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Insights into Long-Term Care for the Older Adults

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Acknowledgments

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Abbreviations

ADLs	Activities of Daily Living
IADLs	Instrumental Activities of Daily Living
LTC	Long-Term Care
MoHSP	Ministry of Health and Social Protection
NEET	Not in Education, Employment and Training
ISHSH	State Health Inspectorate
AKPA	National Employment and Skills Agency
NGO	Non-Governmental Organization
PCA	Principal Component Analysis (if)
FGDs	Focus Group Discussions

Contents

Executive Summary

The growing demand for long-term care (LTC) services in Albania highlights systemic challenges in both care access and workforce capacity.

Demand for LTC services

A. **High Dependency and Care Needs**
The survey of 790 households with people aged 65 and older revealed that two-thirds of older adults require assistance with daily living activities. The highly dependent older adults face the most complex care needs, including physical and cognitive impairments, requiring intensive, ongoing medical, emotional and personal care.

B. **Healthcare Utilization and Medication Burden**
Older adults, particularly those highly dependent, frequently visit doctors, with many requiring regular follow-ups and medical interventions. The medication burden is significant, with 50% of the highly dependent group taking more than five medications. This underscores the necessity for specialized care management, including medication oversight and health monitoring, to manage the growing healthcare demands of older adults.

C. **Financial Needs and State Support**
Older adults face significant financial strain, with many spending up to 60% of their income on healthcare. While pensions are the primary income source, access to state support programs is limited. 41% are unaware of social protection programs. There is a clear need for improved access to social support, simplified application processes, and increased financial assistance to alleviate the economic burden on older adults, especially those with higher dependency.

D. **Social and Emotional Well-being**
High levels of stress and worry are common among older adults, particularly among the ones living alone. Despite the high satisfaction with social interactions, participation in social activities is limited, indicating that older people may find fulfillment in fewer, more meaningful interactions. There is a clear need for programs that address the emotional well-being of older adults and promote social inclusion to combat isolation.

Supply and provision of LTC

A. Family Care as the Core of LTC
Family caregiving remains the primary form of long-term care (LTC) in Albania, with 95% of older persons relying on family members and only 5% receiving care from non-family caregivers, including 2% supported by paid caregivers (primarily state-funded). Despite this reliance, 13% of older persons in need, lack any form of caregiving, revealing critical

gaps in care provision. Cultural norms reinforce caregiving as a family duty, placing an emotional, physical, and financial burden on families, particularly women, who make up 67% of family caregivers. Women are also more vulnerable to unmet care needs, being twice as likely as men to report having no caregiver themselves.

Access to formal caregiving services is further restricted by financial and geographical barriers. Among older persons without a caregiver, 61% cite the absence of nearby relatives, a challenge most acute in non-Tirana areas due to migration and shrinking family networks. Additionally, 80% of older persons state that they cannot afford a paid caregiver, limiting access to professional caregiving support.

B. Institutional Care Services: Limited and Unevenly Distributed

Institutional care services, including **residential homes and day/community centers, are scarce and unevenly distributed**, leaving **rural populations with minimal access** to formal LTC. **Albania has 23 residential care facilities**, serving approximately **705 elderly people—less than 1% of the population aged 65+**. Additionally, **36 community day care centers** cater to **around 3,000 beneficiaries**, yet almost half of Albania's municipalities lack any community services for older persons, deepening regional disparities.

Specialized care is **particularly inadequate**. Only **33% of residential centers** offer dementia care, even though **92% of facilities report a need for it**. Similarly, **only 25% of residential centers provide physiotherapy services**, despite **over 90%** acknowledging the necessity for such services. **Infrastructure limitations further hinder service quality,** with **75% of residential centers identifying urgent modernization needs**. Day centers also struggle, particularly due to **the lack of dedicated spaces** for therapy and social engagement.

Financial constraints remain **a major barrier**, with **two-thirds of facilities citing insufficient funding** as a primary obstacle to expanding services, improving infrastructure, and offering competitive salaries for staff.

C. Workforce and Training Challenges: Limited Reach and Specialization

The workforce challenges in Albania's LTC system differ between family caregivers and institutional caregivers, requiring tailored solutions that address both general and specialized training needs.

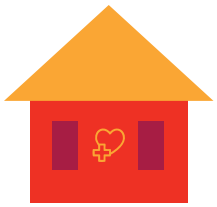
D. Family Caregivers: Untrained and Overburdened

Family caregivers form the backbone of Albania's LTC system, yet 99% report having no formal training. Many care for older persons with complex physical and medical needs, yet lack even basic caregiving education. Training programs focusing on cognitive impairment management, safe physical assistance, and care for highly dependent individuals could significantly enhance care quality and reduce caregiver stress. However, such training remains minimal, and awareness of these opportunities is low.

E. Institutional Caregivers: Staffing Shortages and Limited Specialization

Albania's formal social care workforce includes 3,700 individuals, with 78% working in social care institutions and 22% in municipal-level services. The sector is heavily female-dominated (81%) and faces severe staffing shortages and training gaps.

Albania's Social Care Workforce



23
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3,700
workers
in social care, **81%** of the workforce is female.

25%
of residential centers offer physiotherapy services, while **90%+ recognize the need.**

Residential facilities operate with an average staff-to-resident ratio of 7:1, which is often inadequate for high-dependency residents. Specialized roles are nearly absent, with only 8% of residential centers employing psychologists and none having physiotherapists, limiting the ability to provide comprehensive care.

A lack of specialized training further worsens these issues. Caregivers often lack skills in managing dementia, Alzheimer's, and cognitive impairments, as well as safe handling techniques to prevent workplace injuries. Without targeted training, caregivers struggle to meet the evolving needs of Albania's aging population.

F. Vocational and Training Schools: Limited Reach and Specialization

Vocational and training schools in Albania have the potential to address LTC workforce challenges, but **geographical expansion remains limited**. **Five vocational schools, managed by AKPA (National Employment and Skills Agency)**, offer programs in **Social and Health Services, enrolling 550-600 students annually**. While these **programs prepare graduates for residential and community care roles, they lack specialization** in key areas such as **dementia care and rehabilitative services**. Expanding and modernizing curricula is essential to better equip graduates for Albania's growing LTC demands.

Beyond vocational schools, eight public training centers, along with **NGO-led programs (e.g., Caritas, Ryder)**, provide short-term caregiving courses with a practical focus. However, **in 2023, only 79 caregivers for older persons were trained,** representing a small fraction of the total LTC workforce. Expanding these training programs, **particularly in rural areas, is critical to addressing workforce shortages** and ensuring that all caregivers—both family and professional—have access to essential skills.

Introduction

Albania is undergoing a demographic transition, with old people now constituting 20% of the population due to increased life expectancy and declining birth rates. This shift highlights the urgent need for a robust long-term care (LTC) system to support people with age-related dependencies, chronic illnesses, and disabilities. However, this need emerges against a backdrop of significant socioeconomic vulnerabilities that compound the challenges of caregiving. High unemployment rates, income inequality, and a largely informal economy create persistent financial pressures, particularly in rural and mountainous areas where poverty is more pronounced, and access to services and infrastructure is limited. Emigration, especially among young and skilled workers, has led to a substantial brain drain, weakening the country's capacity for sustainable development and reducing the availability of family caregivers, who traditionally form the backbone of Albania's LTC system.

Public services and social safety nets are under-resourced and not well-equipped to address the growing demands of an ageing population. As a result, Albania's LTC framework remains heavily dependent on family caregivers, reflecting cultural norms that view caregiving as a familial responsibility. Yet, with migration and urbanization reducing family networks and financial constraints limiting access to paid or institutional care, many old people face significant gaps in support. Institutional care facilities, paid caregiving options, and vocational training programs for caregivers remain scarce, particularly in rural areas, leaving the most vulnerable populations without adequate care.

Scope and Objectives

This report provides a comprehensive analysis of the demand and supply dimensions of LTC in Albania. On the demand side, it examines the needs and dependency levels of older persons, including reliance on assistance for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). On the supply side, it evaluates family-based caregiving, institutional services, and vocational training programs. By contextualizing these findings within Albania's broader socioeconomic challenges, this report seeks to identify systemic gaps, propose actionable strategies, and contribute to the development of a resilient and equitable LTC system that addresses the diverse needs of the aging population.

This report seeks to address the critical need for a comprehensive understanding of long-term care (LTC) in Albania by focusing on three interconnected objectives which also comprise the three chapters that this report is formed from:

A. Explore the Demand for LTC Services Among Old People

Examine the specific needs and dependency levels of people aged 65 and above, focusing on their reliance on assistance for Activities of Daily Living (ADLs) such as dressing, bathing, and mobility, as well as Instrumental Activities of Daily Living (IADLs)

like cooking, shopping, and managing finances. The objective is to segment the aging population by their level of dependence, identify geographic and socio-economic variations in care needs, and assess the impact of chronic illnesses and disabilities on the demand for caregiving services.

B. Assess the Supply of LTC Services

Evaluate the caregiving systems in Albania, including the central role of family-based care, the availability and quality of institutional services such as residential and day/community centers, and the role of paid and informal caregivers. This objective also includes analyzing the capacity, accessibility, and quality of vocational training programs for caregivers, highlighting urban-rural disparities, and identifying barriers such as financial constraints, limited infrastructure, and inadequate training.

C. Provide Actionable Insights for Improving LTC Systems

Based on the analysis of demand and supply, propose evidence-based strategies to address gaps and inefficiencies in Albania's LTC system. These recommendations aim to strengthen family caregiving through financial and training support, enhance institutional care by investing in infrastructure and specialized services, expand paid caregiving options to relieve family burdens, and address systemic challenges such as urban-rural disparities and socio-economic vulnerabilities. The goal is to contribute to the development of an equitable, sustainable, and resilient LTC system that effectively meets the diverse needs of Albania's aging population.

Methodology and Scope

This report employs a **multi-methods approach** to comprehensively analyze the long-term care (LTC) needs and caregiving dynamics in Albania. The study focuses on **people aged 65 and older**, who represent a significant proportion of those requiring LTC services. While this demographic forms the primary focus of the analysis, it is important to acknowledge that LTC needs extend beyond the elderly population. Other groups, such as individuals with disabilities, those requiring palliative care, and other vulnerable populations, are also critically relevant to the LTC system. However, these groups fall outside the scope of this report, which is specifically centered on the needs and experiences of Albania's older population.

A. Nationally Representative Survey

Survey was conducted during November 2024, formed the foundation of the study, targeting 790 households with at least one individual aged 65 or older. **Using a stratified random sampling method**, proportional representation was ensured across urban and rural areas, as defined **by the 2023 Census**. Within each household, individuals requiring assistance with **Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)** were prioritized for participation. If multiple eligible individuals were present in a household, one was randomly selected to ensure unbiased representation. Of the households visited, **76% (600 individuals)** reported needing assistance, forming

the final sample. The survey captured data on caregiving needs, health conditions, household composition, financial well-being, and access to LTC services, providing a **comprehensive snapshot of the demand side** of LTC.

B. Qualitative Methods

To complement the quantitative data, qualitative methods were also conducted during November 2024, **including focus groups and in-depth interviews** to explore the caregiving ecosystem in greater depth. Focus groups were organized with **family caregivers—both unpaid and paid—as well as institutional caregivers** working in residential homes and day centers. These discussions offered valuable insights into the **challenges faced by caregivers,** the **emotional and physical toll of caregiving**, and the systemic gaps in both formal and informal care systems. In addition, **in-depth interviews with representatives from civil society organizations**, **NGOs, and the Ministry of Health and Social Protection** provided a **policy-level perspective on LTC challenges and opportunities for systemic improvements**.

C. Online Survey

An online survey targeted institutional care providers, including residential homes and daycare centers, to assess the **supply side of LTC services**. This survey, conducted concurrently in November 2024, gathered data on **facility capacity**, types of care offered, staffing availability, infrastructure adequacy, and operational challenges such as financial constraints and resource shortages.

By combining these methods, the study ensures a **holistic understanding** of Albania's LTC system, encompassing both the demand for care and the availability of resources to meet these needs. (*Details of the methodology are provided in the Annex. A*)

CHAPTER 1

EXPLORING THE DEMAND FOR LTC SERVICES FOR OLDER ADULTS

Drivers of LTC demand

Population aging

Albania's population has seen a significant decline in recent years. According to the 2023 Census, the total population of Albania is now 2,402,113, down from 2,831,741 in 2011. Currently, the proportion of older persons (65+) has increased from 11.3% of the total population in 2011 to 19.7% in 2023, marking a notable shift toward an older demographic profile. This change in age distribution is most evident in the rising old-age dependency ratio, which reflects the increasing proportion of older people who depend on the working-age population. As shown in recent data, the prefectures of Gjirokastra, Vlora, Korca, and Fier have the highest old-age dependency ratios, highlighting regional disparities in aging trends.[1]

The socioeconomic vulnerabilities of older adults are also evident. The percentage of older adults living alone rises sharply after the age of 70, with 12% of those aged 70-79 living alone and 17% of those aged 80 and older[2]. Although living alone is not directly indicative of a need for long-term care (LTC), it suggests that a significant proportion of these individuals may require assistance. The at-risk poverty rate among the older individuals is around 14%, which is lower than the general at-risk poverty rate but still a cause for concern[3].

