aotearoa, New Zealand, with particular attention to the barriers and enablers encountered in a rural setting when implementing this approach to support Pae Ora (Healthy Futures).

Additionally, I will illustrate how collective impact supports transformative moments—where people or events intersect and meaningful change occurs.

Achieving sustainable change, requires a collaborative approach that builds trust and nurtures connections. I believe that collective impact embodies this spirit, acting as a catalyst for enduring, positive transformation within our health system.

217 - How have the demographic characteristics of older general practitioners in rural and remote Australia changed over the past decade?

Dr Saliu Balogun[1], Ms Chipampe Masongo[1], Prof Fiona Doolan-Noble[1]

[1]Goldfields University Department Of Rural Health, Curtin University

Background: There are growing concerns regarding the ageing of the general practitioner (GP) workforce, particularly in rural and remote areas. However, demographic shift in the older GP workforce in rural and remote settings has not been adequately described. This study examined changes in the profile and work settings of GPs aged 65 years and older in rural and remote Australia between 2013 and 2024.

Methods: Data from the annual National Health Workforce Dataset were analysed. Analysis was restricted to registered GPs aged 65 years and older working in rural and remote areas from 2013 to 2024. Descriptive statistics were used to identify trends in demographic and job settings over time.

Results: The number of older GPs increased from 454 in 2013 to 829 in 2024, representing a rise from 12% to 15% of the total rural and remote GP workforce. Over time, the percentage of male GPs decreased from 85% to 73%, while female representation increased from 15% to 27%. Older GPs predominantly work in private settings. However, the number of them working in hospital settings and Aboriginal health organisations increases over time. The percentage of older GPs intending to retire within five years increases from 50% in 2013 to 64.5% in 2024, suggesting a significant potential workforce loss.

Conclusion: These findings highlight the vital contribution of older GPs in sustaining rural/remote healthcare but also demonstrate the urgent need for succession planning and targeted workforce strategies to reduce the impact of the retirements of experienced GPs.

218 - What are the experiences of Stellenbosch University medical students undertaking rural longitudinal integrated training in their final year?

Prof Ian Couper[1], Ms Manoko Lediga[1]

[1]Division of Rural Health (Ukwanda), Stellenbosch University

Introduction
Stellenbosch University (SU) Rural Clinical School offers medical students the chance to apply to spend their final year in the Longitudinal Integrated Model (LIM), based at rural district hospitals. In 2024, 21 students were selected for this option. LIM requires different approaches to learning. This study aimed to explore experiences of SU medical students undertaking rural LIM training.

Methods
A longitudinal exploratory study is being undertaken in three phases, using individual interviews for data collection. This presentation reports on the second phase.
The cohort of medical students undertaking LIM in 2024 were invited to participate. Twelve students were interviewed online in the second half of 2024. The guide for these conversations included exploratory questions on students' experiences, perceptions of LIM, and ideas regarding learning and practice.
Reflective thematic analysis of the transcribed interviews was undertaken.

Results
Students appreciated the clinical exposure that enabled them to bridge the gap between theoretical knowledge and real-world practice. They gained clinical confidence, and developed communication skills, empathy, and the ability to handle patients with varying needs. They felt more in control of their own learning. They enjoyed being valued and treated as part of the medical team, with a downside of spending most of their time in the clinical space and sometimes feeling overwhelmed. They missed the community of students at medical school.

Conclusion
Significant shifts in approaches to learning, understanding, ways of being and functioning in healthcare occurred. Overall, students felt LIM prepared them well for internship and future rural practice.

219 - Creating Health Pathways that Matter: A First Nations Health Education Hub in Higher Education Settings

Dr Clare Quinlan, Donna-maree Stephens[1]

[1]DMS Research Evaluation Consulting, [2]Charles Darwin University

In the two decades since the seminal Behrendt Review (2012), slow progress has been made to increase the success rates of First Nations' engagement in higher education. Focused on metrics that overlook the cultural relevance of education, Indigenous students are still evaluated through the lens of deficit discourses, with success framed by "proximity to whiteness".

