

2026 GLOBAL RURAL HEALTH SUMMIT

GLOBAL RURAL HEALTH SUMMIT

FINAL REPORT

Bridging the Distance

LOCAL REALITIES • GLOBAL EQUITY



Global Rural Health Summit

A focused one-day platform linking local rural health priorities with global knowledge, policy and collective action.

01

MISSION AND COLLABORATIVE VISION

The Global Rural Health Summit (GRHS) is organized by Rural WONCA, the WONCA Working Party on Rural Practice, with diverse local and international partners. Its collaborative vision brings local realities and global priorities into the same conversation.

LOCAL ISSUES AND SUCCESSFUL MODELS

Partners identify pressing community concerns and share effective care models shaped by their context.

GLOBAL DEVELOPMENTS AND CHALLENGES

International partners contribute research, policy innovation and emerging responses to shared rural health challenges.

02 HOSTING HISTORY

2025 • INDIA

Partnership with the Academy of Family Physicians of India (AFPI) and Basic Health Services (BHS).

2026 • MANILA

Collaboration with The Network: Towards Unity for Health (TUFH), the University of the Philippines Manila and other rural health partners.

03 STRUCTURE AND GOVERNANCE

The one-day format combines keynotes, panels and interactive workshops, supported by pre-Summit webinars.

An Organizing Committee and a Scientific Programme Committee jointly manage the Summit, with mandatory Rural WONCA leadership representation to maintain academic integrity and alignment with global rural health goals.

04 EQUITY AND INCLUSION STANDARDS

30%

MINIMUM LMIC SPEAKERS + DELEGATES

30%

MINIMUM MALE LEADERSHIP

30%

MINIMUM FEMALE LEADERSHIP

Participation includes young doctors, Rural Seeds medical students, nurses, public health experts and health policymakers.

05

OUTCOMES AND GLOBAL ADVOCACY

Each Summit seeks actionable publication strategies, position papers and a formal declaration setting policy directions for sustainable rural health equity. The Manila Declaration is the central policy outcome of the 2026 meeting.

THE 2026 THEME *Bridging the Distance: Local Realities, Global Equity*

The legacy begins after the meeting

The purpose of Manila was to listen to rural health challenges, learn across settings and turn shared experience into action.

The journey began before the Summit, through three webinars on emergency preparedness, socially accountable training and Indigenous health workforce development. In Manila, participants brought those discussions into dialogue with frontline experience and global workforce policy.

Thank you to everyone who shared their views and helped shape the Manila Declaration. Its adoption gives our networks a common set of commitments. The responsibility now is to use them to influence policy, strengthen rural health systems and improve the lives of rural and remote communities.

This work will continue through Rural WONCA, the Rural WONCA Institute of Learning and GRACE, in collaboration with communities and partners around the world.

DR PRATYUSH KUMAR

Chair, Rural WONCA • MBBS, DNB – Family Medicine

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Participants in Manila, with the Declaration under discussion. Photographs throughout this report were supplied by the Summit organizers.

Rehearse to Respond

DATE 27 MAY 2026

FOCUS Using tabletop exercises to strengthen health emergency preparedness and response

REHEARSING DIFFICULT DECISIONS

Dr. Aileen Espina and Dr. Pratyush Kumar introduced the opening webinar. The Philippine Society of Public Health Physicians and the Alliance for Improving Health Outcomes contributed to this session on testing emergency plans in rural services.

A tabletop exercise brings decision-makers together around a plausible emergency. Teams examine communication and resource use without the expense and disruption of a full-scale field drill. This makes weaknesses visible while there is still time to address them.

A FLOOD SCENARIO TESTS THE PLAN

Participants considered a rural health centre isolated by floodwaters. Grid power had failed, and the generator had fuel for only 24 hours. A later update introduced 15 residents with severe gastroenteritis as intravenous fluids ran low and the generator stopped. These were simulated conditions, not an actual emergency.

Teams had to weigh patient priorities against fragile supplies, transport and power. The scenario showed how an initially manageable disruption can become more serious when several dependencies fail together.