Youth Dependency and Socioeconomic Challenges

In contrast to the rising old-age dependency ratio, the youth dependency ratio[4] has decreased from 30.4% in 2011 to 24.0% in 2023[5]. However, this decline may reflect a shrinking youth population, compounded by a persistent youth unemployment rate of 22% and a high incidence of young people not engaged in education, employment, or training (NEET), which stands at 25.2% for the age group 15-29[6].

1. INSTAT (2024). Census 2023 database: Resident population by Sex, Age group, Household status , Type and Year (data processed by the author)
2. INSTAT (2024). Census 2023 database: Resident population by Sex, Age group, Household status , Type and Year (data processed by the author)
3. INSTAT (2024). At risk of poverty rate by age groups and sex (%). Available at https://www.instat.gov.al/en/themes/social-condition/income-and-living-conditions-in-albania/#tab2 accessed on December 2024
4. Youth dependency ratio is the ratio of the number of persons under working age 0-14 to the number of persons of working age, 15 to 64)
5. INSTAT (2024).The population of Albania. Available at https://www.instat.gov.al/en/statistical-literacy/the-population-of-albania/#:~:text=The%20youth%20dependency%20ratio%20(the,65%2B%2C%20to%20the%20number%20of accessed on December 2024
6. European Training Foundation (2024). Key policy developments in education, training and employment – Albania 2023. Available at https://www.etf.europa.eu/sites/default/files/2024-01/Countrypercent20Fiche_Albania_2023_EN_editedpercent20percent281percent29.pdf

Disability and Care Needs

Disability among the older adults in Albania is a growing concern. The 2023 Census data reveals that 6.5% of the population aged 5 and older self-identify as having a disability, with the percentage of persons with disabilities increasing with age. Among individuals aged 65-69, 9% of men and 12% of women report disabilities, rising to 49% of men and 57% of women over the age of 90. Despite slight increases in the number of people with disabilities receiving disability benefits from the social protection system, the number of those benefiting from caregiving services has decreased, indicating gaps in support for older individuals with disabilities.[7]

Legal and policy framework

The legal framework for long-term care (LTC) in Albania lacks a single comprehensive legislative act and instead is regulated through various laws primarily within the health and social sectors. LTC in Albania is officially recognized for persons with disabilities and those over 65, extending services such as personal assistance and cash transfers. Key pieces of legislation include Law no. 57/2019 "On Social Assistance," which guarantees social protection through economic assistance, disability payments, and inclusion measures, and Law no. 121/2016 "On Social Care Services," which outlines services such as residential care, home care, and community services for vulnerable groups, including the older adults. However, the healthcare system offers only basic services for older adults and lacks specific provisions for individuals with chronic conditions or long-term care needs.

The policy framework guiding LTC in Albania includes the National Action Plan on Ageing 2020-2024, which emphasizes the integration of social and health services for older adults, aiming to strengthen service delivery and provide financial protection. Another key policy is the National Action Plan for Persons with Disabilities 2021-2025, which focuses on combining cash payments with qualitative social care. Additionally, the National Strategy for Social Protection 2024-2030 seeks to reduce poverty and improve the resilience of vulnerable families through employment support and vocational training.

7. INSTAT (2024). Datasets on social protection. Available at https://www.instat.gov.al/en/themes/social-condition/social-protection/#tab2 accessed on January 2025

Overview of the demand side for LTC

This part of the report examines the demand for long-term care (LTC) services for older adults in Albania, providing key insights into the physical, social, and financial challenges they face.

High Dependency Linked to Chronic Illnesses

The survey revealed that 76% of the older people population in Albania requires assistance with daily living activities. To better understand the diversity of care needs, the survey categorized respondents into three groups: independent or minimally dependent (49%), partially dependent, physically challenged (28%) and highly dependent, multi-morbidity (24%).

As dependency levels increase, so does the prevalence of chronic health conditions. The **highly dependent group** exhibited significantly higher rates of cardiovascular diseases (84%), arthritis (61%), and chronic pain (53%). This group also faced multiple comorbidities, with an average of 4.3 diseases compared to 2.3 in the **independent group**. This finding emphasizes the increased complexity of healthcare needs as dependency rises.

Chronic Illnesses and Medical Needs

The study found that as dependency levels increased, so did the need for medical care. The **highly dependent group** required more frequent doctor's visits, with 56% visiting every 1-2 months. This group also took a higher number of medications, with 50% of the highly dependent individuals taking more than five medications regularly. Access to essential medical equipment was also a significant concern, with 43% of highly dependent individuals reporting the need for additional equipment.

Financial Vulnerability among the Dependent

A key insight from the survey is the financial burden faced by older adults in Albania. Most individuals across all groups rely on pensions (95%) as their primary source of income, but these are insufficient to meet their basic living and medical expenses, particularly for the **highly dependent group**. Over two-thirds of respondents (67%) reported that their income was insufficient to hire a caregiver. This figure rises to 78% in the highly dependent group, indicating the urgent need for financial support for elderly care.

Challenges in Accessing State Support

Despite the high need for financial assistance, many older adults encounter significant barriers to accessing state benefits. Bureaucratic obstacles and a lack of information about social protection programs prevent many from receiving the support they need. Only 6% of the respondents were benefiting from disability payments, and 41% reported being unaware of available social programs. This highlights the need for better outreach and simplification of the application processes for state assistance.

A High Proportion of Older Adults Live Alone

The survey found that a significant number of older adults, particularly those in the **highly dependent group**, live alone. This trend is more pronounced among women and widowed or divorced individuals. Living alone creates increased vulnerability, as these individuals are less likely to have regular access to family support or caregivers.

Impact of Family Support

Family support plays a crucial role in alleviating the caregiving burden. However, the declining number of family members per household (from 3.9 in 2011 to 3.2 in 2023) means that fewer family members are available to provide care. In urban areas, especially those outside Tirana, older adults are more likely to live alone and have less access to familial support.

Lack of Access to Community-Based Service

The availability of community-based services, such as day care centers, is limited in Albania, particularly for those in the **highly dependent group**. 61% of older adults reported that community centers were unavailable, and 23% of those in rural areas noted the absence of such services. This lack of access highlights the need for better distribution of community care services to ensure that elderly individuals, particularly those in remote areas, can access care without traveling long distances.

High Levels of Stress and Emotional Isolation

The survey revealed that **highly dependent** older adults experience significantly higher levels of stress and worry compared to their less dependent counterparts. Among the **highly dependent group**, 72% reported experiencing stress or worry frequently, while only 47% of the **independent group** reported similar feelings. Social isolation, particularly among those living alone, exacerbates emotional distress. While most older adults (89%) reported having someone to provide emotional support, the **highly dependent group** had slightly less access to emotional support, emphasizing the need for integrated social services that address both physical and emotional health.

Findings and Results from the Survey, FGDs and Interviews

A total of 790 households with at least one individual aged 65 and older were visited as part of this survey. Among these households, 76%—or 600 individuals—were identified as needing assistance, based on self-reported challenges with daily living activities. These 600 participants formed the final survey sample, representing the older adults' population in need of care.

790
households
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600
older adults
identified as needing help with daily living activities.

Segmenting the older adults' population

To better analyze the care needs of Albania's aging population, the surveyed individuals were segmented based on their level of dependency. This segmentation was critical for understanding the diverse challenges faced by older adults and tailoring solutions to meet their specific needs. By categorizing individuals into groups based on the type and extent of assistance required, the analysis ensures a more precise assessment of the long-term care landscape and highlights key areas where support systems are most urgently needed. The segmentation process incorporated both functional limitations and health conditions, including:

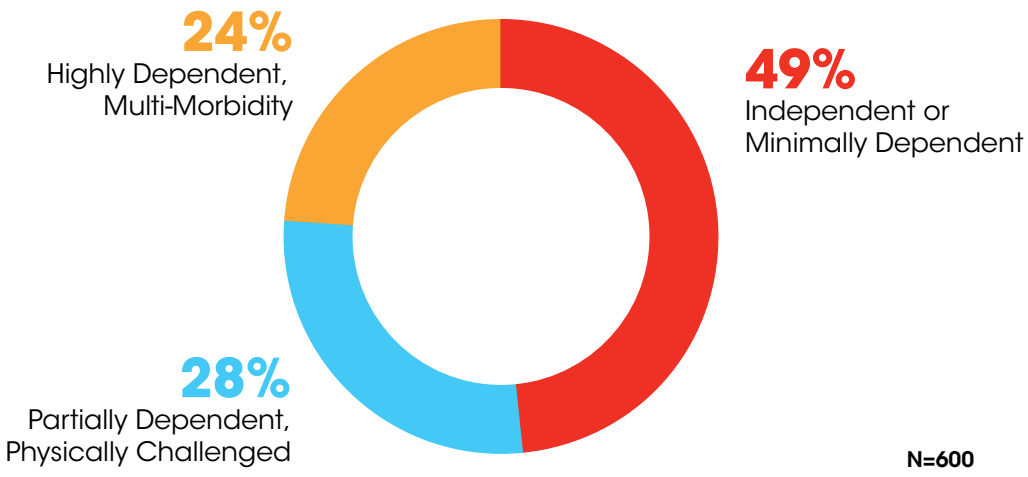
1. **Level of Assistance Required:**

Basic Activities of Daily Living (ADLs): such as dressing, bathing, and eating.
Instrumental Activities of Daily Living (IADLs): such as cooking, shopping, and managing finances.

2. **Chronic Illnesses and Health Conditions:**

Data on conditions like cardiovascular disease, arthritis, diabetes, and dementia were included to capture the broader health-related needs contributing to dependency.

Figure 1. Clustering of older persons based on adls, iadls and chronic diseases[8]



Chronic illnesses, medical needs and dependency in older adults

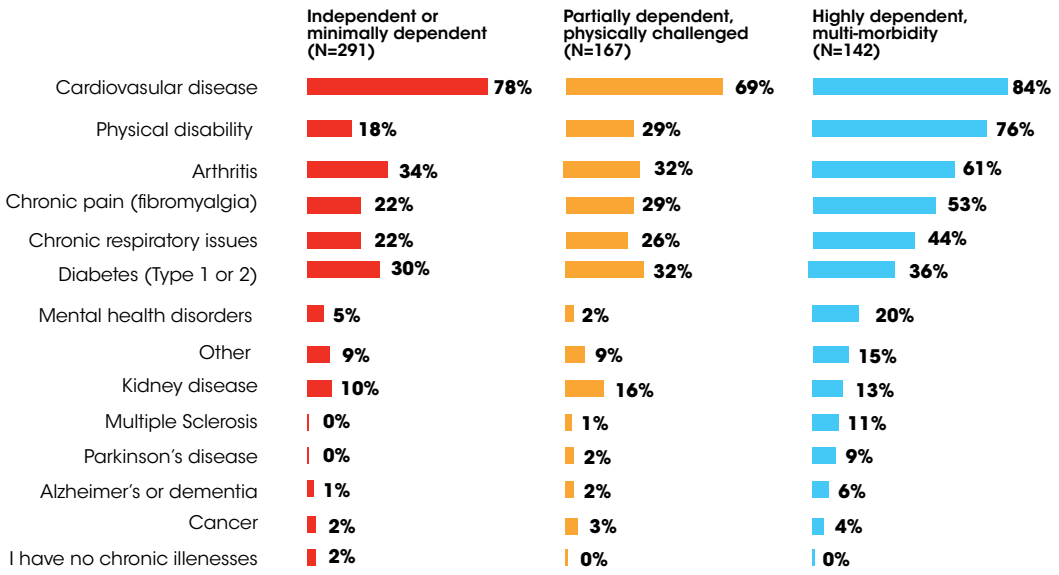
This section focuses on the prevalence of chronic diseases among the three different groups older adults, their medical needs and the demographic factors related to higher levels of dependency. As seen in Figure 2 the results reveal a clear progression in the burden of chronic illnesses as individuals move toward higher levels of dependency.

