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Design and Validation of a Multicultural Curriculum Model at Iran University of Medical Sciences

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A B S T R A C T

Purpose: This study aimed to design and validate a multicultural curriculum model for Iran University of Medical Sciences by identifying its dimensions, components, and indicators and empirically evaluating its structural validity and applicability.

Methods and Materials: This applied study employed a sequential exploratory mixed-methods design with qualitative and quantitative phases. In the qualitative phase, the dimensions, components, and indicators of the multicultural curriculum were identified through document analysis and expert interviews. In the quantitative phase, 271 faculty members of Iran University of Medical Sciences were selected from a population of 922 using proportionate stratified random sampling by gender. A researcher-developed questionnaire and a model-validation checklist were used for data collection. Construct validity was assessed through first- and second-order confirmatory factor analysis, and internal consistency was evaluated using Cronbach's alpha. One-sample t tests were used to compare the observed scores with the theoretical midpoint of 3. The final model was also evaluated by 11 curriculum and medical education experts.

Findings: One-sample t tests showed that the mean scores of all 13 multicultural curriculum components were significantly lower than the theoretical midpoint, with means ranging from 2.20 to 2.82 and negative t values ranging from −17.668 to −2.771 ($p < .01$). Confirmatory factor analysis showed that all factor loadings exceeded 0.30 and all associated t values were greater than 1.96 ($p < .05$). The model demonstrated acceptable to excellent fit indices: $\chi^2/df = 3.21$, RMSEA = 0.071, NFI = 0.97, CFI = 0.98, IFI = 0.98, GFI = 0.90, AGFI = 0.85, and SRMR = 0.045. Expert validation showed that the mean scores of all four dimensions were significantly higher than the criterion value of 3, and the overall model dimensions and components received mean scores of 4.55 and 4.52, respectively ($p < .001$).

Conclusion: The findings confirmed that the proposed multicultural curriculum model, comprising the four dimensions of Goals, Content, Teaching and Learning Strategies, and Evaluation, possesses satisfactory construct validity, reliability, model fit, and expert acceptance and can provide a valid framework for multicultural curriculum development in medical sciences higher education.

Keywords: *Multicultural Curriculum, Curriculum Design, Curriculum Validation, Medical Education, Cultural Competence, Iran University of Medical Sciences*

1. Introduction

The increasing cultural, linguistic, ethnic, religious, and social diversity of contemporary societies has transformed the educational responsibilities of universities and has created new expectations regarding the design of curricula capable of responding to heterogeneous student populations and diverse communities. Higher education institutions are no longer expected merely to transmit disciplinary knowledge; they are increasingly required to prepare graduates who can work effectively, ethically, and responsively within culturally plural environments. This expectation is particularly important in health professions education, where graduates routinely interact with patients, families, colleagues, and communities whose cultural values, health beliefs, communication patterns, socioeconomic circumstances, and expectations of care may differ substantially. In such contexts, a curriculum that remains culturally neutral in form but implicitly reflects the perspectives of dominant groups may inadequately prepare learners for the realities of professional practice. Multicultural curriculum development therefore represents an educational response to diversity that seeks to integrate cultural plurality into curricular goals, content, teaching and learning processes, assessment practices, and institutional experiences rather than treating diversity as an isolated or supplementary topic (Ajani & Govender, 2026; Osiname, 2026).

Multicultural education is generally grounded in the assumption that diversity should be recognized as an educational resource rather than approached primarily as a problem of difference. Within curriculum studies, this perspective requires movement beyond symbolic representation of cultural groups toward systematic incorporation of multiple cultural perspectives, equitable educational opportunities, critical understanding of social structures, and competencies required for meaningful interaction across cultural boundaries. Contemporary multicultural curriculum approaches consequently emphasize not only what learners know about different cultures but also how they interpret cultural difference, communicate with culturally diverse individuals, question stereotypes and structural inequalities, and apply culturally responsive knowledge in real-world settings. Recent studies have highlighted that successful multicultural curriculum implementation depends on coherent alignment among policy, curricular content, pedagogy, teacher preparation, institutional culture, and evaluation mechanisms (Raihani et al., 2025; Rasyid et al., 2026). This systemic understanding is especially relevant for professional education because fragmented inclusion of multicultural concepts is unlikely to produce the integrated competencies required for practice.

The development of multicultural curricula has become increasingly prominent because educational systems worldwide are confronting the challenge of balancing national or institutional identity with social diversity. In multicultural societies, curricula play an important role in defining which forms of knowledge, identity, experience, and cultural expression are formally recognized. Curriculum decisions are therefore not neutral technical decisions; they can contribute either to inclusion and social cohesion or to marginalization and reproduction of dominant cultural narratives. Research on multicultural curriculum policy has shown that appropriately designed educational policies can contribute to learners' psychological and cognitive development, including dimensions such as self-esteem and critical thinking (Arshadi et al., 2025). Similarly, multicultural educational frameworks have been associated with efforts to develop social cohesion while maintaining recognition of distinct cultural and religious identities (Azmira, 2026). These findings suggest that multicultural curriculum design has implications extending beyond knowledge acquisition to identity development, social relations, participation, and the ability to engage critically with diversity.

A central issue in multicultural curriculum development concerns the relationship between curriculum content and the lived cultural realities of learners and communities. Curricula that incorporate only generic or decontextualized descriptions of cultural diversity may fail to address the complexity of intercultural interaction. Effective multicultural curricula should therefore integrate culturally situated knowledge, multiple perspectives, local contexts, and authentic social experiences into educational content. Studies conducted in Iran have similarly emphasized the importance of contextualizing multicultural curricula according to the country's cultural, geographic, and social diversity. For example, efforts to develop multicultural curriculum models based on Iranian ecosystems have demonstrated the importance of connecting curricular design to local cultural characteristics rather than adopting universal frameworks without contextual adaptation (Nakhzari Moghaddam & Akbari Borang, 2025). At the same time, analyses of multicultural curriculum challenges in Iranian education have pointed to conceptual ambiguity surrounding multicultural education, multicultural

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classrooms, multicultural teaching, and multicultural curriculum, indicating that greater conceptual clarification and operationalization are required for effective implementation (Mazaheri Forushani, 2024).

The Iranian educational context is particularly relevant to multicultural curriculum development because the country encompasses considerable ethnic, linguistic, regional, religious, and sociocultural diversity. Such diversity creates an important educational need to ensure that curricula acknowledge differences while also strengthening common professional, ethical, and civic commitments. Research on multicultural education policy in Iran has attempted to develop and validate models capable of embedding multicultural principles within the public education system, demonstrating a growing interest in moving from general theoretical discussion toward formal policy and model development (Mohremi et al., 2025). However, much of the existing domestic research has focused on school education, educational policy, or specific disciplinary contexts. Comparatively less attention has been devoted to the design and validation of comprehensive multicultural curriculum models within medical higher education, despite the particular relevance of cultural diversity to health communication, patient-centered care, health equity, professional ethics, and community responsiveness.