HOW AN EXERCISE WORKS

An exercise needs a clear aim, specific and measurable objectives, and a defined scope. A Master Events List sequences the scenario. Timed updates, known as injects, introduce new pressures and require participants to explain their response. The decisions and assumptions exposed become the focus of the debrief.

WHAT THE DEBRIEF REVEALED

One group recognized an excessive reliance on a single highway and uninterrupted electricity. Another emphasized a clear chain of command and manual triage protocols. These findings gave teams concrete questions to take back to their own services, without requiring a large budget for a full-scale simulation.

PRACTICAL LESSON

Rural teams can begin with one credible local scenario, record difficult decisions and revise the plan together.



WATCH

2026 **GLOBAL**
RURAL
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RECORDING AND SOURCE

[Open the webinar recording](#)

Source: Webinar recording and organizer-supplied transcript summary. Exercise numbers describe the simulation.

Training for the Last Mile

DATE 24 JUNE 2026

FOCUS Socially accountable training and education

LEARNING WHILE SERVING

Convened and moderated by Dr. Aileen R. Espina, this webinar examined how training can support rural service. Australian and Philippine examples placed education within everyday practice, with supervision and professional development adapted to rural settings.

AUSTRALIA'S REMOTE TRAINING MODEL

Dr. Pat Giddings described the Remote Vocational Training Scheme (RVTS), operating for more than 25 years. Doctors continue serving underserved communities while undertaking distance education and receiving remote supervision. Education and local service delivery take place together.

Giddings reported that about 80% achieve fellowship, and around half remain in the same community for at least two years after training. The average first-year trainee was described as 40 years old with ten years of postgraduate experience. Families are funded to attend twice-yearly residential workshops, recognizing the influence of family experience and social connection on retention.

THE PHILIPPINE EXPERIENCE

Dr. Leilani A. Nicodemus described the Philippine Academy of Family Physicians' programme. It began in 2003 for moonlighters in smaller private hospitals. In 2013, the Department of Health engaged the programme to train government physicians without withdrawing them from rural clinics.

Four pathways now serve moonlighters, government physicians, local government physicians and Doctors to the Barrios. Online learning combines with face-to-face skills sessions, practice visits by volunteer faculty and capstone projects. Community needs and socially accountable care shape the curriculum.

BELONGING MATTERS TO RETENTION

Reactor Dr. Anna Gia Limpoco emphasized that retention is a human issue. Doctors need professional support and a sense of belonging. The examples showed why training should consider family and community relationships alongside clinical competence and qualifications.

PRACTICAL LESSON

Training close to the people being served can preserve access to care while doctors develop their skills.



WATCH



RECORDING AND SOURCE

Open the webinar recording

Sources: Recording, organizer-supplied summary and poster.

Advancing Indigenous Health Workforce Models

DATE 29 JULY 2026

FOCUS Chair: Ojistoh Kahanawakeré Horn,
Indigenous Physicians Association of Canada

INDIGENOUS LEADERSHIP

This webinar examined Indigenous workforce development across education, recruitment and retention. Mohawk/Haudenosaunee leader Ojistoh Kahanawakeré Horn chaired the discussion. Dr. Pratyush Kumar welcomed participants on behalf of Rural WONCA. WHO contributors Theadora Swift Koller and Pascal Zurn connected the discussion to international work on Indigenous health.

SUPPORT THROUGHOUT A CAREER

Darlene Kitty, a Cree family physician from Canada, emphasized workplace culture as a condition for retention. Formal mentorship and opportunities for further education support remote staff. Cultural safety training should help colleagues understand the community's history, trauma and resilience.

EDUCATION THAT RESPECTS IDENTITY

Donald Warne, an Oglala Lakota physician, described Indigenous underrepresentation in the United States medical workforce and pressures on students whose culture is not respected in training. His account of developing an Indigenous School of Medicine emphasized student wellness, traditional knowledge and ceremony.

