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Making context curricular in global health education: a ten-cohort content analysis of learner-defined health priorities and responses

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Abstract

Background

Global health curricula may underuse the contextual expertise international students bring from their home countries. We examined health priorities and feasible responses selected after shared foundational teaching and cross-country comparison, and considered how learner-generated contextual knowledge can function as curricular content.

Methods

We retrospectively analysed 302 reflective reports from ten annual cohorts (2013–2022) in a compulsory first-year International Health course in Taiwan. Before the reflective task, students received foundational teaching in population health, disease burden, social determinants and equity, health systems and financing, major disease domains, environmental health, and evidence-informed priority setting, followed by country presentations and peer comparison. Each report identified one home-country priority and feasible response. Two coders independent of course delivery coded all reports using an iteratively developed codebook. Pre-consensus Cohen's kappa was 0.86 for specific topics, 0.91 for priority categories and 0.85 for intervention orientations. Consensus codes were summarised; regional comparisons used chi-square tests and Cramer's V with restricted-cohort sensitivity analyses.

Results

Students often selected diabetes, cancer, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), ischaemic heart disease and health-workforce shortage. Leading categories were metabolic/endocrine (n = 76, 25.2%), infectious (n = 68, 22.5%), cardiovascular (n = 36, 11.9%), malignancy (n = 35, 11.6%) and mental health (n = 17, 5.6%). Proposed responses emphasised public education/awareness (n = 136, 45.0%), medical/service measures (n = 62, 20.5%), policy/legislation (n = 60, 19.9%) and resources/financing (n = 44, 14.6%). Regional patterns differed for priorities (chi-square(10) = 56.87, $p < 0.001$; V = 0.31) and responses (chi-square(6) = 38.81, $p < 0.001$; V = 0.25); sensitivity analyses were similar. De-identified excerpts illustrated how learners used context, evidence and feasibility when translating problems into proposed actions.

Conclusions

A shared foundation in population health and health systems, followed by structured cross-country comparison, can create space for learners' home-country knowledge to become curricular content. The findings support a provisional heuristic of elicitation, juxtaposition and translation for context-sensitive

global health education. They represent curricular attention and perceived feasibility, not objective disease burden or causal learning effects.

Background

Global health education is commonly justified by the need to prepare health professionals to work across borders, systems and cultures. Yet the content of ‘global’ curricula is often organised around competencies, diseases and experiences selected by institutions in high-income settings.[1–5] Recent scholarship has challenged this arrangement, arguing that global health professions education is inseparable from questions of power, place, sustainability and social accountability.[6–13] Who defines the problem therefore shapes what counts as legitimate knowledge, which interventions appear feasible and whose expertise is centred. Related work on the foreign gaze, critical consciousness and cultural humility similarly asks educators to examine who observes, who interprets and how power operates.[14–16] Anticolonial education scholarship has made the empirical gap clearer. A 2023 scoping review of 28 publications found that the literature centred North American learners, that every included article involved a high-income-country institution, and that alternative ways of knowing and partners’ experiences received limited emphasis.[17] A realist synthesis of unfair knowledge practices in global health similarly described credibility deficits and interpretive marginalisation when knowledge and sensemaking from the ‘periphery’ are accorded less authority.[18] Recent student studies in the United Kingdom and Nordic countries show that global health classrooms can both challenge and reproduce cognitive injustice, and that learners want more culturally relevant curricula, diverse knowledge systems and greater agency in shaping education.[19, 20]

These critiques have generated practical responses. Curriculum codesign with people who have direct and lived expertise can redistribute ownership of what is taught,[21] while reciprocal international classrooms can make health systems and social accountability tangible through peer comparison.[22, 23] Yet evidence remains dominated by high-income settings, short-term programmes, outbound experiences or small interinstitutional initiatives. Less is known about learners from multiple resource-constrained settings studying together in a third country, with their home-country knowledge systematically elicited as curricular material over repeated cohorts. There is particularly little multi-cohort evidence on how such learners define priorities, compare contexts and translate contextual knowledge into responses they judge feasible. This leaves both an epistemic gap—whose knowledge enters the curriculum—and a pedagogic gap— how that knowledge is elicited, juxtaposed and translated.