This mismatch is also seen in health education, where the curriculum prioritises Western biomedical models while marginalising Indigenous knowledge of health.

In the Northern Territory of Australia, where forty-eight percent of the land mass is under Aboriginal ownership, Indigenous students, particularly those from remote communities, often face profound tensions between pursuing Western HE and maintaining cultural identity. Barriers such as financial precarity, geographic isolation, and institutional racism compound these challenges, leading to high dropout rates and low retention. Meanwhile, these remote communities are still experiencing shortages of healthcare professionals, with high turnover and limited access to education opportunities.

The First Nations Health Education Hub and Pathways Program (the FNHEH) includes areas such as nursing, midwifery, and allied health. The FNHEH has five key strands: course design, professional development, wraparound support, integration of student placements, and evaluation.

The FNHEH is framed by the First Nations' holistic health concepts and the national Social and Emotional Wellbeing model. The First Nations health framework, together with agreed and shared Principles of Practice, guides decision-making across the five key strands, particularly around learning, teaching, and assessment, that seek to address overlooked areas of culture in higher education health settings.

220 - 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.

221 - Learnings from a Rural Primary Care Physiotherapy Program and its Practice Registry: A Synthesis of Clinical Patterns, PHC Team Competencies, and Care Access in Southern Rajasthan, India

Colis Anwari[1], Mr Gauri Shankar Jha[1], Dr Varsha Shridhar[1,2], Mr Mayank Khurana[1], Dr Gargi Goel[1], Dr Pavitra Mohan[1], Dr Ramakrishna Prasad[1,3,4]

[1] Centre for Primary Health Research, Basic Healthcare Services, [2] Centre for Primary Health Research, Basic Healthcare Services, Udaipur, Rajasthan , [3]National Centre for Primary Care Research & Policy, Academy of Family Physicians of India (AFPI), [4]: Global Engagement Network for Primary Health Care

In 2022, Basic Healthcare Services embedded a primary care physiotherapy program within three rural clinics in southern Rajasthan to address critical rehabilitation needs in underserved communities, strengthen primary care teams, and improve functional outcomes. Operating through AMRIT Clinics, BHS provides physiotherapy across clinic, community, and home settings, emphasizing accessibility, continuity, and collaboration. To systematically document delivery and outcomes, a prospective clinical registry was maintained from July 2022 to July 2024 across the Manpur, Ghated, and Bedawal clinics. Service delivery challenges were analyzed using the three-delays framework, focusing on barriers in recognizing, reaching, and receiving care, while highlighting solutions emerging from a community-anchored model.

Between June 2024 and July 2025, over 1,000 physiotherapy encounters were documented. Patients ranged from children under 10 to elders over 70, with the majority being working-age adults (45%) and older adults (50%). Musculoskeletal disorders (70%), respiratory sequelae, including post-tuberculosis lung disease and COPD (15%), and neurological impairments (10%). Autoimmune conditions, especially rheumatoid arthritis, were notable among women aged 20–50 years. New patients comprised 76%, while 32% of all patients were unemployed and reported disability or functional limitations.

Care was delivered through a holistic, low-cost approach, integrating pain relief, mobility enhancement, and strengthening, with evidence-based interventions such as hot packs, exercise therapy, breathing routines, and functional rehabilitation.

Findings demonstrate that physiotherapy is a core component of primary care, with registry data serving as a powerful tool for learning and adaptation. Scaling such models requires investment in integrated care teams, continuity, and adaptive systems responsive to local contexts.

222 - 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.