RECOGNITION AND AUTHORITY

Michael Edmonds brought a Māori perspective from Aotearoa New Zealand. He advocated recognition, registration and funding of traditional and community health workers, including kaimahi. The discussion linked workforce development to the authority of Indigenous communities to shape their own services: educational access alone cannot address exclusion if training environments, employment conditions and systems of professional recognition remain unchanged.

RECRUITMENT THROUGH LOCAL TRUST

Roshni Jhan Ganguly of Project Setu Foundation, India, described recruitment through community relationships. Women's self-help groups, farmer collectives and artisan networks help identify people who already hold local trust, offering an alternative to externally driven recruitment.

PRACTICAL LESSON

Indigenous communities must help shape the pathways into health work and the conditions that sustain it.



WATCH

Summit conversations

The meeting connected practical rural innovations with questions about education, workforce support and the conditions needed for equitable care.



A Summit presentation at the University of the Philippines Manila.

5 MINUTES TO CHANGE THE WORLD

Short presentations gave participants a platform to share practical and innovative ideas from different rural settings. The format placed local experience at the centre of international exchange and opened discussion about what other communities could learn from it.

WHERE WE EDUCATE MATTERS

Prof Bruce Chater moderated a discussion of whether the urban focus of medical education contributes to rural workforce shortages. The Declaration calls for equitable allocation of education resources to rural, community-based training and rejects training environments built on humiliation or unreasonable work hours.

VOICES FROM THE FRONTLINE

In the fishbowl session “Resilience in Isolation”, moderated by Dr Aileen Espina, participants explored isolation, burnout, mental wellbeing and safety. They valued being heard, family and community support, and contact with colleagues who understand rural practice.

A COMMON POLICY DIRECTION

The Declaration brings education, Indigenous leadership, emergency readiness, rural proofing and digital equity into a shared agenda. The following pages present the workforce keynote evidence and selected workshop observations before reproducing the complete adopted text.

Local experience was not an add-on to the agenda; it was the starting point for collective action.

Sources: Chair’s Summit recap; participant workshop boards; adopted Manila Declaration.

Rural health workforce: putting policy into practice

Dr Pascal Zurn, World Health Organization, and Dr Ligia Paina, Johns Hopkins Bloomberg School of Public Health, connected global recommendations with implementation, monitoring and evaluation.

A DISTRIBUTION CHALLENGE

Zurn traced WHO guidance from the first rural retention recommendations in 2010 to broader 2021 guidelines. The challenge is not simply too few health workers: unequal geographical distribution leaves rural and remote communities underserved.

The WHO Global Strategy on Human Resources for Health: Workforce 2030 identifies workforce maldistribution as a barrier to universal health coverage. The 2021 guidelines address development, attraction, recruitment and retention across the professional lifecycle.

17 RECOMMENDATIONS, FOUR DOMAINS

The recommendations address education, regulation, incentives, and personal and professional support. Country experience is needed to show how these policies work in practice.

A GUIDE INFORMED BY EXPERIENCE

Paina described an implementation, monitoring and evaluation guide in development. Its evidence included a scoping review, targeted searches of grey literature and key-informant interviews.

A WHO-convened Technical Expert Group brought together rural practitioners, including Rural WONCA contributors, policymakers and researchers across WHO regions. Draft reviews and insights from current reforms helped connect the guidance to practice.

A short guide, detailed guide and annexes will support different users. At the Summit, final editing, publication, implementation case studies and dissemination remained next steps.

THE PROPOSED IMPLEMENTATION CYCLE

01

Plan and understand

Define the local situation and scope.

02

Design or update

Tailor a combination of interventions.

03

Implement and adjust

Track delivery and changing conditions.

04

Evaluate and learn

Use findings to adapt the response.

Start with the local problem, involve the people affected, and use monitoring to improve the response as conditions change.

Source: Zurn and Paina, Summit presentation, 6 August 2026, slides 2–9 and 12. This account reflects the status reported at the meeting.

From recommendations to accountable implementation

The keynote linked effective rural workforce policy to local analysis, bundled interventions, community ownership and sustained learning.

