



PATIENT SATISFACTION WITH PRIMARY HEALTH CARE IN SOLIDAR PROJECT AREAS



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ABBREVIATIONS

HAP – Health for All Project

OECD – Organization for Economic Co-operation and Development

PHC – Primary Health Care

WHO – World Health Organization



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INTRODUCTION

Primary health care (PHC)¹ is the main point of contact between the citizens and the health system. It plays a central role in prevention, early diagnosis, treatment, management of chronic conditions and continuity of care. The accessibility and quality of PHC therefore have a direct influence on how people experience the health system and whether their health needs are addressed in a timely and appropriate manner.

Patient satisfaction² is an important component of healthcare quality assessment. It refers to patients' subjective evaluation of the care and services they receive. This evaluation may be influenced by their experiences, expectations, needs and preferences. Satisfaction may relate to the service as a whole or to specific aspects of care, such as accessibility, waiting times, communication with healthcare professionals, information and guidance on health conditions and their appropriate self-management, respectful treatment, privacy, availability of medicines and services, financial accessibility and perceived responsiveness to patients' needs.

Patient satisfaction³ does not, on its own, provide a complete assessment of the clinical quality, safety or effectiveness of care. However, it complements clinical and administrative information by providing the perspectives of people who use health services. When collected and interpreted systematically, patient-reported information can help healthcare providers and decision-makers identify strengths, barriers and areas for improvement that may not be fully captured through routine health-service data.

Across Europe⁴, greater attention has been given to people-centered care and to incorporating patients' perspectives into healthcare performance assessment. This reflects an understanding of healthcare quality that considers not only the availability and clinical effectiveness of services but also whether care is accessible, timely, coordinated and responsive to people's needs. These considerations are particularly relevant to PHC, where patients rely on services for preventive care, acute health needs and the continuing management of chronic conditions.

¹ WHO (2023) Understanding primary health care. Available at: <https://www.who.int/europe/news-room/questions-and-answers/item/questions-and-answers-understanding-primary-health-care>

² Ferreira DC, Vieira I, Pedro MI, Caldas P, Varela M. Patient Satisfaction with Healthcare Services and the Techniques Used for its Assessment: A Systematic Literature Review and a Bibliometric Analysis. Healthcare (2023) Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10001171/>

³ WHO (2025). Patient-reported experiences in primary care: guidance for implementing the assessment. Available at: <https://iris.who.int/server/api/core/bitstreams/1cc11392-ddba-4d4c-9edb-bcc3c0ca61c0/content>

⁴ OECD (2022) Health at a Glance: Europe 2022. Available at: https://www.oecd.org/en/publications/health-at-a-glance-europe-2022_507433b0-en/full-report/component-41.html



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Within this context, this study assesses patient satisfaction with PHC services in SOLIDAR project areas. It examines recent service use, reasons for seeking care, services received, travel and waiting times, communication with healthcare professionals, privacy, respectful treatment and reported payments. It also explores experiences of emergency care, perceived facility preparedness for health emergencies, satisfaction with facility conditions and physical accessibility, and awareness and use of feedback and complaint mechanisms. Together, these findings describe patients' experiences and perceptions and help identify practical opportunities to improve the quality and responsiveness of care at the surveyed facilities.

1.1 Primary health care in Albania

In Albania, strengthening primary health care (PHC) has been a major policy priority over the past several years. The Strategy for the Development of Primary Health Care Services in Albania 2020-2025⁵, established a national framework for moving towards more accessible, affordable, integrated and people-centered PHC. Among its priorities and planned measures, the Strategy aimed to increase the range and quality of PHC services, strengthen family medicine, improve the coordination and continuity of care, expand and redefine the role of nurses, integrate health and psychosocial services, and reduce disparities in service quality between urban and remote areas.

These priorities are consistent with the broader National Health Strategy 2021-2030⁶, which provides the primary policy framework for protecting and improving population health and responding to the changing healthcare needs of the Albanian population. They also reflect a shift from a PHC system centered primarily on the provision of basic medical services, towards one expected to deliver more comprehensive, coordinated and people-centered care.

Several reforms have subsequently translated the national policy objectives into changes in PHC organization and service delivery. Since 2022, psychologists and social workers have been incorporated into family medicine teams through the establishment of socio-health centers. Around one-third of health centers nationally employ psychosocial professionals, including approximately 70 psychologists and 30 social workers. The 2026 HAP report⁷ also documents other approaches to integrated care, including home-care services for older and homebound people, referral linkages with Community Mental Health Centers and collaboration with municipal social services. At facility level, there is evidence that these changes are improving the capacity of PHC teams to respond to a broader range of patient needs. The inclusion of

⁵ Strategy on the Development of primary Health Care Services in Albania. Available at: <https://www.hap.org.al/wp-content/uploads/2021/12/PHC-Strategy-Nov2021-web.pdf>

⁶ National Health Strategy 2021 -2030. Available at: <https://www.qbz.gov.al/eli/vendim/2022/04/06/210/8590c194-dc8b-4fa3-aa49-4140d87e11bb;q=strategjia>

⁷ HAP (2026). Primary Care and Social Services in Albania report. Available at: https://www.hap.org.al/wp-content/uploads/2026/06/1.-Primary-Care-and-Social-Services-in-Albania_Report-2026.pdf



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psychosocial professionals has improved the responsiveness of PHC services to the mental-health and social vulnerabilities of patients already in contact with the system.

1.2 Existing evidence on patient satisfaction in Albania

Previous research provides an important basis for understanding patients' experiences with primary health care (PHC) in Albania. The 2019 Health for All (HAP) report⁸, conducted in 38 health centers in Dibër and Fier, assessed infrastructure, clinical practice and patient satisfaction and compared findings with an earlier baseline assessment. The study found that overall changes between baseline and end line were positive and that patient satisfaction increased over time. However, satisfaction was not uniform: it was higher in Dibër than in Fier, tended to be somewhat higher in rural than urban facilities, and varied according to the reason for the healthcare visit, with some dissatisfaction observed among patients with chronic conditions. The report also documented improvements in several aspects of the physical environment relevant to patients' experience of care. Finally, 95% of assessed facilities had designated waiting rooms, 92% had clean waiting areas and 95% had consultation rooms that ensured patient privacy. Nevertheless, the study continued to identify infrastructure and service-quality gaps and emphasized that patient satisfaction should be interpreted alongside other dimensions of quality rather than as a stand-alone measure.

More recent evidence is provided by 2025 HAP Survey⁹, published in 2026. The study assessed three dimensions of quality of care: health-center capacity and readiness, provider-patient interactions, and patient satisfaction following consultation. The 2025 assessment covered 48 health centers, comprising 24 HAP-supported and 24 comparison facilities, and included 599 observed consultations and 747 patient exit interviews. The findings indicate generally positive patient experiences with PHC, concretely 86.3% of participants reported being very satisfied and a further 13% satisfied with the health services they had received. Satisfaction was high in both HAP-supported and comparison health centers. The study also found high levels of satisfaction with healthcare professionals' behavior, suggesting that patients generally perceived their interactions with providers as respectful, attentive and supportive.

2.3 Rationale for the study

Against the background of Albania's evolving primary health care (PHC) system, this study does not seek to address a complete absence of evidence on patient satisfaction. Rather, it

⁸ HAP (2019) Report on the Assessment of Quality of Care in Primary Health Care Facilities in the Two Pilot Regions. Available at: https://www.hap.org.al/wp-content/uploads/2019/07/Quality-of-Care_Endline-survey.pdf

⁹ HAP (2026) Assessment of Quality of Care in primary Health Care in Albania. Available at: <https://www.hap.org.al/wp-content/uploads/2026/06/2-Assessment-of-Quality-of-Care-in-Primary-Health-Care-in-Albania-2026.pdf>





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complements existing national research by providing a current assessment of PHC services in the specific areas where the SOLIDAR project is being implemented. This is particularly relevant to ongoing efforts to improve access to quality emergency care through a more resilient health emergency system, including stronger capacities at the primary healthcare level. It also contributes to strengthening community engagement, patient empowerment and evidence-based dialogue on health services. Furthermore, the study provides a robust, evidence-based basis for advocacy and for informing policy and decision-making processes, supporting the development and delivery of PHC services that are better aligned with people's needs and expectations.

The study analyses data from 254 completed questionnaires administered to patients attending selected PHC facilities in Dajç, Pukë, Fushë-Krujë, Vorë, Gramsh, Cërrik and Përmet in July 2026. It examines several aspects of PHC service delivery, including accessibility, waiting times, communication with healthcare professionals, provision of information and education to patients, respectful treatment and privacy, payments for services, emergency-care availability and preparedness, facility conditions, feedback mechanisms and overall patient satisfaction.

Geographical focus is an important feature of the study. Although the most recent HAP assessment¹⁰ provides broader national evidence, its purpose and sampling framework differ from those of the SOLIDAR assessment. This study therefore adds specific evidence to the SOLIDAR implementation areas. Its findings can help identify local strengths, barriers and inform project-level actions to improve primary health care (PHC) service delivery.

The study also makes it possible to examine whether the generally high satisfaction levels reported in previous Albanian studies are reflected in the SOLIDAR implementation areas. Importantly, it looks beyond overall satisfaction by examining specific aspects of service delivery that may influence how patients assess the care received. In this way, the study contributes additional evidence to ongoing efforts to strengthen accessible, responsive and people-centered primary health care (PHC) in Albania.

¹⁰ HAP (2026) Assessment of Quality of Care in primary Health Care in Albania. Available at: <https://www.hap.org.al/wp-content/uploads/2026/06/2.-Assessment-of-Quality-of-Care-in-Primary-Health-Care-in-Albania-2026.pdf>



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2.4 Study objectives

The overall objective of the study was to assess patients' satisfaction with primary health care services in SOLIDAR project areas and to identify aspects of service delivery that may require further improvement.

The specific objectives were:

- To examine patients' experiences of accessing and receiving primary health care services, including service use, waiting and travel times, provider communication, privacy, information and advice provided during consultations, and payments for services;
- To measure patients' overall satisfaction with the primary health care services received and with key aspects of the health facility, including cleanliness, signage, accessibility and general condition;
- To explore patients' perceptions of primary health care facilities' capacity to respond to health emergencies, including situations where patients seek emergency care, their experience of emergency care at PHC level and perceived facility preparedness;
- To assess patients' awareness of available mechanisms for providing feedback or submitting complaints, as well as their use of these mechanisms.



Methodology

2.1 Data collection

This study used a quantitative cross-sectional survey to assess patient satisfaction with primary health care (PHC) services in the areas where the SOLIDAR project is being implemented. Data was collected from patients immediately after their consultation at selected PHC facilities using a structured questionnaire.

The questionnaire was developed drawing on internationally recognized patient satisfaction dimensions and adapting questions from previous assessments conducted in Albania. In particular, the survey builds on the patient questionnaire used in the *Report on the Assessment of Quality of Care in Primary Health Care Facilities in the Two Pilot Regions*¹¹, developed under the Health for All Project – Albania (HAP), while incorporating additional questions tailored to the objectives of the SOLIDAR project. The questionnaire collects information on participants' socio-demographic characteristics and their experiences with PHC service delivery, including accessibility, waiting times, communication with healthcare professionals, respectful treatment and privacy, payments for services, emergency-care availability and preparedness, facility conditions, feedback mechanisms and overall patient satisfaction.

The questionnaire was administered digitally to support consistent data collection, reduce data-entry errors and allow real-time validation of responses. Prior to field implementation, the questionnaire was piloted to assess its clarity, relevance, sequencing and administration time. Feedback from the pilot phase was used to further refine the questionnaire prior to full-scale data collection.

¹¹ HAP (2019) Report on the Assessment of Quality of Care in Primary Health Care Facilities in the Two Pilot Regions. Available at: https://www.hap.org.al/wp-content/uploads/2019/07/Quality-of-Care_Endline-survey.pdf





2.2 Sampling

The study used a convenience sampling approach. Data were collected from patients exiting selected primary health care (PHC) facilities in Dajç, Pukë, Fushë-Krujë, Vorë, Gramsh, Cërrik and Përmet. A total of 254 patients completed the questionnaire during the data collection period.

Eligible participants were patients aged 18 years or older who had completed consultation at one of the selected PHC facilities and were invited to participate upon leaving the facility.

The participating PHC facilities were selected based on the geographical coverage of the SOLIDAR project. Both urban and rural facilities were included to reflect the different settings in which the project is implemented and to allow the study to explore potential differences in patients' experiences, access to health services and levels of satisfaction across these settings.

