



Evaluation of the urban family physician plan in Iran using the European Foundation for Quality Management (EFQM) model

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Abstract:

Introduction: The Urban Family Physician plan was established based on primary health care in two provinces of Fars and Mazandaran (Iran). There is insufficient information on the program's effectiveness. This study aims to evaluate the performance of the urban family physician plan using the European Foundation for Quality Management (EFQM) model.

Methods: In a cross-sectional study, physicians and health service providers (n=233) and their clients (n=199) of urban family physicians were selected through multi-stage sampling from Shiraz, Iran. The data were collected using a researcher-made questionnaire based on the EFQM model. Its content and face validity were confirmed by expert panels, and its reliability was assessed using Cronbach's alpha. Data analysis was performed using descriptive statistics, one-sample tests, and MANOVA in SPSS version 25. In all tests, a two-sided significance level of 5% was considered.

Results: No statistically significant difference was observed between physicians and health service providers, except for the staff dimension (p=0.023). On the other hand, the dimensions related to service recipients between women and men were tested using multivariate analysis of variance. Based on these results, no statistically significant difference was observed between women and men (P>0.05).

Conclusion: Based on the evaluation, the scheme's overall performance in key dimensions, especially in staff and leadership, falls short of expected standards. These results indicate a pressing need to improve human resource management, upgrade skills, and motivate staff.

Keywords: Urban family physician, Health care reform, Iran

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Introduction

There are various systems for providing health services in the world, and each of these systems has its own advantages and disadvantages. Over the past century, a model called family medicine has been introduced worldwide and adopted in Iran under the name family physician. As one of the key programs of the health system, this plan tries to reduce the financial burden of the health system by focusing on preventive care and management of chronic

diseases, while improving the quality of services(1, 2). This program was implemented in rural areas of Iran in 2005 and in the cities of Mazandaran and Fars province in 2012 (3). Evaluating such a plan, especially after more than a decade of its implementation, is necessary because it reveals the status of the plan's implementation (4). The program's extensive and complex nature necessitates a targeted evaluation. Given the variety of evaluation methods available, a specific, tailored approach is required to accurately assess its components and outcomes.

Due to the drawbacks of traditional evaluation models, new performance frameworks have emerged. With new public management in the

public sector—emphasizing productivity, cost reduction, and accountability—organizations have adopted organizational excellence models to address environmental requirements and challenges (5, 6). One of these models is the European Foundation for Quality Management (EFQM). The EFQM Excellence Model provides an integrative framework for quality management, encompassing results, customer focus, information management, and employee satisfaction. A key benefit reported by leading European managers is that EFQM enables rapid implementation of innovations in practice, yielding a genuine competitive advantage (7, 8).

The EFFQM model, as a powerful tool for identifying strengths and areas for improvement in organizations such as medical universities, is an absolute necessity that must be used to create transformation and innovation (9).

The urban family physician program in Iran aims to reduce health costs while improving preventive care and chronic disease management, but its decade-long, complex implementation requires a targeted evaluation beyond traditional methods. Adopting an organizational excellence framework like EFQM offers a comprehensive, evidence-based means to assess strengths and weaknesses, identify drivers of patient and employee outcomes, and generate actionable recommendations for policymakers and health managers to enhance performance, adaptability, and sustainability within the health system. Due to this, our study aims to evaluate the performance of the urban family physician plan using the European Foundation for Quality Management (EFQM) model

Methods

Design and sampling

This study was a cross-sectional study conducted in Shiraz city, based on the urban family physician plan, and included two health sub-teams (physicians and health care providers) on the one hand, and service recipients on the other. The sample comprised 233 staff and 199 service

recipients. Physicians and supervisors were sampled using simple random sampling from the existing list of physicians' offices and clinics in the Family Physician Unit of Shiraz University of Medical Sciences (SUMS). The centers were selected using random numbers generated by the computer. The sub-population of service recipients was selected using a consecutive sampling method from referrals to these centers. No sample was selected from the offices that did not have any referrals at that time. Given that the data collection method was in-person interviews conducted by the monitoring team, from the very beginning, people who did not agree to cooperate for any reason were not included in the study and were replaced by others; as a result, the responses were complete.

