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PRIMARY CARE AND SOCIAL SERVICES IN ALBANIA

Capitalisation report

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ACRONYMS

CHCIF	Compulsory Health Care Insurance Fund
CMHC	Community Mental Health Centre
CPD	Continuous Professional Development
E-visitas	National electronic primary health care reporting platform
EU	European Union
FD	Family Doctor
FN	Family Nurse
HAP	Health for All Project
HC	Health Centre
HO	Health Operator
ICC	Integrated Community Care
LUHC	Local Unit of Health Care
MoHSW	Ministry of Health and Social Welfare
NARU	Needs Assessment and Referral Unit
NGO	Non-Governmental Organization
PHC	Primary Health Care
SDC	Swiss Agency for Development and Cooperation
SHSSH	State Social Service (Shërbimi Social Shtetëror)
SHC	Social and Health Care Center
TOR	Terms of Reference
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPHV	Universal Progressive Home Visiting
WHO	World Health Organization
Swiss TPH	Swiss Tropical and Public Health Institute

EXECUTIVE SUMMARY

Background and Purpose

Since 2015, the Swiss Development and Cooperation-funded Health for All Project (HAP) has supported Albania's Ministry of Health and Social Welfare (MoHSW) in strengthening primary health care (PHC) and advancing more people-centred services. In recent years, Albania has accelerated reforms to bring mental health and social services closer to PHC, notably through the introduction of psychologists or social workers into 102 "Social Health Centres" (SHC) (Statute of Health Center, Order of MoHSW, July 13, 2022, prot.no.2954) and through strengthened municipal social services under decentralisation reforms.

As HAP enters a capitalisation phase, this report examines the current state of integration between health and social services in Albania, with a primary focus on PHC-level integration and HAP-supported reforms. The objective is to describe existing integration models, identify enabling factors and bottlenecks, and highlight strategic issues for future consolidation.

In this report, "integration" does not imply institutional merger between health and social sectors. Rather, it refers to a range of mechanisms that facilitate coordination between professionals and services, including inter-professional collaboration, and coordinated workflows aimed at responding to the combined medical, psychological, and social needs of individuals. The analysis draws on qualitative fieldwork (mission 9–13 February 2026), interviews with national and local stakeholders, site visits to PHC/SHCs and municipal facilities, and review of relevant policy documents.

Generic overview of health-social integration

Following several policy developments, health–social integration in Albania does not follow a single unified model. Instead, multiple coexisting approaches operate in parallel:

1. PHC-led integration, including:

- Co-location of psychologists or social workers within PHC (SHCs) family medicine teams;
- Home care service for elderly and homebound patients (supported by HAP);
- Universal Progressive Home Visiting (UPHV) for maternal and child health (supported by UNICEF);
- Referral linkages with Community Mental Health Centres.

2. Social-sector-led integration, including:

- Municipal Needs Assessment and Referral Units (NARUs);
- Municipal community centres delivering multidisciplinary services (supported by UNDP/UN organisations);
- State Social Service disability assessment commissions (supported by UNICEF).

3. NGO model, such as home-based palliative care delivered by Family Doctors under project-based arrangements (standalone initiatives led by civil society actors in collaboration with the health and social sector).

These models reflect different service packages such as shared case management, multidisciplinary co-delivery of services, facilitated interface collaboration between health and social services (e.g. through structured administrative procedures). The policy framework across sectors is strongly supportive of intersectoral collaboration, but consolidation mechanisms (e.g. shared governance, pooled financing, integrated information systems, and joint monitoring) remain underdeveloped.

Integration of psychosocial professionals within PHC: Key findings

The co-location of psychologists or social workers within PHC teams and their positioning at socio-health centre level is a model of PHC-led integration, supported by several HAP interventions.

Policy and staffing progress: National policies have formalised the creation of Social Health Centres (Statute of Health Center, Order of MoHSW, July 13, 2022, prot.no.2954) which are PHC centres hosting psychologist and social workers in the family medicine team. As of early 2026, around 100 PHC centres have employed psychosocial professionals (approximately 70 psychologists and 30 Social Workers are employed nationwide), representing about one-third of health centres. Psychosocial positions are financed through the national health budget via Health Insurance Fund contracts, ensuring basic staffing sustainability.

Service delivery and team collaboration: At facility level, integration is visible through concrete collaboration. Psychosocial professionals participate in case discussions, internal referrals, joint planning of care to patients, assisting patients compiling files to benefit from social protection system and representing them into other institutions out of health centre, and in some cases home visits. Interviews consistently highlighted constructive interprofessional relationships and positive team culture. The presence of psychosocial staff has improved PHC responsiveness to mental health and social vulnerabilities among patients already connected to PHC.

Role clarification and technical guidance: HAP has played a significant role in clarifying professional roles of Social Worker and Psychologist through job profiles, multidisciplinary mental health guidelines/training, and the development of a Manual for Psychologists in PHC, approved by MoHSW, Order nr.103, dated 02.02, 2026. A manual for social workers is under elaboration. These tools have strengthened, overall recognition, role clarity and interprofessional understanding.

Despite progress at policy and facility levels, several gaps limit consolidation/sustainability.

Governance and coordination gaps: There is no formal coordination mechanism between PHC and Social Protection divisions within the MoHSW to steer health–social integration. There is no designated integration focal point within the PHC division of the MoHSW. Health Operators (HO) and Local Units of Health Care (LUHC) play mainly administrative and reporting roles, with limited managerial oversight or supportive supervision of the interprofessional team. Operational leadership is concentrated at facility level, leading to variability in implementation and practices.

Financing and payment: Health and social protection system (including social services) operate under separate budget frameworks, with no pooled or coordinated funding. There is no dedicated budget line for joint functions (e.g. meetings, coordination time, outreach costs). Many enabling elements (guidelines, training, tools) have relied on external technical assistance (e.g. HAP support). Psychosocial staff salaries are secured, but broader integration functions are not systematically financed.

Supervision and professional support: There is no structured supportive supervision system for psychosocial professionals. There is uneven access to accredited continuous professional development (CPD) for social workers and psychologists, with uncertainties around credit recognition. These gaps may affect staff wellbeing, professional motivation, and long-term retention, as well as their ability to maintain their licenses.

Information systems and digital integration: Psychosocial professionals do not have full access to the national electronic platform for data reporting and referrals (E-visitas). Within the PHC teams, referrals and documentation of psychosocial services often rely on paper-based or informal practices. Ethics around information sharing within teams must be clarified.

Measurement and accountability: Monitoring focuses on service volumes rather than quality of coordination or patient-level outcomes. There are no shared indicators to track integrated case trajectories or cross-sector outcomes. Integration remains largely invisible in performance frameworks, with weak incentives for integrated service delivery.

Strategic questions for consolidation (for capitalisation workshop)

Albania has achieved meaningful progress in the area of integrated health and social services. However, integration is progressing unevenly across dimensions. Key strategic questions for the consolidation of these models include:

Ministerial coordination: Should a formal coordination framework or focal mechanism be established to align PHC and Social Protection divisions?

Regional governance: Should HO/LUHC structures assume a clearer mandate for supervision, quality assurance, and guidance of inter-professional collaboration practices?

Financing interprofessional and payment mechanisms: how should services delivered by inter-professional teams be funded (beyond staff salaries), e.g. the specific costs that occur from inter-professional tasks such as transport for home visits, etc? Is greater alignment between health and social budgets feasible?

Professional institutionalisation: Which institutions should lead the formal clarification of psychosocial staff roles (Psychologist and Social Worker role in PHC), CPD accreditation of psychologists and social workers, regulatory alignment and further professional development of these roles in PHC?

Measurement and digital traceability: Can monitoring systems evolve toward indicators that better reflect inter-professional collaboration practices and outcomes? Can monitoring system improve digital reporting/documentation of psychosocial services and referrals?

