Ethics 101 HANDBOOK

Created during "Mental and Physical Health Across Cultures: A Youth Exchange"

VOLUNTARIAT
SCI SLOVENIA

FIZIOTERAPEVTI BREZ MEJA



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1

Core Principles of Healthcare Ethics

Autonomy, beneficence, non-maleficence, justice, and how they guide ethical decisions.



Welcome to Ethics 101 — your pocket-guide to understanding the ethical puzzles that appear whenever healthcare meets culture, communication, and real human lives.

Healthcare ethics may sound complicated, but at its core it's about four simple questions:

- **Am I respecting this person?**
- **Am I helping?**
- **Am I avoiding harm?**
- **Am I being fair?**

These questions shape the famous principles of autonomy, beneficence, non-maleficence, and justice, which are the everyday "tools for reasoning" in modern healthcare practice.
(https://samples.jbpub.com/9781284124910/9781284124910_CH02_OnlineCat.pdf)

But here's the twist: in a multicultural environment, these "simple" principles suddenly become... less simple. Different cultures value family roles differently, understand illness differently, or expect different communication styles — and that makes ethical decisions richer, but also trickier. Real-world ethics is dynamic and context-dependent, full of nuance — far beyond a list of rules.
(https://pmc.ncbi.nlm.nih.gov/articles/PMC1114730/pdf/253.pdf)

Another key perspective highlights the central role of the healing relationship — the unique commitment formed between the person seeking care and the professional offering it. Many ethical obligations grow directly out of this relationship and the trust it requires.
(chrome-native://pdf/link?
url=content%3A%2F%2Fmedia%2Fexternal%2Fdownloads%2F1000015741)



Ethics is also shaped by the world around us. Power, inequality, access to care, and social realities influence what is possible, what is fair, and what “doing good” really looks like. Ethical thinking becomes stronger when it pays attention to these lived conditions and not just ideal principles.
(https://www.arts.uwaterloo.ca/~pthagard/courses/Phil226/farmer.ethics.2004.pdf)

Throughout this youth exchange, we’ve brought together different cultures, professions, and perspectives — and this handbook is one of the results. It captures the ideas we discussed:

- **navigating language barriers,**
- **understanding culturally shaped health beliefs,**
- **recognizing power dynamics,**
- **and making decisions that balance professional ethics with cultural diversity.**

Rather than offering final answers, this handbook reflects our shared learning. It’s a collection of insights, questions, and tools created by participants — something you can take home as a reminder of how ethics becomes richer when explored together. Think of it as a small guide for crossing borders ethically: between cultures, professions, and the ideals and realities of healtcare.



CULTURAL SENSITIVITY

1. Introduction: What Is Cultural Sensitivity?

Cultural sensitivity also known as cultural competence is the ability of health-care providers and health systems to understand, respect, and respond appropriately to the diverse cultural backgrounds of patients and their families. This includes recognition of values, beliefs, traditions, communication styles, and social contexts that shape a patient's experience of health and illness NCBI+2Wikipedia+2.
Modern healthcare serves increasingly diverse populations, and effective care requires more than clinical skill: it requires the capacity to connect, to understand differences, and to integrate cultural perspectives into treatment plans (ScienceDirect +2; PMC +2).
Cultural competence is not a one-time training or checklist — it is an ongoing process of learning, awareness, and adaptation (PMC +2; PMC +2).

2. Why Cultural Sensitivity Matters

2.1 Person-Centered Care

Cultural sensitivity is deeply connected to patient-centered care — care that respects individual preferences, needs, and values, and ensures these values guide clinical decision-making (PMC +2; PMC +2).
When clinicians understand a patient's cultural background, they can tailor care to dietary patterns (e.g., halal/kosher), religious rituals, traditional medicine practices, modesty concerns, or family roles (NCBI +2; PMC +2). This leads to more effective, comfortable, and safe care.

2.2 Improving Communication & Trust

Clear communication is the foundation of safe healthcare. Culturally sensitive communication builds trust, reduces fear, and encourages patients to share concerns openly (ScienceDirect +2; SpringerLink +2).
Using trained interpreters — rather than family members — ensures accuracy and confidentiality (NCBI +2; psnet.ahrq.gov +2). Understanding non-verbal cues, tone, or communication norms prevents misinterpretation and strengthens the therapeutic relationship.



2.3 Increasing Satisfaction & Reducing Health Disparities

Research consistently shows that cultural competence training improves clinicians' knowledge, attitudes, and skills (PMC +2; SpringerLink +2).

For patients, culturally sensitive care increases satisfaction, promotes treatment adherence, and helps create more equitable access across diverse communities (PubMed +2; reviewofconphil.com +2).

This supports fairness in healthcare delivery and helps reduce longstanding health disparities (ScienceDirect +2; journals.lww.com +2).

3. Core Principles of Cultural Competence

3.1 Patient-Centered Approach

Treat every patient as an individual, not a stereotype. Assess personal preferences, beliefs, and expectations before assuming cultural patterns (PMC +2; PMC +2).

3.2 Self-Awareness and Reflexivity

Providers must reflect on their own cultural assumptions, biases, and potential ethnocentrism (Wikipedia +2; SAGE Journals +2). Bias is normal — unexamined bias is harmful.

3.3 Effective, Respectful Communication

Use professional interpreters when needed (NCBI +2; psnet.ahrq.gov +2).
Ask open-ended questions about cultural or spiritual needs (SpringerLink +1).
Adapt non-verbal communication and tone to cultural norms (ScienceDirect +1).

3.4 Flexibility & Tailored Care

Healthcare should adapt to reasonable cultural needs: traditional remedies, modesty preferences, spiritual rituals, dietary rules, or family involvement (NCBI +2; PMC +2; SpringerLink +1).

3.5 Institutional Support

Cultural competence thrives when supported by organizational policies, staff training, interpreter services, diverse hiring, and community partnerships (SpringerLink +1; NCBI +2; County Health Rankings & Roadmaps +2).



4. What Research Tells Us

4.1 Evidence of Benefits

A large body of research confirms that cultural competence training improves provider knowledge, communication skills, and cross-cultural understanding (PMC +2; SpringerLink +2).

Patients also report greater trust and therapeutic satisfaction when care respects their cultural identity (PubMed +2; reviewofconphil.com +2).

4.2 Limitations & Ongoing Challenges

While provider improvements are well documented, evidence for direct impacts on long-term patient health outcomes is mixed (PMC +2; ScienceDirect +2). Challenges include:
inconsistent definitions of cultural competence
variable training quality
limited long-term studies (PMC +2; ScienceDirect +2)
Despite these gaps, experts agree that cultural competence is essential for equitable, safe, and effective healthcare in multicultural societies (Health Policy Institute +2; Nursejournal.org +2).



5. Practical Application in Daily Clinical Work

This chapter closes with concrete steps that clinicians can use to practice culturally sensitive care:

5.1 Ask Respectfully

Ask patients about cultural, religious, or personal beliefs that may influence care. Use curiosity, not assumptions.

5.2 Use Interpreters

Professional interpreters ensure accuracy, confidentiality, and safety. Avoid using children or family members unless absolutely necessary.

5.3 Communicate Openly

Practice active listening, validate patient concerns, and provide space for questions.
Encourage patients to express fears, expectations, and decision-making preferences.

5.4 Adapt the Care Plan Where Reasonable

Modify diet, environment, schedules, or interactions when they have cultural or spiritual importance and do not compromise safety.

5.5 Involve Family or Community

For many cultures, health decisions are collective. Include family or community members when appropriate.

5.6 Engage in Continuous Learning

Cultural competence is lifelong. Seek training, reflect on bias, and stay open to learning from patients and colleagues.

5.7 Support System-Level Change

Advocate for policies that increase cultural and linguistic support services, diversify staff, and strengthen community relations.

Core Principles of Healthcare Ethics
Autonomy, beneficence, non-maleficence, justice, and how they guide ethical decisions

ETHICAL PRINCIPLE	WHAT IS IT'S ETHICAL ROLE
Autonomy	Respecting the patient's right to make informed decisions , self determination, informed consent, respect for personal values/preferences.
Beneficence	The duty of the caregiver to act in the best interest of the patient to promote wellbeing, to benefit the patient (help, heal, alleviate suffering).
Non-maleficence	The obligation to not inflict harm to avoid causing injury, suffering or risk; "first, do no harm.
Justice	Fairness in access to care and to resources; equitable treatment of patients; non-discrimination; fair distribution of benefits and burdens in health care.

