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Standing Up for Culturally Competent Care in Portugal: The Experience of a "Health in Equality" Online Training Program on Individual and Cultural Diversity

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Abstract: Health professionals play an essential role in the protection and promotion of health rights without distinction of sex, sexual orientation, gender identity and expression, ethnicity/race, nationality and migration status, age, functional diversity, or any other individual and/or cultural positions. With the growing diversity of patient populations, health professionals must be able to identify and be responsive to individual and cultural diversity, ensuring equity in access to high-quality individually-centered care. For this, it is fundamental to promote training in cultural competence, understood as responsivity and the ability to work the valorization of multiple and intersectional identities throughout life. The paper aims to describe the experience of the implementation of the program "Health in Equality", aimed at training the primary healthcare workforce in Portugal, which was based on Sue and Sue's (2008) three-dimensional model of multicultural skills, which champions cultural best practices in an intersectional perspective. Based on the trainees' and trainers' evaluation of four completed editions developed online between March and July 2021, this study discusses ways to improve the impact of the training program and amplify the number of leaders and role models for other health care providers towards culturally competent healthcare systems and organizations.

Keywords: cultural competence; diversity; health equity; primary health care; healthcare education

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1. Introduction

As our societies become more diverse, the debate over respect, protection, and promotion of human rights and fundamental freedoms without the distinction of sex, sexual orientation, identity, and gender expression or sexual characteristics, as well as racial and ethnic origin, color, nationality, ancestry, territory of origin, age, and disability or other status has been gaining more attention in the healthcare sector.

The increasing cultural and individual diversity of societies has posed new demands on healthcare systems and workers worldwide. This responsibility implies much more than a simple recognition of existing individual and cultural differences between healthcare professionals and the users of the healthcare system. It is important to ensure that, in addressing individual and cultural differences, healthcare professionals can consider the sociopolitical ramifications of their work (i.e., gender inequality, oppression, discrimination, racism, heterosexism, abuse, and violence) [1–3] and their impacts on health and quality of life. Therefore, it is key that health workers receive proper training to learn how to address cultural and individual differences. "Training for multicultural competence is defined as a training and curricula aimed at increasing the ability and efficiency of individuals to work in multicultural environments, both within a country and in addition to the national borders" [4] (p. 263). Taking into consideration the sociopolitical dimensions of cultural diversity, this has also been referred to as social justice training [5]. This training contributes

to improve the responsivity of the healthcare system and professionals to the diversity of healthcare users. The promotion of a civil environment that welcomes and values multiple and intersectional social identities is vital for the long-term development of societies, at a regional, national, and global level [6].

This paper aims to: (i) describe the experience of the implementation of the program "Health in Equality" for the training of the primary healthcare workforce (e.g., physicians, pediatricians, psychiatrists, nurses, clinical psychologists, and clinical social workers) in Portugal on individual and cultural diversity; and (ii) reflect on how to improve the impact of the training program. To do so, the training design and its theoretical model are presented at the outset. Then, we report on the training program evaluation from both the trainees' and trainers' perspectives. Finally, recommendations on how to amplify the number of leaders and role models for other health care providers towards culturally competent healthcare systems and organizations are discussed.

1.1. Theoretical Model

Currently, there is no doubt that multiculturalism has become "*a central force in psychology*" [7] (p. 103). It is now recognized that culturally competent practitioners should take steps to be knowledgeable about the theory and practice of a culturally sensitive service delivery [8]. Originally named as "*Cross-Cultural Counseling Competencies*" [9], a new model was presented later on that became widely known as "*Multicultural Counseling Competencies*" [1]. More recently, and due to its inclusiveness feature, this model was renamed "*Cultural Competence*" [10]. Current debates have also advocated alternative concepts, such as cultural safety, cultural humility, and cultural responsiveness, in acknowledging the interpersonal and relational nature of the healthcare process, the ability to refine one's empathic capacity, and its ethical commitments [11].

Multicultural counseling competence (MCC) was initially defined as any type of counseling relationship in which the intervenient parties (professional, client/user, or other) differed with respect to their cultural background, beliefs, values, and behaviors [9]. It was also defined as a set of attitudes and behaviors that indicated the professional's ability to establish, maintain, and successfully conclude a counseling relationship with clients/users from diverse cultural backgrounds [12]. Therefore, multicultural competence has been defined as a dynamic and complex process of being aware of and recognizing individual and cultural differences, consisting of three distinct, yet interrelated, components [3].

The first component is Awareness, and it is related to one's own cultural heritage, assumptions about human behavior, values, biases, preconceived notions, personal limitations, and accompanying prejudices. This includes professionals' awareness of the attitudes and beliefs about individuals from ethnic and racial minorities (or other social minority groups), as well as their own cultural background, and how they may affect how they interact with clients/users who are culturally different from themselves. The development of this dimension of cultural competence involves the individual's exploration of the professional identity as a cultural being, and of their cultural prejudices.

The second one is Knowledge, and it is related with the understanding of the worldviews and value patterns of individually and culturally diverse populations. This dimension has to do with the specific knowledge of the professional about the history, traditions, values, and practices of the cultural groups with whom he/she/they work/s and the understanding of the socio-political influences exerted on these groups. It is pertinent that practitioners also have specific knowledge about their own cultural heritage, and how they can personally and professionally affect their perceptions and biases in the process. It is no less important for professionals to be aware of different communication styles, the power of discrimination and stereotypes, and how their own attributes and experience may or may not facilitate the provision of healthcare with stigmatized minority clients.