Conclusion

Albania's health–social service collaboration is supported by a strong policy framework and shows visible progress at PHC level (other models were not assessed in this report). Psychosocial integration within PHC teams is operational and valued, particularly where supported by HAP's technical assistance.

However, consolidation now requires a shift from project-supported models to system-level institutionalisation into a single framework. Strengthening governance alignment, supervision mechanisms, financing structures, digital integration, and performance measurement will be critical to transforming multiple parallel integration initiatives into a more coherent and sustainable integrated care framework.

1. INTRODUCTION AND SCOPE

Context

1.1 The Health for All Project (HAP, 2015-2027) funded by the Swiss Development and Cooperation Agency (SDC) aims to improve the health of the Albanian population through strengthened primary health care (PHC). The project supports the Ministry of Health and Social Welfare (MoHSW) of Albania and its regional structures to manage PHC services more effectively, while ensuring that citizens in targeted regions have access to higher-quality, people-centred care.

Since 2022, Albania has accelerated efforts to bring mental health and social services closer to PHC. HAP has supported this reform process through technical and capacity-building interventions targeting general practitioners, nurses, as well as psychosocial professionals (Psychologists and Social Workers), as part of the family medicine team approach. Through these contributions, HAP has reinforced multidisciplinary teamwork and supported the operationalisation of psychosocial roles within PHC.

As the HAP project reaches a capitalisation phase, it is documenting several aspects of its support to the Albanian primary health and social systems/care to foster reflections among national actors and partners on achievement, bottlenecks and perspectives for future developments.

Purpose of the Assignment

1.2 The purpose of this assignment is to document and analyse the current state of inter-professional collaboration between health and social services in Albania, with particular attention to MoHSW PHC model that received HAP technical support. The primary focus of the report is on inter-professional collaboration at PHC level, including collaboration between family doctors, nurses, psychologists and social workers, as well as linkages between PHC teams and municipal social services. While the report also provides a rapid overview of selected mechanisms within the social protection service system that have an interface with the health sector, a detailed analysis of social sector-led integration models falls outside the scope of this assignment.

1.3 The report serves as a capitalisation document. It aims to document existing models and practices of inter-professional collaboration in PHC; examine enablers and constraints affecting their functioning; and identify key achievements, bottlenecks and sustainability questions. The objective is analytical and not evaluative. The report does not assess performance against predefined targets but provides a synthesis of how integration is currently conceptualised, operationalised, financed and monitored within Albania's institutions. It is intended to inform discussion among Albanian stakeholders, including the MoHSW, Health Operator, CHCIF, SDC, donors and partners as well as Swiss TPH, and the HAP project.

Methodology

The analysis is based on document review and qualitative fieldwork conducted during a mission that took place between 9th and 13th February 2026. Data sources include:

- Semi-structured interviews with representatives of: HAP team members; MoHSW (PHC and Social Protection divisions); PHC/SHCsfacility staff; Municipal and community-based service providers; UNICEF and UNDP; and national CSO in Albania.
- Site visits to PHC-based Social Health centres (Tirana n°7, Tirana n°8, Patos);
- Site visit to Municipal social service centre of Divjakë, Tirana Municipality Social Service Directory.

- Group interview/workshop with representatives of the health system of Tirana (CHCIF, HO, LUHC, PHC medical and psychosocial staff)
- Review of relevant policy documents and strategies related to PHC reform, mental health, and social protection.

The methodological approach is exploratory and analytical rather than evaluative. It is based on the triangulation of perspectives and the identification of patterns and gaps. The agenda of the mission is available in Annex 6.2.

Defining “integrated social and health services”

“Integrated social and health services" in Albania do not correspond to a single, unified institutional model. This report looks at a broad continuum of formal and informal mechanisms
1.4 (e.g. joint workflows, co-location, referral pathways) at the interface between health and social sectors. We thus use a continuum-based definition of integration to capture a range of approaches, from facilitated interface collaboration to co-delivery of services.

The analysis is structured around five interrelated dimensions that together provide a comprehensive overview of integrated social and health services": (1) Policy framework, governance and leadership; (2) Financing; (3) Service delivery; (4) People, skills and working culture; and (5) Enablers and networks. These dimensions were used to guide document review, and interviews, and serve as the organising framework for documenting integration mechanisms.

1.5 Limits of the analysis

This report is commissioned within the HAP project and therefore places emphasis on PHC-led integration and HAP support to PHC reforms. It does not constitute a comprehensive or in-depth evaluation of other donor-supported or government-led initiatives in the field of social protection or municipal services.

Consultations with partners and other programmes were conducted on a light-touch and exploratory basis, with the aim of mapping experience rather than assessing depth of performance. The analysis seeks to identify patterns and gaps rather than to review or compare partner interventions. Findings should therefore be interpreted as an analytical synthesis for future strategic dialogue.

2.1 2. POLICY FOUNDATIONS AND CURRENT LANDSCAPE OF INTEGRATION

Overview of policy frameworks for integration

Integration between health and social services in Albania has evolved progressively across both sectors. Social workers have long been embedded in maternity hospitals (1996), later in mental health services (community and hospital-based), and then in tertiary hospitals. , Two recent sets of reforms have contributed since 2020–2021 to extend integration of health and social services, namely: 1) PHC reforms, and 2) reforms strengthening municipal social service coordination under decentralisation.

Table 1 below summarises the key policy and regulatory instruments shaping integration at PHC/Municipality levels and clarifies how integration is framed and operationalised in each case.

Table 1: Overview of the policy landscape enabling health and social integration

Policy / Instrument	Sector Lead	Year	How Integration is Framed	Type of Integration
National Health Strategy 2021–2030	MoHSW – Health Policy Directorate	2021	Emphasises people-centred care, PHC strengthening, and addressing social determinants of health. Recognises need for intersectoral collaboration.	Strategic coordination and continuity of care across sectors.
Primary Health Care Strategy 2020–2025	MoHSW – PHC Division	2020	Positions PHC as central entry point; promotes multidisciplinary teams and stronger links with social services.	Team-based integration within PHC (including through home care/home visits models) Referral-based coordination with municipalities.
Mental Health Action Plan 2023–2026	MoHSW – Mental Health Unit	2023	Explicit social-health framing; promotes community-based care and collaboration between PHC, specialised services, and social actors.	Cross-sector collaboration, especially for psychosocial conditions.
Order on Reorganisation of PHC Centres (Social Health Centres)	MoHSW – PHC Division	2022	Formalises inclusion of psychologists and social workers in selected PHC centres (initially 50, now ~100).	Organisational integration within PHC teams.
Law No. 121/2016 "On Social Care Services"	Ministry of Social Welfare (now MoHSW – Social Welfare Division)	2016	Establishes decentralised social care system; mandates municipalities to assess needs and coordinate services.	Formalised intersectoral coordination through Needs Assessment and Referral Units (NARU).
National Social Protection Strategy 2024–2030	MoHSW – Social Protection Division	2024	Expands community-based and long-term care; emphasises collaboration with health services for vulnerable groups.	Municipal-led coordination and case management; community-based service integration.
UNDP Framework and Model of Integrated Social and Health Services	UNDP Albania in cooperation with MoHSW	2021	Provides conceptual and operational model for integrated socio-health services at municipal level; defines case management and referral pathways.	Structured interface model; municipal-led integrated service planning.

From this overview, it appears that interprofessional collaboration between health and social services is not framed as a single, unified reform, but rather as a range of approaches that connect health and social services at different levels. At the strategic level, national health and social protection strategies promote a comprehensive service package at primary care level through the collaboration across sectors and recognise that health outcomes are closely linked to social conditions. Within the health sector, PHC reforms and the establishment of Social Health Centres (PHC centres that host social workers and psychologists) promote closer day-to-day collaboration between multidisciplinary professionals.