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Ethical Principle	Articles from the law that establish / protect it	Evidence from the PDF
Autonomy (Right to decide, informed consent, choice, privacy)	Art. 5, Art. 11, Art. 12, Art. 14, Art. 17	- Art. 5: freedom to choose the healthcare facility - Art. 11: right to leave and stop treatment after being informed - Art. 12: obligation to inform the patient about treatments and risks before doing them - Art. 14: mandatory prior free and informed consent for treatment - Art. 17: right of patient to access their medical file
Beneficence (Acting for the patient's best interest)	Art. 4, Art. 6, Art. 7, Art. 8, Art. 9	- Art. 4: right to health services "in the best possible conditions" without discrimination - Art. 6: health professionals must preserve dignity and ensure best service delivery - Art. 7: proper reception, orientation, responses to complaints - Art. 8: priority treatment in emergencies before administrative fees - Art. 9: commitment to ensure patient safety and standards of quality
Non-maleficence (Avoiding harm / risk / unsafe care)	Art. 1, Art. 9, Art. 20–22	- Art. 1: prevention of risks associated with health services is part of the law's purpose - Art. 9: duty to ensure the patient's safety in treatment - Art. 20: the State must adopt policies to prevent risks and harm related to health services - Art. 21: health institutions must implement units for quality + risk management - Art. 22: obligation to report detected risks and protection of whistleblowers
Justice (Fair access, equality, non-discrimination, compensation, accountability)	Art. 4, Art. 10, Art. 18, Art. 23–31	- Art. 4: right to health services without discrimination - Art. 10: obligation to facilitate access for persons with disabilities and limited mobility - Art. 18: breach of rights leads to disciplinary and/or judicial prosecution + compensation - Art. 23–31: medical responsibility and full & fair compensation for damage caused by health services

Cultural Sensitivity and Respect in Healthcare

Understanding beliefs, values, and traditions that shape patient expectations.



Influence of religion and religious practices on healthcare in Slovenia, Türkiye, and Tunisia

SLOVENIA

People in Slovenia are predominantly Catholic, but a lot of people still define themselves as, so religion plays a more personal than institutional role in healthcare. Medical decisions are mainly guided by scientific standards, though individual beliefs can still shape expectations and communication between patients and providers.

Religious practices such as fasting or specific dietary restrictions appear occasionally, and healthcare workers handle these on a case-by-case basis. Personal beliefs may also influence views on end-of-life care, blood transfusions, or certain medical procedures.

Topics like abortion, contraception, sexual education, and LGBTQ+ health can be sensitive for some families influenced by Catholic values. Although Slovenia legally provides reproductive healthcare, individual attitudes may affect how openly patients seek or discuss these services.

Religious influence also varies across the country. Larger urban areas such as Ljubljana and Maribor tend to be more secular and open to discussing taboo topics, while rural regions may hold more traditional views. Because of this diversity, healthcare professionals often adapt their communication to match the cultural and religious context of each patient.





TÜRKIYE

People in Türkiye are predominantly Muslim, and religious practices play an important role in shaping many people's health behaviors. Fasting during Ramadan often influences medication schedules, chronic disease management, and dietary needs, so healthcare providers frequently need to adjust treatment plans or explain exemptions for vulnerable patients. Topics such as contraception, sexual education, and abortion—although legally accessible—can still be approached with caution due to cultural and religious sensitivities. In some cases, patients may also express hesitation toward procedures like organ donation or fertility treatments when they believe these conflict with religious values.

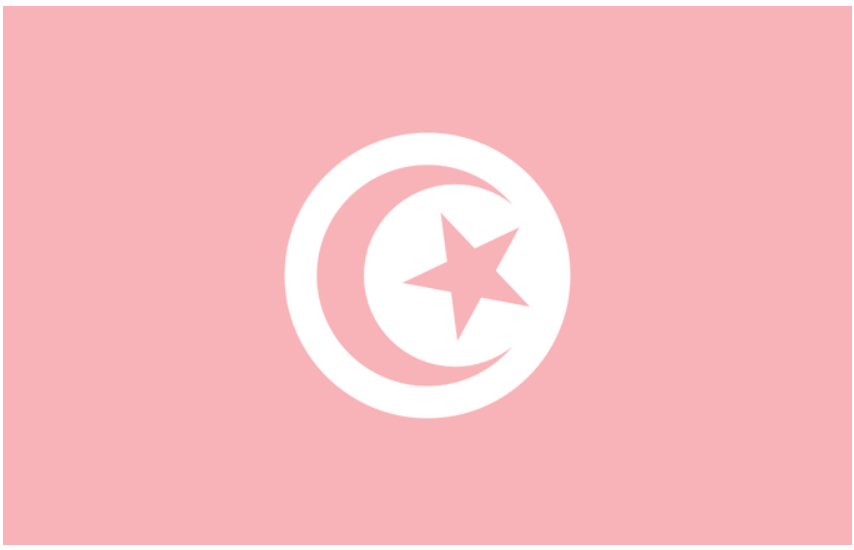
These influences are not uniform across the country. Major cities such as Istanbul, Ankara, and Izmir are generally more secular and open to discussing reproductive or sexual health, whereas more conservative regions in Central and Eastern Anatolia may place greater weight on religious norms and expectations. Because of this diversity, healthcare professionals often need to adapt their communication and care strategies, ensuring they respect individual beliefs while still promoting safe, evidence-based medical practices.



TUNISIA

People in Tunisia are also predominantly Muslim, and religious practices can significantly influence healthcare behaviors. Fasting during Ramadan commonly affects treatment plans, requiring providers to adjust medication schedules or discuss exemptions for vulnerable patients. Topics such as sexual education, reproductive health, and abortion may be sensitive, even though abortion is legally permitted; societal and religious views can still limit open communication. Cultural attitudes toward practices such as female genital mutilation may also appear in some healthcare discussions.

It is important to note that these dynamics vary greatly from region to region. Some areas—especially larger, coastal cities—tend to be more socially liberal and open to discussing topics like sexual education or reproductive rights. In contrast, more conservative or rural regions may adhere more strictly to religious norms, leading to stronger expectations around fasting, greater reluctance to discuss taboo topics, and a higher likelihood of religious belief influencing medical decisions. Because of this regional diversity, healthcare workers often need to adapt their approach, promoting patient education, respectful dialogue, and awareness-raising in ways that fit the local cultural and religious context.



Gender, Family, and Decision-Making in Slovenia, Turkiye, Tunisia

TUNISIA

Tunisia combines relatively progressive laws with diverse cultural and religious norms. Legally, women and men have the right to independent medical decision-making, and urban areas tend to reflect this more clearly. However, in some conservative regions, family opinions carry significant weight, particularly regarding reproductive health, taboo topics, or decisions involving elderly family members. Mental health discussions may be limited by cultural stigma, while physical health decisions often involve collective family input. Awareness and education levels also influence how freely individuals exercise their legal rights.

In recent years, mental health has increasingly become a family-centered topic, with many modern households more willing to seek psychological support and even encourage relatives to consult mental-health professionals. This growing openness reflects a gradual shift toward normalizing therapy and prioritizing emotional well-being within the family unit.

SLOVENIA

Slovenia tends to have a more individual-centered approach: patients usually make their own medical decisions, supported by a legal framework that emphasizes autonomy and informed consent. Family involvement is present but not dominant, and both men and women generally have equal authority over decisions about physical or mental health. Cultural expectations are relatively liberal, and legislation around reproductive rights and end-of-life care is largely aligned with secular European standards.

TÜRKIYE

Türkiye shows greater variation depending on region and cultural background. In large cities, patients often decide for themselves, but in more traditional or rural areas, family—especially male relatives—may strongly influence or even guide health decisions. Gender norms can affect how openly individuals discuss mental health, reproductive health, or chronic illness. Legislation allows patient autonomy, yet cultural expectations often shape how decisions are made in practice. Family support plays a large role in both physical and mental health outcomes.

Across all three countries, culture, education, and family dynamics can strongly shape how decisions are made in healthcare settings. Slovenia leans toward individual autonomy, Turkiye shows a broad spectrum depending on region, and Tunisia blends modern legal frameworks with varying family-based decision traditions.

Language and Communication in Healthcare in Slovenia, Türkiye, and Tunisia

Language and communication play a central role in shaping how patients understand their health, interact with providers, and make medical decisions.

Slovenia has one main official language—Slovenian—which creates a relatively uniform communication environment in healthcare. Challenges arise mostly with immigrant or minority patients, such as those from the Balkans or the Roma community. Clear communication is usually straightforward, and medical terminology is well-integrated into education and public health materials. Patients often feel comfortable asking questions and participating actively in decisions, especially in urban areas with greater awareness of patient rights.

Türkiye is linguistically more diverse. While Turkish is the official language, regions with Kurdish-speaking populations and other minorities may experience communication barriers in healthcare. In some areas, patients—especially elderly or rural residents—may have limited health literacy, which affects understanding of diagnoses or treatment plans. Communication can also be shaped by cultural expectations: some patients may hesitate to ask questions, challenge medical advice, or openly discuss sensitive topics, especially in more traditional settings. Effective healthcare often relies on building trust, using simple language, and involving family when appropriate.

