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The incorporation of interculturality in the training of health professionals: a systematic review

La incorporación de la interculturalidad en la formación de profesionales del área de la salud: una revisión sistemática

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ABSTRACT

The training of health professionals has developed under the predominance of a biomedical rationality that tends to exclude traditional, indigenous, and community-based medical knowledge, despite the growing cultural diversity of Latin American societies. This systematic review aimed to analyze the available empirical evidence on the incorporation of interculturality into the curricula of university health science programs, in order to identify the main strengths, weaknesses, and training gaps reported in the literature, as well as the pedagogical and curricular strategies proposed to strengthen and implement it. Following the PRISMA 2020 statement and the eligibility criteria of the PICO model, a search was conducted in Scopus, Dialnet, Redalyc, LILACS, and SciELO, yielding a final sample of 27 studies reporting primary empirical data, published between 2020 and 2025. The results, organized through a narrative synthesis into four thematic categories, showed that interculturality has been incorporated predominantly in a declarative manner into institutional normative frameworks, but in most cases has not translated into an effective transformation of curricular content. Transversal and sustained training experiences were also identified, along with moderate levels of intercultural competence and sensitivity among students and faculty, and persistent structural barriers to care for indigenous, migrant, and Afro-descendant populations. The review concludes that a critical and effective curricular transformation toward interculturality requires strategies that go beyond the declarative incorporation of isolated content, moving instead toward cross-cutting curricular structures developed in direct dialogue with communities.

Keywords: interculturality, higher education, health sciences, curriculum, systematic review.

RESUMEN

La formación de profesionales de la salud se ha desarrollado bajo el predominio de una racionalidad biomédica que tiende a excluir los saberes médicos tradicionales, indígenas y comunitarios, pese a la creciente diversidad cultural de las sociedades latinoamericanas. El objetivo de esta revisión sistemática fue analizar la evidencia empírica disponible sobre la incorporación de la interculturalidad en el currículo de carreras universitarias del área de la salud, para identificar las principales fortalezas, debilidades y vacíos formativos reportados en la literatura, así como las estrategias pedagógicas y curriculares propuestas para su fortalecimiento. Siguiendo la declaración PRISMA 2020 y los criterios de elegibilidad del modelo PICO, se realizó una búsqueda en Scopus, Dialnet, Redalyc, LILACS y SciELO, que arrojó 27 estudios con datos empíricos primarios, publicados entre 2020 y 2025. Los resultados, organizados mediante síntesis narrativa en cuatro categorías temáticas, evidenciaron que la interculturalidad ha sido incorporada de manera predominantemente declarativa en los marcos normativos institucionales, sin traducirse, en la mayoría de los casos, en una transformación efectiva de los contenidos curriculares; asimismo, se identificaron experiencias formativas transversales y sostenidas en el tiempo, niveles moderados de competencia y sensibilidad intercultural en estudiantes y docentes, sin embargo, barreras estructurales persistentes en la atención a poblaciones indígenas, migrantes y afrodescendientes. Se concluye que la transformación curricular hacia una interculturalidad crítica y efectiva requiere estrategias que trasciendan la incorporación

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declarativa de contenidos puntuales, y se orienten hacia dispositivos curriculares transversales construidos en diálogo directo con las comunidades.

Palabras clave: interculturalidad, educación superior, ciencias de la salud, currículo, revisión sistemática.

INTRODUCTION

The training of health science professionals in Latin America has developed under the predominance of a biomedical rationality that tends to fragment the human being into systems amenable to technical intervention, relegating the cultural, spiritual, and community dimensions of health and illness (Menéndez, 2024). Historically, this model has operated as a mechanism of subordination of traditional and indigenous medical knowledge, whose epistemic validity is denied because it does not conform to the criteria of Western science. Santos (2010) calls this dynamic "abyssal thinking": a line that separates scientific knowledge from traditional knowledge as incommensurable universes, leading to an "epistemicide," or the systematic destruction of cultural knowledge. In response, Santos proposes an "ecology of knowledges" that allows for a non-hierarchical intercultural dialogue, recognizing traditional and indigenous practices as legitimate interlocutors rather than as mere folkloric complements to biomedical knowledge.

Along these lines, Walsh (2023) distinguishes between functional interculturality, which tolerates diversity without modifying existing power hierarchies, and critical interculturality, which questions the colonial structures of knowledge and seeks to "crack" institutions in order to open space for the genuine recognition of subalternized knowledges. This distinction is central to health training, given that a good share of the curricular initiatives aimed at cultural diversity operate within the functional register: they incorporate isolated content without altering the hierarchical structure that continues to place biomedical knowledge as the only legitimate authority. This hegemony also operates in the material sphere, insofar as health systems reserve formal employment for those trained under the biomedical model, relegating wise elders and practitioners of ancestral medicine (a term used here as an analytical category, without implying that all indigenous, peasant, or Afro-descendant communities use this name for their own knowledge of care) to a precarious position (Menéndez, 2024).

Against this backdrop, transcultural nursing theories—taken up here as a common analytical starting point owing to their pioneering theoretical development within the health sciences, as justified in the Methodology section—have proposed frameworks for thinking about care from a culturally sensitive perspective. Leininger (1991), the founder of this current, argued that professional care must adapt to the worldviews of each community, distinguishing between the emic knowledge of communities and universal ethical principles. Complementarily, Watson (1979) holds that health personnel must integrate patients' cultural beliefs as a constitutive, and not accessory, part of care. Both frameworks share the premise that cultural competence is not a technical add-on but a condition for the dignity of care in contexts of diversity.

The translation of these theoretical discussions into the effective training of professionals has been the subject of systematic reviews in different contexts. Arruzza & Chau (2021), in a scoping review focused on undergraduate health science students, found that cultural competence education interventions consistently improve knowledge acquisition, skills performance, attitudes, and student satisfaction, although they point to the absence of control groups in most of the available studies as a fundamental methodological limitation. Bolarinwa & Nkansah (2025) found moderate or low levels of cultural competence in low- and middle-income countries. Gradellini et al. (2021) concluded that the most effective training projects combine multiple strategies in a cross-cutting and sustained manner, in contrast to isolated initiatives. De-María et al. (2024), in the European context, found considerable heterogeneity in the conceptualization of the construct and a still limited adoption of these interventions.