In the social sector, the NARU mechanism and Municipal integrated service planning (the 5-year Municipal Social Plans) introduced more structured coordination at municipal level, formalising assessment and referral pathways between social services, PHC services and community-based

mental health services. Overall, the policy landscape reflects a continuum of approaches, from interface facilitation to integrated case management and team-based integration.

Across these policies, however, the mechanisms to support and facilitate integration, such as data sharing/integrated information system, joint budget or unified governance, remain underdeveloped or unevenly used. As a result, even though the policy framework for integration is supportive, few mechanisms were operationally defined at the time these laws were adopted.

2.2 Coexisting integration models/mechanisms in practice

The translation of policy to practice has led to several, co-existing models of integration between health and social services in Albania. Sector-specific models of integration can be observed. They differ in their institutional positioning (PHC-led vs. social-sector-led), governance, and service delivery orientation. They are not mutually exclusive but rather operate in parallel and occasionally intersect at local level.

2.2.1 PHC-led integration models

1.Team integration in PHC centres: With the recent PHC reform, selected health centres have been designated as "Social Health Centres," adding psychologists or social workers to family medicine teams under the coordination of the PHC centre director. This reform builds on the recognition that health outcomes are closely linked to social conditions, psychological wellbeing, and family environments. The rationale for integration is therefore to provide more holistic, person-centred care within PHC, enable earlier identification of mental health and social vulnerabilities, and reduce avoidable referrals to specialised or hospital services.

Psychosocial professionals are co-located within health centres and participate in multidisciplinary teamwork around patient case management. Family doctors and nurses remain the primary entry point for patients, while psychologists and social workers contribute through specialised assessment, counselling, and referral functions. Integration is embedded in daily clinical workflows through case discussions, shared planning, and coordinated follow-up.

Psychosocial professionals are institutionally positioned within the health system. They can refer patients to municipal social services which assist vulnerable people, especially with a range of support including organising benefits application through referral mechanisms. HAP has supported the operationalisation of this approach through role clarification, development of professional profiles, multidisciplinary training, and preparation of manuals and practical guidance (see chapter 3 for more details)

2. Home care service for the elderly and homebound patients (HAP-supported model)

The PHC reform foresees home visits as a mechanism to bring care closer to vulnerable and homebound patients, particularly elderly people and individuals with (multiple) chronic conditions. The rationale is to improve continuity of care, reduce avoidable hospitalisation, and address medical and social vulnerabilities that may not be visible during facility-based consultations.

HAP supported the development and operationalisation of a structured home care model within PHC, including training, protocols, and practical tools for nurses. Under this model, trained family nurses conduct planned home visits to patients identified as homebound or requiring follow-up. Visits are scheduled and organised through the health centre. Nurses provide clinical monitoring, adherence support, and health education, and are trained to perform basic assessments of social vulnerabilities. Where a Social Health Centre includes a social worker, joint home visits may be conducted by the nurse and social worker. When no social worker is present in the PHC centre, the Home Care Nurse can refer the case through the director of the health centre to municipality services, for three specific social services: 1) Support in case the patient has inappropriate

housing conditions; 2) Support in case the patient is excluded from social protection scheme/benefits, 3) support in case the patient is a victim of domestic violence.

In this model, integration occurs through vulnerability screening and referral embedded within home care services. Where psychosocial professionals are available, integration deepens through joint visits; where they are absent, coordination is referral-based.

3. Universal Progressive Home Visiting (UPHV) for maternal and child health (UNICEF-Supported Model)

The Universal Progressive Home Visiting (UPHV) model builds on Albania's long-standing maternal and child home visiting tradition, dating back to earlier public health approaches. It is a nurse-based model, whereby nurses have some tasks related to social screening of patients. Updated with UNICEF technical support, the model aims to strengthen early identification of health and social risks among mothers, newborns, and young children. The rationale is to promote early childhood development, prevent neglect and violence, and identify vulnerabilities such as poverty, psychosocial distress, or family instability at an early stage. As an important difference to the models described above, in this model mothers and young children are the prime target respectively beneficiary group (and not chronically ill).

UPHV aligns with PHC strategy objectives by embedding vulnerability screening within routine maternal and child health services. Under the updated protocol, and during pregnancy and the postnatal period, nurses conduct routine clinical monitoring and preventive health functions (e.g. promotion of vaccination / verification of vaccination record; assessment of child health status) along with an expanded social vulnerability screening. They use revised tools which include vulnerability screening components covering psychosocial risks, family environment, and social vulnerability. Nurses are trained to identify risks and to refer families to child protection units, municipal social services, or other support structures. The model has been piloted in seven regions and discussions are ongoing with the MoHSW regarding scale-up and integration into the national digital reporting platform (E-visitas).

UPHV represents a PHC-led integration mechanism targeting prevention in the early life stages. Integration occurs through structured screening and referral embedded within routine PHC maternal-child services. While coordination with municipal services is referral-based, the model places stronger emphasis on systematic risk identification compared to the chronic home care approach.

4. Community Mental Health Centres (CMHCs)

CMHCs are specialised services under the health sector that often act as referral points for severe mental health cases and sometimes intersect with social protection mechanisms. They are outpatient facilities designed to provide decentralized mental healthcare, aiming to reduce reliance on institutionalized care. These centres offer psychiatry, psychology, and social work services, primarily focusing on managing severe mental disorders. There are only a limited number of such centres operating in major urban areas. They operate as specialised referral structures for PHC services.

2.2.2 Municipal / Social-Care-Led integration models

Highlight: Summarised overview of Municipal and State Social Service organisation in Albania
Social services in Albania operate under a decentralised framework established by Law No. 121/2016 on Social Care Services. Governance is shared between:

- The State Social Service, a central government body under the Ministry of Health and Social Welfare (MoHSW), responsible for administering national social protection schemes, including economic assistance and disability benefits;
- Regional directorates of the State Social Service, which implement national programmes and oversee compliance;

- Municipal social services, which are responsible for local needs assessment, planning, and delivery of community-based social care services, financed partly through the Social Fund mechanism.

This creates a dual structure in which social protection benefits (e.g. disability payments) remain centrally regulated, while community-based services are primarily decentralised to municipalities. Health services interface with both levels, though through different mechanisms.

State Social Service (SHSSH) and disability assessment commissions

The State Social Service (SHSSH) administers national social protection schemes, including disability benefits and economic assistance. The disability assessment system aims to determine eligibility for social protection entitlements based on medical and functional criteria.

Disability assessment commissions operate at regional level and are responsible for certifying eligibility for disability benefits. The process requires medical documentation provided by health professionals, including PHC centres and specialists. Commissions include multidisciplinary members and are tasked with assessing medical, functional, and social dimensions of disability.

Recent reforms have sought to move toward a more comprehensive bio-psychosocial model of disability assessment, aligning with international standards.[1] UNICEF has supported this reform process by strengthening the capacity of regional multidisciplinary disability assessment commissions. The intent has been to improve the quality, consistency, and fairness of disability evaluations and to ensure better linkage between health assessments and social protection entitlements. UNICEF has supported accredited training of commission members across regions, focusing on needs identification, referral pathways, and the application of a more holistic assessment approach. Through this mechanism, health inputs (medical certificates, diagnoses, clinical documentation) become formal triggers for social protection decisions.

In this model, the health-social interface supports an administrative process and the health sector's role is primarily evidentiary and consultative.

Municipal Social Services

Under the Social Care Law (Law No. 121/2016) and decentralisation reforms, municipalities are responsible for assessing local social needs and delivering community-based social/integrated services. The objective is to bring social protection mechanisms closer to communities and enable tailored responses to vulnerability. Municipal services are supported through the Social Fund financing mechanism and operate within locally developed, triannual social plans.

1. Needs Assessment and Referral Units (NARUs): Municipalities work through NARUs, which structure case identification and service coordination at local level. NARU teams conduct vulnerability assessments, including home visits, and connect individuals to appropriate social support services. The entry point is typically social vulnerability or benefit application. The interface with the health sector occurs primarily where medical documentation is required (e.g. disability certification) or where coordinated responses are needed for complex cases such as elderly patients following hospital discharge, persons with disabilities, or survivors of gender-based violence. Health centres may refer patients to municipal services for financial aid or specialised support, and municipal units may request medical input from PHC.