2.3 Data collection and analysis

Data were collected in July 2026 using structured questionnaires administered face-to-face by trained interviewers. The interviewers recorded participants' responses directly on tablet devices. The questionnaires were completed immediately after patients had finished their consultations at the selected PHC facilities.

Before the fieldwork began, the interviewers received dedicated training on the study objectives, ethical considerations, informed consent procedures and interviewing techniques. The training emphasized the importance of interviewer neutrality, consistency in administering the questionnaire and the protection of participants' confidentiality.

During fieldwork, completed questionnaires were monitored through the online data-collection platform *SURVIO* to identify incomplete records and other potential data-quality issues. This quality-assurance process enabled timely feedback to the interviewers and supported the completeness and consistency of the dataset. The collected data were analyzed primarily using descriptive statistics, including frequencies, percentages and cross-tabulations. The analysis examined patterns in patient satisfaction and, where appropriate, differences among respondent groups and participating PHC facilities.

2.4 Ethical considerations

Participation in the study was entirely voluntary. Informed consent was obtained from all participants prior to the interview, confirming their willingness to participate and their right to decline participation or withdraw at any time, without any consequences. To ensure privacy and confidentiality, interviews were conducted immediately after the consultation in locations that minimized interruptions and protected participants' privacy, such as the health facility courtyard



or, where appropriate, a quiet area within the facility. No personally identifiable information was collected. All responses were treated confidentially and used solely for research purposes.

2.5 Study limitations

Several limitations should be taken into consideration when interpreting the findings of this study. *First*, the study used a convenience sampling approach and included patients who frequented selected PHC facilities during the data collection period. The findings therefore reflect the experiences of patients who accessed these facilities and should not be interpreted as representative of all PHC users in the project areas or of the general population.

Second, the findings are based on patients' self-reported experiences and perceptions. As with all satisfaction surveys, responses may be influenced by individual expectations, previous experiences and participants' willingness to express criticism. Moreover, because questionnaires were administered immediately following a medical consultation, participants' responses may have been influenced more by their experience of that consultation, rather than by their overall experience of accessing and receiving healthcare services at the respective health centers.

Third, the cross-sectional design captures patients' experiences at a specific point in time and does not allow changes in satisfaction or service quality to be assessed over time. The study therefore provides a snapshot of patient experience during the data collection period rather than evidence of longer-term trends.

Finally, the survey primarily measures patient experience and perceived satisfaction with PHC services. While these are important dimensions of quality of care, they do not provide an objective assessment of clinical quality, adherence to clinical protocols, availability of infrastructure and equipment, or health outcomes. The findings should therefore be interpreted alongside other sources of evidence when drawing broader conclusions about the overall quality and performance of PHC services.

Despite these limitations, the study provides useful evidence on how patients experience PHC services in the SOLIDAR project areas and helps identify areas of strong performance as well as specific aspects of service delivery that may require further attention.



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Findings and results

3.1 SOCIO-ECONOMIC PROFILE

A total of 254 patients completed the survey across selected primary health care facilities in the SOLIDAR project areas of Cërrik, Dajç, Fushë-Krujë, Gramsh, Përmet, Pukë and Vorë. Women represented most study participants, accounting for 69.7% (n=177) of the sample, while men accounted for 30.3% (n=77).

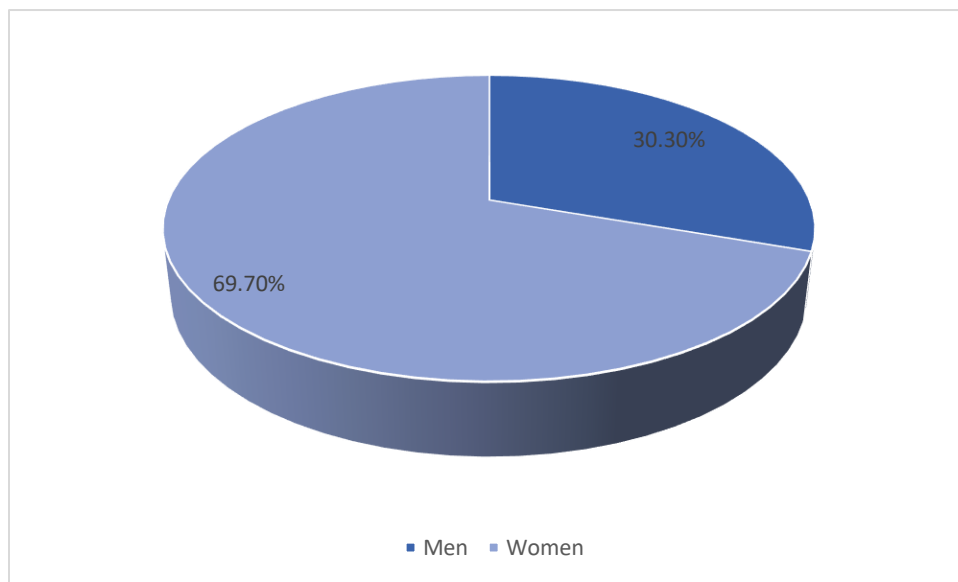


Figure 1: Gender of participants

In terms of age, the participants represented a broad range of age groups. Nearly half (47.3%) were aged 25-44 years, with adults aged 25-34 years representing the largest age group (26.4%; n=67), followed by those aged 35-44 years (20.9%; n= 53). Participants aged 45-54 accounted for



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16.5% (n=42) of the sample, while those aged 55-64 and 65 years and older each represented 13.8% (n=35). Younger adults aged 18-24 accounted for 8.7% (n=22) of participants.

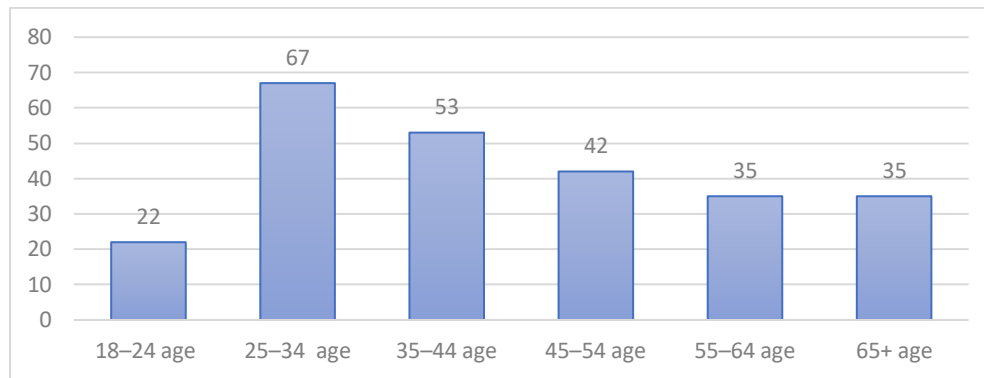


Figure 2: Age distribution of the participants

Participants came primarily from the regions where the primary health care (PHC) facilities surveyed were located. The largest proportion resided in Elbasan Region (33.5%; n=85), followed by Shkodër (26.8%; n=68). Tirana accounted for 13.8% (n=35) of participants, while Durrës and Gjirokastër each accounted for 12.6% (n=32). Two participants reported residing in Fier and Lezhë, respectively (0.4% each). As the survey recorded participants' region of residence separately from the PHC facility where they received care, these cases indicate that a small number of participants accessed PHC services outside their reported region of residence.

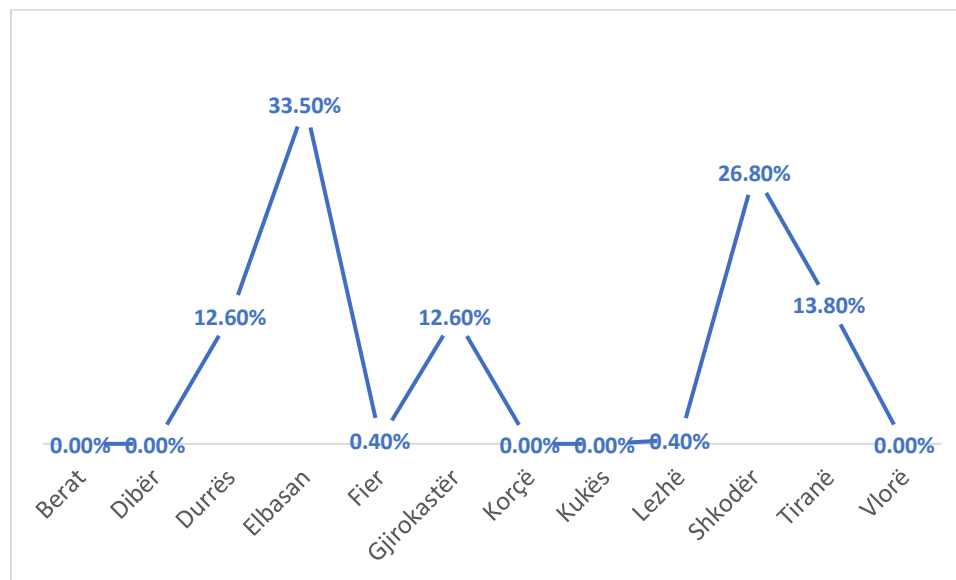


Figure 3: Participants by region of residence



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The educational profile of the participants indicates relatively high levels of formal education. Almost half (46.1%; n=117) reported having completed a university degree, while 24.8% (n=63) had completed upper secondary education and 18.9% (n=48) had completed compulsory lower secondary education. Smaller proportions reported primary education (5.5%; n=14) or no formal education (4.7%; n=12).

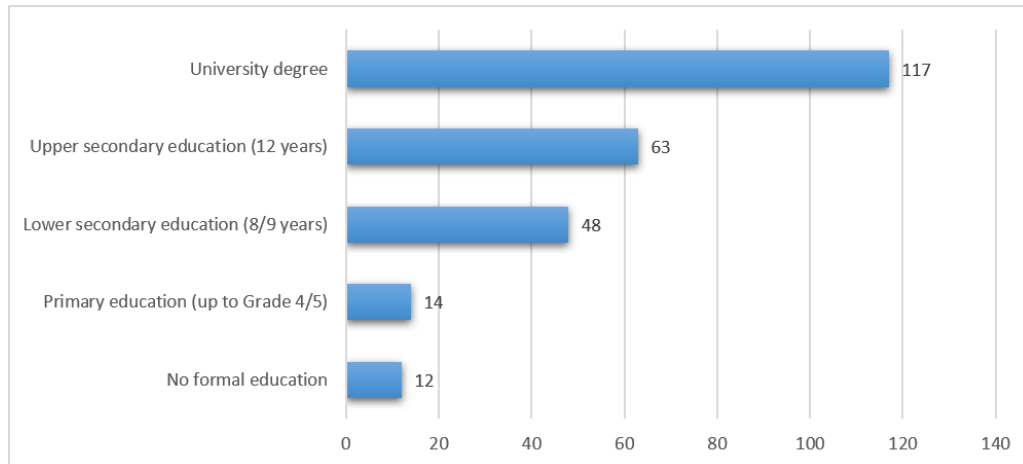


Figure 4: Education level of the participants

In terms of employment status, the largest group of participants were employed (41.7%), while a further 7.1% identified specifically as public-sector employees. Retired participants accounted for 14.6% of the sample, followed by homemakers (11%), unemployed (9.4%), self-employed or business owners (8.7%), those reporting another employment status (5.9%) and farmers (1.6%).

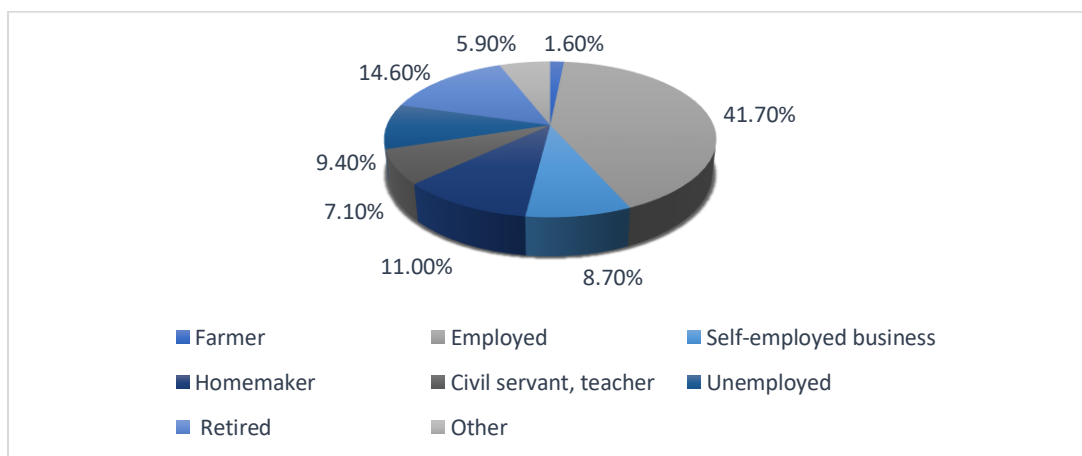


Figure 5: Employment status





Access and utilization of primary health care (PHC) services are closely related to health insurance coverage. More than three quarters of participants (77.6%) reported having a valid health insurance card or booklet, while 22.4% reported that they did not.