Data collection method

In-person interviews conducted by the family physician monitoring team. From the outset, individuals who declined to participate for any reason were excluded from the study and subsequently replaced by other participants. Consequently, the responses obtained constitute a complete dataset from enrolled participants.

Measuring tools

The data were collected using the EFQM model (7) and a researcher-made questionnaire (Supplementary). These questionnaires were developed within the EFQM model framework. Initially, a number of questions were extracted from past studies (10-12). Then, the main items were selected, and the questionnaire was designed accordingly. The number of items and different domains was shown in Table 1. The questionnaire's validity was evaluated by a panel of experts using face and content validity. Also, the questionnaire's reliability was measured using Cronbach's alpha, with the results summarized in Table 1. Each item was scored on a 5-point Likert scale (very low 1, low 2, average 3, high 4, very high 5), and the algebraic sum of the items for each dimension was calculated. After that, the scores were converted based on a scale of 0 to 100. Then, the scores obtained in each dimension were used as the basis for analysis.

Table 1. Domains and number of items in each domain, and their reliability based on the EFQM model

Scale	Number of items	Alpha	95% CI	
			Lower	Upper
leadership	4	0.721	0.657	0.775
Staff	4	0.724	0.661	0.778
Resources	6	0.755	0.701	0.792
Processes	6	0.963	0.955	0.971
Policy and Strategy	4	0.658	0.574	0.728
Employee results	6	0.714	0.650	0.770
Key performance outcomes	4	0.714	0.649	0.770
Community results	4	0.630	0.534	0.702
Customer results	8	0.945	0.932	0.955
Total	46	-	-	-

Statistical methods

In this study, descriptive and analytical statistical methods were used to analyze the data. In the descriptive section, the data were described using the mean and standard deviation for quantitative data and the number (%) for qualitative data. In the analytical section, a one-sample t-test and a multivariate analysis of variance (MANOVA) were used. The tests were two-sided with a 5% significance level and conducted using SPSS version 25.

Ethical considerations

In this study, participants provided verbal informed consent. The study was also approved by the Ethics Committee of Shiraz University of Medical Sciences. (Code: IR.SUMS.MED.REC.1404.349).

Results

In this study, 233 participants were included in the urban family physician subpopulation, of whom 56 (24%) were physicians, and 177 (76.0%) were health care providers. The age of the study subjects ranged from 23 to 77 years, with a mean age of 40.51 ± 11.02 years. 19.3% of them were women. The demographic characteristics of the study subjects in the health team members subgroup are presented in Table 2. Also, 199 Service recipients aged 18 to 74 years, with a mean age of 41.28 ± 11.82 years, participated in this study; the majority of whom

(80.4%, 160) were female. The demographic characteristics of these participants are also summarized in Table 2.

The results of each dimension of the EFQM model based on the responses of employees and service recipients are given in Table 3. In this table, all scores are calculated on a 100-point scale and compared with the expected level of 75, which serves as the critical point. An average score below 75 was considered inappropriate. As shown in the table, all scores are below the defined level. In fact, they are in an inappropriate situation. However, from the employees' perspective, resources have the highest score, and staff has the lowest. Also, the two dimensions of customer results and processes that are related to service recipients have the highest average score.

The different dimensions of the EFQM model within the staff group, between physicians and health care workers, were tested using MANOVA; the results are presented in Table 4. The results showed no statistically significant difference between the two groups, except for the staff dimension ($p=0.023$).

On the other hand, the dimensions related to service recipients between women and men were tested using multivariate analysis of variance, the results of which are summarized in Table 5. Based on these results, no statistically

significant difference was observed between women and men) $P>0.05$)

Table 2. Demographic data of health workers in urban family physicians and their Service recipients

Health workers	
Variables	Value
Age, y, mean $\pm$ SD	40.51 $\pm$ 11.02
Sex (male) n (%)	44 (18.9)
Position, n (%)	
Physician	54 (23.2)
Health care provider	179 (76.8)
Nurse	21 (9.0%)
Midwife	77 (33.0)
Public health expert	81 (34.8)
Work experience with a family physician, months, mean $\pm$ SD	78.05 $\pm$ 58.84
Full-time employment in the program, n (%)	195 (83.7)
Service recipients	
Age, y, mean $\pm$ SD	41.28 $\pm$ 11.82
Sex (male) n, (%)	39 (19.6)
Under diploma	26 (13.1)
Diploma	33 (16.6)
Postgraduate diploma	16 (8.0)
Bachelor's degree	86 (43.2)
Master's degree and above	38 (19.1)