01 PLAN FOR LOCAL REALITY

Understand local labour-market dynamics. Tailor and bundle interventions, then assess feasibility, acceptability and affordability.

02 BUILD OWNERSHIP

Align national and local stakeholders. Community participation, multisector partnerships and long-term financing support implementation and adjustment.

03 MONITOR AND LEARN

Build monitoring into delivery. Record barriers, enabling factors and unintended effects so programmes can be sustained, adapted or expanded.

THAILAND

Rural recruitment linked to education and service

CPIRD, introduced in 1994, recruits rural students and links training to mandatory rural service. ODO, introduced in 2005, subsidizes education for students from underserved districts.

By 2015, the slides reported 29% retention among CPIRD graduates, compared with 18% through the traditional pathway.

Average rural service was 4.2 years for CPIRD graduates and 3.4 years for the traditional pathway.

Long-term monitoring and evaluation were embedded from the start and supported decisions about sustaining, adapting and expanding the reforms.

GHANA

Management capacity and community participation

The Global Health Workforce Program focused on three hard-to-reach districts in the Eastern Region, where turnover was rising and vacancy rates were approximately 30-50%.

A mixed-methods evaluation reported health-worker satisfaction increasing from 46% to 80%, with greater willingness to remain in post.

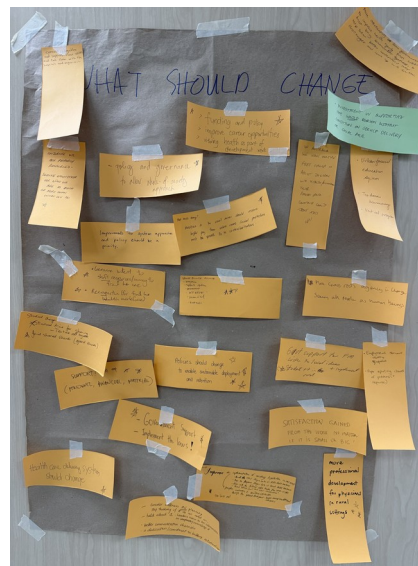
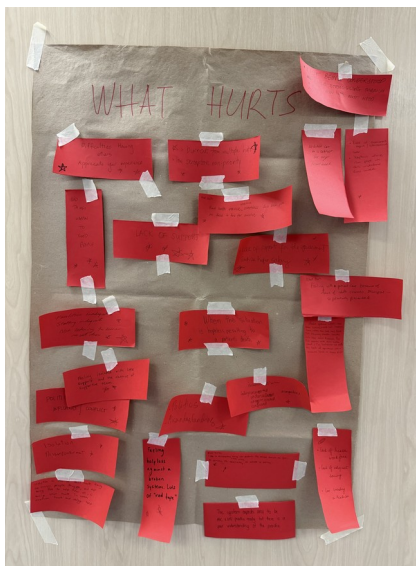
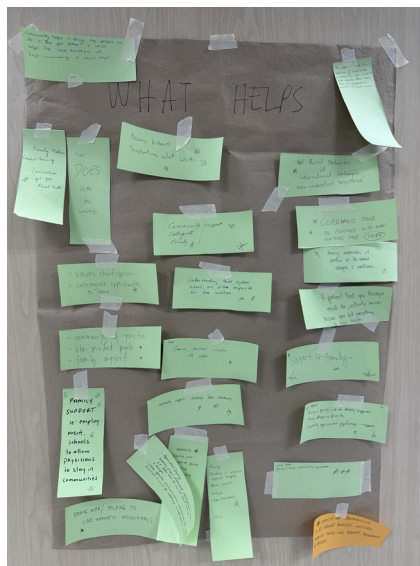
The low-cost package strengthened district management, Community Health Management Committees and facility conditions. The presentation also reported stronger collaboration between communities and health-system actors.

Figures are reproduced as reported in the keynote slides.

Source: Zurn and Paina, *Progress on the development of Rural Health Workforce Guidance*, Summit presentation, 6 August 2026, slides 9-12.

What helps. What hurts. What should change.

