

Expanding the Classroom: A Global Health Immersion in Ghana

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ABSTRACT

This narrative reflects on a field-based experiential learning journey to rural Ghana, designed to deepen student understanding of global health systems, oral health disparities, and the socio-cultural determinants of health. The experience fostered critical reflection on healthcare access, cultural humility, and interdisciplinary collaboration through immersive engagement with community health workers, local leaders, and educational institutions. Anchored in the principles of experiential education, the narrative emphasizes how structured reflection and community-based learning can expand traditional public health pedagogy and prepare students for ethical, equity-centered practice in global contexts.

Keywords: experiential education, global health systems, healthcare delivery, faculty reflection, cultural humility.

This immersion builds on a growing body of global health education literature that emphasizes the need for field-based, reflexive learning experiences to prepare students for ethical and effective practice. Experiential education has been shown to foster cultural humility, systems thinking, and interdisciplinary collaboration, skills increasingly emphasized by public health competency frameworks and accreditation bodies. (Blenner et al., 2021; McKinnon et al., 2016) Moreover, scholars argue that transformative experiences, especially those that challenge positionality and power, are critical to developing globally engaged health professionals. (Kheirkhah Abkenari, 2025; McKinnon et al., 2016)

METHODOLOGICAL FRAMING: A PEDAGOGICAL DESIGN FOR IMMERSION

This field experience was part of a structured undergraduate global health course with experiential education as its core methodology. The design integrated Kolb's experiential learning cycle (concrete experience, reflective observation, abstract conceptualization, and active experimentation) and Mezirow's transformative learning theory, which emphasizes critical reflection and perspective change

through disorienting dilemmas (Kolb, 2014; Mezirow, 1997).

The program unfolded in three stages: (1) a pre-departure module that explored global health ethics, systems thinking, oral health equity, and cultural humility; (2) a two-week in-country immersion involving field visits, collaborative learning, and nightly debriefs; and (3) a post-trip synthesis through reflective assignments and peer dialogue. The course intentionally emphasized nonlinear, affective, and dialogic learning processes over content mastery.

As a faculty member observing students, I had not previously taught, my liminal role allowed me to witness the pedagogical design in action without the burden of assessment. This distance sharpened my awareness of how students engaged with uncertainty, discomfort, and meaning-making. I observed how they moved through Kolb's cycle in real time, feeling disoriented by unfamiliar clinical settings or cultural practices, then journaling or unpacking these moments in group discussions, and ultimately reframing their understanding of health systems and their own professional identities.

Importantly, the methodological structure of the program left room for unplanned learning to emerge. A student who

initially fixated on biomedical protocols later reflected on the value of traditional oral hygiene tools made from tree bark. Another questioned the metrics we use to define “successful” health interventions. These shifts signaled that learning was taking root, not as facts memorized, but as worldviews reexamined.

By scaffolding experience with intentional reflection and ethical framing, the program fostered transformative growth. It offered not just a lesson in global health, but a model for how to teach and learn when the classroom has no walls.

INTRODUCTION: EXPANDING THE CLASSROOM THROUGH IMMERSION

In July 2024, I joined a field-based experiential learning program in rural Ghana. I wasn’t the lead instructor, nor did I know the students beforehand. That distance, unusual for faculty, offered something rare: a chance to observe learning as it unfolded—unfiltered, unforced, and deeply human. Each day revealed layered stories about health systems, resilience, and the ethical entanglements of bearing witness in a place not your own.

The program itself was thoughtfully designed, grounded in experiential education theory and shaped by a belief that the field is not an add-on to the classroom, but an extension of it. Students completed pre-departure modules on cultural humility, social determinants, and interdisciplinary health frameworks. Still, nothing fully prepares you for the moment you meet a rural healthcare worker treating patients without electricity, or watch a teacher explain menstruation with no materials but her hands. These moments became the real curriculum.