223 - Artificial Intelligence vs Physicians Trauma Audits: Insights from a Randomised Cross-Over Trial of 1,021 Trauma Patients from a Rural Indian Emergency Department

A/Prof Nisanth Menon Nedungalaparambil[1,2], Dr. Vinayak S R[1], Dr. Rajalekshmi R[2], Dr. Abishek Anto[2], Manuel Jacob[2]

[1]Wonca Emergency Medicine Special Interest Group, [2]MOSC Medical College Hospital

INTRODUCTION: Clinical practice audits are critical for assessing care quality, identifying protocol deviations, and guiding improvements. Manual audits, though reliable, are resource-heavy and nearly impossible for busy rural practitioners. AI-assisted clinical audits promise efficiency while maintaining diagnostic rigor.
OBJECTIVE: To evaluate the accuracy, efficiency, and agreement of AI audits compared with manual physician audits in trauma care.
METHODOLOGY: A prospective, cross-over randomised controlled trial was conducted at a rural emergency department. Records of 1,021 trauma patients (32,672 datapoints) were audited using the Modified WHO Trauma Checklist. Audits were independently performed by an AI model (Google Gemini Advanced) and physicians, with a consultant-led review as the gold standard. Accuracy, sensitivity, specificity, and inter-rater agreement were assessed.
RESULTS: AI audit demonstrated an overall accuracy of 88.1%, compared with 92.4% for physician audit ($\chi 2$ test, $p < 0.01$). Sensitivity for detecting protocol deviations was 85.7% for AI and 90.8% for physicians, while specificity was 89.9% and 93.2%, respectively (McNemar's test,$p < 0.05$). Agreement with the consultant gold standard was substantial for both methods (AI: $\kappa = 0.80$; physicians: $\kappa = 0.85$; $p = 0.12$). Audit duration averaged 4 minutes per case for
physicians and 30 seconds for AI, a 3.5-minute saving per record, yielding approximately 60 cumulative audit-hours saved across the cohort (t-test, $p < 0.001$).
CONCLUSION: AI audits can achieve accuracy and reliability comparable to physician-led clinical audits & Integrating AI into rural audit workflows can markedly reduce audit time and physician workload, thus allowing continuous quality improvement at a primary care level.

224 - 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.

225 - Advanced Skill Training for Rural Generalists: Lessons from the National Advanced Skills Training Program

Dr Gavin Parker[1], Dr Sarah Lespérance, J Barr, E Blau, I Cochrane, B Geller, L Hetu, S Iglesias, S Kanagaratnam, K Kluke, M Maracle, G Parker, S Poole, J Weidrick, D Parsons

[1]Society of Rural Physicians of Canada

In March 2023-2024, the SRPC implemented the National Advanced Skills and Training Program for Rural Practice (NASTPRP) using $7.4M in funding obtained through Economic and Social Development Canada. Its purpose was to provide training opportunities for practicing rural generalists to enhance their skills, in order to meet identified rural community needs and improve access to care. The response to the training program significantly exceeded the target number of 166 rural physicians. The SRPC received 375 applications between March 2023 and March 2024, and funded training for 342 rural physicians. Participating physicians represented 187 communities across all provinces and territories, with at least 60 Indigenous communities benefiting from the program. Thirty percent of trainees were international medical graduates. Many physicians were unable to participate due to the limited timeframe of the grant, however of those who participated, 94% reported ongoing training needs. The program funded training opportunities to upskill practicing rural physicians, including specialists, nationwide, enabling them to meet specific community needs. Examples of training included diagnostic procedures, emergency medicine, general surgery, obstetrical care, and anesthesia. Overall benefits of the program were enhanced confidence and reduced moral distress by providing opportunities for enhanced skills training via a program that considers the unique needs of rural doctors, improved access to high-quality care close to home and reduce the need for patient transport out of communities, strengthened connections with referral centres and developing regional networks of care, and increased physician retention in rural, remote and Indigenous communities.

226 - 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.

227 - 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.

228 - Harrowing the Furrows- Regrassing Kaikōura Health Services

Dr Andrea Judd[1]

[1]Kaikōura Health Te Ha o Te Ora

Nāu te rourou Nāku te rourou
Ka Ora ai te iwi
 “With your food basket and my food basket we will feed the people “
Aim: By developing an integrated service in our rural community we can share resources, offer continuity of care and so transition between the services is seamless for our patients and community members.
The design of this model has allowed a successful hub for training rural medical students, interns and registrars as well as nursing students and graduates and allied health trainees.