Medical sciences universities occupy a distinctive position within higher education because their curricula connect academic learning directly with human health, clinical practice, community engagement, and professional service. The consequences of curricular limitations in these settings are therefore not restricted to educational outcomes but may extend to patient experiences and the quality of healthcare delivery. Healthcare professionals must frequently interpret health beliefs, symptoms, family relationships, decision-making practices, dietary patterns, communication preferences, religious considerations, and expectations regarding treatment within culturally specific contexts. A multicultural curriculum in medical education should accordingly foster cultural and intercultural competence, social accountability, sensitivity to health disparities, respect for patient rights, and the ability to provide appropriate care in diverse clinical environments. In this sense, multicultural curriculum design in medical sciences requires the integration of cultural issues throughout the curriculum rather than their confinement to a single course or theoretical module.

The goals of a multicultural curriculum are therefore multidimensional. One important goal is the development of cultural and intercultural competence, which includes awareness of one's own cultural assumptions, recognition of cultural differences, effective intercultural communication, and the ability to modify professional responses according to contextual needs. A second goal involves social accountability and equity, whereby learners are prepared to understand and respond to disparities affecting culturally and socially diverse populations. Another goal concerns professional ethics and respect for the rights and dignity of patients from diverse backgrounds. These goals should ultimately prepare graduates to deliver healthcare services effectively in multicultural environments. Such objectives are consistent with broader multicultural curriculum scholarship emphasizing that diversity education should develop competencies that are both cognitive and practical rather than simply increasing exposure to information about cultural groups (Ajani & Govender, 2026; Osiname, 2026).

Curriculum content represents another critical dimension. Multicultural curriculum content should address the cultural, social, and behavioral determinants of health and examine how cultural beliefs and social contexts influence health-related behaviors, interpretations of illness, therapeutic relationships, and access to services. It should also incorporate patient- and family-centered approaches that acknowledge differences in family roles, communication styles, decision-making preferences, and cultural understandings of care. Importantly, multicultural concepts should be integrated across medical sciences curricula rather than presented as peripheral material. Studies of multicultural curriculum integration indicate that educational effectiveness is enhanced when diversity-related content is embedded in authentic learning experiences and disciplinary practices. For example, experiential approaches to multicultural curriculum integration have emphasized the value of practice-based learning and stakeholder involvement in translating multicultural principles into teaching processes (Ambarini et al., 2025). This suggests that medical education curricula should similarly connect multicultural content with clinical, community-based, and professional contexts.

Teaching and learning strategies determine whether multicultural curriculum goals and content are translated into meaningful student experiences. Traditional lecture-centered teaching may be insufficient for developing intercultural competence because learners require opportunities to encounter complexity, reflect on assumptions, solve contextualized problems, communicate across differences, and practice culturally responsive

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decision-making. Active learning, problem-based learning, community-oriented education, interprofessional learning, simulation, reflective practice, and culturally diverse clinical experiences can therefore serve as important mechanisms for multicultural education. Research has shown that experiential approaches can strengthen curriculum integration by allowing learners to apply multicultural concepts in realistic or practice-based situations (Ambarini et al., 2025). Likewise, instructional models drawing on established multicultural curriculum approaches have demonstrated the potential value of structured pedagogical interventions for embedding multicultural principles into specific educational programs (Yim, 2024). These findings reinforce the importance of treating pedagogy as an integral component of multicultural curriculum design.

Recent technological developments have further expanded the possibilities for multicultural curriculum implementation. Artificial intelligence and digital learning environments may facilitate access to diverse cases, adaptive content, multilingual resources, simulations, and culturally varied learning scenarios. Expert-based research on the feasibility of implementing multicultural curricula through artificial intelligence has suggested that technology can provide new opportunities for personalization, accessibility, and exposure to culturally diverse educational content, while also requiring careful attention to ethical, pedagogical, and contextual considerations (Qin & Zhou, 2026). In medical education, such technologies could potentially support culturally diverse virtual patient scenarios, clinical decision-making exercises, or reflective learning activities. Nevertheless, technology itself cannot substitute for an appropriate curricular framework; its educational value depends on the goals, content, pedagogy, and assessment structures within which it is embedded.

Assessment is another essential element of multicultural curriculum development. If multicultural competencies are identified as important curricular outcomes but are not systematically assessed, they may remain secondary in both teaching and learning. Assessment strategies should therefore examine not only learners' declarative knowledge about culture but also their ability to communicate appropriately, interpret culturally influenced situations, make ethically sensitive judgments, and demonstrate culturally responsive behavior in authentic or simulated settings. Formative and performance-based assessment approaches are particularly relevant because intercultural competence is developmental and context-dependent. Assessment of professional performance in clinical environments may also provide evidence regarding the extent to which multicultural learning is transferred from classroom instruction to actual practice. Consequently, curriculum evaluation should be aligned with multicultural goals and should generate evidence regarding both learner competence and the effectiveness of the curricular model itself.

Another challenge is that multicultural curricula operate within institutional and power structures that can either facilitate or constrain implementation. Curriculum management involves decisions regarding whose knowledge is included, which identities are represented, how educational authority is exercised, and how diversity-related priorities are translated into institutional practices. Research examining curriculum management and power relations has shown that multicultural character development is shaped by organizational and cultural structures and that the implementation of multicultural values requires negotiation among institutional traditions, authority relationships, and educational objectives (Najib et al., 2026). This issue is highly relevant to universities, where curricular change depends on faculty beliefs, governance structures, disciplinary traditions, resource allocation, and institutional priorities. Designing a multicultural curriculum model therefore requires attention not only to individual instructional practices but also to the broader institutional conditions influencing implementation.

The psychological experiences of learners from multicultural backgrounds provide an additional rationale for systematic curricular attention to diversity. Students from multicultural families or minority cultural backgrounds may experience challenges associated with identity negotiation, belonging, adaptation, social support, or educational inclusion. Research examining ego-resilience among students from multicultural families illustrates the growing recognition that educational environments should consider the psychosocial experiences of culturally diverse learners and provide conditions that support adaptation and resilience (Kim & Han, 2025). Although such research has primarily focused on school populations, the underlying principle remains relevant to higher education: inclusive curricula can contribute to learning environments in which cultural difference is acknowledged and learners are not required to suppress or marginalize aspects of their identity in order to participate academically.

The relationship between multicultural curriculum and social cohesion also requires careful consideration. Multicultural education should not be reduced to a

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celebration of difference detached from shared educational purposes. Rather, effective multicultural curricula must create a constructive balance between recognition of distinct cultural identities and development of mutual understanding, collective responsibility, and common professional values. Research in religious and culturally diverse educational settings has emphasized the need to negotiate identity in ways that promote social cohesion without erasing meaningful differences (Azmira, 2026). Similar principles are apparent in studies of curriculum reform that seek to integrate multicultural education within broader national curricular frameworks, where implementation depends on reconciling diversity, educational autonomy, institutional priorities, and societal goals (Raihani et al., 2025). In medical education, this balance can be expressed through respect for diverse cultural perspectives combined with commitment to evidence-based practice, professional ethics, patient safety, equity, and universal principles of human dignity.