The workshop boards captured the human experience behind workforce policy. The observations below retain participants' emphasis on support, safety and the ability to shape change.



Original participant boards. Selected legible observations are transcribed or summarized below; this is not a vote count or a ranked analysis.

SUPPORT IS RELATIONAL

The “What helps” board named family support, community appreciation and communities of practice. Participants valued colleagues who understand their experience and opportunities to learn. One note read: “Being heard. Supporting what works.” Family employment and schooling were identified as conditions that can help physicians remain.

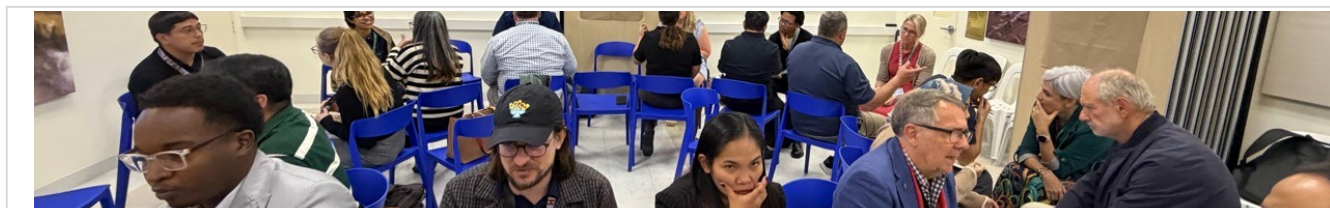
THE COST OF UNSUPPORTED SERVICE

The “What hurts” board described burnout from carrying multiple roles, isolation, inadequate support and feeling unable to overcome system barriers. Participants also named the distress of preventable loss when skills, resources or transport were insufficient.

CHANGE THE CONDITIONS OF PRACTICE

The “What should change” board called for funding, career opportunities, professional development and policies that enable sustainable deployment and retention. Notes challenged urban-focused education and top-down bureaucracy, asking for grassroots agency and investment in the whole person.

These concerns sit alongside the Declaration’s calls for supportive training, rural proofing, safe and dignified service, family support and protected primary-care funding.



The Manila Declaration on Rural Health Equity

ADOPTED AT THE GLOBAL RURAL HEALTH SUMMIT • MANILA • 6 AUGUST 2026

OUR SHARED VISION

We gather in Manila, Philippines—an archipelago whose isolated and disadvantaged areas mirror the profound challenges and extraordinary resilience of rural health systems worldwide. We represent rural health practitioners, educators, indigenous leaders, and policymakers from across the globe.

For too long, the unique needs of rural, remote, and Indigenous communities have been met with a one-size-fits-all approach. Modern healthcare has mistakenly equated "sameness" with equality, leaving these populations to bear a disproportionate burden of preventable illness and mortality. We see how urban-centric health professions education pulls talent away from the communities that need them most, leaving trainees ill-prepared for the realities of low-resource environments.

We affirm that growing and retaining a health workforce in rural areas is fundamentally a human issue, deeply intertwined with how and where we educate, train, and support our workforce. We know that true crisis preparedness relies more on local people who know their communities. Health workers are the first, and often the only, line of defence.

Therefore, we declare our unwavering commitment to five essential areas of action to finally achieve global rural health equity.

01

INVEST IN TRAINING WHERE IT MATTERS

Effective healthcare is context-dependent, and education must engage and occur within the community. We must move away from the urban-centric bias that starves rural communities of vital health workforce. We call on governments and health authorities to adopt policies and allocate an equitable proportion of health education resources directly to rural, community-based training and primary health care. By championing practice-based and distributed training, we can transform health facilities into primary learning environments, allowing clinicians to train exactly where they are needed without abandoning their posts.

Furthermore, we must actively eradicate the high-stress, colonized "education by humiliation" culture and unreasonable work hours, replacing them with supportive environments that build clinical, emotional, and psychological resilience.