The School of Medicine for International Students at I-Shou University in Taiwan offers one such setting. Scholarship-supported students from 18 partner countries complete a compulsory first-year International Health course that combines foundational population-health and health-system knowledge with country-level analysis, peer comparison and individual reflection. This study asked: (1) Which home-country health priorities and responses did students select? (2) How did selections vary across world regions? and (3) What do these patterns suggest for designing socially responsive global health curricula?

Methods

Study design and setting

We conducted a retrospective conventional content analysis of students' reflective reports, followed by quantitative analysis of the resulting categorical data.[24, 25] The setting was the School of Medicine for International Students at I-Shou University, Kaohsiung, Taiwan. Since 2013, the Taiwan International Cooperation and Development Fund has supported eligible students from partner countries to undertake medical training with an expectation that graduates will contribute to their home communities. The analytic dataset contained ten annual cohorts, 2013–2022.

Course design and foundational knowledge

The course was compulsory for all first-year students in the first semester. Across cohorts, its core curriculum established a shared knowledge base before country comparison and the individual reflective task. Foundational teaching addressed: population-health measurement and interpretation of mortality, morbidity, disease burden, service coverage and data quality; culture, behaviour, social determinants and health equity; health-system organisation, financing, access, workforce and sustainability; infectious disease, surveillance and prevention; nutrition, non-communicable diseases and behavioural risk; mental health; injury and violence; environmental health; and the principles of prioritising feasible responses under resource constraints. Students were encouraged to interpret indicators in context rather than rank countries and to consider trade-offs among access, quality, cost, equity, patient choice and implementation feasibility. A detailed mapping of these knowledge domains is provided in Supplementary Table S5 (Additional file 1), and the consolidated course syllabus and implementation guide is provided as Additional file 2.

The consolidated syllabus also organises the recurring curriculum around universal health coverage, public-health preparedness, aging, disability and rehabilitation, maternal-child and reproductive health, migration and vulnerable populations, and comparative health-policy analysis. It is provided as a methodological description of the knowledge domains and learning activities represented across the ten cohorts, not as a claim that weekly sequencing, examples or reading lists were identical in every year.

Following this foundational block, learning proceeded through country analysis, cross-country discussion and individual translation. Students worked in country groups to prepare a State of Health analysis covering geography, population, culture, economy, health-system organisation, morbidity, mortality and strategies addressing major health problems. Presentations made home-country knowledge visible and supported peer and faculty comparison across settings. Each student then submitted an individual reflective report selecting one disease or health-related issue relevant to their home country and proposing a feasible response. We conceptualised this learner-centred sequence as a provisional curriculum-design heuristic: elicitation, juxtaposition and translation. Elicitation surfaced situated home-country knowledge; juxtaposition placed accounts alongside those of peers for comparison and

questioning; and translation required each student to convert contextual reasoning into an explicit priority and feasible response. The heuristic describes the pedagogic sequence embedded in the course rather than a validated causal mechanism.

Data source and content analysis

The source material comprised the complete individual reflective reports. The full report was the context unit. In keeping with the assignment, the student's nominated home-country health issue and proposed feasible response were the principal recording units. Reports were de-identified and assigned study identifiers before coding. We used an inductive, conventional content-analysis approach so that issue and response categories were derived from the reports rather than imposed from a predetermined disease list.[24, 25] The archived reports followed a common assignment structure asking students to identify one serious health issue in their home country, explain why it mattered, propose how it could be improved, describe how the proposed goal could be achieved, and anticipate likely implementation difficulties. Course teaching, student presentations, written reports and coding were all conducted in English.

Two additional authors, who had no role in curriculum development, lecturing or assessment, independently familiarised themselves with the reports, conducted open coding, developed categories and completed abstraction. They first read the complete corpus to understand its range and then independently coded a pilot subset of reports selected to include different cohorts and regions. The coders compared labels and interpretations and developed a codebook containing operational definitions, inclusion and exclusion criteria, hierarchy rules and examples for each code. The codebook was revised iteratively until both coders could apply it consistently. The two primary coders had no role in course delivery or assessment and were blinded to student country and cohort year while coding. Both were clinical educators with more than 10 years of teaching experience and more than 15 years of clinical experience. The codebook specified operational definitions and hierarchy rules for reports containing more than one issue or response, with the student's primary framing and the dominant proposed mechanism of action determining the mutually exclusive final codes. Using the agreed codebook, both coders independently coded all 302 reports. Specific issue codes were compared continuously and abstracted into broader health-priority categories; proposed responses were similarly grouped into intervention orientations. The coders held scheduled calibration meetings to identify coding drift. Disagreements were resolved through discussion and consensus; no case required third-author adjudication. Pre-consensus agreement was assessed for nominal coding using Cohen's kappa: specific health topic, kappa = 0.86; broader priority category, kappa = 0.91; and intervention orientation, kappa = 0.85.