Furthermore, multicultural curriculum implementation requires attention to faculty preparation. Faculty members are central agents in translating curricular principles into educational practice, and the success of multicultural curricula depends substantially on their knowledge, attitudes, pedagogical competence, and willingness to engage with cultural diversity. International research on teacher education has highlighted the need to revise professional preparation programs so that diversity, equity, and inclusion are not treated as peripheral concerns but as central dimensions of professional competence (Ajani & Govender, 2026). Similarly, studies of multicultural curriculum integration have emphasized stakeholder-informed and experiential approaches that enable educators to develop practical competencies for implementation (Ambarini et al., 2025). Within medical universities, faculty development may therefore be necessary to support culturally responsive teaching, assessment, mentoring, and clinical supervision.

Despite increasing international and national attention to multicultural curricula, a significant research gap remains regarding comprehensive, empirically validated models specifically designed for medical sciences higher education in Iran. Existing studies have addressed multicultural educational policy, school-level curricula, specific curricular areas, teacher education, and multicultural teaching strategies (Mohremi et al., 2025; Nakhzari Moghaddam & Akbari Borang, 2025; Rasyid et al., 2026). Other studies have examined the use of technology, outcomes-based teaching, cultural identity, experiential learning, and institutional management in diverse educational contexts (Najib et al., 2026; Osiname, 2026; Qin & Zhou, 2026). However, these strands of research do not by themselves provide an integrated model tailored to the educational and professional requirements of medical sciences universities in Iran. Such a model should identify and empirically validate the interrelated dimensions of curricular goals, content, teaching and learning strategies, and assessment while also evaluating its relevance and applicability within the institutional context.

Developing such a framework is important because an empirically grounded model can provide a coherent basis for curriculum review, faculty development, educational policy, clinical teaching, and institutional quality improvement. Rather than relying on fragmented interventions, a validated multicultural curriculum model can clarify the competencies expected of graduates, specify appropriate curricular content, identify pedagogical strategies capable of developing those competencies, and align evaluation procedures with multicultural educational outcomes. It can also provide medical education policymakers and curriculum planners with an evidence-based framework for assessing the gap between current curricular practices and the desired multicultural orientation. Ultimately, strengthening multicultural dimensions in medical education may contribute to the preparation of healthcare professionals who are more capable of responding to culturally diverse patients and communities in an equitable, respectful, and professionally appropriate manner.

Accordingly, the aim of the present study was to design and validate a multicultural curriculum model for Iran University of Medical Sciences by identifying its dimensions, components, and indicators and empirically evaluating the proposed model within the context of medical higher education.

2. Methods and Materials

This study was an applied investigation conducted using a sequential exploratory mixed-methods design with a qualitative–quantitative sequence. The study was field-based in terms of data collection and was designed to develop and empirically validate a multicultural curriculum model for Iran University of Medical Sciences. In the qualitative phase, an inductive approach was adopted to identify the dimensions, components, and indicators constituting a multicultural curriculum within the context of

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medical higher education. Evidence obtained from document analysis and expert interviews was analyzed to generate the conceptual structure of the proposed model. The qualitative findings subsequently provided the theoretical and empirical foundation for constructing the quantitative instruments and specifying the measurement structure of the model. In the quantitative phase, the components identified during the qualitative phase were operationalized and examined statistically in order to assess the current and desired status of multicultural curriculum implementation, evaluate the construct validity of the identified dimensions and components, and determine the empirical adequacy and applicability of the proposed model. Thus, the quantitative phase served as a validation stage for the findings generated during the exploratory qualitative phase and enabled the conceptual model to be evaluated within the actual educational context of Iran University of Medical Sciences.

Two participant groups were involved in the quantitative phase. The first group consisted of faculty members of Iran University of Medical Sciences in 2026. According to official information obtained from the university, the faculty population comprised 922 individuals, including 504 women and 418 men. Eligibility for participation required at least five years of scientific and teaching experience at Iran University of Medical Sciences so that respondents would possess sufficient familiarity with the university curriculum, teaching practices, clinical education environment, and institutional educational processes to provide informed judgments about the existing and desired status of multicultural curriculum components. The required sample size was calculated using Cochran's finite-population sample size formula at a 95% confidence level and a 5% margin of error, yielding a target sample of 271 faculty members. Proportionate stratified random sampling based on gender was then employed because the faculty population had an unequal gender distribution and simple random sampling could have resulted in inadequate representation of one of the two strata. Accordingly, the sample included 148 women and 123 men, preserving approximately the same gender distribution observed in the source population. This sampling procedure was intended to improve the representativeness of the quantitative sample and increase the generalizability of findings to the faculty population of Iran University of Medical Sciences.

The second participant group consisted of curriculum experts who were responsible for evaluating and validating the proposed model. Eleven experts who had participated in the qualitative phase of the study and had contributed to the identification and interpretation of the dimensions, components, and indicators of the multicultural curriculum model were retained as the expert validation panel. These participants were selected purposively on the basis of their specialized knowledge of curriculum planning, relevant academic and research experience, and familiarity with multicultural and medical education issues. Their previous participation in the qualitative phase also meant that they had detailed knowledge of the process through which the themes and model components had been derived. Retaining the same expert panel across the exploratory and validation phases ensured continuity between model development and model appraisal and enabled the experts to assess the relevance, comprehensiveness, clarity, internal coherence, and practical applicability of the proposed model in the context of medical universities. Their evaluations were used as an additional source of evidence for the content validity and practical acceptability of the final model.

Quantitative data were collected using a researcher-developed questionnaire and a model-validation checklist. The questionnaire was developed directly from the findings of the qualitative phase. The dimensions, components, and indicators identified through thematic analysis of documents and expert interviews were converted into measurable questionnaire items so that the conceptual findings generated qualitatively could be subjected to quantitative assessment. The questionnaire assessed the multicultural curriculum from two perspectives: the existing status and the desired status. This structure made it possible to determine not only the extent to which each identified component was currently represented in the curriculum but also the degree to which faculty members considered that component necessary or desirable within an appropriate multicultural curriculum. The instrument covered four principal curriculum dimensions identified during the qualitative phase: goals, content, teaching and learning strategies, and evaluation. These dimensions comprised 13 components, including development of cultural and intercultural competence; social accountability and equity in health; professional ethics and patients' rights; preparedness for providing healthcare in multicultural environments; cultural, social, and behavioral foundations of health; patient- and family-centered care in multicultural contexts; integration of multicultural concepts into the medical sciences curriculum; design of clinical learning experiences in culturally diverse settings; active, problem-based, and community-oriented learning; interprofessional and reflective learning experiences; comprehensive assessment of students' intercultural

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competencies; assessment of professional performance in clinical settings; and formative and performance-based assessment. Responses were recorded on a five-point Likert scale ranging from 1 to 5, with higher scores indicating greater perceived presence, importance, agreement, or desirability, depending on the section of the questionnaire.

The questionnaire underwent both content and construct validation. For content validation, the preliminary version was reviewed by specialists in curriculum planning who evaluated the relevance of each item to its intended construct, clarity of wording, comprehensiveness, correspondence between individual items and their designated components, and adequacy of content coverage. Expert recommendations were examined and incorporated into the wording, ordering, and formulation of the items before the final instrument was administered. Construct validity was subsequently evaluated through confirmatory factor analysis. The measurement model was examined to determine whether the questionnaire items adequately represented the dimensions and components derived from the qualitative phase. Factor loadings for the retained indicators exceeded the minimum acceptable value of 0.30, and the corresponding t-values were greater than the critical value of 1.96, providing evidence that the observed indicators were significantly associated with their intended latent constructs. These analyses supported the adequacy of the questionnaire's factorial structure for measuring the proposed multicultural curriculum framework.