Table 3. Descriptive statistics and significance values for different dimensions of the EFQM model

Scale	Minimum	Maximum	Mean	SD	Criteria	P-value	Status
Leadership	0	87.5	48.55	16.84	75	<0.001	Not suitable
Staff	0	93.75	38.0	18.27	75	<0.001	Not suitable
Resources	0	95.83	59.88	17.31	75	<0.001	Not suitable
Processes	0	100	67.99	21.34	75	<0.001	Not suitable
Policy and Strategy	0	93.75	56.92	16.47	75	<0.001	Not suitable
Employee results	8.33	87.5	49.23	13.64	75	<0.001	Not suitable
Key performance outcomes	6.25	93.75	57.26	19.28	75	<0.001	Not suitable
Community results	0	87.5	48.33	17.21	75	<0.001	Not suitable
Customer results	4.17	100	65.01	22.49	75	<0.001	Not suitable

Table 4. Comparison of different dimensions of the EFQM model between physicians and healthcare staff.

Scale	Physicians		Healthcare providers		P value
	Mean	SD	Mean	SD	
leadership	50.11	18.51	48.07	16.33	0.437
Staff	42.93	15.92	36.52	18.71	0.023
Resources	61.57	15.54	59.38	17.83	0.416
Policy and Strategy	59.60	13.72	56.11	17.17	0.172
Employee results	47.45	12.64	43.92	13.60	0.450
Key performance outcomes	60.06	17.44	56.42	19.78	0.224
Community results	48.49	17.38	48.28	17.20	0.939

Table 5. Comparison of different dimensions of the EFQM model between male and female service recipients

Scale	Male		Female		P value
	Mean	SD	Mean	SD	
Processes	68.69	20.85	64.11	22.85	0.255
Customer results	71.07	19.69	67.24	21.34	0.317

Discussion

The health system needs leaders who can set the vision, motivate employees, and drive the organization toward excellence. Leaders who can create efficient processes and ensure quality. Leading a health system means facing challenges such as complex structures, unfamiliar strategic and operational issues, and rapid change. Leadership development is a strategic imperative (13). A low score on this dimension may indicate poor coordination across management levels and ineffective communication of the family physician plan's goals and strategies. Incoherent leadership can cause confusion and reduced employee commitment. In fact, leadership is the most fundamental function of employee management and should have the knowledge and potential to make decisions (13, 14).

Strategy defines how the organization will achieve its goals. In the family physician plan, documented strategies to promote health, ensure equity in access, and maintain continuity of care are essential. A low score in this dimension may indicate a lack of strategic

planning, unclear implementation guidelines, and a mismatch between national goals and local implementation of the plan. Establishing and developing strategies is essential for health organizations (15).

Employees are the most important asset of the health system. The general policies of the country's administrative system are based on justice and meritocracy in recruiting, ensuring job security, developing knowledge and expertise, and improving the quality of human resources in terms of commitment and conscientiousness (16). In the family physician plan, the role of physicians and health care providers is very decisive. Their level of satisfaction, motivation, and participation is highly influential in improving the organization's performance. A low score on this dimension, which obtained the lowest value in the present study, can indicate job burnout, high work pressure, an inadequate reward system, and a lack of motivation among human resources. The Partnerships and Resources dimension in the EFQM model

focuses on how the organization manages resources effectively and efficiently(13).

In the Family Physician Plan, the availability of sufficient resources to provide equipment, information systems, and human resources is of great importance. This dimension has received the highest score among other enabling dimensions, indicating that the organization has been somewhat more successful in providing resources, but is still far from the standards of excellence. Processes are policies and procedures that support and support the organization's strategy and enable employees to meet the needs and expectations of internal and external customers with respect to strategic areas(16).