At last, the third component—Skills—involves specific, relevant, and sensitive skills for intervention with these patient populations. This is based on the learned process and the experiential and interactive action of the previous components. It refers to the

set of specific assessment techniques, interventions, and strategies used when working with minority groups that may be more sensitive to culture [3]. These may include linguistic skills, adaptation of diagnostic techniques, and the use of cultural mediators or community leaders.

Essentially, professionals who are culturally competent have heightened awareness, an expanded knowledge base, and use skills in a culturally responsive manner [12]. In addition to building awareness, knowledge, and skills, some authors have stressed the importance of humility and an openness attitude when addressing clients/users from diverse individual and cultural backgrounds [13,14]. The development of such competences may be posited to develop through stages, from a perspective of culturally blind care (i.e., not acknowledging systemic inequalities and diverse needs of patient groups) to pre-competence, competence, and proficiency, in a continuous process of critical reflection and ongoing training in expanding awareness, knowledge, and skills, and translating those into public policies and social justice practices in healthcare [15].

Smith and colleagues performed two meta-analyses on the multicultural education of mental health professionals, involving more than 80 studies [16]. The results revealed that the participants who took part in a specific course on multicultural issues perceived themselves as more competent/skilled/knowledgeable in multicultural competence. Many researchers have reported a positive relation between receiving multicultural education and self-perceived multicultural counseling competence (e.g., [16–20]).

1.2. Intersectionality Framework

Several disciplines develop projects and use intersectionality as a theoretical framework to expand certain concepts: social identities, power dynamics, legal and political systems, and discursive structures [21]. Intersectionality constitutes a theoretical-methodological tool used to reveal processes of interaction between power relations and categories—such as sex and gender, class, race and ethnicity, sexuality, functional ability, age, among others—in individual contexts, collective practices, and cultural/institutional arrangements [22]. Crenshaw [23] emphasizes that all people exist within a "matrix" of power, and intersectionality can be seen as a prism that unveils the power dynamics obscured by the discursive logic at play in a certain context. It seems to be the openness and flexibility of the concept of intersectionality that allows us to capture the fluidity of the dynamics resulting from power relations, and it is precisely this flexibility that makes it possible to be used both as a conceptual tool, as well as a methodological and analytical one [24]. This conceptualization is postulated in the current paper, and its designed training is viewed as a process where these multiple facets of identity may become prominent at any given moment in the interaction between a health care professional and a particular patient or service user. For instance, being of Syrian origin may be a central feature in a particular consultation, whereas being a gay man or a widowed woman may be more relevant in another; being a refugee in Lisbon will be prominent in other interactions; yet, another could be being a father or mother, or one's religious community and practices.

2. Training Design

We proposed a training design on individual and cultural diversity competences for health care professionals that included a modular framework, addressing diversity from an intersectional lens. The overall training program was composed of nine modules, 4-h each, referring to: (i) concepts and models of individual and cultural competence, including awareness, knowledge, and skills; (ii) ethnic/racial minorities, migration, and culture; (iii) global mobility and refugees; (iv) sex and gender; (v) spirituality and religion; (vi) mental health and well-being; (vii) reproductive and sexual health; (viii) sexual orientation, gender identities, and expressions; (ix) intersectionality and clinical case discussions. The intervention followed previous training programs developed by Moleiro et al. [15], either toward ethnic and migrant diversity [25] or sexual orientation and gender identity [26]. It also included previous work on religious diversity [27], and sexual and reproductive

health [28]. The team was composed of individuals belonging to minority groups, and who participated in the intervention design and delivery. One team member was not involved in the training design or delivery as she was responsible for the evaluation (first author). The trainers involved in the modules were very diverse themselves and included both women and men, people with migration backgrounds, members of the LGBTQI community, and people expressing diverse religious identities. In addition, one trainer was a stakeholder from a refugee center. Trainers were recruited based on their expertise (as researchers, clinicians, and/or stakeholders/social actors).

The training program resulted in a 36-h online course, with 27 h of synchronous learning and 9 h of autonomous asynchronous learning activities (such as quizzes, additional reading, and assignments based on videos). Although the course had initially been proposed to be face-to-face, offered at the health care units in the major cities in Portugal with migrant populations, the SARS-CoV-2 pandemic forced it to be adapted into an online course, with a broad recruitment throughout the whole national territory, and a vaster pool of health care professionals. Recruitment was made both through the public health system (a project partner) and via social media; and the training program offered 2–3 modules a week, in the evening or Saturday mornings, throughout a period of 4 weeks, to accommodate, as much as possible, the complex and demanding schedules of the health care professionals, especially during the intense pressures resulting from COVID-19. Skill-building activities were promoted, especially in the last week of the course, as case formulations were requested from health professionals from their actual practices (both past and ongoing practices), and module (ix) was then dedicated to case presentations and discussions, along with the identification of challenges and the sharing of best practices.

A pedagogical perspective was used, reflecting the three-dimensional model of cultural competences by Sue and colleagues [1], where, in each module, the trainers sought to: (i) promote awareness about the specific topic or population; (ii) introduce knowledge about this group or topic, in particular with respect to health inequalities; and (iii) promote practical case discussions/role-plays or clinical case formulations that reflected increased responsiveness, sensitivity, and adjusted interventions to this patient group. As such, both experiential and cognitive-based learning strategies were used. In the case of experiential learning, trainees are encouraged to experience culture through either real or simulated experiences, including role-plays, simulations, self-reflection exercises, and group discussions, whereas the didactic or cognitive understanding of culture is sought through readings, lectures, guest speakers, and other similar means [29].