Internal consistency reliability was evaluated using Cronbach's alpha coefficients. Reliability coefficients for all 13 components exceeded the conventional criterion of 0.70, ranging approximately from 0.76 to 0.84 across the individual components. The overall Cronbach's alpha coefficient for the questionnaire was 0.88, indicating satisfactory internal consistency for the complete instrument. More specifically, the reliability coefficients for the goal-related components ranged from 0.78 to 0.82, those for the content components ranged from 0.76 to 0.84, those for the teaching and learning strategy components ranged from 0.78 to 0.82, and those for the evaluation components ranged from 0.78 to 0.83. These coefficients indicated that the items within each component measured sufficiently coherent constructs and that the researcher-developed questionnaire was suitable for the quantitative assessment of the multicultural curriculum dimensions.

A researcher-developed model-validation checklist was additionally used to obtain expert judgments concerning the final conceptual model. The checklist was constructed from the dimensions, components, and indicators identified during the qualitative phase and therefore covered the complete structure of the proposed multicultural curriculum model. Experts were asked to evaluate the appropriateness, comprehensiveness, clarity, coherence, and practical applicability of the model and its constituent elements within the context of medical higher education. Responses were recorded on a five-point Likert scale ranging from 1, indicating complete disagreement, to 5, indicating complete agreement. Quantification of the expert judgments made it possible to determine the level of agreement regarding the adequacy of each dimension, component, and indicator and to identify any elements requiring revision before finalization of the model. The results obtained from the checklist therefore provided evidence for the content validity and expert acceptability of the proposed multicultural curriculum model.

Data analysis was performed in accordance with the sequential mixed-methods structure of the study. The qualitative phase preceded quantitative analysis and was used to identify the conceptual dimensions, components, and indicators that subsequently constituted the measurement framework of the study. In the quantitative phase, descriptive and inferential statistical procedures were applied to examine faculty responses, evaluate the existing and desired status of the identified curriculum components, test the psychometric properties of the measurement instrument, and empirically validate the proposed model. Descriptive statistics, including means and standard deviations, were calculated for the major dimensions and components. Before inferential analyses were conducted, the distribution of the quantitative variables was examined using skewness and kurtosis indices. Skewness values ranged from 0.322 to 1.217, whereas kurtosis values ranged from −0.170 to 1.633. Because all values were within the acceptable range of ±2, the distributions were considered sufficiently normal for the application of parametric statistical procedures.

To determine the current status of multicultural curriculum components, one-sample t-tests were conducted using the theoretical midpoint of 3 on the five-point Likert scale as the criterion value. The analysis was based on responses from the 271 faculty members and was performed separately for each of the 13 components. The comparison with the criterion score enabled identification of components whose observed mean scores were significantly below, equal to, or above the theoretical midpoint. The current-status means ranged from approximately 2.20 to 2.82, and the one-

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sample t-statistics were negative and statistically significant for all components at $P < 0.01$, indicating that faculty members evaluated the current implementation of all identified multicultural curriculum components as being significantly below the expected midpoint. The lowest mean was observed for active, problem-based, and community-oriented learning, whereas formative and performance-based assessment had the highest mean among the assessed components, although it also remained below the criterion score. These analyses were used to quantify the gap between the existing curriculum and the desired multicultural curriculum framework.

Confirmatory factor analysis was employed to assess the construct validity of the researcher-developed instrument and to examine the correspondence between the empirical data and the theoretically specified structure derived from the qualitative phase. Relationships between observable indicators and their respective latent components were evaluated through standardized factor loadings and associated t-statistics. Loadings greater than 0.30 and absolute t-values exceeding 1.96 were considered evidence of statistically meaningful relationships between indicators and their respective constructs. The overall measurement structure was further examined in terms of model fit to determine whether the four overarching dimensions and 13 components adequately represented the empirical data. Internal consistency was evaluated through Cronbach's alpha, with coefficients of 0.70 or higher interpreted as acceptable. Finally, scores obtained from the expert model-validation checklist were summarized and examined to determine the degree of expert agreement concerning the appropriateness, comprehensiveness, coherence, clarity, and applicability of the proposed model. Integration of the statistical findings from the faculty survey, construct-validation analyses, reliability assessment, and expert appraisal provided the empirical basis for refinement and final validation of the multicultural curriculum model for Iran University of Medical Sciences.

3. Findings and Results

Initially, the components extracted from the qualitative phase are presented in the following table.

Table 1

Reliability of the Questionnaire

Dimension	Component	Cronbach's Alpha
Goals	Development of cultural and intercultural competence	0.81
	Social accountability and equity in health	0.80
	Professional ethics and patients' rights	0.82
	Preparedness for providing healthcare in multicultural environments	0.78
Content	Cultural, social, and behavioral foundations of health	0.81
	Patient- and family-centered care content in multicultural contexts	0.84
	Integration of multicultural concepts into the medical sciences curriculum	0.76
Teaching and Learning Strategies	Design of clinical learning experiences in culturally diverse settings	0.80
	Application of active, problem-based, and community-oriented learning strategies	0.78
	Development of interprofessional and reflective learning experiences	0.82
Evaluation	Comprehensive assessment of students' intercultural competencies	0.80
	Assessment of professional performance in clinical settings	0.78
	Formative and performance-based assessment	0.83
Overall	Overall Cronbach's alpha	0.88

To assess the assumption of data normality, skewness and kurtosis indices were calculated. Skewness values ranged from 0.322 to 1.217, while kurtosis values ranged from −0.170 to 1.633. All values were within the conventional acceptable range of ±2, indicating that the variables were approximately normally distributed and that parametric statistical tests could appropriately be applied.

To answer the research question, "What is the current status of the multicultural curriculum at Iran University of Medical Sciences?", a one-sample t test was conducted using a criterion score of 3, corresponding to the theoretical midpoint of the five-point Likert scale. The analysis was conducted for N = 271 faculty members, with df = 270. The results indicated that the mean scores for all 13 components ranged from 2.20 to 2.82, and the overall means of the four major dimensions were significantly lower than the theoretical midpoint ($p < .001$). The t statistics were negative for all components and ranged from −17.668 to −2.771.

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These findings indicate that the current status of curriculum elements from a multicultural perspective was unfavorable and highlight the need to redesign the curriculum at Iran University of Medical Sciences based on multicultural principles.