In the Latin American context, Álvarez-Cruces et al. (2021) conducted an earlier systematic review on intercultural competence in the health sciences, finding a predominance of studies from the United States and Australia, with training experiences that were mostly extracurricular and short-term. The authors explicitly warned of the

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scarce representation of Latin American research in the corpus available up to 2020, a gap that the present review seeks to help address.

A first group of studies documents the dimension of teaching and curriculum, that is, how interculturality is manifested—or not—in the study plans and concrete pedagogical practices of health training in the region. Villela et al. (2020) showed that, in Guatemala, the Medicine curriculum does not explicitly incorporate the intercultural axis even though institutional regulations declare it. Martínez Pabón et al. (2022) found that only 3% of physiotherapy courses and 5% of nursing courses in Colombia addressed intercultural content. In response to this gap, Farías-Cancino et al. (2021) and Beltrán Abad et al. (2020) documented concrete pedagogical strategies—a participatory methodology in Chile and an experiential approach in Cuba—aimed at strengthening intercultural competence from within the curriculum.

A complementary line of studies situates the discussion at the level of public indigenous health policies, thus differing from the teaching level addressed by the previous group. Aguilar Peña et al. (2020) argued that incorporating the indigenous model of health into health training requires specific intercultural training policies. Vieira Weiss (2023) documented, in Brazil, the persistence of "ninguendade" as an expression of the structural non-recognition of native peoples in training processes. Urrutia et al. (2022) highlighted, in Chile, the need for an anthropological perspective that goes beyond the technical-communicative in the care of migrants.

Returning to the teaching dimension, Mancinelli (2023) showed that sustained collaborative spaces with Argentine Wichí communities are essential for training that respects indigenous realities, while Giménez Milán & Acosta Güemes (2024) reported improvements in students' listening and reflection through narrative methodologies. Türedi et al. (2024) found, among practicing Turkish professionals, that gender, educational level, and prior experience influence intercultural communication competence. Mohiyeddini (2024) argued that medical education must evolve toward culturally competent professionals, while Hilario-Pizarro et al. (2023) identified four recurring axes in the literature: the social role of the professional, their professional development, intercultural training proper, and its effective implementation.

A third axis of studies is situated at the level of the clinical and ethical application of intercultural care, where several authors argue that ethics and interculturality should be cross-cutting elements of the curriculum and not isolated courses (Nárvaez & Gómez, 2022; Gavilanes Llango et al., 2022). Revelo (2019) and Lorenzo Serrano (2019) documented, from ethnographic and communicational approaches, the value of the situated ethics of care in Ecuadorian indigenous communities, while Melo et al. (2021) noted that structural racism continues to hinder, in Brazil, indigenous populations' access to ethical and equitable care.

Despite being distributed across three distinct axes—teaching and curriculum, clinical and ethical application, and public policy—this body of antecedents makes it possible to identify a consistent pattern: although normative frameworks, theoretical models, and pedagogical experiences aimed at incorporating interculturality into health training exist, their translation into study plans and concrete pedagogical practices remains, in most cases, partial or declarative.

Latin America is a territory of profound cultural, ethnic, and linguistic diversity, where biomedical health systems coexist with traditional, indigenous, peasant, and Afro-descendant care practices that have their own cultural validity. Various normative frameworks have installed the discourse of interculturality as a desirable component of health training; however, as the general overview reviewed suggests, there is a considerable distance between these declarative frameworks and their effective curricular translation. This gap constitutes a relevant research problem: it is not enough for interculturality to be mentioned in regulations; it is necessary to examine whether, and in what way, this approach permeates the content and concrete learning experiences.

In addition, the available literature is fragmented across disciplines, countries, and methodological designs, which hinders an overall view of the state of the curricular incorporation of interculturality in health. A systematic review that integrates this dispersed evidence is necessary to identify common patterns and to provide an empirical basis to guide future curricular reform

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processes in university health training at the Latin American level.

In light of the above, the objective of this systematic review is to analyze the available empirical evidence on the incorporation of interculturality into the curricular content of university health programs in Latin America, based on studies published between 2020 and 2025 in at least nine countries of the region, in order to identify the main strengths, weaknesses, and training gaps reported in the literature, as well as the pedagogical and curricular strategies proposed for its strengthening and implementation.

METHODOLOGY

Operational definition of concepts and disciplinary scope

For the purposes of this review, the following operational definitions of the central concepts that structure the analysis are adopted. Interculturality is understood, following Walsh (2023), as an ethical, political, and epistemic disposition of relationship between culturally diverse groups aimed at questioning and transforming the power structures that naturalize the subordination of some knowledges to others, thus distinguishing it from functional interculturality, which recognizes diversity without altering the underlying power relations (Tubino, 2005, as cited in Miranda et al., 2024). The intercultural curriculum is defined as the set of contents, competencies, and training experiences—explicit in study plans or implicit in pedagogical practices—aimed at incorporating this perspective into professional training. Intercultural competence is understood, following Campinha-Bacote (2002), as the ongoing process by which a health professional develops the capacity to work effectively within the cultural context of the patient or community, while intercultural sensitivity refers to the attitudinal and emotional disposition that precedes and sustains such competence, in line with Bennett's model as taken up by Álvarez-Cruces et al. (2025b). Finally, coloniality of knowledge is understood as the persistence of epistemic hierarchies inherited from colonialism that subordinate the knowledge and care practices of indigenous, Afro-descendant, and peasant peoples to biomedical knowledge as the only legitimate authority.

Regarding disciplinary scope, this review considered studies referring to health science programs in general (medicine, nursing, dentistry, obstetrics, nutrition, physiotherapy, and related fields, in accordance with the Population criterion in Table 1). However, the theoretical framework relies primarily on transcultural nursing theory (Leininger, 1991; Watson, 1979) because it is, within the health sciences, the discipline with the greatest explicit theoretical development on culturally congruent care, as confirmed by the corpus of this review itself, in which most of the instruments measuring intercultural competence and sensitivity (Table 2) come from the nursing literature. This does not imply that this framework exhausts the theoretical possibilities of other health disciplines, but rather that it is used here as a common analytical starting point, in dialogue with the contributions of critical pedagogy (Freire, 2005) and critical interculturality (Walsh, 2023) that cut across the analysis.

Design

This research is a systematic literature review whose process of identification, selection, eligibility, and inclusion of studies was carried out following the guidelines of the PRISMA 2020 statement (Page et al., 2021), which standardizes the transparent reporting of systematic reviews through a four-phase flow (identification, screening, eligibility, and inclusion).