2.1. Training Goals and Objectives

In sum, the overall training goals of the program "Health in Equality" were to train health professionals to provide sensitive and quality care with individually and culturally diverse populations. It aimed at promoting skills for individual and cultural diversity in the care of diverse migrant populations, including those related to sex and gender, religious or spiritual identities, sexual orientation and gender diversity, and migration history and status, including refugee populations. These goals were addressed in several domains, namely, in relation to overall health, mental health and well-being, sexual and reproductive health, developmental health, as well as issues regarding access to the health system and its legal framework, as well as linguistic, religious, and community resources.

To support the attainment of these goals, we defined two main objectives:

1. To evaluate primary health care professionals' satisfaction with the training sessions.
2. To present a critical evaluation of the training program by both trainees and trainers in order to gain knowledge on the degree of achievement of its objectives and on the training process.

2.2. Training Participants

We implemented four training editions from March to July 2021. In total, 100 primary health care professionals registered for the "Health in Equality" training program,

75 trainees enrolled in the training course, and 62 completed the training sessions with an attendance rate above 50%. As aforementioned, recruitment was conducted by disseminating course information through both the health system (our project partners) and social media. Enrollment and participation were free and voluntary, and a diversity in terms of gender, age, regions of Portugal, and professional background was obtained. Participants were informed that the training program was funded and that the team encouraged those who were willing to participate in the study to fill in their training evaluation, satisfaction, and other materials (such as best practices). No personal data were collected on the participants, and results were stored in an individual anonymized file, which was kept separate from their initial enrolment information.

2.3. Analysis

In order to assess the overall satisfaction and applicability of the training program used, we applied a SWOT analysis method, which is based on the Strengths (S), Weaknesses (W), Opportunities (O), and Threats (T), and provides a situational analysis of the subjects where they analyze their characteristics internally.

The purpose of the SWOT analysis is to develop plans and strategies for the future by analyzing the current situation (the four training sessions that were implemented), considering internal and external factors, maximizing strengths and opportunities, and minimizing the identified threats and weaknesses [30].

We conducted an in-depth analysis with eight individual anonymized SWOT self-reports. These included interview forms from the training team to assess and evaluate the training program's favorable and unfavorable factors and conditions, recognize the challenges and obstacles faced, and identify scientific strategies to further the training program (Table 1).

Table 1. Questions included in the study.

1.	What went best in the training (Strengths)?—Things to keep
2.	What went worst in the training (Weaknesses)?—Things to review
3.	What are the training opportunities (Opportunities)?—Maximize
4.	What are the training obstacles (Threats)?—Explore challenges and solutions

In addition, a satisfaction evaluation questionnaire, including open-ended questions on what went best, what could be improved, and overall suggestions and comments, was used to analyze the trainees' experiences and personal perspectives about the training program.

3. Results

The training program was evaluated from both the trainees' (n = 42) and trainers' (n = 8) perspectives. The evaluation of the trainees with the training program is presented first, and secondly, the analysis of the data collected for the SWOT analysis.

3.1. Trainees' Satisfaction Evaluation

Figures 1 and 2 illustrate the trainees' very positive evaluation of the training program considering the training contents, the way the training was conducted, the training team, the overall satisfaction with the program, and the benefit of the program for professional practice. Most of the trainees would recommend the training program to colleagues. As one trainee wrote: *"I really liked the training. I feel more capable and aware of my prejudices."* (Trainee 23).

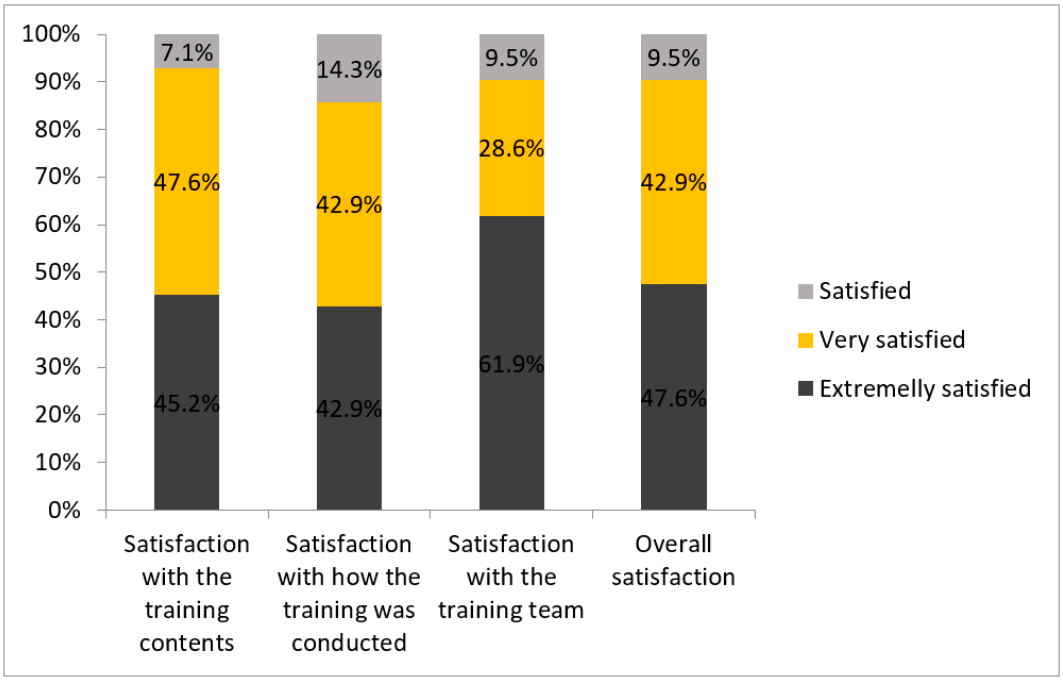

Figure 1. Trainees' satisfaction with the "Health in Equality" program.

