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Cultural Humility: Enhancing Nursing Practice Across Diverse and Global Contexts

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Abstract

Cultural humility is a lifelong process of self-reflection, recognition of personal biases, and continuous learning in cross-cultural engagement, and is a cornerstone of global health sciences. In 2023, the University of California, San Francisco's Center for Global Nursing (CGN) launched the Introduction to Cultural Humility course, a three-hour virtual training designed to prepare nurses and advanced practice providers (APPs) to engage in equitable global collaborations.

Between 2023 and 2024, CGN conducted six sessions, reaching a total of 108 participants. Following the training, a post-course survey was administered using the modified Dillman method to evaluate knowledge gains and participant experience. The survey included 16 Likert-scale questions and optional open-ended items, with results analyzed using descriptive statistics and thematic analysis.

Thirty-six participants completed the survey (response rate: 32%). Results demonstrated an average one-point increase in perceived knowledge across all course objectives, along with enhanced self-reflection in both clinical and collaborative settings. Nearly all respondents highly recommended the course to UCSF faculty, staff, and leaders, regardless of direct involvement in global health.

These findings highlight the effectiveness of the *Introduction to Cultural Humility* course in equipping nurses and APPs with the foundational skills necessary to engage in cross-cultural collaboration and cultivate equitable global partnerships. The course serves as a critical component of professional development for health professionals working in increasingly diverse and interconnected healthcare environments.

Keywords: Cultural humility; Cultural safety; Global health; Healthcare disparities; Health equity; Cross-cultural collaboration; Global nursing

Background

For generations, nurses have worked across cultural boundaries in both local and global contexts, leveraging these partnerships to enhance patient- and family-centered care. A pioneering figure in this movement, Madeleine Leininger developed the theory of transcultural nursing, which emphasized the importance of understanding cultural values, beliefs, and practices as essential components of quality care and global health. Her seminal works, including *Culture Care Diversity and Universality: A Theory of Nursing* [1] and *Transcultural Nursing: Concepts, Theories, Research, and Practice* [2], laid the foundation for embracing cultural diversity in nursing and reframed cultural sensitivity as a critical dimension of effective healthcare delivery.

Building on these ideas, Cross and colleagues [3] introduced the concept of cultural competence, which became a widely adopted framework for healthcare providers. While this approach encouraged cultural awareness, it has been critiqued for implying that clinicians can achieve a finite level of "competence" in another's culture [4,5]. Scholars have also noted its tendency to overemphasize shared group characteristics, underrepresent individual variation, and fail to address issues of privilege and power [6-8].

In response, cultural humility has emerged as a more equity-oriented and relational framework, particularly in global and public health. Defined by lifelong learning, self-reflection, and a commitment to addressing power imbalances, cultural humility shifts the focus from cultural mastery to mutual respect and accountability [6,9]. It aligns with the World Health Organization's Global Strategic Directions for Nursing and Midwifery [10], which emphasize culturally responsive care and cross-cultural collaboration as critical to workforce development and equitable health systems.

Recent literature affirms the growing importance of cultural humility in improving trust, communication, and care outcomes for diverse and marginalized populations [11,12]. Cultural humility also supports decolonizing approaches to global health [13,14] and promotes inclusive team dynamics in diverse practice settings [15]. In nursing education, cultural humility has been shown to foster safe, inclusive spaces for both patients and providers [16] and is increasingly recognized as a core competency for both clinical care and research engagement [17].

Despite this, most nursing educational programs still prioritize cultural competence, and in the United States, only ten states mandate any related training, with none requiring cultural humility [12]. Given the continued need for lifelong learning and reflection, integrating cultural humility into nursing curricula and professional development is essential to preparing nurses to lead equitable, culturally responsive care in diverse and global settings.

