17th World Rural Health Conference
Conference Declaration
Bangladesh 2021

The 17th World Rural Health Conference hosted, in rural Bangladesh, at the Brahmanbaria Medical College (BMC) by *Primary Care and Rural Health Bangladesh,* and joined internationally through a virtual conference over four months, has considered how best to ensure that high quality health care is delivered to the almost half the world's population that live in rural and remote areas. The conference was addressed by experts in rural health from all regions of the world.

The conference heard of the substantial progress of rural health in Bangladesh. We congratulate the government of Bangladesh for tremendous improvement of rural health care by establishing community clinics for every 6000 people throughout Bangladesh. We also note that this and other measures have improved life expectancy and decreased maternal and infant mortality, and narrowed the urban/rural gap. We acknowledge these achievements make Bangladesh an exemplar in LMIC and demonstrate that country's commitment to ensure health care of all people. (1)

But there is more to do to build on this in Bangladesh and Worldwide. During this conference we have clarified the key practical elements that can provide short- and long-term change that will bring better services to rural people. We commit ourselves to these through a:

Blueprint for Rural Health

This **Blueprint for Rural Health** is designed to inform rural communities, academics, and policy makers about how to reach the goal of delivering high quality health care in rural and remote areas most effectively.

Introduction

All Rural communities, and the people who live in them, need to ensure through electoral processes, advocacy and local action, that their voices are heard, and expressly and directly actioned through proactive partnerships with policy makers, health professionals, academic institutions, and health managers.(2)

Rural Healthcare needs

Primary Health Care (PHC) in rural areas should have the characteristics of being both primary in terms of including all *first contact care*, and *comprehensive, local, grounded, and proactive* in addressing the health needs of rural communities.

Rural Primary Health care should address all basic healthcare needs, including community care, family practice/general practice, emergency care, preventative care, and public health, and should provide timely access to maternity, surgical, sexual and reproductive, family violence and mental health services. It should be delivered as close as possible to the people thereby ensuring equitable access for all. Rural services must provide first contact care and have suitable equipment for immediate care including diagnostic imaging and point of care pathology. Preventive health including health promotion, rehabilitative, vaccination, and palliative services should also be included in package of care available at the local primary care level.

Rural PHC should, wherever possible, be enabled and enhanced by, but not substituted by, technology because it cannot fully substitute for emergency and procedural services, it has limited diagnostic capabilities and is not necessarily integrated into the local rural context (such as local referral and retrieval pathways).

Universal Health Care (UHC) is not possible without access to care. It should ensure that resources are not only available but can be accessed conveniently by all rural people irrespective of their background, gender, and financial situation. Emphasis should be placed on engaging with, and understanding the needs and health beliefs of, historically marginalized populations, including indigenous peoples, and respectfully informing them about their health, rights, and responsibilities. Local health services should be affordable to all.

Primary Health Care in rural areas should be predicated on fit-for-purpose community infrastructure. Education, employment, housing, clean water, sanitation, and sustainable energy are essential to this. Communities should be enabled and resourced to identify and address, and indeed solve, their local health care challenges.

Developing a rural workforce – selection, training. and support

Rural health workforce must be systematically supported and planned, and have clear *rural health pathways(3),* often termed a *rural health pipeline*. Like a pipeline it is important that the are no blockages within, nor leaks from, any of the pipeline elements. A comprehensive, complete, and place-based policy framework is required. Rural WONCA working with the WHO has developed 8 actions required in implementing rural pathways (4)

The key elements to this comprehensive approach are:

Rural health workforce should as much as possible be derived from the local areas that it serves ("grow your own"). It should allow "stepladder" progression of skills attainment and certification. Local health workers must be recognised as teachers by academic institutions utilizing their services for their academic mission, respected for their contextualised knowledge, and supported to develop further their experience and expertise in teaching and stimulating learning.

The community needs to be understood, and the capability of local health workers, and their scope of work established, to identify service gaps or sustainability issues that rural training and development

pathways can support.

School students in rural areas should be actively exposed to, selected for, and educated in, and for, health science careers, understanding that students at all stages cannot aspire to a career that is not visible to them. "You cannot be what you cannot see."

The proportion of students with rural backgrounds in health science courses should at least equal the rural/urban ratio of the society. Students in rural areas should be provided with access to preparatory courses that enable students to enter health science courses well prepared. Students in health science courses should also have rural immersion that reflects the significance and importance of rural areas. All students in health science courses should have repeated and/or longitudinal immersion and learning in rural areas, in at least the same proportion to population, to ensure familiarity and comfort with the rural environment.

They should be enabled, sensitised, and expected to provide culturally safe and competent care, both as students and future practitioners. This should involve considering the various determinants that effect well-being and health including culture, education, environment and equitable development.