Table 2

Descriptive Statistics and Results of the One-Sample t Test

Dimension	Component	*M*	*SD*	*t*	*df*	*p*
Goals	Development of cultural and intercultural competence	2.62	0.95	−6.506	270	< .001
	Social accountability and equity in health	2.35	0.83	−12.735	270	< .001
	Professional ethics and patients' rights	2.47	0.90	−9.499	270	< .001
	Preparedness for providing healthcare in multicultural environments	2.50	0.90	−9.087	270	< .001
Content	Cultural, social, and behavioral foundations of health	2.33	0.80	−13.768	270	< .001
	Patient- and family-centered care content in multicultural contexts	2.45	0.65	−13.600	270	< .001
	Integration of multicultural concepts into the medical sciences curriculum	2.34	0.83	−12.955	270	< .001
Teaching and Learning Strategies	Design of clinical learning experiences in culturally diverse settings	2.31	0.77	−14.668	270	< .001
	Application of active, problem-based, and community-oriented learning strategies	2.20	0.74	−17.668	270	< .001
	Development of interprofessional and reflective learning experiences	2.36	0.84	−12.551	270	< .001
Evaluation	Comprehensive assessment of students' intercultural competencies	2.28	0.74	−15.872	270	< .001
	Assessment of professional performance in clinical settings	2.21	0.84	−15.252	270	< .001
	Formative and performance-based assessment	2.82	1.05	−2.771	270	.006

To examine the construct validity of the model, first- and second-order confirmatory factor analyses were performed using LISREL software.

Regarding factor loadings and coefficients of determination, the factor loadings of all 45 indicators and 13 components exceeded the criterion value of 0.30, and all corresponding t-values were greater than 1.96 ($p < .05$). The coefficients of determination ranged from 0.40 to 0.65 for the Goals dimension, from 0.23 to 0.58 for the Content dimension, from 0.41 to 0.54 for the Teaching and Learning dimension, from 0.32 to 0.57 for the Evaluation dimension, and from 0.45 to 0.71 for the overall model. These values indicate that the indicators possessed satisfactory explanatory power in relation to their respective dimensions.

Table 3

Model Fit Indices

Fit Index	Abbreviation	Acceptable Criterion	Calculated Value	Fit Status
Chi-square to degrees-of-freedom ratio	χ^2/df	< 5, preferably < 3	3.21	Acceptable
Root Mean Square Error of Approximation	RMSEA	< 0.08	0.071	Acceptable
Normed Fit Index	NFI	> 0.90	0.97	Excellent
Comparative Fit Index	CFI	> 0.90	0.98	Excellent
Incremental Fit Index	IFI	> 0.90	0.98	Excellent
Goodness-of-Fit Index	GFI	> 0.90	0.90	Acceptable
Adjusted Goodness-of-Fit Index	AGFI	> 0.80	0.85	Acceptable
Standardized Root Mean Square Residual	SRMR	< 0.05	0.045	Acceptable

Regarding the structural model fit indices, all goodness-of-fit indices obtained for the individual dimensions and for the final structural model fell within acceptable or desirable ranges. In the overall model, the chi-square to degrees-of-

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freedom ratio was 3.21, while the Root Mean Square Error of Approximation was 0.071. In addition, the NFI, CFI, and IFI values were 0.97, 0.98, and 0.98, respectively, indicating a very good fit of the proposed structural model to the observed data.

Figure 1

Standardized factor loadings of the multicultural curriculum model.

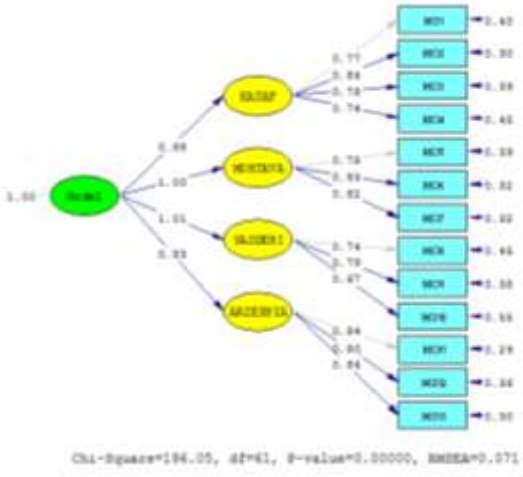
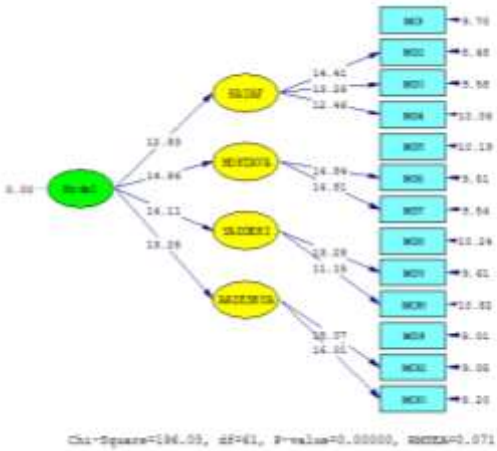


Figure 2

Significance coefficients of the multicultural curriculum model.



To perform the final validation of the developed multicultural curriculum model and assess its acceptability and applicability within the medical education system, the model was presented to 11 experts and specialists in curriculum planning and medical education after confirmation of its structural fit. At this stage, the dimensions and components of the model were evaluated in terms of comprehensiveness, appropriateness, clarity, feasibility, and scientific validity using a validation checklist based on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. A one-sample *t* test was employed to examine whether the mean ratings assigned by the experts differed significantly from the theoretical midpoint criterion of 3. The results of this evaluation are summarized in Table 4.

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Table 4

Validation of the Multicultural Curriculum Model

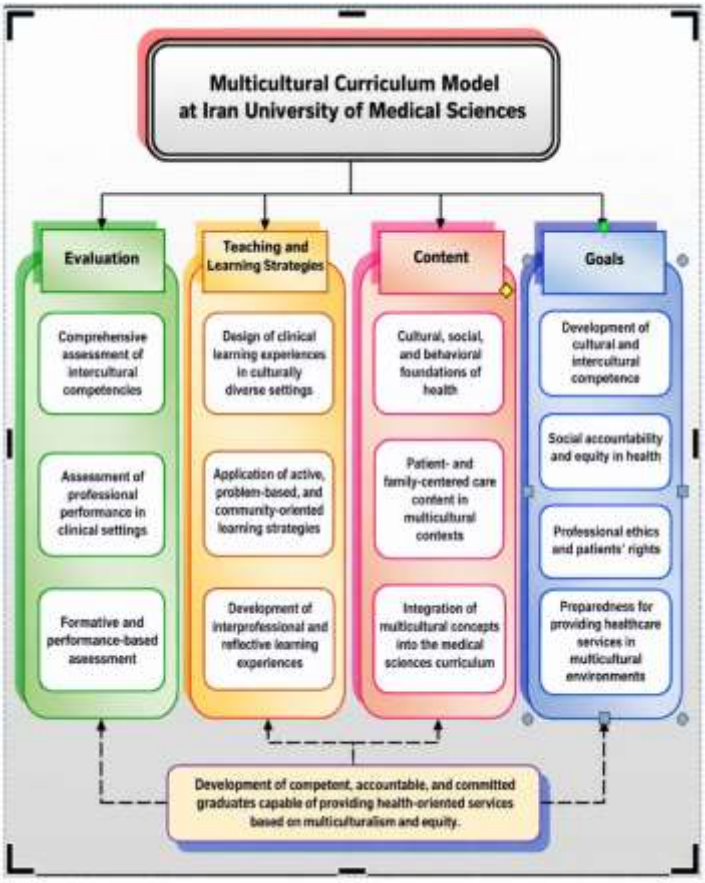
Model Dimension	*M*	*SD*	*t*	*df*	*p*	Evaluation Result
Goals	4.82	0.40	14.91	10	< .001	Confirmed at a desirable level
Content	4.64	0.67	8.05	10	< .001	Confirmed at a desirable level
Teaching and Learning Strategies	4.54	0.69	7.46	10	< .001	Confirmed at a desirable level
Evaluation	4.45	0.82	5.88	10	< .001	Confirmed at a desirable level
Overall Model Dimensions	4.55	0.28	18.04	10	< .001	Excellent validity and confirmed
Overall Components (13 components)	4.52	0.31	13.67	10	< .001	Excellent validity and confirmed