Methods Kaikōura Health Te Ha O Ta Ora, a partnership between private general practice and Health NZ - Waitaha developed a holistic Model of Care to serve the rural Kaikōura community of 4000 people and 1 million visitors per annum which continues to evolve. Although design work had begun in 2012 the Kaikōura Earthquake 2016 tested and fast tracked the embedding of the model .
 The fluidity of the model and the blurring of boundaries is what worked so well . The integration of Rural Hospital Medicine, General Practice, Mental Health and Wellbeing,,Long term Residential and Palliative care and non-regulated workforce as well as teaching on the job enables a truely rural generalist approach and puts the patient at the centre of care.

Key Learnings This highlights the importance of collaboration, community effort, and shared resources. It emphasizes that by everyone contributing their unique skills and resources, the community can flourish and go beyond mere survival to truly thrive.

229 - 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.

230 - POC NOW: From Evidence to Action — Strengthening Rural Primary Care through Point-of-Care Testing

Dr Ruben Burvenich, A/Prof Jan Verbakel[1], Dr Fiona Bolden, Prof Fabian Dupont

[1]Ku Leuven

Title: POC NOW: From Evidence to Action — Strengthening Rural Primary Care through Point-of-Care Testing

Authors / Convenors:
Jan Verbakel (KU Leuven, Belgium) on behalf of the POC NOW Collaboration Hub group (WONCA World Conference 2025, Lisbon).

Background & Rationale:
Point-of-care testing (POCT) can transform rural and remote family practice by enabling timely diagnosis and treatment where laboratory access is limited. Yet adoption is fragmented, with gaps in guidance, training, and implementation.

At the WONCA Collaboration Hub 2025, a diverse international group of clinicians, educators, and researchers launched POC NOW (Point-of-Care NOW). This initiative unites WONCA networks to accelerate the safe, effective, and equitable use of POCT in primary care, with strong relevance for rural practice.

Objectives:
This workshop will:

Present the three pillars of POC NOW: a global position paper, a practical implementation toolkit, and a research & scholarship agenda.

Explore rural diagnostic priorities, barriers, and opportunities in integrating POCT.

Co-create rural-specific recommendations for inclusion in the POC NOW outputs.

Format & Methods:

Introduction (10 min): overview of POC NOW and its origins in Lisbon.

Group work (30 min): participants discuss rural diagnostic needs, implementation challenges, and training requirements.

Plenary synthesis (15 min): develop recommendations and identify champions.

Commitment round (5 min): connect participants to the global collaboration.

Expected Outcomes:

Participants will contribute rural perspectives to the global POC NOW initiative, gain access to draft toolkit resources, and join a collaborative network shaping research and education in POCT for family medicine.

231 - An introduction to the European Rural Isolated Practice Association (EURIPA)

Prof Joyce Kenkre[1,3], Dr Ferdinando Petrazzuoli[2,3], Dr Oleg Kravtchenko[3], Dr David Halata[3,4], Dr Miriam Dolan[3,5]

[1]University of South Wales, [2]University of Malmo, [3]EURIPA, [4]Czech Society of General Practice, [5]Queen's University

Established in 1997, EURIPA was the first regional rural health network set up under umbrella of WONCA. It was initially set up to gain recognition of rural practice and rural health and eventually became recognised as a network of WONCA Europe.
EURIPA published Charted for Rural Practice in 1997, but this was superseded by the Blueprint for Rural Practice published in 2022. The Blueprint for Rural Practice in Europe aim is to ensure that rural communities have access to high quality, safe and effective health care irrespective of where they live,
EURIPA organises an annual Rural Health Forum. In 2025, the 14th Forum was held in Wittenberg, Germany. A report of the Forum has been published together the Wittenberg Statement, addressing the theme of the Forum- Rural Reformation: Meeting Wellbeing and Healthcare Needs in Rural Communities. Research priorities for EURIPA were also developed to be taken forward in collaboration with members of the network. In 2024, in Lincoln led to the formation of a working group under EURIPA: RHEAN - Rural Health European Academic network. RHEAN was established to bring together clinicians and academics from across Europe to understand what activity in terms of rural health research and education is currently taking place.
The ultimate aims of EURIPA are to have rural included in education curricula, clinicians in rural areas undertaking their own research and delivering education at undergraduate and post graduate levels and having academic titles and to have rural health recognised as an academic discipline.