As a faculty member, I entered this space expecting to teach or at least support. Instead, I found myself learning—quietly, humbly, and often unexpectedly. It became clear that immersive education is not about exporting knowledge, but expanding one’s capacity to listen, to notice, and to sit with discomfort. The classroom had no walls here. And in its place was something much more alive: shared inquiry, ethical presence, and moments of transformation—for the students and for me. My experience was grounded in the pedagogical belief that students learn best by doing, particularly when challenged to reflect critically on social and structural determinants of health.(Frenk et al., 2010; Lasker, 2016b) The immersion began with daily observations and reflections that intentionally linked place, practice, and pedagogical purpose.

GHANA’S HEALTHCARE SYSTEM: STRUCTURES, GAPS, AND LIVED REALITIES

Ghana’s healthcare system is decentralized and organized into a three-tiered model: primary care delivered through Community-based Health Planning and Services (CHPS) compounds, secondary care via district hospitals, and tertiary services at regional and teaching hospitals. While this structure is designed to promote access across rural and urban populations, it remains vulnerable to inequities rooted in geography, staffing shortages, supply chain gaps, and sociopolitical instability. Ghana has made measurable gains in maternal and child health indicators, yet persistent challenges in oral health and chronic disease care reflect broader global disparities in what counts as “essential” healthcare.(Aikins & Koram, 2017; Sakeah et al., 2023)

These structural realities became palpable during our site visits. Oral health clinics often lacked basic infection control measures, anesthesia, and functioning equipment, forcing reliance on manual tools and improvisation. For patients with chronic diseases such as hypertension or diabetes, continuity of care was compromised by logistical barriers and erratic medication availability. Despite these limitations, local providers displayed remarkable resourcefulness, innovating through community partnerships, mobile outreach, and culturally grounded health education. These gaps, particularly in oral health and chronic disease management, revealed how field-based learning allows students and faculty to witness the disjuncture between policy frameworks and lived experience. It was in these spaces that experiential education catalyzed deeper engagement with the ethics of intervention, the politics of visibility, and the power of local knowledge.

This field experience highlighted the fragmented nature of care, particularly in the areas of oral health and preventive services. Health workers frequently voiced frustration over insufficient training and limited allocation of resources to CHPS sites, many of which lacked essential infrastructure such as electricity or diagnostic tools. Observing these realities through a systems lens enabled students to appreciate how national goals such as Universal Health Coverage (UHC) are experienced unevenly on the ground. During visits to local clinics and hospitals, students reflected on the ingenuity of staff working under constraint and the fragility of systems that depend on improvisation.

Oral health emerged as a powerful entry point for analysis and dialogue. Many individuals used traditional cleaning

methods such as chewing sticks, charcoal, or shared toothbrushes, practices rooted in both necessity and cultural identity. These observations provoked discussions about the meaning of prevention, the intersections of education and access, and the importance of embedding oral health within broader public health priorities. (Marmot et al., 2008; Organization, 2022; Watt et al., 2019)

EXPERIENTIAL ENCOUNTERS: COMMUNITY, CLASSROOM, AND THE EMBODIED CURRICULUM

Through home visits, health assessments, and dialogues with community health workers, I gained insights into challenges such as sanitation, HIV/AIDS, and nutrition. One particularly memorable interaction involved learning about the “fish for sex” practice in a coastal village, an economic and gendered phenomenon that illuminated the intersection of survival strategies and public health risk. This transactional dynamic, where women engage in sexual relations with fishermen in exchange for access to fish or livelihood opportunities, has been documented in several sub-Saharan African contexts. (Kyei-Gyamfi et al., 2025) While often rooted in economic precarity, it reflects deeper structural inequities related to gender, power, and informal economies. This practice contributes to heightened vulnerability to sexually transmitted infections, including HIV, particularly in areas with limited access to preventive services and condoms. (Khalifa et al., 2025) As one health worker shared, “Many women depend on this for survival. But it comes at a cost they often have no power to negotiate protection.” Witnessing these lived realities prompted students to interrogate the intersection of poverty, gender, and health access, and raised critical questions about how public health frameworks might respond to such embedded practices without pathologizing communities. This encounter underscored the value of experiential education in helping learners understand how sociocultural norms shape health risks in ways not easily captured in curricula or policy briefs. These engagements provided material for reflective journaling and group debriefs that deepened our shared learning. (Lasker, 2016a)