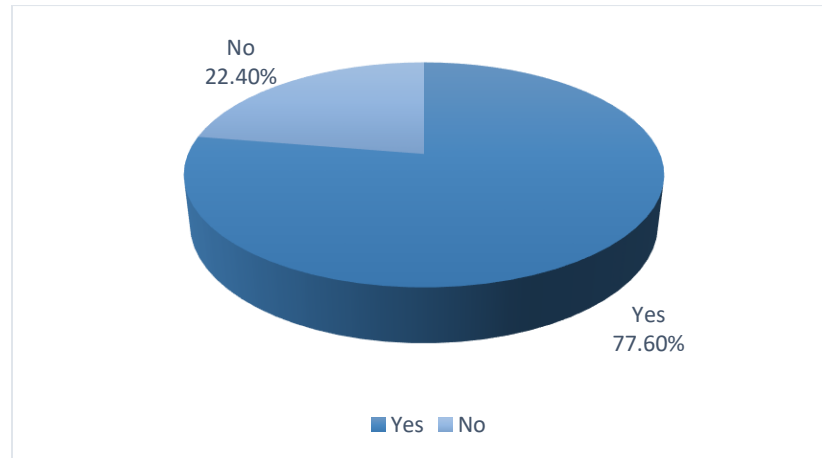


Figure 6: Valid health insurance card

The majority of study participants (72.4%; n = 184) reported that they did not receive social assistance or economic support, while 18.9% (n = 48) reported receiving such support and 8.7% (n = 22) preferred not to answer.

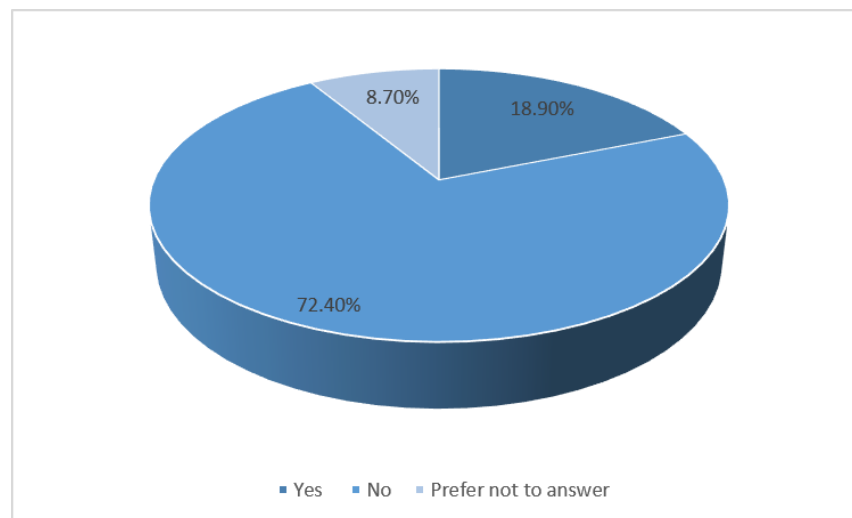


Figure 7: Beneficiaries of social assistance or economic support

As shown in Table 1, the proportion of participants reporting no valid health-insurance card or booklet was higher among those receiving social assistance or economic support (27.1%) than among those not receiving such support (20.1%). However, this difference was not statistically



significant, and the analysis did not provide sufficient evidence of an association between the two variables in the study sample.

Table 1: Health insurance status by receipt of social assistance or economic support¹²

Receipt of social assistance/economic support	Has valid health insurance, n (%)	Does not have valid health insurance, n (%)	Total, n
Yes	35 (72.9%)	13 (27.1%)	48
No	147 (79.9%)	37 (20.1%)	184
Prefer not to answer	15 (68.2%)	7 (31.8%)	22
Total	197 (77.6%)	57 (22.4%)	254

Most participants, 75.2% (n=191), did not identify themselves as belonging to an ethnic minority, while 20.9% (n=53) preferred not to disclose this information and 3.9% (n=10) reported belonging to an ethnic minority.

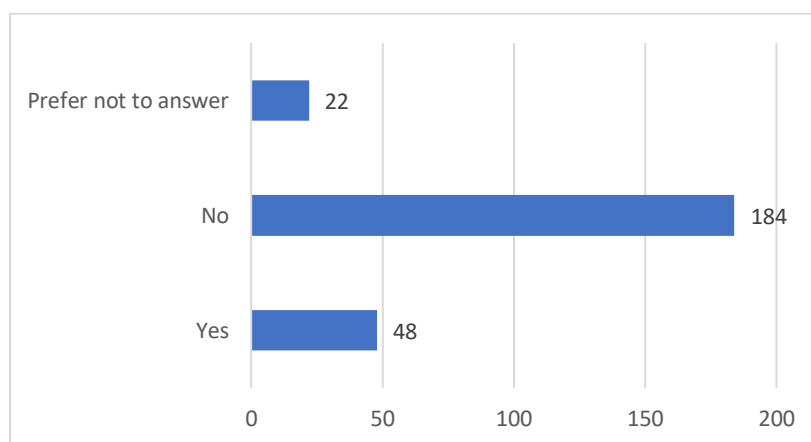


Figure 8: Belonging to an ethnic minority

3.2 Patient experience and satisfaction with primary health care

3.2.1 Access to primary health care

The largest proportion of participants surveyed received services at Gramsh Health Centre (15.4%; n = 39), followed by Pukë Health Centre (14.6%; n = 37), Cërrik (13.4%; n = 34), Dajç (13%; n = 33) and Fushë-Krujë (13%; n = 33). Përmet accounted for 11.8% (n = 30) of participants, while

¹² The association analysis excludes the 22 participants who preferred not to disclose their social assistance status and is based on 232 responses.





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Vorë accounted for 5.9% (n = 15). A further 13% (n = 33) selected “Other” and specified health centres in Kamëz, Pishaj, Fushë-Arrëz, Elbasan, Belsh, Shkodër and Poroçan.

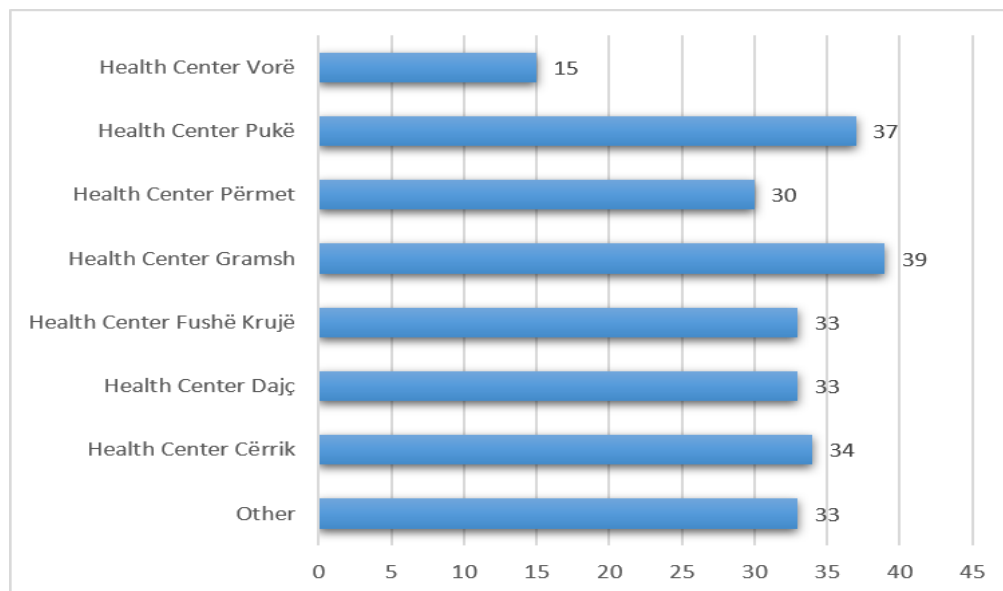


Figure 9: Distribution of participants by Health Center

The frequency of recent visits suggests that many participants were regular users of primary health care (PHC) services. More than half (57.5%; n=72) reported visiting the health center between one and three times during the previous three months, including the day of the survey, while a further 28.3% (n=72) had visited more than three times. Only 14.2% (n=36) reported no previous visits to the health center during the last period.

These findings indicate that the survey captured the experiences of both occasional and more frequent users of PHC services, providing a useful basis for assessing different aspects of patient experience.



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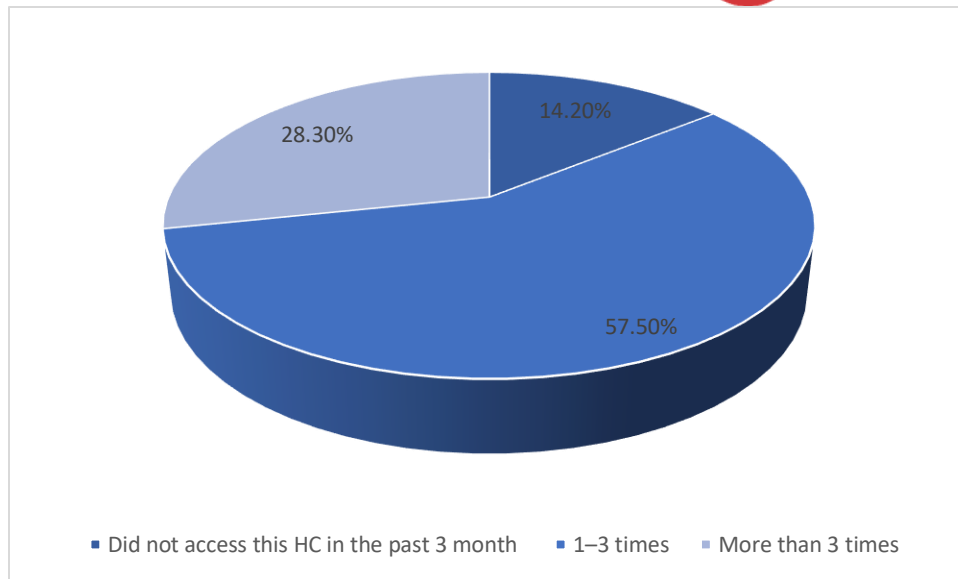


Figure 10: Frequency of Health Center visits in the past three months

When asked about the main reason for their medical visit or consultation on the day of the survey, participants reported a diverse range of reasons. Health emergencies were the most frequently reported, accounting for 19.7% of participants (n=50). Child health consultations were the second most common reason (15.7%; n=40), followed by arterial hypertension (14.2%; n=36) and other non-chronic conditions (11 %; n=28). A further 15.4% of participants (n=39) selected “Other” as the main reason for their visit. The reasons reported included check-ups and general health examinations, laboratory tests or review of test results, specialist consultations and referrals, urinary infections, flu-like illnesses, kidney and rheumatic problems, post-operative care, administrative documentation and other specific health concerns.