Eligibility criteria

The eligibility criteria were structured on the basis of the PICO model (Population, Intervention, Comparison, and Outcomes), which is widely used in health sciences research to delimit the scope of a bibliographic search (Uman, 2011). Original scientific articles with primary empirical data, published between January 2020 and the search closing date (January 2026) and available in full text, were included; book chapters, books, theses, conference proceedings, editorials, and literature reviews without original data were excluded because they are not systematically subject to peer review, which makes it difficult to assess their methodological quality uniformly. Table 1 summarizes the eligibility criteria according to each component of the PICO model.

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Table 1

Eligibility criteria according to the PICO model for study selection

Component	Element	Inclusion criteria	Exclusion criteria
P Population	Students and/or faculty of undergraduate programs in the health sciences (medicine, nursing, dentistry, obstetrics, nutrition, physiotherapy, and related fields).	Undergraduate programs in the health sciences. Studies that include students, faculty, or curricula as the unit of analysis.	Postgraduate programs or continuing education as the exclusive focus. Studies conducted in populations not linked to health training.
I Intervention / Phenomenon	Inclusion, integration, or development of interculturality as a competence, curricular content, or pedagogical approach in the training of health professionals.	Design, implementation, or evaluation of intercultural strategies in the curriculum. Programs or courses that address cultural diversity, cultural competence, or intercultural health.	Studies focused exclusively on linguistic diversity with no explicit link to interculturality. Clinical interventions without a training component.
C Comparison	No mandatory comparison group is established; however, studies that contrast curricular models with and without an intercultural approach are considered.	Studies with or without a comparison group. Reviews that contrast different approaches to intercultural training.	No exclusion applies for the absence of a comparator.
O Outcomes	Findings related to the development of intercultural competencies, attitudes, perceptions, curricular changes, or impact on professional practice in health.	Studies reporting measurable results on intercultural competencies or attitudes. Analyses of curricular content with original empirical data.	Studies without verifiable results. Opinions, editorials, or theoretical reflections without primary data.

Authors' own elaboration.
The criteria were applied independently by the reviewers; disagreements were resolved by consensus.

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The 2020 starting point reflects a deliberate methodological decision: to prioritize the currency of academic output on interculturality in health training over its complete historical coverage, given that this is a period marked by an increase in the debate on equity and cultural relevance in educational systems, heightened by the COVID-19 pandemic and its differential effects on ethnically and culturally diverse populations. It is acknowledged, however, that this cut-off may have excluded training experiences prior to 2020 in countries with a longer history of incorporating interculturality into health training, such as Colombia; this limitation is explicitly addressed in the Limitations section. It should be noted that, during extraction and analysis, it was found that a subset of the identified studies consisted of theoretical reflection essays and narrative reviews without their own primary empirical data; consequently, they were excluded from the final extraction matrix, although their content was preserved to inform the conceptual discussion.

Information sources and search strategy

The search combined strings in Spanish and English, adapted to the language coverage of each database. In Scopus, whose coverage is predominantly English-language, only the English strings health AND interculturality AND higher education and health AND interculturality AND university were used, restricting the search to the title, abstract, and keyword fields (equivalent to TITLE-ABS-KEY). In Dialnet, whose coverage is predominantly Spanish-language, only the Spanish strings salud AND interculturalidad AND educación superior and salud AND interculturalidad AND universidad were used. In Redalyc and LILACS, both sets of strings (English and Spanish) were used, and in SciELO the Spanish strings were used together with the English string health AND interculturality AND university. In Dialnet, Redalyc, LILACS, and SciELO, the search was conducted through each platform's general search engine, since none of them offers field-restriction options comparable to those of Scopus.

Selection process

The selection process was carried out in the four phases proposed by PRISMA 2020 (Figure 1). In the identification phase, 21,798 records were retrieved (Scopus = 37; Dialnet = 1,001; Redalyc = 20,686; LILACS = 53; SciELO = 21). After applying filters for date range, language, document type (articles only), and open access, 21,079 records were removed, leaving 719 records screened. Title screening excluded 644 records, leaving 75 articles selected for full-text screening. From this set, 32 duplicates were removed (14 internal to Redalyc and LILACS; 6 cross-database; 12 when consolidating the final list). All authors took part in the search and screening of the studies; disagreements about eligibility were discussed collectively among the reviewers and resolved on the basis of the previously established search and eligibility criteria.