The consensus dataset used for analysis contained 27 specific topics, 14 priority categories and four intervention orientations: public education and awareness; medical treatment and service measures; policy, legislation and taxation; and resources, financing and insurance. An audit trail documenting

codebook revisions and consensus decisions was maintained. Reporting was informed by the Standards for Reporting Qualitative Research (SRQR).[26]

Participants

All 302 records in the archive were included; there were no missing values in the six variables analysed. Students represented 18 countries in the Caribbean and Latin America (n = 151), Africa (n = 89) and the Pacific Islands (n = 62). Country and annual cohort distributions are provided in Supplementary Table S1.

Analysis

We first summarised the consensus-coded specific topics, priority categories and intervention orientations using counts and percentages. To avoid an omnibus table dominated by sparse cells, the primary regional comparison retained the five most frequent priority categories and combined the remaining nine as 'other priorities'. We used Pearson chi-square tests and Cramer's V for effect size. Adjusted standardised residuals with an absolute value of 2 or greater were used descriptively to locate cells contributing to omnibus associations. Intervention orientations were compared in their four original categories. The later cohorts were composed almost entirely of students from the Caribbean and Latin America; therefore, sensitivity analyses repeated both comparisons among the 2013–2018 cohorts, when all three regions were represented in every year. Two-sided p values below 0.05 were considered statistically significant. Analyses were reproduced from the SPSS system file using a verified parser and SciPy 1.17; the outputs were independently checked by a second author.

Ethics and reflexivity

The Institutional Review Board of E-Da Hospital reviewed the study and granted exemption (reference 2026014), approving secondary use of de-identified educational assignments and waiving individual informed consent. The study was conducted in accordance with the Declaration of Helsinki. Student identifiers were removed before coding, the linkage file was stored separately on access-restricted institutional systems, and analyses used only de-identified consensus codes. We treated reflexivity as an ongoing analytic practice. The first author had no educational or assessment relationship with the students; two members of the author team, including the corresponding author, had served as teachers in the programme. The two primary coders were independent of course delivery and grading. Before coding and during consensus meetings, the team considered how relationships to the course, disciplinary backgrounds and assumptions about disease burden, feasibility and region might shape category development and interpretation. Reflexive notes and the audit trail documented these decisions. We therefore interpret students' selections as evidence of curricular attention and perceived feasibility, not as validated national needs assessments.

Use of generative AI in manuscript preparation

Generative AI was used only after the study analyses were completed to support language editing, manuscript organisation and document formatting under human oversight. It was not used to generate or code study data, define analytic categories, resolve coding disagreements, calculate statistics or make substantive interpretations. All AI-assisted text was reviewed by the authors, who take responsibility for the accuracy and final content.

Results

Cohort and topic distribution

The 302 students were distributed across ten cohorts: 35 in 2013, 34 in 2014, 40 in 2015, 39 in 2016, 40 in 2017, 40 in 2018, 17 in 2019, 14 in 2020, 22 in 2021 and 21 in 2022. The largest country groups were Eswatini (n=88), St Lucia (n=58), Belize (n=32) and Solomon Islands (n=28). Across 27 specific topics, the five most frequently selected were diabetes mellitus (n=64, 21.2%), cancer (n=35, 11.6%), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (n=21, 7.0%), ischaemic heart disease (n=17, 5.6%) and health-workforce shortage (n=15, 5.0%). The complete topic distribution is shown in Supplementary Table S2.