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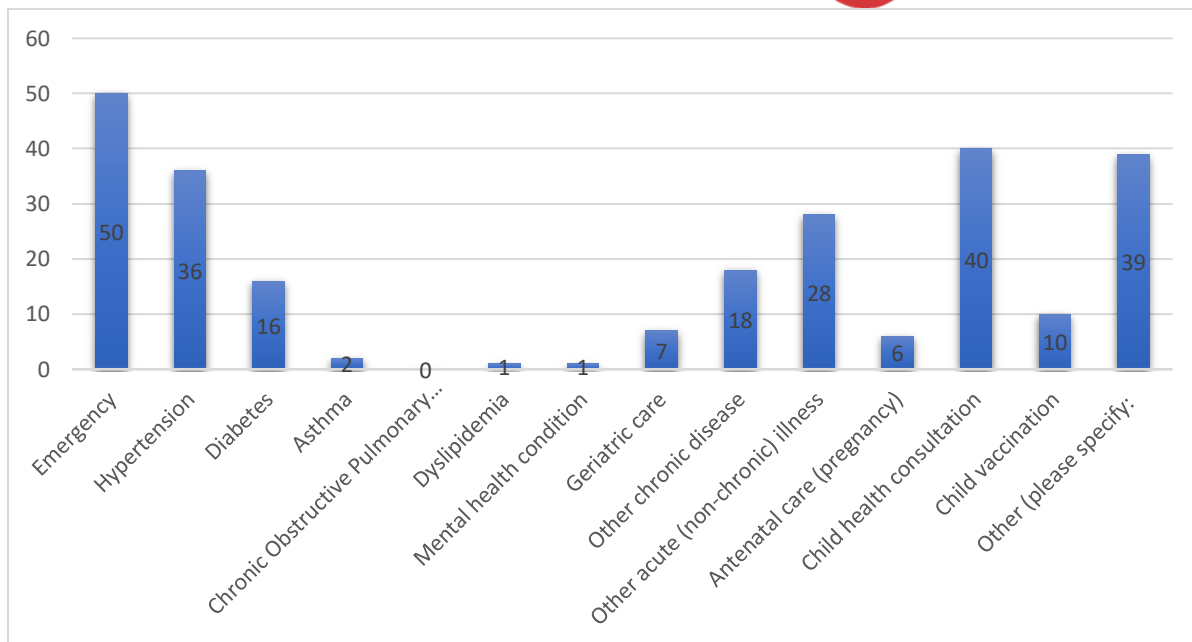


Figure 11: Main reason for the current PHC visit

Family doctors were the main point of clinical contact for most participants. Almost two-thirds (64.6%; n=164) reported being seen by a family doctor during their visit, while 16.1% (n=41) were seen by a general practitioner and 13.4% (n=34) by a specialist doctor. The remaining 5.9% of participants (n=15) reported seeing another type of healthcare professional, including nurses, a psychologist and a pediatrician. The predominance of family doctors is consistent with their central role in the delivery of primary health care (PHC) at facility level, while the presence of general practitioners, specialists and other professionals indicates some variation in the type of provider consulted by the study participants.

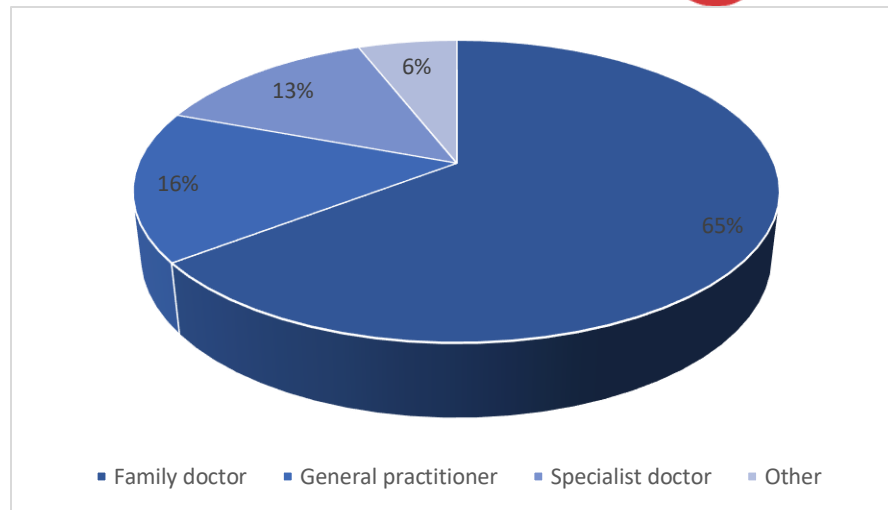


Figure 12: Healthcare professional consulted during the visit

Reported travel times suggest that the health centers were relatively accessible for most participants. More than half of participants (54.3%; n=138) reported travelling less than 10 minutes from their home to the health center, while 38.6% (n=98) reported a travel time of 10–30 minutes. Overall, 92.9% of participants reached the health center within 30 minutes. Longer travel times were uncommon: 6.3% (n = 16) reported travelling between 45 and 60 minutes, while only 0.8% (n = 2) reported travelling for more than one hour, residing in the Shkodër and Elbasan regions, respectively.

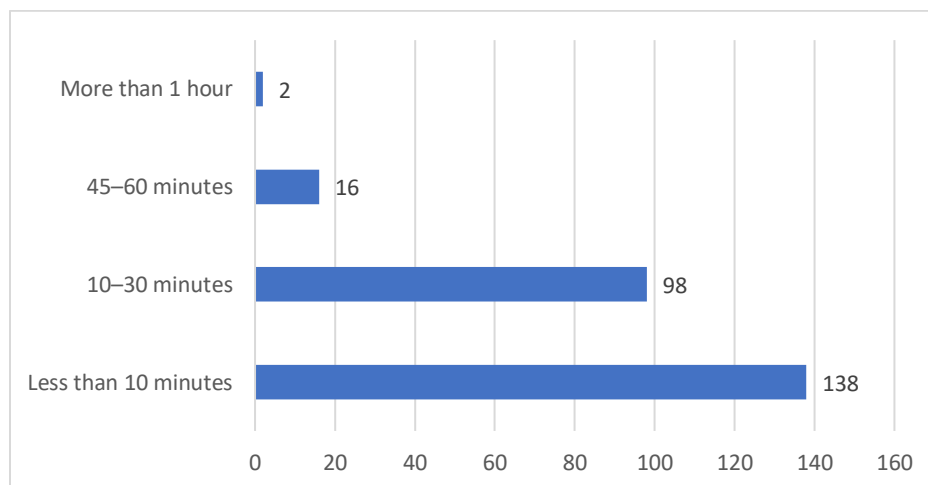


Figure 13: Travel time from home to the Health Centre

The findings suggest relatively positive geographical access among the participants surveyed, with the vast majority reaching their health center within 30 minutes.



3.2.2 Waiting time and services received

Participants reported receiving different types of services during the consultation, depending on their healthcare needs. As more than one service could be reported per participant, the percentages presented below are not mutually exclusive and therefore do not sum to 100%. A physical examination was the most frequently reported service, received by 55.1% of participants (n=140). Almost one-third (32.3%; n=82) were referred for laboratory tests or other examinations, while 23.2% (n=59) received a prescription for medicines. A similar proportion, 22.4% (n=57), were referred to as a specialist. A further 8.7% of participants (n=22) reported other services during the visit, including blood pressure and blood glucose measurements, vaccinations, injections or IV treatment, counselling and post-operative care.

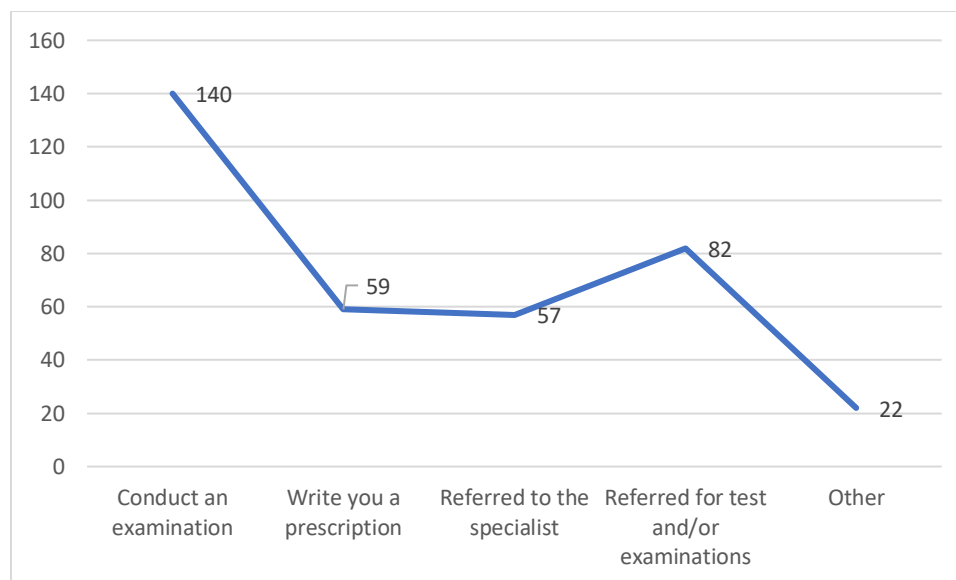


Figure 14: Services provided by the doctor during the visit

Waiting times to receive healthcare services were relatively short for most participants. More than two-thirds (67.3%; n=171) reported waiting less than 15 minutes before their consultation, while a further 26.8% (n=68) waited between 15 and 30 minutes. Overall, 94.1% of participants were therefore visited within 30 minutes. Longer waiting times were considerably less common: 3.9% (n=10) waited between 31 and 60 minutes, while 2% (n=5) reported waiting for more than one hour.

Analysis by health center showed that short waiting times were reported across most surveyed facilities, although some variation was observed. All participants in Gramsh and Dajç reported waiting no more than 30 minutes, while the corresponding proportions were 97.3% in Pukë,

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97.1% in Cërrik and 97.0% in Fushë-Krujë. Waiting times were somewhat longer in Përmet, where 12.5% of participants reported waiting more than 30 minutes.

Table 2: Waiting time by Health Centre

Health Centre	n	<15 min	15–30 min	31–60 min	>1 hour	Within 30 min
Pukë	37	27 (73%)	9 (24.3%)	0 (0%)	1 (2.7%)	97.3%
Fushë-Krujë	33	27 (81.8%)	5 (15.2%)	0 (0%)	1 (3.0%)	97%
Vorë	15	0 (0%)	9 (60%)	6 (40%)	0 (0%)	60%
Përmet	32	16 (50%)	12 (37.5%)	3 (9.4%)	1 (3.1%)	87.5%
Cërrik	34	24 (70.6%)	9 (26.5%)	0 (0%)	1 (2.9%)	97.0%
Gramsh	39	31 (79.5%)	8 (20.5%)	0 (0%)	0 (0%)	100%
Dajç	33	25 (75.8%)	8 (24.2%)	0 (0%)	0 (0%)	100%
Other facilities	31	21 (67.7%)	8 (25.8%)	1 (3.2%)	1 (3.2%)	93.5%
Total	254	171 (67.3%)	68 (26.8%)	10 (3.9%)	5 (2%)	94.1%

Vorë health center showed a different waiting-time pattern compared with the other health centers surveyed, with a higher proportion of participants reporting longer waiting times. While 60% of participants reported waiting up to 30 minutes to be seen by a doctor, 40% reported waiting between 31 and 60 minutes, and none reported waiting less than 15 minutes. These findings suggest that waiting times were generally short across the health centers surveyed, while also indicating some variation between facilities. The findings for Vorë health center should be interpreted cautiously given the relatively small number of participants surveyed at this facility (n=15).

3.2.3 Interaction with healthcare professionals

The study participants reported generally positive interactions with healthcare professionals across several aspects of the consultation, including opportunities to communicate their concerns, privacy, explanations and information, responsiveness to questions and respectful treatment.

At the beginning of the consultation, 93.7% of participants (n=238) reported that they were given the opportunity to explain their health problems, while 6.3% (n=16) indicated that they were not.

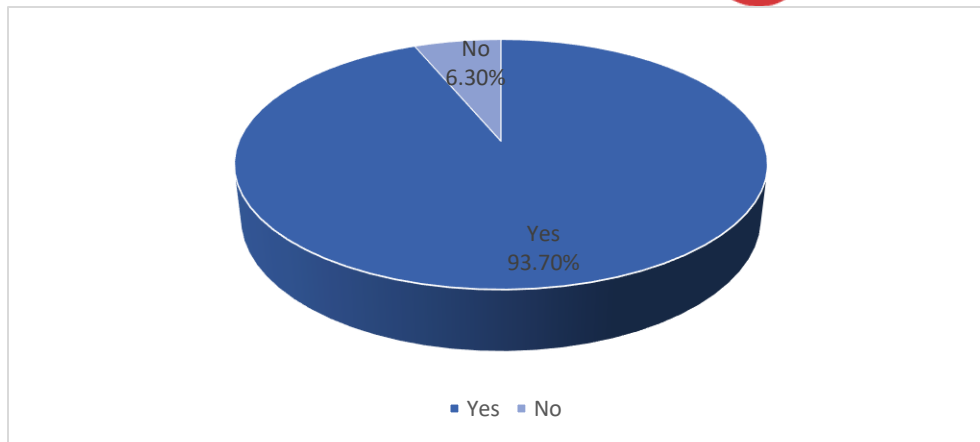


Figure 15: Opportunity to explain the health problem

Opportunities for active participation remained high during the consultation: 97.2% (n=247) of participants reported being given the opportunity to ask questions about their health problem, the examination and the treatment provided, while 2.8% (n=7) reported that they were not given this opportunity.