Tunisia primarily uses Arabic as the main language, with French widely used in medical education and often in healthcare settings. This mix can create challenges for patients who are more comfortable in one language than the other. Younger, urban populations tend to navigate this dual-language environment easily, while older or rural populations may struggle with French-based medical terminology. Communication about mental health, sexual health, and other taboo topics can be constrained by cultural norms, making it harder for patients to express concerns clearly or seek help openly.

Overall, Slovenia experiences fewer structural language barriers, Türkiye must navigate regional linguistic diversity and varying levels of health literacy, and Tunisia balances a bilingual healthcare system with cultural communication norms. In all three countries, effective communication relies on cultural sensitivity, clear explanations, and ensuring that patients feel safe to express their needs.

Stereotypes and Power Dynamics in Healthcare in Slovenia, Türkiye, and Tunisia

Stereotypes and power dynamics shape the relationship between healthcare providers, patients, and families, influencing how care is delivered and how decisions are made.

Slovenia generally follows a professional, patient-centered healthcare model, where medical staff are expected to treat all patients equally and where power is mostly rooted in medical authority rather than social hierarchy. However, subtle stereotypes may still affect interactions—for example, assumptions about gender roles, migrant communities, or older adults. Patients usually feel empowered to voice concerns or challenge decisions, especially in urban and more educated settings.

Türkiye shows more variation. In many regions, traditional gender norms can influence how much authority men and women feel they have in healthcare settings. Providers may unintentionally rely on stereotypes regarding women's involvement in reproductive decisions or men's emotional expression. Power dynamics also shift when families play a dominant role, sometimes overshadowing the patient's voice. In urban areas, interactions tend to be more egalitarian, but in conservative areas, hierarchical relationships—respect for elders, male authority, or doctor-centered communication—can shape the decision-making process.

Tunisia reflects a blend of modern legal equality and culturally rooted expectations. While men and women have equal rights to medical decision-making, stereotypes about gender, mental health stigma, or sexual health can still influence the care environment. In some regions, male relatives may be seen as protectors or primary decision-makers, affecting how women access or discuss certain health services. At the same time, doctors are often viewed as strong authority figures, which can limit patients' willingness to ask questions or participate actively in decisions.

Across all three countries, stereotypes—whether based on gender, age, culture, or social role—can shape who holds power in healthcare interactions. Slovenia tends to have more balanced dynamic, Türkiye shows a wide range shaped by regional traditions, and Tunisia blends legal equality with ongoing cultural hierarchies. In every setting, reducing stereotypes and promoting patient empowerment remain essential for equitable care.

Cross-Cultural Communication in Health Settings

Language barriers, nonverbal communication, and strategies for clear, respectful dialogue





This chapter focuses on what happens when patients and health professionals do not share the same language, culture or communication style. We look at language barriers, the role of interpreters and family members, and the risks when patients do not fully understand their diagnosis or treatment.

The chapter also explores how nonverbal communication – eye contact, touch, body language and physical distance – can have different meanings in different cultures. Instead of assuming that “normal” is the same everywhere, we highlight simple strategies for clear, respectful dialogue: using plain language, asking open questions, checking understanding and showing genuine curiosity about the patient’s perspective.

Good cross-cultural communication is not about perfect English; it is about making sure that patients feel heard, respected and safe enough to participate in decisions about their own health.



CASE 1:
Less Helpful Communication

Role play

Doctor: Tell her the ultrasound showed a small gallstone, but we don't operate now. She just needs to manage the pain and follow the regimen I will prescribe.
Daughter (to mother, quickly): It's okay, nothing big. You take pills.
Patient: So... I am fine? No problem?
Doctor (to daughter): Yes, yes, tell her it's fine. She just needs to lose some weight and follow the diet. No more fatty food.
Daughter (embarrassed): You must... eat less... greasy.
Patient: But my pain... is from God? Maybe test?
Doctor (sighs): Tell her it's not from God, it's from her lifestyle. She just has to follow instructions.
(The patient nods politely, but is confused and feels judged.)





CASE 2:
The “Yes-Yes” Patient Who Doesn’t Actually Understand

Role play

Doctor: You need to take this pill twice a day with food. Understand?
Patient (smiling politely): Yes, yes. I understand.
Doctor: And avoid dairy for 48 hours.
Patient: Yes, yes.
Doctor: Can you repeat the instructions?
Patient (panics): Uh... take pill... sometimes... after dinner?
Doctor: Okay—let’s go slower. (Hands them a paper with drawings instead of text.)

In different cultural contexts like Slovenia, Türkiye, and Tunisia, communication styles can vary due to social norms, language, and expectations. When considering the issues and solutions from the doctor-patient dialogue you provided, it's important to tailor communication strategies to align with the cultural expectations and nuances in each of these countries.

Slovenia

Main Issue: Patients may say “yes” out of politeness but still feel confused; they avoid interrupting doctors.

Solutions:
- Use clear, direct, step-by-step instructions.
- Ask them to repeat what they understood.
- Give short written or visual guidance.

Türkiye

Main Issue: High respect for doctors means patients rarely question instructions, even when unsure.

Solutions:
- Actively encourage questions.
- Explain slowly and in detail.
- Involve family members when appropriate.
- Use visuals to support explanations.



Tunisia

Main Issue: Indirect communication and strong family roles can make patients hide confusion.

Solutions:

- Use warm, empathetic language.
- Avoid medical jargon; keep terms simple.
- Provide written/visual instructions for patient + family.
- Invite a family member if it helps understanding.





CASE 3:
Direct vs. Indirect Communication

Role play

Doctor (very direct): Your blood pressure is high because you are not following the diet.
Patient (from a culture that values softer speech): I'm... trying.
Doctor: Trying is not enough. You must follow instructions.
Patient (hurt): You sound angry. Did I do something wrong?
Doctor: I'm not angry. I'm being factual.

Real impact: Tone is misread → trust breaks.

To understand how the dialogue might be perceived in Slovenian, Turkish, and Tunisian cultures, we need to consider how each culture approaches communication, particularly the balance between directness and indirectness.

Slovenian Culture

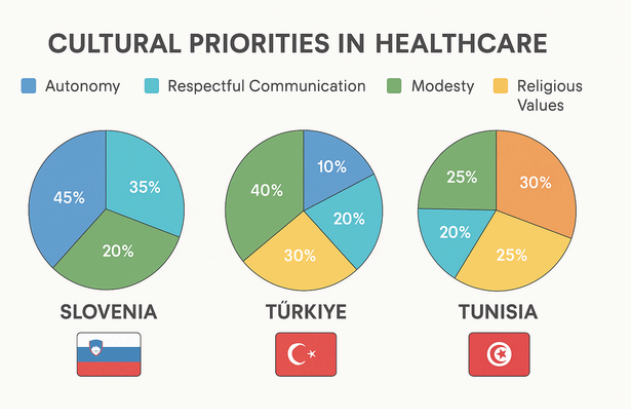
Problem: The doctor's bluntness may seem too harsh for Slovenian patients, who prefer direct but respectful communication.
Solution: Softening the tone while staying clear, e.g., "I know it's tough, but let's work together on this."

Turkish Culture

Problem: Directness might be perceived as judgmental in Türkiye, where indirect communication is valued.
Solution: Use a more empathetic tone, e.g., "I know it's hard, but we need to improve together. I'm here to help."

Tunisian Culture

Problem: Blunt communication may feel impolite or cold in Tunisia, where indirectness and politeness are preferred.
Solution: Show care and reassurance, e.g., "I understand it's difficult, but let's take it step by step together." In all cultures, the key is to soften the message with empathy and avoid sounding too harsh or critical.





CASE 4:
Male Doctor Conflict

Role play

Doctor (male, entering in a hurry): Hello. Let's check your abdomen. Please lift your top so I can palpate properly.
Patient (surprised, panics internally): I—I thought the doctor was a woman? The nurse told me "she will see you."
Doctor (not noticing the distress): We're short on staff today. I'm here now. Please lie back.
Patient: I... I'm not comfortable lifting my shirt in front of a man. Can I wait for a female doctor? Even if it takes longer?
Doctor (a bit frustrated). A female doctor won't be available for at least two hours. The pain you're having could be serious. This is a basic exam, I don't need to fully expose you.
Patient (voice shaking): But my religion doesn't allow me to uncover like that... I feel... very uncomfortable.
Nurse (female, trying to help): Doctor, maybe we can find another female staff just to be in the room?
Doctor: I only need five minutes. This shouldn't be a big issue.
Patient (hurt by "not a big issue"): It is a big issue for me. I feel unsafe like this.
Doctor (softens, but still rushed): I understand, but medically, waiting could delay diagnosis.
Patient (tears starting): Please don't pressure me... I want care, but not like this.
I want dignity too.
Doctor (finally pausing properly): ...Okay. I hear you. Let me call the senior female resident. It may take some time, but we'll arrange it.
Patient (relieved but exhausted): Thank you. I just... needed someone to understand that it's not about refusing care, it's about privacy.