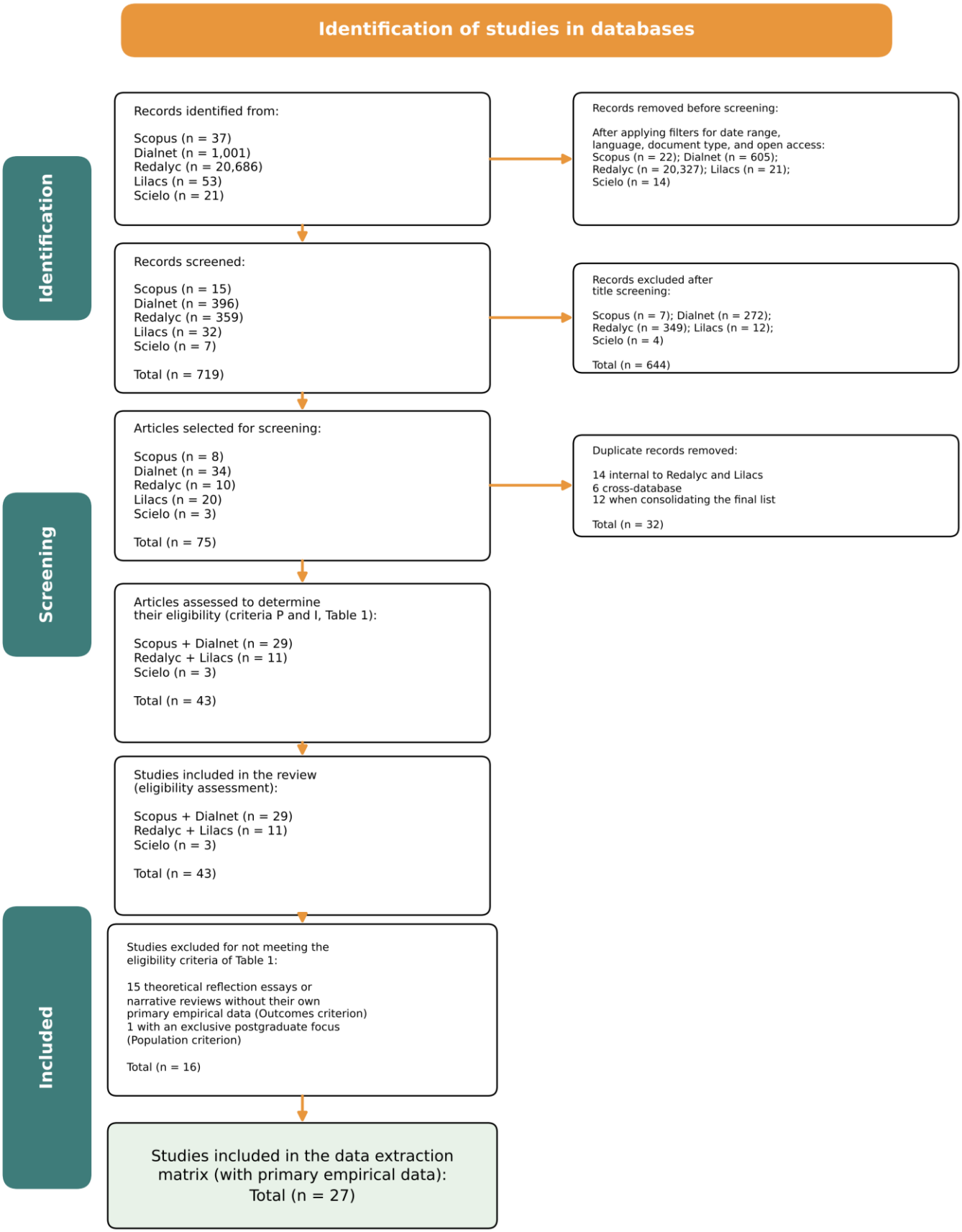
After this clean-up, 43 articles met the eligibility criteria relating to population and intervention/phenomenon of interest (components P and I of Table 1) and were formally included in the systematic review following the PRISMA 2020 flow (Scopus + Dialnet = 29; Redalyc + LILACS = 11; SciELO = 3). During full-text data extraction, it was found that 16 of these 43 studies were theoretical reflection essays or literature reviews without their own primary empirical data, and therefore did not meet the eligibility criterion for the Outcomes component of Table 1; consequently, they were excluded from the data extraction matrix (Table 2), although their content was kept as a conceptual reference for the discussion. The remaining 27 studies, which did report primary empirical data, constitute the final corpus of this review and are those presented in Table 2. The complete process is illustrated in Figure 1.

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Figure 1

PRISMA flow diagram of the identification, screening, eligibility, and inclusion of studies



Source: Page et al. (2021)

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RESULTS

Table 2 presents the data extraction matrix corresponding to the 27 studies reviewed in this systematic review. It is organized alphabetically by author and includes, for each study, the methodology used, the participating population, the country and context in which it was carried out, and a synthesis of the most notable results reported.

Table 2

Data extraction matrix: interculturality in the curricular content of university health programs

#	Authors (year)	Methodology	Population	Country / context	Summary of results
1	Álvarez-Cruces et al. (2025a)	Multiple case study with a hermeneutic scope; document analysis of graduate profiles and in-depth interviews; Grounded Theory.	179 key informants: internship students, directors, faculty, and clinical guides.	Chile; health disciplines at three regional higher education institutions.	Current curricula do not integrate the International Migrant Health Policy; the concept of "Gringola Cultural" is coined to describe how faculty and clinicians deliberately ignore migratory and ethnic factors, which translates into subtle racism and negative vicarious learning in internships.
2	Álvarez-Cruces et al. (2025b)	Interpretive qualitative study; virtual semi-structured interviews, mixed coding under Bennett's Intercultural Sensitivity Model.	15 program heads and curriculum coordinators in the health area.	Chile; three regional higher education institutions.	Those who design health curricula show an intercultural sensitivity stalled in ethnocentric stages (Minimization and Defense), upholding the fallacy of universality and delegating intercultural training to the clinical field; only Nutrition shows incipient signs of Acceptance.
3	Cantele P. (2023)	Descriptive study based on the systematization of experiences; proposes a micro-curricular design for decolonial tele-education.	Wise elders, shamans, faculty, and students of the intercultural health program.	Venezuela; Universidad Indígena de Venezuela, Yekuana community of Cacuri.	A decolonial tele-education model was designed that integrates Yekuana wise elders into the health curriculum, using their own identity codes to overcome geographic barriers and avoid the Westernization of knowledge.
4	Castillo Mariqueo et al. (2024)	Cross-sectional descriptive study; analysis of courses transformed through Service-Learning.	259 undergraduate students from five health disciplines.	Chile; Universidad Católica de Temuco, Mapuche territory.	The cross-cutting Integrated Health Modules device, using a Service-Learning methodology, articulates family, community, and intercultural health through interdisciplinary rotations, fostering critical self-reflection and two-way partnerships with Mapuche communities.
5	Cruz Romero & Ospina Lozano (2024)	Systematization of experiences with an ethnographic approach; four-year territorial intervention, participant observation, and interviews.	Four dentistry students, one faculty member, and the Pijao community (~50 families).	Colombia; Pijao indigenous communities, Ortega, Tolima.	Territorial practice in Pijao communities made it possible to move from conventional clinical dentistry to Collective Oral Health, showing that curricular design can act as a driver of rights enforcement in the face of state neglect.
6	Esquivel Rubio et al. (2023)	Account of professional experiences with a narrative design; chronological analysis of field interventions (2018-2022).	Migrant population (Haiti, Honduras, El Salvador, Guatemala); nursing faculty and students.	Mexico; northwestern border, Mexicali, Baja California.	The "Salud Migrante" project on the Mexicali border identified language barriers and discrimination; applying Purnell's model, the team managed to culturally adapt sexual health interventions through dialogue with migrant community leaders.