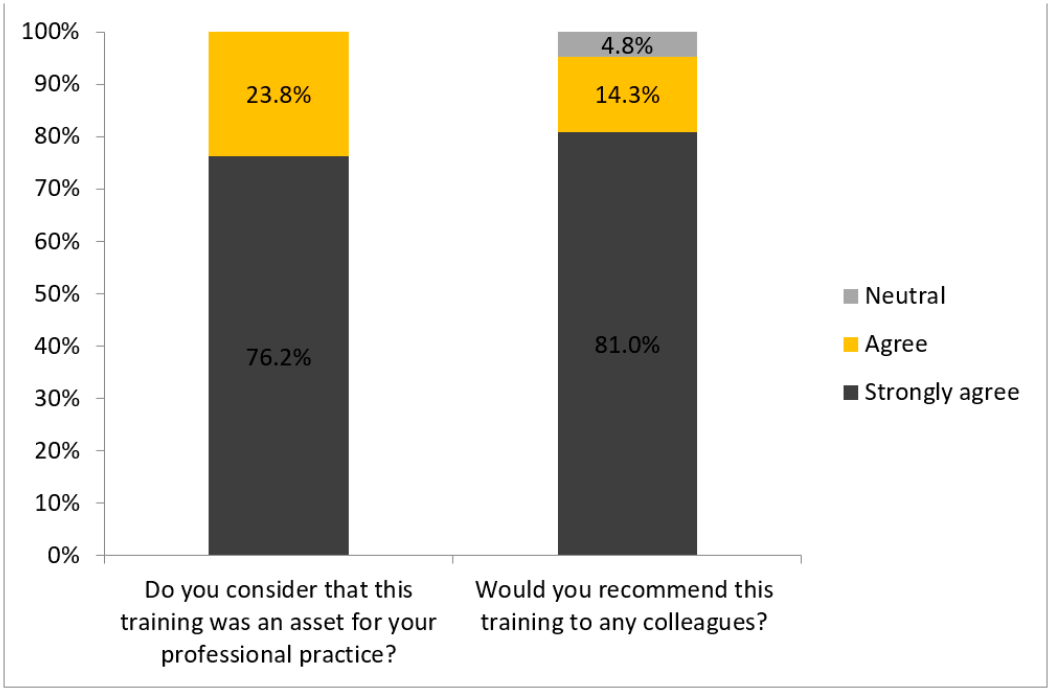

Figure 2. Trainees' evaluation of the "Health in Equality" program.

3.2. Critical Reflection of the Training Program

Based on the interpretation of the data collected for the SWOT analysis, four common themes that explain both the trainees' and trainers' opinions of the training program were elicited: quality of the training contents; quality of the trainers; facilitating aspects of distance training; and barriers of distance training.

3.2.1. Quality of the Training Contents

In the theme quality of the training contents, the trainees mentioned the diversity of themes; complementarity of themes; utility; materials made available; reflexivity; relevance of the contents; contents; conceptual models; intersectionality; new concepts; new approaches; themes that are still taboo; and knowledge updates:

"Appropriation of new concepts, becoming aware of new views. A more systemic view of the person."

(Trainee 4)

"The relevance of the training contents since it is still a taboo subject in society."

(Trainee 5)

"In general, I liked all the topics and I consider them all very useful for both my personal and professional training."

(Trainee 6)

"The clarification of concepts of the various areas. The training provided me with vocabulary, understanding, and resources."

(Trainee 23)

"All topics added knowledge that I can apply in my daily practice."

(Trainee 28)

In line with the trainees' evaluation, the trainers also mentioned the diversity and complementarity of themes anchored in the intersectionality approach as the most positive aspects of the training contents.

"The intersectionality of themes allowed for a global, transversal and multiple learning experience regarding health intervention with different stigmatized people and groups."

(Trainer 1)

"The proposal of the very rich and complementary training modules and the consistency with the perspective of intersectionality."

(Trainer 2)

3.2.2. Quality of the Trainers

The trainees' statements regarding the quality of the trainers referred to the diversity of trainers; quality of trainers; learning dynamics; availability of trainers for case discussion; questioning; sharing experiences; collective growth; knowledge sharing; new thinking; critical thinking; and change.

"The questioning, restlessness and internal reflection (potentially generating change) that was motivated/triggered and widely achieved in certain modules (. . .); the highly technical, communicational and dynamic quality of the trainers."

(Trainee 10)

"(. . .) the diversity of trainers (. . .) the open environment for discussion and collective growth."

(Trainee 11)

"The fact that it is a very interactive training program, even in an "online" model, gave openness to moments of reflection and introspection that I consider very important in relation to the themes addressed."

(Trainee 25)

"The fact that several teachers and specialists in their fields were invited; and the module on intersectionality."

(Trainee 34)

> *"The trainers' technical and scientific approach and their ability to stimulate the group."*
>
> (Trainee 35)

The trainers also shared their satisfaction in successfully gathering a team of specialist trainers: "*All of them specialists in their modules*". (Trainer 2)

3.2.3. Facilitating Aspects of Distance Training

The trainees stated that the online format could be maintained, and the training hours could be increased. The trainers identified several facilitating aspects of distance training, such as the diversity of the group of trainees in terms of training and professional experience, the knowledge in this area, and the eLearning support, with diverse and high-quality content.