Program Overview

In response to the growing recognition of cultural humility as a core nursing competency and gap in education, the Center for Global Nursing (CGN) at the University of California, San Francisco (UCSF) developed the *Introduction to Cultural Humility* course and launched its first cohort in February 2023. This three-hour virtual training is designed to equip nurses and advanced practice providers (APPs) with foundational, practical tools to reflect on their own biases, build stronger patient relationships, and collaborate cross-culturally. The course combines didactic lectures with interactive discussions and supports CGN's broader mission to promote health equity, strengthen global partnerships, and embed hands-on learning in nursing education [18].

Between February 2023 and October 2024, six sessions of the course were offered, with a total of 108 participants completing the training. The program was provided at no cost to UCSF nurses and APPs and included continuing education (CE) credit. To assess the course's effectiveness, participants completed post-training surveys evaluating changes in their knowledge, attitudes, and ability to apply principles of cultural humility in clinical and collaborative practice.

Methods

This cross-sectional survey study evaluated the impact of CGN's Introduction to Cultural Humility course on participants' understanding and application of cultural humility principles in their professional practice. Eligible participants were UCSF nurses and APPs who completed the course in 2023 or 2024. Participants received an email invitation to complete the electronic survey, with follow-up email survey requests sent at one-week intervals for four weeks. Survey participation was voluntary, and responses were anonymously analyzed through Qualtrics application.

The survey consisted of twenty-two questions, including both Likert-scale and free-response questions. Self-rated understanding of cultural humility concepts, such as bias recognition, positionality, and structural humility, was assessed using a Likert scale from one (no understanding) to five (excellent understanding). Participants were asked to rate their understanding of these concepts retrospectively for both before and after taking the course. The pre- and post-course self-assessments were then compared to evaluate changes in participants' knowledge and confidence. Other Likert-scale questions measured the frequency with which participants applied cultural humility concepts in their clinical practice and professional collaborations. Mean scores and standard deviations were calculated using Microsoft Excel for Likert-scale responses, and pre- and post-course comparisons assessed changes in knowledge and confidence [19,20].

Participants were also asked to rate the course's relevance to their work, its impact on their patient care approach, and their level of confidence in integrating cultural humility into interactions with colleagues and patients. Six free-response questions invited participants to reflect on specific ways they applied cultural humility in patient care or team interactions, describe the most impactful aspects of the course, and offer suggestions for content improvement. These qualitative responses were systematically analyzed using thematic analysis to identify common patterns and key areas of application.

We have reviewed and analyzed the survey responses to better understand participants' experiences in the course. The results are presented overall, showing how many people answered each question or section, along with the corresponding percentages. Their responses were not included in the percentage calculations for those items.

Results

Participant Profiles

Out of the 108 participants who participated in the training course, 33% (n=36) took the online survey, though not all respondents answered every question. Of the 33 (92%) who answered sociodemographic questions, more than half were registered nurses (n=22, 67%), followed by nurse practitioners (n=5, 15%) and nurse leaders or managers (n=2, 6%). Other roles included one certified registered nurse anesthetist (CRNA) (3%), one clinical nurse specialist (3%), one nurse midwife (3%), and one physician assistant (3%). Thirteen respondents (39%) reported 11 to 15 years of experience in nursing or advanced practice roles, and eleven (31%) had more than 16 years of experience. Some participants were earlier in their careers, including one with less than one year of experience, four (12%) with two to five years, and four (12%) with six to ten years of experience. Over half of the participants (n=17, 52%) held doctoral degrees, while 39% (n=13) had bachelor's degrees and 9% (n=3) had master's degrees.

Participant Professional Practice Profiles (N=33)	
Professional Role (all that apply)	**n (%)**
Registered Nurse	22 (67)
Nurse Practitioner	5 (15)
Nurse Leader/Manager	2 (6)
Certified Registered Nurse Anesthetist	1 (3)
Clinical Nurse Educator	1 (3)
Clinical Nurse Specialist	1 (3)
Nurse Midwife	1 (3)
Physician Assistant	1 (3)
School of Nursing Faculty	1 (3)
Professional Experience (years)	**n (%)**
1 or less	1 (3)
2 to 5	4 (12)
6 to 10	4 (12)
11 to 15	13 (39)
16 to 20	6 (18)
20 or greater	5 (15)
Highest Professional Degree	**n (%)**

