SOLIDAR

BASHKË NË EMERGJENCAT SHËNDETËSORE

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SURVEY REPORT

ON PERCEIVED NEEDS AND VULNERABILITIES IN HEALTHCARE SERVICES

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency for Development and Cooperation SDC

Suedi Sverige

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TFL TOGETHER FOR LIFE

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List of Acronyms

CHIF – Compulsory Health Insurance Fund

CRN – Community Resilience Networks

SSA – Supreme State Audit

MHSW – Ministry of Health and Social Welfare

WHO – World Health Organization

TFL – Together for Life

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1. Introduction

This public survey report presents findings on citizens' perceptions regarding needs, vulnerabilities, and gaps in healthcare services, serving as a guiding tool for identifying key priorities for intervention. It aims to provide a comprehensive, evidence-based overview of the challenges citizens face in accessing, affording, and receiving quality healthcare services, as well as their level of information and communication with relevant institutions. In this sense, the report not only documents perceptions, but also translates them into a concrete basis for more informed planning and decision-making.

The importance of this report is closely linked to the fact that it is based on data collected directly from the community through an independent and impartial process led by the Together for Life (TFL) association. This approach creates conditions for citizens to freely express their opinions and experiences without fear of possible consequences, significantly increasing the credibility and authenticity of the data collected. Although formal institutional mechanisms are available to citizens, such as the co-governance platform or official channels for complaints and suggestions, these often remain underutilized due to limited internet access, low levels of trust in institutions, or lack of awareness of these tools. In contrast, the survey conducted by TFL offers a more inclusive and accessible alternative for assessing perceptions. Furthermore, this research and advocacy approach empowers citizens by actively involving them in articulating concerns and in advocacy processes.

As part of the implementation of the **SOLIDAR project – "Together in Health Emergencies,"** and particularly under its third component aimed at strengthening community engagement, this survey on healthcare service beneficiaries' perceptions was conducted during March–April 2026. Its findings constitute an important basis for targeted interventions and will be used directly for local-level advocacy. Evidence-based advocacy is essential for effectively addressing the issues identified, promoting concrete improvements in the quality and accessibility of services, and increasing the accountability of public institutions. In this regard, the report serves as a bridge between citizens' voices and policymaking, ensuring that the real needs of communities are reflected in decision-making.

The report also sheds light on marginalized groups by identifying the categories perceived as most deprived of access to healthcare services, as well as the factors contributing to this exclusion. At the same time, it analyzes gaps in information and communication between institutions and citizens, which directly affect the use of and benefit from existing services. This makes the report an important instrument for guiding more inclusive interventions that are responsive to the needs of vulnerable groups and grounded in realities on the ground.

The study's findings and recommendations will be validated through a series of roundtables in **Gramsh, Cërrik, Fushë Krujë, Vorë, Pukë, Dajç, and Përmet**, with the active participation of community members and local stakeholders. This process aims not only to verify the results, but also to build shared consensus on priorities and possible solutions, thereby increasing local ownership of the process. Based on these validated findings, members of the Community Resilience Networks (CRNs) will engage in structured local-level advocacy by interacting with relevant institutions to seek concrete improvements in service delivery and greater inclusiveness in access.

Beyond the information and communication dimension, the findings of this report also provide important indications regarding the level of preparedness of both communities and the primary health carë system to respond to health emergencies. Reported barriers to access, including high healthcare costs, transportation difficulties, shortages of medicines and specialists, and the postponement of care for economic reasons—suggest that factors limiting access under normal circumstances may become even more pronounced during emergency situations. At the same time, the partial level of information regarding available services during emergencies points to the need for stronger public communication and greater community awareness. These findings underscore the importance of investing not only in emergency response capacities, but also in strengthening the resilience of the health system and communities, particularly among the most vulnerable groups.

The complex nature of health emergency preparedness calls for more in-depth research to better understand patients' experiences when accessing healthcare services, particularly in situations requiring rapid and sustained responses, such as pandemics. In this regard, assessing patient satisfaction with healthcare services, with a particular focus on emergency care, could generate additional evidence on the effectiveness of response mechanisms, the accessibility of services, the quality of communication with patients, and the health system's capacity to respond to citizens' needs during emergencies. Such an approach would contribute to strengthening citizen feedback mechanisms and identifying concrete opportunities to enhance the preparedness and resilience of the health system.

2. Methodology

2.1 Methodological approach

This study is based on a quantitative approach, which aims to collect and analyze structured data in order to identify patterns, trends, and differences in citizens' perceptions regarding healthcare services. This approach enables comparability across different respondent groups and provides a solid foundation for analysis and use in advocacy processes.

2.2 Data collection instrument

The instrument used was a semi-structured questionnaire, designed to balance the need for standardized data with the opportunity to capture nuances in respondents' experiences. The questionnaire (Annex 2) included sections on: demographic data, use of healthcare services, access to services, economic affordability, service needs and gaps, as well as issues related to vulnerability, equity, and exclusion. A separate section addressed communication and information exchange between citizens and institutions.

2.3 Sampling

The selection of respondents was guided by the aim of ensuring a diversity of experiences and profiles, including different population groups with high needs for healthcare services. In particular, respondents were included whose households comprised elderly persons (over 65 years old), persons with disabilities, persons with chronic illnesses, pregnant women, and children under 5 years old. This approach aimed to provide a more comprehensive picture of needs and challenges. Detailed demographic data, as well as the geographic distribution of the sample, are presented in Annex 1.

2.4 Data collection and analysis

The questionnaire was distributed randomly within the CRN networks, with the aim of collecting concrete data from the respective communities. In total, 339 respondents are included in this study. Data collection was carried out primarily through face-to-face interviews, during which responses were recorded in real time on the Google Forms platform, increasing the accuracy and efficiency of the data entry process. At the same time, the questionnaire was also distributed online through TFL's social media networks, enabling the inclusion of a broader audience.

Following data collection, the data were exported and processed in Microsoft Excel, where they were cleaned, structured, and analyzed. The use of Excel enabled not only descriptive data analysis (frequencies, percentages, and comparisons across groups), but also the thematic coding of responses to open-ended questions. For survey questions with fewer than 20 responses, findings are reported in absolute numbers (n) rather than percentages

(%), as the interpretation of percentages in such cases is methodologically less reliable due to the limited sample size.

2.5 Ethical considerations

The study was conducted in accordance with ethical research principles, ensuring voluntary participation, informed consent, anonymity, and confidentiality. Data were handled securely, and no personally identifiable information was collected or published.

2.6 Study limitations

The study presents several limitations that should be taken into account when interpreting the findings. The statistical sample size (339 questionnaires) remains limited for drawing generalizable conclusions at the national level. The geographic focus on areas where CRNs operate may limit the representation of other areas, making caution necessary when generalizing the results beyond these communities. However, the inclusion of diverse communities and varied respondent categories contributes to strengthening the validity of the findings at the local and programmatic levels.

Another limitation relates to the self-reported nature of the data, which relies on respondents' subjective perceptions and may be influenced by memory, personal experience, or individual expectations. As a result, the findings reflect how services are perceived and not necessarily their objective performance.

Despite these limitations, the methodology applied provides a solid basis for understanding citizens' perceptions and for informing evidence-based interventions and advocacy processes.

3. Use of healthcare services

The use of primary health services is considered a key indicator of effective access and the functioning of the system. In the Albanian context, existing evidence shows that access to services continues to be influenced by factors such as out-of-pocket costs, the geographical distribution of services, and their organization. Strategic documents of the Ministry of Health and Social Welfare (MoHSW), including the National Health Strategy 2021–2030[1], emphasize that reducing out-of-pocket payments, improving access in rural areas, and strengthening primary healthcare remain key priorities for the country's health system. These documents also underline the importance of increasing the use of preventive and early intervention services as a way to improve health outcomes and reduce long-term costs.

To analyze these dynamics, this chapter presents an assessment of citizens' use of health services, focusing on the level of interaction with the system, the types of services used, the frequency of use, the first points of contact, as well as the barriers affecting access to and use of these services. Through these indicators, the aim is to understand not only how often and which services are used, but also the reasons why part of the population remains outside the system or does not receive the necessary care in a timely manner, thereby providing a solid basis for identifying gaps and priorities for intervention.

1 in 3 respondents had not visited a doctor at all during the last 12 months

To ensure the analysis focused on the most relevant data, respondents were asked whether they had used any health service during the previous 12 months. Out of the sample of 339 respondents, 64% had used at least one health service during the past year (217 respondents), while 35% of the sample had not used any health service recently (120 respondents). These findings indicate that a considerable proportion of the population remains outside regular interaction with the healthcare system, which may be related both to a lack of perceived need and to barriers in access or use.

When the data were cross-tabulated with respondent categories, it was observed that even within groups usually considered to have higher healthcare needs, there was still a number of individuals (16 respondents) who had not used any service during the last year. Specifically, 7 respondents over the age of 65, 5 people with chronic illnesses, 1 person with disabilities, and 3 family caregivers for people in need reported that they had not used any health service throughout the year.

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[1] Ministry of Health and Social Welfare, *National Health [Strategy Strategjia Kombëtare e Shëndetësisë] 2021–2030*, (Tirana: MSHMS, 2021), https://www.ishp.gov.al/wp-content/uploads/2017/05/Strategjia-Kombetare-e-Shendetesise-2021-2030.pdf.

Although these figures are relatively small, the finding is particularly significant, as it suggests that categories at higher risk for health problems may face barriers in access, may postpone seeking care, or may fail to perceive the need for services in a timely manner. In the case of people with chronic illnesses or older adults, the lack of service utilization (including annual check-ups) may be linked to factors such as medication costs, mobility difficulties, lack of information, or limited trust in services. For family caregivers, meanwhile, this may reflect a greater focus on the person they care for, leading them to neglect their own healthcare needs.

Visits to family doctors and laboratory tests were the most commonly used services during the last 12 months

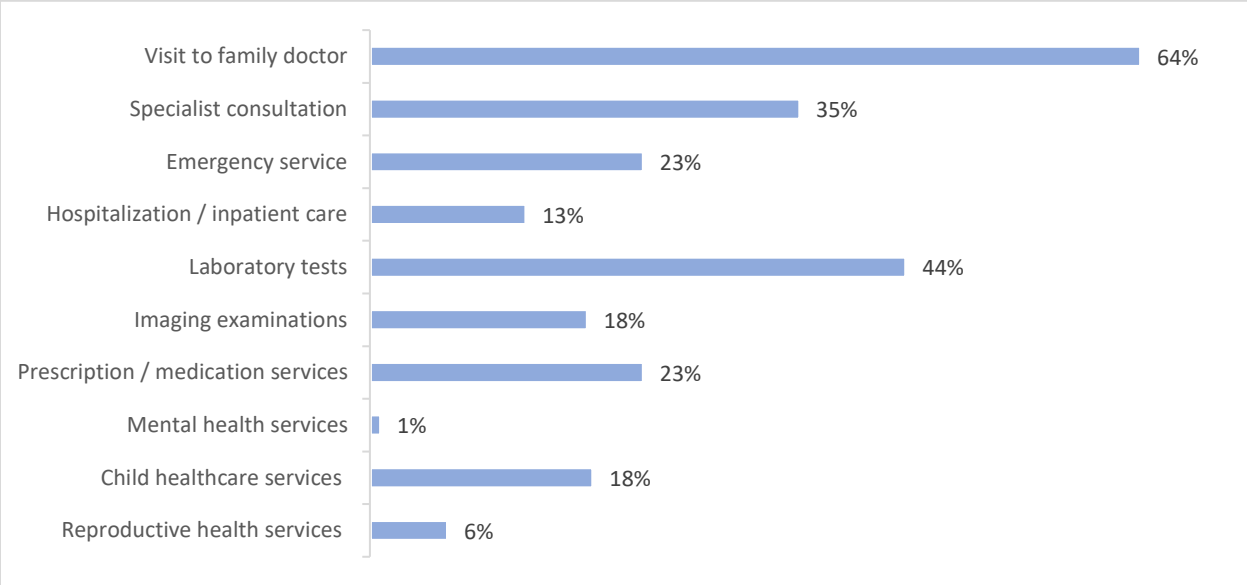
Respondents were further asked what type of health services they had used during the previous 12 months and were allowed to select more than one option from a list of different services. The most needed services among surveyed citizens were visits to family doctors (64%) and laboratory tests (44%). Visits to specialist doctors were also frequent (35%), followed by emergency services (23%) and medication/prescription services (23%).

Other services used by respondents show a more fragmented distribution of healthcare needs, reflecting both the demand for specialized care and access to supportive services. Imaging examinations were used by 18% of respondents, indicating a moderate level of need for advanced diagnostics. Similarly, child healthcare services were reported by 18% of respondents, reflecting the presence of families with children and the demand for pediatric care within the surveyed sample.

A smaller proportion of respondents (13%) reported using hospital services. Meanwhile, reproductive health services were used by 14 respondents, indicating a relatively low level of reporting, which may be related both to access issues and to social and cultural factors influencing the use of these services. Particularly low was the use of mental health services,

reported by only 2 respondents. This result may not necessarily signal a lack of need, but rather strong barriers to access, lack of information, or social stigma.

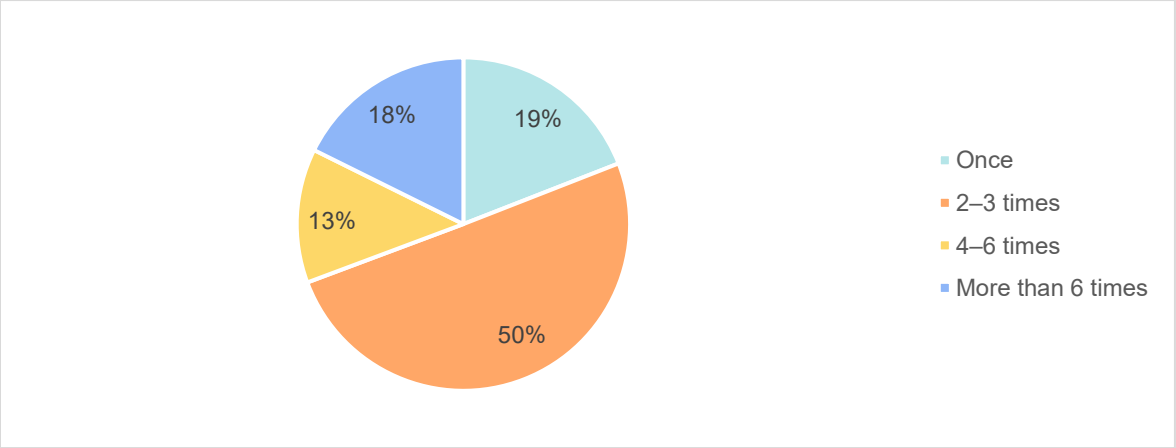
Figure 1 Typologies of health services that respondents have used during the last 12 months (N=217)



1 in 3 respondents used health services at least twice during the last 12 months

Half of the respondents who had used primary health care services during the last 12 months reported using them 2–3 times (50%), while 19% of respondents had used them only once. A smaller number reported more frequent use, specifically 4–6 times (13%) and more than 6 times (18%). These data suggest that interaction with the healthcare system is present for the majority of citizens, though not necessarily frequent for everyone.