Specifically, the highly dependent group exhibits a notably higher prevalence of chronic illnesses compared to the independent and partially dependent groups. Cardiovascular diseases affect 84% of the highly dependent group, while physical disabilities, which are present in only 18% of the independent group, increase dramatically to 76% in the highly dependent group, highlighting the significant care needs of this group. Similarly, conditions like arthritis (61%) and chronic pain (53%) are much more common in the highly dependent group, as are chronic respiratory issues (44%). Although diabetes shows only a slight increase across the groups, mental health disorders are far more prevalent in the highly dependent group (20%), reflecting the mental health challenges tied to higher dependency. Other chronic conditions, such as kidney disease, Alzheimer's/dementia, cancer, and Parkinson's, are rare but slightly more common in the highly dependent group. Overall, this pattern shows that the highly dependent group faces a much greater burden of multiple chronic illnesses, with a significant rise in both physical and mental health issues.

8. For a detailed methodology on how the groups were defined and the statistical techniques used (including the k-means clustering approach), refer to the annex section of this report.

Clearly, the findings portray a strong relationship between the severity of dependency and the prevalence of chronic illnesses. As individuals progress from being independent to highly dependent, the burden of physical, mental, and multimorbid conditions intensifies, emphasizing the need for targeted healthcare strategies and resources to address the complex needs of the highly dependent group.

Figure 2. Chronic illnesses by clusters of needs

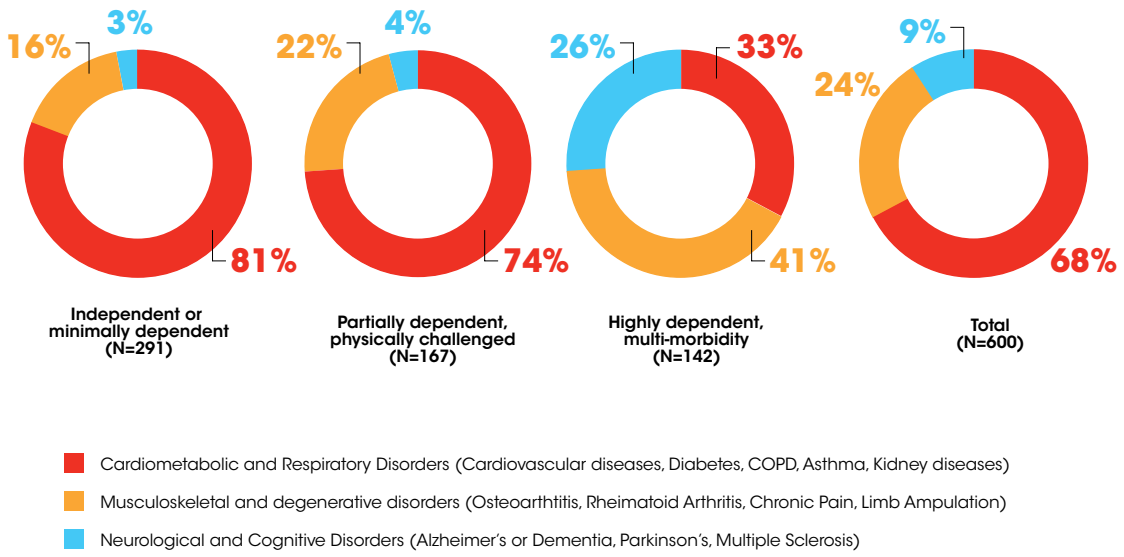


Cardiometabolic and Respiratory Disorders dominate across all levels of dependency, affecting **81%** of the independent group, **74%** of the Partially Dependent group, and **33%** of the highly dependent group, making them the most prevalent illness type overall (**68%** of all individuals). **Musculoskeletal and Degenerative Disorders** increase significantly as individuals become more dependent, affecting **16%** of the independent group, **22%** of the Partially Dependent group, and **41%** of the highly dependent group, reflecting their growing role in physical disability and reduced independence (**24%** of all individuals).

Neurological and Cognitive Disorders have a smaller overall prevalence, affecting only **3%** of the independent group and **4%** of the Partially Dependent group, but disproportionately impact the highly dependent group (**26%**), underlying their contribution to severe dependency and multimorbidity (**9%** of all individuals) (Figure 3). Evidently, while cardiometabolic and respiratory illnesses are the most prevalent across all groups, affecting the majority of older adults, they do not contribute significantly to their levels of dependence.

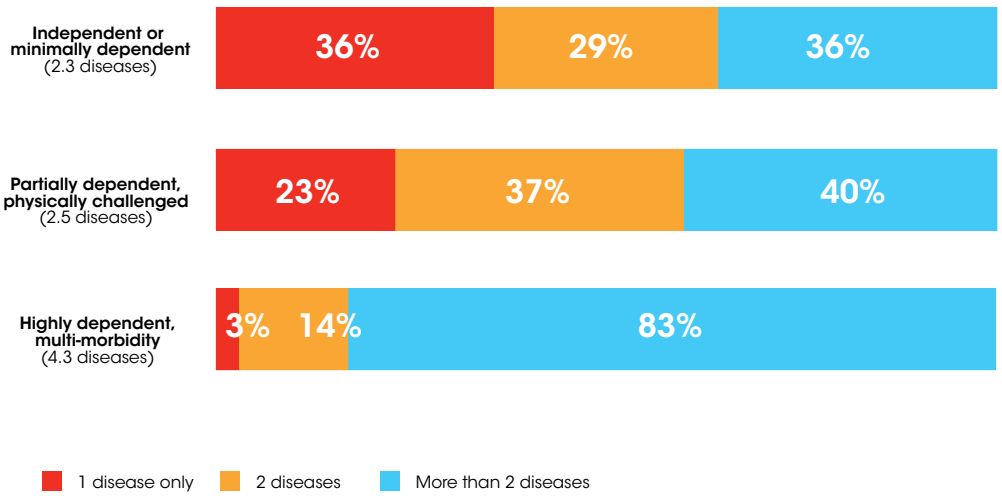
On the other hand, musculoskeletal, degenerative, and neurological disorders become more common as dependency increases, particularly in the highly dependent group, where they contribute significantly to the person's physical disability, cognitive decline, and overall multimorbidity.

Figure 3. Impact of illness types and levels of dependence



Moreover, the **average number of medical conditions increases** with the level of dependency from 2.3 to 4.3. A significant **83% of the highly dependent group** have more than two diseases, indicating the heavy disease burden and need for comprehensive health and social care and the scale of care family members should provide. In the partially dependent group, **40% have more than two diseases**, representing a shift toward increasing comorbidity, which should be in focus in order to prevent further decline in their health (Figure 4).

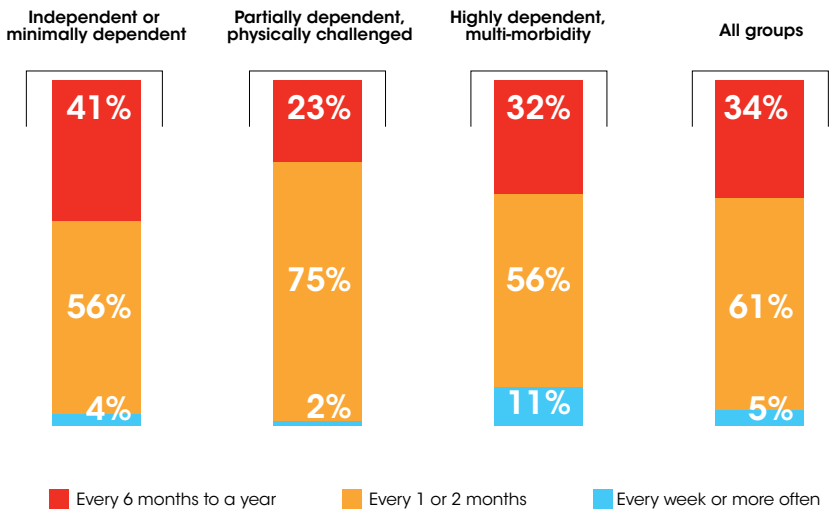
Figure 4. Comorbidities across dependency levels



The frequency of doctor's visits varies significantly across dependency levels, reflecting the differing healthcare needs of each group of older people. The **independent older adults** visited doctors less frequently, with **41%** reporting visits every 6 months to a year indicating lower overall healthcare needs. The **partially dependent group** relied heavily on regular visits, with **75%** reporting doctor visits every 1 or 2 months—the highest proportion among all groups. In contrast, **while 56%** of **highly dependent** older adults visiting every 1 or 2 months, **11%** of them required very frequent visits (the highest among all groups), that shows both the need regular follow-ups and for intensive medical attention (χ^2 (10, N=600) =38.57, p<0.001). Considering the complex needs and high dependence of this group a caregiver is definitely needed to accompany them on these visits, besides the care needed in their houses (Figure 5). To add to this burden, as pointed out by an NGO representative the health sector is not open to changing their routine and providing home-based health care services, rather than center-based.

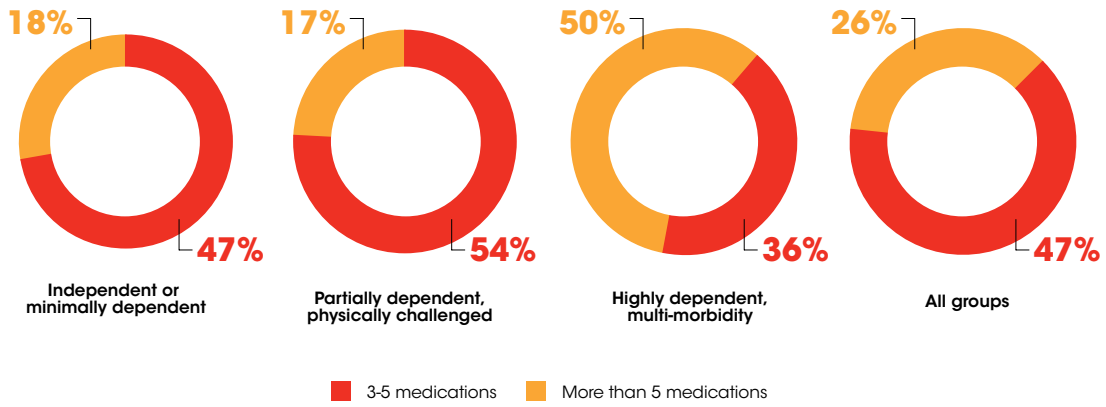
> *"The needs are not covered... because the context is changing fast... certain things have happened, demographic changes are very strong, with the displacement of young people and the remaining elderly, leaving us with many problems. Opportunities are few, the movement [of service provision] is becoming very slow, the introduction of these services is slow. Because it requires reforming existing services, to take them out of the center and bring them to the homes of those who cannot move. They do not like it [the practitioners in health section] because they are used to the sick going there, not the services going to their homes"*. **NGO representative, Tirana**

Figure 5. Frequency of doctor's visits



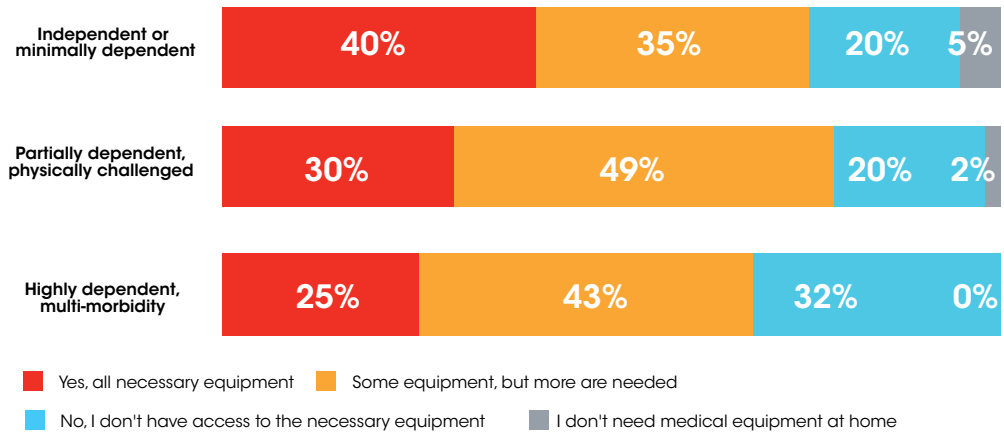
Regarding the prescribed medications, among all groups of older adults the majority of them (47%) take 3-5 medications, while 26% take more than 5. The **highly dependent group** shows the greatest medication burden, with half of the older adults (50%) taking more than 5 medications demonstrating the increasing healthcare needs as dependency levels rise (x^2 (6, N=600)=67.46, p<0.001) (Figure 6). This trend also brings to focus the need for assistance in instrumental activities of daily life (IADLs) such as medication management and assistance with doctor's visits.

Figure 6. Percentage of respondents taking 3+ medications



35% of the **independent group** reported needing additional equipment and 20% lacked access to necessary medical equipment. For the p**artially dependent older adults**, the need for more equipment rises to 49%, reflecting increasing dependency. Finally, 43% of the h**ighly dependent older adults** require additional equipment and 32% report a complete lack of access to necessary equipment (x^2 (6, N=600) = 27.58, p<0.001). These trends show a consistent shortfall in medical equipment needed for their health care that may compromise their health and safety but also increase their dependency and the caregiving burden for the family caregivers.