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7	Ferreira do Nascimento et al. (2025)	Exploratory documentary and geospatial research; cross-referencing of enrollment databases with thematic maps (ArcGIS).	50 indigenous university students from 42 ethnic groups.	Brazil; Intercultural Indigenous Faculty (FAINDI), Mato Grosso.	The Intercultural Indigenous Faculty (FAINDI) operates as an institutional catalyst by validating pre-existing community capacities and designing a curriculum that dialogues symmetrically between Western biomedical theories and the worldviews of 42 ethnic groups.
8	Ferreira do Nascimento et al. (2020)	Exploratory qualitative study (COREQ); in-depth interviews, Freirean thematic content analysis.	11 graduated indigenous nurses in clinical practice.	Brazil; public-university graduates from Mato Grosso, native communities.	Indigenous nurses denounce the total omission of indigenous health in their Eurocentric university training and the racism suffered during their studies; once graduated, they autonomously build intermedicality dialogues with traditional knowledge holders.
9	Ferreira & Martins Borges (2021)	Descriptive and exploratory study; document analysis of psychological care records (2016-2017) with frequency statistics.	225 care requests from immigrant students.	Brazil; Federal University of Latin American Integration, triborder area.	Cultural distance affects the mental health of immigrant students (greater anxiety, depression, and dropout); the study warns of academic ethnocentrism, or "epistemicide," and calls for training in intercultural care for university staff.
10	Flores Flores & Calva Cabrera (2025)	Mixed, non-experimental, cross-sectional study; document analysis with a validated competency instrument.	10 micro-curricular documents from health programs.	Ecuador; Faculty of Human Health, public university of Loja.	The health programs allocate unequal time to research and maintain traditional summative assessment, which limits the effective incorporation of the human and intercultural component despite declaring dynamic teaching strategies.
11	García Pérez et al. (2022)	Exploratory pedagogical research with a historical-trend approach; document analysis and source triangulation.	Medicine curricula and programs on Health Situation Analysis.	Cuba; university medical training and community health.	Health Situation Analysis became historically consolidated as a curricular axis in Cuban medicine, but insufficient intercultural links persist for achieving a truly comprehensive community intervention.
12	Guerra-Zúñiga & Segovia-Chamorro (2020)	Descriptive and interpretive qualitative study; analysis of graphic artifacts and focus groups.	17 medical students in focus groups.	Chile; School of Medicine, Universidad de Valparaíso.	Graphic medicine (comics) proved a powerful tool for addressing social determinants of health, making the hidden curriculum visible, and consolidating cross-cutting competencies such as empathy and reflexivity, despite initial student resistance.
13	Larson, Choufani, & Płaszewska-Żywko (2025)	Descriptive qualitative study; content analysis of reflection papers from an international virtual course, following COREQ.	18 nursing students from Poland and the United States.	Poland and the United States; virtual course on the health of Ukrainian refugees.	Polish and American nursing students identify problematic communication, neglected trauma-informed care, and compromised vaccination status as the main barriers to intercultural care of Ukrainian refugees, recommending certified interpreters and curricular training in trauma and intercultural competence.

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14	Martínez Pabón et al. (2022)	Exploratory qualitative research; document review of curricula (SNIES) and semi-structured interviews.	15 accredited Physiotherapy and 26 Nursing programs.	Colombia; national coverage.	Only 3% of physiotherapy courses and 5% of nursing courses include an intercultural approach; a biologicist model predominates that confuses multiculturalism with critical interculturality, without moving beyond Walsh's (2008) proposal.
15	Pérez Pinto, Aquino Zúñiga, Cisneros Chacón, & Berttolini Díaz (2024)	Exploratory qualitative case study; semi-structured interviews with graduates and employers, affinity diagram.	Seven Intercultural Nursing graduates and three employers.	Mexico; Universidad Intercultural del Estado de Tabasco, Ch'ol population.	Intercultural nursing graduates in Tabasco value the integration of traditional medicine and the mother tongue into the curriculum, but both prove limited in practice: traditional medicine cannot be applied in clinical settings because of allopathic regulations, and oral command of the native language is insufficient upon graduation, affecting communication with indigenous patients.
16	Quintano-Méndez et al. (2023)	Cross-sectional psychometric study; Exploratory Factor Analysis for scale validation.	127 health professionals who are clinical instructors and tutors.	Chile; clinical placement sites of the Universidad Católica de Temuco.	Validates a highly reliable scale showing that intercultural training ("knowing how to be") is a construct distinct from technical clinical knowledge, requiring its own explicit training strategies.
17	Rivera Lersundi (2021)	Phenomenological qualitative case study; life stories of nurses.	Nurses who provide care in contexts of cultural diversity.	Chile; nursing training and practice in intercultural contexts.	Identifies stages and dimensions of intercultural competence in nursing care, which fosters more respectful relationships; points to the insufficient presence of this approach in curricula.
18	Rosero Medina, Zuñiga Meneses, Ortega Hernández, Guzmán Rivera, & Ordoñez Andrade (2025)	Hermeneutic qualitative study; semi-structured interviews with faculty.	Nursing faculty who teach Totonac- and Nahuatl-speaking students.	Mexico; university with Totonac and Nahua indigenous students.	Intercultural strategies in nursing education are influenced by faculty trajectory and institutional guidelines, and are key to preserving cultural identity and transmitting ancestral knowledges despite institutional barriers.
19	Sagarra-Romero et al. (2024)	Multicenter cross-sectional quantitative study; survey with three validated psychometric scales (ISS, CCATool, CAS).	168 undergraduate nursing students.	Europe; four institutions (Spain, Turkey, Belgium, Portugal), TC-NURSE project.	European nursing students show high intercultural sensitivity, but only moderate cultural competence and awareness, with no differences between years of study, showing that cultural competence is not consistently incorporated into study plans.
20	Salazar Escobedo & Galán López (2025)	Qualitative research; literature review and structured interviews.	38 advanced-semester Nursing students.	Mexico; Universidad Intercultural del Estado de Puebla, Sierra Norte.	The Bachelor's in Nursing with an intercultural approach at UIEP fulfills a relevant social function, strengthening language skills and articulating biomedical knowledge with ancestral knowledges in indigenous contexts.