232 - Collaboration for multidisciplinary research to address health inequalities

Prof Joyce Kenkre[1], Shelley Nowlan[2], Dr Gobith Ratnasingam[3]

[1]University of South Wales, [2]Queensland Health, [3]University of Jaffna

In 2019, at the WONCA Rural Health participants endorsed the Albuquerque Statement to support, advocate and promote nurses and midwives in a leadership role globally. The statement saw nurses as collaborative leaders who could impact on service delivery in remote and rural area around the world to enable universal health care coverage. It is known that less than 10% of the world's biomedical research funds are dedicated to addressing problems that are responsible for 90% of the world's burden of disease and the inequity is probably even greater in rural areas specially in LIMCs. The statement highlights the need to strengthen the evidence base to enable multidisciplinary and multiprofessional practice in the future.

Th aim of the workshop is discuss the important issues to be addressed be enable research in rural and remote communities from a multidisciplinary approach and prepare a plan for future collaborative initiatives.

Objectives are to:

- Raise issues preventing multidisciplinary research
- Highlight the Importance of networking and communication to create opportunities for collaboration
- Agree on key topics for which research evidence is needed
- Agree on next steps to meet the aim of the workshop

Attendance

Any person interested in addressing the development of multidisciplinary research to tackle disease and health inequalities.

233 - Kia whakatōmuri te haere whakamua – Looking back to move forward. Enhancing rural community wrap around support for rural students and locums.

Gill Genet

In July 2025, the New Zealand Government announced the establishment of a third medical school with a strong focus on rural and primary health. The University of Waikato accelerated graduate entry medical programme aims to produce an increased proportion of graduates choosing to work in rural general practice, rural hospitals, be trained as generalists or be able to meet other rural health needs for example, aged care. The school adds to the work the existing Auckland and Otago schools do in rural medical training, including the recent expansion of their well-proven fifth year Rural Medical Immersion Programmes.

Almost immediately the Rural Communities Chapter of Hauora Taiwhenua proposed to undertake a project focused on ensuring that students will have a great experience when on placement as this is critical to retaining them. The programme will include being welcomed into the wider community, meeting the people, and getting to experience the local culture, attractions, and activities unique to it.

In August 2025, the Golden Key Project began and was immediately expanded to include locums. The whakatauki (proverb) - kia whakatōmuri te haere whakamua, guided the initial approach, with the project team identifying what has worked well in the past for rural student placements and building on that, to design the future.

The presentation will include an update on progress made, challenges faced, and identify any lessons already learnt.

234 - How to support the development of clinical courage in our rural generalist registrars

Prof Lucie Walters

How to support the development of clinical courage in our rural generalist registrars

Background
Clinical courage describes the ability of rural generalists to work at their full scope of practice in order to provide their patients with access to clinical care not otherwise available in their rural locations. Clinical courage requires both contextualised competence in the health service and responsiveness to community. It involves facing cognitive hurdles when providing care. Recent research demonstrates that clinical courage is associated with sustained clinical work in rural areas.
This study explores how clinical courage develops in doctors-in-training and how it can be strengthened by different aspects of formal education and supervised rural practice.

Methods
Current, past and future rural generalist trainees were interviewed about how they have developed their clinical courage. Learning theories were used as conceptual frameworks to explore how rural clinical immersion and formal rural curricula activities facilitate the development of clinical courage.

Results
This presentation will describe the results of thematic analysis and present ten tips of clinical supervisors and medical educators engaged in training the next generation of rural doctors.

Conclusion
Rural clinicians and trainees will be encouraged to consider how relevant clinical courage is to their practice, and how they can potentially facilitate its development in themselves and their rural peers.

Acknowledgement
This research has been funded by an ACRRM Education Research Grant.

235 - 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.