Cultural safety and local preparedness

02

Honor Culturally Safe and Indigenous-Led Health Care

Sustainable rural health is impossible without actively decolonizing our health systems and empowering Indigenous and tribal health workers. We must grant Indigenous community health workers formal national registration and protected professional titles, giving them the regulatory security they deserve.

Recruitment must change, too: instead of top-down job postings, we must grow and nurture our workforce organically from within existing local networks—like women’s self-help groups and artisan circles—to build deep, lasting community trust. We strongly support paradigms like the Two Row Wampum model, which allows Western medicine and traditional Indigenous healing to operate side-by-side with mutual respect. Finally, rigorous cultural safety and anti-racism standards must become a legal mandate across all health professions education institutions and licensing bodies.

03

Master the “Rural Golden Hour” and Disaster Readiness

In disaster-prone, resource-limited environments, centralized emergency management often falls short. Preparedness must be local, practical, and heavily rehearsed. We urge rural health facilities, with support from national governing bodies and other disciplines, to prioritize routine, low-cost tabletop exercises to stress-test their communication and command structures. Knowing what to do locally saves far more lives than a theoretical plan sitting on a desk in the city.

Clinical training must focus on the “Rural Golden Hour”—teaching providers to recognize, stabilize, and treat emergencies using only the limited resources at hand, empowering them to act decisively when roads and power grids fail. During these crises, central authorities must trust local rural health leaders to make rapid, context-specific decisions without bureaucratic red tape.



Participants at the Global Rural Health Summit in Manila. Photograph supplied by the Summit organizers.

Accountability and digital equity

04

Demand Rural Proofing and Systemic Accountability

Policy designed in the city is prone to failure in the country. We must challenge the negative narratives surrounding rural practice and hold health systems accountable for the environments they create.

Moving forward, every national health policy, educational curriculum, and workforce plan must be explicitly "rural-proofed" and co-designed by the people actually living in these realities.

We must also recognize that severe burnout and family isolation drive practitioners away; workplace well-being, including the right to safe and dignified service, security from harassment, succession planning, and support for practitioners' families must be fiercely protected.

Ultimately, health ministries must be held accountable for rural health inequities, and funding for rural primary care must be shielded from political volatility.

05

Secure Digital Rights and Technological Equity

As digital health expands, technology must bridge the rural divide, not widen it. High-speed internet is no longer a luxury; it is fundamental health infrastructure. Governments must guarantee reliable, affordable connectivity for geographically isolated and disadvantaged areas so rural providers can access telehealth, electronic records, and distance learning.

Technological innovations must be tailored for rural communities—capable of functioning offline or in low-bandwidth settings, and developed alongside rural end-users, with safeguards for privacy and data security. Above all, no rural practitioner should have to abandon their community-embedded training or specialty advancement simply because they lack digital access. Health systems must step up and ensure access to this vital technological link.

OUR PLEDGE

We, the participants, commit to translating these words into tangible action. We will leverage our global networks to implement these principles across our nations, institutions, and communities, ensuring that no rural community is left behind.



READ + SHARE

Turning commitments into sustained action

Rural WONCA, the Rural WONCA Institute of Learning and GRACE will provide networks through which the work can continue with rural communities and partners.

The priorities below translate the Declaration into a practical follow-up framework.

01	Rural education	Support training in community settings and rural facilities. <i>Suggested evidence: Training opportunities, supervision access and continuity of local service.</i>
02	Indigenous leadership	Develop workforce pathways with Indigenous communities and recognize their health workers. <i>Suggested evidence: Community leadership, cultural-safety standards and career progression.</i>
03	Emergency readiness	Use local tabletop exercises and review communication, command and stabilization capability. <i>Suggested evidence: Exercise debriefs, agreed improvements and follow-through.</i>
04	Accountable systems	Review policies for rural impact and protect safe work, family support and primary-care funding. <i>Suggested evidence: Rural participation in decisions and documented responses to workforce concerns.</i>
05	Digital equity	Improve affordable connectivity and services that work in low-bandwidth settings. <i>Suggested evidence: Access to telehealth and learning, usability, privacy and service reliability.</i>

KEEPING THE CONVERSATION OPEN

Planned publication pathways include the Declaration, learning on socially accountable rural training, and rural innovation examples.