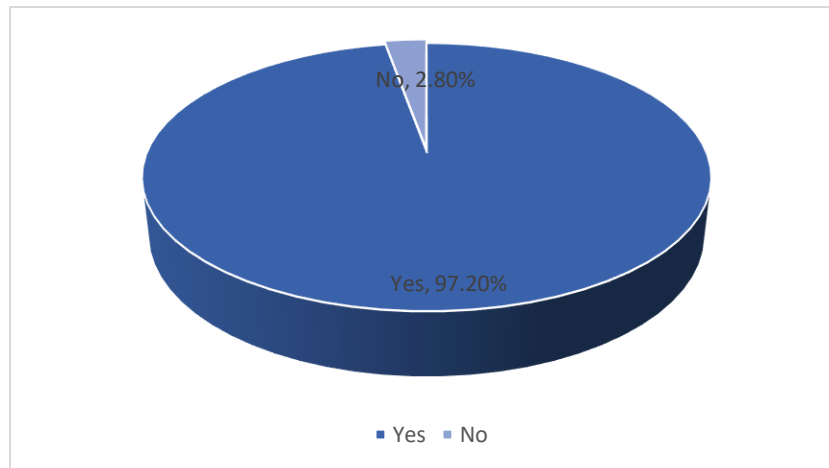


Figure 16: Opportunity to ask questions during the consultation

In addition, 95.7% (n=243) felt that the doctor or nurse listened carefully to their concerns and questions and provided satisfactory answers. These findings indicate that most patients experienced the consultation as an interactive process in which they were able both to describe their concerns and to seek clarification about their health condition.

Privacy and respectful treatment were among the most positively rated aspects of the interaction. Almost all participants (98.8%; n=251) reported that the doctor or nurse ensured their privacy



during the visit, with only 1.2% (n=3) reporting otherwise. Similarly, 98% (n=249) described the healthcare professional as polite during the consultation.

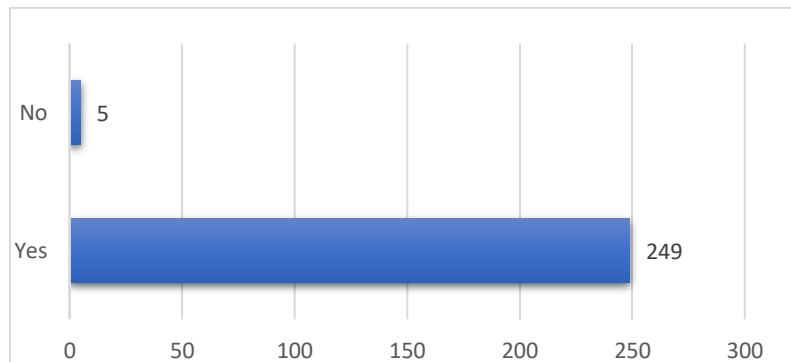


Figure 17: Politeness of the healthcare professional during the visit

Study participants also reported high levels of communication and explanation from healthcare professionals, although some variation was observed depending on the type of information. The highest proportion concerned explanations of the patient's health problem, reported by 92.1% of participants (n=234). Explanations or clarification of issues about which patients had questions or uncertainties were reported by 88.2% (n=224), while 87% (n=221) reported receiving explanations about the physical examination. Explanations regarding the reasons for additional tests or examinations were reported by 80.7% (n=205).

Lower proportions were recorded for information related to prescriptions and referrals. In each case, 77.2% of participants (n=196) reported receiving an explanation about the prescription, the reason for referral to a specialist, and how to take prescribed medicines. These findings suggest that communication was strongest around patients' health problems and the immediate examination, while information related to subsequent treatment and referral was reported less consistently.



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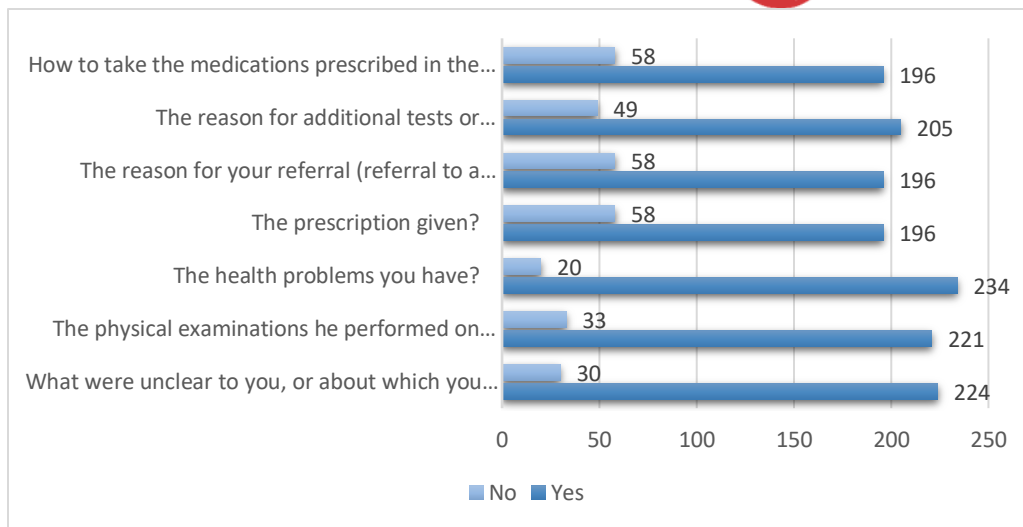


Figure 18: Explanations provided during the medical visit

Medication-related communication showed a similar pattern. So, 85.8% of the study participants (n=218) reported that the doctor or nurse asked whether they were taking any other or new medicines, while 14.2% (n=36) reported that they were not asked. In addition, 90.6% (n=230) reported receiving advice from the healthcare professional about their health problem, compared with 9.4% (n=24) who did not.

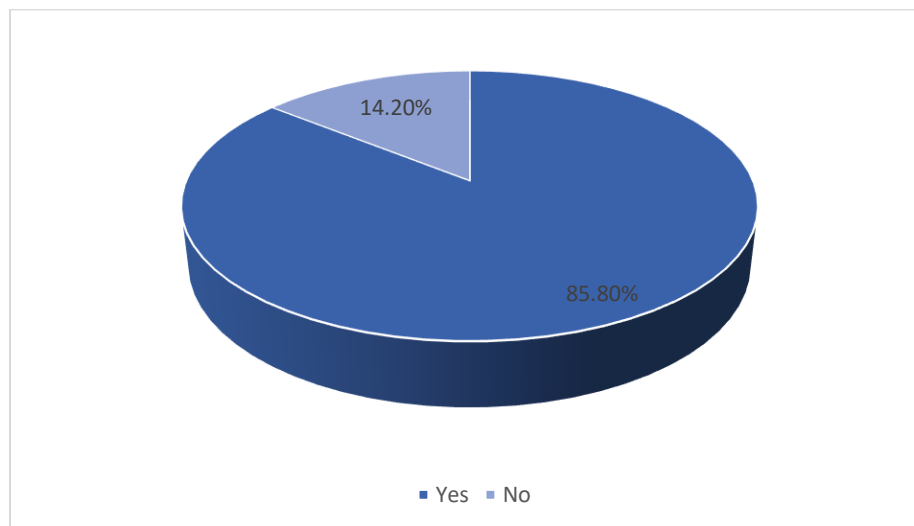


Figure 19: Medication related communication by healthcare professionals

A health center level analysis was conducted to examine whether participants' experiences of communication with healthcare professionals varied across the surveyed facilities. The analysis focused on four key indicators covering different aspects of the consultation: whether participants had an opportunity to explain their health problem, whether they were given an opportunity to



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ask questions, whether the healthcare professional listened and responded satisfactorily to their questions, and whether they received advice about their health problem. The positive communication experiences observed across the sample were broadly reflected at Health Centre level, although some variation was evident. In Pukë, all participants reported positive experiences across all four indicators, while responses in Gramsh and Dajç were also consistently high. In Fushë-Krujë, all participants reported having an opportunity to ask questions, but lower proportions reported having an opportunity to explain their health problem (81.8%) and receiving advice about their health problem (81.8%).

The greatest variation across facilities was observed in the provision of health advice. While all participants surveyed in Gramsh, Pukë and Përmet reported receiving advice about their health problem, this proportion was substantially lower in Vorë (60.0%) and among participants attending other facilities (69.7%). By comparison, the other three communication indicators generally remained high across Health Centres.

Table 3: Patient - healthcare professional communication by Health Center

Health Centre	n	Opportunity to explain health problem	Opportunity to ask questions	Healthcare professional listened and answered satisfactorily	Received health advice
Gramsh	39	94.9% (37)	100% (39)	97.4% (38)	100% (39)
Pukë	37	100% (37)	100% (37)	100% (37)	100% (37)
Cërrik	34	94.1% (32)	91.2% (31)	97.1% (33)	97.1% (33)
Dajç	33	93.9% (31)	100% (33)	100% (33)	97% (32)
Fushë-Krujë	33	81.8% (27)	100% (33)	90.9% (30)	81.8% (27)
Përmet	30	100% (30)	96.7% (29)	93.3% (28)	100% (30)
Vorë	15	100% (15)	93.3% (14)	100% (15)	60% (9)
Other facilities	33	87.9% (29)	93.9% (31)	87.9% (29)	69.7% (23)



These findings suggest that the core elements of direct patient–healthcare professional communication, particularly opportunities to explain health concerns, ask questions and receive satisfactory responses, were relatively consistent across the surveyed health centers.

3.2.4 Financial access and availability of appropriate services

Financial access was examined through participants' health insurance status and payments reported in connection with the services received on the day of the survey. More than three quarters of participants (77.6%; n=197) reported having valid health insurance, while 22.4% (n=57) did not.

Most participants reported making no payment in connection with their visit to the Health Center. Overall, 92.1% (n = 234) stated that they had not paid, while 7.9% (n = 20) reported having made a payment.

Table 4: Reported payment for services by health insurance status

Health insurance status	Paid, n (%)	Did not pay, n (%)	Total, n (%)
Valid health insurance	15 (7.6%)	182 (92.4%)	197 (100%)
No valid health insurance	5 (8.8%)	52 (91.2%)	57 (100%)
Total	20 (7.9%)	234 (92.1%)	254 (100%)

As shown in Table 3, reported payment was uncommon among both insured and uninsured participants. A payment was reported by 7.6% of participants with valid health insurance and 8.8% of those without valid insurance. The descriptive results therefore show little difference in reported payment according to health insurance status within this sample.

The open-ended responses provide additional context for the expenses reported by participants. Some referred to purchasing medicines and medical supplies from pharmacies, including intravenous fluids and needles. In a few cases, participants linked these purchases to items being unavailable at the health center. Two participants, for example, reported buying “serum and



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needles from the pharmacy because the health center did not have them available”, while adding that “the doctors were very kind”. Other reported expenses included specialist consultations, medical visits and laboratory tests. Several participants also mentioned giving healthcare staff a small amount of money, which they presented as a voluntary gesture of appreciation for the service received, for example, “a coffee for the good service” or “I liked the doctor’s service and gave a coffee as a gesture of appreciation”.

These responses indicate that the costs reported in connection with a PHC visit included not only payments for specific health services, but also out-of-pocket purchases of medicines and supplies outside the facility and occasional voluntary monetary gestures to healthcare staff.

Availability of appropriate care was further explored through participants’ reported care-seeking patterns and experiences in health emergencies. When asked where they would first seek care in the event of a health emergency, 59.1% (n=150) identified a PHC facility, while 39% (n=99) reported that they would go directly to a hospital. Only one participant (0.4%) selected a private clinic and four (1.6%) another option. This indicates that PHC was the most reported first point of contact, although hospitals also accounted for a substantial share of intended emergency care-seeking.

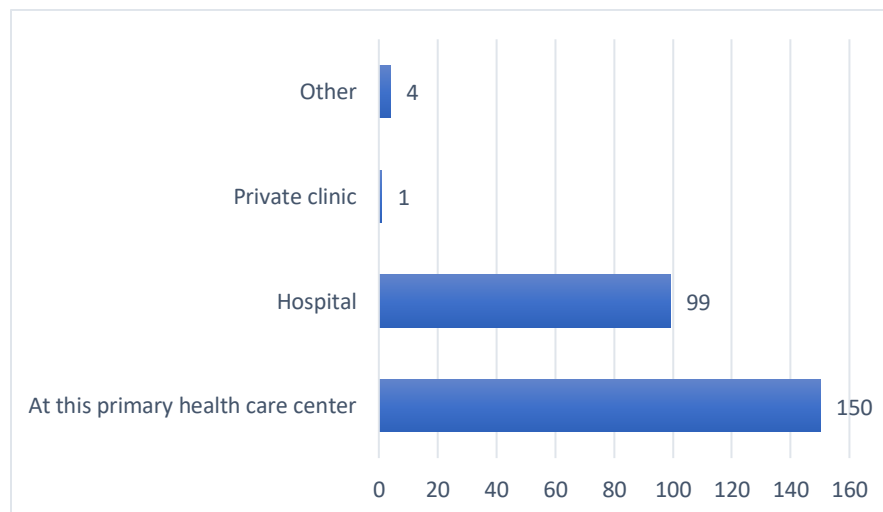


Figure 20: First point of care for health emergencies

Participants’ experiences of their most recent emergency provide additional information on the role of PHC facilities in responding to urgent health needs. Overall, 81.9% (n=208) reported that their most recent emergency had been managed at the PHC facility, while 18.1% (n=46) reported that it had not.