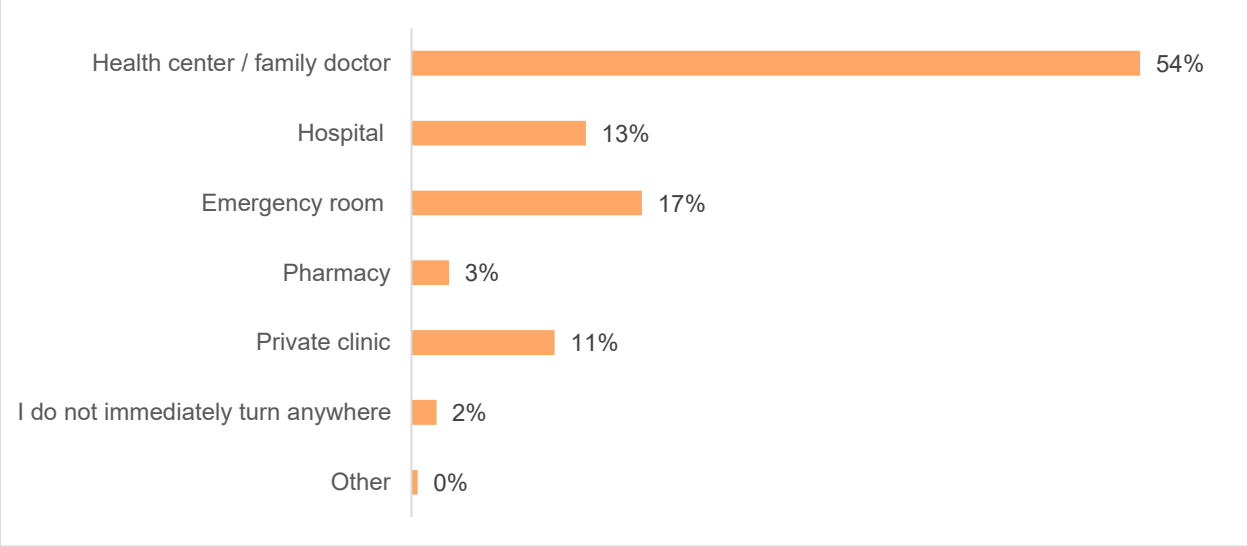
Figure 2 Frequency of use of health services during the last 12 months (N=215)



Health centers and family doctors remain citizens' main entry point into the system

When asked about the first place they usually turn to for healthcare, the overwhelming majority of respondents reported the health center or family doctor (54%), confirming their role as the main gateway to the system. Emergency services were mentioned by 17% of respondents, while hospitals were cited by 13%. A portion of respondents seek care at private clinics (11%), while very few choose pharmacies (6 respondents) as their first point of contact. A very limited number reported that they do not immediately turn anywhere (4 respondents) or choose other alternatives (1 respondent).

Figure 3 First place respondents turn to when they need healthcare (N=216)

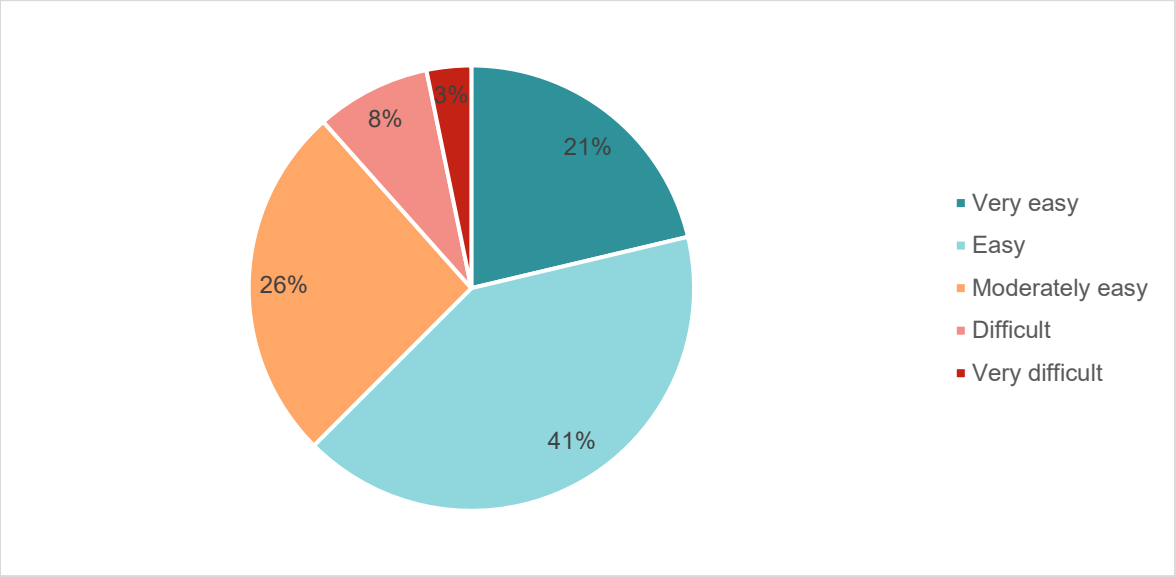


Most respondents know where to seek care within the healthcare system

Respondents who had received services during the previous 12 months were asked how easy it was for them to identify where to obtain the healthcare service they needed. Most perceived this process as relatively easy. Specifically, 41% considered navigation easy and 21% very easy, while 26% assessed it as moderately easy. Nevertheless, some respondents face difficulties, with 18 respondents considering navigation difficult and another 7 very

difficult. These findings indicate that although most people are able to navigate the system, barriers still exist for a segment of the population.

Figure 4 Respondents' ability to navigate the healthcare system to obtain needed services (N=216)



62 reported cases of unmet healthcare needs

To identify cases of unmet healthcare needs, respondents were asked whether there had been situations in which they needed healthcare but were unable to receive it. Only 18% of the total sample (62 respondents) reported that during the last 12 months there had been instances when they needed a service but could not obtain it. Meanwhile, the majority (65%) stated that they had not encountered such a situation, while 15 respondents expressed uncertainty.

High costs and long waiting times remain the main barriers to accessing healthcare

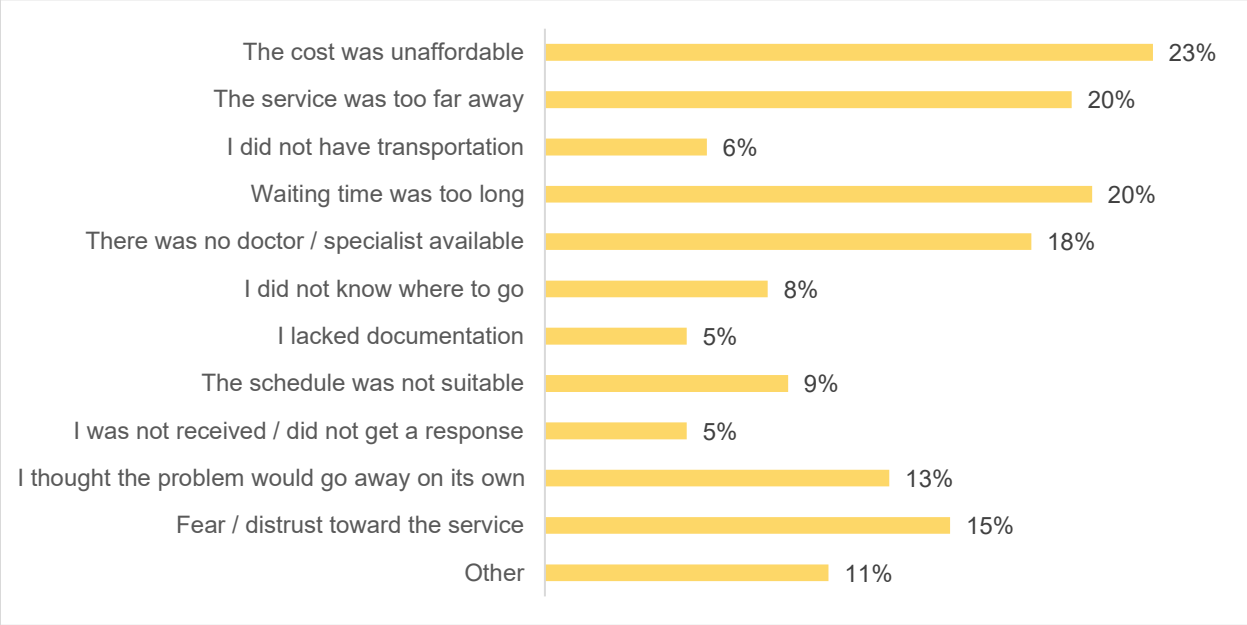
Respondents were further asked about the reasons for not receiving healthcare and were allowed to select more than one option. The most frequent reason was unaffordable costs (23%), followed by long waiting times (20%). For 26 respondents, 12 of whom were residents of rural areas, the needed service was located far from their place of residence. Lack of doctors or specialists was mentioned by 18% of respondents, while other factors such as fear or distrust toward services (20 respondents) and the perception that the problem might resolve on its own (17 respondents) also influenced decision-making.

Some respondents also reported lack of information about where to seek care (11 respondents), inconvenient service hours (12), lack of transportation (8) or documentation (7), as well as cases where they were not received or did not obtain a response (7). The "other" category (14 respondents) suggests the presence of additional factors affecting

access to services, including lack of transportation means to travel to the service location or lack of family members to assist them during treatment.

Among respondents who declared that costs were unaffordable, the majority were employed (29 respondents). At least 16 of them were employed full-time and described their economic situation as average, while 13 other respondents described their economic situation as difficult or very difficult. According to respondents' self-reporting, the cost of services was unaffordable for at least 2 unemployed persons, 1 student, and 1 pensioner.

Figure 5 Reasons for not receiving healthcare (N=133)



In conclusion, the findings of this chapter show that although a significant proportion of citizens interact with the healthcare system, there remains a considerable segment that stays outside it, with 1 in 3 respondents not having used any service during the last 12 months. The structure of service utilization indicates a strong orientation toward primary healthcare, with the family doctor serving as the main entry point. This is consistent with the intended model of the system; however, the fact that utilization remains relatively limited in frequency suggests that this role is not yet being fully leveraged for preventive care and regular monitoring. On the other hand, the very low use of mental health and reproductive health services should not be interpreted as a lack of need, but rather as an indication of deeper barriers such as social stigma, lack of information, or limited access to these services.

The reported reasons for not receiving care further clarify the nature of these barriers. The predominance of cost as the main factor, even among employed individuals, indicates that financial protection remains insufficient and that out-of-pocket expenditures continue to significantly influence decision-making. At the same time, factors such as long waiting times,

distance, and the lack of specialists point to problems in the organization and distribution of services. Meanwhile, reasons such as distrust, fear, or lack of information highlight a perceptual and cultural dimension that affects citizens' behavior.

These findings suggest that the main challenge is not only related to the availability of services, but also to the low level of awareness regarding their effective use. The healthcare system appears to be accessible for the majority of the population, but not equally and not always in a timely manner. This points to the need for integrated interventions that simultaneously address costs, service organization, and public trust, with a particular focus on the most vulnerable groups and on increasing the use of preventive care.

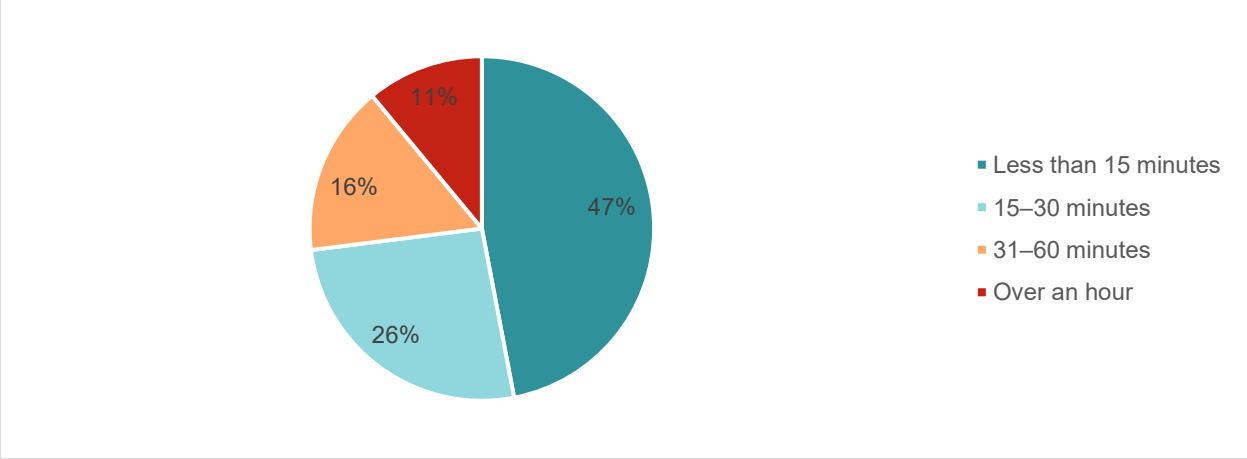
4. Access to healthcare services

This chapter analyzes respondents' perceptions of the key components of access, including distance and travel time to primary healthcare services, means of transportation, waiting times, the suitability of service hours, as well as the concrete difficulties citizens face when interacting with the healthcare system. Through these indicators, the aim is to understand whether access is truly equal and functional for everyone, or whether hidden barriers exist that affect the quality and continuity of healthcare. The analysis of these elements is essential for identifying not only infrastructural and geographical limitations, but also organizational and systemic issues that influence citizens' experiences.

Healthcare services accessible within less than 30 minutes for the majority

Regarding the time needed to reach the healthcare service most frequently used, the majority of respondents reported relatively quick access. Specifically, 47% are able to reach the service in less than 15 minutes, while another 26% do so within 15–30 minutes. A smaller proportion reported longer travel times, namely 31–60 minutes (16%) and more than 1 hour (11%), indicating that for a segment of the sample, distance remains a barrier to access.

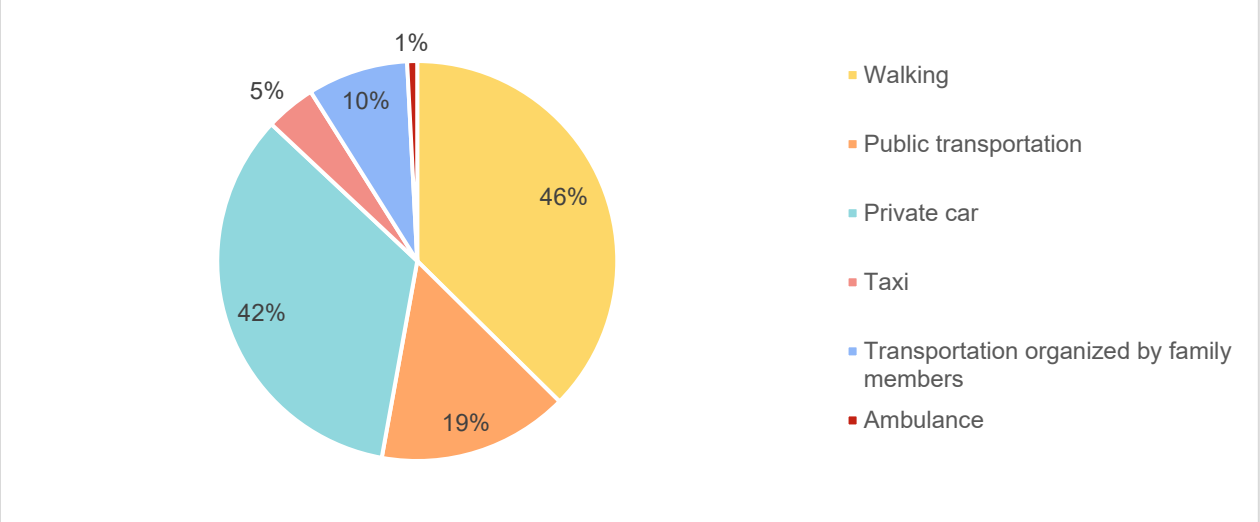
Figure 6 Time needed to reach the most frequently used healthcare service (N=216)



More than half of respondents walk or use private cars to reach healthcare services

When asked what type of transportation they use to reach healthcare services, respondents reported relying mainly on individual or alternative means of transport. A considerable number either walk (46%) or use a private car (42%), while public transportation is used by 19% of respondents. A smaller proportion rely on family members for transportation (10%), taxis (10 respondents), or ambulance services (3 respondents).

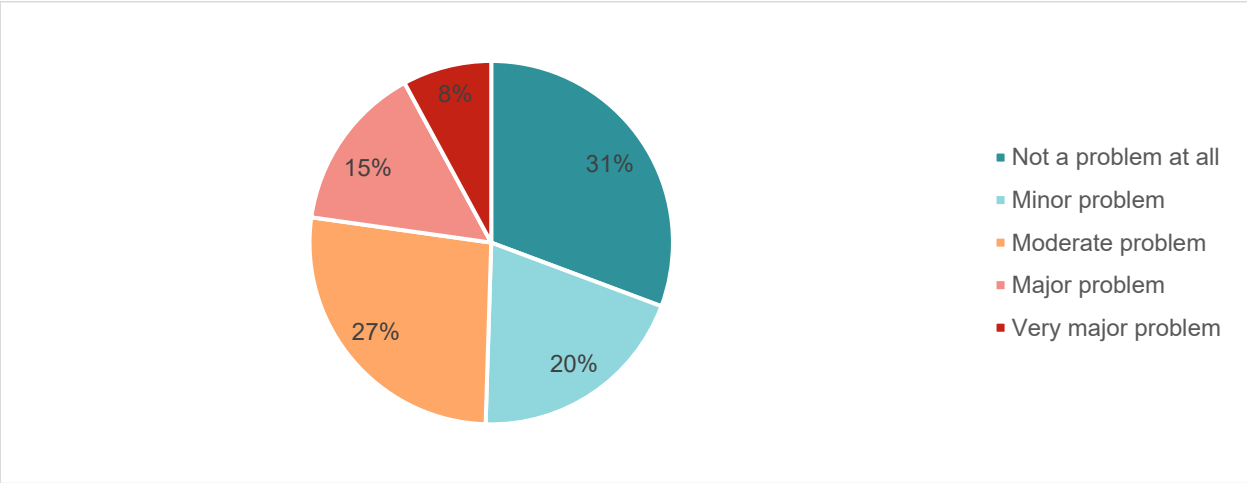
Figure 7 Transportation device used to reach the healthcare service (N=217)



Transportation remains a barrier to healthcare access for 23% of respondents

In assessing the role of transportation as a barrier to obtaining healthcare services, perceptions were divided. While half of the respondents did not consider transportation to be a problem at all (31%) or considered it only a minor issue (20%), a significant proportion viewed it as a challenge: 27% assessed transportation as somewhat problematic, while others described it as a major problem (15%) or a very major problem (17 respondents). This suggests that although transportation is not a barrier for some citizens, for at least 49 respondents (23% of the sample) it remains an important factor affecting access.