FUTURE GATHERINGS

2027 Global Rural Health Summit — details to be announced.

2028 Calgary, Canada — 22nd WONCA World Rural Health Conference.

Sources: adopted Declaration; Chair's recap; Summit programme.

Sources, credits and access

ABOUT THIS EDITION

Global Rural Health Summit 2026 Final Report Bridging the Distance: Local Realities, Global Equity

Issued by Rural WONCA
WONCA Working Party on Rural Practice
Publication edition: October 2026

Prepared with materials supplied by Dr Pratyush Kumar, Chair, Rural WONCA. This edition includes the full adopted Manila Declaration, whose pledge opens with “We, the participants”.

SUGGESTED CITATION

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PHOTOGRAPHY AND IDENTITY

Summit photographs and webinar materials were supplied by the organizers. Organizational logos identify credited hosts and partners. Photographs are captioned by activity; people are not individually identified unless supported by the supplied record.

SOURCE RECORD

1. The Manila Declaration on Rural Health Equity. Full text supplied by the Chair and confirmed as the final adopted Declaration.
2. Chair’s Summit recap and GRHS executive overview supplied by Dr Pratyush Kumar.
3. Organizer-supplied summaries of the three pre-Summit webinars, with speaker names cross-checked against the supplied official posters.
4. Zurn P, Paina L. “Progress on the development of Rural Health Workforce Guidance.” Presentation, Global Rural Health Summit, Manila, 6 August 2026. Slides and speaker notes supplied by the organizers.
5. Photographs of participant workshop boards: “What helps”, “What hurts” and “What should change”.
6. TUFH 2026 Summit webpage: event details, content leads, partner organizations and planned publication pathways.



READ AND SHARE THIS REPORT

www.ruralwonca.org/maniladeclaration
Summit programme and webinar archive

Webinar recording links and QR codes appear on pages 4–6.



Connect. Collaborate. Host the next conversation.

Help carry the Manila commitments into education, practice and policy. Rural WONCA welcomes participation across professions, career stages and regions.

JOIN RURAL WONCA

Membership is free. Connect with rural health professionals, educators, researchers and advocates worldwide.

[OPEN MEMBERSHIP FORM](#)



EXPRESS INTEREST IN GRACE

Global Rural Health Action Collaboration Excellence brings partners together around shared rural health priorities.

[OPEN INTEREST FORM](#)



HOST A FUTURE GLOBAL GATHERING

Would you like to host the next Global Rural Health Summit or a future WONCA World Rural Health Conference? Send an expression of interest to Rural WONCA.

rural@wonca.com



THE MANILA DECLARATION AND REPORT

Keep the shared commitments accessible to your community and institution.

www.ruralwonca.org/maniladeclaration

www.ruralwonca.org

Thank you for making Manila possible



Connections beyond the formal sessions were part of the Manila gathering.

Thank you to every organization and individual who contributed their experience, time and support to the Global Rural Health Summit 2026.

CONVENING AND LOCAL COLLABORATION

Rural WONCA

The Network: Towards Unity for Health
University of the Philippines Manila

RURAL HEALTH PARTNERS

National Center for Rural Health Professions
Rural Coordination Centre of British Columbia
RDN – The Charity for Health Access

WEBINAR AND KNOWLEDGE CONTRIBUTORS

Philippine Society of Public Health Physicians
Alliance for Improving Health Outcomes
Foundation for Family Medicine Educators
Remote Vocational Training Scheme
Philippine Academy of Family Physicians

Indigenous health leaders, World Health Organization contributors, and the speakers and facilitators who shared their expertise across the webinar series and Summit.

Our thanks to the moderators, presenters, organizing and scientific programme contributors, participants and rural communities whose experience shaped the meeting and its Declaration.



The meeting in Manila has concluded, but the real measure of success will be the positive change and lasting legacy we create together afterwards.

DR PRATYUSH KUMAR / CHAIR, RURAL WONCA