Figure 7. Availability and adequacy of medical equipment

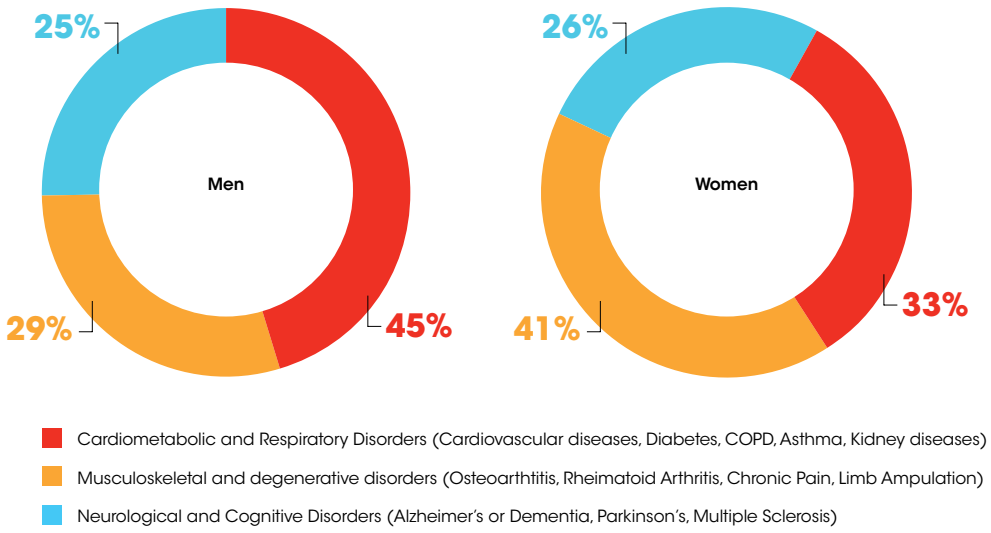


Demographic analysis and dependency levels

Gender differences

By looking closer to the gender differences of the chronic conditions it is observed that cardiometabolic and respiratory disorders are more prevalent in men, with 78% of men affected, compared to 60% women. In contrast, musculoskeletal and degenerative disorders are much more common in women, with 31% of women affected, significantly higher than the 14% of men.This gender disparity suggests that women may face higher levels of dependency due to the greater prevalence of these conditions among them. (Figure 8).

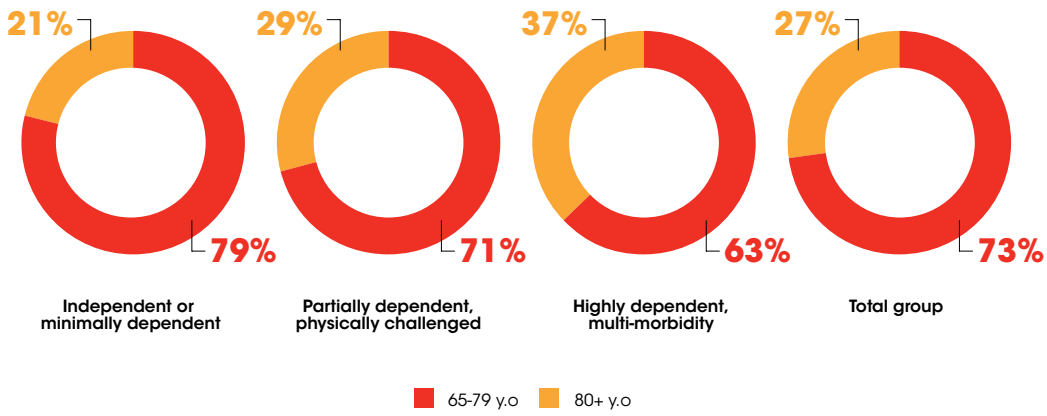
Figure 8. Gender and disease: who faces what? (Highly dependent, multi-morbidity group)



Age

As expected, in terms of age the proportion of people aged 80+ increases with the level of dependency, rising from **21% in the "independent or minimally dependent" group** to **37% in the "highly dependent, multi-morbidity" group** (Figure 9).

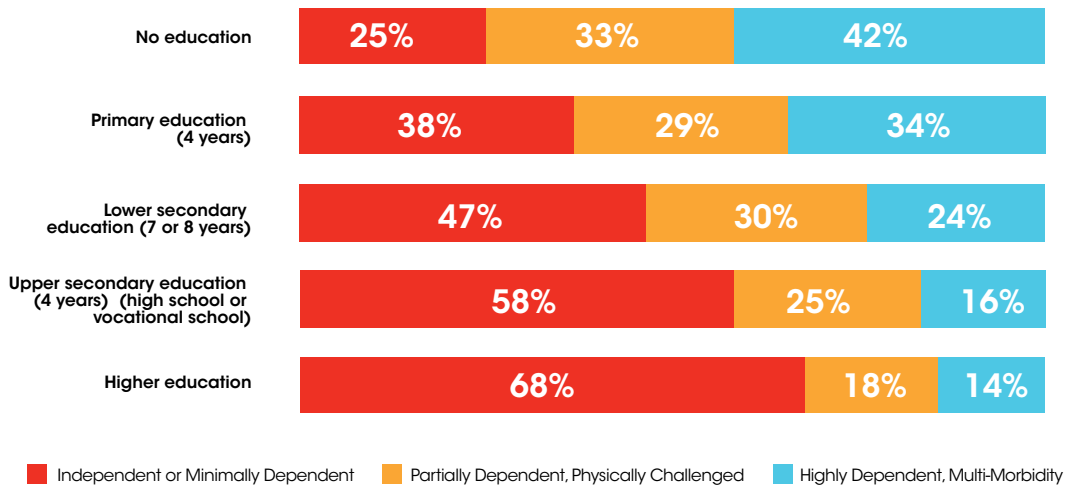
Figure 9. Age distribution by dependency levels



Education

In terms of formal education there is a stark contrast in educational levels between the **independent** and **highly dependent** groups.The **independent** group has significantly higher formal education levels, with **47%** having **lower secondary education**, **26%** completing **upper secondary education**, and **5%** achieving **higher education**. In contrast, the **highly dependent** group shows a much lower level of formal education: **42%** have **No education**, **34%** completed only **Primary education**, and only **18%** achieved **Upper secondary education**, with a mere **3%** reaching **Higher education** (Figure 10). These differences support the notion that higher levels of education are linked to greater independence. Education may be a key factor influencing one's dependency status, with lower educational attainment potentially leading to higher dependency, possibly due to fewer opportunities for self-sufficiency and greater difficulty in navigating social and healthcare systems, but also because of the better quality of life that people with higher education might have had.

Figure 10. Education across different dependency groups



Need for assistance with ADLs and IADLs

This section examines the varying levels of assistance needed for both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) across the three distinct groups of older adults. Across all groups, **ADL needs** (e.g., bathing, dressing, walking, toileting, eating) are highest in the **highly dependent group**, where **92%** require help with walking or moving, **85%** with getting in and out of bed, and **77%** with bathing and dressing. These basic self-care needs are significantly lower in the **partially dependent group**, where the highest ADL dependency is for walking or moving (**69%**) and getting in and out of bed (**37%**). The **independent group** reports no ADL-related support needs, meaning they have full autonomy in personal care. The results suggest that the highly dependent group is most at risk of requiring intensive, ongoing care and medical support, and may benefit from interventions focused on mobility assistance, personal care, and overall well-being. On the other hand, the partially dependent group also requires support, but less extensively, and might benefit from a mix of rehabilitation and assistive technologies to maintain their autonomy and to prevent escalation to higher levels of dependency.

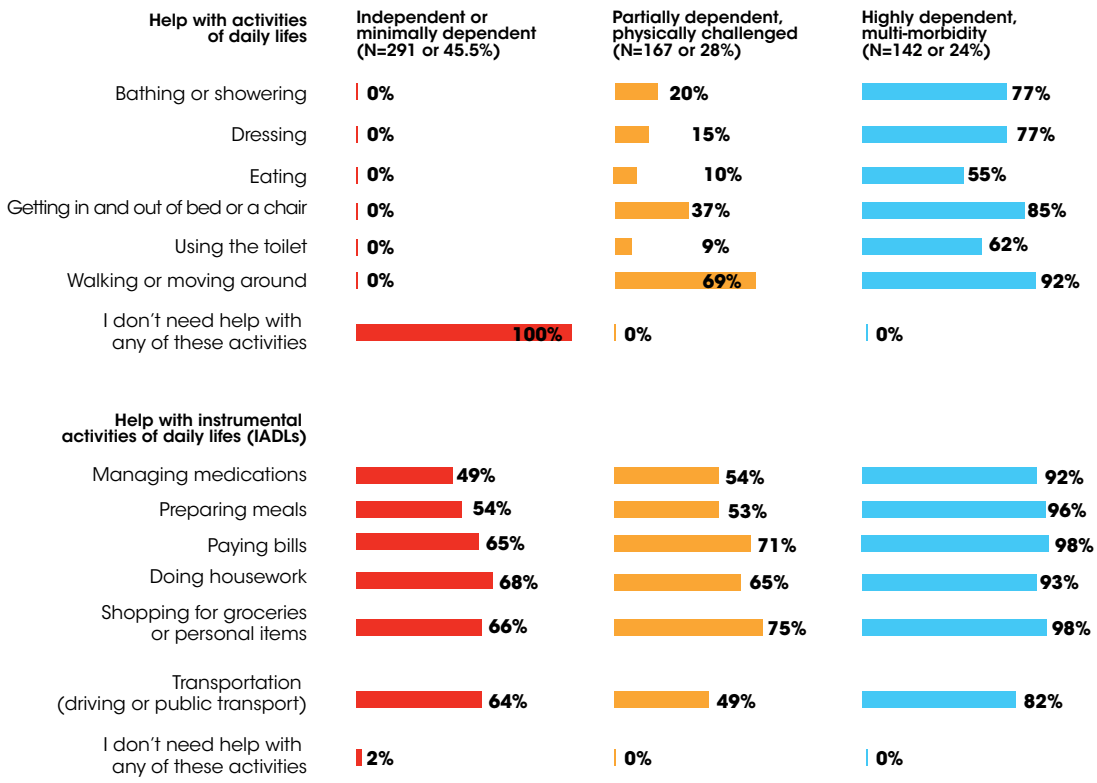
For **IADLs** (e.g., shopping, managing medications, preparing meals), the dependency is similarly higher in the **highly dependent group**, with nearly all individuals needing assistance across tasks such as shopping (**98%**), paying bills (**98%**), preparing meals (**96%**), and managing medications (**92%**). In the **partially dependent group**, moderate needs are observed, particularly for shopping (**75%**) and paying bills (**71%**), while the **independent group** shows relatively lower dependency, with the highest needs for housework (**68%**) and shopping (**66%**) (Figure 11).

The results reveal that individuals in the highly dependent group require substantial assistance with nearly all IADLs, including shopping, paying bills, preparing meals, and managing medications, reflecting their high level of dependency. In comparison, the partially dependent group experiences moderate support needs, especially for tasks like shopping and paying bills, while the independent group, though generally self-sufficient, still shows some need for help with activities like housework and shopping, indicating occasional support may be beneficial.

When combining ADLs and IADLs, the **highly dependent group** requires comprehensive assistance in both personal and instrumental tasks, indicating a need for extensive caregiving support.

The **partially dependent group** faces notable challenges, particularly with mobility and managing logistical tasks, while the **independent group** maintains autonomy in ADLs but still requires occasional help with IADLs. This progression highlights the increasing breadth and complexity of care required as dependency levels rise. These differences among the three groups should inform the interventions needed for each of them.

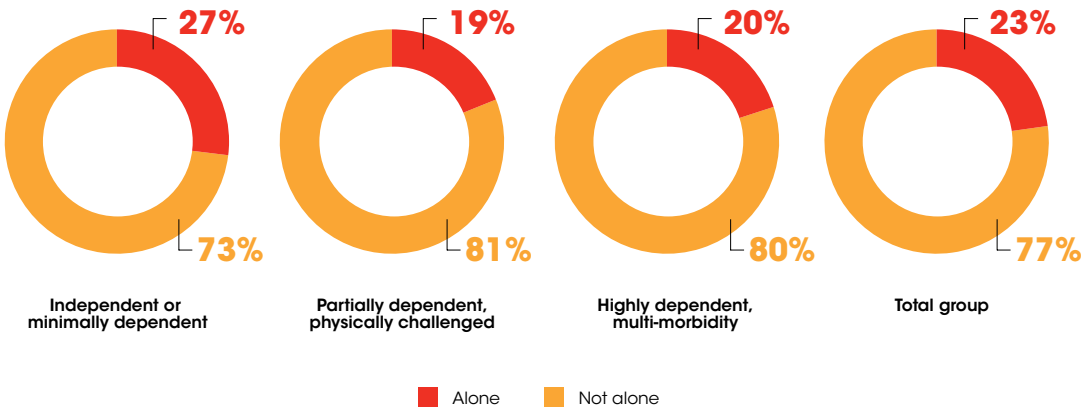
Figure 11. Needed help by cluster of needs



Living arrangements and house safety

The need for care and support from family members is very important for all groups of older adults, but in particular for the highly dependent group, which affects the living arrangements for them and their families. In this study, while the older adults that managed to live **alone** were most common in the **independent group (27%)** it is concerning that **1 out of 5** older adults in the **highly dependent group** currently lives alone (Figure 12).