> *"The diversity of the groups of people in the training program, considering the professional background (multidisciplinarity) and the high degree of sensitivity towards LGBTI+ diversity."*
>
> (Trainer 1)

> *"The implementation of the online training program using the ZOOM video conferencing platform has provided a great opportunity to reach various audiences, from various geographical and educational backgrounds, reinforcing the diversity of each session."*
>
> (Trainer 3)

> *"The capacity of reaching diverse professionals."*
>
> (Trainer 7)

3.2.4. Barriers of Distance Training

Both trainees and trainers expressed that the use of the eLearning platform was not very intuitive. The trainers also referred to technological difficulties and some trainees that were less participative (e.g., with their video cameras off) as barriers of distance training. References were also made to the impossibility of applying face-to-face training methodologies, as expressed by the following statements:

> *"The difficulties and weaknesses arising from the impositions of the pandemic context, the fact that the training was not in-person, inhibiting the use of certain methodologies that would be very important."*
>
> (Trainer 1)

> *"Sometimes the trainees' technological difficulties and the quality of the internet connection compromised the quality of training."*
>
> (Trainer 2)

> *"The unavailability of some people to be more participative (e.g., being simultaneously at work or on their way to work)."*
>
> (Trainer 5)

Following the work of Wang and Wang [31], a strategic analysis was performed based on the results of the SWOT steps to identify actionable priority plans (Table 2).

Table 2. Strategic analysis of the "Health in Equality" program.

Internal environment Strategic analysis External environment	**Strengths (S)**	**Weaknesses (W)**
	S1: Multidisciplinary and high-quality training team S2: Comprehensive modules, complementary with each other, and consistent with the perspective of intersectionality S3: Materials with diverse, valuable, and quality content S4. Practicality and relevance of the themes, both for personal and professional training S5: Increasing critical thinking awareness and a more systemic view of the person	W1: Lack of at least one face-to-face session (resulting from the pandemic context) W2: Lack of time to deepen themes and allow further discussion W3: The *eLearning* platform was not very intuitive to use
Opportunities	**Strengths–Opportunities**	**Weaknesses–Opportunities**
O1: Geographical and professional diversity of trainees (different professional contexts, areas of activity, and experiences) O2: Possibility of articulation between synchronous sessions (for more experimental processes) and asynchronous (for content enrichment) O3: Development of strategies to increase health literacy on equality in the workplace and on communication with colleagues needing awareness	SO1: Create more standardized content to enable replication by trainers external to the training team SO2: Record some of the sessions to increase the replicative capacity of the training program SO3: Maximize network with partners to ensure scientific support and free training	WO1: Create moments for health professionals to meet in this network of ambassadors trained for diversity WO2. Increase practical and effective online materials (e.g., films, testimonials) to complement written materials (articles, reports) WO3: Strengthen the intersectional approach with in-depth clinical case discussion, and integrate previously obtained knowledge WO4: Improve guidance on asynchronous training
Threats	**Strengths–Threats**	**Weaknesses–Threats**
T1: Despite being an added value, the diversity of the trainees, adding the disparity in the awareness and knowledge of the themes, poses challenges to the training T2: The lack of time for health professionals reduces the number of trainees per session and limits their active participation	ST1: Increase training time with experimental methods (concrete examples) ST2: Provide innovative training, avoiding expository methodologies ST3: Establish protocols with health units to meet anticipated challenges in the implementation of change at the institutional level	WT1: Gaps between the expected and actual availability of trainees (dropouts, absences, disconnection) WT2: Difficulties in implementing best practices for online training (e.g., the image on and sound off)

3.3. Strategic Analysis of the "Health in Equality" Program

3.3.1. Strengths–Opportunities (SO) Strategy

SO1: Create more standardized content to enable replication by trainers external to the training team.

The possibility of creating more standardized content with trainer's notes for each slide, and with clearer pedagogical objectives for each session plan, could allow an increase in their training capacity, facilitating replication by trainers external to the training team.

SO2: Record some of the sessions to increase the replicative capacity of the training course.

For some modules, it could be strategic to consider recording the training sessions to present it in different settings, enhancing the potential replication of the training, and expanding its reach.

SO3: Maximize network with partners to ensure scientific support and free training.

It could be strategic to foster collaboration between the professional and scientific associations involved with the aim of safeguarding scientific distinction. Another opportunity would be to identify potential sponsors for the development of funding opportunities to guarantee the continuity of the training program.

3.3.2. Weaknesses–Opportunities Strategy

WO1: Create meetings among health professionals within this network of ambassadors trained for diversity.

Meetings amongst groups from different editions could be foreseen. These groups would facilitate health professionals to meet informally to increase trust between elements of a network for diversity.

WO2. Increase practical and effective online materials (e.g., films, testimonials) to complement written materials (articles, reports).

Increase and diversify the didactic material provided. An example would be to provide a list of existing services and support groups available for migrant and minority populations.

WO3: Strengthen the intersectional approach with in-depth clinical case discussion, and integrate previously obtained knowledge.

The emphasis on the debate, analysis, and reflection would raise awareness for health workers on how power dynamics operate.

WO4: Improve guidance on asynchronous training.

Stimulate and increase the use of multiple documents made available for consultation and further study.

3.3.3. Strengths–Threats Strategy

ST1: Increase training time with an experimental method (concrete examples).

By increasing the number of training hours, the practical component of the course would be strengthened with more opportunities for brainstorming and practical activities.