Bachelor's	13 (39)
Master's	3 (9)
Doctorate	17 (52)
Clinical Field(s) of Expertise (all that apply)	**n (%)**
Acute Rehabilitation	1 (3)
Adult/Geriatric	6 (18)
Cardiology/Cardiac Surgery	4 (12)
Critical Care/Emergency	5 (15)
Hematology/Oncology	1 (3)
Infectious disease	1 (3)
Medical/Surgical Care	6 (18)
Neurosciences (including neurology/neurosurgery)	5 (15)
Pediatrics	7 (21)
Peri-operative Care	5 (15)
Quality Improvement/Evidence-Based Practice	3 (9)
Reproductive health/Obstetrics	8 (24)
Other	7 (21)

Table 1: Participant practice profiles by question group, showing count and percentage of total respondents.

Respondents were affiliated across UCSF campuses, often with multiple affiliations, including UCSF Medical Center at the Parnassus campus (n=20, 61%), followed by the Mission Bay campus (n=9, 27%) and UCSF Benioff Children's Hospitals (n=11, 31%). The majority were full-time employees at UCSF Health (n=29, 82%), while others worked in part-time (n=3, 9%) or adjunct/non-salaried faculty roles (n=2, 6%). One respondent identified as an advanced practice student (3%). Respondents also practiced in a range of clinical specialties, including pediatrics (n=7, 21%), adult/geriatric care (n=6, 18%), reproductive health/obstetrics (n=6, 18%), medical-surgical care (n=6, 18%), critical care (n=5, 15%), and perioperative care (n=5, 15%).

Changes pre- and post-course understanding of cultural humility

Participants reflected on their understanding of the following concepts before and after completing the course: cultural humility, cultural competence, personal biases, and collaborative communication. Of the 28 (78%) participants who completed this section, the mean understanding of cultural humility prior to the course was 2.96 (SD=1.14) and increased to 4.25 (SD=0.52) post-course. Comprehension of the difference between cultural competence and cultural humility increased from a pre-course rated mean of 2.82 (SD=1.06) to 4.21 (SD=0.50) post-course. Participants' ability to define cultural humility and its main principles also increased from 2.50 (SD=1.11) before the course to 4.00 (SD=0.61) after course completion. Participants' ability to recognize the impact of their biases on global health partnerships had a mean pre-course rating of 2.89 (SD=1.13) and increased to 4.21 (SD=0.69) post-course. Lastly, the ability to identify three examples of collaborative communication increased from a pre-course mean of 2.93 (SD=0.98) to 4.04 (SD=0.64) post-course.