At local schools, the experiential learning took on new dimensions. Conversations with students and teachers exposed menstruation-related stigma and the absence of hygiene infrastructure, while also revealing children’s joy, resilience, and curiosity. In one junior high classroom, a teacher admitted that many girls stay home during their periods due to lack of access to pads or clean bathrooms. A

student quietly shared that she used pieces of cloth and feared teasing from boys if they noticed a stain. Despite this, the atmosphere was not one of despair. Girls were eager to learn, asked candid questions about menstruation, and smiled shyly when we discussed hygiene products. Their resilience and curiosity underscored the duality of vulnerability and strength so often present in under-resourced school settings. These visits emphasized how structural inequities affect education and health outcomes and encouraged pedagogical strategies that blend observation with advocacy. (Sommer et al., 2015)

INTEGRATIVE IMPACT: REFLECTION, PARTNERSHIP, AND PROFESSIONAL GROWTH

Reflection was central to the experience. Whether visiting spiritual trees revered for their symbolism, listening to a village chief discuss leadership, or participating in local meals, each moment invited critical thinking about culture, power, and positionality. Journaling, nightly group discussions, and structured prompts helped bridge experience with analysis, aligning with Kolb’s experiential learning cycle and Mezirow’s transformative learning theory. (Kolb, 2014; Mezirow, 1997)

Collaboration with the University of Cape Coast’s Population Health Department underscored the importance of sustainable, bidirectional partnerships. Joint discussions focused on integrating oral health into primary care and the need for curriculum development that reflects local priorities. These exchanges were informative and helped model ethical engagement and co-learning. (Nguyen-Truong et al., 2018) For example, during a discussion with the University of Cape Coast’s Population Health faculty, our team shared a visual case study on oral health screening in rural Ecuador. Rather than simply presenting findings, we paused to ask whether similar methods could be adapted locally in Ghana. A Ghanaian faculty member responded by sharing a parallel effort led by nursing students, highlighting the importance of community oral health days in CHPS zones. This mutual sharing, where both sides brought knowledge, listened with care, and refrained from prescribing solutions, embodied co-learning in action. It was not about imposing a “global best practice,” but about asking, “What works here, and what do you want to build?” That shift in posture from expert to partner was deeply instructive.

Students emerged from the experience with a heightened awareness of global health inequities and a deeper appreciation for community-based health work. The fieldwork

promoted key competencies such as cultural humility, systems thinking, and reflective practice skills that are increasingly valued in graduate education and global health careers. For instance, after visiting a rural clinic that lacked running water and basic instruments, one student reflected, “I used to associate quality care with technology. Now I see it’s also about adaptability and trust.” Another, during a debrief, questioned their assumptions about traditional oral hygiene methods, noting, “People here have been caring for their teeth with sticks and charcoal for generations. Maybe prevention looks different in different contexts.” These reflections illustrate how immersive learning facilitated not just awareness but deeper epistemological shifts in how students viewed health systems and global equity. Importantly, participants reported an increase in their confidence when engaging with diverse populations and navigating ethical complexities in real-world settings.(De Visser et al., 2020; Rodríguez et al., 2021)

STUDENT REFLECTIONS AND TRAJECTORIES

Throughout the program, students were encouraged to document daily reflections, drawing connections between their observations and broader themes of global health justice, resource distribution, and human dignity.