CASE 5:
Intercultural doctor communication

This dialogue shows a conflict between a female patient and a male doctor during a medical exam. The patient feels uncomfortable exposing herself due to privacy, modesty, or cultural reasons, while the doctor is rushed and initially dismissive. Different cultures interpret this situation differently, and their solutions prioritize different values such as autonomy, modesty, or dignity.

Slovenian Culture

In Slovenia, where the culture is mostly secular, it's normal for male doctors to examine female patients, so modesty is not the main concern. Instead, problems arise when the doctor is rushed or dismissive, which can cause the patient emotional discomfort. A better approach is to explain the exam calmly, offer a female chaperone or another doctor if the patient prefers, and respect her choices. The key values in Slovenian healthcare interactions are autonomy, clear communication, and patient comfort.

Turkish Culture

In Türkiye, modesty and privacy strongly influence women's comfort in healthcare settings, especially during exams that require undressing. While Western Türkiye is more relaxed about mixed-gender care, Eastern Türkiye has stronger modesty expectations. Many Turkish women prefer female doctors and may feel uncomfortable removing hijab or exposing their body to a male provider. Problems arise when a male doctor rushes the exam or dismisses her discomfort. The solution is to offer a female doctor or at least a female nurse, explain the steps clearly, and respect her need for modesty and dignity.



Tunisian Culture

In Tunisia, expectations are very similar to those in Eastern Türkiye. Modesty and religious norms make many women prefer female healthcare providers, especially for intimate exams. A male doctor insisting on examining the patient alone or asking her to remove her hijab quickly can feel culturally insensitive and intimidating. The best approach is to acknowledge her modesty concerns, provide a female staff member, and ensure privacy and consent at every step.



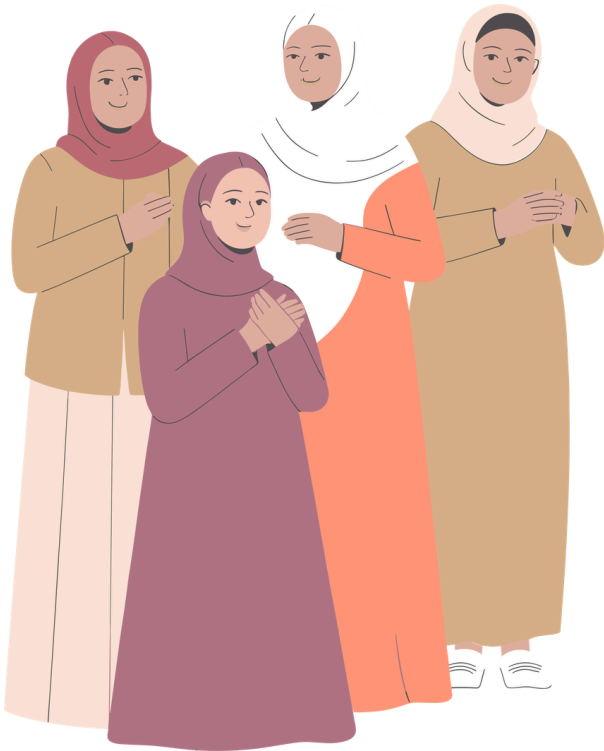
CASE 6:
Personal experience from different culture

I'm physical therapist from Slovenia. I have participated at various trainings, programs and courses for physical therapists in Slovenia and other European countries.

While participating at aquatic therapy training for physical therapists in Cairo, Egypt I have experienced different circumstances of course program compared to the courses organised in Europe. In accordance with local customs we were required to be separated by gender in the pool. The teacher was male and he was allowed to demonstrate the therapeutic techniques on male participants and on me, not on Egyptian women. Even in swimming pool women should have her bodies covered, including me. In Slovenia we would be separated by gender in changing rooms but then in the pool it would be expected to change the partners as much as possible to have the opportunity to experience how various bodies respond in therapeutic movement. The teacher would demonstrated on males and females, and we would not cover our bodies.

This arrangement aligned with local cultural and social norms, which prioritize gender segregation in certain public and therapeutic settings. The experience highlighted the importance of cultural sensitivity and demonstrated how health services may be structured differently depending on societal values and beliefs. It also reinforced the need for flexibility and awareness when providing or receiving care in multicultural contexts. This practice is a consequence of cultural norms in many parts of Egypt. Initialy, this was unfamiliar to me, but it offered a meaningful perspective on how therapeutic services adapt to the cultural context.

I have learned the importance of approaching care with cultural humility, recognazing that effective practice may look different across settings, and that respecting local customs is an integral part of working within multicultural environment. Beside gaining the new knowledge and skill, I have learned how to approach the patients from different cultural backgrounds with sensitivity and respect, meaning to adapt my approach to meet cultural needs of every individual.





CASE 7:
Ageism in Health Care

If you are an elderly person and you are hospitalized, if you come to the hospital, if you are not smiling all the time and the people you go to are not geriatricians or gerontologists, you will most likely be started on antidepressants :)) and if you refuse to use them, most of the time this will not be accepted and your prescription will be written anyway instead of being directed to a gerontological treatment.

Therefore, I think that raising awareness about AGEISM is important both in health care and in daily life, so Idd like to offer a few recommendations for this.





CASE 8:
Unheard in Her Own Diagnosis

Role play

The patient was a woman who was deaf and unable to speak, accompanied by her husband. She sat nervously beside him, her hands shaking on her lap. The doctor opened the file and looked directly at the husband.

Doctor: “So, her breast cancer has progressed. We need to start treatment as soon as possible. This is the plan: chemotherapy first, then we will evaluate. She will also need these medications for pain and nausea.”
The husband nodded slowly, his face tense.
Husband: “Okay, doctor. I understand.”
As the doctor continued explaining, the woman lifted her hands and began signing quickly. Her eyes filled with tears. Her gestures were urgent, almost trembling. She was trying to say that she was scared, confused — that she wanted to know what was happening to her own body.
The husband placed his hand on her arm gently.
Husband: “Calm down... let me talk to the doctor first. I’ll explain everything to you later.”
She shook her head, signing again with more intensity: I want to know. I’m anxious. I’m scared. Please, talk to me.
But the doctor did not look her way. He continued the conversation as if she were not part of it.
Doctor: “The treatment may cause fatigue, vomiting, hair loss. Make sure she takes the prescribed doses. It’s very important.”
The woman tried once more, signing slowly this time, tears rolling down her cheeks. She pointed at her chest, then at the doctor — asking silently for attention, for reassurance, for inclusion.
The **husband** whispered again: “Please... calm down. The doctor is explaining. We’ll talk later.”
She lowered her hands, defeated, her silent cry filling the room with a pain no sound could describe. She sat there, unheard, watching two people speak about her life while she remained outside the conversation.
When they left the room, she was still wiping her tears, still trying to ask questions no one had answered.

Ethical Challenges in Multicultural Care

Common dilemmas involving family roles, informed consent, traditional practices, and differing health beliefs.





TUNISIA

During our visit to the Tunisian clinic, we observed how family roles, gender norms, and social expectations strongly shaped medical decisions. In many cases, a husband, father, or elder relative spoke to the doctor and decided on treatments, even when the patient was fully capable of deciding for herself. This limited real informed consent and reduced the patient's autonomy, especially for women. We were told that women often prefer to have their partner present during appointments; if the partner insists on being in the room, this is usually allowed, and the doctors generally do not object.

The majority of gynaecology doctors are male, and many women change their preferred doctor multiple times over the course of their lives, or even see two gynaecologists at the same time. Many topics related to sexual health and education remain taboo. Discussing masturbation and related subjects is not culturally acceptable, and certain words are considered inappropriate to say out loud. As a result, people often use euphemisms or similar terms that do not accurately reflect the medical concepts, which can lead to misunderstandings of medical explanations and instructions. This, in turn, may contribute to patients refusing treatment, for example due to the belief that vaccinations have the opposite effect of what is intended. What is more, many individuals, when faced with illness, are more inclined to turn to prayer than to consult a medical professional.

Mental health remains a taboo subject in Tunisia, often surrounded by stigma and misunderstanding. Many people are reluctant to speak openly about their struggles for fear of being judged, dismissed, or labeled as "weak." As a result, psychological difficulties frequently go unrecognized and untreated, and seeking help from a mental health professional is still not as normalized as it should be.

We also saw how gender influenced doctor choice — some families insisted that female patients be examined only by female doctors, even in urgent situations. At the same time, certain patients, such as single mothers, faced subtle stereotyping or judgement.



