

Rural Training Pathways and Pipelines

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Rural Health

**The Wonca Working
Party on Rural Practice**

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Pathway



Rural service



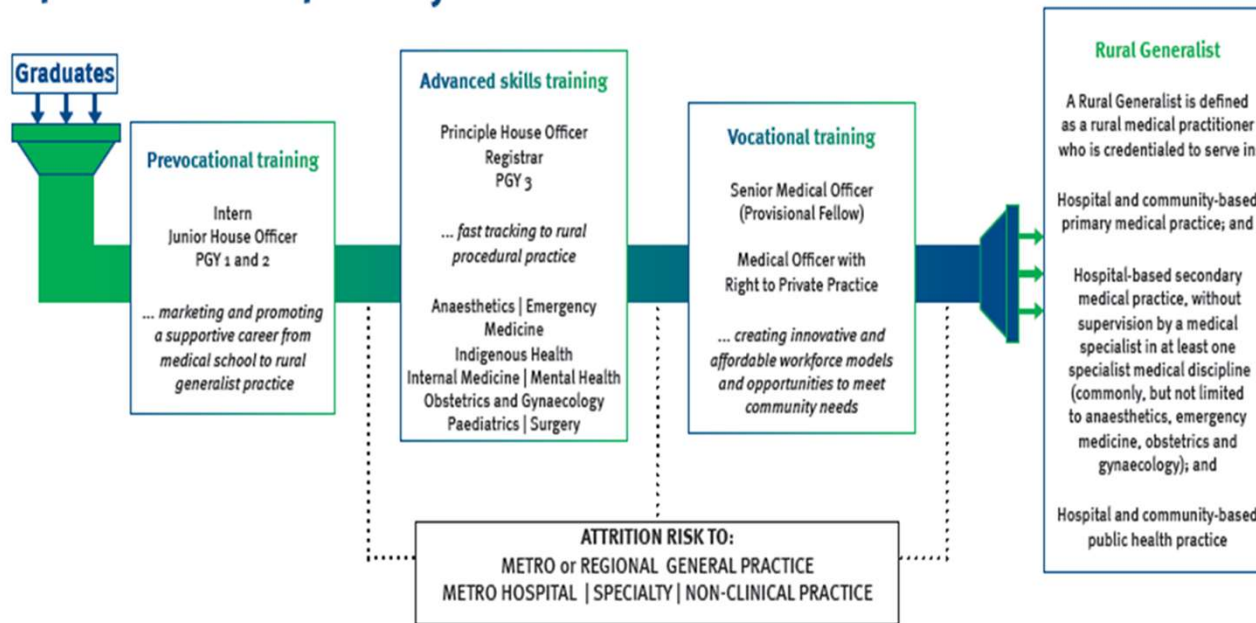
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Operation of the pathway



