Policy Document

Global Health and the Medical Curriculum (2025)

Executive Summary

Global health education is critical for preparing future doctors to provide equitable, culturally safe, and socially accountable care in an increasingly interconnected world. In Australia, however, global health teaching remains fragmented, inconsistently delivered, and rarely evaluated in a standardised way, frequently leaving graduates underprepared to navigate cross-cultural communication, complex health systems and practice in diverse or resource-limited contexts. While recent reforms by the Australian Medical Council (AMC) have incorporated cultural safety, Indigenous health, and planetary health into accreditation standards, global health content is often delivered through optional electives or didactic lectures, which are insufficient to cultivate reflective, experiential, and competency-based learning. Decolonisation, cultural humility, and ethical governance of global health opportunities are pressing gaps, particularly in international electives, where inequities in access, reciprocity, and oversight can perpetuate systemic injustices. Emerging technology, such as the ethical integration of artificial intelligence (AI) in medical education, further highlight the need for forward-looking curricula that bridge the gap, equipping graduates with the skills to critically engage with global health data, reduce bias, and maintain equity.

AMSA believes that global health should be embedded as a core, longitudinal, and assessable component of every Australian medical program, grounded in principles of reciprocity, equity, and cultural humility. Medical curricula must move beyond optional, siloed initiatives to incorporate experiential learning, co-created content with Indigenous communities and global South partners, and structured assessments that evaluate cross-cultural competencies, ethical reasoning, and global health literacy. AMSA calls on the AMC, Medical Deans Australia and New Zealand (MDANZ), medical schools, the Department of Health, and global health organisations to collaboratively strengthen global health education through national frameworks, transparent curriculum mapping, robust faculty development, equitable and ethically governed international electives, and the responsible incorporation of AI-enabled learning tools.

This policy applies nationally across all Australian medical schools and is particularly relevant at the interface of accreditation, curriculum design, and student training. The urgency is immediate: Australia faces growing health inequities, climate-related health challenges, and a diversifying patient

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population, making it essential that medical graduates are globally competent, culturally safe, and prepared to meet both national and international health responsibilities. By implementing these reforms, AMSA seeks coordinated leadership and partnership between accreditation bodies, universities, and governments to ensure that Australia produces doctors equipped to advance health equity, social accountability, and culturally informed care at all levels of practice.

Policy Points

AMSA calls upon:

1. The Australian Medical Council (AMC) to:

a. Mandate a standardised integration of cultural safety, Indigenous health, and global health as longitudinal, assessable competencies across all accredited medical programs, embedded within the Health & Society domain;
b. Lead a national review of global health education in Australia, modelled after the UK GHEMS study, with findings published transparently with clear feedback and program-specific improvements required to meet the standards;
c. Set minimum standards for faculty expertise, leadership training, and curriculum quality in global health education to ensure high-quality learning;
d. Assess schools based on graduate outcomes and competencies, not just curriculum inputs, and:
    i. Require medical schools to demonstrate how their curriculum content equips graduates with the knowledge to recognise and manage conditions of global importance;
e. Embed ethical AI and digital literacy in accreditation standards, ensuring cross-cultural relevance, algorithmic equity, and responsible data use; and
f. Require pre-departure training and assessment for international placements, including education on pathologies uncommon in Australia and ethical partnership principles to uphold beneficence.

2. Medical Deans Australia and New Zealand (MDANZ) to:

a. Audit global health curricula biannually, publishing transparent national reports on effectiveness and competency outcomes;
b. Develop and maintain a national, open-access repository of teaching cases, simulation scenarios, and problem-based learning focused on high-burden global diseases and ethical dilemmas in resource-limited settings, and:
    i. Review and update the content repository annually to ensure information accuracy and cultural sensitivity;
c. Support faculty leadership through mentorship and professional development in global health and cultural safety;
d. Coordinate curriculum mapping to the CUGH Global Health Competencies Toolkit, ensuring clarity on what should be assessed and how; and
e. Facilitate AI-driven scenario banks and reflective tools that can be adapted across medical schools to assess adaptability, systems thinking, and communication.