236 - Preparedness of West Coast for the Alpine Fault rupture: a qualitative exploration

Annise Boothroyd-drury, Dr Emma Boddington[1], A/Prof Katharina Blattner[1]

[1]Centre for Rural Health, UoO

Background
The West Coast of Aotearoa is classified as rural or remote rural. The Alpine Fault traverses the entirety of the 600km region and has a 75% chance of rupture causing a magnitude 8 earthquake within the next 60 years, codenamed by civil defence as 'AF8'.
Following AF8, it is likely that the West Coast will face numerous challenges, including inaccessibility, infrastructure destruction, displacement, injuries, and limited access to basic necessities. Primary health teams play a significant role in the response; it is vital to understand the perspectives of GPs regarding their preparedness.
Method
A narrative review of Aotearoa and Australian published literature was undertaken. Qualitative, semi-structured interviewers were conducted with GPs working on the West Coast. A deductive thematic analysis methodology was used. Ethics approval was attained through the UoO. Ngai Tahu Research Committee consultation was undertaken.
Results
Narrative literature review discovered learnings in disaster response and preparation from previous adverse events. These were sorted into the PPRR model (Presentation, Preparation, Response, Recovery), including both medical and non-medical considerations. Semi-structured interviews covered: the context in which care is delivered, current confidence and concerns, perceived strengths and challenges; and what readiness would look like.
Conclusions
The topography of the West Coast region and proximity to the Alpine Fault makes it vulnerable to devastation following an AF8 event. Findings inform a recognition of the current state of GP preparedness, and consideration of what future step(s) can be taken to strengthen readiness.

237 - Beyond Technology Transfer: Developing PEARLS Obstetrics & Gynaecology in Response to Pacific Community Demand for Sustainable Maternal Health Capacity

Jo McCann[1], WC Tse[2], L Nguyen[3], S Paulo[4], J Henry[5], S Orde[6], B Hafeez[7], I Bokolon[8], M Misivet[9], L McClean[6]

[1]Otago Medical School, [2]Burnet Institute Disease Elimination Program, [3]Western Health, [4]Ministry of Health, [5]Bayside Health & Monash University, [6]Nepean Hospital, [7]University of Calgary, [8]Rabaul Provincial Hospital, [9]Warangoi Rural Hospital

Background
Point-of-care ultrasound (PoCUS) has potential to address diagnostic inequity in low resource populations. PEARLS (PoCUS in Emergency and Acute care in Resource-Limited Settings) was designed to create sustainable educational ecosystems through local ownership, culturally adapted mentorship, and longitudinal support using a three-phase approach: hands-on workshops in two streams (Emergency and Critical Care) with device provision; 12-month remote mentorship with image review via secure cloud platform; and return visits transitioning previous participants into faculty roles.

Methods
Cross-sectional analysis of post-course surveys from August 2022 to August 2025 was conducted. Participants rated nine domains using a 5-point Likert scale (1 = very dissatisfied; 5 = very satisfied), including content relevance, facilities, equipment, and pre-course materials. Free-text responses were analysed to identify unmet training needs. Scans uploaded to the cloud platform were tracked throughout the remote mentorship phase.

Results
From 8 courses, 69/94 (73%) attendees completed the survey, showing high satisfaction across all nine domains (mean 4.8/5.0). Out of 576 scans uploaded, 135 (23.4%) were first-trimester obstetric assessments. Second and third trimester scanning was the fourth most requested training.

Conclusion
PEARLS-O&G emerges from the identified need. Working with Pacific clinicians, the programme is developed specifically for practitioners providing first contact maternal care in settings with limited specialist access. Expanded obstetric PoCUS capability is expected to support earlier risk stratification, more appropriate referral, and improved clinical decision-making. The model centres on fostering local champions and respecting indigenous knowledge, embodying Nāku te rourou nāu te rourou, ka ora ai te iwi: with your basket and my basket, the people will thrive.