Figure 12. Older adults living alone

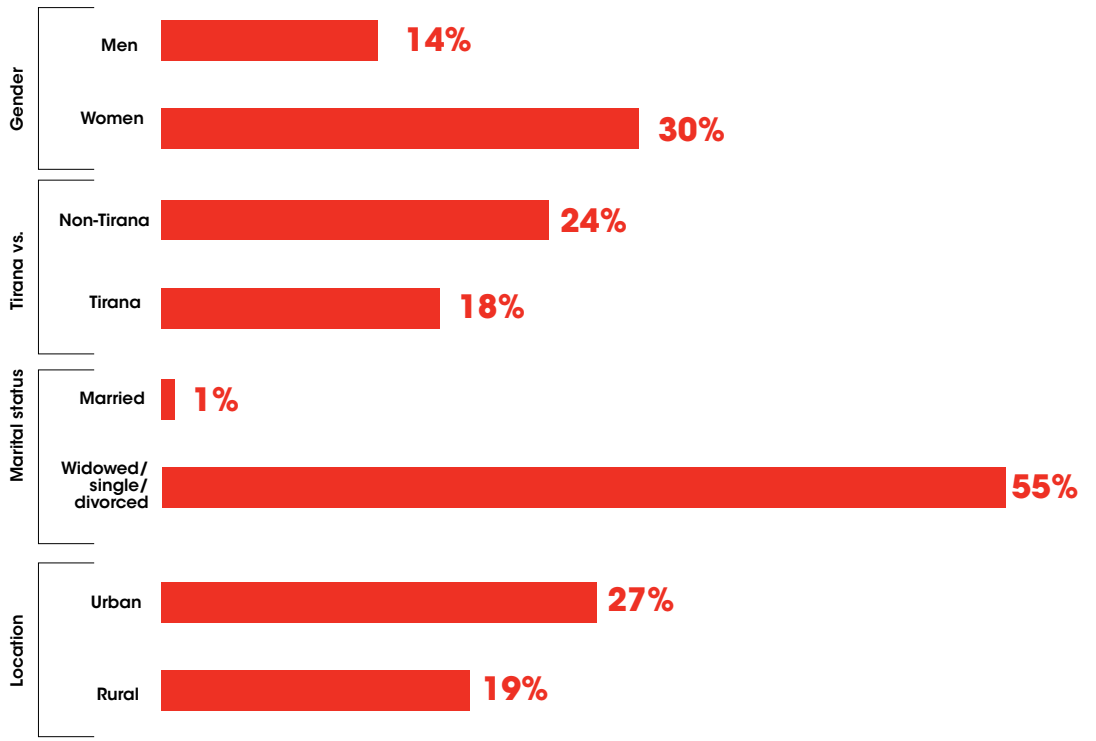


Focusing more on the differences of persons living alone it results that women lived alone more than men (30% vs 14%), which can be attributed to the longer life-expectancy for women, but also the social norms and roles pushing women to be self-sufficient in their house in contrast with men so their relatives don't necessarily take them to live with them. Living alone by far more common in widowed/divorced or single older adults (55% vs 1% of the married). In terms of Tirana and non-Tirana comparison older adults residing outside Tirana lived alone (24% vs 18% in Tirana), a potential result of the migration flows towards Tirana in the last decades.

On the other hand, the respondents in urban areas featured more in the "living alone" option compared to the rural areas (27% vs 19%), which means that in rural areas the notion of living with the extended family is more present, compared to the urban areas. Therefore, based on the above it can be assumed that the most probable group to live alone is that of women, living in urban areas outside Tirana (smaller cities), that are widowed/divorced or single (Figure 13). This group is at greater need for care, taking into consideration the above results indicating that women were more prevalent in the highly dependent group.

In addition, a significant proportion of individuals (34%) reported that relatives visit them "rarely" even the ones living alone. This high percentage suggests a potential lack of regular familial interaction for many, which may contribute to lack of needed care and feelings of isolation or reduced social support among older persons.

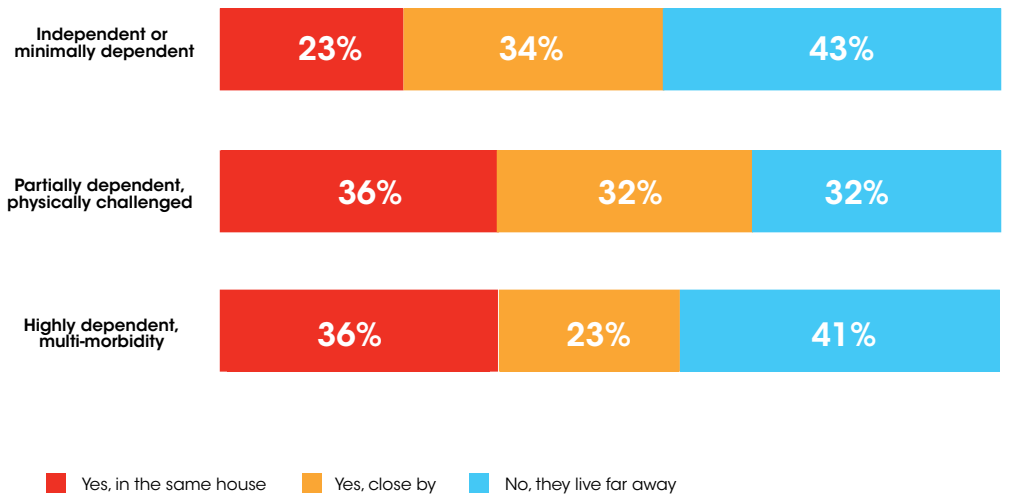
Figure 13. Who are the older adults living alone?



Furthermore, the average number of family members per household in Albania is declining from 3.9 in the 2011 Census to 3.2 in 2023[9].The average number of cohabitants in the households of the respondents was 2.5 (a total of 3.5 per household).This decline adds more burden among the family members that need to care for an older adult in the family. Cohabitation is most common among the h**ighly and partially dependent groups (36% in of each group), which relates to** their increased caregiving needs. Approximately 30% live in the same house, **31%** have relatives close by, and **39%** report relatives living far away, showing a shift towards cohabitation as dependency increases (x^2 (4, N=600) =15.63, p=0.004) (Figure 14).

Older adults in areas outside Tirana had their children and relatives living far away compared to the ones living in Tirana (42% vs 28%), potentially a result of the massive migration and emigration in such areas. By living alone and far away from their relatives, older adults are at high risk of not accessing help in cases of emergencies, experiencing further decline in their physical, emotional and cognitive functions as well as difficulties in maintaining their houses, that can lead to safety risks.

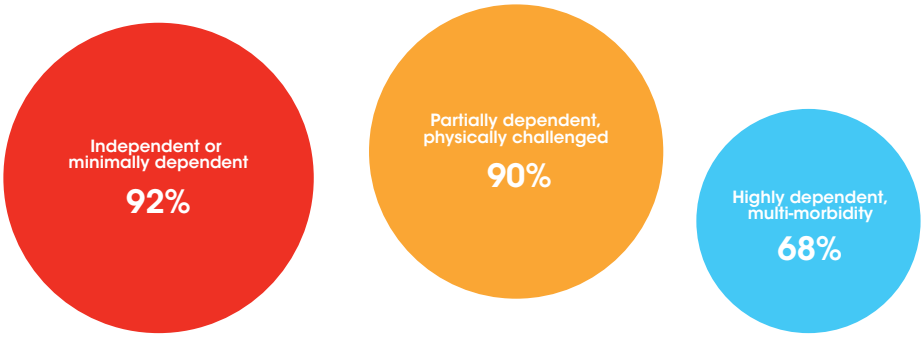
Figure 14. Do your children or other relatives live nearby?



The tendency to feel unsafe in the apartment increases significantly as dependency levels rise. Among the **independent group 92%** reported feeling safe, whereas the same percentage for the **highly dependent older adults** declines **to 68%** (x^2(6,N=600)=67.44, p<0.001).This trend shows a direct link between increasing dependency and heightened feelings of insecurity, likely driven by reduced mobility, reliance on caregivers, and potentially inadequate living environments, without the necessary home adaptations. (Figure 15).

9. Institute of Statistics (INSTAT). (2023). Census of Population 2023. Institute of Statistics of Albania. Available at https://www.instat.gov.al/media/13615/cens-i-popullsise-2023.pdf accessed on January 2025

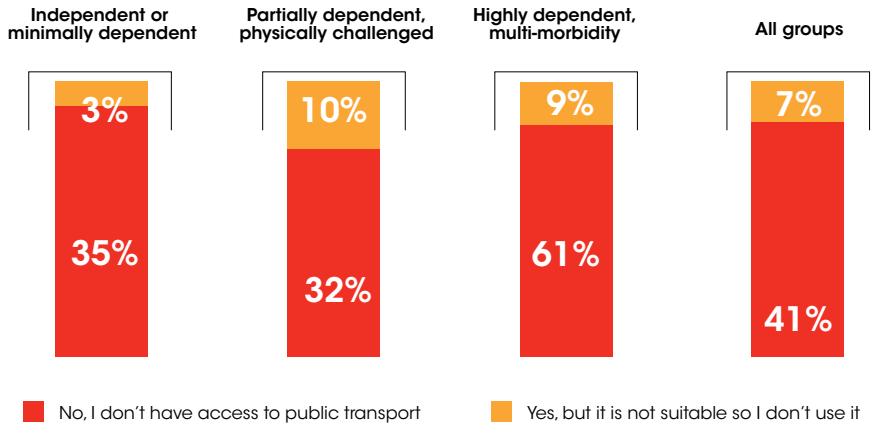
Figure 15. Percentage of older adults stating they have a safe appartment



Access and use of public transport

Access to and suitability of public transport follow similar patterns with the above findings. Overall, **41%** of all the respondents reported lacking access to public transport, with this barrier becoming more pronounced as dependency increases. The **highly dependent group** experiences the most significant challenges, with **61%** having no access to public transport. Among the **partially dependent group**, **32%** lack access, indicating that even moderate dependency also presents notable challenges. Additionally, **7%** of individuals across all groups indicate that while public transport is available, it is unsuitable for their needs (Figure 16). These results show a mismatch between the needs of the different groups and the availability of public transport as well as the design of public transport systems. Overall, there is a clear trend where both lack of access and unsuitability of public transport increase with higher levels of dependency (x^2 (10, N=600) =6 0.11, p<0.001). Public transport is a much bigger problem for older adults in areas outside Tirana, where almost half of them (44%) reported lacking access to any public transport compared to 24% in Tirana. Access and suitability of public transport is of outmost importance for older adults, especially because of their higher needs for medical visits, as mentioned above.

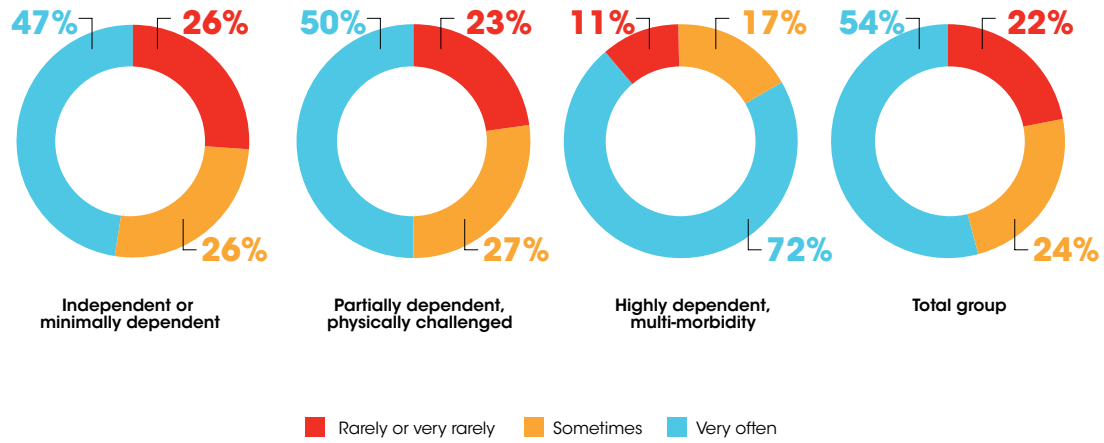
Figure 16. Percents of respondents without access to any/suitable public transport



Emotional and social needs

When it comes to emotional needs of older people, it appears that a majority (**54%**) of the respondents across all groups experienced **worry or stress very often**. The frequency of stress and worry increases with higher levels of dependency. Among the h**ighly dependent, 72%** experience stress or worry **very often**, compared to **50%** in the **partially dependent group** and **47%** in the **independent group** (x^2 (8, N=600) = 47.51, p<0.001) (Figure 17). Also, older adults living alone experience considerably higher levels of worry and stress compared to the ones living with others (69% of the ones living alone stated "often" or "always vs 49% of the ones living with other persons). When asked about the presence of persons to provide them with the needed emotional support, the participants responded in their majority that they had at least one person in their life that offered them comfort in times of need (89% of them). In line with the general trend, here too, the highly dependent group has slightly less emotional support compared to the other groups.