3. Australian Medical Schools and Faculties of Medicine to:

a. Embed cultural safety and global health principles as core competencies across all teaching, with structured self-reflection, patient-centred care, and critical analysis of cultural identity;
b. Shift delivery methods from didactic lectures to interactive, experiential models including but not limited to:
    i. PBL;
    ii. reflective journaling;
    iii. simulation; and
    iv. community placements.
c. Co-create curricula and elective placements with marginalised communities to ensure reciprocity and equity, including but not limited to:
    i. Aboriginal and Torres Strait Islander peoples;
    ii. refugee advocates; and
    iii. global South educators.
d. Mandate student engagement in global health learning beyond electives, embedding longitudinal, assessable modules via integrated workshops, symposiums, and placements across all years of the program;
e. Design assessments that test students' ability to reason through diagnostic and management challenges in resource-limited and cross-cultural contexts, assessing adaptability and perspective-taking;
f. Govern international electives ethically with reciprocity, transparent eligibility criteria, comprehensive pre-departure training, and structured post-return debriefing;
g. Expand global health opportunities through accessible exchange programs, local community partnerships, and virtual collaborations with LMICs and Indigenous communities;
h. Integrate AI-enabled tools into curricula for cross-cultural peer-learning, formative feedback and bias-aware assessment in OSCEs and group projects;
i. Implement formative exit interviews or viva voce as a final-stage assessment to confirm competency in global health knowledge, cultural humility, and adaptability; and
j. Provide financial support (scholarships, grants, stipends) to democratise access to placements and exchanges.

4. The Department of Health and Health Education Policymakers to:

a. Fund national initiatives to support cultural safety, Indigenous leadership, and decolonisation in medical curricula;
b. Allocate targeted resources for universities to strengthen global health teaching through faculty development and co-designed reforms;
c. Expand scholarships and institutional support for equitable participation in international and community-based placements;
d. Align medical curricula with Australia's commitments to the Sustainable Development Goals (SDGs) and global health equity; and

e. Support innovation by investing in AI-enabled educational infrastructure that strengthens equitable access and assessment in medical training.

5. The Australian Medical Students' Association (AMSA) and Global Health Organisations to:

a. Advocate for decolonisation of medical education through student-led campaigns, curriculum reviews, and national representation;
b. Develop and disseminate open-access educational resources to create equitable access to quality global health education such as:
    i. workshops;
    ii. case libraries;
    iii. AI learning modules;
    iv. reflective tools; and
    v. the CUGH Global Health Competency Toolkit.
c. Platform diverse global health voices, especially those from Indigenous and global South communities, through panels, events, and publications;
d. Develop equitable and reciprocal international partnerships, prioritising ethical engagement and shared benefit for all participants; and
e. Monitor and report medical student perspectives to inform ongoing national curriculum reviews and reforms.

Background

DEFINITION OF GLOBAL HEALTH

The World Health Organization (WHO) defines global health in the preamble of its constitution, linked in the further information section at the bottom of this policy. In short, all of humanity is entitled to physical and emotional well-being achieved through cooperation, collaboration, and the security efforts of all states and parties worldwide [1]. The United Nations (UN) Declaration of Human Rights includes the right for everyone to have health and well-being of themselves and their families through all stages of life [2]. The UN further defines 17 separate Sustainable Development Goals to broadly support the end of poverty and other suffering globally to improve health and education, reduce inequality, and spur economic growth [3].

GLOBAL HEALTH CURRICULUM

Policy, Governance, and Global Health Education in Australia.

In Australia, governance of medical curricula is primarily set by the Australian Medical Council (AMC). The 2024 revision of the Standards for Assessment and Accreditation of Primary Medical Programs strengthened requirements around social accountability, cultural safety, Indigenous health, and planetary health [4]. While this represents progress, the standards provide broad guidance without mandating specific global health competencies or assessment requirements, leading to variability across universities. Integration most often occurs through public health, Indigenous health, planetary health teaching, and optional international electives [5, 6].

Research on global health education in Australian medical schools remains limited and fragmented. Much of the literature consists of commentaries, single-school case studies, or evaluations of specific initiatives, rather than systematic reviews. For instance, mapping studies in planetary health show momentum in embedding climate and environmental health into curricula, but also highlight major inconsistencies in delivery and assessment [6, 7, 8]. Importantly, there is little evidence linking curriculum exposure to graduate competencies or professional outcomes in global health domains [10].