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21	Sequeda Villarraga et al. (2023)	Cross-sectional descriptive quantitative study; validated Cultural Competence Scale (CCS-S).	148 undergraduate nursing students.	Colombia; border area with Venezuela, Cúcuta.	Nursing students in the border area with Venezuela show a moderate level of cultural competence, with significant differences only according to prior training and experience with patients from other cultures; strengthening the curriculum is recommended.
22	Silva Guayasamín et al. (2024)	Descriptive qualitative research; structured online survey with intercultural sensitivity dimensions.	475 university students.	Ecuador; Universidad Nacional de Chimborazo.	Most students value interculturality positively in their training and want language training, but a high percentage do not self-identify with any indigenous or Afro-descendant people, which limits their understanding of traditional medicines.
23	Silva Pertuz & Staaden Mejía (2020)	Phenomenological qualitative study; life-history method with interviews and triangulation of voices.	Single case study of an Afro-descendant Bacteriology instructor.	Colombia; Universidad Metropolitana de Barranquilla, Caribbean region.	Through the life story of an Afro-descendant instructor, her contribution to health higher education is made visible, showing historical debts of substantive recognition toward indigenous and Afro-descendant knowledges.
24	Tapia-Mieles, Chávez Vélez, Guaranguay-Chaves, & Sánchez-Choez (2022)	Observational documentary research; comparative analysis of curricular documents.	Curricular documents and Nursing graduates.	Ecuador; Universidad Laica Eloy Alfaro de Manabí.	Nursing graduates consider their job training adequate, but a need is identified to strengthen intercultural and language competencies for discrimination-free care in the Ecuadorian multicultural context.
25	Valdez (2020)	Hermeneutic descriptive qualitative research; grounded theory, interviews, and focus groups.	Nursing students, faculty, and administrators; Misak indigenous community.	Colombia; Universidad del Cauca, Cauca region.	Bioethics training in nursing privileges technical knowledge over the human dimension, showing coloniality of knowledge; the curriculum needs to be humanized by incorporating intercultural perspectives and dialogue with indigenous communities.
26	Valdéz Fernández & Jácome Velasco (2025)	Case study with hermeneutic Discourse Analysis; documentary corpus of reports, syllabi, and public policies.	Practicum reports and course curricula of the final semesters.	Colombia; Universidad del Cauca, southwestern part of the country.	There is a divorce between the policies that demand interculturality and the micro-curricular reality, which omits it; however, the rural territory operates as an "emergent curriculum" where students autonomously acquire intermedicality skills.
27	Villela, Locón, & Gatica (2020)	Descriptive research; document review of laws, curriculum, and syllabus.	Curricular and regulatory documents of Medicine and Surgery.	Guatemala; Centro Universitario de Oriente (CUNORI).	Although university regulations establish the intercultural axis, the Medicine syllabus does not explicitly incorporate it; there is evidence of an absence of training in bilingualism and intercultural health with respect to native peoples.

Note. N = 27 studies with primary empirical data, ordered alphabetically by author. Authors' own elaboration.

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Before presenting the synthesis by thematic categories, it is worth distinguishing the findings according to the type of methodological design used, since not all of them allow the same level of generalization. Of the 27 studies included, three used quantitative designs with validated psychometric scales (Quintano-Méndez et al., 2023; Sagarra-Romero et al., 2024; Sequeda Villarraga et al., 2023), which allows more precise comparisons of the level of intercultural competence and sensitivity among subgroups of students or faculty, although limited to the specific populations of each study. Most of the remaining studies correspond to qualitative designs (interviews, focus groups, case studies, phenomenology, or grounded theory), whose findings describe situated perceptions, experiences, and meanings, without claiming statistical generalization. A third group relies predominantly on document analyses of curricula, syllabi, and institutional policies (for example, Ferreira do Nascimento et al., 2025; García Pérez et al., 2022; Tapia-Mieles et al., 2022), which report on the declarative presence of interculturality in the formal curriculum, but not necessarily on its effective implementation in the classroom or in clinical practice. Finally, a fourth group consists of systematizations of experiences or narrative accounts of field interventions (Cantele P., 2023; Cruz Romero & Ospina Lozano, 2024; Esquivel Rubio et al., 2023), which document specific, contextualized pedagogical processes whose results cannot be directly extrapolated to other settings. The thematic categories presented below integrate these different types of evidence, so statements about general trends should be read in light of the type of design that supports them in each case. From the analysis of the corpus, four thematic categories were identified: (1) the gap between institutional regulations and the actual curriculum; (2) pedagogical strategies and curricular devices for developing intercultural competence; (3) the measurement of intercultural competence and sensitivity in students and faculty; and (4) structural barriers and the coloniality of knowledge in the care of indigenous and migrant populations. These categories were constructed inductively from the synthesis of the results of each study (Table 2), grouping the articles according to the main focus of their finding—normative-curricular, pedagogical-instrumental, evaluative, or structural—and were discussed and agreed upon among the authors; a single study may contribute evidence to more than one category when its content justifies it.

Gap between institutional regulations and the actual curriculum

Villela et al. (2020) showed that, although the regulations of the Universidad de San Carlos de Guatemala establish the importance of the intercultural axis, the Medicine program's syllabus does not explicitly incorporate it, leaving a gap in training in bilingualism and intercultural health. Martínez Pabón et al. (2022) found that only 3% of physiotherapy courses and 5% of nursing courses in Colombia addressed intercultural content, showing the predominance of a biologicist model that confuses multiculturalism with Walsh's (2008) critical interculturality.

This tension is also reproduced in Chile: Álvarez-Cruces et al. (2025b), for example, argue that those who design health curricula show an intercultural sensitivity stalled in ethnocentric stages, upholding the fallacy of universality and delegating intercultural training to the clinical field. Álvarez-Cruces et al. (2025a) found that curricula do not integrate the International Migrant Health Policy, coining the concept of "gríngola cultural" to describe how migratory factors are deliberately ignored, generating subtle racism in internships.

This gap is also manifested in bioethics training. Valdez (2020) found that bioethics training in Colombian nursing privileges technical knowledge, evidencing coloniality of knowledge, while Valdéz Fernández & Jácome Velasco (2025) identified a divorce between public policies and micro-curricular reality, although they highlight that the rural territory operates as an "emergent curriculum" where students autonomously acquire intermedicality skills. In Ecuador, Flores Flores & Calva Cabrera (2025) confirmed that health programs maintain traditional summative assessment, limiting the incorporation of the intercultural component despite declaring teaching strategies.

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Pedagogical strategies and curricular devices for developing intercultural competence

On the other hand, several studies report training experiences described by their authors as effective approaches to the curricular treatment of interculturality in the health area. Ávila León & Hernández Díaz (2020), for example, designed an intercultural communicative competence course taught in English for Cuban physicians on international missions. Cantele P. (2023), likewise, developed a decolonial tele-education model at the Universidad Indígena de Venezuela, which integrates Yekuana wise elders directly into the curriculum, avoiding a single, Westernized view of knowledge.