ST2: Provide innovative training, avoiding expository methodologies.

Innovate by presenting content more practically and interactively (questions with real-time on-screen response).

ST3: Establish protocols with health units to meet the challenges anticipated in the implementation of change at the institutional level.

Start by asking participants about the biggest challenges and barriers they encountered in their organizations, and how they could propose solutions and intervention plans, and which protocols could be developed.

3.3.4. Weaknesses–Threats Strategy

WT1: Gaps between the expected and actual availability of trainees (dropouts, absences, disconnection).

The number of trainees registered does not correspond to the actual number of those who attended the sessions. In fact, and despite the motivation shown for the training program, health professionals lack sufficient time (in particular, during the period with increased pressure on the health services due to the SARS-CoV-2 pandemic), and this reduced the number of trainees per session and limited active participation. A higher number of people enrolled (i.e., accepted registration) in each edition of the course should be considered in the future, to accommodate possible last-minute conflicts by a few participants due to difficulties in attendance. It would also be important to schedule reminders before each session to ensure attendance throughout the various sessions.

It could be strategic for each of the trainers to record a very short presentation of their module to sharpen curiosity, and that could be disseminated in the opening session of the training program.

WT2: Difficulties in implementing best practices for online training (e.g., the image on and sound off).

It may be useful to identify and share the best practices for online training among the training team.

4. Discussion

The main goal of this paper was to analyze the experience of the implementation of a training program on individual and cultural diversity competences for health care

professionals. In line with Govere and Govere [32], our study shows training programs focused on raising the competence of healthcare workers by improving their cultural competences, knowledge, and skills. As the training program took place during the first two years of the global health crisis, trainees were overloaded due to the extra burden brought to the national health system by the COVID-19 pandemic. However, like the findings of McGregor et al. prior to the pandemic [33], they still acknowledge the merits of this training program to equip them with providing adequate health care and to cater to the distinct needs of their complex and diverse user population.

Reducing prejudice and discrimination was one of the main points highlighted by our participants as an outcome of the training program, confirming its impact on awareness change. Although we cannot assess the effectiveness of our cultural diversity competences training at their individual performance, we argue that fostering awareness and acknowledgment is a fundamental step to promote change in cultural diversity sensitivity [34].

The scholarship on cultural diversity competence training indicates only weak links between online training and positive outcomes related to cultural diversity behavior [35]. However, the feedback from our participants brings new insights to this debate. The social distance measures enforced by the worldwide COVID-19 pandemic boosted the use of online learning modalities, both asynchronous and synchronous. Due to the mandatory transition to the online learning environment, both trainers and trainees became more familiar with the remote tools, and acquired new skills on how to better interact and collaborate virtually [36]. Although both trainees and trainers acknowledged some challenges imposed by the distance training format, namely the technical issues and the impossibility of using an active form of instruction, they also identified positive aspects and opportunities. For instance, trainers referred to the diversity of the training group. The literature has vouched for the benefits of a diverse healthcare workforce to promote a culturally responsive environment [37]. Hence, the fact that the course could contribute to qualifying an already diverse trainee pool enhances its outcomes. Participants also identify the online format as an opportunity to boost the replicability of the course via recorded training sessions. Although we acknowledge the potential of video podcasts in education, we are aware that it encompasses a series of technical and infrastructure challenges, as well as legal aspects related to image rights [38]. Furthermore, as Moridani [39] points out, the lack of any live interaction might have a negative impact on the students'/participants' learning outcomes. Thus, this remark would have to be considered more carefully.

Additionally, the outstanding evaluation that the trainees made of the teaching content and the quality of the trainers might have compensated for the regular perceived disadvantages of the online training [35]. Indeed, Brown [34] states that in cultural diversity awareness courses, the methodology has a positive influence on precipitating some change in cultural diversity sensitivity.

The intensive workload for healthcare workers, boosted by the massive demand brought by the COVID-19 pandemic, limited their availability to take part in the training. Though we agree with the series of specific recommendations made by our participants to improve the training format, we argue that cultural competence training should be a part of healthcare workers' curriculum [35]. This would ensure that the new generation of healthcare workers are already aware and equipped with basic tools to deal with diverse populations.

4.1. Strengths and Limitations

The primary strength of this project was its theoretical framework, which provided the context for the training program targeting awareness, knowledge, and skills for individual and cultural diversity in the care of diverse migrant populations, within an intersectional approach. Professional training has been slow to observe, especially in European contexts, which contrasts with the recognized and increasing needs experienced in health systems [15].

The promotion of individual and cultural diversity competencies [1,8] among health care practitioners recognizes—and brings awareness to the fact—that each clinical interaction is a cultural one. Thus, clinicians need to be able to be responsive to this cultural encounter, i.e., be competent and responsive to individual and cultural diversity [11]. Our results support the relevance of such training courses [16], highlighting, on the one hand, the positive aspects of using an intersectional lens [22–24], and, on the other, the benefits of its application to clinical case discussions and formulations. The use of experiential methodologies, over and above the didactic information, was perceived as one of its main strengths and is in line with the extant literature that reinforces the need for awareness amplification techniques and practical skills [29].

The modular training that was implemented had an applied focus, with the discussion of several clinical cases, allowing for a combination of translational, transdisciplinary, and transformational learning regarding health intervention with different stigmatized people and groups.