International placements and global health electives are common but inconsistently governed. Reviews stress the need for structured oversight, ethical reciprocity with host communities, and national standards for preparation and supervision [11, 12]. While Indigenous health and cultural safety benefit from a dedicated Aboriginal and Torres Strait Islander Health Curriculum Framework [13] and new AMC implementation guidance [14], these frameworks are not consistently linked to broader global health domains such as health systems, humanitarian response, global surgery, and multilateral governance [10].

Overall, the Australian approach to global health education is piecemeal and poorly evaluated, with delivery relying heavily on voluntary initiatives by individual schools. Stronger policy and governance mechanisms are needed to ensure all medical graduates are prepared to address global health challenges.

Decolonising Global Health Education and Embedding Cultural Safety.
Despite increased attention to global health in medical curricula, global health education often continues to reflect colonial structures, epistemologies, and hierarchies. A 2020 UK-wide curriculum review by InciSioN UK found that global health content remains fragmented, with most medical education delivered through didactic lectures - a method ill-suited to building the reflective and interpersonal competencies required for culturally safe practice [15]. This mirrors similar limitations observed in Australian medical programs.

The Australian Medical Council (AMC) in its 2023 revised Standards for Assessment and Accreditation of Primary Medical Programs formally integrated cultural safety into core expectations. These standards define cultural safety as being based on the experience of the patient, achieved only when a practitioner has reflected on their own cultural identity and how it influences their care [4]. This reflection cannot be cultivated through lectures alone; it requires transformative, experiential, and case-based learning that centers lived experiences, community engagement, and critical consciousness.

Moreover, global health education remains dominated by global North-centric narratives and values, marginalising knowledge systems and healthcare frameworks from the global South and Indigenous communities. Scholars and educators have called for epistemic pluralism, critical consciousness, and cultural humility as essential pillars in truly decolonising the medical curriculum [16, 17].
The Consortium of Universities for Global Health (CUGH) echoes these views and provides a comprehensive Global Health Competencies Toolkit, which supports culturally safe, context-sensitive, and experiential learning [18].

Global health education in Australia should be reoriented towards decolonisation and cultural safety by embedding these as longitudinal, assessable competencies across curricula. This requires shifting from didactic lectures to experiential, case-based learning, co-developing content with Aboriginal and Torres Strait Islander communities and global South educators, and valuing plural knowledge systems. Adopting best practice tools such as the CUGH Global Health Competency Toolkit will help ensure graduates are equipped with the cultural humility and critical consciousness needed to deliver socially accountable and culturally safe care.

Assessment and Accreditation of Global Health Competencies.
Assessment is central to legitimising the value of global health education in medical curricula, yet in Australia it remains inconsistent, fragmented, and often not translated into measurable learning outcomes. While the AMC sets broad expectations under the Health and Society domain - including equity, determinants of

health, and cultural safety - these standards are not consistently embedded in assessment across programs. This risks graduates leaving medical school underprepared for the realities of cross-cultural care, complex health systems, and practice in resource-limited contexts.

Effective assessment of global health must go beyond rote knowledge or isolated lectures. Applied skills such as cross-cultural communication, ethical reasoning, and decision-making in resource-limited settings can be effectively tested through OSCEs, case-based exams, role-play scenarios, and portfolio reflections [19, 20]. Such assessments should include global pathologies and diverse simulated patients, not just Australia's specific health concerns, as a part of building global competency and awareness. Longitudinal integration into high-stakes assessments ensures these competencies are prioritised rather than marginalised. At the same time, formative approaches such as structured group projects, reflective journaling, and a formative exit interview or viva voce can help evaluate whether students have developed perspective-shifting, adaptability, and cultural humility.

Standardised frameworks such as the CUGH Global Health Competencies Toolkit provide a foundation for national curriculum mapping and competency-based assessment [18]. Innovation also has a role: AI can generate realistic global health scenarios for OSCEs, provide adaptive formative feedback, support reflective learning, and reduce bias in marking. Pre-departure training and assessment for international placements, including exposure to pathologies less common in Australia, further ensures graduates are prepared for diverse clinical environments and can engage ethically with host communities.