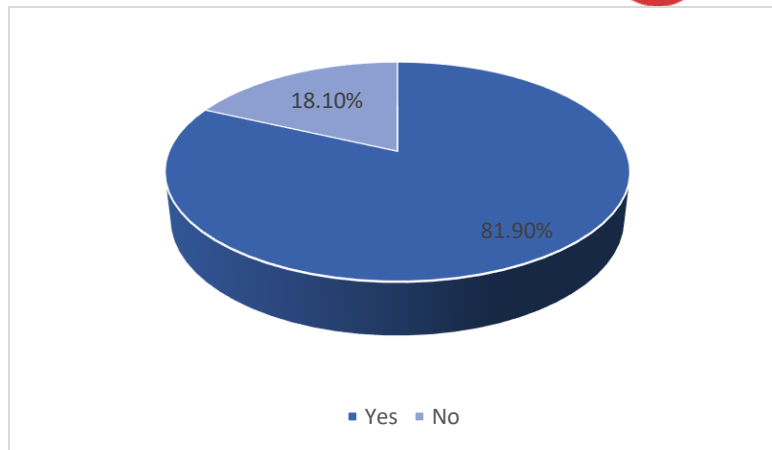


Figure 21: Management of the recent health emergency at the PHC

Among the 46 participants whose most recent emergency was not managed at the PHC facility, the most frequently reported reason was the need for hospital-level care (52.2%; n=24). A further 13% (n=6) reported being referred to another facility by health center staff. Directly reported service limitations were less frequent: five participants (10.9%) reported that the required service or treatment was unavailable, two (4.3%) that no staff were available at the time and one (2.2%) cited insufficient equipment, medicines or diagnostic capacity. Three participants (6.5%) preferred to seek care from a private provider, while five (10.9%) reported other reasons. These included being transported by ambulance to hospital, being directed to hospital-level care and experiencing the emergency outside the health center's working hours.

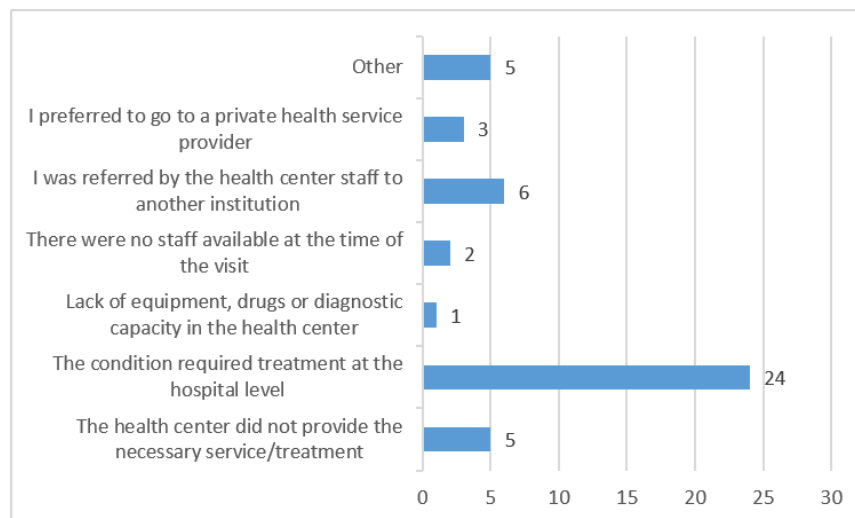


Figure 22: Main reasons for seeking care outside the PHC



3.2.5 Overall patient experience and satisfaction

Overall satisfaction with the services received on the day of the survey was high. Almost half of participants (48.8%; n=124) reported being very satisfied with the care they received, while a further 47.2% (n=120) reported being satisfied. Combined, these two categories accounted for 96.0% of participants, indicating a high level of overall satisfaction with the services received. By comparison, 3.5% (n=9) reported being dissatisfied, while only one participant (0.4%) reported being very dissatisfied with the service received.



Figure 23: Patient satisfaction with the service received

A similarly positive pattern was found among participants whose most recent health emergency had been managed at the PHC facility. Of the 208 participants for whom this question was applicable, 52.9% (n=110) were very satisfied with the way their most recent emergency had been managed and 45.7% (n=95) were satisfied. This means that 98.6% (n=205) reported a positive experience of emergency management at the facility. Only three participants (1.4%) were dissatisfied and none reported being very dissatisfied.

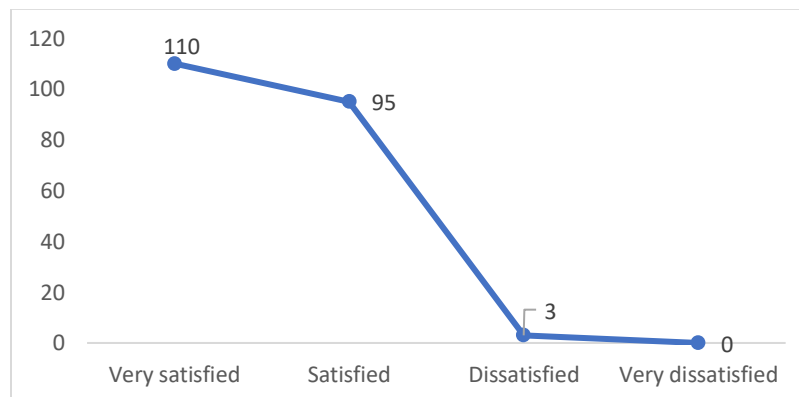


Figure 24: Patient satisfaction with the emergency care received



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The high levels of satisfaction with both the current visit and the management of previous emergencies are consistent with the positive experiences reported across other aspects of care, particularly communication with healthcare professionals, privacy, respectful treatment and relatively short waiting times.

3.2.6 Health facility environment and emergency preparedness

Participants were asked to assess several aspects of the health facility environment, including cleanliness, signage and ease of finding services, accessibility for older adults and persons with disabilities, and the overall condition and maintenance of the health center.

Satisfaction was generally high across most aspects of the health facility environment. Cleanliness received particularly positive assessments, with 55.1% of participants (n=140) reporting that they were very satisfied and a further 36.2% (n=92) satisfied. In total, 91.3% of participants reported being satisfied or very satisfied with the cleanliness of waiting areas, consultation rooms and toilets.

A similarly positive pattern was observed for signage and ease of finding the required service. More than half of participants (54.7%; n=139) were very satisfied and 37.4% (n=95) were satisfied, resulting in an overall satisfaction level of 92.1%. The overall condition and maintenance of the health centers were also assessed positively, with 49.6% (n=126) very satisfied and 41.3% (n=105) satisfied, equivalent to 90.9% of participants overall.

Accessibility for older adults and people with disabilities received comparatively fewer positive assessments. While 48% of participants (n=122) were very satisfied and 28.7% (n=73) satisfied, 19.3% (n=49) were dissatisfied and a further 1.6% (n=4) were very dissatisfied. Overall, 20.9% expressed some level of dissatisfaction with accessibility, compared with less than 8% for cleanliness, signage and the general condition of the health facilities. Accessibility therefore stands out as the aspect of the facility environment with the greatest reported need for improvement.



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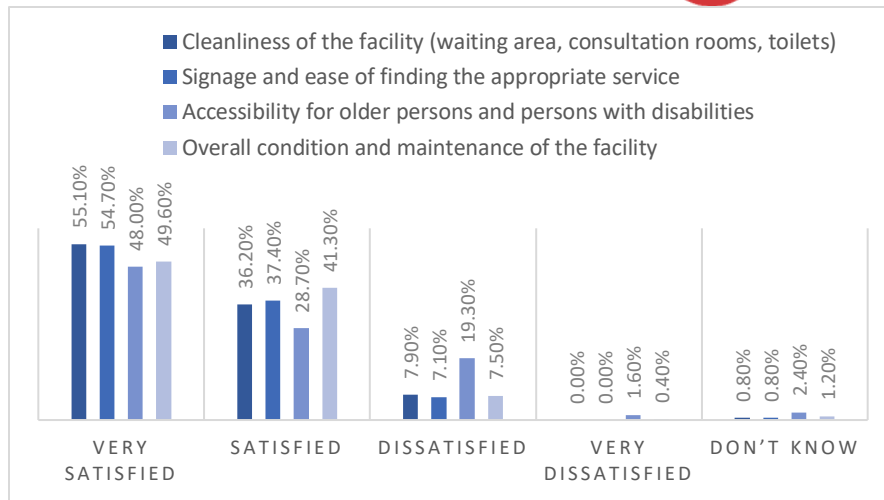


Figure 25: Satisfaction with the Health Center environments

Study participants were also asked to assess the facility's preparedness to respond to health emergencies. Overall, their perceptions of emergency preparedness were positive. Nearly half (48.4%; n = 123) considered the PHC facility very prepared to respond to health emergencies, while 35% (n = 89) considered it somewhat prepared. A relatively small proportion considered the facility not very prepared (5.1%; n = 13) or not prepared at all (0.4%; n = 1), while 9.1% (n = 23) reported that they did not know how prepared the facility was.

A health facility level analysis provides a more detailed picture, showing that the generally positive overall assessment was not uniform across all surveyed facilities.

Table 5: Perceived emergency preparedness by Health Centre

Health Centre	Very prepared	Somewhat prepared	Neither prepared nor unprepared	Not very prepared	Not at all prepared	Don't know	Total n
Gramsh	27 (69.2%)	11 (28.2%)	1 (2.6%)	0	0	0	39
Pukë	28 (75.7%)	8 (21.6%)	0	1 (2.7%)	0	0	37
Cërrik	17 (50%)	11 (32.4%)	0	5 (14.7%)	0	1 (2.9%)	34
Dajç	20 (60.6%)	13 (39.4%)	0	0	0	0	33
Fushë-Krujë	5 (15.2%)	12 (36.4%)	0	0	1 (3%)	15 (45.5%)	33

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Përmet	15 (46.9%)	12 (37.5%)	4 (12.5%)	1 (3.1%)	0	0	32
Vorë	0	10 (66.7%)	0	5 (33.3%)	0	0	15
Others	11 (35.5%)	12 (38.7%)	0	1 (3.2%)	0	7 (22.6%)	31

Perceptions were particularly positive in Dajç, where all participants considered the facility either very or somewhat prepared, and in Gramsh and Pukë, where positive assessments reached 97.4% and 97.3%, respectively. In Cërrik, 82.4% considered the facility very or somewhat prepared. However, 14.7% reported that it was not very prepared, indicating a less consistently positive assessment than in Gramsh, Pukë and Dajç.

A different pattern was observed in Vorë. Although two thirds of participants (66.7%) considered the facility somewhat prepared, none selected “very prepared”, while one third (33.3%; n=5) considered it not very prepared. This represents the highest proportion of explicitly negative assessments among the individual health centers.

Fushë-Krujë also stands out but for a different reason. Just over half of participants (51.5%) considered the facility very or somewhat prepared, while 45.5% (n=15) selected “don’t know”. Similarly, among participants grouped under “Other facilities”, 74.2% gave a positive assessment, while 22.6% reported that they did not know.

3.2.7 Patient feedback and complaint mechanisms

Study participants were asked about their opportunities to provide feedback on the services they receive, their awareness and information level on complaint and feedback mechanisms, and their experience of using these mechanisms.

More than half of participants (56.7%; n=144) reported that they had an opportunity to provide comments or feedback on the services they received. However, 33.1% of the participants (n=84) did not know whether such opportunity was available, while 10.2% (n=26) stated that they did not have an opportunity to provide feedback. The relatively high proportion of “don’t know” responses suggests that feedback opportunities may not be sufficiently visible or clearly communicated to all patients. This highlights the need for clearer information about available feedback mechanisms and how to use them.