The results of the one-sample t tests showed that the mean scores for all four dimensions—Goals, Content, Teaching and Learning Strategies, and Evaluation—as well as the overall mean scores for the model dimensions (M = 4.55) and components (M = 4.52), were significantly higher than the theoretical midpoint of 3 ($p < .001$).

A more detailed examination showed that the Goals dimension, with a mean score of 4.82, achieved the highest level of expert acceptance and validation. The consistently positive t statistics, which were statistically significant at the 99% confidence level in all cases, indicate a high degree of agreement among the experts regarding the effectiveness and comprehensiveness of the proposed model. These findings demonstrate that the developed model was supported not only structurally through confirmatory factor analysis but also in terms of content validity and practical applicability based on expert consensus. Accordingly, the proposed model can be regarded as a valid framework for implementation within the academic context of medical sciences education.

Figure 3

Final multicultural curriculum model at Iran University of Medical Sciences: dimensions, components, and structural relationships.



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4. Discussion and Conclusion

The present study was conducted to design and validate a multicultural curriculum model for Iran University of Medical Sciences and to determine the extent to which its proposed dimensions and components were supported empirically. The findings indicated that the final model was organized around four major dimensions—Goals, Content, Teaching and Learning Strategies, and Evaluation—and 13 components. The reliability results demonstrated satisfactory internal consistency for all components, with Cronbach's alpha coefficients ranging from 0.76 to 0.84 and an overall coefficient of 0.88. In addition, confirmatory factor analysis supported the construct validity of the model; the factor loadings of all 45 indicators and 13 components exceeded the minimum acceptable threshold, and all corresponding *t*-values were statistically significant. The structural model also demonstrated acceptable to excellent goodness-of-fit indices, including $\chi^2/df = 3.21$, RMSEA = 0.071, NFI = 0.97, CFI = 0.98, IFI = 0.98, GFI = 0.90, AGFI = 0.85, and SRMR = 0.045. These findings indicate that the proposed conceptual structure was empirically compatible with the observed data and that the relationships among the dimensions, components, and indicators were sufficiently coherent to support the validity of the multicultural curriculum model.

One of the most important findings was that the current status of all 13 multicultural curriculum components was below the theoretical midpoint of the five-point scale. The mean scores ranged from 2.20 to 2.82, and all one-sample *t* tests were negative and statistically significant. This suggests that faculty members perceived the existing curriculum as insufficiently responsive to multicultural educational requirements. This finding is consistent with the broader literature showing that the formal recognition of diversity does not necessarily translate into systematic curricular integration. Ajani and Govender emphasized that diversity, equity, and inclusion often remain inadequately embedded in curricular structures and professional preparation programs unless explicit curricular reform is undertaken (Ajani & Govender, 2026). Similarly, Osiname argued that multicultural approaches require intentional curricular alignment rather than occasional or symbolic reference to cultural diversity (Osiname, 2026). The results of the present study therefore reinforce the argument that multiculturalism cannot be adequately addressed through isolated educational activities; rather, it must be systematically incorporated into curriculum objectives, content, learning experiences, and assessment procedures.

Among the four dimensions, the Goals dimension comprised cultural and intercultural competence, social accountability and equity in health, professional ethics and patients' rights, and preparedness for providing healthcare services in multicultural environments. The inclusion of these components indicates that a multicultural curriculum in medical sciences should ultimately be outcome-oriented and should prepare graduates for professional practice in culturally diverse contexts. This interpretation is supported by research demonstrating that multicultural curricula can influence both cognitive and psychosocial outcomes. Arshadi et al. found that multicultural curriculum policies were associated with important learner outcomes such as critical thinking and self-esteem, suggesting that the goals of multicultural education should extend beyond factual knowledge and encompass broader competencies and personal capacities (Arshadi et al., 2025). Likewise, Rasyid et al. emphasized the importance of integrating multicultural values into curricular goals so that education contributes to tolerance, respect for diversity, and constructive social interaction (Rasyid et al., 2026). In medical education, these principles acquire additional importance because cultural competence and sensitivity directly affect interactions with patients, families, colleagues, and communities.

The strong emphasis on social accountability and equity in health in the proposed model is particularly noteworthy. Medical universities have a social responsibility to prepare graduates capable of responding to the health needs of diverse populations. Cultural background can influence perceptions of illness, treatment-seeking behaviors, family involvement, communication with health professionals, and trust in healthcare systems. A multicultural curriculum can therefore contribute to reducing inequities by helping students understand the cultural and social contexts within which health and illness are experienced. The importance of preserving identity while strengthening cohesion has been emphasized in multicultural educational research. Azmira showed that multicultural curriculum design can facilitate social cohesion when different identities are acknowledged rather than ignored or assimilated into a dominant framework (Azmira, 2026). This is relevant to medical education because equitable care requires recognizing meaningful differences while maintaining common ethical and professional standards.

The findings also identified Content as a distinct core dimension consisting of the cultural, social, and behavioral

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foundations of health, patient- and family-centered care in multicultural contexts, and integration of multicultural concepts throughout the medical sciences curriculum. The current-status scores for these components were all below the theoretical midpoint, indicating that multicultural content was not perceived as sufficiently embedded in the existing curriculum. This finding is consistent with Mazaheri Forushani's analysis of multicultural curriculum challenges in Iranian education, which highlighted conceptual ambiguity and insufficient differentiation among multicultural education, multicultural classrooms, multicultural teaching, and multicultural curriculum (Mazaheri Forushani, 2024). Such ambiguity may make it difficult for institutions to convert broad commitments to cultural diversity into clear curricular content. The present findings suggest that in medical sciences, multicultural content should not be restricted to separate lectures or optional modules but should be distributed across basic sciences, clinical education, community health, ethics, communication, and patient-centered care.

The contextual orientation of the Content dimension is also supported by Nakhzari Moghaddam and Akbari Borang, who emphasized the importance of designing multicultural curricula according to the ecological and cultural characteristics of the Iranian context (Nakhzari Moghaddam & Akbari Borang, 2025). Their work suggests that multicultural curriculum design becomes more meaningful when it is grounded in local cultural realities rather than relying exclusively on imported conceptual models. The present model similarly implies that multicultural medical education should address the actual diversity encountered by students and practitioners in Iranian society. In other words, the curriculum should enable students to connect general principles of cultural competence with the specific cultural, regional, linguistic, social, and family contexts influencing healthcare practice.