The report text added contextual meaning to these categorical patterns. Students linked priorities to cultural norms and institutional power, economic dependency, inequities in diagnostic access and data visibility, locally perceived disease burdens, workforce distribution and experiences of cross-country comparison. One learner described entering the course with low expectations but changing their view after classroom discussion revealed that countries represented by classmates shared both health problems and some response strategies. Another explicitly distinguished the leading cause of death from the condition judged most serious, using rising case numbers and socioeconomic consequences rather than mortality rank alone. Learners also connected course concepts to home-country reasoning: one mapped a taught planning framework onto a familiar health-situation analysis, while another described the course as shifting their thinking away from simply importing university-based knowledge toward understanding a community's political, economic and social context. Proposed actions ranged across education, regulation, intersectoral collaboration and policy, while students also identified communication, language and patient understanding as conditions for feasible implementation. One learner additionally situated their own government-supported medical education within a return-to-practice strategy for addressing a physician shortage, while another considered how redirecting resources toward an emerging non-communicable disease burden could unintentionally weaken progress against HIV/AIDS.

De-identified excerpts illustrating this analytic range are presented in Table 4.

Health-priority categories

Metabolic and endocrine diseases were selected by 76 students (25.2%), infectious diseases by 68 (22.5%), cardiovascular diseases by 36 (11.9%), malignancies by 35 (11.6%) and mental disorders by 17 (5.6%). The remaining categories together accounted for 70 selections (23.2%), including insufficient health-system resources, poverty and inequality, gynaecological and obstetric conditions, intentional injury and violence, environmental health, renal disease, unintentional injury, malnutrition and one other issue (Supplementary Table S3).

Regional variation in priorities

The six-category priority distribution differed across regions (chi-square(10)=56.87, p<0.001; Cramer's V=0.31) (Table 2). Metabolic and endocrine disease was selected by 31.1% of students from the Caribbean and Latin America and 32.3% from the Pacific Islands, compared with 10.1% from Africa. Infectious disease accounted for 32.6% of African selections, versus 17.2% in the Caribbean and Latin America and 21.0% in the Pacific. Cardiovascular disease and malignancy were over-represented in the Caribbean and Latin America, whereas mental disorders were selected by 12.9% of Pacific students and 9.0% of African students but only 0.7% of students from the Caribbean and Latin America. Adjusted residuals supported these contrasts. In the 2013-2018 sensitivity sample (n=228), the regional association remained (chi-square(10)=41.19, p<0.001; V=0.30).

Proposed responses

Public education and awareness was the most common proposed response (n=136, 45.0%), followed by medical treatment and service measures (n=62, 20.5%), policy, legislation and taxation (n=60, 19.9%), and resources, financing and insurance (n=44, 14.6%). Response orientations differed by region (chi-square(6)=38.81, p<0.001; V=0.25) (Table 3). Public education and awareness accounted for 60.9% of proposals from the Caribbean and Latin America, compared with 41.9% from the Pacific and 20.2% from Africa. African students more often proposed medical or service measures (31.5%) and policy or legislation (28.1%). The regional association persisted in the 2013-2018 sensitivity analysis, although it was smaller (chi-square(6)=16.89, p=0.010; V=0.19).

Discussion

Principal findings

Across ten first-year cohorts, students did not converge on a single global health agenda. Their selections reflected a double burden of non-communicable and infectious disease alongside workforce, poverty, violence, environmental and system-resource concerns. Regional differences were moderate for priorities and small-to-moderate for proposed responses, and persisted in the restricted-cohort sensitivity analyses. More importantly for education, the reports showed that learners used contextual

knowledge to decide what counted as a problem, what evidence mattered and what responses seemed feasible.

These selections were made after a common curricular foundation rather than in the absence of formal teaching. Students had encountered shared concepts in epidemiology, social determinants, health systems, disease patterns, evidence interpretation and feasible intervention design before completing the report. The regional contrasts should therefore be read as differences in what learners chose to foreground and how they applied a shared conceptual vocabulary to different settings, not as evidence that particular groups lacked exposure to other health domains. The study did not, however, include pre-course testing or a direct measure of mastery of the foundational content.

From importing content to learner epistemic participation

The central contribution is not a new ranking of disease burden, but an example of how knowledge authority can be redistributed within a global health curriculum.[8-13,27] Global health classrooms may simultaneously resist and reproduce cognitive injustice,[19] while students across Nordic programmes have called for culturally relevant curricula, diverse knowledge systems and greater agency.[20] Curriculum codesign with people holding direct and lived expertise offers one response.[21] Our findings show a complementary mechanism within routine teaching: learners' home-country knowledge did not merely illustrate externally selected content; it helped determine which problems, criteria and responses entered collective consideration.