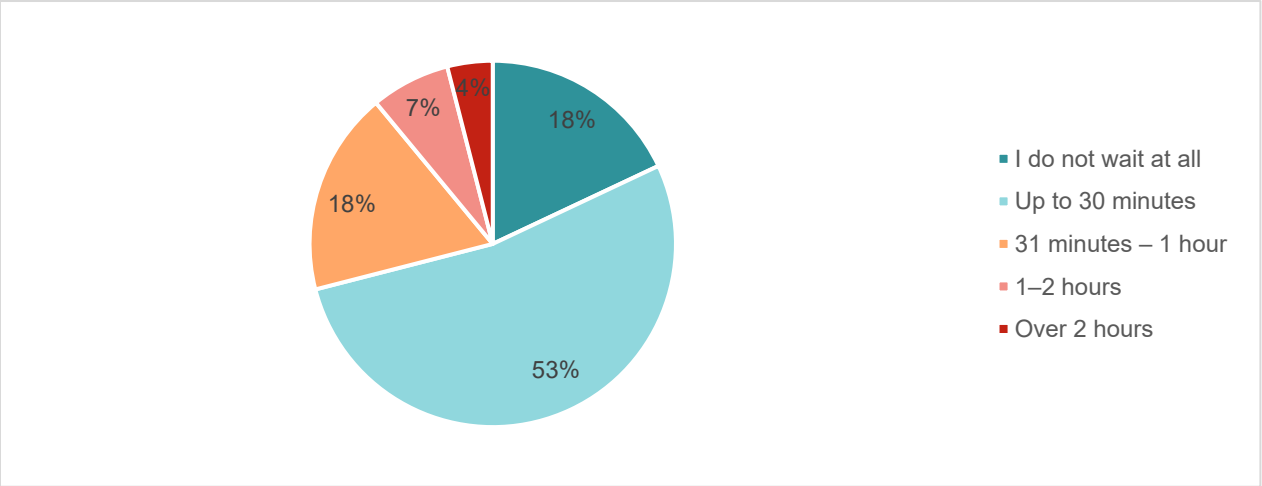
Figure 8 Transportation as a problem in receiving treatment (N=216)



7 in 10 respondents waited less than 30 minutes to receive services

When asked how long they usually wait to receive healthcare services, most respondents reported relatively short waiting times. Specifically, 53% wait up to 30 minutes, while 18% stated that they do not wait at all. However, some respondents experience longer waiting times: 18% wait between 31 minutes and 1 hour, 15 respondents wait 1–2 hours, and another 9 respondents reported waiting more than 2 hours. These findings indicate that although services are relatively prompt for most respondents, significant delays still exist in some cases.

Figure 7 Waiting time to obtain the service (N=217)

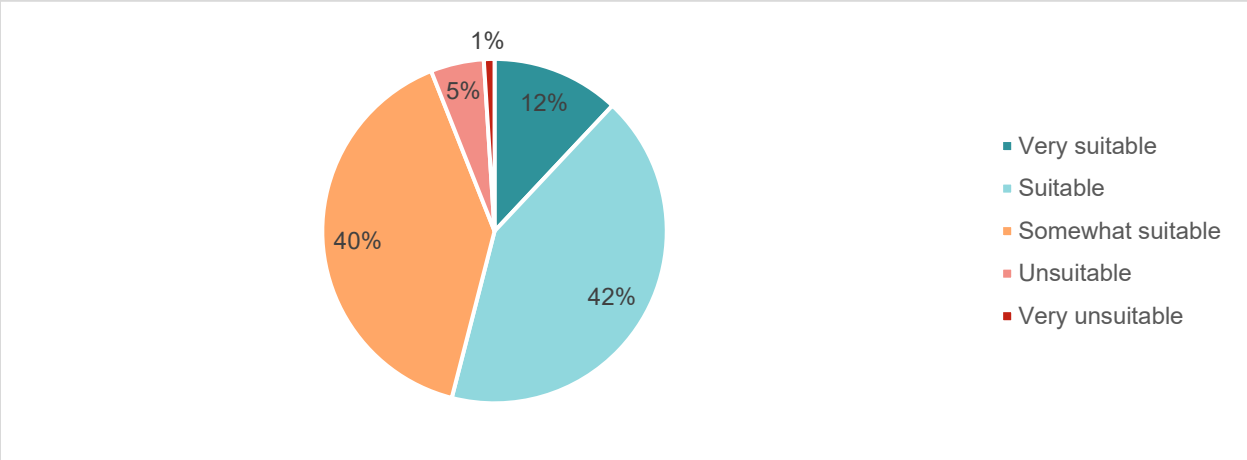


Service hours are suitable for more than half of respondents

Regarding the suitability of service hours, the majority of respondents considered them acceptable. Specifically, 42% assessed them as suitable and 12% as very suitable, while 40% considered them somewhat suitable. Only a limited number of respondents perceived service hours as unsuitable (11 respondents) or very unsuitable (3 respondents). This

suggests a relatively good level of adaptation of service schedules, although there is still room for improvement.

Figure 8 Suitability of service hours for respondents (N=216)

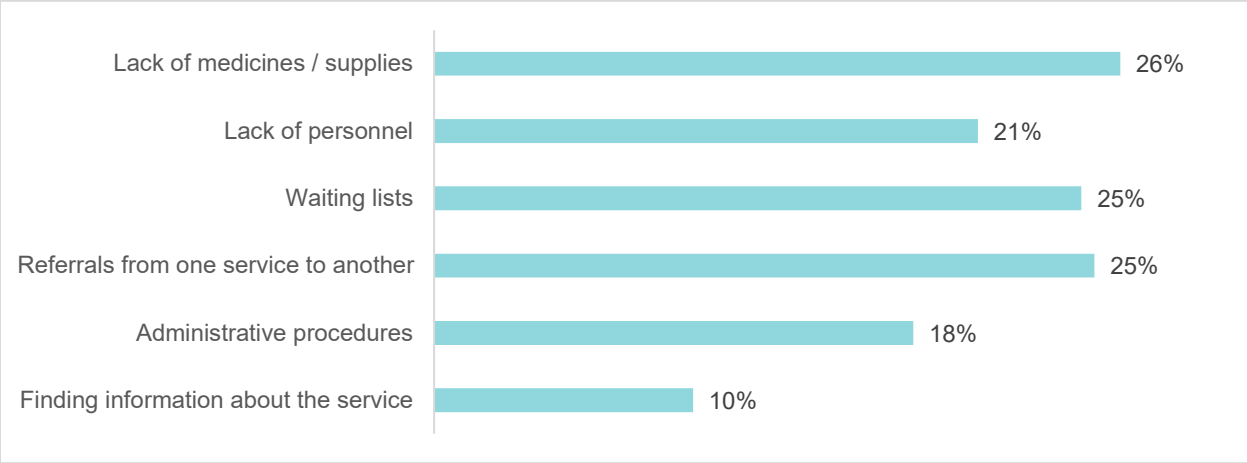


Lack of medicines and referrals between services among the most frequent difficulties faced by respondents in accessing healthcare

Respondents reported a range of difficulties in their interaction with the healthcare system. The most frequently reported issue was the lack of medicines or medical supplies (26%), followed by difficulties with referrals from one service to another and waiting lists (25%). In addition, lack of personnel (21%) and administrative procedures (18%) constitute significant challenges. A smaller number reported difficulties in finding information about services (20

respondents). These findings suggest that barriers are not only physical or economic, but also organizational and systemic in nature.

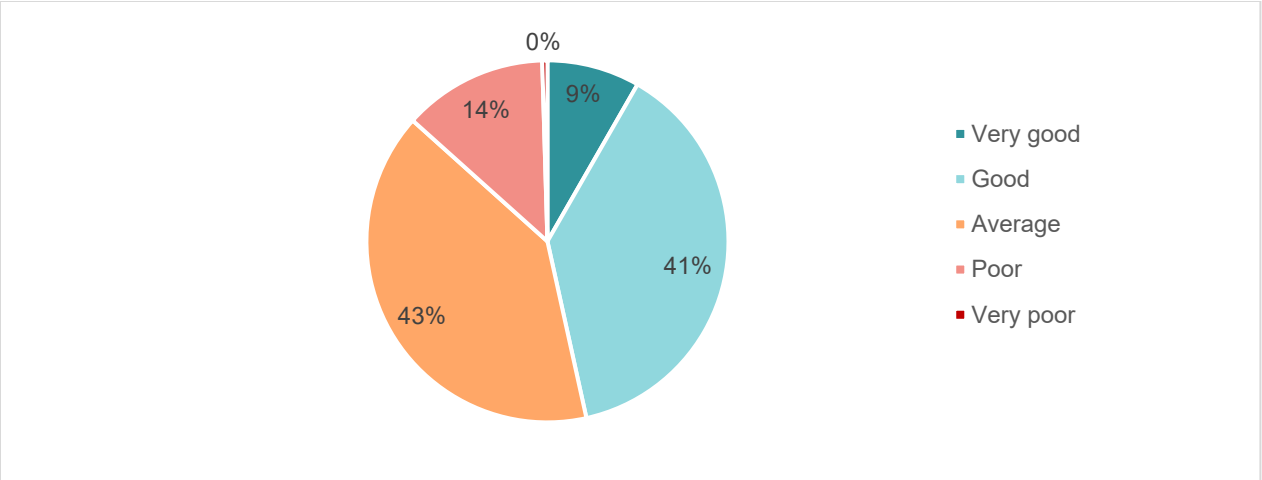
Figure 9 Difficulties encountered in accessing services (N=202)



Approximately half of respondents have a positive assessment of access to healthcare services

Overall, the assessment of access to healthcare services was moderately positive. Specifically, 41% of respondents considered access to be good and 18 respondents considered it very good, while 43% assessed it as average. On the other hand, 14% considered access poor, and only one respondent described it as very poor. These results indicate a generally moderate perception, where most citizens are able to obtain services, but still face limitations and challenges that affect the quality of access.

Figure 10 Assessment of respondents' access to health services (N=202)



The survey findings show that access to healthcare services is perceived as relatively achievable for the majority of respondents, particularly in terms of physical proximity and

waiting times, as most respondents can reach healthcare services within 30 minutes and receive services without significant delays. Nevertheless, beyond this generally positive perception, important barriers continue to affect comprehensive access. Transportation remains a challenge for a considerable proportion of citizens, while other difficulties relate to shortages of medicines, referral problems, waiting lists, lack of personnel, and administrative procedures. These findings indicate that barriers are not only physical, but also organizational and systemic in nature.

Furthermore, the lack of updated protocols and clear methodologies for planning needs contributes to additional difficulties in providing quality and continuous services. In this context, although physical access may be guaranteed for a large part of the population, structural and organizational challenges continue to limit real and quality access, emphasizing the need for integrated interventions that address the functioning of the healthcare system as a whole.

5. Economic affordability

Economic affordability constitutes one of the main pillars of effective access to healthcare services, as it determines whether citizens are able to receive the care they need without facing excessive financial burden. This section examines the economic dimension of access, focusing on the level of out-of-pocket payments, the types of services for which citizens most frequently pay, and the extent to which costs influence decisions to seek or postpone healthcare. In this context, the analysis assesses not only the scale of the financial burden, but also its distribution among different socio-economic groups, in order to understand whether this burden disproportionately affects certain categories of the population. The analysis of these indicators is essential for identifying gaps in financial protection and for understanding the extent to which the healthcare system succeeds in ensuring equal and affordable access for all citizens.

7 out of 10 respondents report paying out-of-pocket for healthcare services

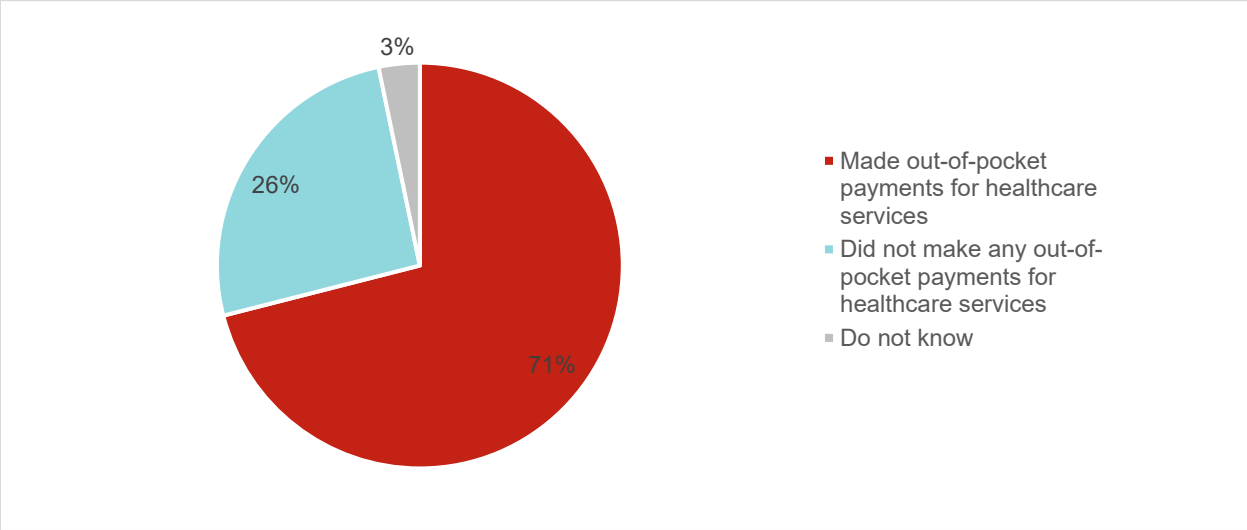
The overwhelming majority of respondents reported having made out-of-pocket payments for healthcare services during the last 12 months. Specifically, 71% responded “Yes” (152 respondents), while only 26% stated that they had not made such payments (55 respondents), and 7 respondents were uncertain. It should be taken into account that these data reflect only the experiences of respondents who had received healthcare services during the previous 12 months. These findings indicate a high level of direct spending by citizens, suggesting a considerable financial burden in accessing healthcare services.

Cross-tabulation of the data with demographic characteristics shows that the majority of respondents reporting out-of-pocket payments did not belong to any vulnerable group. Among the more vulnerable categories were people with chronic illnesses (23 respondents), family caregivers (10), older adults aged 65+ (8), and persons with disabilities (4), with some overlap between categories.

Regarding health insurance coverage, 73% declared that they were insured (111 respondents). In terms of economic status, respondents from the middle-income category dominated the sample (87 respondents), while at least 20 respondents described their economic condition as good and 3 as very good. At the same time, a considerable number

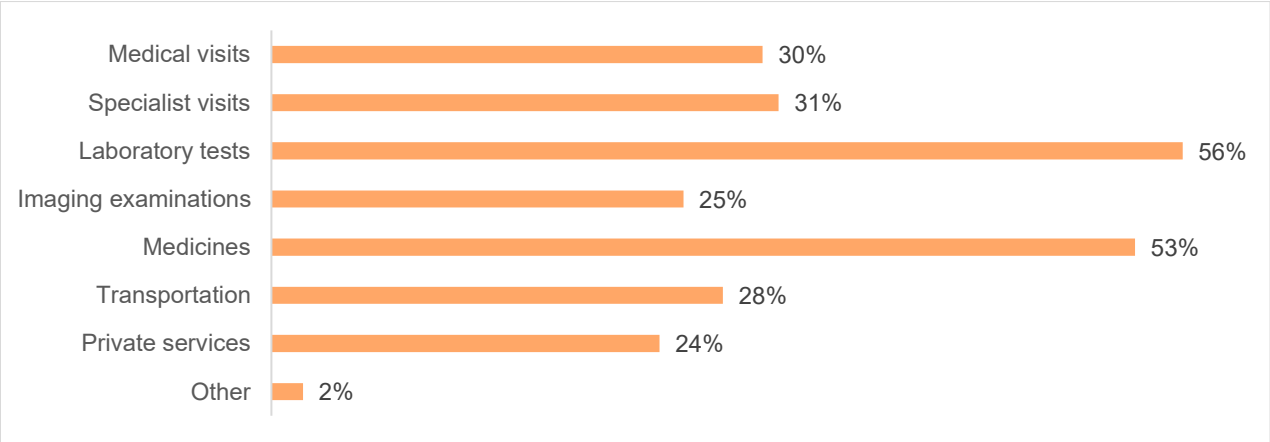
of respondents who had made out-of-pocket payments described their economic situation as difficult (15%) or very difficult (10%).