TÜRKIYE

In some parts of Türkiye, traditional beliefs still influence how people choose doctors, including preferences based on gender. However, a doctor's gender should not matter; what truly counts is their expertise and ability to treat the patient.

Religion does not significantly shape the healthcare system as a whole; however, its influence can vary depending on the region. For example, in some eastern areas, religious norms are more likely to affect medical practice: abortion is neither performed nor openly discussed, some communities continue to justify practices such as female genital mutilation, and male physicians may be discouraged from examining female patients. In Turkish culture, it is common for some individuals to visit healthcare practitioners for procedures that involve the controlled removal of blood. This practice is believed to help expel 'impure' blood from the body and is viewed as a form of cleansing or detoxification, particularly for the cardiovascular system.

Within families, two main approaches to healthcare decision-making can often be observed. In some families, relatives take charge of all major health decisions, not out of oppression, but from a belief that they are acting in the patient's best interest. In others, individuals are encouraged to make their own choices, with the understanding that every action has consequences; for example, if someone refuses to see a doctor when ill and their condition worsens, the responsibility is recognized as their own. This latter approach can lead individuals to develop a sense of autonomy and learn important life lessons earlier than many of their peers.

In larger cities, gender-based doctor selection is far less common, and people generally focus on competence rather than gender. Informed consent is legally required, yet its practice can vary, especially in rural areas where communication about examinations or procedures may not always be fully explained.

Linguistic barriers mainly affect refugees, migrants, and tourists, as not all hospitals have consistent interpreting support. Additionally, disrespect toward patients' stories is not widespread but can appear in overcrowded or high-pressure environments, where staff may rush or overlook patient concerns. Overall, Türkiye's health sector is improving, but cultural norms, communication gaps, and workload issues continue to influence patient experiences.



SLOVENIA

In most parts of Slovenia, cultural factors play a smaller role in choosing a doctor, and patients rarely select based on gender alone. While some women prefer a female gynecologist for comfort, the general expectation is that a doctor's expertise matters far more than their gender. In urban and rural areas alike, gender-based doctor selection is uncommon, as the healthcare system emphasizes professionalism, equal treatment, and patient rights. Informed consent is legally required and strongly regulated, meaning that patients must be clearly informed about examinations and procedures before they happen. The standard is consistent across the country, though the level of explanation can depend on the workload of the staff.

There is also a language barrier that influences how clearly patients receive and understand information about their care. Linguistic barriers mainly affect foreigners, tourists, and migrants, as Slovenia does not have a nationwide medical interpreting system. Many healthcare workers speak English or other regional languages, but communication can still be challenging for non-Slovenian speakers, especially in emergency settings. Hospitals often rely on ad-hoc solutions: simplified explanations, family members interpreting, or staff who happen to know the language, which in some cases is too difficult to carry out.

In Slovenia we jump to conclusion that the woman is being abused if the partner insists on being with her at all times. In ob-gyn hospitals we practice separating women from their partner when leaving the waiting room. Men are not allowed in the outpatient clinic nor the wards. If a woman wishes for her partner to be present in the maternity ward, she must pay the fee for high standard room.

Disrespect toward patients is not a systemic issue, but it can appear in situations of high workload, long waiting times, or emergency units where staff must prioritize urgent cases. In Slovenia, single mothers generally receive equal medical treatment, but subtle stereotypes can still appear — for example, assumptions about their financial stability, lack of support, or questions implying that a two-parent household is the "expected norm." In general, Slovenian healthcare aims to maintain a respectful, patient-centered approach, though time pressure sometimes limits communication. Overall, Slovenia's health sector is stable and rights-based, yet communication gaps, staff shortages, and occasional rushed encounters still shape how patients experience care.



FUTURE IMPROVEMENTS

Across all three contexts, patient experience is shaped not only by medical expertise but also by communication practices, cultural expectations, and the organization of healthcare systems. To improve future patient care, several directions stand out. First, strengthening patient autonomy is essential — through clearer communication, consistent use of informed consent, and reducing family-dominated decision-making, especially in situations where women are expected to defer to male relatives. Second, all three countries would benefit from better linguistic support, whether through trained interpreters, multilingual staff, or accessible information materials, so that foreign patients, migrants, and refugees can receive treatment without misunderstandings. Third, improving gender sensitivity and reducing stereotypes, including those affecting single mothers or women without family support, would create a more inclusive environment for all patients. Additionally, addressing workload pressures and improving staff-to-patient ratios would help ensure that respect, empathy, and patient-centered communication do not get lost in busy clinical settings. Finally, promoting continuous training in cultural competence, ethics, and communication can support healthcare workers in navigating complex social dynamics while maintaining high-quality and equitable care.



Health Perspectives from Turkiye, Slovenia, and Tunisia

Key cultural insights and comparative approaches to care, decision-making, and patient relationships.



Health Perspectives from Turkiye, Slovenia, and Tunisia

Through memes

In this chapter, young people use **meme language and humour** to show what health and healthcare look like in their everyday lives. Through self-made memes, they highlight the challenges they face at home when trying to access care or take care of their physical and mental health – from long waiting times and confusing systems to stigma, taboos and “just be strong” attitudes.

The memes also reveal what is typical for their environments: family expectations, traditional remedies, cultural norms around food, rest, work and emotions, as well as gender roles or silence around certain topics. By laughing about these realities, young people make visible how traditions, social norms and daily habits shape their health choices and behaviours. This chapter gives an honest, visual insight into how they experience healthcare and what supports or blocks their wellbeing in their own communities.

TUNISIA HEALTHCARE POSTER

Country Tunisia, 2025

Poulation 12,1 millon people

INTRODUCTION

This summary presents essential health and demographic data for Tunisia, including population, age structure, economic indicators, leading causes of death, life expectancy, mortality, maternal health, and major diseases and vaccines.

LIFE EXPECTANCY

Infant mortality rate: 11.4% (2022)
Life expectancy at birth 76.9% (2022)
Top 3 causes of death:

- Coronary heart disease
- Strokes
- Alzheimer's disease and dementia

AGE PROFILE

Age profile:

- 22,9% : 0 to 14 years old
- 60,2 % : 15 to 59 years old
- 16,9 % : more than 60 years old

HDI / GDP

HDI:

- 0,746 % by the year 2023
- 0,75 % by the year 2025

GDP per capita: 4,290 dollar
Context: Tunisia continues to face economic hardship, youth unemployment, and regional inequalities that place many communities in vulnerable situations.

Access gaps

- Low income/Inflation
- Lack of medecine
- Lack of equipment in public hospitals
- Immigration of doctors due to low salaries
- Big migration flow (internal/external)
- Bureaucracy, even though the law allows everyone to get what they need without paperwork in emergency case (life threats)
- Rehab: Limited number of rehab centers and the hight cost of it

NEEDS

Hospitals:

- Increase workforce and equipment
- Hospital staff (increase salaries/hours)
- High quality trainings

Health authorities:

- Data visualization (lack of visibility about performance indicators)
- Updated national guidlines
- Stability

Voluntary sector:

- Funding/Media visibitlity (Press)
- Verified sources

OUR ROLE:

For health care profissionals:

- Be implicated in the reform process
- Advocating towards legislation changes
- Raising awarness about the current problems

For public:

- Raising awarness about the current problems
- Preventive Healthcare Services
- Protesting



TURKIYE HEALTHCARE POSTER

Country Turkiye, 2025

Poulation 85,664,944 people

INTRODUCTION

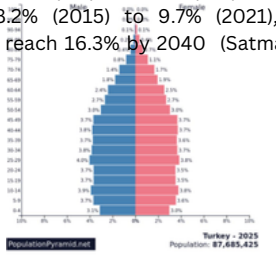
This summary presents essential health and demographic data for Türkiye, including population, age structure, economic indicators, leading causes of death, life expectancy, mortality, maternal health, and major diseases and vaccines.

Figure 1: Elder age



AGE PROFILE

The median age increased from 24.8 (2000) to 33.1 years (2019). The proportion of people aged 65+ rose from 8.2% (2015) to 9.7% (2021), and is projected to reach 16.3% by 2040 (Satman et al., 2023).



ECONOMIC

Türkiye is classified as an upper-middle-income country with a developing economy. The Human Development Index (HDI) and GDP per capita are not specified in the provided papers, but Türkiye is noted for its economic growth and health system reforms (Dundar et al., 2010).

MOST PREVALENT DISEASE

Diabetes is a major and growing public health issue, with prevalence projected to reach 17.5% by 2030 and 19.2% by 2045 (Satman et al., 2023).

POPULATION

Urbanization is high, with 75% living in urban areas by 2008 (Dundar et al., 2010).