238 - Bridging the Gap: A Telehealth Simulation to Prepare Urban Nursing Students for Rural Healthcare Challenges

Kim Hicks

Rural communities face unique healthcare challenges, including limited access to services, geographic isolation, and workforce shortages. To address the educational gap in preparing urban-based nursing students for rural practice, faculty from the University of California, Irvine's Sue and Bill Gross School of Nursing have partnered with the University of Alaska Anchorage to develop a telehealth-based simulation experience. This collaborative educational intervention immerses students in the complexities of transitioning a patient from an urban hospital to a rural home setting.

The simulation centers on a 65-year-old patient recovering from hip replacement surgery at UC Irvine Medical Center following an injury sustained while visiting California. Upon discharge, the patient returns to a rural community in Alaska, where follow-up care is coordinated by nursing students at UAA. Through a series of virtual sessions, students engage in discharge planning, interprofessional communication, and telehealth-based follow-up care. The scenario challenges students to navigate real-world barriers such as limited access to physical therapy, transportation difficulties, and cultural considerations in rural settings.

Learning objectives include applying discharge planning principles, demonstrating interprofessional collaboration, analyzing rural healthcare disparities, and utilizing telehealth technologies to ensure continuity of care. The simulation is designed to foster critical thinking, teamwork, and cultural humility while highlighting the importance of equitable healthcare delivery across diverse geographic contexts.

This initiative exemplifies a scalable, innovative model for integrating rural health education into urban nursing curricula. It promotes mutual learning between institutions and prepares future nurses to deliver patient-centered care in underserved areas. By simulating the lived realities of rural healthcare, this project aligns with the conference theme, "Rural Health in Real Life," and contributes to the development of a resilient, adaptable, and culturally responsive nursing workforce.

239 - Power in partnerships: Growing a culturally safe rural workforce

Richard Colbran, Chris Russell, Dr Robyn Ramsden, Yann Guisard

Introduction
Addressing critical rural workforce shortages is essential to reducing health inequities. The Rural Doctors Network (RDN) Cadetship Program is a long-standing initiative that has strengthened the rural health workforce for over 35 years with NSW Ministry of Health support. This presentation highlights how the Cadetship has supported Aboriginal and Torres Strait Islander students to thrive in rural practice as part of RDN's commitment to social accountability and long-term workforce solutions.
Methods
Drawing on three longitudinal studies spanning 35+ years, this research examined attraction, retention, workforce capability and community impact. Quantitative data from cadet alumni and qualitative interviews with health administrators and community stakeholders identified factors influencing successful rural workforce outcomes. Statistical analyses (descriptive, chi-squared, logistic regression) explored relationships between program experience and career trajectories.
Results
Since 2014, 37 Aboriginal and Torres Strait Islander students have entered the program, with 26 already contributing to rural hospitals. The co-designed model incorporates Indigenous mentorship, connection to Country, and support networks as key enablers of retention and success.
Across the broader program, 455 cadets have worked in rural NSW; 64% now practise in MM3–7 locations, and cadets are twice as likely to become GPs or Rural Generalists.
Discussion and conclusion
Integrating Indigenous knowledge into workforce initiatives strengthens belonging, accountability and continuity of care. Culturally grounded mentorship and country-based learning sustain "fit-for-place" rural practitioners.

240 - Joining the journal community – how becoming a reviewer enriches your professional work!

A/Prof Katharina Blattner[1], Prof Ian Couper, Prof Paul Worley

[1]Centre for Rural Health, University of Otago

The workshop aims to introduce clinicians and researchers to the benefits, concepts and processes of peer review, and to encourage participants to be part of the broad community of journal reviewers. It will provide tools and tips to conduct a review, and discuss how reviewing within an international community of practice enriches your professional work. Participants will also discuss how to use this knowledge to increase their success in publishing their own work.

RRH is an open-access international academic journal publishing articles by rural health practitioners, educators, researchers and policy makers.

Learning outcomes
- Describe the purpose of peer review.
- Recognise the professional and personal benefits that come from being a reviewer.
- Appreciate journal processes from article submission to acceptance.

INDEX by AUTHOR

FINAL COMMENTS

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: wprural@wonca.net and Rural WONCA | Advancing Rural Health Everywhere

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