The implementation of online training using the ZOOM platform gave us a greater capacity to reach various audiences from different geographical areas and professional contexts, thus strengthening the diversity of the training groups with various degrees of sensitivity to diversity. Despite presenting an added value, this diversity, and the disparity of the level of knowledge of certain themes, in particular, also posed some pedagogical challenges. The possibility of implementing tailored courses for more specific contexts and groups of professionals could be tested in the future. Given the experiential context of the training course, it would also be important to have time for more engaging dynamics and small discussion groups.

4.2. Implications for Research and Practice

The results of this study suggest that there is a place for distance training to enable health professionals to identify and deal with individual and cultural variety, ensuring equity in access to high-quality individually centered care.

The following steps include the evaluation of the effectiveness of the formative intervention among all the participating primary care professionals by measuring the increase in the overall cultural competence in working with diverse populations, and in each of its constructs (knowledge, skills, and attitudes), from baseline to post-intervention.

This project lays a solid foundation for incorporating cultural competence training into existing health sciences curricula, such as medicine and nursing.

5. Conclusions

Based on the authors' participation in the design and implementation of the "Health in Equality" training program on individual and cultural diversity, the objective of this paper is twofold. First, it looked at healthcare workers' satisfaction with the training sessions, and then conducted a comprehensive and critical evaluation of the training program considering both trainees' and trainers' perspectives. The training program was designed in accordance with the "Multicultural counseling competence", consisting of three interrelated components: awareness, knowledge, and skills for intervention. Despite the unprecedented situation under which the program was carried out due to the COVID-19 pandemic constraints, we argue that the training program attained its goals. Following the SWOT analysis principles, our evaluation points out that trainees became more aware of their own prejudices regarding migrant populations, and were better equipped to deal with the cultural diversity of healthcare system users. Additionally, the trainees' positive feedback on its online format reveals the advantages of remote training courses with synchronous and asynchronous sessions for the healthcare sector, given healthcare workers' intense workload.

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References

1. Sue, D.W.; Arredondo, P.; McDavis, R.J. Multicultural Counseling Competencies and Standards: A Call to the Profession. *J. Couns. Dev.* **1992**, *70*, 477–486. [CrossRef]
2. Hall, C.C.I. The evolution of the revolution: The successful establishment of multicultural psychology. In *APA Handbook of Multicultural Psychology Vol. 1: Theory and Research*; Leong, F.T.L., Ed.; American Psychological Association: Washington, DC, USA, 2014; pp. 3–18. [CrossRef]
3. Sue, D.W.; Sue, D. *Counseling the Culturally Diverse*, 5th ed.; John Wiley & Sons Inc.: Hoboken, NJ, USA, 2008.
4. Chao, M.M.; Okazaki, S.; Hong, Y.-Y. The Quest for Multicultural Competence: Challenges and Lessons Learned from Clinical and Organizational Research. *Soc. Pers. Psychol. Compass* **2011**, *5*, 263–274. [CrossRef]
5. Pieterse, A.L.; Evans, S.A.; Risner-Butner, A.; Collins, N.M.; Mason, L.B. Multicultural Competence and Social Justice Training in Counseling Psychology and Counselor Education. *Couns. Psychol.* **2008**, *37*, 93–115. [CrossRef]
6. Vauclair, C.-M.; Hanke, K.; Fischer, R.; Fontaine, J. The Structure of Human Values at the Culture Level: A Meta-Analytical Replication of Schwartz's Value Orientations Using the Rokeach Value Survey. *J. Cross Cult. Psychol.* **2011**, *42*, 186–205. [CrossRef]
7. Miller, M.J.; Sheu, H. Conceptual and measurement issues in multicultural psychology research. In *Handbook of Counseling Psychology*, 4th ed.; Brown, S.D., Lent, R.W., Eds.; Wiley: New York, NY, USA, 2009; pp. 103–120.
8. Hall, J.C.; Theriot, M.T. Developing Multicultural Awareness, Knowledge, and Skills: Diversity Training Makes a Difference? *Multicult. Perspect.* **2016**, *18*, 35–41. [CrossRef]
9. Sue, D.W.; Bernier, J.E.; Durran, A.; Feinberg, L.; Pedersen, P.; Smith, E.J.; Vasquez-Nuttall, E. Position Paper: Cross-Cultural Counseling Competencies. *Couns. Psychol.* **1982**, *10*, 45–52. [CrossRef]
10. Sue, D.W. Multidimensional Facets of Cultural Competence. *Couns. Psychol.* **2001**, *29*, 790–821. [CrossRef]
11. Kirmayer, L.J. Rethinking cultural competence. *Transcult. Psychiatry* **2012**, *49*, 149–164. [CrossRef]
12. Peek, E.-H.; Park, C.-S. Effects of a Multicultural Education Program on the Cultural Competence, Empathy and Self-efficacy of Nursing Students. *J. Korean Acad. Nurs.* **2013**, *43*, 690–696. [CrossRef]
13. Hook, J.N.; Davis, D.E.; Owen, J.; Worthington, E.L.; Utsey, S.O. Cultural humility: Measuring openness to culturally diverse clients. *J. Couns. Psychol.* **2013**, *60*, 353–366. [CrossRef]
14. Sue, S. In search of cultural competence in psychotherapy and counseling. *Am. Psychol.* **1998**, *53*, 440–448. [CrossRef]
15. Moleiro, C.; Freire, J.; Pinto, N.; Roberto, S. Integrating diversity into therapy processes: The role of individual and cultural diversity competences in promoting equality of care. *Couns. Psychother. Res.* **2018**, *18*, 190–198. [CrossRef]
16. Smith, T.B.; Constantine, M.G.; Dunn, T.W.; Dinehart, J.M.; Montoya, J.A. Multicultural Education in the Mental Health Professions: A Meta-Analytic Review. *J. Couns. Psychol.* **2006**, *53*, 132–145. [CrossRef]
17. Constantine, M.G.; Ladany, N. Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *J. Couns. Psychol.* **2000**, *47*, 155–164. [CrossRef]
18. Pope-Davis, D.B.; Reynolds, A.L.; Dings, J.G.; Nielson, D. Examining multicultural counseling competencies of graduate students in psychology. *Prof. Psychol. Res. Pract.* **1995**, *26*, 322–329. [CrossRef]
19. Sodowsky, G.R.; Kuo-Jackson, P.Y.; Richardson, M.F.; Corey, A.T. Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology, and multicultural training. *J. Couns. Psychol.* **1998**, *45*, 256–264. [CrossRef]
20. Constantine, M.G.; Sue, D.W. *Strategies for Building Multicultural Competence in Mental Health and Educational Settings*; John Wiley & Sons Inc.: Hoboken, NJ, USA, 2005.