Stream



Rural service

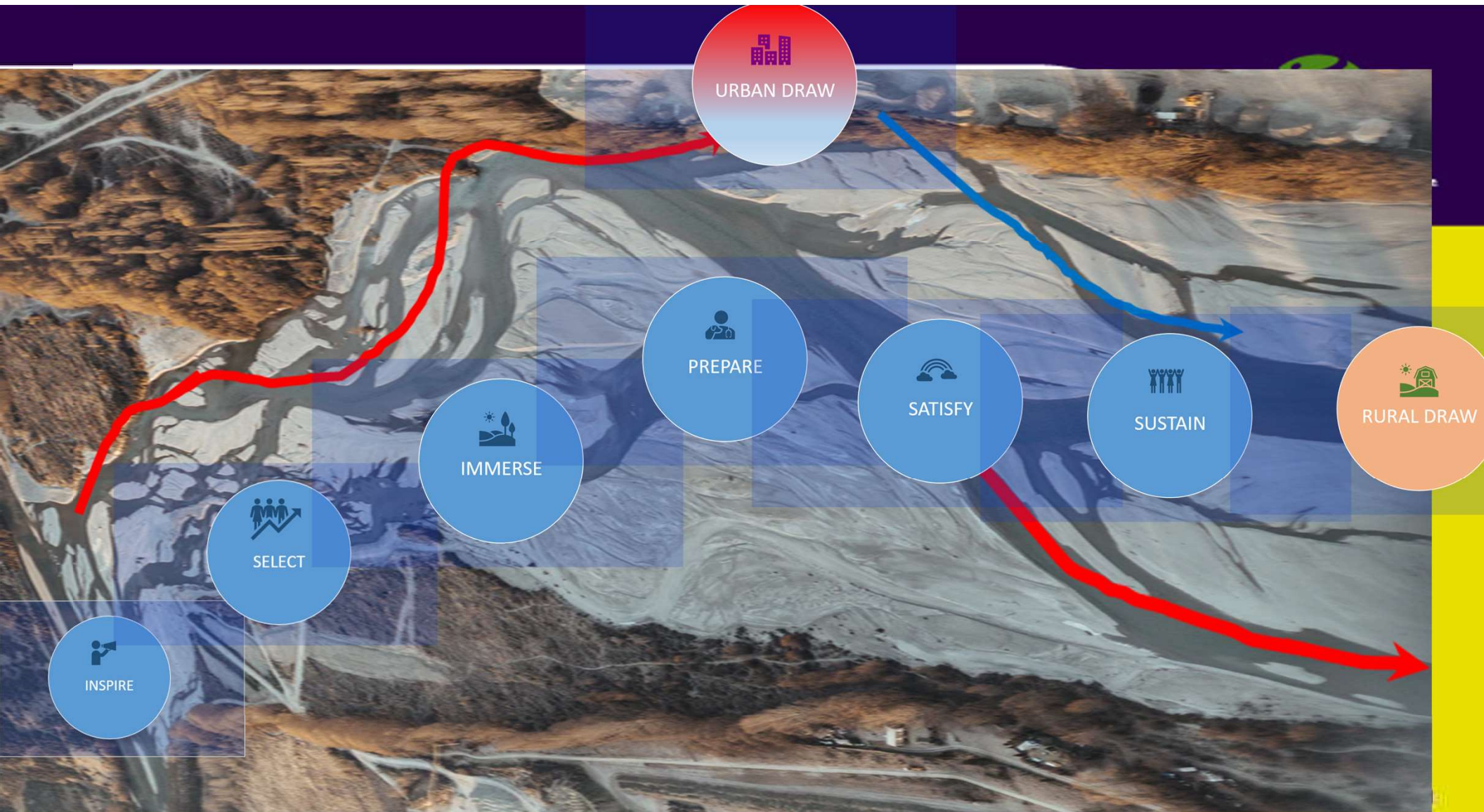


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INSPIRE

Inspiration to rural

Lower education level but just as smart

Grow your own

Rural comfort

Need to open their eyes to
role models
quality practice

Inspire

Exposure

Mentoring and “shading while they grow”

Show how to get there

Community support e.g. Jichi

Apprenticeships

Stepladder e.g. Zamboanga



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SELECT

Selecting the right people

Selection by area

Selection by preference

Selection by rural background

Section by rural experience

Rural more important than type of
experience

Selection by intent

Selection by community

Stepladder

Bridging training

Lateral entry



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IMMERSE

Students

Immerse in the rural context

Education in the area

Support students in rural

Contextualise curriculum

Value local expertise

Education in rural at the front line

The frontline are the teachers

- support them
- value them
- pay them

Role models

Longitudinal placements

Repeated placements for “convertibles”

Build attachment to and identity with community and their needs



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PREPARE

Doctors, nurses, community and other workers

Preparation in rural for rural

Generalist – broad but also tailored

Full scope - Primary and secondary care, public health, curative

Recognition and qualification

- Family medicine
- Full scope family medicine including secondary (“Rural Generalist”)

Prepare but not for too long (esp. in highly specialised settings)

Team training especially with local team

Vertical integration

End the training in rural

Tailor the training to the desired location

Allow lateral entry and stepladder

Include and guide telehealth implementation

Prepare for lifelong learning



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SATISFY

Satisfying life

- Desirable community
 - Engaged
 - Social contract

“Health worker looks after community, community looks after health worker”
- Accommodation including the little things
- Spouse support
 - Employment
 - Satisfaction
- Education for children
- Allow part-time work/ liveable rosters
- Cultural competence
 - Both ways
- Remuneration
- Recognition and valued
- Safety
- Sanitation



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Satisfying work

Desirable workplace

- “Can do” culture
- Hospitals that work
- Primary care that works
- Teamwork with support and backup
- Integration – can be a great strength in rural
- Rosters
- Never alone
 - Need 2FTE to make one health worker or burnout
- Support like city
 - They are the teacher
 - Support staff e.g. Intern
 - Point of care technology
 - IT
- Local upskilling
 - In context
 - In teams



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SUSTAIN

Keeping it alive

Infrastructure
Quality
Workforce

Being a teacher helps
Teamwork helps
Engaged community helps

Respond to community needs
Practically address community needs
Identify community opportunities

Financial viability
Develop services to assist in community viability



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URBAN DRAW

City Draw



- Remuneration
- Facilities
- Support
- Status
- Opportunity
- Flow back to "home country"
- Partner origin
- Role models
- FOMO – fear of missing out



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RURAL DRAW

Advantaging rural

From the country, return to country (more that those for elsewhere)

Community engagement

Need active intervention

Need role models

Needs case managers e.g. Vocational Indicative Planning

The efficiency and effectiveness advantage comes if

- Integration
- Continuity
- Generalism – breadth
- Full scope – depth
- Enabled and valued practice
- Transferable skills
- Credentialable skills



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Increasing access to health workers in remote and rural areas through improved retention

A Checklist – implementing rural pathways to train and support health workers in low and middle income countries

Checklist actions



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making it work

Work for Remote Rural
Force Stability

Overview



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