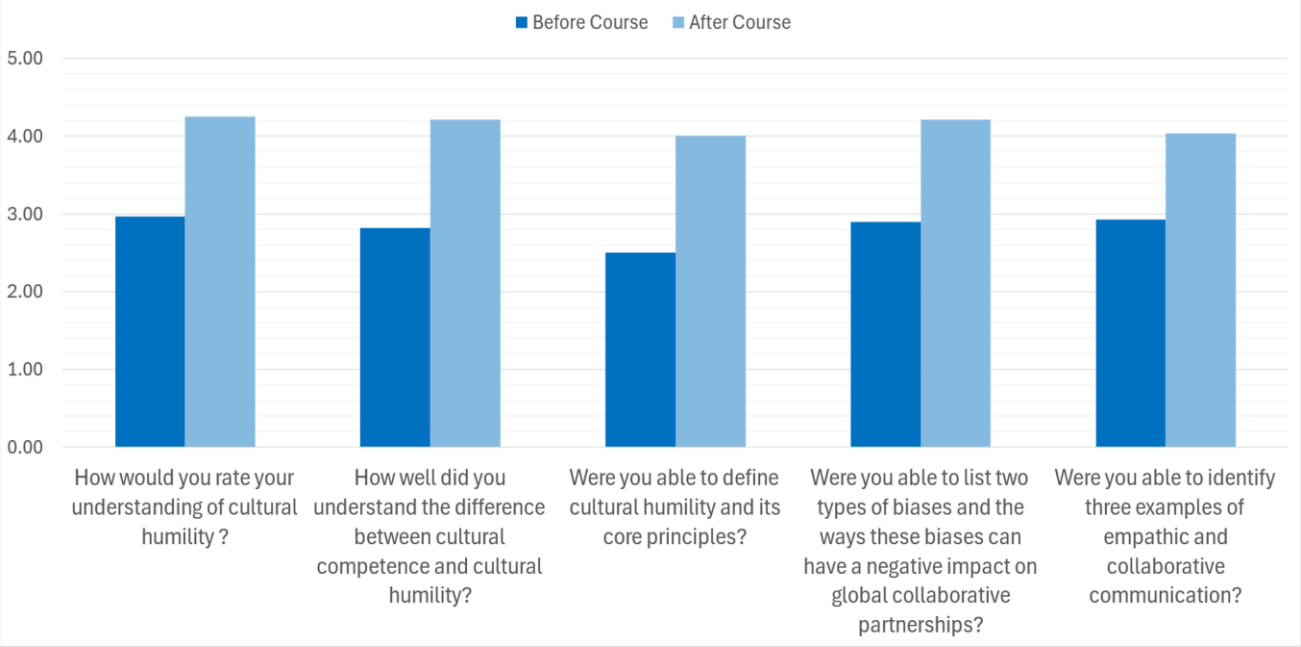

Figure 1: Participant responses for pre- and post-course understanding of cultural humility.

Integration of cultural humility and reflections post-course

Twenty-four (67%) participants out of the total of 36 responded to the open-text response question describing how they applied cultural humility principles in both local and global health contexts. Their responses clustered into four main domains: collaboration and communication, self-awareness and bias reflection, patient-centered care, and education and training. Collaboration and communication were the most frequently cited areas of application (33%), with participants highlighting the importance of culturally sensitive interactions to foster trust and mutual understanding in clinical and team settings. Self-awareness and bias reflection followed closely (29%), with participants acknowledging and exploring their own biases as a step toward continuous personal and professional growth. Patient-centered care (29%) emerged as another significant domain, with participants describing how they tailored care to align with patients' cultural values and beliefs, both at UCSF and in global health settings. A smaller group (8%) reported applying cultural humility in education and training, particularly by mentoring others and fostering cultural awareness among colleagues and healthcare teams.

In a second set of open-ended questions, 22 (61%) participants out of the total of 36, responded to the open-text response question reflecting on how the course influenced their awareness of personal biases, privilege, and assumptions in both professional and personal environments. The most common theme was general awareness of bias (41%) and following by personal reflection and change (36%), with participants actively working to recognize and adjust their biases. Additionally, 9% described changes in professional practice, particularly in decision-making and interpersonal interactions. A further 9% noted increased engagement in bias testing or structured reflection, while 5% emphasized cultural competence and perspective-taking, where they utilized tools or exercises to apply cultural humility principles in their interactions.

Application of CH in work and/or global efforts in:	Self-awareness and bias reflection (n = 7, 329%)
	Collaboration and communication (n = 8, 33%)
	Patient-centered care (n = 7, 29%)
	Education and training (n = 2, 8%)
Did this course prompt you to reflect on your own biases, privileges, or assumptions in personal and professional settings?	General awareness of bias (n = 7, 41%)
	Personal reflection and change (n = 8, 36%)
	Impact on professional practice (n = 2, 9%)
	Cultural competence and perspective-taking (n = 1, 5%)
	Bias testing and structured reflection (n = 2, 9%)

Table 2: Application of cultural humility in work, global efforts, and personal/professional reflection post-course.