21. Carbado, D.W.; Crenshaw, K.W.; Mays, V.M.; Tomlinson, B. Intersectionality: Mapping the Movements of a Theory. *Du Bois Rev. Soc. Sci. Res. Race* **2013**, *10*, 303–312. [CrossRef]
22. McCall, L. The Complexity of Intersectionality. *Signs J. Women Cult. Soc.* **2005**, *30*, 1771–1800. [CrossRef]
23. Crenshaw, K. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ. Chic. Leg. Forum* **1989**, *1989*, 8.
24. Brah, A.; Phoenix, A. Ain't I a woman? Revisiting intersectionality. *J. Int. Womens Stud.* **2004**, *5*, 75–86.
25. Moleiro, C.; Marques, S.; Pacheco, P. Cultural Diversity Competencies in Child and Youth Care Services in Portugal: Development of two measures and a brief training program. *Child. Youth Serv. Rev.* **2011**, *33*, 767–773. [CrossRef]
26. Moleiro, C.; Pinto, N.; Changalal, A. Development and Evaluation of a Brief LGBT Competence Training for Psychotherapists. *Transcultural* **2014**, *6*, 87–100.
27. Freire, J.; Moleiro, C.; Rosmarin, D.H. Calling for Awareness and Knowledge Perspectives on Religiosity, Spirituality and Mental Health in a Religious Sample from Portugal (a Mixed-Methods Study). *Open Theol.* **2016**, *2*, 681–699. [CrossRef]
28. Candeias, P.; Alarcão, V.; Stefanovska-Petkovska, M.; Santos, O.; Virgolino, A.; Pintassilgo, S.; Pascoal, P.M.; Costa, A.S.; Machado, F.L. Reducing Sexual and Reproductive Health Inequities Between Natives and Migrants: A Delphi Consensus for Sustainable Cross-Cultural Healthcare Pathways. *Front. Public Health* **2021**, *9*, 656454. [CrossRef]
29. Rogers-Sirin, L. Approaches to multicultural training for professionals: A guide for choosing an appropriate program. *Prof. Psychol. Res. Pract.* **2008**, *39*, 313–319. [CrossRef]
30. Topuz, Ş.; Sezer, N.Y.; Aker, M.N.; Gönenç, I.M.; Cengiz, H.; Korucu, A.E. A SWOT analysis of the opinions of midwifery students about distance education during the COVID-19 pandemic a qualitative study. *Midwifery* **2021**, *103*, 103161. [CrossRef]
31. Wang, J.; Wang, Z. Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis of China's Prevention and Control Strategy for the COVID-19 Epidemic. *Int. J. Environ. Res. Public Health* **2020**, *17*, 2235. [CrossRef]
32. Govere, L.; Govere, E.M. How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. *Worldviews Evid. Based Nurs.* **2016**, *13*, 402–410. [CrossRef]
33. McGregor, B.; Belton, A.; Henry, T.L.; Wrenn, G.; Holden, K.B. Improving Behavioral Health Equity through Cultural Competence Training of Health Care Providers. *Ethn. Dis.* **2019**, *29* (Suppl. 2), 359–364. [CrossRef]
34. Brown, E.L. What Precipitates Change in Cultural Diversity Awareness during a Multicultural Course: The Message or the Method? *J. Teach. Educ.* **2004**, *55*, 325–340. [CrossRef]
35. Hussain, B.; Sheikh, A.; Timmons, S.; Stickley, T.; Repper, J. Workforce diversity, diversity training and ethnic minorities: The case of the UK National Health Service. *Int. J. Cross Cult. Manag.* **2020**, *20*, 201–221. [CrossRef]
36. Adedoyin, O.B.; Soykan, E. COVID-19 pandemic and online learning: The challenges and opportunities. *Interact. Learn. Environ.* **2020**, *2*, 1–18. [CrossRef]
37. Wilbur, K.; Snyder, C.; Essary, A.C.; Reddy, S.; Will, K.K.; Saxon, M. Developing Workforce Diversity in the Health Professions: A Social Justice Perspective. *Health Prof. Educ.* **2020**, *6*, 222–229. [CrossRef]
38. Kay, R.H. Exploring the use of video podcasts in education: A comprehensive review of the literature. *Comput. Hum. Behav.* **2012**, *28*, 820–831. [CrossRef]
39. Moridani, M. Asynchronous Video Streaming vs. Synchronous Videoconferencing for Teaching a Pharmacogenetic Pharmacotherapy Course. *Am. J. Pharm. Educ.* **2007**, *71*, 16. [CrossRef] [PubMed]