In family medicine, the proper design of processes such as referrals, ongoing care, and patient follow-up is critical. This dimension has one of the highest staff scores, suggesting relative consistency in the implementation of some processes. However, to achieve excellence, continuous review and optimization are needed. The customer outcomes dimension refers to the level of satisfaction and trust of service recipients. A relatively high score on this dimension in the family medicine plan may indicate greater satisfaction among service recipients and patients with interactions with family physicians and primary care providers. But it is still far from the desired level. A successful doctor-client relationship, access to services, quality of services, and the ability to provide services correctly and on time are factors affecting satisfaction (17, 18).

The employee results dimension shows employees' levels of satisfaction, motivation, and commitment. Ignoring service providers' satisfaction will eventually lead to their indifference, which will seriously undermine service quantity and, over time, quality. Satisfaction with wages, appropriate working conditions, honesty, and cooperation among colleagues can be effective in creating job satisfaction (18). The score obtained in this dimension in the present study is clear evidence of serious dissatisfaction among the staff of the family physician plan. The community outcomes dimension addresses the

impacts of the family physician plan on the community.

The family physician should be effective in promoting public health and increasing health literacy in the community. A low score in this dimension could indicate a lack of educational activities and poor dissemination of information. Access to appropriate knowledge and the development of the correct attitude in people require education and information. People expect their family physician to familiarize them with health-related issues. However, if the family physician team does not receive money and benefits when providing preventive and health services, such as medical services, they will certainly pay less attention to preventive and sociological issues(18-21).

Key performance results, as one of the model's outcome dimensions, measure the organization's final achievements against the set goals and specific performance indicators. In the urban family physician plan, this dimension can include indicators such as population coverage, referral rates, reductions in treatment costs, reductions in the burden of referrals to specialized centers, and increased public health. A low score in this dimension indicates that the program has serious weaknesses in achieving its macro goals and has not attained an acceptable level of effectiveness and efficiency. The European Performance Excellence Model of Quality Management is based on the hypothesis that excellent results, including key performance results, can be achieved through strong leadership, competent and committed employees, appropriate processes, and capable resources and partnerships. The link between the organization's goal and strategy simultaneously ensures performance and drives transformation.

Study limitations

Urban family medicine is being implemented in two provinces: Mazandaran and Fars, while this study was only conducted in Shiraz, which could distort the generalizability of the study. Also, the absence of standard questionnaires and the variation in

methodologies across previous studies may limit the generalizability of findings.

Conclusion

The performance evaluation of the Urban Family Physician plan, based on the organizational excellence model, showed that the project's overall performance across all key dimensions, especially staff and leadership, is below the desired level and established standards.

This indicates the need for special attention to improving the human resource management system, enhancing skills, and motivating the project's staff. On the other hand, despite the challenges, the dimensions of resources, customer outcomes, and processes had relatively higher scores, indicating the potential for strategic and operational improvement of the Family Physician plan. This provides a good opportunity for policymakers and managers to focus on strengthening leadership, developing effective strategies, and building innovation and learning systems to provide a basis for improving service quality.

Finally, the results of this study emphasize that the successful implementation of the Urban Family Physician plan requires a comprehensive, integrated approach grounded in the EFQM model to improve patient and staff satisfaction and enhance the overall effectiveness of the health system by reforming structures and processes. This is only possible through the continuous cooperation of all stakeholders and the adoption of innovative solutions in program management and implementation.

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Authors' Contribution

Z.Z., L.F., and Y.A. conceptualized the study, conducted the research, wrote the manuscript, and approved the final version of the manuscript.

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Data Availability

The research data are available and can be sent upon contacting the corresponding author.

Ethics Approval

The study was approved by the Shiraz University of Medical Sciences Local Ethics Committee (code: IR.SUMS.MED.REC.1404.349).

Conflict of Interest

There are no conflicts of interest

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Appendix:

Family Physician Program Questionnaire

Consent from the Interviewee:

We need to assess the quality of the Family Physician Program to plan for the future and improve the information collection system. We would like your cooperation in this regard. This interview will take about half an hour, and you may choose not to answer any part of the questionnaire or any question you do not wish to answer. We assure you that the information will remain anonymous and completely confidential, and the data will be analyzed collectively. If you are willing to participate in this study, please give your consent and answer the questions honestly and accurately.