This mechanism also speaks to unfair knowledge practices described by Abimbola and colleagues, particularly the discounting of peripheral cultural knowledge and local sensemaking. [18] Learner accounts should not displace epidemiological evidence; they can help interrogate how evidence is produced, interpreted and prioritised. In our data, one student distinguished mortality rank from their own priority judgement, while another reasoned that unequal testing could distort official statistics. A learner also described changing their initial view after classroom discussion revealed shared problems across classmates' countries. This converges with the Samoa-New Zealand Global Health Classroom, where peer learning made global health more tangible and prompted new perspectives,[22] and with a four-country online programme in which students valued international perspectives and reported greater reflexivity.[23] Our study adds scale and continuity—302 learners across ten cohorts—and examines the priorities and responses such comparison generated. Figure 1 summarises this provisional design heuristic.

Interpreting regional patterns

The regional patterns should not be read as cultural traits. The contrast between infectious disease, non-communicable disease, mental health and system concerns instead demonstrates plurality within the broad category of low- and middle-income countries. A preference for education, clinical measures,

policy or resources may reflect disease causation, institutional reach, prior public-health campaigns, financing arrangements or what a first-year student sees as actionable. These categories are prompts for dialogue, not labels for regions.

Curriculum implications

Three curriculum implications follow. First, courses can begin with learner-generated, locally accountable questions rather than appending ‘local context’ to a universal syllabus. Second, structured comparison should make power and positionality explicit. Third, responses should be mapped across educational, clinical, financial and policy levels to support systems thinking. Within this course, priority setting was therefore taught as a transparent, context-sensitive judgement that considers local evidence, equity, health-system capacity, feasibility, affordability, stakeholder perspectives and implementation conditions rather than a single universal ranking of priorities. A 2025 scoping review of 219 social-accountability education studies found reflection, small-group learning and didactic teaching were common, but 82% of publications came from North America and called for more deliberate, longitudinal, context-sensitive integration [28]. Hershberger et al. likewise found that 200 medical students perceived weak alignment between curricular emphasis and regional health priorities [29]. Learner-perceived home priorities are not equivalent to community-defined need; future iterations should therefore add validation by home-country practitioners and communities.

Relationship to reflective learning

The reports contained examples of self-reported perspective change, but these should not be interpreted as demonstrated transformation. Reflection is an established approach in health professions education, [30,31] while much directly comparable global health work has centred outbound experiences and the ethical responsibilities they create.[32,33] Miller et al. analysed reflective journals from 52 US medical students in international placements and identified cultural humility, resilience and realignment of professional motivations.[34] Our configuration differs: internationally diverse students analysed their own home systems while studying together in a third country. Structured comparison may therefore support reflection without outbound placement, but repeated reflections, interviews and follow-up after return to practice are needed to establish change over time.

Strengths and limitations

Strengths include complete participation across ten cohorts, an unusually diverse international sample, authentic assessed work, independent double coding, an explicit codebook, pre-consensus reliability assessment, consensus adjudication and sensitivity analyses. The design also captures an under-represented configuration: learners from multiple partner countries comparing their own health systems in a shared third-country classroom.

Limitations

Limitations include the single-institution setting, uneven country representation and association between region and cohort year, although restricted-year analyses were similar. The course evolved over a decade; the consolidated syllabus documents stable curricular domains and the current educational framework but does not imply identical weekly sequencing, examples or reading lists for every cohort. Selecting one primary issue and response compressed complex narratives into mutually exclusive codes, and content analysis remains shaped by the coding framework despite reflexive documentation and consensus procedures. The reports measured curricular attention and perceived feasibility, not baseline knowledge, mastery of each foundational domain, objective disease burden, competence, causal learning effects or subsequent action. Scholarship-supported students studying abroad may not represent other learners or the communities they discussed.