The Teaching and Learning Strategies dimension included clinical learning experiences in culturally diverse settings, active, problem-based, and community-oriented learning, and interprofessional and reflective learning experiences. Importantly, the lowest mean among all 13 components was obtained for the application of active, problem-based, and community-oriented learning strategies ($M = 2.20$). This finding indicates that the greatest perceived deficiency was not merely in curricular content but in the pedagogical mechanisms through which multicultural competencies are developed. Multicultural competence is fundamentally experiential and cannot be acquired effectively through passive exposure to theoretical information alone. Learners must have opportunities to confront real or simulated culturally complex situations, discuss competing perspectives, solve contextualized problems, reflect on their assumptions, and interact with diverse individuals and communities.

The importance of experiential pedagogy is strongly supported by Ambarini et al., who showed that multicultural curriculum integration can be strengthened through microteaching, experiential learning, and stakeholder-informed instructional practices (Ambarini et al., 2025). Their findings are consistent with the present model's emphasis on active and reflective learning. Likewise, Yim demonstrated that applying a structured multicultural curriculum approach within an educational program can translate multicultural concepts into concrete learning activities and instructional experiences (Yim, 2024). These studies support the interpretation that multicultural curriculum effectiveness depends substantially on the design of learning experiences rather than only on the presence of multicultural topics. For medical sciences students, this may involve culturally diverse clinical cases, community placements, interprofessional discussions, simulations, reflective writing, and problem-based scenarios involving ethical or communicative challenges.

The low score obtained for active and community-oriented learning also suggests that the current curriculum may provide limited opportunities for students to engage directly with the cultural complexity of healthcare delivery. This is a significant issue because community exposure can help students move beyond abstract assumptions and develop a more contextualized understanding of health beliefs, social inequalities, and patient expectations. Osiname's discussion of multicultural approaches to outcomes-based curricula similarly emphasizes that instructional strategies must be aligned with expected multicultural competencies (Osiname, 2026). If learning outcomes include culturally responsive practice, then instructional methods must create conditions in which such practice can be rehearsed, evaluated, and refined. Therefore, the gap identified in the present study between desired multicultural competencies and existing teaching strategies reflects a broader issue of constructive alignment within the curriculum.

The findings related to the Evaluation dimension are also significant. Although formative and performance-based assessment received the highest mean among the 13 current-status components ($M = 2.82$), it nevertheless remained

significantly below the theoretical midpoint. The other evaluation components—comprehensive assessment of intercultural competence and assessment of professional performance in clinical settings—also received low scores. These results suggest that multicultural outcomes may not currently be assessed systematically. This is important because students often prioritize competencies that are explicitly evaluated. If cultural awareness, intercultural communication, social accountability, and culturally responsive clinical performance are emphasized rhetorically but excluded from formal assessment, their curricular status may remain marginal.

The inclusion of comprehensive, formative, and performance-based assessment in the validated model therefore represents an important strength. It indicates that multicultural competence should be evaluated as a multidimensional professional outcome rather than solely as theoretical knowledge. This is consistent with the outcomes-based perspective discussed by Osiname, according to which multicultural teaching should be connected to observable learning outcomes and appropriate assessment mechanisms (Osiname, 2026). In a medical education context, such assessments may include structured clinical encounters, reflective portfolios, community-based projects, case analyses, observed communication with culturally diverse patients, and formative feedback. The present study therefore extends the multicultural curriculum literature by showing that evaluation should be considered a core structural dimension rather than an endpoint added after teaching has already been designed.

The confirmatory factor analysis provided further support for the multidimensional organization of the model. All factor loadings were statistically meaningful, and the coefficients of determination suggested that the identified indicators explained a substantial proportion of variance in their respective dimensions. The overall goodness-of-fit indices likewise indicated satisfactory correspondence between the proposed structure and the data. This empirical validation is consistent with previous Iranian attempts to move multicultural education beyond conceptual discussion toward model development. Mohremi et al. designed and validated a multicultural education policy model within Iran's public education system, demonstrating the need for systematic frameworks that integrate multiple policy and curricular dimensions (Mohremi et al., 2025). The present research builds on this trajectory by extending model development to the specialized context of medical sciences higher education and by validating a model centered specifically on curriculum design.

The final expert validation provided additional support for the applicability of the model. All four dimensions received mean scores considerably above the theoretical midpoint, with the Goals dimension receiving the highest expert rating (M = 4.82), followed by Content (M = 4.64), Teaching and Learning Strategies (M = 4.54), and Evaluation (M = 4.45). The overall mean for the model dimensions was 4.55, and the overall mean for the 13 components was 4.52. All differences from the criterion score were statistically significant. These results indicate strong expert agreement regarding the comprehensiveness, appropriateness, clarity, feasibility, and scientific validity of the proposed model. The particularly high rating of the Goals dimension may indicate that experts considered clearly articulated multicultural outcomes to be the necessary foundation for subsequent curricular decisions.

The high level of expert agreement is consistent with research emphasizing that multicultural curriculum reform requires coherent institutional vision. Najib et al. showed that curriculum management and power relations play an important role in shaping multicultural character development, indicating that curricular change depends not only on technical design but also on organizational and institutional processes (Najib et al., 2026). Similarly, Raihani et al. demonstrated that multicultural education within broader curriculum reform requires systematic integration rather than isolated curricular additions (Raihani et al., 2025). The strong expert endorsement of the present model suggests that a coherent structure connecting goals, content, pedagogy, and evaluation may provide a useful basis for institutional curriculum reform at Iran University of Medical Sciences.

The model also reflects contemporary developments in educational technology. Qin and Zhou examined the feasibility of implementing multicultural curricula through artificial intelligence and highlighted the potential of AI-supported environments to provide diverse educational experiences, personalized learning, and access to multiple cultural perspectives (Qin & Zhou, 2026). Although technology was not treated as a separate dimension in the present model, its integration is compatible with the identified components, especially active learning, simulation, reflective practice, and culturally diverse clinical experiences. AI-supported virtual patients, multilingual learning materials, culturally varied clinical scenarios, and adaptive case-based learning may become useful

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mechanisms for implementing the model. However, such technologies should remain subordinate to clearly defined curricular goals and ethical standards.

The relevance of the model also extends to student adaptation and inclusion. Kim and Han's systematic review of ego-resilience among students from multicultural families highlights the importance of educational environments that support learners facing culturally complex experiences (Kim & Han, 2025). While the present study focused primarily on curriculum structure rather than student psychosocial outcomes, the validated model may indirectly contribute to more inclusive educational environments by normalizing cultural diversity within curriculum content and learning processes. A curriculum that explicitly recognizes multiple cultural perspectives may strengthen students' sense of belonging and reduce the implicit marginalization of those whose cultural experiences differ from dominant educational norms.