On a larger institutional scale, Castillo Mariqueo et al. (2024) described, in Chilean Mapuche territory, a cross-cutting Integrated Health Modules device that articulates family, community, and intercultural health through service-learning. Rosero Medina et al. (2025) found that intercultural strategies at a Mexican university depend heavily on faculty trajectory. Cruz Romero & Ospina Lozano (2024) documented, in Colombian Pijao communities, a transition from conventional dentistry to Collective Oral Health through sustained territorial practice.

On a smaller scale, Guerra-Zúñiga & Segovia-Chamorro (2020) found that graphic medicine (comics) is powerful for addressing social determinants and consolidating empathy, despite initial student resistance. Salazar Escobedo & Galán López (2025) found that the Bachelor's in Nursing at the Universidad Intercultural del Estado de Puebla effectively articulates biomedical knowledge with ancestral knowledges.

Measurement of intercultural competence and sensitivity in students and faculty

Quintano-Méndez et al. (2023) validated a scale showing that intercultural training is a construct distinct from technical clinical knowledge, which requires explicit training strategies. Rivera Lersundi (2021) identified stages in the development of intercultural competence among Chilean nurses, pointing to its insufficient curricular presence.

At the international level, Sagarra-Romero et al. (2024) found, among European students, high intercultural sensitivity but only moderate cultural competence and awareness, with no differences between years of study. Sequeda Villarraga et al. (2023) found a similar pattern in a Colombian border area, with differences associated only with prior training and experience with patients from other cultures.

Two Ecuadorian studies qualify these findings: Tapia-Mieles et al. (2022) found that graduates considered their training adequate, although they identified the need to strengthen intercultural and language competencies. Silva Guayasamín et al. (2024) found that, despite valuing interculturality positively, a high percentage of students did not self-identify with any indigenous or Afro-descendant people, limiting their understanding of traditional medicines.

Structural barriers and coloniality of knowledge in the care of indigenous and migrant populations

Ferreira do Nascimento et al. (2020) documented that Brazilian indigenous nurses denounce the omission of indigenous health in their Eurocentric training and the racism suffered during their studies. Ferreira do Nascimento et al. (2025) showed, by contrast, that the Intercultural Indigenous Faculty of Mato Grosso validates pre-existing community capacities, dialoguing between biomedical theories and the worldviews of 42 ethnic groups.

Regarding migration, Esquivel Rubio et al. (2023) identified language barriers toward the Haitian population in Mexicali, managing to culturally adapt their interventions through Purnell's model. Ferreira & Martins Borges (2021) found that cultural distance increases anxiety and dropout among immigrant students in Brazil, warning of an academic "epistemicide." Larson et al. (2025) documented that Polish and American students identify problematic communication and neglected trauma care as the main barriers to caring for Ukrainian refugees.

Finally, Pérez Pinto et al. (2024) found that intercultural nursing graduates in Tabasco valued the integration of traditional medicine and the Ch'ol language, although both proved limited in practice because of allopathic regulations and insufficient command of the language upon graduation. Silva

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Pertuz & Staaden Mejía (2020) made visible, through the life story of an Afro-descendant Colombian instructor, the historical debts of recognition that higher education maintains toward its own indigenous and Afro-descendant faculty.

DISCUSSION

In line with the objective of this systematic review—to analyze the available empirical evidence on the incorporation of interculturality into the curricular content of university health programs, in order to identify the main strengths, weaknesses, and training gaps reported in the literature, as well as the pedagogical and curricular strategies proposed for its strengthening and implementation—the findings are organized below around these axes. First, the gap between regulations and the actual curriculum, seen in Villela et al. (2020), Martínez Pabón et al. (2022), and Álvarez-Cruces et al. (2025a, 2025b), can be read through Walsh's (2023) distinction between functional and critical interculturality. A good share of the studies reviewed describe experiences that fall within the former register: they incorporate declarative mentions without altering the curricular structure that continues to place biomedical knowledge as the only legitimate authority. This diagnosis coincides with Miranda et al. (2024), who argue that regional indigenous health policies operate under a functional interculturality assimilable to neoliberal multiculturalism. Véliz-Rojas & Bianchetti-Saavedra (2023) systematized, along the same lines, that intercultural competence has materialized in a fragmented way, without achieving cross-cutting integration. This pattern echoes the early warning of Walsh (2008), who already identified that the multicultural reforms of recent decades in Latin America have frequently operated as a discursive inclusion that does not redistribute power, absorbing the demand for cultural recognition without altering the structures that Walsh (2023) seeks to "crack" a decade later; the findings of this review suggest that this institutional crack remains, in the field of health, a pending task rather than a consolidated achievement. This reading is not exclusive to the Latin American context: Melro et al. (2023), in a scoping review of the frameworks used to design and evaluate courses addressing historical colonialism in Indigenous peoples' health, documented a convergent pattern of fragmentary incorporation and an absence of robust evaluation frameworks in health science programs across different regions, which situates the gap detected in this corpus as part of a broader structural tension between curricular decolonization projects and their effective institutionalization.

This biomedical hegemony (Menéndez, 2024) is manifested sharply in Pérez Pinto et al. (2024), where allopathic regulations prevent the application of traditional medicine already formally integrated into the curriculum, and in Ferreira do Nascimento et al. (2020), where graduated indigenous nurses must autonomously build the intermedicality dialogues that their Eurocentric training did not provide.

These findings are in dialogue with Santos's (2010) proposal of an ecology of knowledges. Within this framework, non-hierarchical dialogue between knowledges remains, in training practice, more an aspiration than a reality. Cantele P.'s (2023) experience at the Universidad Indígena de Venezuela is one of the few exceptions that approaches this ideal, which suggests that replicating experiences like this requires explicit institutional decisions—such as the creation of specific programs, formal alliances with indigenous communities, and the allocation of dedicated resources—and does not depend solely on the initiative of an individual instructor or researcher. This same tension between theoretical framework and training practice was explicitly named by Ferreira & Martins Borges (2021), who identified in Brazilian immigrant students a process of academic "epistemicide"; their empirical finding gives situated concreteness to Santos's (2010) theoretical warning about the systematic destruction of cultural knowledge operated by abyssal thinking, showing that this mechanism is not limited to the relationship between biomedicine and traditional medicines, but also runs through the subjective experience of those trained within curricula that do not recognize their own cultural background as a legitimate interlocutor.