Figure 11 Number of respondents who made out-of-pocket payments for healthcare services (N=214)



Regarding the services for which payments are made most frequently, laboratory tests (56%) and medicines (53%) emerged as the main expenditure categories. Visits to specialists (31%) and medical visits in general (30%) also account for a significant share of the payments reported by respondents. Imaging examinations were reported by 25% of respondents, while transportation (28%) and private services (24%) indicate that indirect costs and alternatives outside the public system play an important role in the financial burden. Only a very small number mentioned other categories (4 respondents).

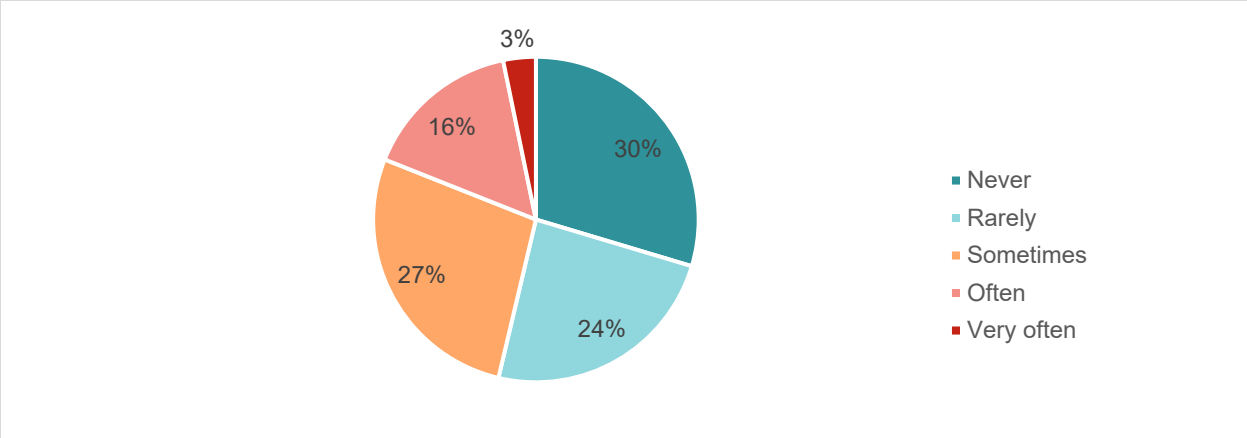
Figure 12 Most frequent out-of-pocket payments for healthcare services (N=204)



Approximately 1 in 5 respondents frequently experience economic barriers in accessing healthcare

When asked how often they had postponed or avoided receiving services for economic reasons, more than half of respondents tended to state that this had never happened to them (30%) or had happened rarely (24%). At least 27% of respondents reported that they had sometimes postponed or not received services because of costs. Meanwhile, 19% of respondents reported having had such experiences often (16%) or very often (7 respondents).

Figure 13 Frequency of postponing or not receiving service due to economic reasons (N=216)

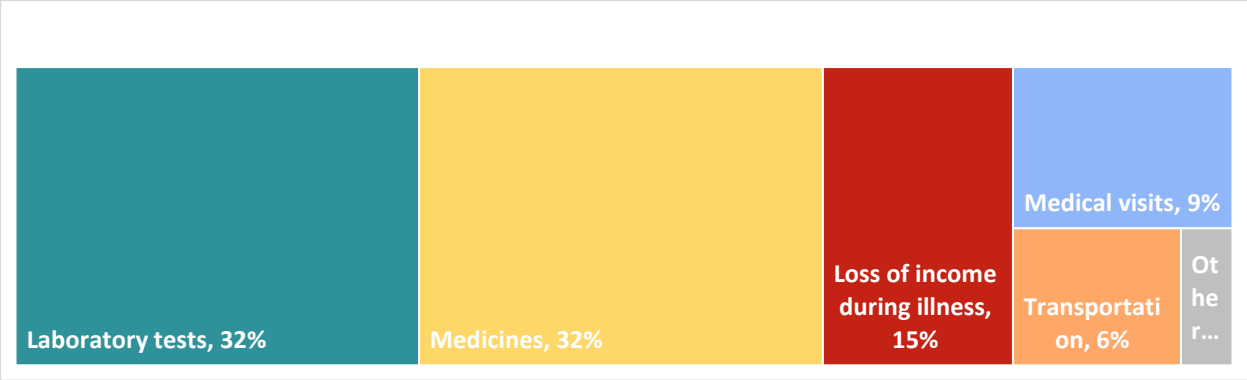


Laboratory tests and medicines identified as the main economic burden in healthcare, according to respondents

Respondents were invited to share the aspects on which they spend the most. In assessing the greatest financial burden, laboratory tests (32%) and medicines (32%) emerged as the main factors weighing financially on citizens. Loss of income during periods of illness was mentioned by 15% of respondents, highlighting the indirect economic impact of health problems. Medical visits (20 respondents) and transportation (13 respondents) were mentioned less frequently as the main burden, while a small number reported other factors

(4 respondents), including the lack of medical equipment and specialist doctors, and being forced to use private services for specific cases.

Figure 14 Main economic burden related to healthcare (N=214)



This chapter highlights that economic affordability remains a challenge for a considerable proportion of citizens when seeking medical care. The high level of out-of-pocket payments, reported by 7 out of 10 respondents, demonstrates a significant financial burden that is not limited only to the most vulnerable categories, but also broadly affects middle-income and employed individuals. Laboratory tests and medicines emerged as the main expenditure categories, reflecting a shift of costs toward citizens. This finding is also supported by the 2024 audit of the Compulsory Healthcare Insurance Fund, which identified that the lack of oversight over medicine reimbursement and the low level of inspections increase the risk of financial abuse and inflated costs[2]. As a result, failures in monitoring not only burden the public budget, but also transfer a significant portion of costs onto citizens, making medicines and laboratory tests the main economic burden for Albanian households.

In addition, indirect costs, such as transportation or the use of private services, contribute significantly to citizens' expenditures. Furthermore, the fact that around 1 in 5 respondents reported that they often or very often postponed or avoided receiving care for economic reasons indicates that costs directly affect real access to services. In this context, improving financial protection mechanisms, increasing transparency, and strengthening institutional oversight remain essential to ensuring that access to healthcare services is not determined by ability to pay, but is instead based on the principles of equity and need.

[2] "*Drug reimbursements out of control, only 24% of doctors were checked by FSDKSH in 2024*", Ekofin, (Tiranë: Ekofin, 2024), https://ekofin.al/rimbursimet-e-ilaceve-jashte-kontrollit-vetem-24-e-mjekeve-u-kontrolluan-nga-fsdksh-ne-2024/.

6. Needs for services and gaps in the system

Identifying service needs and gaps in the healthcare system is an essential step in understanding whether existing services respond adequately to community demands. This chapter analyzes citizens' perceptions regarding the most urgent needs in the field of healthcare, focusing on key dimensions such as human resources, the availability of diagnostic services and medicines, economic affordability, and access to information in the context of health emergencies. Through this assessment, the aim is to highlight not only the most pronounced shortcomings, but also how these gaps affect citizens' experiences and their ability to benefit from timely and quality services.

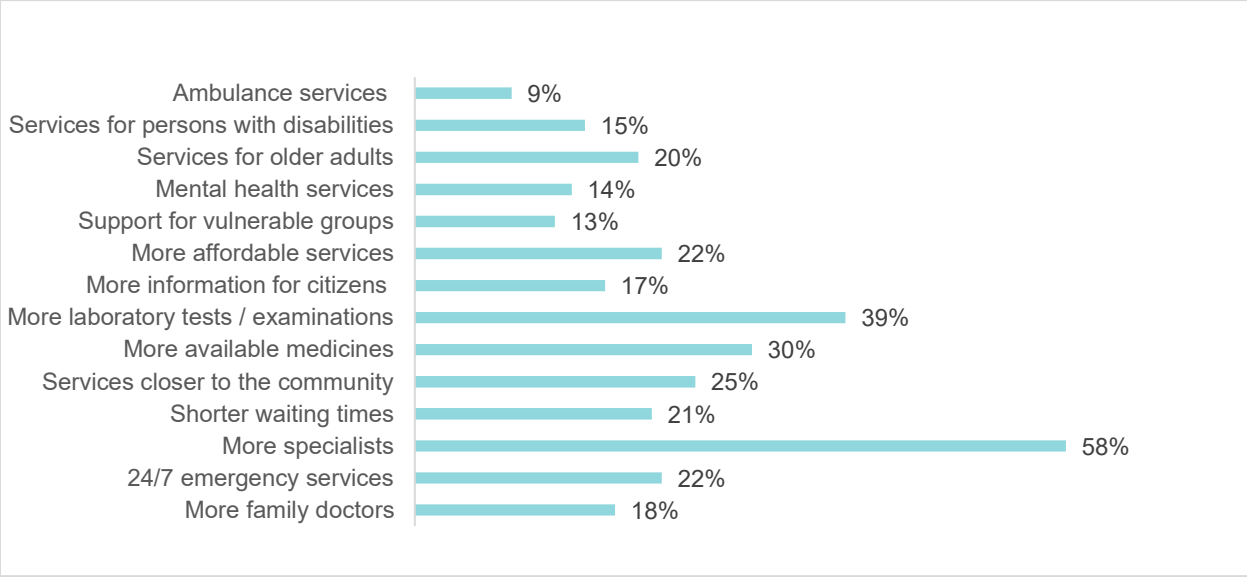
Increasing the number of specialists among the main needs of communities

When asked about the main healthcare needs of their communities, respondents identified increasing the number of specialists as the top priority (58%), reflecting a significant shortage in this area. The need for more laboratory tests and diagnostic examinations also ranked very highly (39%), followed by the demand for greater availability of medicines (30%). A considerable number emphasized the need for services closer to the community (25%), as well as 24/7 emergency services and more affordable healthcare services (22%). Reducing waiting times (21%) and improving services for older adults (20%) were also among the major concerns. Meanwhile, the demand for more family doctors (18%), more information for citizens (17%), services for persons with disabilities (15%), and mental health services (14%) points to diverse and comprehensive needs. Support for vulnerable groups (13%) and the need for ambulances (9%) complete the range of demands identified by communities.

The demand for more specialists is widespread across all municipalities, but is particularly concentrated in Gramsh (78 respondents), Shkodër (52), Përmet (40), Elbasan (32), and Krujë (27), indicating significant gaps in the provision of specialized services, especially in smaller and peripheral areas. At the same time, the need for more laboratory tests and diagnostic examinations follows a similar distribution, with the highest demand reported in

Gramsh (65), Shkodër (44), Elbasan (28), and Krujë (24), suggesting that alongside shortages in human resources, there are also clear limitations in diagnostic capacities.

Figure 15 Main healthcare service needs identified by communities (N=335)



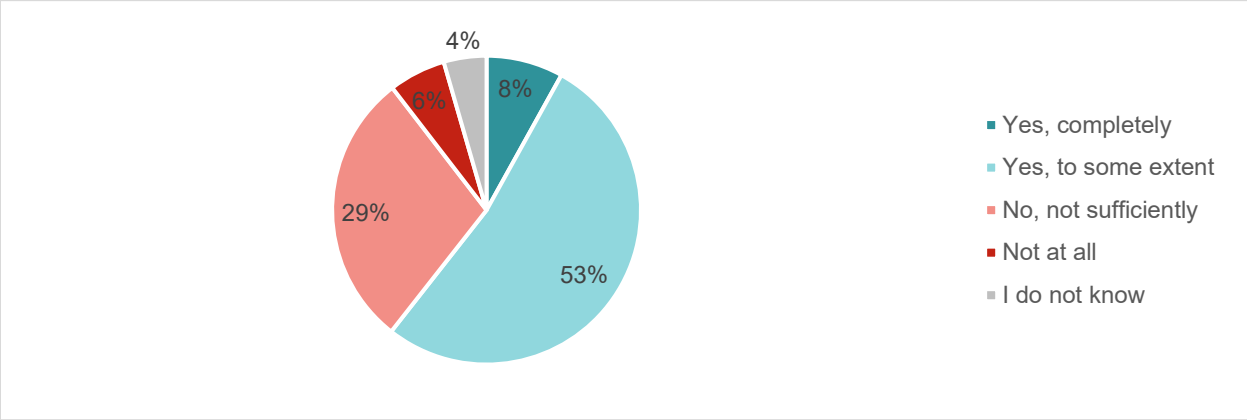
For 1 in 3 respondents, information about healthcare services during emergencies is insufficient

Regarding the adequacy of information about primary healthcare services during emergencies, most respondents gave only a partial assessment. Specifically, 53% believed that the information was sufficient only to some extent, while 8% considered it fully sufficient. On the other hand, a considerable proportion expressed dissatisfaction: 29% assessed the information as insufficient and 20 respondents considered it completely insufficient. A small number (15 respondents) expressed uncertainty.

Demographic data show that respondents who assessed emergency-related information as insufficient or completely insufficient represent a diverse educational profile, but are clearly dominated by individuals with university education (67 respondents). This is followed by respondents with secondary education (29), while a significant presence is also observed among individuals with postgraduate education (16). This distribution indicates that dissatisfaction with information during emergencies is not limited to groups with lower levels of education, but strongly includes highly educated individuals as well, suggesting that the

challenge relates more to the quality, clarity, and adequacy of the information rather than simply to the level of comprehension.

Figure 16 Adequacy of information about healthcare services during health emergencies (N=335)

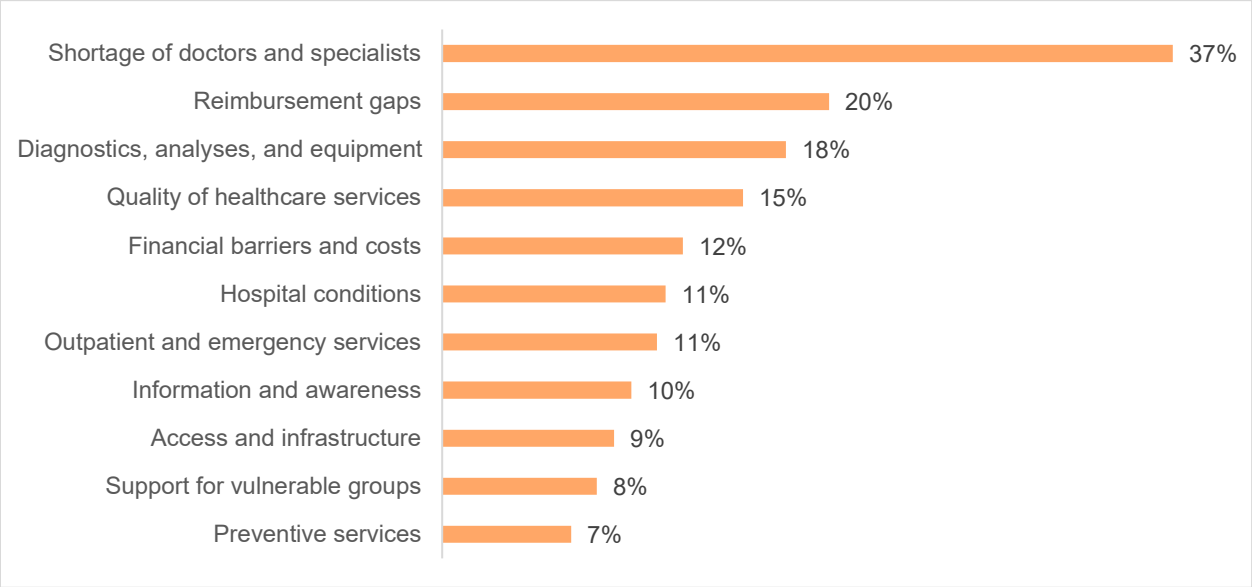


Gaps in human resources among the main concerns of respondents

Through an open-ended question, respondents identified the most urgent needs that should be addressed. Most suggested that the shortage of doctors and specialists ranks as the main concern (37%), once again confirming the importance of human resources within the healthcare system. Issues related to medicines and reimbursement (20%), as well as diagnostics, laboratory tests, and equipment (18%), also constitute important priorities. Improving the quality of medical services (15%) and addressing financial barriers (12%) are among citizens' major concerns. Likewise, improving hospital conditions (11%) and outpatient and emergency services (11%) are considered essential. Other factors such as information and awareness (10%), access and infrastructure (20 respondents), support for

vulnerable groups (18), and the development of preventive services (15) complete the list of urgent priorities, reflecting a broad range of needs requiring coordinated intervention.