2.Municipal community centres are the output of the decentralised social-care model. Municipalities have established or strengthened multidisciplinary community-based services with support from programmes such as Leave No One Behind[2] (18 Municipality centres developed)

[1] Bisha, E. (2025). *Roadmap for the organization of needs assessment and referral units: Implementing the functions of the local government units in the field of social protection and social services*. UNICEF.

[2] https://www.undp.org/albania/projects/leave-no-one-behind

and EU-funded initiatives[3]. These centres provide social support, psychosocial services, rehabilitation and, in some instances, health services delivered by health professionals employed by the municipality. The Development Centre of Divjakë is an example of this configuration: although institutionally classified under municipal social protection, it delivers specialised health services such as speech therapy, physiotherapy and psychological counselling. It thus effectively functions as a paediatric rehabilitation centre. It also provides basic health preventative services from a Family Doctor to elderly and vulnerable groups on a planned basis.[4] Discussions are ongoing at the MoHSW to expand the service portfolio of these centres to include support for adults with mental health issues and psychosocial vulnerability (most likely through the services of psychologists).

NGO-Led model

A third model is illustrated by NGO-led service delivery models, such as the Ryder Albania home-based palliative care service.[5] In this model, an NGO provides multidisciplinary home care for terminally ill patients, combining medical and social support. Doctors, employed by the NGO for prescribing reimbursable drugs dedicated to palliative care, operate under contracts with the Health Insurance Fund, while broader psychosocial support and coordination functions are organised by the NGO.

In this model, a non-governmental actor organises and delivers specialised health and social services to patients. This NGO employs GPs to provide the services. GPs working for this NGO are allowed to prescribe the reimbursed drugs for palliative care under a contract with CHCIF. On the other hand, the funding of this model (e.g. staff salary, logistics costs) come from external donors, under project-based arrangements which offer limited sustainability.

Table 2: Overview of the integrated health and social service/collaboration models analysed as part of this assignment

Model	Type of integration/collaboration	Sectoral governance	Target/beneficiary groups
1. Co-location of psychosocial workers in PHC teams	Team-based, clinical integration	Health sector (PHC)	All patients consulting PHC services
2. Home visits (focus: elderly & homebound patients)	Outreach-based, health service with social screening and referral	Health sector (PHC)	Chronically ill/ homebound patients
3. Home visits (focus: mother and child)	Outreach-based, preventive screening and referral model	Health sector (PHC)	Pregnant women, mothers, newborn and children
4. Disability commissions of state social service (focus: benefit eligibility and certification of entitlements)	Procedural/administrative interface (role of health sector is consultative)	Central social protection – State Social Service (SHSSH)	Vulnerable people eligible to social aid benefits
5. Needs Assessment & Referral Units (NARUs) of Municipal social services	Structured case-management and referral coordination	Municipal social protection	Vulnerable people eligible to social aid benefits and other social services (e.g.

[3] https://euprojects.al/euprojects/eu4socialcare-enhancing-local-social-care-services-partnerships-with-citizens-and-toward-eu-standards/

[4] https://www.undp.org/albania/publications/best-practices-provision-social-services

[5] https://ryderalbania.org.al/en/2023/06/20/palliative-care-at-home-support-for-patients-and-families/

			housing, domestic violence)
6. Municipal social services -Community centres (paediatric rehabilitation + some GP preventative services for elderly/vulnerable)	Community-based multidisciplinary/specialised health service delivery	Municipal social protection	Children with disability Elder community members
7. NGO model (e.g. Palliative Care)	Service-level integration	Mixed (Health + NGO/donor)	Terminally ill patients

Taken together, these models reflect a diverse landscape of interprofessional collaboration / integrated health and social services (see Table 2). These mechanisms correspond to different levels of integration, from facilitated collaboration at the interface between sectors to joint case management and co-delivery of services.

3. INTEGRATION OF PSYCHOSOCIAL WORKERS WITHIN PHC FAMILY MEDICINE TEAMS

This section analyses how the PHC-based co-location model functions in practice. Although not a part of the objectives of HAP project, this aspect of the PHC reform received some support from HAP, which contributed to generate specific experience and learning. We thus examine this model through a 5-dimension framework, namely: 1) Policy framework, governance and leadership; (2) Financing; (3) Service delivery; (4) People, skills and working culture; and (5) Enablers and networks.

3.1 Policy framework, governance and leadership for psychosocial integration within PHC

Policy foundations

National policies (see section 2.1) foresee the integration of psychologists or social workers within PHC teams and the promotion of coordinated care pathways. There are currently 100 “Social Health Centres”, that is, PHC structures with at least one psychologist or social worker as part of the PHC team. Presently there are about 20 social workers and 80 psychologists directly employed by Social Health Centers.

Cross-sectoral governance within the MoHSW

Despite a strong policy framework, governance and oversight of the operational arrangements of interprofessional collaboration remain underdeveloped**.** At national level, there is no framework or formal mechanism across sectoral divisions within the MoHSW to steer, coordinate, and oversee integrated health and social services. Although the PHC and the Social Protection divisions are housed within the same ministry, they function largely as parallel entities, with limited collaboration or exchanges on these aspects. A dedicated focal point for health–social integration within the PHC division does not yet exist, although such an appointment is reportedly under consideration.

Regional oversight

At regional and local level, Health Operators (HO) and Local Units of Health Care (LUHC) primarily fulfil reporting and supervisory functions related to health service volumes (e.g. quantitative data on number of services). There is limited evidence of managerial leadership, coordination support, or supportive supervision for psychosocial professionals. Governance and coordination of integration are therefore absent at this intermediate level.

Facility-level leadership

In practice, operational leadership for integration takes place at health centre level. Family medicine teams determine how psychologists or social workers are incorporated into daily workflows. Regular team meetings, case discussions, and direct communication between family doctors and psychosocial workers serve as the main coordination mechanisms. Collaboration was consistently observed as constructive across site visits. However, significant variation exists across facilities in how the model is operationalised, including differences in tools used, scope of work, referral practices, and interpretation of professional boundaries. In the absence of strong system-level steering, operational practices are shaped primarily by local initiative rather than standardised governance guidance.

Psychologists and social workers can refer vulnerable patients to Municipal social health services for social assistance through formal referral procedures. Psychologists and social workers in PHC teams can also coordinate with Municipal services by participating in thematic mechanisms, such as gender-based violence protocols (e.g. in Tirana Municipality).

Accountability and supervision

Accountability for integration remains based on quantitative data reporting: HOs collect and report statistical indicators, such as number of consultations or sessions delivered. There is no systematic monitoring of coordination quality, case management processes, or intersectoral outcomes. Integration performance is therefore monitored in terms of service volumes rather than collaborative effectiveness. Examples of such indicators could include:

Collaboration within PHC teams (family doctors, nurses, psychologists, social workers)

- Number of patients referred by family doctors or nurses to psychosocial professionals (psychologists or social workers).
- Proportion of referred patients who actually receive an assessment by the psychosocial worker (psychologist or social worker) (to identify loss to follow-up).
- Average time between referral by the family doctor or nurse and the first consultation/assessment with the psychologist or social worker.
- Number of joint case discussions held within PHC teams involving both medical and psychosocial staff.
- Patient feedback or patient experience regarding psychosocial services provided at PHC level.
- Staff feedback on teamwork and collaboration within the PHC team.

Collaboration between PHC teams and municipal social services

- Number of referrals from PHC psychosocial professionals to municipal social services.
- Proportion of referrals that receive feedback from municipal social services.
- Average time between referral and response from municipal services.