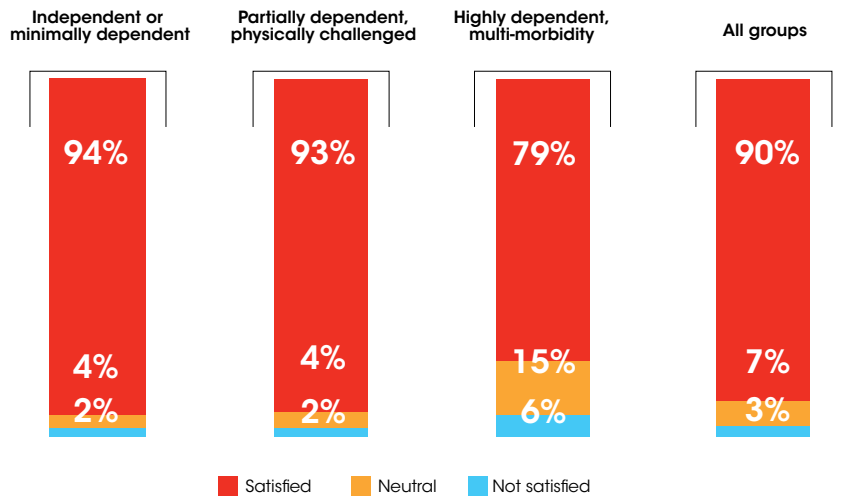
Figure 17. **Worry and stress among older adults**



Regarding the participants' social interactions, the results show a contradiction between the satisfaction reported from social interactions and the actual participation in social activities. While the overwhelming majority of older persons (**93%**) across all groups rarely participate in social activities with the highly-dependent group reporting less participation than the other two, the satisfaction level from social interactions is high across all groups report being satisfied with their social interactions. Yet, the highly dependent older adults again experienced less satisfaction compared to the other groups (Figure 18).

The contradiction can potentially be attributed to the fact that older adults may find satisfaction in limited but meaningful interactions, such as family visits or one-on-one connections, rather than frequent participation in broader social activities, which is in line with the presence of a person offering emotional support, as mentioned above.

Figure 18. Satisfaction from social interactions



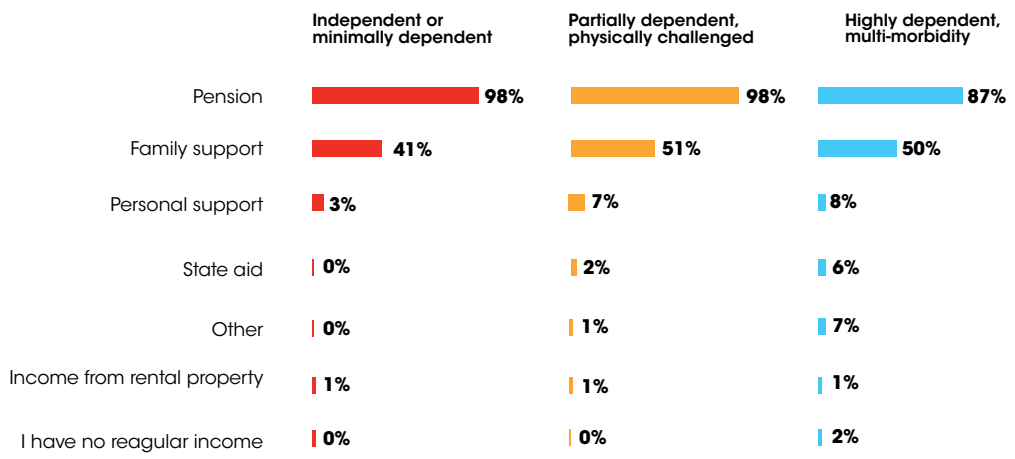
Financial needs

Pensions are the primary income source across all groups (95%), again with declining trends according to dependency. Family support becomes increasingly significant when dependency rises, with reliance growing from **41%** in the independent group to **50-51%** in the more dependent groups. Similarly, personal savings, state aid, and other income sources become more present, reflecting the need for supplementary financial resources to meet higher care needs (Figure 19).

While economic assistance and disability allowances are crucial cash benefits for the highly dependent older adults, to ease the financial burden for their families, the required procedures to acquire state support are discouraging, based on the FGD with family caregivers.

> One of them describes: *"I went through the process [of receiving payment as a carer], since I'm employed, we applied for my brother, who's unemployed. It was horrible so complicated and so many documents. They would tell you go there, come here, go there... We just got tired and gave up"*
>
> ***Family caregiver, tending to care for her paralysed mother, Tirane***

Figure 19. Sources of income



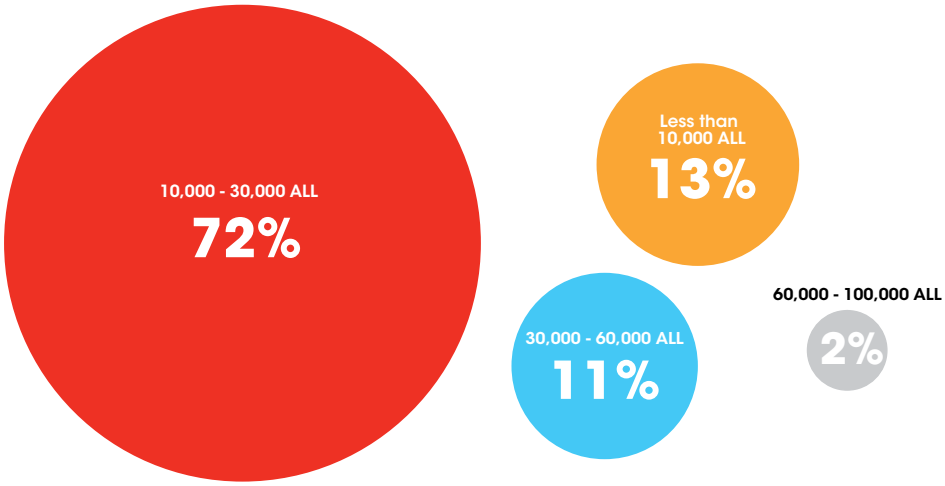
The majority of older adults across all groups have low personal monthly incomes, with **72%** earning between **10,000 and 30,000 ALL**, and a small but significant proportion (**13%**) earning even less than **10,000 ALL** (Figure 20). Gender-wise women representation in the groups under 30,000 was higher, which means that again women may face greater difficulties to receive care for their needs.

When asked about the proportion of their monthly income used to meet the basic needs and the one that goes for health care services, the results were striking. Approximately 55% of the monthly income of older persons is used for basic needs and 45% goes for health care services. This ratio changes across the groups, with the independent group spending 60% for basic needs and 40% for medical expenses, while for the highly dependent group the ratio is the opposite: 40% for basic needs and 60% for medical expenses. Considering the at-risk poverty threshold for one-member household in Albania for 2023 was **22,547 ALL** (monthly) and the high percentage of out-of-pocket expenses for healthcare needs it becomes clear that older adults are at a high risk for poverty.

Several family caregivers confirmed these findings. In addition, they pointed out that their families' limited budgets, exacerbated by medical expenses and caregiving duties often prevent them from working.

> " I'm not working a well paid job since I have to tend to mom and can not work long hours, and mom's not working as well because of her disability. And my brother is also unemployed. So the family budget is very thin"
>
> **Family caregiver, 38, tending to her paralysed mother, Tirane**

Figure 20. **Personal monthly income**

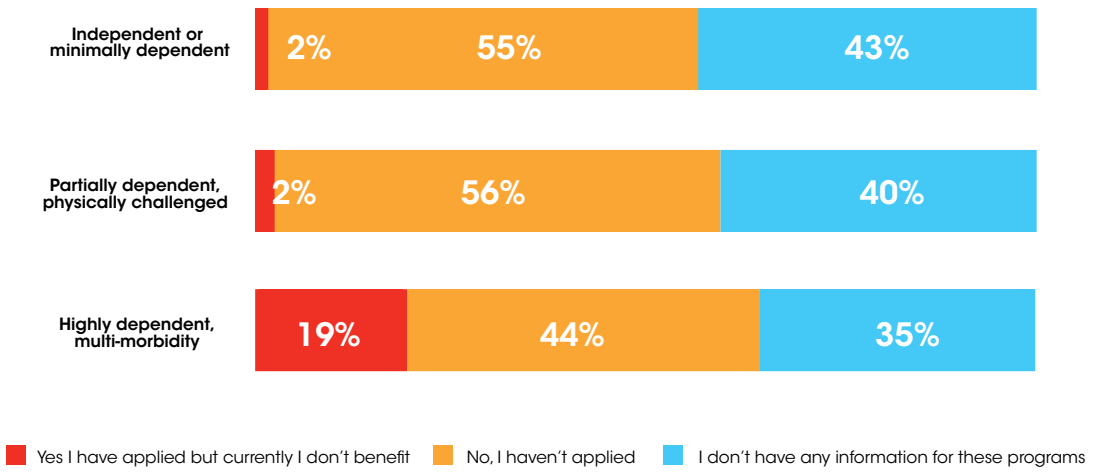


They also stated that the state support is minimal and the process for obtaining carer status is bureaucratic and discouraging. Only 6% of the total number of the respondents received disability payments, a percentage that ranged from 2% of the respondents in the independent group to 18% of the ones in the highly dependent group.

Across all groups, **41%** reported they didn't have any information about social protection programs. Moreover, **19%** of the highly dependent older adults had applied but were not currently benefiting (χ^2 (6, N=600) = 58.30, p<0.001) (Figure 21). These findings suggest that older adults, regardless of dependency level, face significant barriers in accessing or engaging with social programs, particularly due to a lack of information and many bureaucratic procedures. Region-wise older adults from Tirana were less likely to have applied and not benefit from these programs, but what is important is that they were much more informed about their existence compared to the ones in other areas.

A recent initiative of the Ministry of Health and Social Protection was to include social workers in the Health Centers, which are currently named "Socio-health centers". This is an important milestone showing its effort to complete both the social and health needs of the citizens. However, according to an NGO representative, this initiative is still in its early steps and the currently employed professionals are both psychologists and/or social workers, reflecting the confusion or difficulty to implement in practice integrated social and health services, which are very important for the older adults in need.

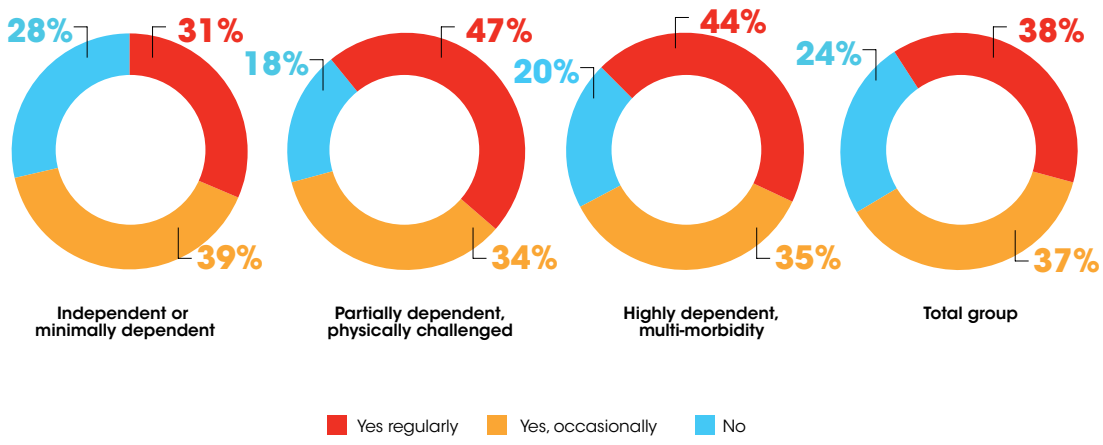
Figure 21. Older adults' awareness, access and benefitting from social protection programs



Under these circumstances reliance on a family's financial support is of crucial importance to alleviate financial challenges. More than **2 out of 3 dependent older adults** receive regular or occasional financial support from their families to buy food, medicine and for other needs. On the other hand, in all groups, **24%** reported receiving no financial help from their families, with this figure slightly decreasing among the more dependent groups. It is worth mentioning **that 20% of highly dependent older adults receive no financial support** from their families, which may exacerbate their financial vulnerabilities (Figure 22).