Conclusions

Global health curricula may become more socially responsive when a shared foundation in population health and health systems is combined with opportunities for learners to contribute situated knowledge as material for collective inquiry. Elicitation, juxtaposition and translation offer a provisional design heuristic for doing so. The next step is to test the approach prospectively, connect learner-generated priorities with community and practitioner validation, and examine whether these learning processes translate into durable competence and socially accountable practice.

Abbreviations

ART
antiretroviral therapy
HIV/AIDS
human immunodeficiency virus/acquired immunodeficiency syndrome
LMIC
low- and middle-income country
NCD
non-communicable disease
SRQR
Standards for Reporting Qualitative Research
UHC
universal health coverage.

Declarations

Ethics approval and consent to participate

The Institutional Review Board of E-Da Hospital reviewed the study and granted exemption (reference 2026014), approving secondary use of de-identified educational assignments and waiving individual informed consent. The study was conducted in accordance with the Declaration of Helsinki. Student identifiers were removed before coding, and analyses used only de-identified consensus codes.

Consent for publication

Not applicable. No identifiable individual-level information is presented. Illustrative quotations are de-identified excerpts from educational assignments covered by the Institutional Review Board-approved secondary-use protocol and consent waiver.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

CHY contributed to formal analysis, investigation, drafting and revision of the manuscript. TCS contributed to methodology, data curation and manuscript revision. HWC contributed to formal analysis, investigation, drafting and revision. YWC contributed to validation and data curation. YCY contributed to conceptualisation, methodology, investigation, project administration, supervision, funding acquisition and manuscript revision. All authors read and approved the final manuscript.

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Availability of data and materials

The de-identified analytic dataset used and analysed during the current study is not publicly available because the source educational assignments contain potentially sensitive contextual information. The analytic dataset may be available from the corresponding author on reasonable request and subject to institutional and ethical approval.

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Tables

Table 1. Course sequence, foundational knowledge and analytic contribution

Component	Core knowledge or learning activity	Student product	Role in this study
1. Foundational knowledge	Population-health indicators and disease burden; culture, behaviour, social determinants and equity; health-system organisation, financing, access and workforce; infectious disease and surveillance; nutrition and non-communicable disease; mental health; injury and violence; environmental health; priority setting, evidence interpretation and feasibility.	Shared conceptual vocabulary	Established a common knowledge base for interpreting health problems, systems and response options.
2. Elicitation: country analysis	Country teams analysed geography, demography, culture, economy, health-system organisation, morbidity, mortality and existing strategies using country-level evidence.	State of Health analysis	Made situated home-country knowledge explicit and available for classroom inquiry.
3. Juxtaposition: cross-country presentation	Country presentations, peer questions and faculty-guided comparison made similarities, differences, assumptions and system trade-offs visible across settings.	Oral presentation and cross-country discussion	Placed contextual knowledge from multiple countries into direct comparison.
4. Translation: individual reflection	Each student selected one home-country disease or health issue and proposed one feasible response, considering context, resources and implementation constraints.	Reflective report	Generated the archived topic, priority-category and intervention-orientation codes analysed here.

Table 2. Health-priority categories overall and by region

Priority category	All students n (%)	Caribbean & Latin America n (%)	Pacific Islands n (%)	Africa n (%)
Metabolic and endocrine diseases	76 (25.2)	47 (31.1)	20 (32.3)	9 (10.1)
Infectious diseases	68 (22.5)	26 (17.2)	13 (21.0)	29 (32.6)
Cardiovascular diseases	36 (11.9)	26 (17.2)	6 (9.7)	4 (4.5)
Malignancies	35 (11.6)	23 (15.2)	7 (11.3)	5 (5.6)
Mental disorders	17 (5.6)	1 (0.7)	8 (12.9)	8 (9.0)
Other priorities	70 (23.2)	28 (18.5)	8 (12.9)	34 (38.2)

Note. Other priorities combined insufficient health-system resources, poverty and inequality, gynaecological and obstetric conditions, intentional injury and violence, environmental health, renal

diseases, unintentional injuries, malnutrition and one other issue. Omnibus regional comparison: chi-square(10)=56.87, p<0.001; Cramer's V=0.31. Full 14-category results are in Supplementary Table S3.