LIFE EXPECTANCY

Estimates for 2013 show life expectancy at birth as 76.4 years for males and 82.4 years for females (Özdemir et al., 2015). Other sources report 75.9 years for men and 81.2 years for women in 2019 (Satman et al., 2023).

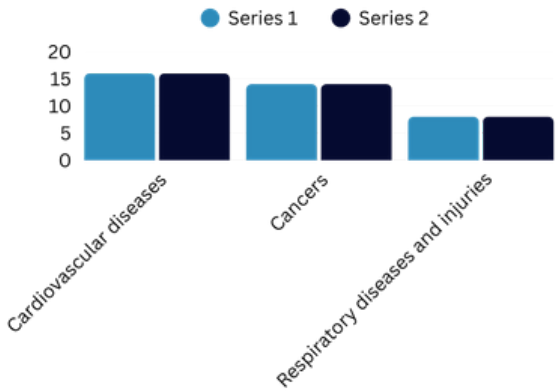
VACCINATION

Türkiye has implemented national immunization programs, including pneumococcal conjugate vaccines (PCVs) and is evaluating RSV vaccination strategies for infants and pregnant women (Pouwels et al., 2016; Sanchez et al., 2023).

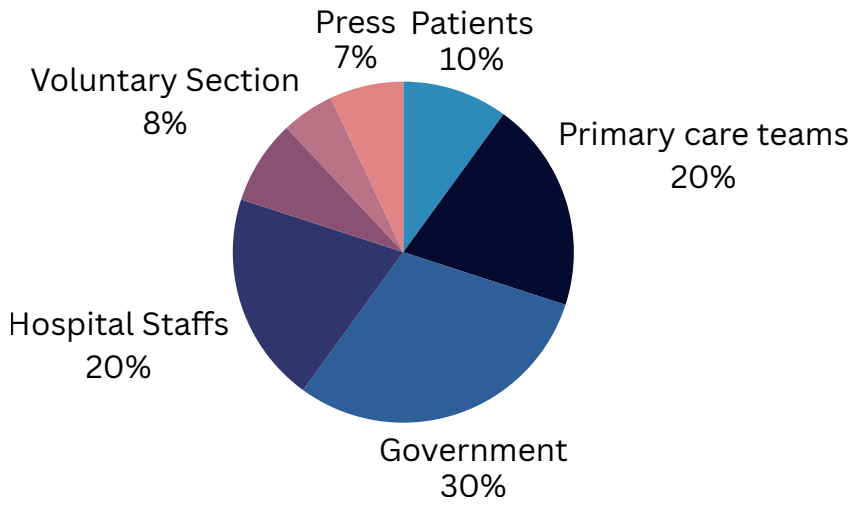
Table 1. Maternal Mortality

Group 1			Group 2
hemorrhage (20%),	hypertensive disord...	embolism (10.3...	cardiovascu...
			infection

Figure 3: Mortality Causes



Turkiye OUR NEEDS&ROLES



According to the Turkish Ministry of health, around 17% percent of population faces mental health issues.

Depression is more common among older adults, women and people with chronic illnesses.
Because of the lack of awareness of mental health issues the percentage is lower than the actual rate.

According to a report on chronic illness in Türkiye, chronic diseases are a significant burden.

Primary care often lacks capacity for mental-physical integrated care.

Patients: Engage in care; Communicate symptoms; Follow treatment; Self-advocate

Governments: Fund services; Set policy; Ensure equity; Regulate care

Primary Care Teams: Screen early; Refer; Provide basic treatment; Coordinate care

Hospital Staff: Provide specialized care; Inpatient management; Liaise with community centers

Health Authorities: Provide specialized care; Inpatient management; Liaise with community centers

Health Authorities: Oversee system; Monitor quality; Expand CMHCs; Integrate services

Voluntary Sector: Advocate; Provide peer support; Raise awareness; Deliver outreach services

Regional Executives / Local Government: Support community services; Create supportive environments; Mobilize local resources; Run promotion programs

SLOVENIA

Country

Slovenia, 2025

POPULATION

2.130.986

Slovenia is a small Central European country with a population of just over 2.1 million people.

INTRODUCTION

This summary presents essential health and demographic data for Slovenia, including population characteristics, age structure, economic indicators, leading causes of death, life expectancy, mortality trends, maternal and child health statistics, as well as the country's major diseases and vaccination programs.

LIFE EXPECTANCY

Life expectancy in Slovenia remains relatively high:

- Men live to about 78.9 years,
- Women to around 84.1,

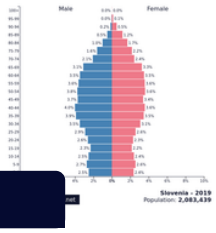
which brings the overall average to roughly 81 and a half to 82 years.

Figure 1: Elder age



AGE PROFILE

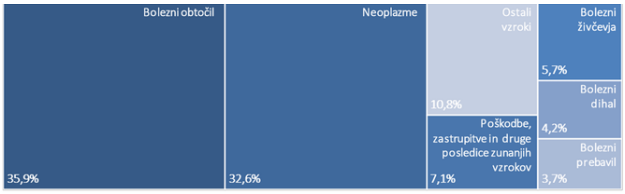
Our age structure is shifting quite quickly: around 14 and a half percent of the population are children, and more than 21 percent are over the age of 65. So, like much of Europe, Slovenia is aging fast.



VACCINATION

In terms of prevention, child vaccination rates are high, typically above 93 percent, with MMR around 94 percent and DTP around 95 percent.
Among adults, priorities include influenza and COVID-19 vaccination, especially for older populations.

Table 1. Maternal Mortality



ECONOMIC

In terms of development, Slovenia scores very high — the Human Development Index is 0.918, and the GDP per capita is around 29 to 30 thousand US dollars.

MAIN CAUSES OF DEATH

1. Cardiovascular diseases — including heart attacks and stroke,
2. Cancer — especially lung, breast, colorectal, and prostate cancer,
3. Chronic respiratory diseases together with diabetes.

Figure 3: Mortality Causes



Slovenia OUR NEEDS & ROLES

Main Healthcare Needs in Slovenia

1. Aging population & chronic disease management
Slovenia has an aging demographic, which increases:
Prevalence of chronic diseases (cardiovascular disease, diabetes, COPD, dementia)
Need for long-term care services
Demand for integrated care models, home care, and geriatric services

2. Strengthening primary care
Primary care is strong, but faces challenges:
Shortage of family doctors in some regions
Overloaded primary care clinics
Growing need for preventive services and health promotion

3. Preventive healthcare & lifestyle-related risks
Slovenia faces:
High rates of smoking and alcohol consumption
Overweight and physical inactivity issues
Need for early detection programs (cancer screening, cardiovascular risk)

4. Mental health services
Growing demand for:
Accessible psychological and psychiatric services
Youth mental health programs
Community-based mental health support

ROLES:

1. National Screening Programs (DORA, ZORA, SVIT)
Slovenia promotes early cancer detection through organized screening for breast, cervical, and colorectal cancer. Healthcare providers encourage participation and ensure proper follow-up.

2. Patient & Community Education
Health professionals offer guidance on healthy lifestyles, disease prevention, mental health, and responsible medication use through workshops, counseling, and local initiatives.

3. Vaccinations
A strong national immunization program provides protection against major infectious diseases and maintains high vaccination coverage for children, adults, and vulnerable groups.

4. Systematic Check-ups
Regular preventive exams identify risk factors early and support the timely management of chronic conditions such as hypertension, diabetes, and high cholesterol.

5. Health Promotion Centers
These centers offer free programs on physical activity, healthy eating, stress management, and chronic disease prevention, helping people build healthier daily habits.

6. Sports and Education Card
Schools track children’s fitness and physical development through standardized tests, promoting regular movement and early identification of potential health issues.





1. The first picture shows tunisian red chilli peppers which are blemded into harissa and its used fresh for cooking, its like the one ex who burn you but somehow makes you better. It helps the heart, boosts the metabolism and helps fight germs.
2. The second picture is lablebi, which is a tunisian chaotic but wholesome bestie who will fix your health and mess with your stomach but only out of love. Lablebi is hight in protein, full of fiber and helps you stay full longer.
3. The third picture is olive oil which represents tunisian medicine for every health problem (parents think its good for heartbreak as well).Its full of antioxidant, good for your skin and helps lower bad cholesterol.
4. The last picture is vix its an ointment it helps with muscle pain, helps you sleep when you are sick, helps clear a stuffy nose (source: parents and grandparents).





In Tunisia people believe Lablebi (famous traditional dish made of chickpeas, olive oil, tuna, eggs, spices especially cumin and harissa) heals everything, thats why the guy in the meme is torn between the two. (Tunisian parents and grandparents).



Public health care is free but hard to access fast, private health care costs a lot of money, but at least gets your health back on track fast (source: public health system participant).