Internationally, consensus exists on the importance of defining core global health competencies, but debates around accreditation highlight the need to balance standardisation with flexibility, equity, and inclusivity [21]. For Australia, this underscores the urgency of moving beyond broad expectations to concrete, nationally consistent assessments that ensure graduates are not only knowledgeable, but also adaptable, culturally safe, and globally competent.

GLOBAL HEALTH CURRICULUM DELIVERY

Faculty Development and Institutional Leadership.

Strong leaders and faculty in medical programs are key to medical student success. With global health education, diverse informed views need to be the foundation of education. To help ensure a robust and high-quality global health curriculum, we must start at the top of the education system with faculty and leadership.

A study examines the long-term impact of FAIMER's international Faculty Development Programs (FDPs) via surveys to their global alumni [22]. This FDP is designed for global health professions educators and leaders around the world. The study found that participants attributed their professional successes to a combination of personal motivation, strong mentoring, supportive networks, and structured program components. The results indicate that the FDP had a significant impact on its participants and provide a baseline of requirements for success [22].

Researchers examined global health mentorship at Johns Hopkins University involving students and their faculty mentors [23]. The study identified a conceptual "building blocks" model where mentorship dynamics are shaped by factors from individual to institutional levels, including motivation, aligned expectations, time, finances, and knowledge. Mentors and mentees both emphasized that strong institutional support (e.g., funding, recognition, resources) is vital for effective mentoring; without it, mentorship can hinder rather than enhance global health training [23].

A 2023 review [24] examined how and why Leadership Development Programs (LDPs) for physicians yield organization-level outcomes. Their research found that the more resources invested in LDPs, the more widespread and impactful they are. These mechanisms are sustained within a broader "leadership ecosystem", which includes infrastructure, funding, alumni networks, and career pathways. Ongoing leadership development promotes organisation-wide improvements, and these LDPs require adequate support and resources to be successful in the long term [24].

To foster impactful global health mentorship and education, institutions must support alignment of motivations and expectations to create support systems for faculty. With medical education dependent on its educators, there needs to be robust support for development and growth for faculty and leadership.

Integrating AI Ethically into Global Health Education.
The emergence of Artificial Intelligence (AI) for educational reform opens a new era of potential solutions to many challenges faced in global health. The WHO has emphasized the importance of AI in overcoming mass health emergencies and improving the minimum standards for global health as early as 2018. Prospective AI promises to counter the rigidity of traditional educational systems by personalized communication and behavioral modelling [25].

AI offers an opportunity to strengthen global health education by breaking language barriers and reducing the cost of learning, improving multi-national collaboration. Practical implementations already exist: AI-driven generative language models have been used to translate pediatric educational content, broadening accessibility for health workers and learners [26].

Despite global interest, reviews show a lack of standardisation in how AI is taught in medical education. A recent study found limited consensus on core competencies, inconsistent curriculum design and absence of formal ethical training in AI-integrated medical curricula. This highlights the need for a constantly evolving universal medical education (UME) that is consistent with the rapid development of AI [27].

The primary challenge of global AI integration is equitable implementation. Resource constraints, limited faculty expertise and risks that models trained on high-income

country data will embed bias when applied elsewhere suggest that the current scope of global AI integration can be unjust. Co-development with local stakeholders in low and middle income countries (LMICs) and marginalised communities is recommended to ensure generalisability and shared ownership. Studies show that co-creation in LMIC public-health interventions improves acceptability and sustainability but requires funding, time, and careful attention to power dynamics [28].

WHO guidance on medical AI governance and recent international consensus frameworks recommend core frameworks including equity, transparency accountability, data protection and oversight to be translated into curricular learning outcomes and practical exercises within global health teaching [29].

As per these suggestions, specific innovations in global health education include:

- AI-generated global case scenarios for OSCEs, ensuring assessments reflect diversity and health inequities;
- AI-driven interactive Q&A modules, tailored to student knowledge gaps and language needs; and
- AI-supported reflected journaling tools, providing feedback on bias, perspective-taking, and cultural safety.