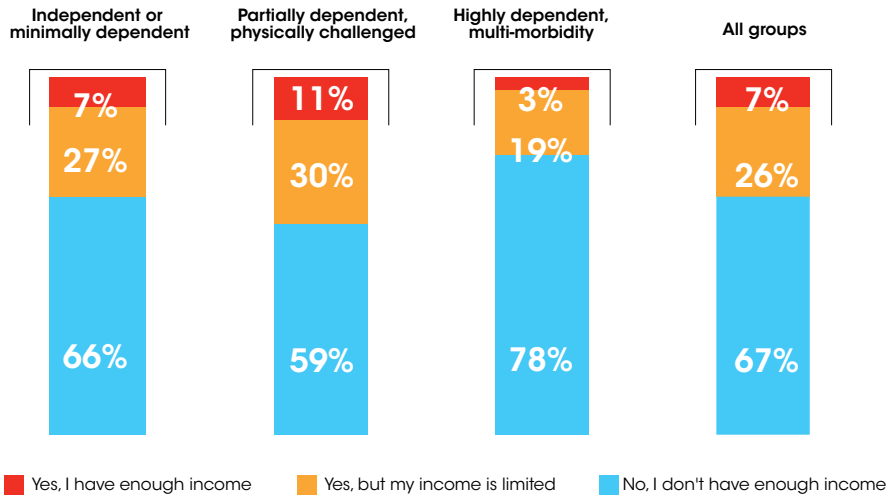
Participants from urban areas reported more that their families are not helping them financially, which may suggest a greater need for assistance (29% in urban areas vs 19% in rural areas).

Figure 22. Financial assistance from family members for basic and medical needs



2 out of 3 older adults across all groups (**67%**) report that their income is insufficient to hire a carer. This percentage increases with dependency, reaching **78%** in the **highly dependent**. (Figure 23). When asked about the amount of money they would make available to employ a carer privately if needed, the vast majority of them (above 84%) stated that they couldn't afford to give any money at all to pay for a private carer. In addition, 97% of them reported that they are not willing to go to a nursing facility for older people. When comparing women and men, it seems that women reported more to have an insufficient income and were less able to afford a carer.

Figure 23. How many older adults have sufficient income to employ a carer privately?

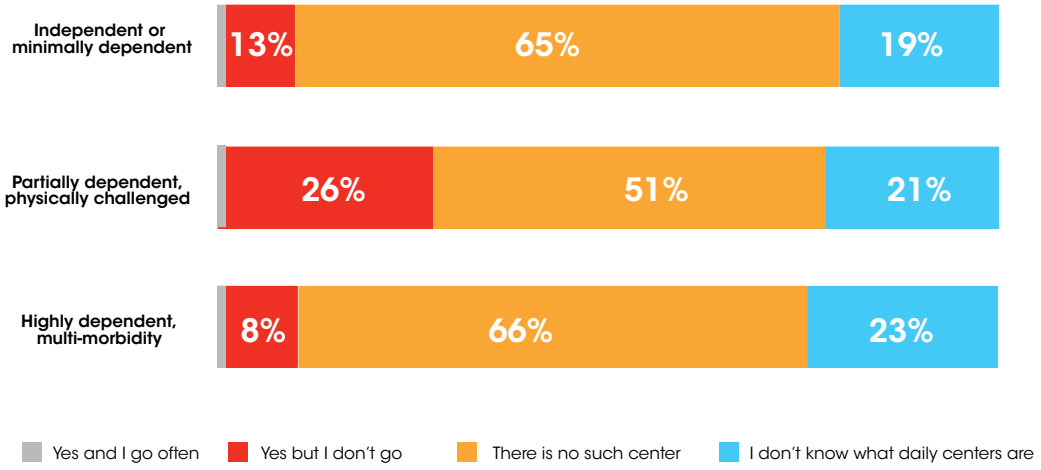


Awareness, availability and use of community centers and digital platforms

Awareness, availability and use of community day care centers are limited across all dependency levels, with a significant majority of older adults reporting these centers as unavailable (**61%**) or being unaware of their existence (**21%**). Frequent use is most common among the **partially dependent group (26%)**, while the **highly dependent group** faces the most significant barriers to usage, with only **8%** reporting regular attendance and **66%** stating no centers available (x^2 (8, N=600) = 24.14, p=0.002) (Figure 24). By 23% difference more respondents from rural areas or outside Tirana reported that there aren't any such centers in their area.

Family caregivers in FGDs confirmed the severe limitations in accessing services, with a near-total absence of specialized care in rural areas. They stated that this forces them to travel long distances for therapy or consultations, which disproportionately impacts low-income families already burdened by the financial strain of long-term care.

Figure 24. Information, availability and utilization of community centers



Asked about their willingness to move in a residential center, if needed, the vast majority of the respondents said "no" (97%).This result shows clearly the need for more community-based and homecare services, but also it might be an indication of the lack of trust in residential institutions.

Regarding the use of digital platforms to receive services, only **12%** of the respondents reported using them while the overwhelming majority (**86%**) did not use digital platforms for this purpose. When asked about their willingness to receive services through digital platforms, **20%** of older persons expressed willingness, which is higher than the percentage currently using digital platforms. However, the majority (**74%**) were unwilling to receive services digitally.

CHAPTER 2

SUPPLY OF LONG-TERM CARE (LTC) IN ALBANIA

Introduction

This chapter analyzes the supply of LTC in Albania through two main dimensions: **home-based care**, which relies heavily on family caregivers and informal support networks, and **institutional care**, encompassing residential facilities and community/day centers. Additionally, this chapter also analyzes the presence of vocational schools as part of the broader LTC framework, highlighting their potential to address workforce challenges by providing essential training for caregivers. Together, these perspectives provide a comprehensive understanding of the challenges and gaps within Albania's LTC framework.

Despite the pressing need, Albania's LTC system remains underdeveloped, with family members bearing the impact of caregiving responsibilities. This reliance on informal caregiving reflects both cultural norms and systemic gaps in the availability of professional care services. The strain on family caregivers is compounded by limited formal care options and inadequate support mechanisms, leaving a significant portion of older persons without the care they need.

Recognizing these challenges, Albania has taken steps to address the growing demand for LTC services. Legislative frameworks such as Law No. 121/2016 on Social Care Services and the **National Action Plan on Ageing (NAPA) 2020-2024** represent key milestones. These policies aim to improve service delivery, expand access to care, and ensure that older persons live with dignity and security. However, despite these initiatives, the pace of progress has not kept up with the needs of an aging population, revealing critical gaps in coverage, equity, and quality of care.

By examining the interplay between formal and informal care systems, geographic disparities, workforce issues, training availability, financial constraints, and the role of public-private partnerships, this chapter offers actionable insights for building a more inclusive and sustainable LTC framework to address the needs of Albania's aging population.

Methodology Overview

This report is grounded in a multi-method approach designed to provide a comprehensive understanding of the supply of Long-Term Care (LTC) in Albania. The methodologies employed include:

A. **Nationally Representative Survey**: A survey was conducted among 600 persons 65+, representative of Albania's aging population. The survey collected quantitative data on the reliance on family caregiving, dependency levels (based on activities of daily lives or household tasks), barriers to receiving care, and financial and emotional well-being. The findings provide a detailed snapshot of LTC supply at the household level.

B. **LTC Institutional Study**: The survey aimed to investigate the challenges, service provision, and operational dynamics of residential and day care centers for older persons in Albania.

C. **Focus Group Discussions**: Focus groups were organized with caregivers from formal care institutions and those providing service at households to capture qualitative insights. These discussions explored societal norms, perceptions of caregiving responsibilities, challenges faced by caregivers, and preferences for alternative LTC options.

D. **Vocational Training in LTC Landscape**: An evaluation was conducted of existing vocational training programs for caregivers, with a focus on identifying gaps in skill development for family caregivers and the potential for formalized training initiatives in Albania.

Part 1. Home-Based Long-Term Care (LTC) in Albania

Overview of the home-based care

In Albania, long-term care (LTC) is predominantly provided within households, with families playing a crucial role in supporting older persons in need. However, the limited availability of formal and paid caregiving services presents challenges for families, particularly in meeting the needs of highly dependent individuals.

These gaps, combined with societal norms that frame caregiving as a family duty, emphasize the importance of exploring new ways to strengthen and complement family caregiving.

A. Family as the Cornerstone of LTC

Family caregiving is the foundation of LTC in Albania, with **95% of older persons who receive care relying on family members**, and only **5% receiving assistance from non-family caregivers**. However, **13% of older persons in need lack a caregiver**, highlighting the need to better support families and address unmet needs. This reliance on family caregivers reflects Albania's tradition of intergenerational support but also underscores the need for policies and programs to ease the growing demands placed on families as the older persons population increases.

B. Caregiver Dynamics Across Dependency Levels

Caregiving needs vary by dependency level. **Independent or Minimally Dependent individuals (49%)**, require occasional help with **Instrumental Activities of Daily Living (IADLs)**, such as shopping or transportation. However, **20% of this group lack a caregiver**, the highest proportion across dependency levels.

C. Gender Dynamics in Caregiving roles and Care Support type

Caregiving roles within families are often shaped by traditional gender norms. Women represent **67% of primary caregivers**, primarily handling household tasks such as **cooking (87%)** and **cleaning (87%)**, while men focus on external responsibilities like **paying bills (87%)** and accompanying older persons to **medical appointments (89%)**.

When women require care, they rely on a **broader network of support**, including children, in-laws, and extended family, as their husbands provide direct care in only **~30% of cases**. Women are also **twice as likely as men to report having no caregiver**, making them more vulnerable to unmet care needs. For men, caregiving overwhelmingly falls to their **wives (74%)**, highlighting the critical role women play in providing care, often with minimal external support.

D. Barriers to LTC in Households

Family caregiving is widely seen as a **familial responsibility**, leaving little room for external or formal caregiving solutions. Among older persons without a caregiver, **61% cite the absence of nearby relatives** as the primary barrier, particularly in outside Tirana areas where internal and external migration has reduced available family networks.

Partially Dependent individuals (28%), need increasing support for both Activities of Daily Living (ADLs) and IADLs, primarily provided by family caregivers. **Highly Dependent individuals (24%)** require intensive care for physical and medical needs. While only **3% of this group lack a caregiver**, formal and paid caregiving support remains extremely limited, placing significant pressure on family networks.

E. Paid Caregiving

Paid caregiving plays a minimal role in Albania's LTC system. Among the **600 older persons in need**, only **12 were supported by paid caregivers**, with just **5 of these paid by state as custodial**. Even among highly dependent individuals, paid caregiving represents only a small proportion of the overall support system. Financial barriers, along with societal norms favoring family caregiving, contribute to this limited uptake. Expanding access to affordable and trained paid caregivers could provide critical relief for families and enhance the overall care system.

Challenges in Home-Based Care: Family caregivers in Albania lack formal training, with **99% of caregivers untrained**. This affects the quality of care provided, particularly for highly dependent individuals with complex needs.

Results from the survey and focus groups

The analysis below combines the nationally representative survey data with the 65+ old people with focus group with caregivers' insights to provide a comprehensive understanding of caregiving for older persons in need. Respondents were asked several questions about caregiving, including who provides care, the characteristics of caregiving, and the dynamics of family involvement. The findings highlight the central role of families, the challenges faced by caregivers, and the limited involvement of formal or paid caregiving services.

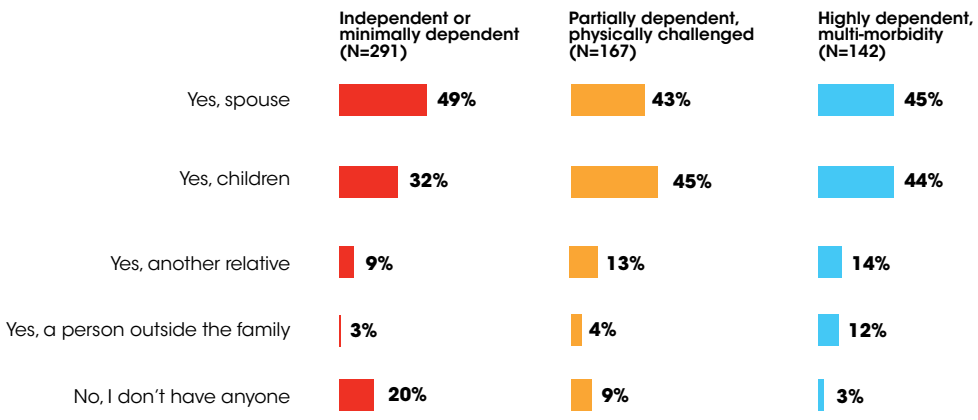
"Family as the Cornerstone of Care"

Who Provides Care?