The absence of a formal supportive supervision framework constitutes a further gap. Although existing/draft professional manuals envisage supervision arrangements, there is currently no established managerial mechanism to ensure ongoing professional guidance, or supervision to prevent burn-out psychologists or social workers.

Table 3: Summary of governance dimension

Governance Element	Observed Situation	Level of Institutionalisation
Policy framework	Clear and explicit policy endorsement	High
Cross-division coordination	No formal mechanism between PHC and Social Protection divisions	Low
Regional (HO/LUHC) leadership	Primarily data reporting role	Low
Facility-level leadership	Active coordination within teams	Moderate
Accountability	Focused on activity indicators	Low
Supportive supervision	Not formally structured	Low

Financing and service payment for integrated health and social services

Service payment structure

3.2 Health and social protection services operate under separate budget frameworks, and no joint funding arrangement exists to support integrated service delivery across sectors.

The integration of psychosocial workers within PHC teams is financed through the general health system budget. Psychosocial professionals are paid under the annual contracts between the Compulsory Healthcare Health Insurance Fund (CHCIF) and PHC centres, which guarantees relative stability. These contracts are largely based on historical budgets. There is no dedicated budget line for “integration” as such nor payment mechanisms of services provided jointly by a multi-disciplinary team matter (e.g. payment through capitation or lumpsum payments for a case management).

No recognition of integration-related costs

While staffing positions are funded, several integration-related functions are not explicitly costed within the PHC financing framework. These include for example: time allocated to multidisciplinary meetings and case discussions; or costs related to outreach and home visits, particularly transport costs. These activities are therefore absorbed within existing resources rather than formally paid for as core integration components.

Incentives and disincentives

No financial or contractual incentives are attached to collaborative intersectoral practice. Performance monitoring focuses primarily on service volume (e.g. number of consultations or sessions delivered), rather than on coordination quality or integrated case management outcomes. Collaboration therefore depends on organisational culture and facility-level leadership rather than on financial drivers or incentives.

Sustainability considerations

Many operational elements supporting integration, such as development of manuals, role clarification, and specialised training, have received external technical assistance, and specifically the HAP project. The sustainability of integration depends not only on funding psychosocial positions, but also on embedding integration-related operational costs within routine financing arrangements.

Table 4: Summary of financing dimension

Financing Element	Observed Situation	Level of Institutionalisation
Staffing positions	Salaries funded through national health budget/stable staffing funding	High

Dedicated integration funding	No specific budget line	Low
Alignment with social sector financing	No pooled or joint financing mechanisms	Low
Incentives for collaboration	No financial incentives linked to integration quality	Low
Coverage of coordination & supervision costs	Not explicitly financed	Low
Sustainability beyond external support	Staffing secured; operational support partially external	Moderate

Service delivery and integration within PHC Teams

Entry point and identification of psychosocial needs

3.3 In practice, interprofessional collaboration/integrated health and social services is most visible in daily service delivery. Patients usually enter the system through the family doctor or family nurse. During consultations, doctors and nurses identify psychosocial needs based on their professional judgement. Patients are then referred internally to the social worker/psychologist for further assessment, sometimes over several visits.

Standardised screening tools for social vulnerability are not consistently used across health centres. As a result, identification depends largely on the awareness and experience of individual practitioners and the level of teamwork within each centre. In some facilities, psychosocial workers have developed their own screening and referral templates or tools, but these are local initiatives rather than nationally standardised instruments.

Multidisciplinary team functioning

Team-based collaboration constitutes the core of a comprehensive service package. Psychosocial professionals participate in case discussions and contribute to the management of patients with complex social or psychological needs. Internal coordination occurs through regular meetings, formal or informal feedback, and direct communication between professionals, but all these mechanisms vary by facility.

There is no nationally mandated format for joint case review, and documentation practices vary. HAP is providing support to the standardisation of documentation practices by proposing reporting tools as part of the Manual on social workers' role in PHC, currently under development.

Integration functions through team routines rather than through formally structured clinical pathways. Multidisciplinary practice thus depends more on internal organisation, PHC director leadership, and shared role clarity than on formal external standards.

Referral between health and social services (within PHC teams; between PHC and Municipal social services)

Multidisciplinary teamwork operates through two main referral channels:

1. Internal referral from family doctor or nurse to Psychologist or Social worker;
2. External referral from PHC to municipal social services, specialised health services and NGOs network of services.

Internal referrals are frequently verbal or paper-based, as electronic referral through the E-visitas platform is not yet accessible to psychosocial workers.

Internal referrals can sometimes be ad-hoc (e.g. family doctor sends patients to social worker or Psychologist within a day/immediately after consultation) which can affect workload planning for psychosocial workers.

External referral to municipal services/NGOs occurs in cases requiring financial aid, long-term social support, or specialised services beyond PHC scope. Feedback from external actors is not consistently formalised and may depend on interpersonal relationships rather than institutionalised reporting mechanisms.

Referral to CMHCs/psychiatric services is paper based (only the referral to this specialty is paper based) and can only be authorised by the family doctors and not the psychosocial worker.

Overall, coordination mechanisms at facility level function, but they lack technological and procedural standardisation.

Reach of vulnerable groups

The presence of psychosocial professionals within PHC has improved care for patients already connected to primary care, particularly women, children, patients with mental health concerns, and elderly persons known to the team.

However, individuals who rarely attend PHC facilities or who are reluctant to seek psychological support remain harder to reach. The model therefore strengthens responsiveness within PHC but does not fully address broader access barriers linked to social determinants or stigma. There was anecdotal evidence that the collaboration between Municipal Community Centres and Social Health Centres can help address some of these barriers by encouraging mutual referrals.

Measuring outcomes and impact

Outcome of integrated care is informally observed by the PHC teams but not measured. Qualitative observations from PHC teams suggest perceived benefits, including reduced unnecessary psychiatric referrals, improved management of psychosocial dimensions of chronic conditions, and better handling of complex family situations. Patient feedback is reported as positive where psychosocial services are accessible within the health centre, although systematic satisfaction data specific to psychosocial services are not collected.

Table 5: Summary of service delivery dimension

Service Element	Observed Situation	Level of Institutionalisation
Identification of psychosocial needs	Primarily based on professional judgement	Moderate
Multidisciplinary teamwork	Regular but locally structured	Moderate
Internal referral systems	Functioning but not standardised	Moderate
External referral coordination	Present but feedback inconsistent	Moderate
Standardised tools & pathways	Not nationally harmonised	Low
Outcome measurement	Focus on activity rather than integration/patient outcomes	Low

3.4 People, skills and working culture

Availability and distribution of psychologist and social worker professionals

Psychologists and social workers have been progressively positioned at the level of “Social” Health Centres. However, coverage remains uneven. With 365 HCs in Albania, and approximately 100 psychosocial staff currently deployed to PHC (20 social workers and 80 psychologists), 2/3 of HCs currently operate without any psychosocial staff, and 1/3 operate with one psychosocial professional. Rural and remote centres face additional human resource constraints. The HAP project supports 150 HCs, out of which 62 are Social Health Centres. HAP support has thus targeted a majority of psychosocial professionals in PHC teams.

Role clarity and division of tasks

National guidance on roles and tasks of psychosocial professionals in PHC is lacking. At the outset of implementation, both psychologists and social workers reported significant ambiguity regarding their scope of work within the family medicine team. The clarification of professional roles and interprofessional collaboration is a central element in consolidating psychosocial integration.

HAP has played a substantial role in addressing this gap. Through the development of multidisciplinary mental health guidelines and associated training delivered to family medicine teams, psychosocial professionals were integrated into a team-based learning model. This approach clarified interprofessional responsibilities by defining diagnostic categories and specifying the contribution of each cadre (family doctors, nurses, psychologists, social workers). The team-based training format reinforced role recognition and reduced initial confusion regarding task allocation.