Research found that AI-powered educational tools show promising use for personalised cases, simulations and feedback generation cases but have inconsistent evidence of measurable learning outcomes [30]. Standardised evaluation is essential to judge effectiveness prior to large scale implementation. The study also states that the main obstacles faced by the medical students is unfamiliarity with AI systems and lack of institutional guidance and regulated ethical framework, further highlighting the need for AI integration in UME [30].

Ongoing Education for Medical Staff.

Junior doctors receive limited ongoing formal global health education within their core training in spite of interest expressed by trainees. Ongoing Global Health Education for Junior Doctors is largely limited to optional, extra-curricular endeavours - many of which incur personal financial cost, such as postgraduate courses, volunteer work and work with non-governmental organisations. Despite growing demand for formal global health training and recognition of its importance in addressing health equity, Australian postgraduate programs often lack robust integration with clinical training, making access to such experiences limited and often reliant on self-directed efforts [31].

INTERNATIONAL MEDICAL ELECTIVES

Persistent Barriers to Equitable Participation.

Financial constraints present the most significant obstacle, with the high costs of international travel, accommodation, and insurance excluding students from lower socioeconomic backgrounds. For example, nearly half of medical students in the UK cite financial limitations as their primary barrier to undertaking global electives [36].

Similar trends are evident in Australia, where participation often depends on personal or family resources rather than merit or interest. Visa restrictions, language requirements, and safety concerns in politically unstable regions further compound these disparities, perpetuating a system where ILEs become privileges for those with the financial backing and institutional support, rather than standardised components of medical training [36].

Moreover, the logistical complexity of organising these international placements without centralised institutional assistance also deters many students. From securing clinical supervision to arranging housing, this 'hidden curriculum' of self-directed planning disadvantages first-generation and international students who may lack professional networks or familiarity with overseas systems [37]. Consequently, students from underrepresented or marginalised backgrounds that would benefit most from global health exposure are frequently excluded from these formative experiences.

Moving Beyond Voluntourism.

In Australia, the majority of students opt for placements in low-income countries; with 59% of graduate entry (GE) program students and 56% high school entry HSE program students selecting low- or middle-income (LMIC) countries for their overseas placements [38]. Critiques often highlight how short-term placements can prioritise student learning over host-country needs, draining local resources without reciprocal gains. Furthermore, students may inadvertently harm patient care by practicing beyond their competency or reinforcing dependency on foreign aid rather than sustainable local healthcare systems [39, 40].

These challenges exist within a broader context of post-colonial power dynamics in global health. High-income countries (HICs) frequently dominate partnership agendas, by imposing curricula or research priorities on LMIC institutions, undermining local autonomy and perpetuating dependency. Conversely, LMICs may feel pressured to accept inequitable partnerships to access academic opportunities, such as co-authorship in research publications. Such transactional relationships risk reducing ILEs to exploitative ventures rather than collaborative exchanges [41].

Innovations and Alternatives.

For students unable to travel, virtual electives and hybrid models offer partial solutions. While virtual platforms cannot replicate the immersive cultural experience of in-person placements, they can facilitate collaborative research, case discussions, and telehealth projects with global partners [41]. Local placements with refugee [42] and Indigenous [43] health programs can further offer globally-relevant yet community-based learning opportunities.

For More Information

The WHO Constitution establishes health as a fundamental human right and frames global health as a collective responsibility requiring international cooperation. This principle underpins AMSA's call for embedding global health into Australian medical education, ensuring graduates are equipped to advance equity and uphold these rights.

World Health Organization's Constitution
https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

The 17 SDGs provide a shared global framework for addressing health inequities, climate change, and social determinants of health. By aligning medical curricula with the SDGs, Australian medical education can better prepare future doctors to address both national and global health challenges.

United Nations Sustainable Development Goals
https://www.un.org/en/exhibits/page/sdgs-17-goals-transform-world

This toolkit outlines standardised global health competencies and provides practical guidance for curriculum mapping and assessment. It directly supports AMSA's policy recommendations to adopt competency-based frameworks, ensuring consistent, measurable outcomes in global health education across Australian medical schools.