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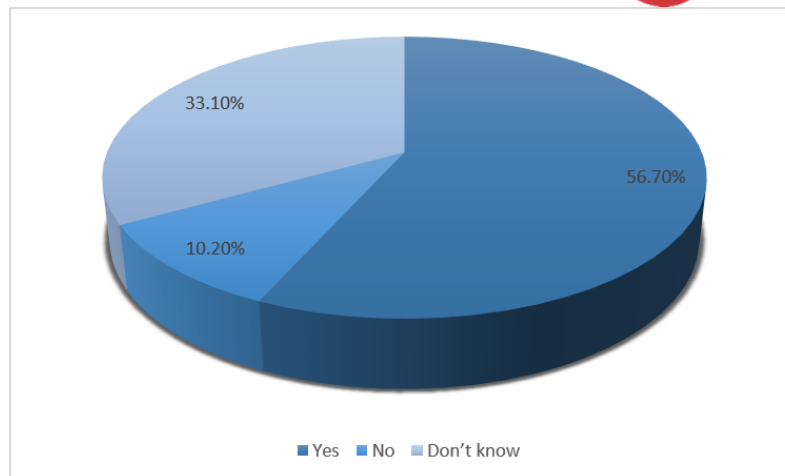


Figure 26: Opportunities for patients to provide feedback on health services

A similar pattern emerged when participants were asked whether they knew where to submit a complaint or provide feedback on the health services they received. Slightly more than half (54.7%; n=139) reported knowing where to do so, while 45.3% (n=115) did not.

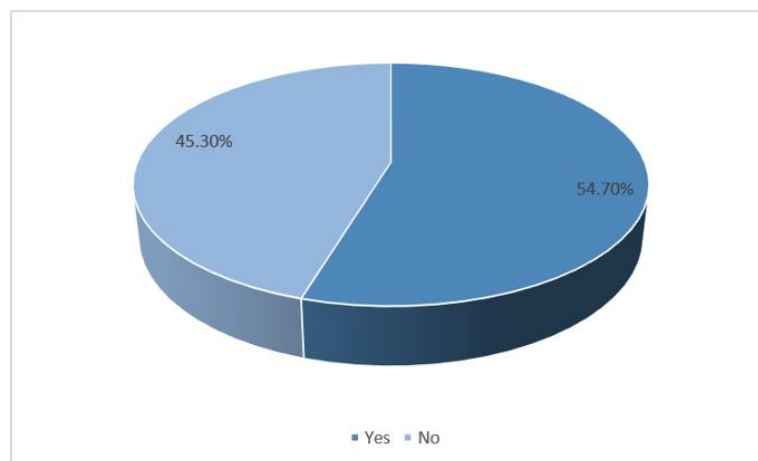


Figure 27: Patients aware of where to submit complaints and feedback

Awareness was lower when the question addressed the complaint process more specifically. Only 42.9% (n=109) reported knowing how to submit a complaint and how it would be handled by the health center, compared with 57.1% (n=145) who did not. These findings indicate that a significant number of participants lacked clear information about the channels available for raising concerns and the process that follows once a complaint is submitted to the health center management staff.



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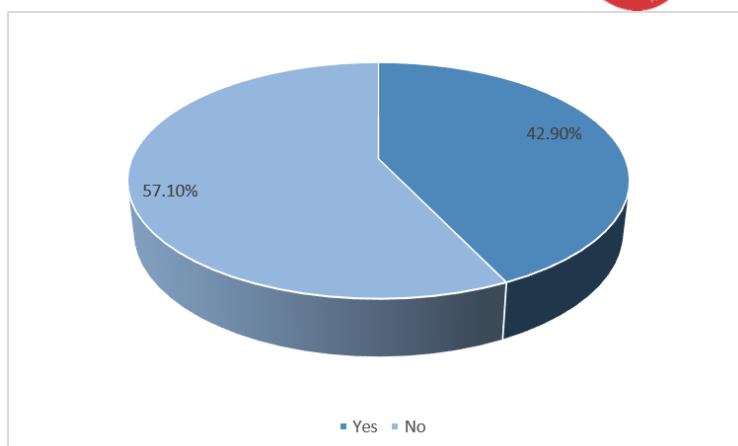


Figure 28: Patients awareness of complaint submission and handling at the PHC

Actual use of feedback mechanisms was considerably less common. Only 17.7% of participants (n=45) reported having used a mechanism to provide feedback about this health center, while 82.3% (n=209) did not.

This low level of use of feedback mechanisms should not necessarily be interpreted as patients' lack of willingness to provide feedback. Rather, when considered alongside the gaps in awareness described above, the findings suggest that limited knowledge of available feedback and complaint channels may be one factor contributing to their limited use. Other factors, such as limited confidence that feedback or complaints will lead to an appropriate response, may also influence patients' use of these mechanisms. However, these factors were not explored in the survey and would require further investigation.

Among the 45 participants who had used a feedback mechanism, verbal complaints to health center staff were the most reported approach, accounting for 42.2% (n = 19) of responses. Written complaint forms were reported by 26.7% (n = 12), while 13.3% (n = 6) reported using the social media channels of public institutions. Only one participant (2.2%) reported using an electronic complaint platform, such as Doctors for Albania¹³ or the Co-Government Platform¹⁴. The remaining 15.6% (n = 7) selected "other" mechanisms. The responses provided under the "other" category included direct communication with the health center director or management, use of the complaint box at the health facility, contacting public institutions through their social media accounts and participation in a municipal public hearing.

¹³ <https://mjeke.shendetesia.gov.al/>

¹⁴ <https://shqiperiaqeduam.al/>





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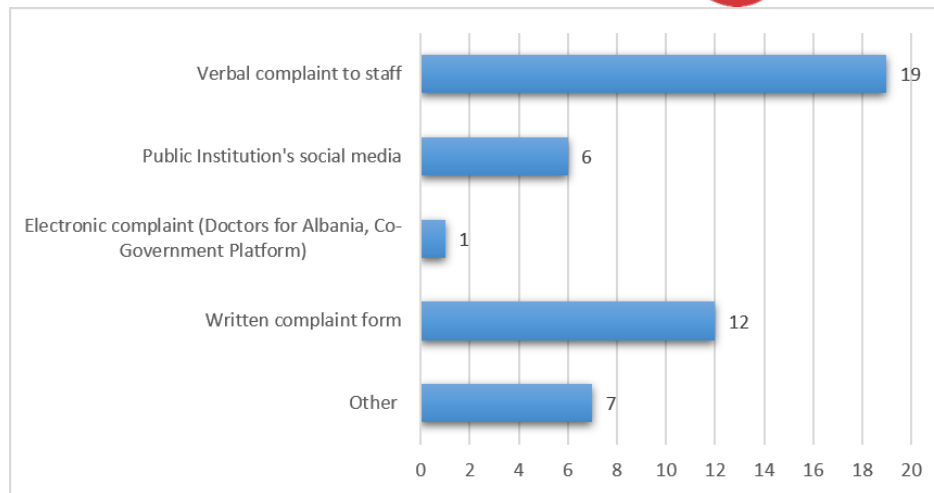


Figure 29: Types of feedback mechanisms used

In the follow-up question on responses to complaints, 37 participants reported having submitted a complaint, while eight indicated that they had not. Of those who had submitted a complaint, 25 (67.6%) reported receiving a response and 12 (32.4%) did not. The analysis does not distinguish between anonymous complaints and those submitted with contact details, which may affect whether an individual response was possible. These findings describe reported receipt of a response and do not establish whether complaints were reviewed or acted upon.

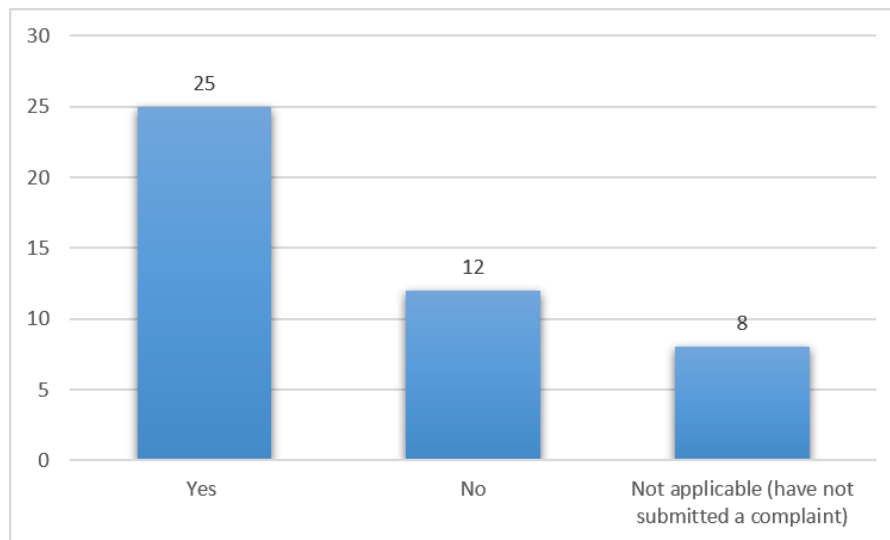


Figure 30: Response to complaints submitted



4. Conclusions

The findings provide a generally positive picture of patients' experiences with primary health care (PHC) services in the surveyed SOLIDAR project areas. Across several dimensions of care, participants reported positive experiences, particularly in relation to waiting times, communication with healthcare professionals, privacy and respectful treatment, the physical environment of health centers and overall satisfaction with the services received. However, the survey identifies specific areas where the patient experience could be improved, particularly regarding accessibility for older adults and persons with disabilities, consistency of information and communication about treatment and referrals, awareness and use of patient feedback mechanisms, and some aspects of perceived emergency preparedness.

Geographical access to the surveyed health facilities appears relatively positive for the participants included in the study. More than nine in ten patients reached their health center within 30 minutes and a substantial proportion had used PHC services several times during the last three months. This indicates that the survey largely captured the experience of patients with recent and, in many cases, repeated contact with primary care services. Waiting times on the day of the survey were also generally short: 94.1% of participants reported being seen by healthcare professionals within 30 minutes, with more than two-thirds waiting less than 15 minutes.

Communication with healthcare professionals emerged as one of the strongest dimensions of patient experience. Most participants reported being able to explain their health concerns, ask questions, receive satisfactory answers and discuss their health problems with the healthcare professional. Almost all study participants reported that their privacy was respected and that they were treated politely during their visit. These findings are important because they indicate that the interpersonal aspects of care, including listening, respect, participation and confidentiality, were experienced positively by most patients surveyed.

Communication was not equally consistent across all stages of the consultation with healthcare professionals. Information about patients' health problems and the examinations performed was reported more consistently than explanations related to prescriptions, how medicines should be taken and the reasons for specialist referrals. Although majority of participants reported positively on these aspects of communication, the differences suggest a need to improve the consistency of information provided about next steps in care, particularly when medication, diagnostic testing or referral are required. This also highlights the importance of upholding patients' right to clear, understandable and relevant information about their care, including how prescribed medicines should be used and combined, the purpose of diagnostic tests, and the reasons for referral to other specialists or healthcare providers.



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The Health Centre-level analysis also shows that the generally positive overall findings were not consistent across all facilities. Communication indicators were particularly strong in Pukë, Gramsh and Dajç, while lower results were observed for individual indicators in some other facilities. Health advice showed particularly notable variation, with lower proportions reported in Vorë, Fushë-Krujë and among participants for other facilities.

Direct payments at health centers on the day of the survey were uncommon, with more than nine in ten participants reporting no payment and there is little difference between those with and without a valid health-insurance card or booklet. However, the absence of payment at the health center does not necessarily mean that obtaining care was free of expense. Some participants described costs incurred outside the center for medicines, intravenous fluids, other medical supplies and certain specialist services. A small number also reported informal monetary gestures to healthcare staff. These responses require further attention and observation, since the survey does not provide sufficient information to assess how frequently such practices occur or the circumstances in which they take place.

Patients also described PHC facilities as an important point of contact for emergency health needs. More than half of participants reported that they would first seek care at a PHC facility in an emergency case, while most stated that their recent emergency had been managed at PHC level. Among those whose last recent emergency was managed elsewhere, the need for hospital-level care or referral to another facility was the most reported reasons. As the survey did not collect information on the type or clinical severity of these emergencies, these findings describe patients' reported pathways for seeking emergency care and should not be interpreted as an assessment of the clinical capacity of PHC facilities to manage emergency conditions.

Overall satisfaction with the services received was high, with 96% of participants reporting that they were either satisfied or very satisfied with their visit. Similarly, high levels of satisfaction were reported among participants whose most recent emergency had been managed at the PHC facility. These findings are consistent with the generally positive results observed for waiting times, communication with healthcare professionals, privacy and respectful treatment. However, patient satisfaction reflects participants' reported experiences and perceptions of care and should not be interpreted as a measure of technical quality, clinical outcomes or compliance with professional standards.

Participants were also generally satisfied with the physical environment of the health centers surveyed. Cleanliness, signage, and the overall condition and maintenance of the facilities were assessed positively. Accessibility for older adults and persons with disabilities received fewer positive assessments, with around one in five participants expressing dissatisfaction. This was the



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least positively assessed aspect of the facility environment and indicates an area where further attention may be needed, to improve the situation.