Preparedness in applying cultural humility and course improvement suggestions

Participants were asked to reflect on how confident they were in integrating cultural humility into their professional and personal interactions following the course. Of the 36 participants who responded to the survey, 23 (64%) completed the open-ended survey questions. A total of 57% (n=13) reported feeling prepared to implement cultural humility in work and/or global efforts and the remaining 43% (n=10) noted that they were in the process of still developing their understanding of its application.

The same 23 participants provided feedback on potential improvements to the course content and structure. The majority (70%, n=16) were overall satisfied and stated that no changes were needed. However, 13% (n=3) suggested improvements to the course structure and format, and an additional 13% (n=3) requested more features and resources to enhance learning. One individual expressed interest in expanding the course curriculum to include cultural humility principles and their application in more detail.

Course recommendation likelihood

Twenty-five participants (69%) out of the total number of people who completed the survey rated how likely they would recommend the course to others. Roughly two-thirds (60%, n=15) indicated that they were extremely likely to recommend the course, with an additional 12% (n=3) reporting they were somewhat likely to recommend it. When asked who they believed would benefit most from the training, participants identified a broad range of professional roles and settings: 92% (n=22) recommended the course for individuals working in community health settings, 88% (n=21) endorsed it for nurses and advanced practice providers (APPs) working in UCSF's hospital systems and clinical care, 83% (n=20) saw value for professionals in global health and healthcare leadership, and 79% (n=19) recommended the course for individuals in academic and educational settings.

Discussion

The findings from the course evaluation highlight the increasing recognition of cultural humility as a core competency for healthcare professionals, particularly nurses and advanced practice providers working in diverse and global contexts [6,9,21]. Participants in the UCSF Center for Global Nursing's Introduction to Cultural Humility course reported increased perceived knowledge across all course learning objectives. The study also revealed meaningful insights from participants' reflections following the course, with many reflecting on greater awareness of personal biases and enhanced confidence in engaging in culturally respectful communication. These results suggest that even brief, focused training can positively influence how clinicians relate to patients and collaborators across cultural contexts [17,22].

Notably, while some participants demonstrated integration of the cultural humility principles into their practice, others expressed a need for additional exposure and practice before fully applying these concepts. This underscores the importance of sustained and iterative learning opportunities in nursing education [23]. Feedback also pointed to potential

improvements, including the incorporation of more case-based learning and follow-up sessions to reinforce application in real-world contexts. Participants recommended broadening access to the course across UCSF, not only for direct care providers but also for individuals in leadership and administrative roles, highlighting its relevance at every level of healthcare delivery [7,16].

This study has several limitations. First, the data is self-reported, which may introduce response bias. The timing of survey distribution following the course varied considerably, ranging from one month to one year after completing the course, which may have impacted recall and response quality. Additionally, the response rate was 33% of the total participants, which limits the generalizability of the findings. To better assess the long-term outcomes of the course, future research should incorporate longitudinal follow-up and qualitative approaches, such as interviews, to capture deeper insights over time.

This study contributes to the growing body of evidence that cultural humility is a critical component of nursing education and professional development. By promoting self-awareness and cultural exploration, cultural humility equips nurses with the tools to provide equitable care and engage in meaningful collaboration within diverse healthcare settings [9,21]. While foundational to global health, these competencies are essential in all healthcare settings and should be intentionally embedded into nursing and advanced practice curricula to advance inclusive, responsive, and effective healthcare delivery.

Conclusion

UCSF's *Introduction to Cultural Humility* course represents a critical step toward cultivating a more reflective, inclusive, and equity-driven nursing workforce equipped to deliver responsive care across diverse and global contexts. While the course provided meaningful foundational training, further research is warranted to examine how principles of cultural humility translate into sustained changes in clinical practice and interprofessional team dynamics. Future studies incorporating longitudinal assessments, qualitative interviews, and observational methods may yield deeper insights into the long-term impact of cultural humility education. These findings will inform ongoing curriculum refinement and contribute to the broader discourse on integrating cultural humility into global health nursing education and practice.

Conflict of Interest

The authors deny any conflicts of interest.

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