



Gramado Statement



on Rural Health in Developing Countries - April, 2014

We, gathered here at the XII WONCA World Conference on Rural Health, in Gramado, Brazil, declare the following reflections and recommendations on rural health, with particular reference to developing countries.

Health Systems for Better Rural Health

- Rural Health cannot be considered independently from the development of the country's health system as a whole.
- The rural populations of developing countries deserve a rational and efficient use of the resources available for health care in order to optimize health outcomes and service satisfaction – strong primary care can achieve this. Therefore, rural health improvements must be linked to policies supporting a strong Primary Care system (Starfield, 1998).
- Universal health coverage with equity in health systems must be a global priority (WHO, 1978; Quito Declaration, 2014) - this must apply as equitably to rural and remote populations as for urban.
- Health policies must aim to provide comprehensive longitudinal and integrated care.
- Community centered care with cultural competence must underpin the principles for all health system policies.
- Rural health units and hospitals must be adequately linked in a continually evaluated health network and that network must be linked to specialized services through communications, regulation and transport.
- Community engagement in all levels of decision making must be encouraged for all health systems.
- Rural proofing involves 'thinking rural', consulting with rural communities, exploring rural evidence and developing rural solutions (Swindlehurst HF, et al., 2005). The solutions must be acted upon, and regularly reviewed and monitored in response to changing circumstances. The rural proofing process is person and family-centered and seen through the lens of rural contextual knowledge. It is the aim of the WONCA Working Party in Rural Practice (WWPRP) that rural proofing should be a routine aspect of policy development and implementation. The WWPRP aims to develop a guide to the development of local tools which it will launch at the 2015 13th WONCA World Rural Health Conference.
- Strategies for continuing professional development should involve training and remote support (including the use of technology) for learning and clinical skills development. Existing successful programs and good practice should be disseminated globally. Each community will have different learning needs dependent on local context, remoteness and national health systems.
- It is necessary to educate and empower health managers to adopt responsible policies aimed at the culturally appropriate use of best available evidence.
- The nature, context and needs of rural communities and rural practice will differ around the world. Local solutions will require local research and local initiatives. However, the excessive pursuit of very strict definitions of "rural" may not help when developing and implementing policies that actually impact upon the health of these populations. Intermediate categories generated by the concept of

“rururban¹” (Freire, 1982) are fundamental in stimulating the exchange of knowledge about rural medicine in light of the complex nature of the changing contemporary social environment.

- The establishment of a healthy health system, which specifically includes concern for the health of rural populations, implies establishing effective cooperation between communities, educational and research institutions, health services and management.

We recognize and value the work done previously at Rural Forums in Cartagena, Santa Fe and Montevideo as important for rural health development in Latin America.

Human Resources for Rural Health

- The shortage of suitably trained human resources for health is significantly greater in developing countries. Interventions must be based on evidence based research taking into consideration WHO and similar guidance (WHO,2010). Low and middle income countries continue to experience significant loss of local educated health care professions who migrate to richer economies. The conference reiterates the adherence to ethical international recruitment codes such as the Melbourne Manifesto (WWPRP, 2002)

- The development of a specialist (post-graduate trained) Family Medicine generalist is the key professional within a strong primary care structure in any health system. Governments and health policy makers must ensure that high priority policies are put in place in order to optimize rural health throughout the world. Developing countries will often require time and resources to enable this process, but in middle-to-long term it is cost effective (Starfield, 1998).

- Family medicine residency programs in rural settings are the gold-standard strategies to achieve this goal. Policies to increase the number of posts, decentralization of the settings for these posts, and strategies to guarantee an adequate time and quality of training are key to any residency program.

- In developing countries temporary measures may be put in place to increase the number of physicians providing care in rural areas. These short term measures must not compete with residency programs or replace the need to fully trained family physicians. All rural residents must eventually have the right to a residency trained family doctor.

- Rural training programs need to have a broader scope. Family medicine programs must include a rural placement lasting for at least one year. The rural curriculum must be tailored to specific and local. Those working in more isolated and remote communities will need further additional procedural and specialist training linked to local requirements, which may include surgery, obstetrics, emergency care, pediatrics, etc. Migration policies, rural compulsory service and recruitment to temporary rural posts have limited impact and without robust evidence based retention strategies.

Decentralization of rural training, policies to stimulate recruitment of students from rural areas, enhancement of the quality of work, life and remuneration, and professional career programs must be part of multifactorial policies for retention.

- Rural health workers living and working in rural areas must be valued and their needs and views must always be considered in the development of new policies.

- Migration of international professionals must always respect national legislation and international recommendations.

¹ From Rural/Urban = Rururban. “The process of social and economic development combines, in terms of form and content, a unique regional and national experiences (rururban). It represents a rejection of absolute urbanization and at the same time, the idealization of peasants living in rural archaically space.”(Freire, 1982, p.). Veiga also uses it to discuss the complexity of the decisions to define what is rural and urban in Brazilian legislation, since almost 15% of national population cannot easily fit rural or urban categories. (VEIGA, J. E. Cidades imaginárias: o Brasil é menos urbano do que se calcula. Campinas: Autores Associados, 2002)

- The clinical exposure of students must include all possible scenarios of professional practice, including rural and 'rururban', and be extended in time if possible. Skills training should be targeted to local needs. The basic competencies (knowledge, skills and attitudes) of rural family medicine should be part of undergraduate training, and all students should have some familiarity with the differences between rural and urban settings. Clinical teaching units in rural areas are the optimal setting for rural health training and education.

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