Figure 17 Most urgent needs to be addressed (N=227)



In conclusion, the findings show that gaps in the healthcare system are perceived mainly at the level of human resources, with the shortage of doctors and especially specialists emerging as the most dominant concern across all included areas. This is accompanied by high demand for diagnostic services and greater availability of medicines, reflecting simultaneous limitations both in technical capacities and in the provision of basic services. Respondents' open-ended answers reinforce these findings, emphasizing the need for coordinated interventions that simultaneously address shortages in staff, medicines, equipment, service quality, and access. At the same time, the demand for services closer to communities, improvements in service delivery, and reduced waiting times indicates that citizens face not only structural shortages, but also challenges in the organization and distribution of services. Respondents' answers also suggest that the problem with information during health emergencies is not related to citizens' ability to understand it, but rather to the way it is communicated - specifically, its clarity, quality, and mode of delivery.

This chapter highlights that improving the healthcare system requires a comprehensive approach that goes beyond expanding capacities, and also includes strengthening the organization of services, increasing transparency, and improving communication with citizens. Only by addressing these gaps can healthcare services become accessible, trustworthy, and aligned with the real needs of communities.

7. Assessment of vulnerabilities, equality, and exclusion

This chapter analyzes citizens' perceptions regarding the groups that face the greatest difficulties in accessing healthcare services, as well as the factors contributing to these inequalities, including economic, geographical, health-related, and social dimensions. International evidence shows that inequalities in healthcare are closely linked to socio-economic status, place of residence, and individual characteristics, directly affecting access to and the quality of care. In this regard, the World Health Organization emphasizes that vulnerable groups, including older adults, persons with disabilities, and low-income families, face disproportionate barriers in accessing healthcare services,[3] while previous analyses and reports by Together for Life have consistently highlighted that the most marginalized groups encounter multiple barriers to access, including costs, lack of information, and difficulties navigating the system.[4]

At the institutional level, the Ministry of Health and Social Welfare holds the primary role in drafting, implementing, and monitoring policies related to accessibility in healthcare services, including improving physical conditions in healthcare institutions through concrete standards such as ramps, elevators, and adapted infrastructure. At the same time, municipalities are responsible for implementing these standards at the local level, including the construction and reconstruction of public facilities and the supervision of compliance. However, despite this clear legal framework, significant challenges remain in practical implementation, as many services and public infrastructures are still not fully accessible. This situation becomes even more critical within the Albanian social context, where a large proportion of older adults live in rural areas with limited access to services, making the analysis of vulnerability and exclusion even more important.

Older adults and persons with disabilities are the groups facing the greatest difficulties in accessing healthcare services

When asked which groups have the greatest difficulty obtaining healthcare services in their community, respondents primarily identified older adults (67%) and persons with disabilities (53%) as the most affected. Low-income families (49%) and residents of rural or remote areas (46%) were also considered groups facing significant barriers to access. A considerable number of respondents also mentioned unemployed individuals (29%), people

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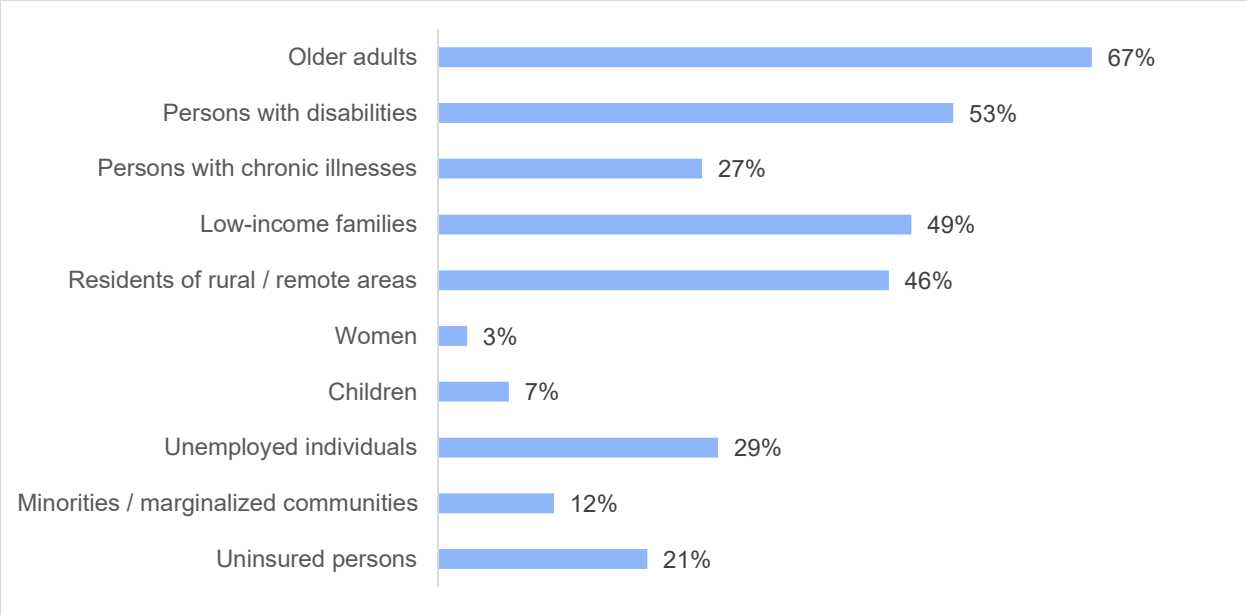
[3] World Health Organization (WHO), *Health Equity Status Report Initiative (HESRI)*, https://www.who.int/europe/initiatives/health-equity-status-report-initiative.

[4] Together for Life (TFL), *Reporting of High-Level Corruption in Healthcare (2014–2024)*, (Tirana: Together for Life, 2025), https://smartbalkansproject.org/smart-news/together-for-life-reporting-of-high-level-corruption-in-healthcare-2014-2024/.

with chronic illnesses (27%), and uninsured persons (21%). To a lesser extent, minorities or marginalized communities (12%), children (7%), and women (9 respondents) were mentioned. These findings indicate that perceptions of vulnerability are mainly associated with economic, geographical, and health-related factors.

Figure 18 Groups facing the greatest difficulty in accessing healthcare services in their communities (N=333)

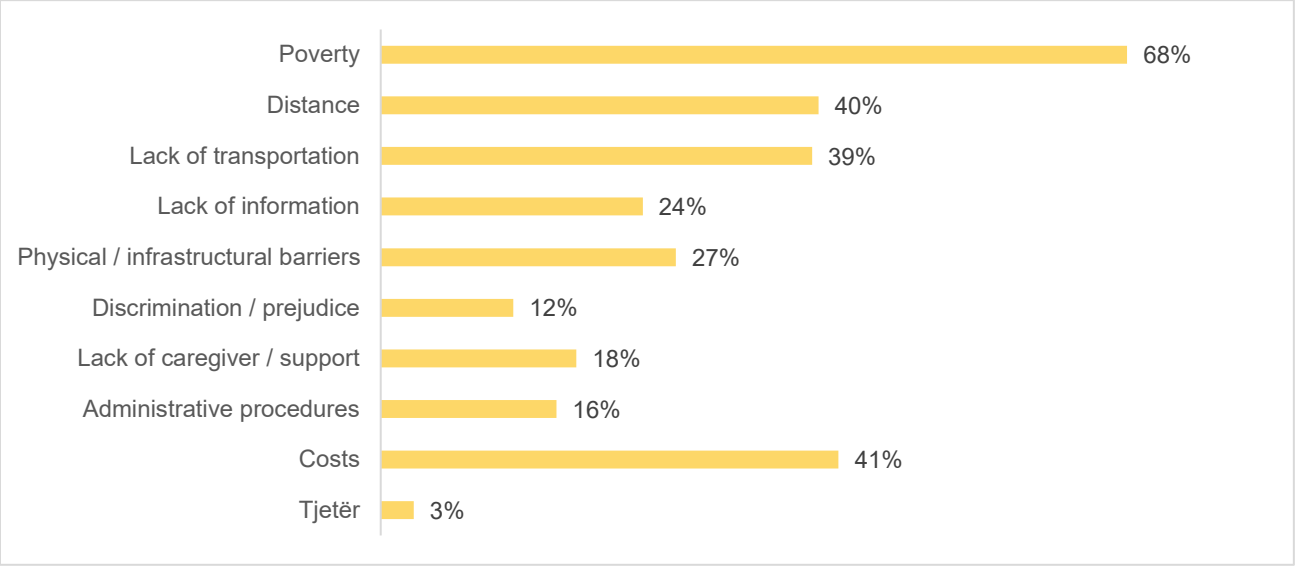


Poverty, service costs, and distance are the main difficulties faced by vulnerable groups

Regarding the factors influencing these difficulties, poverty emerged as the main reason (68%), followed by service costs (41%), distance (40%), and lack of transportation (39%). A considerable number of respondents also mentioned physical or infrastructural barriers (27%), lack of information (24%), and lack of caregivers or support (18%). Administrative procedures (16%) and discrimination or prejudice (12%) were also reported as factors

affecting access. These findings show that the difficulties are multidimensional and related both to economic factors and to structural and social barriers.

Figure 19 Reasons why certain groups face difficulties in accessing healthcare services (N=333)

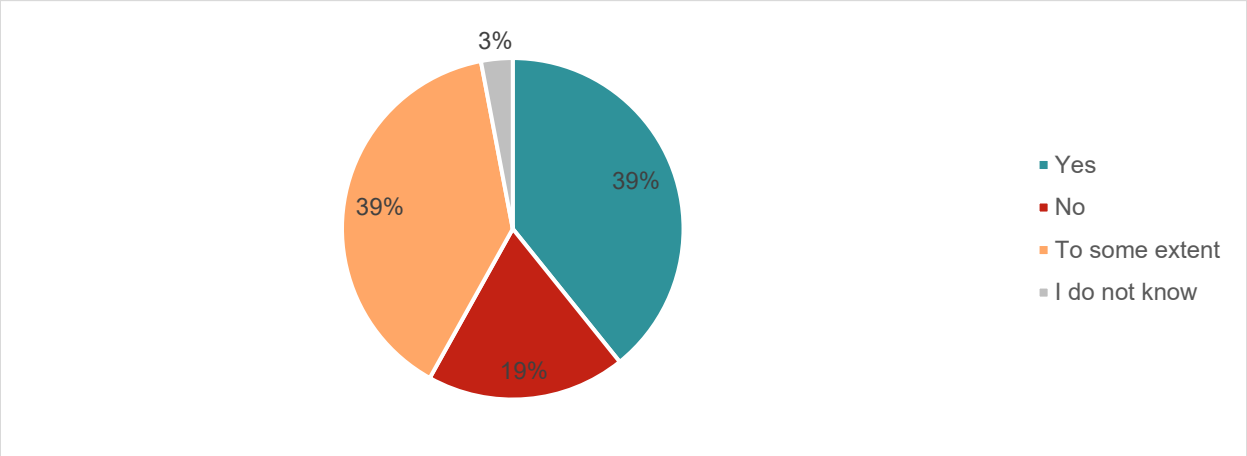


4 out of 10 respondents suggest that citizens are not treated equally within the healthcare system

When asked whether all citizens are treated equally within the healthcare system, respondents' perceptions were divided. Specifically, 39% of respondents (131) believed that citizens are not treated equally, while another 39% (130 respondents) considered that equality exists only to some extent. Only 19% of respondents (63) believed that treatment is

equal for everyone, while 10 respondents expressed uncertainty. These findings suggest a widespread perception of inequality within the system.

Figure 20 Respondents' perceptions of whether all citizens are treated equally within the healthcare system (N=334)

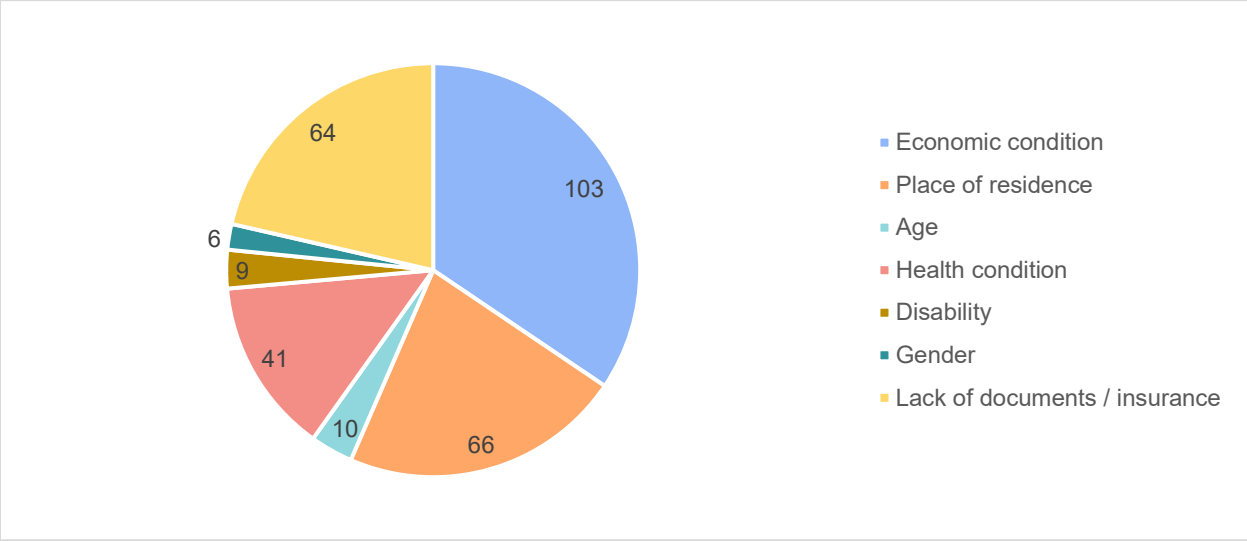


On average, 1 in 3 respondents has personally experienced difficulties obtaining healthcare services due to their economic situation

A considerable proportion of respondents reported having personally experienced difficulties in obtaining healthcare services for various reasons. The most frequently mentioned factor was economic condition (34%), followed by place of residence (22%) and lack of documents or insurance (21%). Health status (14%) was also mentioned as a factor affecting access, while reasons such as age (10 respondents), disability (9), and gender (6)

were reported less frequently. These findings indicate that economic and administrative barriers remain among the main factors directly affecting citizens' experiences.

Figure 21 Reported situations where respondents experienced difficulties obtaining services for various reasons (N=299)

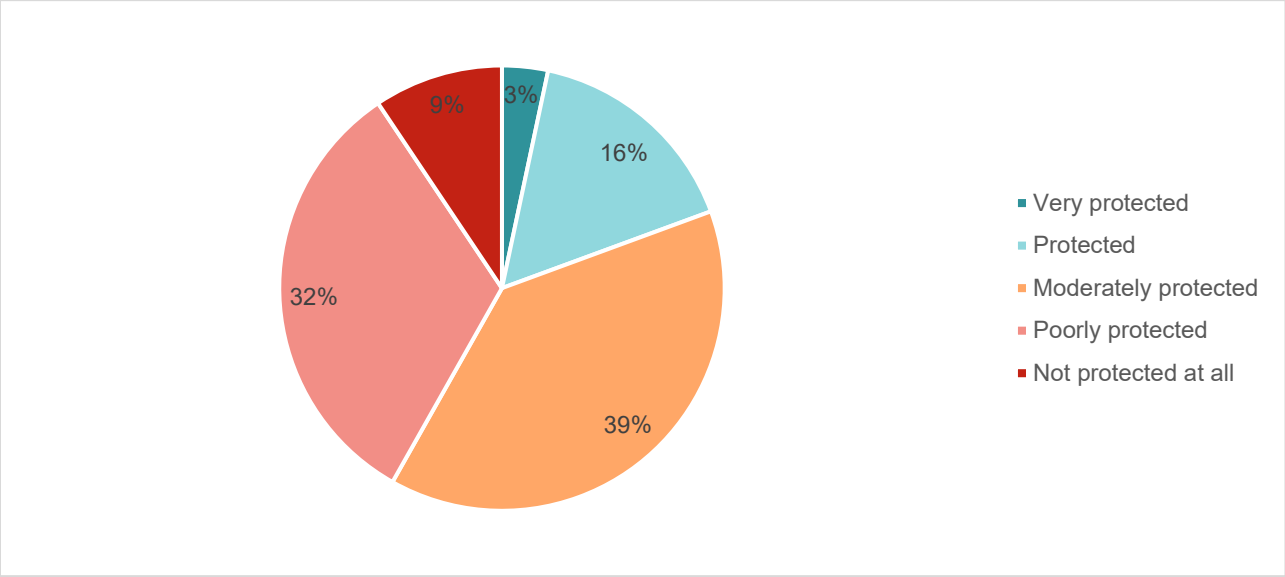


According to 4 out of 10 respondents, vulnerable groups are little or not at all protected by the healthcare system

Regarding the level of protection provided to vulnerable groups by the healthcare system, most respondents assessed this protection as limited. Specifically, 41% of respondents considered these groups to be little protected (107 respondents) or not protected at all (31 respondents). Meanwhile, 38% of the sample (128 respondents) considered protection to be average. Only a small number of respondents (19%) believed that these groups are protected (53 respondents) or very protected (11 respondents). These findings highlight a general

perception that support for vulnerable groups remains insufficient and requires further improvement.