Overall, the findings indicate a clear contrast between the current status and the desired structure of multicultural curriculum development at Iran University of Medical Sciences. Faculty perceptions showed that the current curriculum did not sufficiently incorporate multicultural goals, content, pedagogical strategies, or assessment approaches, while confirmatory factor analysis and expert evaluation strongly supported the proposed model. This combination of findings is important because it demonstrates both a need for curricular reform and empirical support for a structured response to that need. The model therefore provides an integrated framework in which multiculturalism is conceptualized not as a separate topic but as a principle extending across the full curriculum cycle—from definition of graduate competencies to content selection, learning experiences, and evaluation. In this respect, the findings are broadly aligned with international and Iranian literature advocating systematic, contextualized, experiential, and institutionally supported approaches to multicultural education (Mohremi et al., 2025; Raihani et al., 2025; Rasyid et al., 2026).

The present study had several limitations that should be considered when interpreting its findings. First, the quantitative phase was conducted among faculty members of a single medical sciences university, which may limit the generalizability of the results to other universities with different institutional structures, academic cultures, geographical contexts, or student populations. Second, the assessment of the current curriculum was based on faculty perceptions and therefore may have been influenced by individual experiences, expectations, or differences in familiarity with multicultural education. Third, although the expert panel possessed relevant academic expertise and had participated in the qualitative phase, the relatively small number of experts may have limited the diversity of perspectives represented in the final validation process. Fourth, the study focused primarily on structural and content validity and did not evaluate the effects of implementing the model on student competencies, clinical performance, patient experiences, or educational outcomes. Finally, because the study employed a cross-sectional design in its quantitative phase, it was not possible to examine changes in multicultural curriculum implementation over time.

Future studies should examine the proposed model in other medical sciences universities and in different geographical and cultural settings in order to assess its external validity and determine whether specific components require contextual modification. Multi-institutional studies with larger and more heterogeneous samples could provide stronger evidence regarding the stability of the model. Future research should also include students, curriculum administrators, clinical instructors, healthcare professionals, patients, and community representatives so that the model can be evaluated from multiple stakeholder perspectives. Longitudinal and intervention-based studies are recommended to investigate whether implementation of the model improves cultural competence, intercultural communication, critical thinking, professional behavior, social accountability, and clinical decision-making among students. Researchers could also examine the relative effectiveness of different instructional strategies, including simulation, community-based education, interprofessional learning, reflective practice, and digital or artificial intelligence-supported learning environments. Further psychometric studies may assess measurement invariance across disciplines, gender groups, academic ranks, and professional programs.

At the practical level, Iran University of Medical Sciences and comparable institutions should use the validated model as a framework for systematic curriculum review rather than introducing isolated multicultural courses. Curriculum committees should first revise educational goals to explicitly incorporate cultural and intercultural competence, social accountability, health equity, professional ethics, and preparedness for culturally diverse practice. Multicultural content should then be integrated horizontally and vertically across basic sciences, clinical courses, community health, ethics, communication training, and professional education.

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Faculty development programs should prepare instructors to use active, problem-based, community-oriented, interprofessional, and reflective teaching strategies. Clinical and community placements should expose students to culturally diverse populations under appropriate supervision. Assessment systems should include formative and performance-based methods capable of evaluating culturally responsive communication and professional behavior. Finally, implementation should be accompanied by continuous curriculum monitoring, stakeholder feedback, periodic evaluation of student outcomes, and institutional support mechanisms to ensure that multicultural curriculum reform becomes an embedded and sustainable component of medical education rather than a short-term educational initiative.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

All procedures performed in studies involving human participants were under the ethical standards of the institutional and, or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

References

Ajani, O. A., & Govender, S. (2026). Revising Pre-Service Teacher Education for Diversity, Equity, and Inclusion: Multicultural Curriculum Challenges and Prospects in South Africa. *European Journal of Education*, *61*(1), e70493. https://doi.org/10.1111/ejed.70493

Ambarini, R., Yuliasri, I., Widhiyanto, W., Yuniawan, T., & Sukarno. (2025). Empowering Multicultural Curriculum Integration through Microteaching: An Experiential and Stakeholder-Informed Approach. *The New Educational Review*, *81*, 167-181. https://doi.org/10.15804/tner.2025.81.3.11

Arshadi, N., Hemmati, S., Karimzadeh Mohammadabadi, A., Hajian Hosseinabadi, Z., & Kazemi, A. A. (2025). Statistical Analysis of the Role of Multicultural Curriculum Policies in the Development of Self-Esteem and Critical Thinking among Upper Primary School Learners. *Strategic Research in Education*(60), 343-369.

Azmira, T. (2026). Multicultural Islamic Education Curriculum and Social Cohesion: Negotiating Religious Identity in Diverse Communities. *Multicultural Islamic Education Review*, *4*(1), 145-160. https://doi.org/10.23917/mier.v4i1.16875

Kim, Y., & Han, J. (2025). A Systematic Literature Review on Ego-Resilience of Middle and High School Students From Multicultural Families. *Korean Association for Learner-Centered Curriculum and Instruction*, *25*(9), 437-451. https://doi.org/10.22251/jlcci.2025.25.9.437

Mazaheri Forushani, E. (2024). Challenges of multicultural curriculum in Iranian education with an emphasis on clarifying concepts such as multicultural education, multicultural class, multicultural teaching and multicultural curriculum. The second international conference on sociology, social sciences and education with a future perspective,

Mohremi, J., Keyhan, J., & Samari, M. (2025). Designing and Validating a Multicultural Education Policy Model in Iran's Public Education System. *Curriculum Planning Research*, *83*(21), 48-67.

Najib, M., Maskuri, M., & Sa'id, M. M. (2026). Curriculum Management and Power Relations: Strategies for Multicultural Character Development of Santri in Traditional Pesantren. *Munaddhomah: Jurnal Manajemen Pendidikan Islam*, *7*(1), 109-124. https://doi.org/10.31538/munaddhomah.v7i1.2261

Nakhzari Moghaddam, L., & Akbari Borang, M. (2025). Designing a Multicultural Art Curriculum Model for Upper Primary Education Based on Iran's Ecosystems. *Strategic Studies of Education*, *3*(2).

Osiname, A. (2026). Multicultural Approaches to Teaching Outcomes-Based Curricula. *Journal for Multicultural Education*, 1-14.

Qin, H., & Zhou, Z. (2026). Feasibility of Implementing a Multicultural Curriculum through Artificial Intelligence: Perspectives of Educational Science Experts. *Scientific reports*, *16*, 18137. https://doi.org/10.1038/s41598-026-48953-x

Raihani, R., Issabekova, G., Maulana, T., & Abdrakhman, G. (2025). Multicultural Education in Indonesia's "Merdeka" Curriculum. *Journal of Education, Culture and Society*, *16*(1), 413-432. https://doi.org/10.15503/jecs2025.2.413.432

Rasyid, M., Hidayat, M. I., Nurannisa, I., Tang, M., & Syahrul, M. (2026). Integration of Multicultural Values in the Development of Islamic Religious Education Curriculum. *Edusoshum: Journal of Islamic Education and Social*

E-ISSN: 2645-3460

Humanities, *6*(1), 116-125. https://doi.org/10.52366/edusoshum.v6i1.225

Yim, J. M. (2024). Development and Application of a Dance Education Program Using the Banks Multicultural Curriculum Approach. *Journal of Sport and Dance Science*, *4*(3), 191-204. https://doi.org/10.54109/jsds.2024.4.3.17

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