In parallel, HAP supported the development of professional job profile for social workers in PHC (2022–2023). This profile was transmitted to the Health Insurance Fund and incorporated into contractual arrangements of social workers and psychologists. Building on this work, a manual for social workers is currently under development by HAP through a consultative process and is expected to include instruments, tools, and clearer delineation of professional boundaries.

The job profile for psychologist working in PHC is included in the Manual for Psychologists working in PHC approved by the MoHSW, Order nr.103, dated 02.02, 2026. This manual provides as well as operational guidance on scope of practice, number of sessions, referral criteria, and documentation standards, contributing to greater standardisation of psychological services within PHC.

Despite these advances, interpretation of scope of practice of Psychologists and Social Workers remains partly context dependent. Some stakeholders continue to frame PHC-based social workers primarily as referral agents to municipal services, while others describe a broader mandate including assessment, follow-up, and elements of case management. PHC-based social workers do not conduct financial aid evaluations, which remain under municipal authority, yet overlaps persist in areas such as psychosocial assessment and counselling. Role interpretation also leads to the situation whereby PHC social workers conduct home-visits (e.g. as part of home care services) but psychologists do not.

Overall, role clarity has improved, particularly following the development of job profiles and manuals. However, these tools are not yet fully embedded in regulation or consistently applied across centres.

Training, supervision and professional support

Training (e.g. multidisciplinary mental health training peer groups,) has been a key enabling factor in strengthening interprofessional collaboration. This training offer has been strongly supported by HAP. Looking forward, the sustainability of family medicine team training opportunities and their alignment with the accrediting Agency for Quality Assurance of Health and Social Services require clarification to ensure continuity and institutional coherence for psycho-social staff as well.

Access to CPD for psychosocial staff, however, remains uneven. The availability of training specifically tailored to psychosocial roles within PHC is limited. Psychologists and social workers report uncertainty regarding accreditation procedures and recognition of training credits, which has created professional tension.

Professional Orders (namely Order of the Psychologists in the Republic of Albania[6], and Order of Social Workers in the Republic of Albania[7]) and the Agency for Quality need to clarify requirements and procedures as it directly affects professionals' ability to obtain and maintain their mandatory licenses to practise in clinical settings, especially the Order of Psychologists.

A significant gap concerns supportive supervision. Psychosocial professionals manage emotionally complex cases but do not systematically receive structured clinical or peer supervision. Although draft manuals envisage supervision arrangements and peer models are under discussion, a formalised and routine supervision mechanism is not yet established. This represents a management and quality assurance gap with potential implications for staff wellbeing and long-term retention.

Table 6: Summary of Working culture dimension

Workforce Element	Observed Situation	Level of Institutionalisation
Availability and distribution of psychosocial staff	Progressive recruitment but uneven national coverage	Moderate
Role clarity within PHC teams	Significantly strengthened through guidelines, job profiles and manuals; formal alignment ongoing	Moderate to High
Differentiation of psychologist vs social worker roles	Improving; formal differentiation underway	Moderate
Access to tailored CPD and credit recognition	Uneven; accreditation uncertainties persist	Low
Supportive supervision	Not formally structured or routine	Low

3.5 Enablers, tools and service networks

Guidelines, manuals and tools

Several guidance instruments support the inclusion of psychosocial tasks in the service package provided by PHC, including the Mental Health Management Guidelines for PHC, the recently approved Manual for Psychologists, and the draft Manual for Social Workers. These documents, supported by HAP, aim to clarify scope of practice, documentation standards, and referral criteria to specialized services (e.g. CMHC), social assistance services.

In practice, psychosocial professionals report using elements of these guidelines, particularly for clinical orientation and role clarification. However, in the absence of fully disseminated and standardised instruments, many centres rely on locally developed forms, referral templates, case documentation tools, or on informal procedures such as verbal feedback. While these adaptations facilitate day-to-day functionality, they contribute to variability across facilities. Standardisation of psychosocial documentation and operational instruments remains incomplete.

Documentation and information sharing about patients

Information sharing about patients within PHC teams operates through a hybrid system combining verbal communication, paper-based documentation, and partial digital tools.

Doctors and nurses record consultations in the E-visitas platform linked to the Health Insurance Fund. Psychosocial professionals do not have access to this platform. Their documentation is

[6] Created with Law No. 40/2016 "On the Order of the Psychologist in the Republic of Albania", and responsible for licensing psychologists, maintaining professional standards, and accrediting continuing education programs.

[7] Created with Law No. 163/2014 "On the Order of Social Workers in the Republic of Albania" and overseeing professional standards, ethics, and licensing of social workers, including the Social Workers' Code of Ethics adopted by the order.

typically maintained in personal registers, confidential session notes, and summary forms shared with family doctors.

There is currently no unified psychosocial file integrated into either the paper based or electronic medical record. Discussions are ongoing regarding the inclusion of psychosocial visits within E-visitas, but digital integration remains at a pilot stage. In practice, data entry into the E-visitas system, even for family doctors and nurses, has largely been learned informally rather than through structured training or formal guidance. As a result, coordination is possible but not digitally standardised or traceable.

Confidentiality and ethics

Confidentiality considerations significantly shape information-sharing practices. Psychosocial professionals maintain detailed confidential notes that are not fully incorporated into medical records. Information shared with the broader PHC team is generally restricted to elements directly relevant to clinical care, sometimes supported by patient consent. This approach aligns with professional ethics and privacy standards but would benefit from clearer procedural guidance.

External referral mechanisms and service networks

External referral to municipal social services, community centres, specialised providers, or NGOs is common for cases requiring financial assistance, disability assessment, long-term support, or specialised care. There was anecdotal evidence of mutual referrals between the Patos Social Health Centre and the Municipal Community Centre offering specialized services to children and vulnerable groups. Feedback mechanisms from external services are not consistently formalized and often rely on direct communication.

Service directories and mapping exercises, including those supported by HAP in 6 Municipalities[8], have facilitated navigation of local networks. Where these directories do not exist, psychosocial workers have created their own.

Dissemination, systematic updating and institutional maintenance of these directories are important issues to address in the near future.

Current, the HAP website serves as a repository of several tools, manuals and reference documents related to PHC, including the psychologist and social workers.


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Mbulimi gjeografik: Bashkia Fier, në 13 njësitë administrative (9 rurale dhe 4 urbane)

Koha e ofrimit të shërbimit: Prej vitit 1991

INFORMACION MBI LLOJIN E SHËRBIMEVE

Qëllimi i shërbimit

- Të kontribuojë në funksionim dhe integrimin e grupeve të pafavorizuara në Bashkinë Fier.

Fushat e shërbimeve

- Planifikim, administrim dhe monitorim i shërbimeve sociale në bashkinë Fier.
- Koordinim i shërbimeve parashkollore, multifunksionale, shërbimeve të punësimit, edukimit, rehabilitimit fizik e psikologjik dhe të këshillimit ligjor.

Llojet e shërbimeve

- Koordinon funksionimin e Grupit Teknik Multidisiplinor (GTM) për rastet e fëmijëve në rrezik.
- Koordinon funksionimin e Ekipit Teknik Multidisiplinor (ETN) për rastet e dhunës në familje.
- Koordinon "Shërbimin e urgjencës për rastet e dhunës në familje".
- Evidenton nevojat e grupeve vulnerabël që trajton përmes vlerësimit të gjendjes reale socio-ekonomike.
- Monitoron dhe menaxhon rastet e fëmijëve viktima të dhunës, abuzimit dhe keqtrajtimit.
- Shërben si qendër informacioni për grupet e synuara vulnerabël.
- Realizon përgjegjësitë e përfituesve të skemës së ndihmës ekonomike (NE) dhe bën shpalosjen e pagesave të NE-së.
- Jep informacion mbi dokumentacionin e nevojshëm për t'u regjistruar në azilet e të moshuarve dhe mbledh, shqyrton dhe paraqet dosjet në Këshillin Bashkiak, Fier.

