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An educational program for enhancing cultural competence and cultural self-efficacy in healthcare providers:

A quasi-experimental single-group study in Southern Iran

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65
healthcare providers

4 × 2 h
weekly training sessions

+128.11
cultural competence mean change

+22.16
cultural self-efficacy mean change

BACKGROUND & AIM

Cultural competence is essential for providing effective, culturally congruent care to diverse patients. Cultural self-efficacy reflects healthcare providers' confidence in navigating cultural differences and applying culturally appropriate care.

Despite the importance of these competencies, evidence on the impact of cultural care training among healthcare providers in Southern Iran was limited.

STUDY DESIGN & SETTING

- Quasi-experimental, single-group pretest–posttest design with no control group.
- Conducted in comprehensive urban health service centers in Jiroft, Southern Iran, in 2024.
- Eligible healthcare providers had ≥1 year of work experience and had not previously received cultural-care training.
- Convenience sampling; 100 eligible providers were identified, 80 were approached, and 65 participated.
- Written informed consent was obtained; study protocol approved by Jiroft University of Medical Sciences Ethics Committee (IR.JMU.REC.1401.024).

MEASURES & DATA COLLECTION

- Demographic questionnaire: age, sex, marital status, work experience, residence status and ethnicity.
- Cultural Care Inventory: 51 items assessing awareness, attitude, skills and preparation.
- Cultural Self-Efficacy Scale (CSES): 25 items covering knowledge of cultural concepts, comfort in performing cultural skills and knowledge of cultural patterns.
- Reliability in the present study: Cronbach's α = 0.81 for the Cultural Care Inventory and 0.77 for CSES.
- Data collection period: May–August 2024; outcomes assessed before and one month after training.

EDUCATIONAL INTERVENTION

Four weekly 2-hour sessions combining knowledge acquisition, discussion and practice.

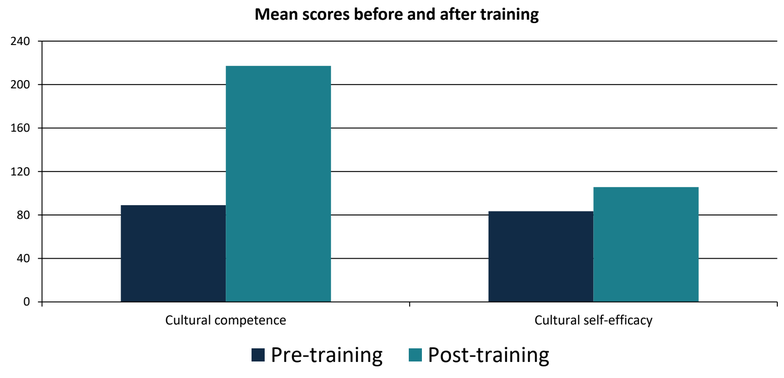
1 — Concepts & principles
Cultural care concepts, culture, ethnicity, cultural competence and cultural self-efficacy.

2 — Assessment
Cultural assessment, communication barriers, beliefs, values, health practices and culturally relevant needs.

3 — Culturally congruent care
Planning and delivering care while respecting cultural beliefs, values, lifestyle and health practices.

4 — Practice & integration
Role-play, experience sharing, Q&A and application of culturally appropriate communication and care.

PRIMARY OUTCOMES



CULTURAL COMPETENCE: DIMENSIONS

Dimension	Pre	Post	Δ	Effect size
Awareness	19.41	47.63	+28.21	8.40
Attitude	16.56	39.78	+23.21	7.45
Skills	21.81	51.55	+29.73	8.93
Preparation	31.33	78.05	+46.71	8.91

All dimensions improved significantly (p = 0.001). The largest absolute gain was observed in preparation (+46.71).

CULTURAL SELF-EFFICACY: DIMENSIONS

Dimension	Pre	Post	Δ	Effect size
Knowledge: cultural concepts	5.33	12.30	+6.97	5.35
Comfort: cultural skills	10.11	12.30	+2.18	1.39
Knowledge: cultural patterns	68.8	68.08	−0.72	—

Overall self-efficacy increased from 83.53 ± 4.95 to 105.70 ± 7.24 (mean change +22.16; effect size 3.57; p = 0.001). The strongest dimensional improvement was in knowledge of cultural concepts.

STATISTICAL FINDINGS

- Cultural competence: 89.05 ± 12.30 → 217.16 ± 12.09; mean change +128.11; effect size 10.5; t = −65.99; p = 0.001.
- Awareness: +28.21; t = −53.84; p = 0.001.
- Attitude: +23.21; t = −45.63; p = 0.001.
- Skills: +29.73; t = −56.69; p = 0.001.
- Preparation: +46.71; t = −50.88; p = 0.001.

INTERPRETATION

The intervention was associated with substantial improvement in both cultural competence and cultural self-efficacy. The findings support the value of structured, evidence-informed in-service education that combines cultural knowledge with interactive methods such as role-play, discussion and experience sharing.

IMPLICATIONS FOR MEDICAL EDUCATION

- Integrate cultural-care content into medical and nursing curricula and continuing professional education.
- Use interactive educational strategies to translate cultural concepts into practical care behaviors.
- Prepare healthcare providers to assess cultural needs and adapt communication and care plans.
- Use ongoing assessment of cultural competence and self-efficacy to guide educational needs.

LIMITATIONS & FUTURE RESEARCH

- No control or comparison group limits causal inference.
- Single-city setting and relatively small sample limit generalizability.
- Only one post-intervention assessment was conducted.
- Future studies should use larger samples, include immigrant communities and other provider groups, and apply multiple follow-up assessments.
- Interventional, qualitative and longitudinal designs are recommended in culturally diverse settings.

CONCLUSION

A four-session cultural-care training program significantly enhanced cultural competence and cultural self-efficacy among healthcare providers in Jiroft. The findings provide a practical model for continuing education and support the integration of cultural-care training into health-professional education to promote culturally congruent care and potentially improve patient satisfaction and care quality.

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