Figure 22 Perception of the level of protection of vulnerable groups by the healthcare system (N=330)



Respondents perceive inequalities in access to healthcare services as being present and disproportionately affecting the most vulnerable groups. Older adults and persons with disabilities are identified as the groups facing the greatest difficulties, followed by low-income families and residents of rural areas, reflecting an intersection of economic, geographical, and health-related factors. The main contributing factors to these difficulties — such as poverty, service costs, distance, lack of transportation, and administrative barriers — indicate that exclusion from the system results from multiple and interconnected obstacles.

At the same time, the widespread perception of unequal treatment and the low level of protection for vulnerable groups underline a clear gap between the legal framework and the reality on the ground. Although central and local institutions, including the Ministry of Health and Social Welfare and local government units, have clear responsibilities for ensuring accessibility, implementation of these obligations remains partial. This is reflected not only in inadequate infrastructure, but also in limited access to services for certain categories, particularly in rural areas where a considerable proportion of the older population lives and where coverage with social services remains low.

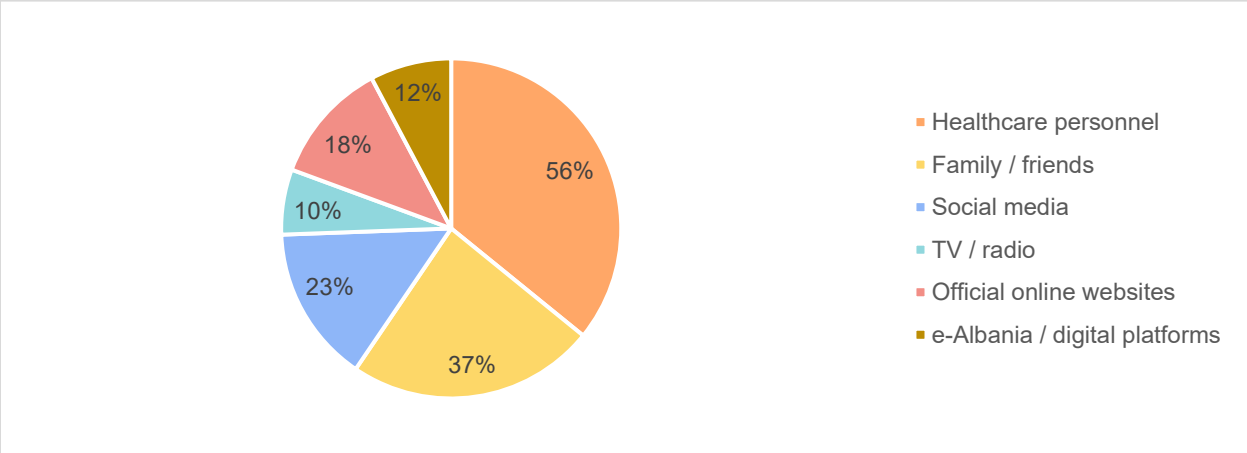
8. Communication and information

Factors such as the timeliness, clarity, and reliability of information, particularly in emergency situations, directly affect access to care and health outcomes. In such cases, it is essential for citizens to know exactly where to turn, which services are available, and how to act without delays or uncertainty. This section presents the main sources of information, the level of comprehensibility of information, and the most effective communication channels, reflecting on how these factors influence citizens' navigation of the healthcare system, both in routine situations and during emergencies. The survey findings show that trust in healthcare personnel and preference for direct communication remain key, suggesting that in emergency situations, information channels should be clear, immediate, and based on reliable sources.

Healthcare personnel considered the most reliable source of information on healthcare services by respondents

When asked about the main sources of information regarding healthcare services, the overwhelming majority of respondents referred to healthcare personnel (56%), positioning them as the most reliable and direct source of information. Family and friends also constitute an important source (37%), reflecting the role of informal social networks in the dissemination of information. Social media are used by 23% of respondents, while official online websites are used by 18%, indicating a growing use of digital sources. A smaller proportion obtain information through platforms such as e-Albania (12%) and traditional media such as TV/radio (10%). These findings demonstrate a combination of traditional and digital sources, with direct contact with healthcare professionals remaining dominant.

Figure 23 Sources of information on healthcare services (N=333)

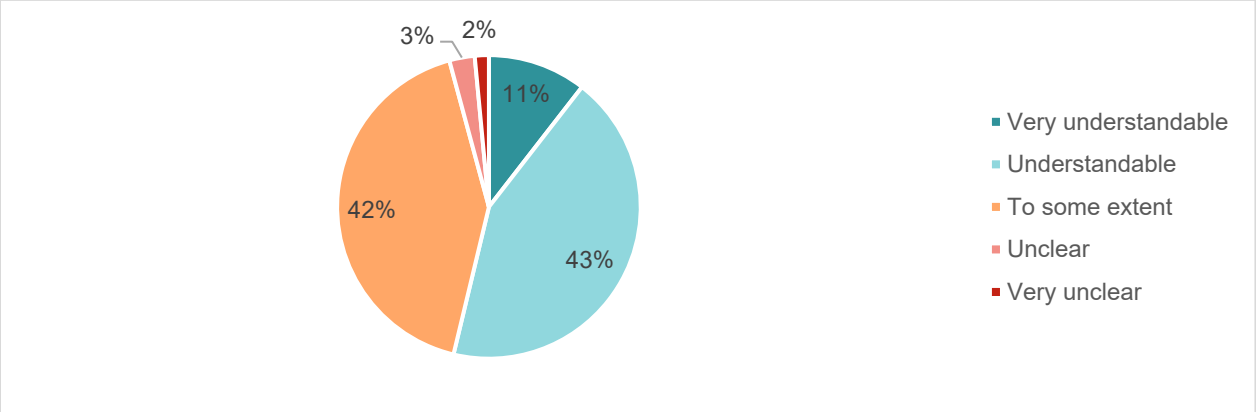


Need for greater clarity in the information provided to patients

Regarding the clarity of the information provided, the majority of respondents (54%) perceived it as understandable. Specifically, 43% assessed the information as

understandable and 11% as very understandable, while 42% stated that it was understandable only to some extent. A small number reported difficulties in understanding, considering the information unclear (9 respondents) or very unclear (5 respondents). These findings suggest that although information reaches citizens, there is still a need to make it simpler, clearer, and more accessible to everyone.

Figure 24 Comprehensibility of information provided on healthcare services (N=333)

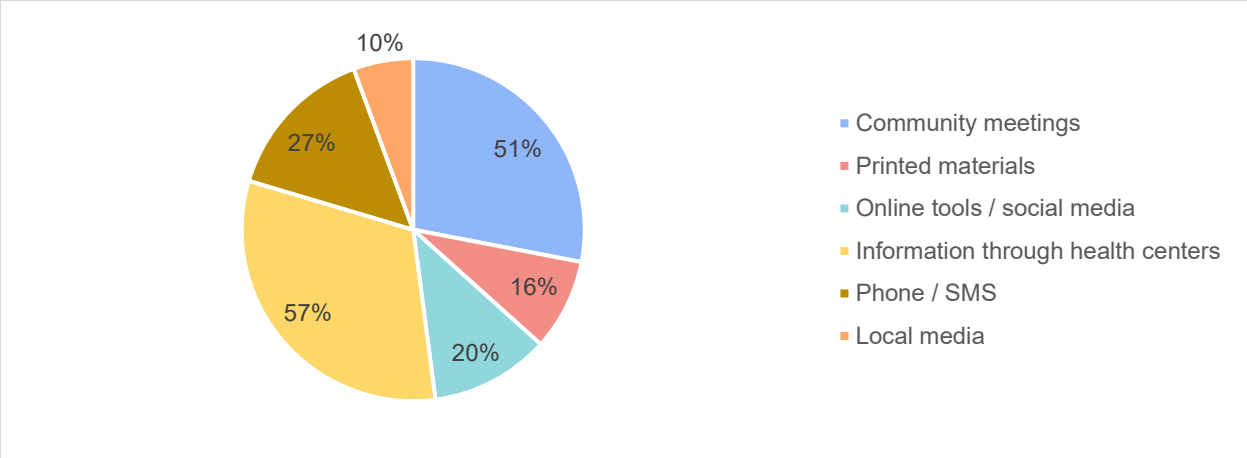


Health centers and community meetings are the preferred formats for receiving information

Regarding the most effective formats for informing the community, respondents mainly preferred direct channels facilitated by healthcare institutions. Information provided through health centers emerged as the most preferred format (57%), followed by community meetings (51%), highlighting the importance of face-to-face communication. A considerable proportion also considered communication via phone/SMS (27%) and online tools or social media (20%) useful. Printed materials (16%) and local media (10%) also remain important

channels, although less preferred. These findings indicate the need for a combined communication approach that integrates both traditional and digital channels.

Figure 25 Most useful ways of informing the community (N=333)



Improvement of equipment, infrastructure, and medicine supplies among the main identified needs

Through an open-ended question, respondents shared a range of suggestions and experiences related to improving healthcare services. Among the most emphasized themes were the improvement of equipment, infrastructure, and supplies (12 respondents), as well as increasing the number of specialist doctors (10). Reducing costs and increasing financial coverage (9), together with improving access and territorial coverage (8), also emerged as important concerns. Some respondents highlighted the need to improve the professional and ethical quality of staff (8), organization and adherence to schedules (7), as well as reducing bureaucracy and simplifying procedures (6). Concerns about corruption and favoritism (6) were also raised, alongside the need for more mental health services (2) and improved information and communication (2).

Figure 26 Respondents experiences and comments on healthcare services (N=70)

Communication within the healthcare system is primarily based on direct contact with healthcare personnel, who are perceived as the most reliable source of information. Informal networks such as family and friends also play an important role, while the use of digital channels and official platforms is increasing but remains non-dominant. Although the majority of respondents consider the information understandable, a considerable proportion perceive it as only partially clear, indicating the need to improve communication methods and simplify information. The strong preference for information delivered through health centers and community meetings underlines the importance of direct and personalized communication.

9. Conclusions and recommendations

The report's findings suggest that the communities included in the study have a basic level of access to healthcare services, but their preparedness to cope with health emergencies may be affected by gaps in communication, financial protection, continuity of services, and support for vulnerable groups during emergency situations. These results demonstrate that strengthening resilience requires not only enhancing emergency response capacities, but also investing in equitable access, social protection, effective public communication, and the sustainable functioning of healthcare services both during normal times and in periods of crisis.

The findings indicate that community preparedness to receive and act upon information during health emergencies remains partial. Although most respondents consider information on health services during emergencies to be somewhat sufficient, only a small proportion view it as fully adequate. The results suggest that the main challenges relate to the clarity, quality, and delivery of information. In the context of the objectives of the National Disaster Risk Reduction Strategy and the Sendai Framework[5], these findings highlight the need to strengthen public communication mechanisms, early warning systems, and citizen information channels, particularly for the most vulnerable groups.

Although most respondents report relatively good physical access to health services, the findings reveal structural weaknesses that may affect the functioning of the health system during crises and emergencies. Shortages of medicines, difficulties with referrals, waiting lists, shortages of specialists, and administrative barriers suggest that the system may face challenges in maintaining continuity of services during periods of increased demand. These findings are directly linked to the objective of the National Social Protection Strategy[6] to strengthen the resilience of infrastructure and essential services, including healthcare facilities.

The high level of out-of-pocket payments and the fact that a significant proportion of citizens delay or avoid seeking care for economic reasons indicate that financial protection against health-related risks remains limited. In emergency situations, when healthcare needs and household expenditures tend to increase, these vulnerabilities may exacerbate existing inequalities and further restrict access to care. The findings reinforce the importance the

[5] UNDRR. Implementing Sendai Framework. https://www.undrr.org/implementing-sendai-framework/what-sendai-framework

[6] Ministria e Shëndetësisë dhe Mirëqënies Sociale 2024-20230, https://arkiva.shendetesia.gov.al/wp-content/uploads/2024/10/VKM2024-03-13-152_.pdf

strategy places on developing adaptive social protection mechanisms and economic support measures during crises.

The study addresses older people, people living with chronic illnesses, persons with disabilities, pregnant women, and family caregivers as population groups with specific healthcare needs. The fact that some individuals within these groups reported not having used any healthcare services during the previous year suggests the existence of barriers that may become even more pronounced during emergencies. This is consistent with the priorities of the National Disaster Risk Reduction Strategy[7], which emphasizes that preparedness and response measures should address the specific needs of the most vulnerable population groups.

The findings also show that the use of healthcare services remains primarily oriented toward primary healthcare, while at the same time one in three respondents reported not having used any health service during the previous 12 months. This suggests limited opportunities for regular monitoring, early detection of health problems, and the promotion of preventive health behaviors. Since community resilience is built before emergencies occur, strengthening preventive care and increasing citizens' engagement with the healthcare system are important components of improving preparedness for future crises.

In this context, improving the functioning of the system requires an integrated approach that simultaneously addresses the financial, organizational, and communication dimensions of healthcare delivery. In support of the study findings, the following key measures are recommended:

- **Strengthening financial protection for patients**, through the expansion and stricter monitoring of reimbursement schemes, with particular focus on medicines and diagnostic services, in order to reduce out-of-pocket payments.
- **Improving the distribution and capacities of human resources**, especially at the local level and in rural areas, by addressing the shortage of doctors and specialists.
- **Reorganizing referral and service coordination mechanisms**, in order to reduce fragmentation and facilitate patients' movement within the system.
- **Ensuring a stable supply of medicines and medical materials**, through improved planning, management, and procurement processes.

[7] Ministria e Mbrojtjes, AKMC. Strategjia Kombëtare për Reduktimin e Rrezikut nga Fatkeqësitë 2023-2030 https://www.undp.org/sites/g/files/zskgke326/files/2024-01/strategjia_kombetare_-_albanian.pdf

- **Reducing the administrative burden and simplifying procedures**, thereby increasing efficiency and lowering barriers to access services.
- **Strengthening communication with citizens**, through the provision of clear, understandable, and accessible information, combining traditional and digital channels while preserving the key role of healthcare personnel.
- **Developing information and guidance mechanisms during emergencies**, ensuring that citizens have clear and immediate instructions for obtaining timely services.
- **Increasing focus on vulnerable groups**, through targeted policies that address the specific economic, geographical, and social barriers they face.
- **Enhancing transparency and strengthening accountability mechanisms**, in order to build trust and ensure more efficient use of public resources.

The implementation of these recommendations requires coordinated engagement between central and local institutions, as well as the active involvement of communities. Such an approach would contribute to building a fairer, more sustainable, and more responsive healthcare system that is aligned with the real needs of citizens.

Annexes

Annex 1: Profile of survey respondents

The profile of respondents is an essential element for interpreting the findings of this study, as it provides the necessary context for understanding how experiences and perceptions regarding healthcare services are shaped by socio-economic and demographic factors. Characteristics such as age, gender, education level, employment status, economic condition, and place of residence directly influence the way individuals access services, cope with costs, and interact with the healthcare system.