Prolonged and repeated immersion in rural settings also increases their chance of finding a life partner with similar, rural interests and this contributes significantly to rural recruitment and retention providing that the partners also have a meaningful life and work in the rural environment. Rural health careers should also be promoted especially to young doctors as a rewarding career where individual clinicians can really make a difference.

Educational institutions have a social obligation to respond better to the health priorities for the benefit of every citizen living in the area they are supposed to serve. They must therefore orient their training, research, and service provision to privilege the underserved population living in rural and remote areas(5) Academic assessment must include examination in and about the rural context. It has been shown that this learning in rural environments provides a rich, patient-centred and practical learning environment upon which academic learning can be scaffolded. Rural clinical learning is made more possible now with on-line resources and instruction. It more closely reflects the modern clinical environment with a constant connection to and integration of online learning and resources. Extensive research now confirms that rural clinical education delivers at least equal academic outcomes to urban based coursework and a work-ready workforce.

Rural coursework should ensure community engagement in health improvement initiatives and research guided by communities that foster and enhance rural services. Local research must be action based, involve academic institutions, proactively assist in health service improvement, and should be guided by the community and its needs. Local communities should be provided with meaningful and local data and data analysis that allows benchmarking and facilitates action by local community and health professionals. For rural communities, there should be “nothing about us, without us”.

Regional teaching hubs should enhance but not replace the immersive rural experience and learning in smaller, distributed communities.

Rural training at the undergraduate, graduate, and postgraduate levels should be based on curricula that include rural context and include specific curricula for effective rural practice. (e.g. Australian College of Rural and Remote Medicine curriculum(6))

In Family Medicine, training should be aimed at producing Rural Generalist (7) family doctors who provide comprehensive, whole-person and continuous care in rural areas This is supported by similar initiatives in rural midwifery and nursing(8), and allied health professions and is applicable in other health professions.

Policy and advocacy

Rural health services should be staffed by generalist/ extensivist staff in all health professions, each working at full scope of their capabilities in teams. The scope of health professionals can be expanded and enhanced by technology including telehealth, but trained health professionals are needed locally.

Policy for rural health should include input from and decisions by rural communities and rural organisations. Rural professional organisations should be encouraged and supported, and should participate in decision making as key informants about rural health. They should be equal partners in this process. Government policies should be assessed in terms of their impact on rural communities ("rural proofed") to mitigate any deleterious effects of these in rural areas. Government should strengthen coordination among various departments and work towards developing a unified policy to promote rural health. Government policy should promote rural resilience, be responsive, reassuring, and responsible - both clinically and fiscally. It is necessary to evaluate the effect of these policies continuously.

The investment in rural health should ensure a healthy local workforce, short supply chains, a business multiplier effect on local opportunities, opportunities for economic development and opportunities for individual progression and improved opportunities for women in the workforce. (9) They should ensure a sufficient health safety net that enable people to feel confident and safe in rural areas. Private and public health providers should be encouraged to share facilities, resources, and staff. (10) The ageing population in rural areas means both an increase in health care workload and an opportunity to retain and employ a younger workforce to provide this care.

Developing versatile resilient teams by allowing for part time and flexible working patterns, which can particularly benefit healthcare workers with young families or portfolio careers, would enable greater participation. This could be supported further by developing a wider regional team through collaboration particularly in specialist interest areas and continuing professional education.

While not a solution in themselves, payment incentives do make a difference to recruitment. (11-13). Good management which understands and supports the health needs and services at a local level are vitally important. Working conditions, lifestyle and other non-monetary factors can have a multiplier effect, good or bad, on existing monetary incentives(14).

Successful recruitment requires inter-sectoral investment in training and career promotion, creating a desirable workplace and first creating and then incentivizing a pool of workers to make a longer-term commitment to a rural area(15) . These factors are all vital in attracting and retaining young doctors to rural areas.

Challenges

COVID-19

The COVID-19 pandemic has shown the importance of local resources and self-sufficiency during a crisis and provides the rationale for major investment in local rural health service capacity. It has also shown that information communication technology (ICT) can effectively enhance rural health care, education and training, and rural health service delivery.

Climate Change

The changing climate will put further challenges on rural areas - especially arid and coastal zones - making these less habitable or uninhabitable. It will also bring new diseases to some rural areas. These issues must be addressed.

Conclusion

Rural Wonca and the participants in this conference commit to actively adopting these principles and actions and calls on the World Health Organisation (WHO), Governments, Policy makers, Academic institutions and indeed communities in all countries around the world, to honour their commitment to their rural populations by providing fair and targeted health resources and opportunities for their rural people.

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