Table 3. Proposed intervention orientations overall and by region

Intervention orientation	All students n (%)	Caribbean & Latin America n (%)	Pacific Islands n (%)	Africa n (%)
Public education and awareness	136 (45.0)	92 (60.9)	26 (41.9)	18 (20.2)
Medical treatment and service measures	62 (20.5)	23 (15.2)	11 (17.7)	28 (31.5)
Policy, legislation and taxation	60 (19.9)	21 (13.9)	14 (22.6)	25 (28.1)
Resources, financing and insurance	44 (14.6)	15 (9.9)	11 (17.7)	18 (20.2)

Note. Omnibus regional comparison: chi-square(6)=38.81, p<0.001; Cramer's V=0.25.

Table 4. Contextual knowledge in students' reflective reports: de-identified illustrative quotations

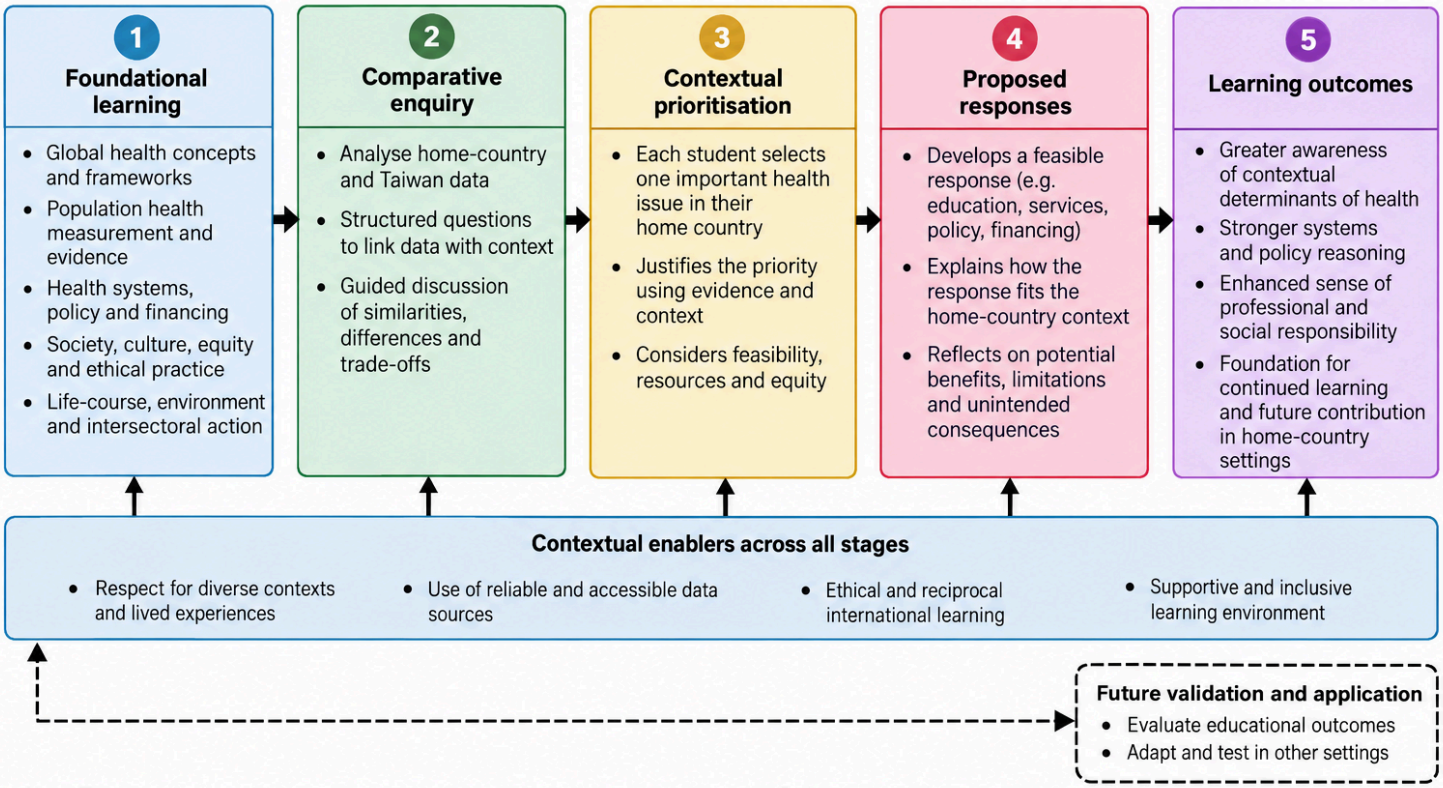
Code	Analytic interpretation	Illustrative quotation
P01	Cross-country classroom discussion changed the learner's prior view and made shared health problems visible	“In the beginning of the course I thought it will be boring ... But throughout the course I really changed my mind. ... we concluded that many of our countries represented in the classroom shared the same health issues ...”
P02	Local context complicated generic lifestyle recommendations	“[People in my country] typically walk long distances ... to avoid the costs of transportation. So exercise is part of the routine lifestyle ... The main reason for this is ... excessive amount of salt.”
P03	Locally named cultural norms and institutional power were linked to under-reporting and persistence of gender-based violence	“Cultural norms such as ‘tibi tendlu’ which means family secrets ... prohibits women from reporting cases of abuse ... our legislation also places women inferior to men ...”
P04	Priority was redefined by weighing trends and socioeconomic consequences rather than mortality rank alone	“Malignant neoplasm continues to be the leading cause of death over the last 5 years but it is not the most serious health problem in the country. The most serious health problem stems from two non-communicable diseases: hypertension and diabetes mellitus ... [because] the number of cases continues to rise each year ... and this can cause lost productivity and reduced economic growth ...”
P05	Financial inequality was framed as shaping both access to diagnosis and the disease burden visible in official data	“Persons of higher socioeconomic status will get tested ... while those of the lower socioeconomic bracket will not get tested due to financial constraints and will then go undiagnosed ... This situation provides false statistics ... and therefore gives the Ministry of Health a false sense of sufficiency of interventions and protocols ...”
P06	A course planning framework was integrated with a familiar home-country public-health assessment practice	“When I investigated this theory, it reminded me of a very common practice in [my country] in terms of public health, which is the analysis of the health situation. ... Once implemented, a constant evaluation will be necessary ... and, if it is positive, [it could be] implemented in the other ... regions.”
P07	The learner attributed a shift from importing decontextualized knowledge to context-sensitive health reasoning to the course	“This class made me realize that. ... To help a community we cannot expect that bringing modern knowledge that we learned at a university far away will be enough. We must know the context of the region, its politics, its economy, the people.”
P08	The learner situated their own medical education within a government-supported return-to-practice workforce strategy	“One way in which the government has began addressing the shortage of physicians is by implementing training programs like the one I am currently enrolled in, where my medical education is supported by the government with the expectation that I will return home to practice medicine. ... In a few years, my colleagues and I will return home as physicians ...”
P09	Feasibility was linked to language, patient	“Sometimes they don’t understand the nurses and doctors language. Patients make decision based on how they understand what will be done to improve their health. ... if