In this context, the collected data reflect diverse perspectives stemming from different social and economic realities. These differences affect not only the level of access to services, but also perceptions regarding their quality, availability, and fairness, as well as the gaps and vulnerabilities that exist within the system. Likewise, socio-economic factors influence the level of information and the ways in which citizens communicate and understand information related to healthcare services.

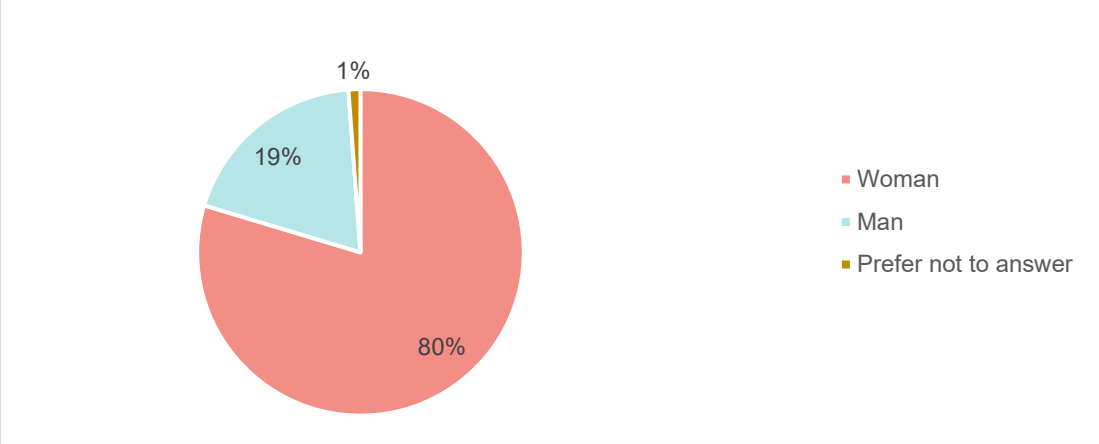
As a result, analyzing the respondents' profile helps place the findings within a broader context, enabling a more accurate and nuanced interpretation, while also facilitating the identification of the specific needs of different population groups.

It is important to emphasize that the sample presents a higher representation of women, which may be related to the fact that women often play a more active role in family healthcare and are generally more likely to engage in surveys of this type. Furthermore, women are usually more frequent users of healthcare services, both for themselves and for family members, making them more available to share their experiences and perceptions.

This should be taken into account when interpreting the findings, as it may influence the emphasis placed on certain specific perspectives.

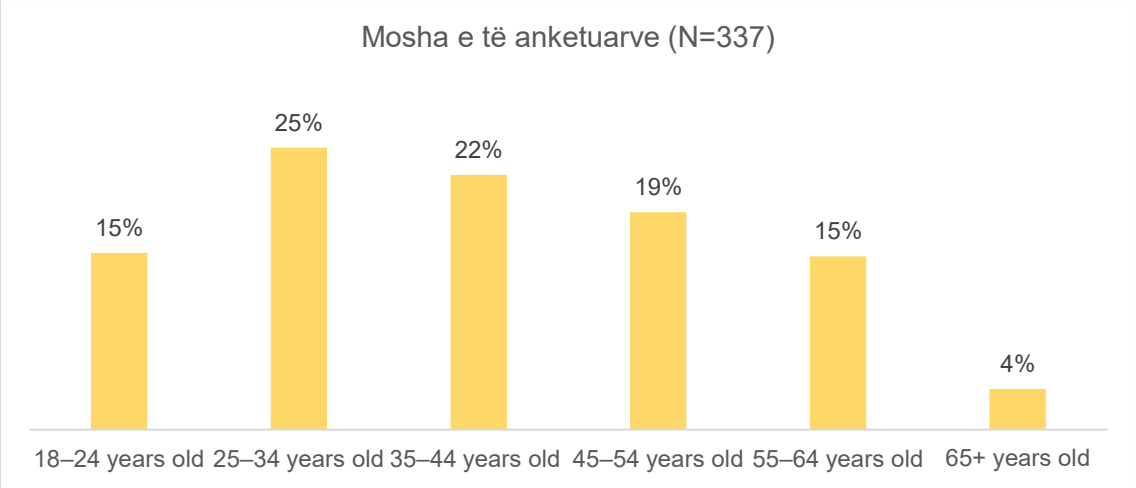
Thus, the majority of respondents were women (270), while men constituted a smaller proportion (65); 4 respondents preferred not to answer. This indicates a higher representation of women within the sample.

Figure 27 Gender of respondents (N=339)



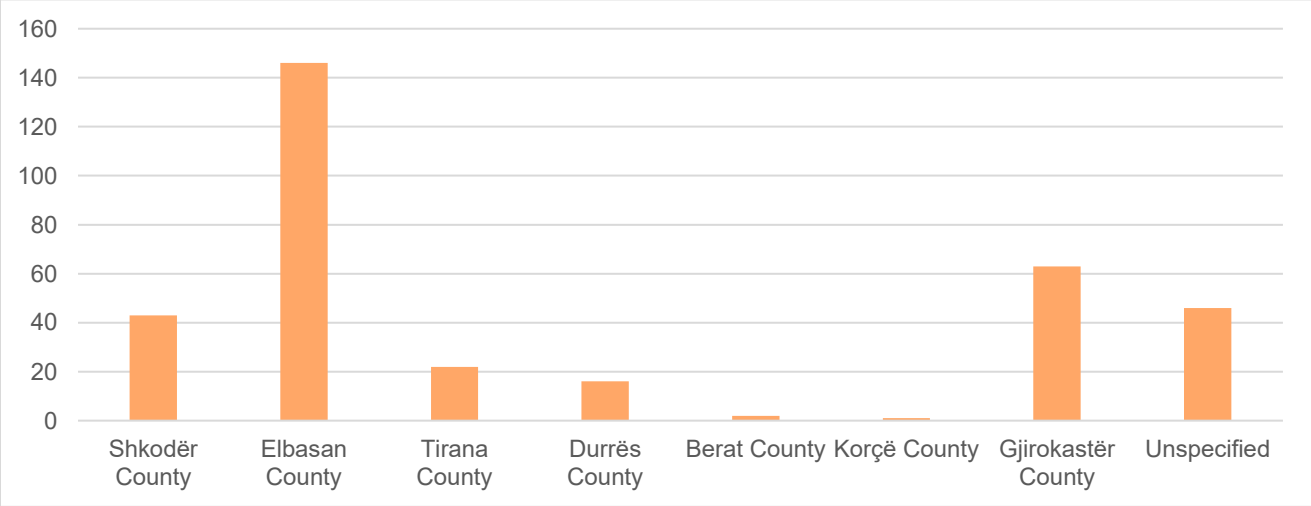
Regarding age, the distribution was relatively balanced. The largest group was aged 25–34 years (83 respondents), followed by those aged 35–44 (75), 45–54 (64), 18–24 (52), and 55–64 (51), while the age group over 65 was represented by only 12 respondents.

Figure 28 Age of respondents (N=337)



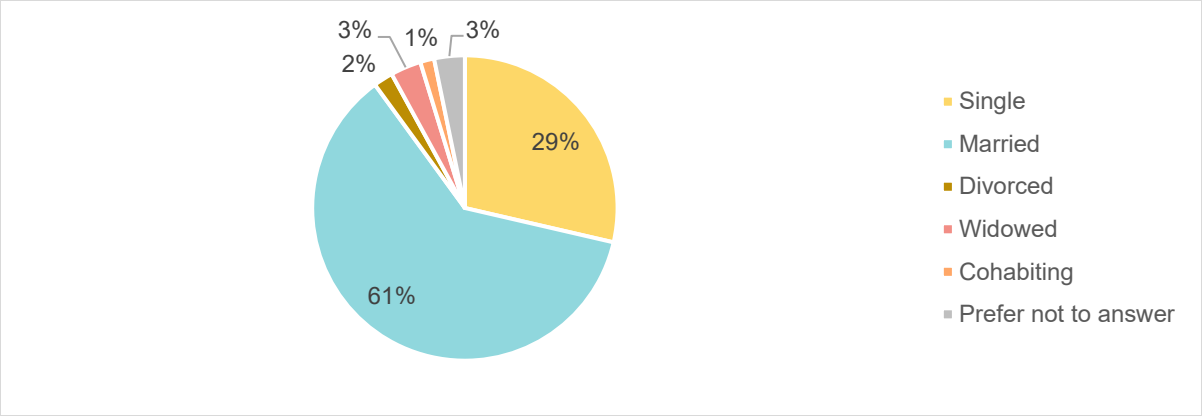
In terms of residence, the majority of respondents live in urban areas (244), while 91 live in rural areas, reflecting a higher representation of the urban population within the sample.

Figure 29 Geographical distribution of respondents by region (N=339)



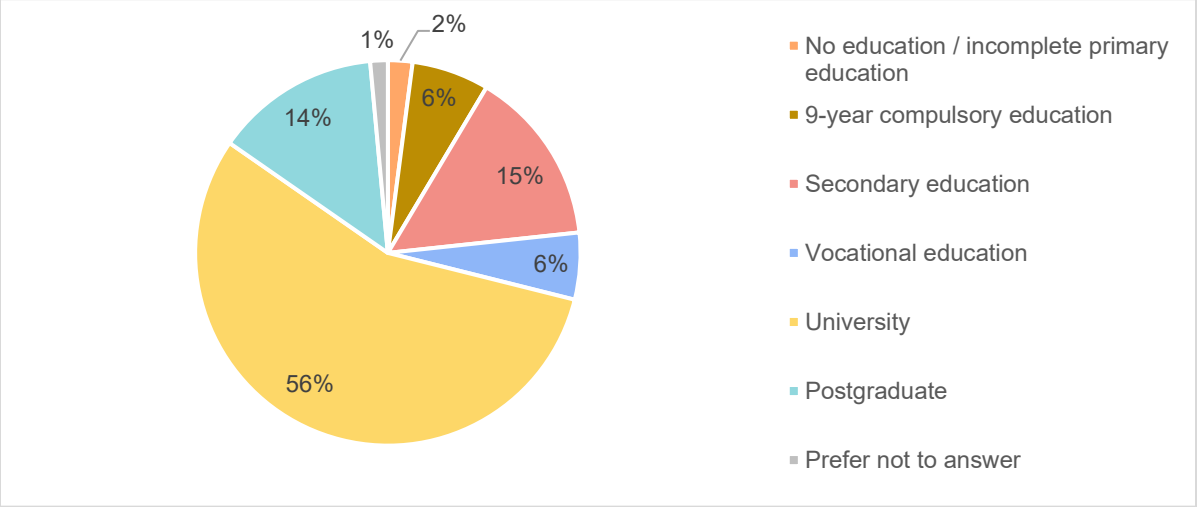
Regarding marital status, most respondents were married (208), followed by single respondents (97). Smaller numbers were widowed (11), divorced (7), or cohabiting (5), while 11 respondents preferred not to answer.

Figure 30 Marital status of respondents (N=339)



In terms of education, the majority had completed university education (189), while 47 had postgraduate education. Some respondents had completed secondary education (50), vocational education (19), or 9-year compulsory education (22), while a small number reported incomplete education or no education (7); 5 preferred not to answer.

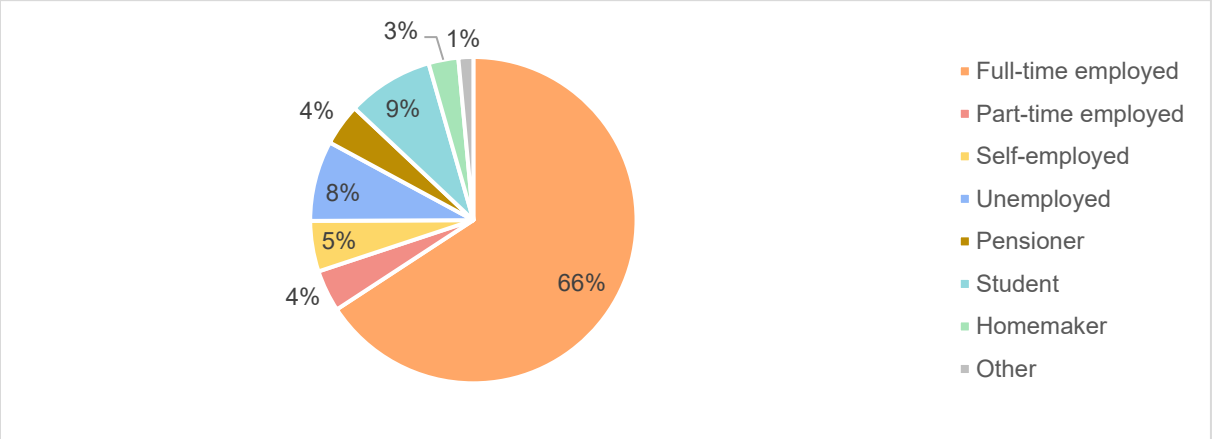
Figure 31 Educational level of respondents (N=339)



Regarding employment status, the majority were employed full-time (223). Others included students (29), unemployed individuals (27), self-employed individuals (17), pensioners (14),

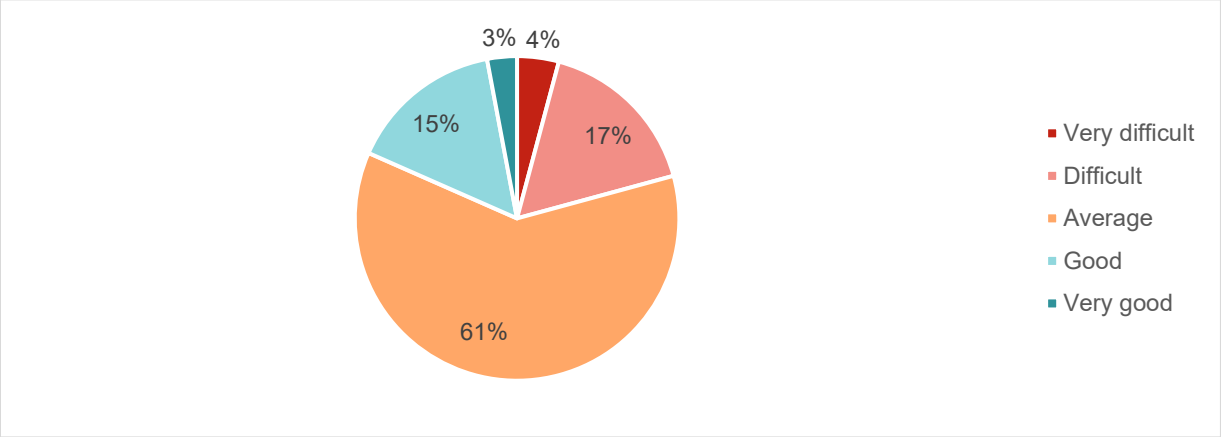
part-time employees (14), and homemakers (10), while 5 respondents selected other categories.