Consortium of Universities for Global Health (CUGH) Competency Sub-Committee (2022). CUGH. ***Global Health Education Competencies Tool Kit (3rd edition)****, Washington, DC: Author.*
https://www.cugh.org/wp-content/uploads/sites/95/2025/03/Global-Health-Competencies-Tool-Kit-3rd-Ed-Updated-3_4.pdf

References

1. World Health Organization. Constitution [Internet]. World Health Organization. [cited 2025 Aug 17]. https://www.who.int/about/governance/constitution
2. United Nations. Universal Declaration of Human Rights. United Nations. https://www.un.org/en/about-us/universal-declaration-of-human-rights
3. United Nations. The 17 Sustainable Development Goals. United Nations Department of Economic and Social Affairs. https://sdgs.un.org/goals
4. Australian Medical Council (AMC). Standards for Assessment and Accreditation of Primary Medical Programs 2 Standards for Assessment and Accreditation of Primary Medical Programs JULY 2023 Approval [Internet]. 2024 Jan. Available from: https://www.amc.org.au/wp-content/uploads/2023/08/AMC-Medical_School_Standards-FINAL.pdf
5. Iyer HS, DeVille NV, Stoddard O, Cole J, Myers SS, Li H, et al. Sustaining Planetary Health through Systems thinking: Public health's Critical Role. SSM - Population Health [Internet]. 2021 Jun 11;15. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8213960/
6. Murray RB, Larkins S, Russell H, Ewen S, Prideaux D. Medical Schools as Agents of Change: Socially Accountable Medical Education. Medical Journal of Australia. 2012 Jun;196(10):653–3.
7. Phillips-Wilson T, Khadke S, Mares A, Lawrence J, Shah J, Rajagopalan S, et al. Integrating Planetary Health into Medical Education. JACC: Advances. 2024 Dec;3(12):101366.
8. Doctors for the Environment Australia (DEA). Mapping Climate Change and Health into the Medical Curriculum co-development of a "planetary health-organ System map" for Graduate Medical Education [Internet]. 2021. Available from: https://assets.nationbuilder.com/docsenvaus/pages/377/attachments/original/1708553463/Mapping-Climate-Change-FINAL-v3-compressed.pdf?1708553463
9. Burch H, Beaton LJ, Simpson G, Watson B, Maxwell J, Winkel KD. A Planetary Health–organ System Map to Integrate Climate Change and Health Content into Medical Curricula. Medical Journal of Australia. 2022 Sep 29;217(9):469–73.
10. Eichbaum QG, Adams LV, Evert J, Ho MJ, Semali IA, van Schalkwyk SC. Decolonizing Global Health Education: Rethinking Institutional Partnerships and Approaches. Academic Medicine [Internet]. 2021 Mar 1;96(3):329–35. Available from: https://journals.lww.com/academicmedicine/Fulltext/2021/03000/Decolonizing_Global_Health_Education__Rethinking.16.aspx
11. Turissini M, Mercer T, Baenziger J, Atwoli L, Einterz R, Gardner A, et al. Developing Ethical and Sustainable Global Health Educational Exchanges for Clinical Trainees: Implementation and Lessons Learned from the 30-Year Academic Model Providing Access to Healthcare (AMPATH)