	understanding and whether patient voice was represented	the public don't understand our language ... then its just a waste of time."
P10	Changing health needs were weighed against the unintended consequences of reallocating attention and resources	"Reassigning of funds to NCDs may be interpreted as HIV/AIDS taking a back seat ... individuals may also use the co-occurrence as an excuse to stop or not take ART at all ... The question remaining therefore still is: Have we simply exchanged one cause of death for another?"

Note. Participant codes are study-specific pseudonyms and do not correspond to student identifiers. Quotations were purposively selected from the coded reports to maximise conceptual range across regions and analytic categories rather than to represent prevalence. Country names were omitted or bracketed where feasible; quotations otherwise retain the students' original wording apart from ellipses and bracketed de-identification. The excerpts illustrate students' own framing, experiences and reasoning and should not be interpreted as independently verified estimates of national disease burden, audited programme outcomes or regional exemplars. Abbreviations: ART, antiretroviral therapy; HIV/AIDS, human immunodeficiency virus/acquired immunodeficiency syndrome; NCD, non-communicable disease.

Figures

Figure 1. Making context curricular: a provisional design heuristic for internationally diverse global health classrooms.



Note. The figure summarises the study's provisional curriculum-design heuristic. Solid arrows indicate the curricular sequence observed in the course; dashed arrows indicate future validation and application. The heuristic describes a pedagogic sequence and should not be interpreted as a validated causal mechanism.

Figure 1

See image above for figure legend

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Additionalfile1.docx
- Additionalfile2.docx