Valdéz Fernández (2023) found in the reviewed literature that Campinha-Bacote's model and Leininger's (1991) Theory are the predominant

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frameworks in intercultural training, confirming that these proposals have permeated the conceptual field of Latin American transcultural nursing. However, this declarative adoption does not guarantee effective implementation: Rivera Lersundi (2021) and Quintano-Méndez et al. (2023) show that intercultural competence remains insufficient in formal curricula, in contrast to Watson's (1979) argument that cultural recognition must be constitutive, and not accessory, of professional training. This multiplicity of theoretical frameworks coexisting without an integrative synthesis—Campinha-Bacote's model, Leininger's (1991) theory, and Watson's (1979) proposal—is not an artifact exclusive to the Latin American literature: De-María et al. (2024) found, in the European context, a similar heterogeneity in the conceptualization of the cultural competence construct, together with a still limited adoption of evidence-based training interventions. The coincidence between both settings suggests that the conceptual fragmentation identified in this corpus does not respond solely to regional methodological weaknesses, but to a fundamental theoretical indefiniteness that runs through the field of intercultural competence in health at the international level, and that probably contributes to the difficulty of consolidating evaluable and comparable curricular devices across programs.

The results of the present research converge with international reviews of the state of the art on the subject. The methodological heterogeneity observed, with a predominance of descriptive qualitative designs, echoes Arruzza & Chau's (2021) questioning of the robustness of the available evidence. The moderate or low levels of cultural competence reported by Bolarinwa & Nkansah (2025) coincide with the findings of Sagarra-Romero et al. (2024) and Sequeda Villarraga et al. (2023) in the present corpus. The conclusion of Gradellini et al. (2021) on the effectiveness of cross-cutting and sustained strategies finds direct support in Castillo Mariqueo et al. (2024) and Cruz Romero & Ospina Lozano (2024), both cases of institutional continuity over time.

The distinctive contribution of this review lies in the empirical confirmation of the gap pointed out by Álvarez-Cruces et al. (2021): the 27 studies identified, carried out between 2020 and 2025 in at least nine countries, suggest that this gap is in the process of being actively addressed, although patterns of fragmentation persist that limit generalizable conclusions about comparative effectiveness.

This review also brought to light tensions in the studies' results. While Ferreira do Nascimento et al. (2025) and Salazar Escobedo & Galán López (2025) document experiences in which interculturality effectively permeates curricular design, Martínez Pabón et al. (2022) and Hernández-Martínez et al. (2021) show a critical persistence of exclusion; the latter reports that about 86% of Colombia's ethnic populations lack access to ethno-education in health. This heterogeneity suggests that the explanatory factors are not merely normative, but depend on situated conditions, such as sustained institutional commitment and the availability of long-term community partnerships, as Cantele P. (2023), Castillo Mariqueo et al. (2024), and Cruz Romero & Ospina Lozano (2024) jointly suggest.

CONCLUSIONS

From the analysis of the studies included in this systematic review, it is possible to conclude that interculturality has been incorporated predominantly in a declarative manner into the normative frameworks of health science programs, without translating, in most cases, into an effective transformation of curricular content, course syllabi, and concrete pedagogical practices.

Among the main strengths identified is the existence of training experiences that have managed to incorporate interculturality in a cross-cutting and sustained manner over time, particularly when such experiences are grounded in long-term community partnerships, such as the Integrated Health Modules documented in Chilean universities or the territorial practice with Pijao indigenous communities in Colombia. Likewise, innovative teaching strategies were identified, such as graphic medicine or decolonial tele-education models, reported by their authors as favorable for developing cross-cutting competencies such as empathy and critical reflexivity, as well as validated instruments that allow the level of intercultural competence and sensitivity achieved by students and faculty to be measured more precisely.

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Among the main weaknesses and training gaps, it was repeatedly found that the proportion of courses with explicit intercultural content in the health programs analyzed is markedly low, that a biomedical-biologicist model predominates that delegates intercultural training to the clinical field instead of assuming it as a curricular responsibility, and that even when traditional medicine or native languages are formally incorporated into the curriculum, their effective application in professional practice is limited by current allopathic clinical regulations and by insufficient language proficiency upon graduation. Likewise, specific structural barriers were identified in training oriented to the care of indigenous, migrant, and Afro-descendant populations, including racism experienced during the training trajectory, the absence of training in trauma-informed care for refugee populations, and an identity disconnect of the student body from the peoples whom such training aims to serve culturally.

These findings suggest that the curricular transformation toward a critical and effective interculturality in Latin American health training requires strategies that go beyond the declarative incorporation of isolated content, and that are oriented toward the design of cross-cutting, institutionally sustained curricular devices built in direct dialogue with the communities and knowledges they aim to recognize.

This review has limitations that should be noted. First, the search was restricted to five databases and to a limited time period between 2020 and the search closing date, which may have excluded relevant studies published before that period or indexed in databases not consulted. Second, the final corpus shows a significant geographic concentration in a small number of countries, mainly Chile, Mexico, Colombia, Brazil, and Ecuador, while other national contexts of the Latin American region, with equally complex ethnic and cultural realities, are not represented in the available empirical evidence, which limits the generalizability of the findings to the region as a whole.

In light of the findings and limitations noted, there is a need to expand empirical production toward Latin American countries and contexts currently underrepresented in the available literature, particularly those with a high indigenous or Afro-descendant population density that do not yet have their own studies on the incorporation of interculturality into their health science programs.

It would also be valuable for future research to delve into the longitudinal follow-up of graduates of programs with an intercultural approach, in order to determine whether the competencies declared in the graduate profile effectively translate into culturally relevant professional practices once graduates are inserted into the health system, and not only into self-reported perceptions at the end of university training. Finally, it is suggested that the institutional conditions that explain the heterogeneity of results identified in this review be examined in greater depth, that is, which organizational, normative, and community factors allow some training experiences to achieve an effective and sustained curricular interculturality, while others remain at a merely declarative level, in order to generate guidance applicable to the design and curricular reform of health science programs in the region.

Use of artificial intelligence

Claude (Anthropic) was used as a support tool for the English translation of this manuscript. The authors bear full and sole responsibility for the content of the manuscript.

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Author contributions

Contributions are reported according to the CRediT taxonomy. Freddy Patricio Cabrera-Ortiz: conceptualization, investigation, formal analysis, and writing of the original draft. Mauricio Esteban Reyes-Guaranda: conceptualization, investigation, methodology, data curation, and writing (review and editing). Christhye Ionne Briones-Arias: investigation, data curation, and validation. Nube Janeth Clavijo-Morocho: project administration, funding acquisition, and validation.

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