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Figure 1: a Mapping of Social Health Services done by HAP

Table 7: Summary of Enablers & networks dimension

Element	Observed Situation	Level of Institutionalisation

[8] https://www.hap.org.al/en/rrjeti-i-sherbimeve-socio-shendetesore/

Availability of guidance documents	Manuals and guidelines developed (HAP-supported); dissemination ongoing	Moderate
Standardised psychosocial documentation tools	Partial; local forms and informal practices common	Moderate
Digital integration (E-visitas access)	No access for psychosocial staff; pilot inclusion of visits	Low
Training on digital systems	Informal/self-directed learning; no structured training	Low
Internal referral mechanisms	Functioning but not electronically structured	Moderate
External referral feedback	Present but inconsistently formalised	Moderate
Service directories and network mapping	Available in some municipalities; not systematically maintained	Moderate
Confidentiality procedures	Ethically applied; procedural guidance incomplete	Moderate

4. COMPARATIVE PERSPECTIVES: OTHER COUNTRY EXPERIENCES WITH INTEGRATED CARE

Moldova: integrated community care to elderly and multi-morbidity patients in rural Communities[9]

In Moldova, the Ministry of Health and the Ministry of Labour and Social Protection, supported by SDC and the Healthy Life project facilitated by Swiss TPH, have piloted an Integrated Community Care (ICC) approach. Between 2019 and 2024, the project piloted the ICC model in 69 localities across 32 districts and 2 municipalities. The ICC model brings together primary health care providers, social workers, community nurses, and local public authorities around coordinated responses to vulnerable households, particularly those affected by non-communicable diseases, poverty, and social exclusion. Integration occurs through structured collaboration at local level. Multidisciplinary teams conduct joint needs assessments, develop coordinated care plans, and organise regular case discussions.

Importantly, the model institutionalises operational routines: defined referral pathways, scheduled coordination meetings, supervisory mechanisms, and locally agreed action plans. Supervision and capacity building are considered core components of the system. Monitoring frameworks aim to capture continuity of care and responsiveness to vulnerability, rather than focusing solely on service volumes. Cascade training approach, and strengthening of the regional level management capacities, along with support to the national policy context of ICC and community nurse profile, were additional key interventions.

[9] Dnestrean, T., Pascaru, O., Prytherch, H., Curteanu, A., et al.. (2025). Support in implementation of the Integrated Community Care and ensuring continuity and supervision in Moldova. International Journal of Integrated Care, 25, Article 149. https://doi.org/10.5334/ijic.ICIC24071

Zahorka, M. *et al.* (2025). Integrated Community Care: A Last Mile Approach—Case Studies from Eastern Europe and the Balkans. In: Amelung, V., Stein, V., Suter, E., Goodwin, N., Balicer, R., Beese, AS. (eds) Handbook of Integrated Care. Springer, Cham. https://doi.org/10.1007/978-3-031-96286-8_59

Dnestrean, T., Curteanu, A., Pascaru, O., Zatic, T., Ciobanu, E., Prytherch, H., et al. (2023). Adaptability of Integrated Community Care models in Moldova to overcome compounded crisis, including supporting refugees. International Journal of Integrated Care, 23(S1), Article 575. https://doi.org/10.5334/ijic.ICIC23215

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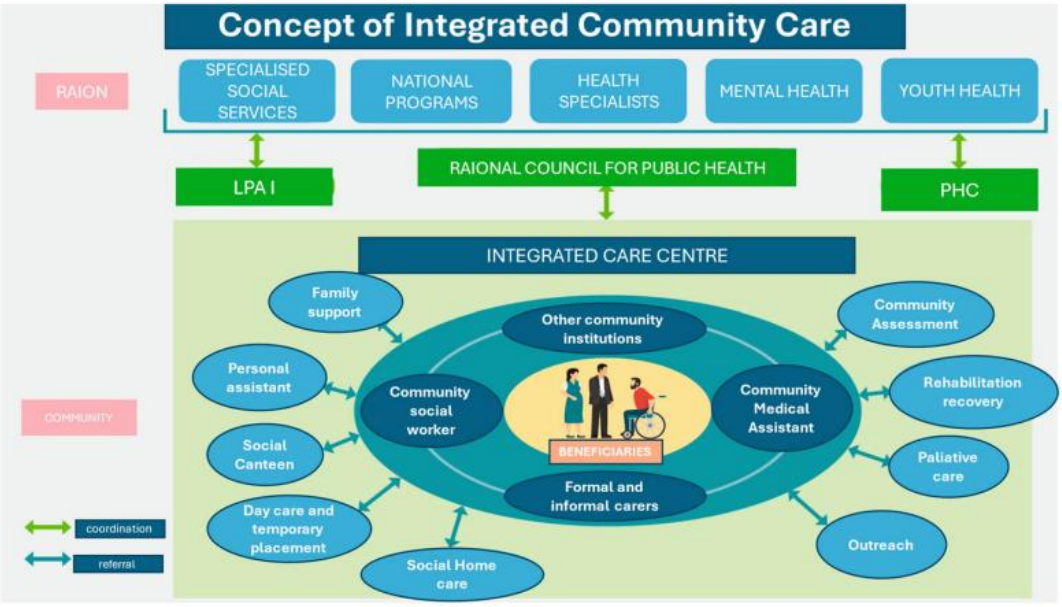
Figure 2: the Integrated Care Concept in Moldova (Source: Zahorka 2025)



Several elements are directly relevant for Albania. Firstly, Moldova shows that sustainable integration requires formalised routines, structured supervision, and clear cross-sector coordination platforms. Second, supervision is treated in Moldova as a systemic quality function whereas in Albania, supportive supervision for psychosocial professionals remains under development. Third, Moldova's experience highlights the value of local governance platforms that align health and social actors around shared priorities. Finally, Moldova demonstrates the importance of measuring integration beyond activity indicators. While Albania's monitoring systems mainly track the number of consultations, the ICC experience highlights the importance of monitoring coordinated case management, interdisciplinary collaboration, efficiency and service providers' benefit. This comparative experience suggests that Albania's next phase of reform may benefit from strengthening operational standardisation, supervision mechanisms, and integration-sensitive monitoring frameworks to consolidate the gains already achieved in policy and staffing.

Romania: Community centres, community nurses and health mediation[10]

In Romania, integration has mainly developed through community-based primary care. Two key mechanisms stand out: community health nurses and Roma health mediators, complemented more recently by efforts to strengthen integrated community centres.

The Health Mediation Programme, introduced in the early 2000s, employs community mediators (often from Roma communities) to act as bridges between vulnerable populations and the health system. Mediators help individuals navigate administrative procedures, access services, and overcome barriers linked to poverty, discrimination, and low health literacy. Although they are positioned within the health sector, their work directly addresses social determinants of health and requires close coordination with local authorities and social services. This represents a

[10] Zahorka, M. *et al.* (2025). Integrated Community Care: A Last Mile Approach—Case Studies from Eastern Europe and the Balkans. In: Amelung, V., Stein, V., Suter, E., Goodwin, N., Balicer, R., Beese, AS. (eds) Handbook of Integrated Care. Springer, Cham. https://doi.org/10.1007/978-3-031-96286-8_59

Fota, N., Furtunescu, F., Negraru, A., & Zahorka, M. (2019). *Community integrated care in rural Romania – The role of community centres*. International Journal of Integrated Care, 19(S1), 250. https://doi.org/10.5334/ijic.s3250

https://www.integratedcare4people.org/practices/200/strengthening-local-capacity-to-implement-integrated-community-health-services-in-rural-romania/

practical form of integration through outreach and social navigation rather than formal structural reform.

In parallel, Romania has invested in strengthening local capacity for integrated community services. Through various projects, including WHO-supported initiatives, municipalities have developed community centres bringing together family doctors, community nurses, and social actors to respond to underserved populations. Local authorities play a central role in shaping and coordinating these services.