Research Team: 1- Yes, I give my consent. 2- No, I do not give my consent.

Section A – General Information related to the Center		
Respondent:	1- Family Physician	2- Health Care Provider

Section B – Demographic Information:		
Gender:	1- Male	2- Female
Age (years):		
How long have you been in the Family Physician Program? months. How long have you been in this center/base? months		

Please indicate your opinion regarding the Family Physician Program:

Leadership	Very little	Low	Average	A lot	Too much
Does the Family Physician Program prioritize health over treatment?					
Has the program achieved its goals?					
To what extent are people aware of the program's objectives and cooperate?					
How effective is inter-sectoral cooperation (Ministry of Health and other organizations, such as insurance)?					
Staff	Very little	Low	Average	A lot	Too much
Has the program ensured your job security?					
Are you satisfied with local authorities' follow-up?					
Do you find the supervision of officials reasonable?					
Are you satisfied with staff training and instruction?					
Strategy	Very little	Low	Average	A lot	Too much
Has the Health Center/Medical University fulfilled its commitments?					
Do you find IT systems (e-health, AI, etc.) important for efficiency?					
How effective is sustainable financing for program performance?					
How effective is proper use of the referral system (level 1 to level 2)?					
Participation & Resources	Very little	Low	Average	A lot	Too much
Are media and government effective in informing the public?					
Is training and empowering general practitioners important?					
Is it important to train and employ family physicians at universities?					
Is public participation effective in improving the program?					

How useful are the Family Physician Program's systems?					
Are you satisfied with the available facilities (internet, water, electricity, gas, etc.)?					
Key Performance Results	Very little	Low	Average	A lot	Too much
Has the program reduced people's medical costs?					
Has it improved health indicators?					
Has it improved public health?					
Has higher-level supervision improved efficiency?					
Staff Results	Very little	Low	Average	A lot	Too much
Are you satisfied with the behavior of the covered population?					
Do you believe your income is unfair compared to the services provided?					
Are you satisfied with access to your workplace (distance, etc.)?					
Are you satisfied with the cooperation of local officials?					
Are you satisfied with your colleagues?					
Are you satisfied with your salary and income?					
Community Results	Very little	Low	Average	A lot	Too much
Has the program helped prevent communicable diseases?					
Has it helped prevent non-communicable diseases (diabetes, obesity, hypertension, etc.)?					
Are people's requests reasonable?					
Are local officials' requests aligned with program goals?					

Service recipient questionnaire

Participant Consent:

We need to gather information from you on the quality of the Urban Family Physician Program to inform future planning and improve the information collection system. We would like you to cooperate with us on these matters.

This interview will take about 30 minutes, and you are free to skip any question or the entire questionnaire if you wish. We assure you that all information will remain anonymous and confidential, and that the data will be analyzed collectively.

If you agree to participate in this study, please give your consent and answer the questions as accurately and honestly as possible.

Research Team ☐ Yes, I agree. ☐ No, I do not agree.

Demographic Information	
1. Gender:	☐ Male ☐ Female
2. Age (years):	
3. Occupation:	
4. Education Level:	Illiterate Primary ☐ Primary School ☐ School Middle to High School ☐ High School Diploma ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Professional Doctorate / Specialist ☐

Please indicate your level of satisfaction. Use the given scale to select the degree that best reflects your opinion.

Questions	Not at all	Low	Moderate	High	Very High
	1	2	3	4	5

Physician's attitude and explanations regarding your consultation questions					
Health workers' attitude and explanations regarding your consultation questions					
Education provided by the health worker					
Accuracy and appropriate time spent on clinical examinations and assessments					
Reviewing your medical history and giving enough time for you to explain your illness history					
Providing enough time to read your test results and related materials.					
Overall, how satisfied are you with this health worker?					
Overall, how satisfied are you with this family physician?					
Health workers' responses and explanations regarding completing health questionnaires, files, forms, or examinations					
Family physician's response and explanations regarding your illness and prescribed medications					
Punctuality and regularity of the health worker in the workplace					
Punctuality and regularity of the family physician in the clinic/center					
Health workers' follow-ups and communication with you					
Follow up on your illness and conduct periodic examinations					