Figure 32 Employment status of respondents (N=339)



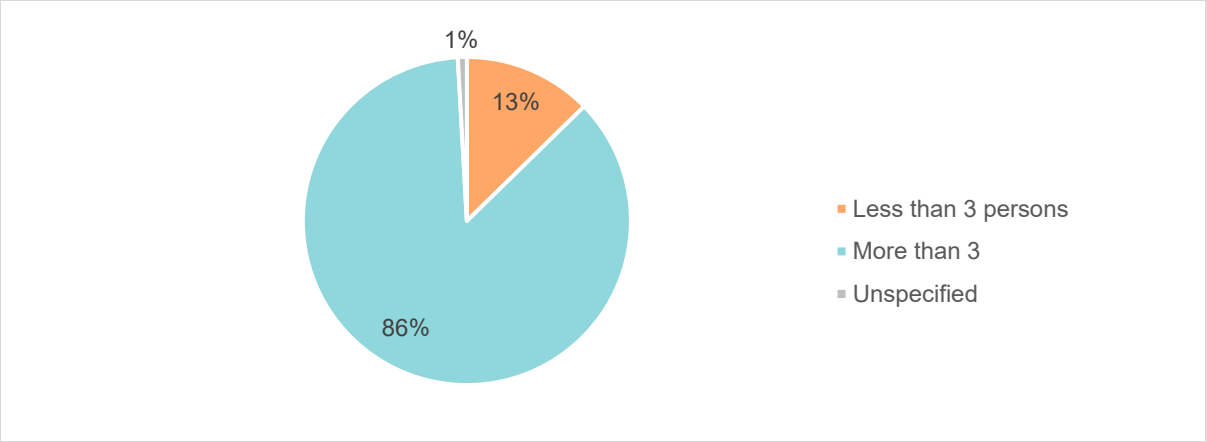
With regard to the household's economic condition, most respondents assessed it as average (205). A considerable proportion described it as difficult (56) or very difficult (14), while 52 assessed it as good and 10 as very good

Figure 33 Economic condition of respondents (N=337)



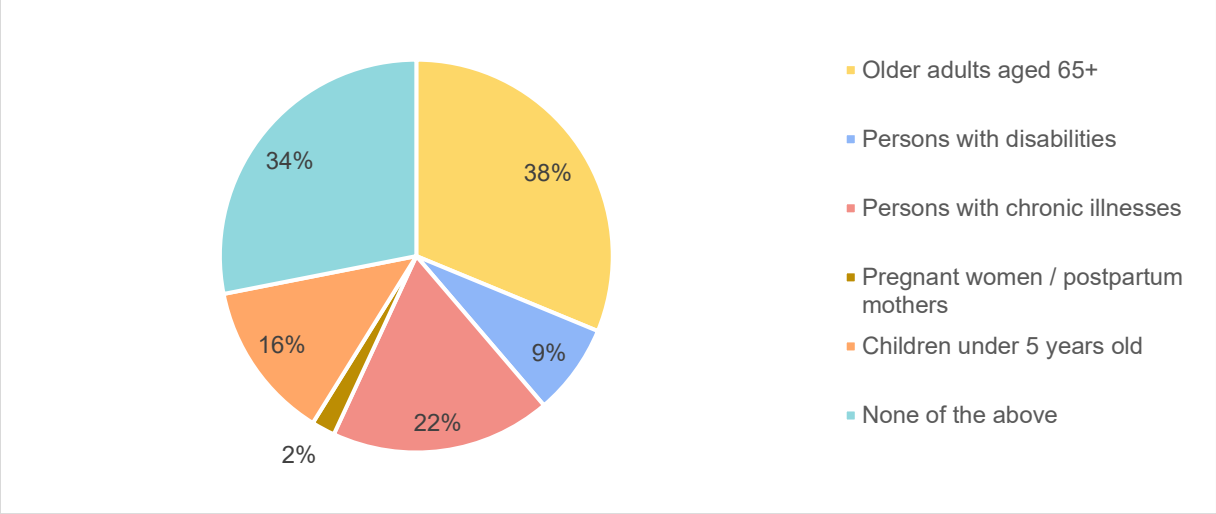
Regarding family size, the majority of respondents live in households with more than 3 members (293), while 43 live in households with fewer than 3 members; for 3 cases, no specific response was provided.

Figure 34 Family composition of respondents (N=339)



Regarding family composition, 129 respondents reported having older adults above the age of 65 in their household, 75 reported persons with chronic illnesses, 54 reported children under the age of 5, and 31 reported persons with disabilities. A smaller number reported pregnant women or postpartum mothers (8), while 116 stated that they did not belong to any of these categories.

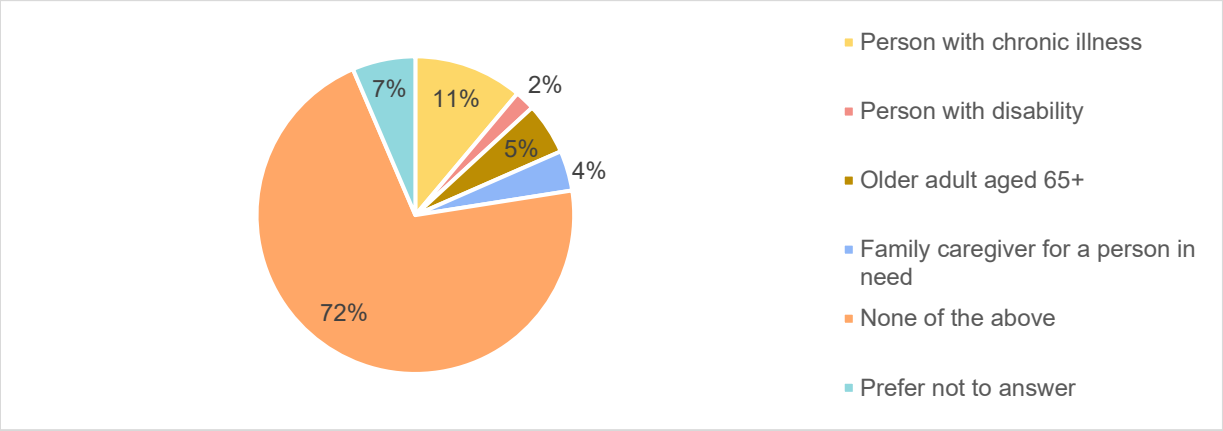
Figure 35 Respondents' households include at least one of the following categories (N=337)



Regarding individual belonging to specific categories, the majority of respondents stated that they did not belong to any category (243). Among the others, 38 reported having chronic

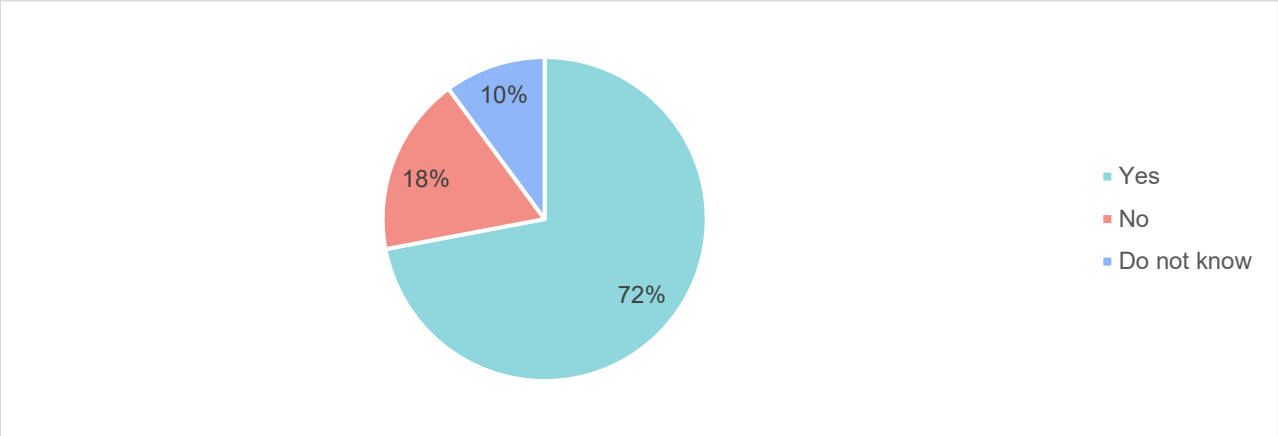
illnesses, 18 were over the age of 65, 14 were family caregivers for a person in need, and 7 were persons with disabilities; 22 preferred not to answer.

Figure 36 Respondents included in specific categories (N=337)



Regarding health insurance, the majority of respondents declared that they had health insurance coverage (242), while 60 did not have insurance and 34 stated that they were uncertain.

Figure 37 Respondents covered by public or private health insurance (N=336)



Annex 2: Survey

Study: "Healthcare Services: Challenges, Needs, and Vulnerabilities"

Introduction for Respondents

Hello,

This questionnaire is conducted within the framework of a study on healthcare services as part of the SOLIDAR – Together in Health Emergencies project, focusing on community challenges, needs, and vulnerabilities. Its purpose is to understand citizens' experiences and perceptions regarding access, quality, affordability, and equity in the use of healthcare services.

Participation is voluntary. The data will be used solely for research purposes and will be treated with full confidentiality. The questionnaire does not collect personally identifiable information, except in cases where this is explicitly requested and with your consent.

Estimated completion time: approximately 10–15 minutes.

Section A. General Socio-Demographic Information

1. **Gender:**
   - ☐ Woman
   - ☐ Man
   - ☐ Prefer not to answer
2. **Your age**
   - ☐ 18–24 years old
   - ☐ 25–34 years old
   - ☐ 35–44 years old
   - ☐ 45–54 years old
   - ☐ 55–64 years old
   - ☐ 65+ years old
3. **Your place of residence:**
   - ☐ Urban
   - ☐ Rural

   Administrative unit / area where you live:_____
4. **Marital status:**
   - ☐ Single
   - ☐ Married
   - ☐ Divorced

- ☐ Widowed
- ☐ Cohabiting
- ☐ Prefer not to answer

5. **Highest level of education completed:**
   - ☐ No education / incomplete primary education
   - ☐ 9-year compulsory education
   - ☐ Secondary education
   - ☐ Vocational education
   - ☐ University
   - ☐ Postgraduate
6. **Your employment status:**
   - ☐ Full-time employed
   - ☐ Part-time employed
   - ☐ Self-employed
   - ☐ Unemployed
   - ☐ Pensioner
   - ☐ Student
   - ☐ Homemaker
   - ☐ Other: _____
7. **How would you describe your household's economic condition?**
   - ☐ Very difficult
   - ☐ Difficult
   - ☐ Average
   - ☐ Good
   - ☐ Very good
8. **How many people live in your household?** ___ persons
9. **Does your household include persons belonging to one or more of the following categories?**
   - ☐ Older adults aged 65+
   - ☐ Persons with disabilities
   - ☐ Persons with chronic illnesses
   - ☐ Pregnant women / postpartum mothers
   - ☐ Children under 5 years old
   - ☐ None of the above
   - ☐ Other: _____
10. **Do you personally belong to any of the following categories?**

- ☐ Person with chronic illness
- ☐ Person with disability
- ☐ Older adult aged 65+
- ☐ Family caregiver for a person in need
- ☐ None of the above
- ☐ Prefer not to answer

11. Do you have public or private health insurance coverage?

- ☐ Yes
- ☐ No
- ☐ Do not know

Section B. Use of Healthcare Services

12. During the last 12 months, have you used any healthcare service?

- ☐ Yes
- ☐ No

If "No," skip to Question 20.

13. **What type of healthcare service have you used during the last 12 months?** (You may select more than one)

- ☐ Visit to family doctor
- ☐ Specialist consultation
- ☐ Emergency service
- ☐ Hospitalization / inpatient care
- ☐ Laboratory tests
- ☐ Imaging examinations
- ☐ Prescription / medication services
- ☐ Mental health services
- ☐ Child healthcare services
- ☐ Reproductive health services
- ☐ Other: _____

14. How often have you used healthcare services during the last 12 months?

- ☐ Once
- ☐ 2–3 times
- ☐ 4–6 times
- ☐ More than 6 times

15. What is the first place you usually turn to when you need healthcare?

- ☐ Health center / family doctor
- ☐ Hospital
- ☐ Emergency room
- ☐ Pharmacy
- ☐ Private clinic
- ☐ I do not immediately turn anywhere
- ☐ Other: _____

16. How easy is it for you to identify where to obtain the healthcare service you need?

- ☐ Very easy
- ☐ Easy
- ☐ Moderately easy
- ☐ Difficult
- ☐ Very difficult

17. During the last 12 months, were there situations when you needed healthcare but did not receive it?

- ☐ Yes
- ☐ No
- ☐ I am not sure

18. **If yes, what was the main reason?**
(You may select more than one)

- ☐ The cost was unaffordable
- ☐ The service was too far away
- ☐ I did not have transportation
- ☐ Waiting time was too long
- ☐ There was no doctor / specialist available
- ☐ I did not know where to go
- ☐ I lacked documentation
- ☐ The schedule was not suitable
- ☐ I was not received / did not get a response
- ☐ I thought the problem would go away on its own
- ☐ Fear / distrust toward the service
- ☐ Other: _____

Section C. Access to Healthcare Services

19. How long does it usually take you to reach the healthcare service you use most often?

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

20. What type of transportation do you use to reach the service?

- ☐ Walking
- ☐ Public transportation
- ☐ Private car
- ☐ Taxi
- ☐ Transportation organized by family members
- ☐ Ambulance
- ☐ Other: _____

21. To what extent is transportation a problem in obtaining healthcare services?

- ☐ Not a problem at all
- ☐ Minor problem
- ☐ Moderate problem
- ☐ Major problem
- ☐ Very major problem

22. How long do you usually wait to receive the service once you arrive?

- ☐ I do not wait at all
- ☐ Up to 30 minutes
- ☐ 31 minutes – 1 hour
- ☐ 1–2 hours
- ☐ Over 2 hours

23. How suitable are the service hours for you?

- ☐ Very suitable
- ☐ Suitable
- ☐ Somewhat suitable
- ☐ Unsuitable
- ☐ Very unsuitable

24. **Have you experienced difficulties with:**

Type of difficulty	**YES**	**NO**
Finding information about the service		
Administrative procedures		

Referrals from one service to another		
Waiting lists		
Lack of personnel		
Lack of medicines / supplies		

25. Overall, how would you rate your access to healthcare services?

- ☐ Very good
- ☐ Good
- ☐ Average
- ☐ Poor
- ☐ Very poor

Section D. Economic Affordability

26. Have you made out-of-pocket payments for healthcare services during the last 12 months?

- ☐ Yes
- ☐ No
- ☐ Do not know

27. For which of the following have you most often paid out-of-pocket?

- ☐ Medical visits
- ☐ Specialist visits
- ☐ Laboratory tests
- ☐ Imaging examinations
- ☐ Medicines
- ☐ Transportation
- ☐ Private services
- ☐ Other: _____

28. How often have you postponed or avoided receiving services for economic reasons?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very often

29. What is the greatest economic burden for you related to healthcare?

- ☐ Medical visits
- ☐ Laboratory tests

- ☐ Medicines
- ☐ Transportation
- ☐ Loss of income during illness
- ☐ Other: _____

Section F. Service Needs and Gaps

30. **In your opinion, what are the main healthcare needs of your community?** (You may select up to 3)
    - ☐ More family doctors
    - ☐ 24/7 emergency services
    - ☐ More specialists
    - ☐ Shorter waiting times
    - ☐ Services closer to the community
    - ☐ More available medicines
    - ☐ More laboratory tests / examinations
    - ☐ More information for citizens
    - ☐ More affordable services
    - ☐ Support for vulnerable groups
    - ☐ Mental health services
    - ☐ Services for older adults
    - ☐ Services for persons with disabilities
    - ☐ Ambulance services
    - ☐ Other: _____
31. **Do you think information about healthcare services during health emergencies is sufficient for the community?**
    - ☐ Yes, completely
    - ☐ Yes, to some extent
    - ☐ No, not sufficiently
    - ☐ Not at all
    - ☐ I do not know
32. **What is the most urgent need that should be addressed?**

_____

_____

Section G. Vulnerability, Equality, and Exclusion

33. **In your opinion, which groups face the greatest difficulties in obtaining healthcare services in your community?**
(You may select more than one)

- ☐ Older adults
- ☐ Persons with disabilities
- ☐ Persons with chronic illnesses
- ☐ Low-income families
- ☐ Residents of rural / remote areas
- ☐ Women
- ☐ Children
- ☐ Unemployed individuals
- ☐ Minorities / marginalized communities
- ☐ Uninsured persons
- ☐ Other: _____

34. **Why do you think these groups face greater difficulties?**
(You may select more than one)

- ☐ Poverty
- ☐ Distance
- ☐ Lack of transportation
- ☐ Lack of information
- ☐ Physical / infrastructural barriers
- ☐ Discrimination / prejudice
- ☐ Lack of caregiver / support
- ☐ Administrative procedures
- ☐ Costs
- ☐ Other: _____

35. Do you think all citizens are treated equally within the healthcare system?

- ☐ Yes
- ☐ No
- ☐ To some extent
- ☐ I do not know

36. Have you personally experienced any situation where it was more difficult to obtain services because of:

Factor	**Yes**	**No**
Economic condition		
Place of residence		

Age		
Health condition		
Disability		
Gender		
Lack of documents / insurance		

37. How protected do you think vulnerable groups are by the healthcare system?

- ☐ Very protected
- ☐ Protected
- ☐ Moderately protected
- ☐ Poorly protected
- ☐ Not protected at all

Section H. Communication and Information

38. From which sources do you usually obtain information about healthcare services?

- ☐ Healthcare personnel
- ☐ Family / friends
- ☐ Social media
- ☐ TV / radio
- ☐ Official online websites
- ☐ e-Albania / digital platforms
- ☐ Other: _____

39. How understandable is the information provided about healthcare services?

- ☐ Very understandable
- ☐ Understandable
- ☐ To some extent
- ☐ Unclear
- ☐ Very unclear

40. Which method would be most useful for informing the community?

- ☐ Community meetings
- ☐ Printed materials
- ☐ Online tools / social media
- ☐ Information through health centers
- ☐ Phone / SMS

- ☐ Local media
- ☐ Other: _____

Section I. Suggestions and Recommendations

41. Would you like to share any additional experience or comment related to healthcare services?

_____

_____