Participants' perceptions of emergency preparedness were positive overall, although differences were observed between facilities. Confidence in preparedness was particularly high in Gramsh, Pukë and Dajç. In Vorë, a higher proportion of participants considered the facility not very prepared, while in Fushë-Krujë a relatively large proportion reported that they did not know whether the facility was prepared. As these findings reflect patients' perceptions, they should not be interpreted as an objective assessment of emergency preparedness. However, the differences between facilities indicate areas that may warrant further examination alongside objective information on emergency protocols, staffing, equipment, medicines and referral arrangements.

Patient feedback and complaint mechanisms emerged as an area where greater clarity may be needed. While slightly more than half of participants reported having an opportunity to provide feedback or knowing where to submit a complaint or comment, fewer were familiar with how the complaint process worked. Actual use of feedback and complaint mechanisms was also limited and participants who had used them mostly relied on direct verbal communication with health center staff rather than on institutional mechanisms. Among those who reported having submitted a complaint, around one third stated that they had not received a response. Overall, the findings indicate a need for clearer information on available feedback channels, how complaints can be submitted and what patients can expect after doing so. Strengthening transparency on the complaint process, including patient confidentiality, handling and resolution of complaints, and the follow-up provided to patients, may also contribute to greater trust and confidence in the use of these mechanisms.

The findings show a generally positive patient experience across the surveyed PHC facilities, particularly in relation to several interpersonal and organizational aspects of care. At the same time, the results identify specific areas where experiences were less consistent across facilities or aspects of service delivery. These include physical accessibility, communication related to medicines and referrals, awareness and use of feedback and complaint mechanisms, as well as differences between facilities in communication and perceived emergency preparedness. Addressing these areas could help promote a more consistent and patient-responsive experience of PHC services across the surveyed locations.



5. Recommendations

The study findings highlight the need to consolidate practices that patients already value, while addressing a few clearly identified areas for improvement. The recommendations therefore focus on practical actions for the PHC facilities surveyed.

1. Maintain and reinforce good practices in patient-healthcare professional communication

The high levels of reported respectful treatment, privacy and opportunities to ask questions and responsiveness from healthcare professionals should be maintained as core standards of care. Facility managers should continue reinforcing these practices through routine supervision, staff orientation and patient-experience monitoring. Attention should be given to the aspects of communication that were less consistently reported. Healthcare professionals should routinely explain the purpose of prescribed medicines, how they should be taken, the reasons for diagnostic tests and the reasons for referral to another provider or specialist. A simple consultation checklist or communication standard could help ensure that these explanations are provided consistently, particularly where a patient's care continues beyond the immediate consultation.

2. Improve physical accessibility for older adults and people with disabilities

Accessibility should be treated as a priority for facility improvement because it was the aspect of the health center environment with the highest level of dissatisfaction. Each participating facility should undertake a basic accessibility assessment covering access to and entry into the building, ramps and stairs, doorways, internal movement, waiting areas, consultation rooms, toilets and signage. Where deficiencies are identified, facilities should prepare feasible improvement plans, giving priority to barriers that prevent or significantly hinder independent access or safe movement.

3. Make patient feedback and complaint procedures visible, simple and understandable

Health centers should clearly explain where and how patients can provide feedback or submit a complaint. A simple guide should describe how complaints are received, reviewed, addressed and followed up. It should identify responsible staff and expected timeframes. This information should be written in plain language and displayed prominently in waiting areas and other patient spaces. Confidentiality and protection from negative consequences should be core principles of the mechanism. Patients and family members should know that they can submit complaints anonymously and that all complaints will be handled confidentially. They should feel free to raise concerns without fear of pressure, intimidation or neglect. They should also be reassured that

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making a complaint will not adversely affect their care. Several safe and accessible channels should be available. These may include speaking with a doctor, designated staff or the center director, submitting a written complaint at the center, or sending one by post. A complaint box should also be available in an accessible but discreet location. All complaints, including anonymous ones, should be recorded, reviewed and followed up within defined timeframes. Where contact details are available, staff should acknowledge receipt and provide an individual response. For anonymous complaints, centers should explain how general updates on actions taken will be shared while protecting confidentiality.

4. Use patient feedback systematically for quality improvement

Health centers should periodically review complaints and other feedback together to identify recurring problems and priorities for improvement. Findings should inform specific corrective actions, with assigned responsibilities and deadlines, and progress should be monitored to assess whether the problems have been addressed. A summary of improvements made in response to patient feedback should be shared in accessible formats, while protecting confidentiality.

5. Assess patient expenditure on medicines and medical supplies

Although direct payments at PHC facilities surveyed were uncommon, the open-ended responses indicate that some patients paid for medicines and medical supplies obtained elsewhere. The availability of commonly required medicines and medical supplies, such as syringes and intravenous fluids, should therefore be assessed, to ensure proper response to the needs of the patients. Facilities and relevant health authorities should review whether patients are required to purchase items externally because they are not routinely available at PHC level, how often this occurs, and which medicines or supplies are most involved. This would help identify systematic availability gaps and provide a stronger basis for targeted action. Any future assessment of financial access should measure the full cost of seeking care, including medicines, diagnostics, transport and services obtained outside the PHC facility rather than considering only payments made at the health center.

6. Review emergency preparedness of PHC using objective facility-level criteria

The generally positive patient perception of emergency preparedness should be complemented by an objective assessment of readiness. Such an assessment should consider availability of essential equipment and medicines, availability and competencies of staff, emergency procedures, communication arrangements, stabilization capacity and referral pathways. Facilities where perceptions were less positive or where many participants were unable to assess preparedness, particularly Vorë and Fushë-Krujë in this survey, could be prioritized for closer



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review. Patient perceptions should be considered alongside, rather than in place of technical readiness assessments. Health centers should also ensure that patients understand which urgent conditions can appropriately be managed at PHC level and when hospital or emergency medical services should be used.



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ANNEXES

PATIENT SATISFACTION QUESTIONNAIRE FOR PRIMARY HEALTH CARE

As part of a Swiss government-funded project, a patient satisfaction assessment is being conducted to evaluate the quality and accessibility of primary health care services. Your feedback will help us identify strengths, areas for improvement, and inform efforts to enhance the quality of health services.

Your participation is entirely voluntary. All responses will be treated with strict confidentiality and will be used solely for research purposes. The questionnaire does not collect personally identifiable information.

Thank you for taking the time to complete this questionnaire!

Informed Consent	Yes / No
Respondent Code	
Health Center	

SECTION 1: PATIENT EXPERIENCE OF RECENT CARE AT THE HEALTH FACILITY

1. Including today's visit, how many times have you visited this Primary Health Care Center during the past three months?

- ☐ Did not access this HC in the past 3 month
- ☐ 1–3 visits
- ☐ More than 3 visits

2. What was the main reason for today's visit?

- ☐ Emergency
- ☐ Hypertension
- ☐ Diabetes
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Dyslipidemia
- ☐ Mental health condition
- ☐ Geriatric care
- ☐ Other chronic disease
- ☐ Other acute (non-chronic) illness
- ☐ Antenatal care (pregnancy)
- ☐ Child health consultation



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- ☐ Child vaccination
- ☐ Other (please specify: _____)

3. Which health professional did you see today?

- ☐ Family physician
- ☐ General practitioner
- ☐ Specialist physician
- ☐ Other (Please specify: _____)

4. Did the health care provider...

(multiple answers allowed)

- ☐ Conduct an examination
- ☐ Write you a prescription
- ☐ Referred to the specialist
- ☐ Referred for test and/or examinations
- ☐ Other (Please specify: _____)

5. Approximately, how long did you wait before your consultation?

- ☐ Less than 15 minutes
- ☐ 15–30 minutes
- ☐ 31–60 minutes
- ☐ More than an hour

6. Approximately how long does it take you to travel from your home to this Health Center?

- ☐ Less than 10 minutes
- ☐ 10–30 minutes
- ☐ 45–60 minutes
- ☐ More than an hour

7. At the beginning of the consultation, were you given enough opportunity to explain your health concern?

- ☐ Yes
- ☐ No

8. During today's visit, did the doctor or nurse ensure your privacy?

- ☐ Yes
- ☐ No



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9. Did the health care provider explain:

	Yes	No
the questioning to you?		
the physical examination to you?		
your health problem to you?		
the prescription to you?		
the reason for the referral to you?		
the reason for additional tests or examinations to you?		
the intake of prescribed medicines to you?		

10. Did the doctor or nurse ask whether you were currently taking any other medications?

- ☐ Yes
☐ No

11. Did the health care provider listen carefully to your concerns and questions and did he/she give satisfactory answers?

- ☐ Yes
☐ No

12. Did the health care provider listen carefully to your concerns and questions and did he/she give satisfactory answers?

- ☐ Yes
☐ No

13. During consultation, did you get any advice on your health problem?

- ☐ Yes
☐ No

14. Was the health care provider polite during consultation?

- ☐ Yes
☐ No

15. Did you pay for any of the services you received today?

- ☐ Yes
☐ No

16. If yes, what did you pay for?

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17. Overall, how satisfied are you with the service you received today?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

SECTION 2: AVAILABILITY OF EMERGENCY SERVICES AND PATIENT FEEDBACK

18. When you experience a health emergency, where do you first seek care?

- ☐ This primary health care facility
- ☐ Hospital
- ☐ Private clinic
- ☐ Other (specify)

19. Was your most recent emergency managed at this primary health care facility?

- ☐ Yes
- ☐ No

20. If yes, how satisfied were you with the management of your most recent emergency at this facility?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

21. If not, what was the main reason you needed to seek care elsewhere?

- ☐ The health center did not provide the required service/treatment
- ☐ Condition required hospital-level care
- ☐ Lack of equipment, medicines, or diagnostic capacity at the health center
- ☐ No available staff at the time of visit
- ☐ Referred by health center staff to another facility
- ☐ Preferred to seek care from a private provider
- ☐ Other (specify: _____)

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22. Based on your experience or what you know, how prepared do you think this PHC facility is to respond to health emergencies (e.g., disease outbreaks, natural disasters, or other public health emergencies)?

- ☐ Very prepared
☐ Somewhat prepared
☐ Neither prepared nor unprepared
☐ Not very prepared
☐ Not prepared at all
☐ Don't know

23. How satisfied are you with the following:

	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Irrelevant/Do not know
Cleanliness of the facility (waiting area, consultation rooms, toilets)	☐	☐	☐	☐	☐
Signage and ease of finding the appropriate service	☐	☐	☐	☐	☐
Accessibility for older persons and persons with disabilities	☐	☐	☐	☐	☐
Overall condition and maintenance of the facility	☐	☐	☐	☐	☐

24. Do patients have the opportunity to provide feedback on the services they receive?

- ☐ Yes
☐ No
☐ Don't know

25. Do you know where you can submit a complaint or provide feedback about the services?

- ☐ Yes
☐ No

26. Have you ever used a complaint box or any other feedback mechanism at this health facility?



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☐ Yes

☐ No

27. If yes, which mechanism did you use?

☐ Verbal complaint to staff

☐ Written complaint form

☐ Electronic complaint (Mjeke per Shqiperine, Platforma e Bashkeqeverisjes)

☐ Public Institution's social media

☐ Other (please specify: _____)

28. If you have submitted a complaint, did you receive a response?

☐ Yes

☐ No

☐ Not applicable (have not submitted a complaint)

29. Have you been informed about how to submit a complaint and how it will be handled at this facility?

☐ Yes

☐ No

☐ Don't know

SECTION 3: SOCIO-ECONOMIC PROFILE

30. Location (District):

31. Age:

32. Gender:

☐ Male

☐ Female

33. What is the highest level of education you have completed?

☐ No formal education

☐ Primary education (up to Grade 4/5)

☐ Lower secondary education (8/9 years)

☐ Upper secondary education (12 years)

☐ University degree

☐ Other

34. What is your current employment status?

☐ Farmer



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- ☐ Employed
- ☐ Self-employed/business owner
- ☐ Homemaker
- ☐ Public sector employee (including teachers)
- ☐ Unemployed
- ☐ Retired
- ☐ Other

35. Do you have a valid health insurance card/booklet?

- ☐ Yes
- ☐ No

36. Do you benefit from any social assistance or economic support scheme?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

37. Do you identify yourself as belonging to an ethnic minority?

- ☐ Yes (Please specify: _____)
- ☐ No
- ☐ Prefer not to answer



PATIENT SATISFACTION WITH PRIMARY HEALTH CARE IN SOLIDAR PROJECT AREAS



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