However, Romania's experience shows that decentralisation alone does not guarantee effective integration. Many municipalities lacked the managerial capacity to coordinate multidisciplinary teams. Successful implementation required structured support: local needs assessments, participatory planning, modest investments, and ongoing coaching. Where this support was strong, integration improved. Where it was absent, services remained fragmented.

Romania's experience highlights two key lessons for Albania. First, local governance capacity is critical: municipalities need practical tools and managerial support to coordinate integrated services. Second, expanding service models must go hand in hand with sustainable financing and supervision arrangements. Without these, integration risks remaining project-dependent rather than system-based.

5. SUMMARY POINTS: CURRENT ACHIEVEMENTS, GAPS AND OPPORTUNITIES FOR CONSOLIDATION

5.1 Ministerial coordination and internal alignment

Current situation	Tension/Gap	Possible area for consolidation
PHC-led and Social Protection-led interprofessional collaboration models (integrated health and social services) operate under distinct governance, financing, and accountability structures, target different beneficiary groups.	Coexisting approaches without an overarching alignment or coordination mechanism at ministerial level.	Is a formal coordination framework needed at national level?

There are multiple health–social integration models in Albania. While these approaches are complementary and can continue functioning in parallel, they remain structurally separate. At ministerial level, there is no formal coordination mechanism to align the PHC and Social Protection divisions around a shared integration agenda. As a result, alignment relies largely on local initiative. Strengthening ministry-level coordination would support a more coherent and progressively integrated system.

5.2

Multi-level governance/coordination

Current situation	Tension/Gap	Possible area for consolidation
HOs and LUHCs supervise PHC facilities and collect service data, including psychosocial activity indicators.	Their role in integration is limited to reporting and administrative oversight, with no explicit mandate for coordination, quality assurance,	Should HO/LUHC have a clearer role in guiding, supervising, and supporting

	or supportive supervision of psychosocial integration.	integration practices across PHC centres? Can elements of regional models of integrated care (e.g. Moldova) and especially multidisciplinary coordination mechanisms be adapted and tested in Albania?

Currently, governance/coordination of psychosocial integration at regional level remains primarily administrative. HO and LUHC focus on data collection and reporting. Active coordination, managerial guidance, or quality oversight of multidisciplinary integration is lacking. As a result, integration leadership occurs mainly at facility level, contributing to variability in practice. Clarifying whether regional structures should play a stronger coordination or supervision role could improve consistency across health centres.

Financing and payment

5.3

Current situation	Tension/Gap	Possible area for consolidation
Different models of health-social integration funded by separate budgets (HIF/health, Social Fund, Municipality budgets). Many operational tools and training activities have been supported by external partners.	Integration costs are not identified in budgets nor funded. No joint or coordinated funding mechanism for integrated care. Integration remains partially dependent on external technical support.	Is there scope to cover integration functions (e.g. coordination, supervision, tools) with domestic financing? What is the possibility of introducing payment mechanisms which favour multi-disciplinary collaboration and joint case management (e.g. capitation possibly linked to a performance reward, or payment by case). Can we improve alignment between health and social funding streams?

5.4 Health and social services operate under separate financing streams, with no pooled or coordinated budget for shared cases. Many of the operational elements that enable integration (e.g. guideline development, training) have relied on external partner support. Consolidation may require domestic financing arrangements for integration-related functions and alignment between health and social sector funding.

Professional roles

Current situation	Tension/Gap	Possible area for consolidation
Standardisation of psychosocial roles is uneven, with important areas to be clarified (professional boundaries, CPD, credit recognition)	Unresolved areas may affect motivation and long-term retention.	Which institution should lead and formalise discussions to clarify professions in integrated care?

Considerable progress was made in defining psychosocial roles within PHC through manuals, job profiles, and training. However, full consolidation requires clearer alignment between regulatory

texts, contractual arrangements, professional orders and accrediting institution. Differences in decision-making authority between PHC-based and municipal and CMHC social workers, as well as ongoing uncertainty regarding CPD accreditation and credit recognition (particularly for psychologists), are areas where clarification would reinforce integration.

Measurement and performance

Current situation	Tension/Gap	Possible area for consolidation
PHC and municipal social services collect data separately, primarily focused on service volumes. Psychosocial activities are only partially integrated into digital systems.	No shared indicators or mechanisms to track integrated case trajectories, coordination quality, or cross-sector outcomes. Integration remains invisible in performance frameworks.	Can measurement systems evolve towards a set of integration-sensitive indicators and improve digital traceability of referrals and psychosocial activities across systems?

5.5

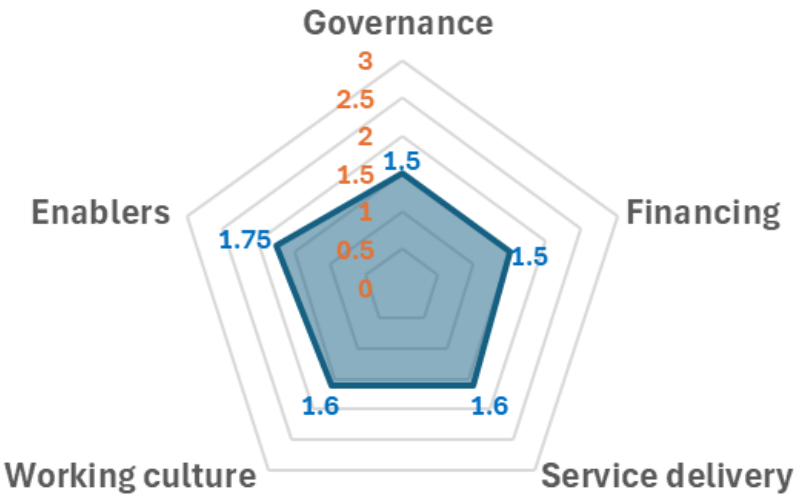
Monitoring systems currently capture the number of consultations and services rather than the quality of coordination or outcomes of integrated care. Health and social sectors report through separate administrative systems, with no shared framework for tracking cases that move between them. Integration is measured through activity data, but continuity of care or patient level outcome of integration is not assessed. Strengthening measurement mechanisms could enhance accountability and provide a clearer basis for future policy decisions.

In Annex 6.3, we propose a visual tool to support discussions during the capitalisation workshop. This tool is a summarised representation of the observations outlined in Chapter 4.

Suggested visualisation for capitalisation workshop

6.3

Current institutionalisation profile of psychosocial workers integration in PHC team



Methodological note and limits

This graph provides a visual summary of the level of institutionalisation of the model "integration of psychosocial workers within PHC teams." It reflects the observations made against the five analytical dimensions used throughout this report: policy and governance, financing, service delivery, people and working culture, and enablers/tools. Each sub-criterion was scored based on its observed level of institutionalisation, as documented in summary tables 3 to 7. A score of 3 corresponds to high institutionalisation (clear mandate, structured mechanisms, and routine implementation), 2 to moderate institutionalisation (partially defined or unevenly implemented), and 1 to low institutionalisation (limited formalisation or reliance on ad hoc practices). The graph showcases the average score per dimension. This visualisation should not be interpreted as a precise quantitative measurement or as a judgement of performance. Rather, it is a synthesis based on interviews, document review, and site visits, intended to support structured reflection and discussion.

Interpretation and use in the capitalisation workshop

The graph illustrates an integration model in which work culture (service delivery) and operational measures (enablers) are comparatively stronger than governance, financing alignment, supervision, and measurement frameworks. In other words, psychosocial integration functions at PHC level and is operationally visible, but its consolidation at system level remains uneven. The key message is that integration is progressing unevenly across dimensions. This graph can serve as a discussion tool to explore questions such as: Which dimensions should be prioritised for consolidation in the next phase? What concrete changes would move a domain from "moderate" to "high" institutionalisation? Where are responsibilities located for strengthening governance, supervision, or measurement? And how can existing strengths (e.g. positive team culture and policy endorsement) be leveraged to reinforce structural aspects of integration?

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