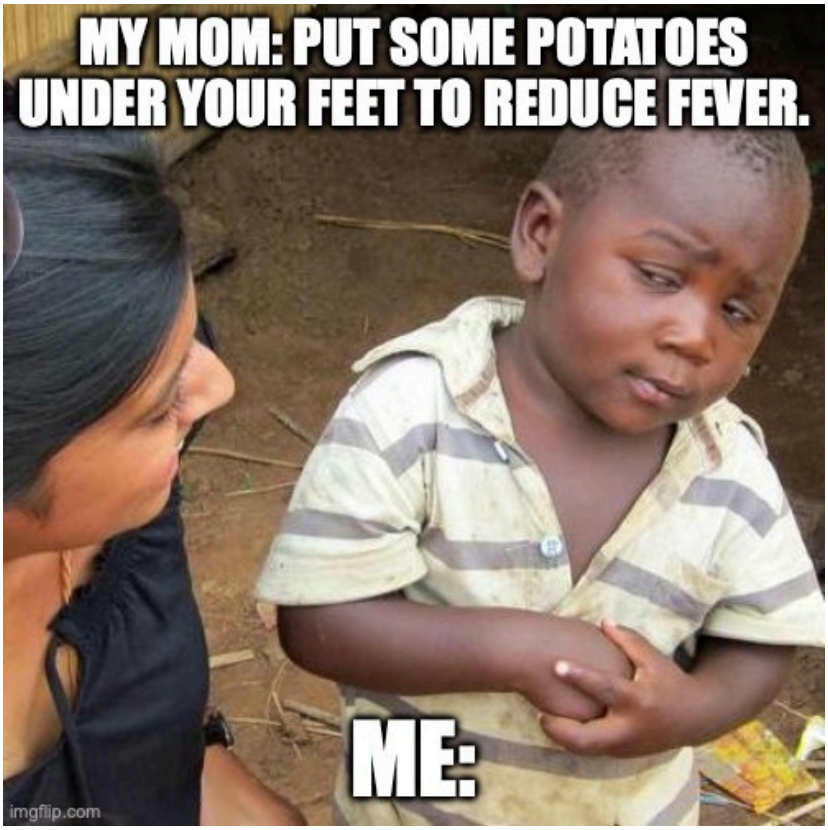


1. Tea: In Türkiye, tea is basically an over-the-counter medicine. Fever? Tea. Stress? Tea. Broken leg? Still tea.
2. Wool Socks: The national prescription. No matter the illness “Put on socks, you’ll be fine.”
3. Wet Towel on Forehead: The classic emergency treatment for any fever.
   Science? Unknown. Turkish moms? “It works.”
4. Cupping: When modern medicine fails, Turkish people activate ancient powers. You end up with 12 purple circles but somehow feel “renewed.” (source: ??)





The meme is trying to tell us that if you have connections in healthcare you will get an appointment way faster (source: Slovenian citizen).

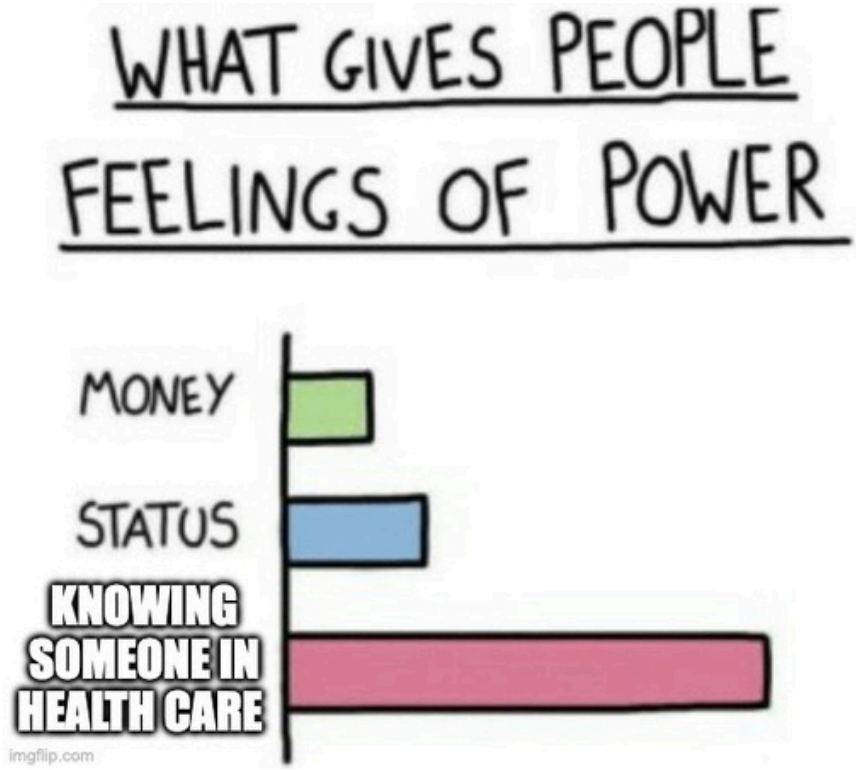


Most of our parents and grandparents believe that putting potatoes on the bottom of your feet and putting socks on top it will help reduce the fever (source: Slovenian grandmas).



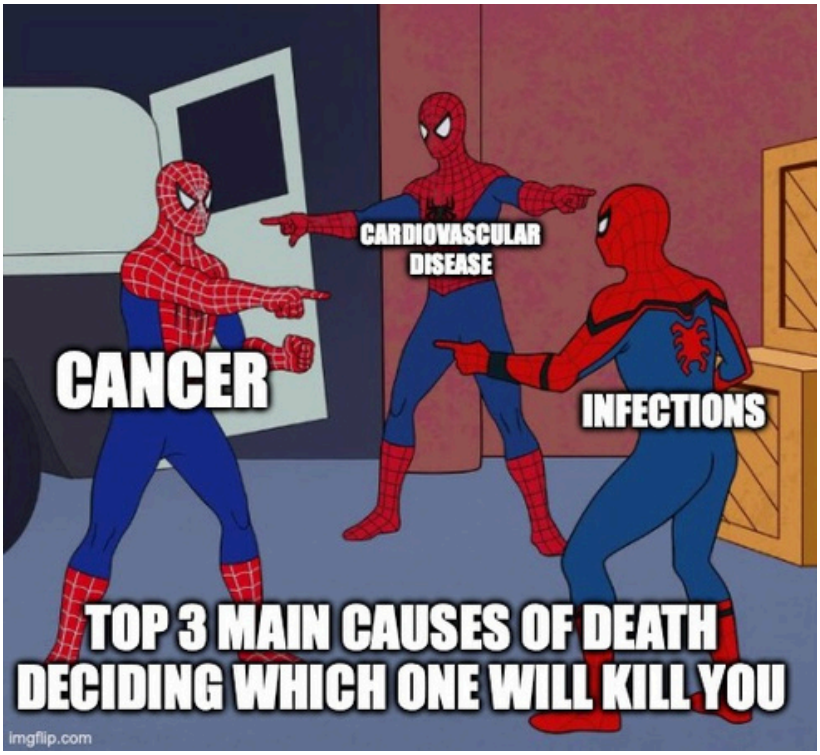


Increasing waiting lines makes people feel they are waiting for their doctors appointments forever (source: experience in the hospital).

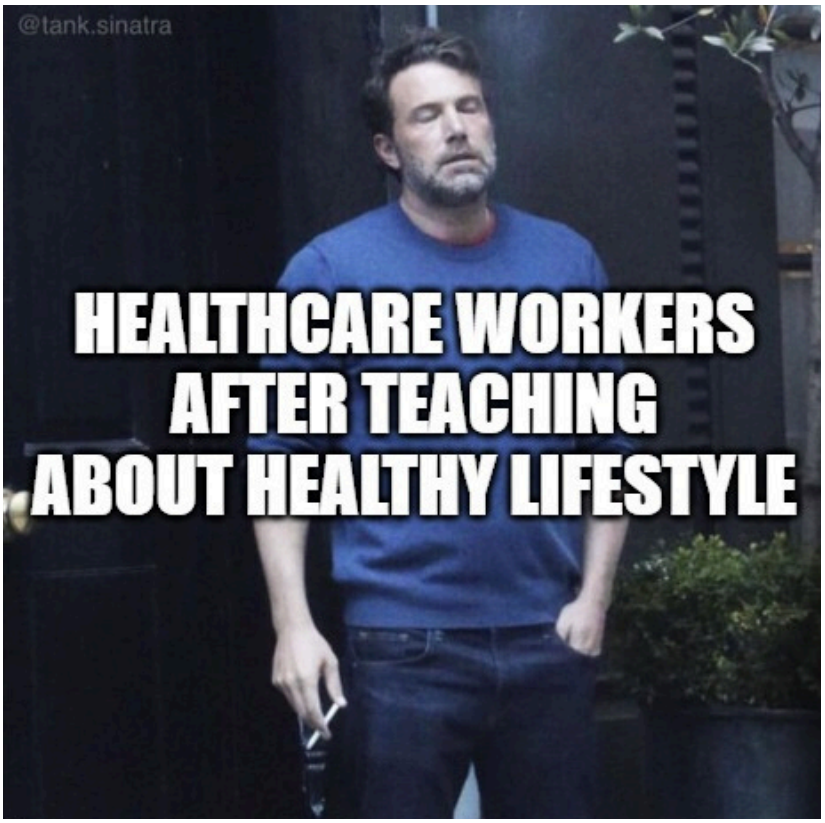


Knowing someone in health care usually gives you the power to skip the waiting lines or get into the system more quickly. Since our health is our biggest treasure getting treatment fast is really beneficial (source: experience in the hospital).