Partnership. Annals of Global Health [Internet]. 2020 Oct 26 [cited 2021 Mar 27];86(1). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7597575/
12. Kraeker C, Chandler C. “We Learn from Them, They Learn from Us.” Academic Medicine. 2013 Apr;88(4):483–7.
13. Department of Health. Aboriginal and Torres Strait Islander Health Curriculum Framework [Internet]. 2014. Available from: https://www.health.gov.au/sites/default/files/documents/2020/12/aboriginal-and-torres-strait-islander-health-curriculum-framework.pdf
14. Australian Medical Council (AMC). Guidance resource: Aboriginal and/or Torres Strait Islander Health and Cultural Safety Standards Supporting Implementation of the National Framework for Prevocational Medical Training [Internet]. 2024 Mar. Available from: https://www.amc.org.au/wp-content/uploads/2024/05/Implementation-guidance-resource-May-2024-1.pdf
15. InciSioN UK Collaborative. (2020). Global Health Education in Medical Schools (GHEMS): a national, collaborative Study of Medical Curricula. *BMC Medical Education*, *20*(1). https://doi.org/10.1186/s12909-020-02315-x
16. Wong, S. H. M., Gishen, F., & Lokugamage, A. U. (2021). ‘Decolonising the Medical Curriculum‘: Humanising Medicine through Epistemic pluralism, Cultural Safety and Critical Consciousness. *London Review of Education*, *19*(1). https://doi.org/10.14324/lre.19.1.16
17. Garba, D. L., Stankey, M. C., Jayaram, A., & Hedt-Gauthier, B. L. (2021). How Do We Decolonize Global Health in Medical Education? *Annals of Global Health*, *87*(1), 29. https://doi.org/10.5334/aogh.3220
18. Consortium of Universities for Global Health (CUGH) . (2024). *Global Health Education Competencies Tool-Kit (3rd edition)* (A. Moore, B. Astle, S. Chowdhury, C. Cook, H. Lee, C. Lang, & L. Romocki, Eds.). https://www.cugh.org/wp-content/uploads/sites/95/2025/03/Global-Health-Competencies-Tool-Kit-3rd-Ed-Updated-3_4.pdf
19. Jogerst K, Callender B, Adams V, Evert J, Fields E, Hall T, et al. Identifying Interprofessional Global Health Competencies for 21st-century Health Professionals. Annals of Global Health. 2015 Jun 16;81(2):239.
20. Gibson C, Madawa Chandratilake, Hull A. Use of Portfolios for Assessment of Global Health Residents: Qualitative Evaluation of Design and Implementation. Canadian Medical Education Journal [Internet]. 2018 May 31 [cited 2025 Apr 27];9(2):e20. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC6044301/
21. Siegert TF, Gladding SP, Walker PF, Tupesis JP, Hendel-Paterson BR. Core Content, Competencies, and Accreditation in US Global Health Fellowships: a Survey of Leaders’ Perspectives. The American Journal of Tropical Medicine and Hygiene [Internet]. 2024 Nov 12;112(1). Available from: https://www.researchgate.net/publication/385748729_Core_Content_Competencies_and_Accreditation_in_US_Global_Health_Fellowships_A_Survey_of_Leaders
22. Yuan S, Rahim A, Kannappan S, Dongre A, Jain A, Kar SS, et al. Success

stories: exploring perceptions of former fellows of a global faculty development program for health professions educators. BMC Medical Education. 2024 Sep 30;24(1). https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-024-05823-2
23. Charron K, Kalbarczyk A, Martin NA, Combs EA, Ward M, Leontsini E. Building Blocks of Global Health Mentorship: Motivation, Expectations, and Institutional Support. Annals of Global Health. 2019. 85(1). https://annalsofglobalhealth.org/articles/10.5334/aogh.1537?utm_&sa=D&source=docs&ust=1755214002755589&usg=AOvVaw2QJMXPX36ecK0VtjAi3VXI
24. Debets, M., Jansen, I., Lombarts, K. et al. Linking leadership development programs for physicians with organization-level outcomes: a realist review. BMC Health Serv Res 23, 783 (2023). https://doi.org/10.1186/s12913-023-09811-y
25. Wang J, Li J. Artificial intelligence empowering public health education: prospects and challenges. Frontiers in Public Health. 2024 Jul 3;12.
26. Fouzi Benboujja, Hartnick E, Zablah E, Hersh C, Callans K, Villamor P, et al. Overcoming language barriers in pediatric care: a multilingual, AI-driven curriculum for global healthcare education. Frontiers in public health. 2024 Feb 22;12.
27. Rincón E, Jimenez D, Alexandra L, Miguel J, Romero E, Liliana C. Mapping the use of artificial intelligence in medical education: a scoping review. BMC Medical Education. 2025 Apr 12;25(1).
28. Giuliana Raffaella Longworth, Oritseweyinmi Erikowa-Orighoye, Ebuka Miracle Anieto, Danielle Marie Agnello, Jorge Raul Zapata-Restrepo, Masquillier C, et al. Conducting co-creation for public health in low and middle-income countries: a systematic review and key informant perspectives on implementation barriers and facilitators. Globalization and Health. 2024 Jan 17;20(1).
29. WHO. Ethics and governance of artificial intelligence for health: WHO guidance Executive summary [Internet]. www.who.int. 2021. Available from: https://www.who.int/publications/i/item/9789240037403
30. Blanco MA, Nelson SW, Ramesh S, Callahan CE, Josephs KA, Jacque B, et al. Integrating artificial intelligence into medical education: a roadmap informed by a survey of faculty and students. Medical Education Online [Internet]. 2025 Jul 14 [cited 2025 Jul 26];30(1). Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC12265092/
31. Mitchell RD, Jamieson JC, Parker J, Hersch FB, Wainer Z, Moodie AR. Global Health Training and Postgraduate Medical Education in Australia: the Case for Greater Integration. Medical Journal of Australia. 2013 Apr;198(6):316–9.
32. Imafuku R, Saiki T, Hayakawa K, Sakashita K, Suzuki Y. Rewarding journeys: exploring medical students' learning experiences in international electives. Medical Education Online. 2021 Jan 1;26(1):1913784.