- “The CHPS clinic visit opened my eyes. I always thought of healthcare as sterile, clinical, and detached—but the midwife there knew everyone by name and family. It was healthcare as a relationship,” noted a public health major, junior.
- One student noted, “Being in Ghana challenged the way I thought about what healthcare access really means. I realized it’s not just about medicine or infrastructure, it’s about trust, community, and listening.”
- Another pre-dental student, a senior aspiring to become a public health dentist, reflected on how seeing traditional oral hygiene practices reshaped her understanding of prevention and cultural competence, and shared, “I had no idea what oral health access looked like in rural settings until I watched someone use charcoal and a twig to clean their teeth. That moment stayed with me.”
- “When I saw a girl get teased for having her period at school, I felt ashamed, not for her, but because I’d taken menstrual products and privacy for granted my whole life,” said a nursing student, a sophomore, feeling emotional at that time.
- Another global health minor, senior, said, “At first, I felt

helpless! What could I possibly contribute here? But then I realized my role wasn’t to fix, it was to witness, to learn, and to carry stories home.”

The trip had a lasting impact beyond the field experience. Several participants have since pursued international public health internships, global health minors, or capstone projects addressing health equity. One student began developing a research proposal on integrating oral health into maternal health frameworks, while another co-authored a campus presentation on menstruation equity in global contexts. These student-led trajectories underscore how experiential education fosters not just awareness, but tangible academic and professional development rooted in equity and advocacy.

ETHICS, FACILITATION, AND FACULTY REFLEXIVITY

Participating in this immersion as a faculty observer and not the primary instructor offered a rare pedagogical vantage point to observe student learning from the margins. This liminal role afforded distance from evaluation and control, enabling me to engage in what is described as a pedagogy of presence, being with learners rather than above them.(Vygotsky & Cole, 2018) Unencumbered by facilitation duties, I became attuned to subtle cues: how discomfort manifested, how curiosity unfolded, and how meaning was constructed in situ. The experience reminded me that faculty development, like student growth, is ongoing, relational, and often nonlinear.(Dumas & McNeish, 2017)

Several moments prompted critical reflection on my own assumptions and pedagogical habits. At times, I felt the urge to contextualize complex issues, such as HIV stigma or traditional oral health practices, for students. Instead, I chose to observe how they processed these encounters independently. During one debrief, a student voiced concern about a clinic’s limited infection control. Another gently countered, “Maybe we should ask what the clinic does have before we judge what it lacks.” That exchange was humbling, not only for them, but for me. It underscored the peer-generated pedagogical power that arises when faculty step back.(Narayan, 2011)

This experience also reshaped my understanding of what counts as learning in field-based education. In academic settings, we often privilege articulation, clear arguments, verbal reflections, and written assessments. Yet in Ghana, I witnessed learning that was embodied, emotional, and at times unspoken. One student wept after a school visit and

remained quiet for two days. When she finally shared, her words were raw, yet deeply profound. As faculty, we must honor such affective and nonlinear modes of knowing and build pedagogies that allow them space to emerge.

As I return to designing and teaching global health courses, I carry these lessons forward. I plan to integrate more structured, ethically grounded reflection activities, not only for students, but also for co-faculty. We, too, must journal, debrief, and name the tensions we encounter. As an observing faculty member, my experience was uniquely enriched by informal debriefs with the lead faculty who directly guided student learning. These conversations offered a powerful mirror: while I witnessed student transformation from the margins, she navigated its orchestration in real time. In one evening dialogue, she shared how she managed emotional intensity among students after a particularly difficult school visit. In contrast, I had been quietly observing how they coped without intervening, learning to let silence speak. These reflective exchanges deepened my insights into liminality: neither student nor lead, I was navigating an observational space that required ethical restraint, attunement, and shared vulnerability. We did not always see the same things, but our dialogue surfaced multiple truths, each shaped by role, lens, and pedagogical proximity. Ultimately, field-based education offers a mirror: it asks not only what we teach, but how we listen, how we interpret, and how we grow. (Fedesco et al., 2020)

Ethical engagement in immersive learning is both a pedagogical and logistical commitment. In this program, structured reflection was facilitated through pre-travel workshops on cultural humility and power dynamics, daily evening debriefs during the field stay, and guided prompts embedded in journaling. Reflection questions included: “What assumptions did you bring into this encounter?” and “How do your observations challenge dominant narratives about global health?” One student shared, “Today I felt overwhelmed watching a midwife do so much with so little. I wanted to ask questions but also didn’t want to intrude. It made me question how I define professionalism; it looks different here, and maybe better in some ways.”