According to recent statistics, the 3 main causes of death in the world are cancer, cardiovascular disease and infections (Source: World Health Organization (WHO).



Usually it is hard for health care workers to find time for their own health so they develop poor health habits, like smoking. Even though they preach about healthy lifestyles (source: general observation).





Slovenia: In Slovenia it usually takes really long to get a doctors appointment, because of the long waiting lines and really slow health care system managing the lines and prominence of chronic illnesses (source: Slovenian citizen).
Turkiye: If you are going to the hospital for the first time, you will have to fill out a lot of documents to make an appointment. This is mandatory only for first time (source: Turkish citizen).
Tunisia : in Tunisia the hospital time is only in the morning, so if you come late at the end of the morning, and the lines are full, they would tell you to come back tomorrow, and you should come early to find your spot (source: Tunisian citizen).

MY JOURNEY IN TUNIS

Throughout the process, the group workshops, terms, and research topics were the things i was already interested in due to my academic interests and openly discussed in my daily life. This made me feel like i grounded, that i was in the right place, and that i could contribute more. Developing my discussion skills on different techniques, approaching issues from different cultural perspectives, and prioritizing human dignity was invaluable to me as always. Mehlika Nuran Gündoğmuş, Türkiye.

From this project, I gained a clearer understanding of how cultural norms, family roles, and communication styles shape patients' experiences in healthcare. Working in an international team helped me see how gender expectations and language barriers affect trust and decision-making. Overall, the project strengthened my skills in cultural observation and intercultural communication as an anthropologist. Hana Selišnik, Slovenia.

The workshops helped us see how healthcare is influenced by many gentle layers such as cultural traditions, family support, social expectations, and the way people connect with their healthcare system. Looking at Slovenia, Türkiye, and Tunisia showed us that every country cares for its people in its own way, shaped by history and community. Özün Özcan, Türkiye.

"I have observed that although people from three different continents, Asia, Africa and Europe, seem to be very different, they converge on similar socio-psychological reflexes in the field of health. Thanks to Erasmus+" Gurkan A,Türkiye.

During this project, I learned firsthand about both the strengths and challenges facing the healthcare systems of Slovenia and Tunisia. The workshops we held were impressive, and the collaboration between the teams was truly exemplary. Hamza, Türkiye.

I learned a lot of insightful information about Tunisian and Slovenian culture and their healthcare system. It was also fun to explore Tunisia and experience their culture firsthand. Ceren Tan, Türkiye.

This is experience was very rich in informations. as a law student i thought i would be lost but i actually learned a lot in a very smooth and fun way! Health care in Türkiye, slovenia and tunisia are different is some aspects but has the same importance. Yosr zayen, Tunisia.

During the project it surprised me how similar our problems in health care are in Slovenia, Turkiye and Tunisia and how we all strive to find solutions in the future. Tajda, Slovenia.

From this project, I learned how cultural differences strongly shape people's approach to mental health and communication. I also saw how physical therapy practices can be influenced by lifestyle and cultural habits. Overall, the project helped me understand the importance of adapting support to each person's cultural background. Bahadır Durmuşoğlu, Türkiye.

Although I come from outside the health field, this exchange gave me valuable insights into my own physical and mental wellbeing and how they are shaped by cultural and socioeconomic factors. Learning directly from youth in the field through dynamic activities, movement, and sports made the experience both meaningful and energizing. Farah, Tunisia 🇹🇳

Throughout the exchange, I gained valuable insights. I learned to communicate better, collaborate respectfully in diverse teams, and appreciate different perspectives. The sessions, workshops, and shared experiences helped me grow. I internalized the importance of active participation, intercultural understanding, and the impact of youth driven initiatives in building stronger communities. Sara Kanaan,Türkiye.

For me it was a very valuable experience that forced me to socialize and think with the others, about problematic sides of healthcare which are more than important to discuss. Plain transparency and allowing yourself to speak about how you see the issues, often does a lot. Karolina Fatur, Slovenia.

I was inspired by the focus on the mental a physical health , which was embedded throughout the program. Through dynamic discussions, simulations, and group work, I deepened my understanding of the importance of creating healthy spaces for all youth, regardless of their background. This experience not only broadened my perspective but also encourage me to change my daily habits and creat a healthy community. Nahla Hamdani, Tunisia.

This project gave me new perspectives on physical and mental health i wasnt really aware of the meantal health part for a long time this project helped me understand a lot more about everything (health , culture , teamwork , etc). Ömer Kanaan, Türkiye.

Through this project, I was fortunate to discover the perspectives of non-healthcare individuals regarding physical and mental health—their visions, experiences, and concerns. I was also surprised to see how much we actually have in common across the three countries. The workshops were very beneficial, clear, and well-organized. They encouraged us to think critically about the situation, reflect deeply, and work together to find practical solutions that we can apply in our daily practice.
Fatma, Tunisia

Major benefit of this experience was learning to adapt to different perpectives and ways of working. Another point, it was building inter-cultural connection that broadened my worldview and enriched my personal and professional growth. Ghasssen Marzouk ‘G’,Tunisia.

This project became a unique and meaningful experience that gave me a new perspective about health, wellbeing and human nature. I knew lots of wonderful people thanks to the project. Dila, Türkiye.

Health is more than medicine.. it’s the echo of our cultures, the strength of our communities, and the kindness we offer one another. Through conversations with friends from around the world, I saw how their healthcare systems carry the imprint of history, traditions, and collective choices. Each story reminded me that well-being is shaped as much by people and culture as by science itself. Asma, Tunisia.

Being part of this exchange showed me how powerful it is to connect with people through empathy and active listening. I discovered how different cultures understand communication, personal boundaries and emotional expression. It made me more mindful and more patient, and I’ll always remember the group energy during our activities. I’m going back home with new habits, new friends, and a deeper understanding of how mental and physical health are strongly connected. Raed Jaoua “pif..paf ”Tunisia.

It was amazing how we have create a bond during a short period in which i learned about others cultures, habits and issues. Especially learning about mental and physical health that seemed to be having the same issues for all the countries. Youssef kammoun from Tunisia.

I learned a lot by sharing and comparing different health practices, the way each culture approaches different issues and problems regarding medical treatment. The experience added many new aspects to my perspective of healthcare. Lucija Posega, Slovenia.

I found it fascinating to visit the hospital, as it gave me a clearer picture of their environment and approach to patient care. I also really enjoyed how, through our shared ideas and brainstorming, we developed ways to integrate healthy habits into our daily lives and improve our well-being with small, meaningful steps. Timeja Čerenak, Slovenia.

Participating at this exchange has been a meaningful experience for me which allowed me to explore how mental and physical health are undstood and expressed in Turkish and Tunisian culture. Through various interactive activities and interactions with other participants I have gained a deeper awarness of how cultural backgrounds shape people’s experiences with health and of importance of being culturally sensitive as a healthcare worker. This project has helped me to grow pesronally and remind me to value the human conecctions across cultures. Ajda Hrovat, Slovenia.

In the exchange i had the chance to learn more about healthcare in different cultures, it was interesting to see that we also have some similarities. The experience made me be more aware of different cultures and their lifestyle. Merisa Kovačević, Slovenia.

“Participating in the Health Across Cultures exchange improved my understanding of culturally sensitive health. I learned how communication styles, traditions, and beliefs affect health decisions. The project helped me grow as a team member and strengthened my interest in inclusive healthcare”. Amal .E, Tunisia.

It was impressive to see every health worker , regardless of nationality , so engaged and determined to improve their country’s healthcare system by learning from other countries’ solutions and practices. Mariam,Tunisia.

Participating in this Erasmus project has been an eye-opening experience. One of the most profound moments of this journey occurred during our visit to a hospital, that not only broadened my understanding of healthcare systems but also taught me about cultural norms and practices related to health, gender, and family roles. Lara Marija Valenčič, Slovenia🇸🇮

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