33. H Patrick McNeil, Wild P, Harris H, S Bruce Dowton. The benefits of international health experiences for Australian and New Zealand medical education. Medical Journal of Australia. 2017 Jun 1;206(10):429–30.
34. Slifko SE, Vielot NA, Becker-Dreps S, Pathman DE, Myers JG, Carlough M. Students with global experiences during medical school are more likely to work in settings that focus on the underserved: an observational study from a public U.S. institution. BMC Medical Education. 2021 Oct 29;21(1).
35. Australian Medical Students Association. Overseas Medical Placements Position Statement [Internet]. 2021 [cited 2025 Aug 29]. Available from: https://amsa.org.au/wp-content/uploads/2023/10/Overseas-Medical-Placements-2021.pdf
36. Sarela S, Asim N, Atapaka S, Sheriff V, Barzyk-Sheriff G. Understanding Barriers and Motivations: Enhancing Support for UK Medical Students' Participation in Foreign Medical Electives. Advances in Medical Education and Practice. 2025 Apr;Volume 16:637–49.
37. Koutsouris G, Mountford-Zimdars A, Dingwall K. The "ideal" higher education student: understanding the hidden curriculum to enable institutional change. Research in Post-Compulsory Education [Internet]. 2021 Apr 3;26(2):131–47. Available from: https://www.tandfonline.com/doi/full/10.1080/13596748.2021.1909921
38. Law IR, Worley PS, Langham FJ. International medical electives undertaken by Australian medical students: current trends and future directions. Medical Journal of Australia. 2013 Mar 26;198(6):324–6.
39. Willott C, Khair E, Worthington R, Daniels K, Clarfield AM. Structured medical electives: a concept whose time has come? Globalization and Health. 2019 Dec;15(1).
40. Watson DA, Cooling N, Woolley IJ. Healthy, safe and effective international medical student electives: a systematic review and recommendations for program coordinators. Tropical Diseases, Travel Medicine and Vaccines [Internet]. 2019 Apr 3 [cited 2019 Dec 19];5(1). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6448218/
41. McCarron L, Nihal Sogandji, Coakham L, Zhu L, Tulinius C. A systematic review of virtual elective programmes for medical students. The Clinical Teacher [Internet]. 2024 Nov 6;22(1). Available from: https://www.researchgate.net/publication/385599805_A_systematic_review_of_virtual_elective_programmes_for_medical_students
42. Jit M, Jacob W. Framework for implementing asylum seekers and refugees' health into the undergraduate medical curriculum in the United Kingdom. Health education research [Internet]. 2024 Jan 25 [cited 2024 Apr 14];39(2):170–81. Available from: https://academic.oup.com/her/article-abstract/39/2/170/7595384
43. Odgers-Jewell K, Nelson A, Brown R, Hunter N, Atkins T, Menzel K. Students' experiences of placements in urban indigenous health contexts: developing a culturally responsive workforce. BMC Medical Education. 2024 Dec 18;24(1)

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