As a faculty observer, I noted how essential it was to allow for both silence and dialogue to create room for discomfort without rushing to resolve it. As one student noted, “During the debrief, I realized I’d been focusing on what the clinic lacked instead of what it offers the community. That shift felt uncomfortable, but necessary.”

Reflection was not only about what students saw, but how they came to see it: whose voices they prioritized, what systems they questioned, and which truths they centered. My mental notes echoed, “I thought reflection would be easy; I’ve done it in class before. But here, it feels heavier. There’s no ‘right answer’ to what I’m seeing.”

Ethical facilitation also required constant attention to community relationships: ensuring introductions were respectful, feedback was reciprocal, and data collection, where applicable, was non-extractive. One student mentioned, “I assumed our way of doing things was more advanced, but honestly, their community relationships felt more human than our tech-heavy clinics back home.”

These intentional design choices framed reflection not as an afterthought, but as a core method for cultivating ethical awareness, humility, and sustained engagement in global health practice.

RELEARNING IN THE FIELD

This structured immersion not only catalyzed transformative learning for students but also for me as a faculty member. Positioned as an observer rather than a traditional instructor, I experienced a kind of pedagogical unlearning, one that reintroduced me to the emotional and intellectual vulnerability that often defines authentic learning. The reflective structure of the program, grounded in experiential education theory and critical pedagogy, created a scaffold for ethical discomfort, humility, and personal growth, not just for students, but for faculty as well.

In witnessing students wrestle with inequities, navigate cultural tensions, and reflect aloud in evening debriefs, I found myself revisiting fundamental questions about power, positionality, and what it means to “know” in a global health context. At moments, I was reminded that facilitation is not synonymous with control, and that stepping back can reveal more than stepping in. The field became a shared learning space, one where my faculty title was secondary to the shared labor of meaning-making.

This experience reaffirmed the value of immersive, reflective global health education not as a tool to teach about communities, but as a process for all participants, including faculty, to continually reexamine their own assumptions, roles, and educational philosophies. As universities deepen their commitments to experiential education, faculty must be supported not only as designers or facilitators but also as reflective learners who are shaped, challenged, and renewed by the very experiences they help create.

CONCLUSION: TOWARD A PEDAGOGY OF PRESENCE AND EQUITY

This Ghana field immersion exemplifies the transformative potential of structured experiential education in global health. The design and delivery of this program, anchored in reflection, cultural humility, and community engagement, fostered student growth not only in content knowledge but in empathy, systems thinking, and ethical reasoning. These skills are essential for navigating the complexities of health-care systems and social determinants that characterize 21st-century global health practice.

More significantly, this experience highlighted the role of faculty not merely as content experts, but as co-learners and reflexive practitioners. Participating in the field as an observer allowed for a reengagement with the pedagogical foundations of experiential education, including the cultivation of discomfort, the value of silence, and the nonlinear nature of transformative learning. It became evident that faculty, too, benefit from structured immersion—not just to assess student learning, but to renew their own perspectives, challenge their assumptions, and embody the reflective practices they seek to instill in others.

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In expanding the boundaries of the classroom into a global field context, this program offers a model for interdisciplinary, equity-driven, and ethically grounded experiential learning. It underscores the imperative for institutions to support faculty not only in facilitating global experiences but in participating in them as reflective learners. Such engagement deepens the relational and epistemological foundations of experiential education, ultimately shaping more compassionate, contextually aware, and socially responsive health professionals and educators.

BEYOND THE CLASSROOM, BEYOND THE TRIP

Months after returning, the experience in Ghana continues to echo through my teaching. I find myself redesigning syllabi with more room for discomfort, dialogue, and emotional processing, hallmarks of the field that are often absent in classroom settings. When I speak to students about equity or global systems now, I do so with greater humility, carrying the weight of stories shared in clinics, schools, and village homes. Ghana did not just shift what I teach, it shifted how I listen, how I notice, and how I hold space for complexity. That, more than any learning outcome, may be the most enduring gift of immersion.

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