Older persons respondents in need of care were asked about the people who assist them. The findings reveal a striking dependence on family caregivers. Among the older persons receiving support, **95% report receiving care from family members**, while non-family caregivers account for just **5% of cases**. However, **13% of older persons in need lack a caregiver entirely**, underscoring significant gaps in care provision.

The graph illustrates that family remains the cornerstone of long-term care for older persons in Albania. Spouses and children are the primary sources of support, while reliance on non-family caregivers is minimal. These results align with societal norms in Albania, where caregiving is predominantly viewed as a family responsibility.

Figure 25. Who provides care for the older persons?



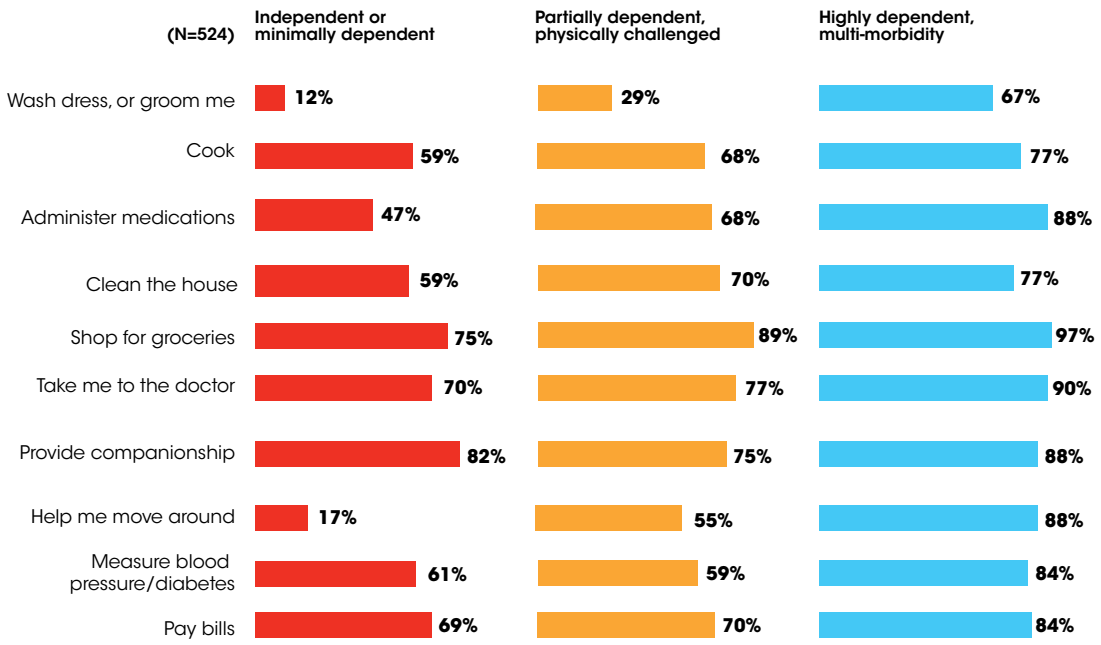
Services Provided by Caregivers: A Comprehensive Support Network

When asked about the specific services that caregivers provide, the survey revealed a broad spectrum of responsibilities tailored to the level of dependency of the older persons. Caregivers in households often take on multiple roles, from personal care and household tasks to emotional support and medical management, highlighting the increasing demands placed on them as dependency levels rise.

As dependency increases, so does the complexity and extent of caregiving. For personal care tasks such as washing, dressing, or grooming, **only 12% of minimally dependent older persons** require assistance, but this rises sharply to **29% among partially dependent individuals** and **67% among the highly dependent group**.

Household responsibilities, such as cooking and cleaning, remain a significant part of caregiving across all levels of dependency. Between **59% and 77% of caregivers** are involved in these tasks, ensuring the daily functioning of the household. This consistency highlights the essential nature of these services, regardless of the older persons individual's level of dependency.

Figure 26. How caregivers support older persons needs



Medical assistance becomes even more critical for highly dependent individuals, with 88% of caregivers administering medications or injections and 84% measuring blood pressure or treating wounds.

> This highlights the burden on caregivers who often lack formal training, as Miranda, 53, from Tirana, explained: "At times it is difficult because you just don't know what to do. I used to get really nervous with her [my mother] because I expected her to behave as an adult as she had always behaved. It took me some time to realize that in that manner I wasn't getting anywhere. I had to change my communication with her to make her more cooperative."

Emotional support and companionship are equally vital, with 88% of caregivers for the highly dependent group ensuring emotional well-being.

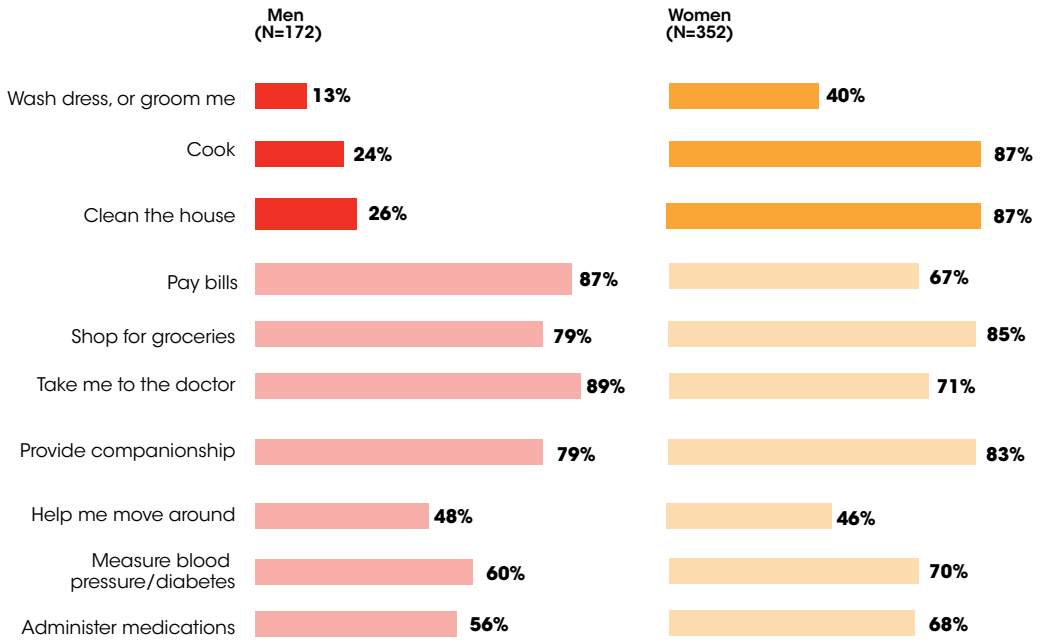
> Alma, 46, from Shkoder, expressed this sentiment: "Besides the personal and physical care, which is all the time, every day, the most important service I do is to offer him [her son] comfort and make sure he's not feeling distressed."

Mobility and transportation also play a significant role, with 55% of partially dependent and 88% of highly dependent individuals requiring assistance with moving around. Additionally, caregivers take older persons to medical appointments in 70-90% of cases across all groups, further underscoring the essential and multifaceted nature of caregiving responsibilities.

Gender Dynamics in Caregiving

When looking at the data by gender, it's clear that long-term care for the older persons relies on women taking on most of the responsibility. Women overwhelmingly take on primary caregiving responsibilities, representing **67% of caregivers**. This caregiving often requires physically and emotionally demanding tasks, such as **cooking (87%)** and **cleaning (87%)**, along with intimate personal care, including bathing and dressing.

Figure 27. Gender Differences in types of care



What happens when the person in need of care is a woman?

The caregiving dynamic shifts when the care recipient is a woman. Instead of relying on their husbands, women are supported **by a broader network, including sons, daughters, and daughters-in-law**. This broader network, while mitigating some challenges, also exposes gaps. Women are **twice as likely as men** to lack caregivers (16% vs. 8%), a statistic resonated in focus groups where participants noted women's higher vulnerability to being left without support.

This disparity reflects societal expectations that women are expected to provide care for others, even when they themselves require support.

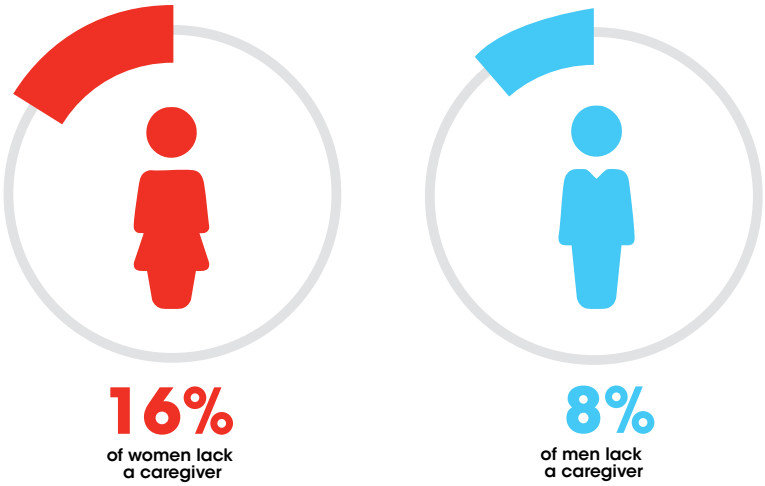
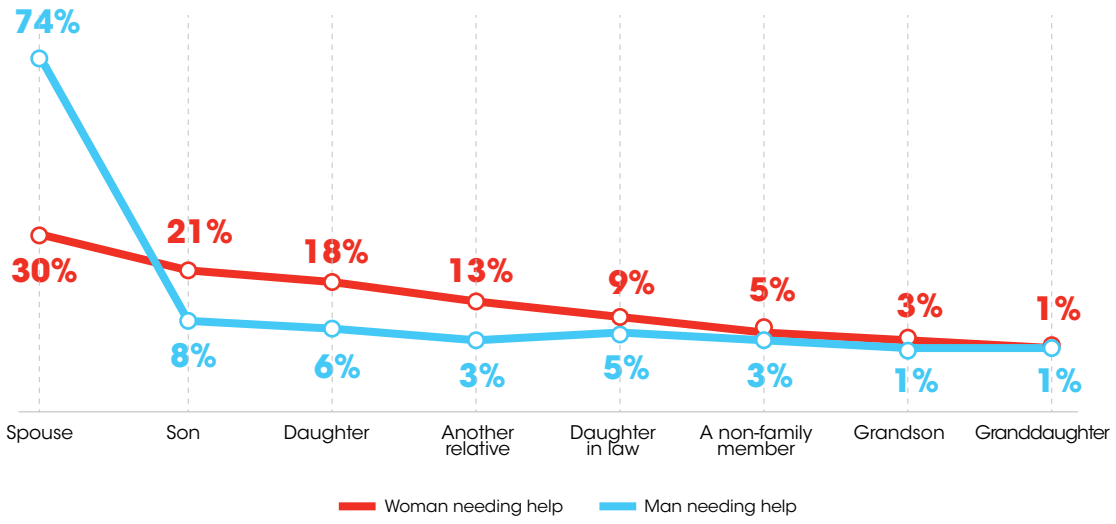


Figure 28. Gender differences in caregiver roles: who provides support?



Focus group participants underscored the weight of caregiving responsibilities that fall disproportionately on women.

> As Besjana (38, Tirana) shared, "My mom's hernia got really bad, and after two unsuccessful surgeries she was rendered paralyzed in bed. Since then I have been her main caregiver as the only girl in the house."

This experience highlights the cultural expectations that caregiving, especially for incapacitated family members, is primarily a woman's responsibility, often leaving women with little or no support.

Men's Dependence on Spouses

Men's caregiving patterns contrast sharply with women's. Among men receiving care, **74% depend exclusively on their wives**, reflecting societal norms that position caregiving as a woman's duty. Men are significantly less involved in household caregiving tasks, with only **13% of male caregivers providing personal care (e.g., washing)** compared to **40% of female caregivers**. Instead, men typically focus on external tasks, such as **paying bills (87%)**, **taking older persons to medical appointments (89%)**, and **shopping for groceries (79%)**. This division reflects traditional gender roles and societal norms discouraging men from engaging in personal or domestic caregiving responsibilities.

> As Marsela (Tirana) noted during discussions, "Men may do the external tasks like shopping or paying bills, but they rarely help with personal care—it's left to us."

Barriers to Caregiving

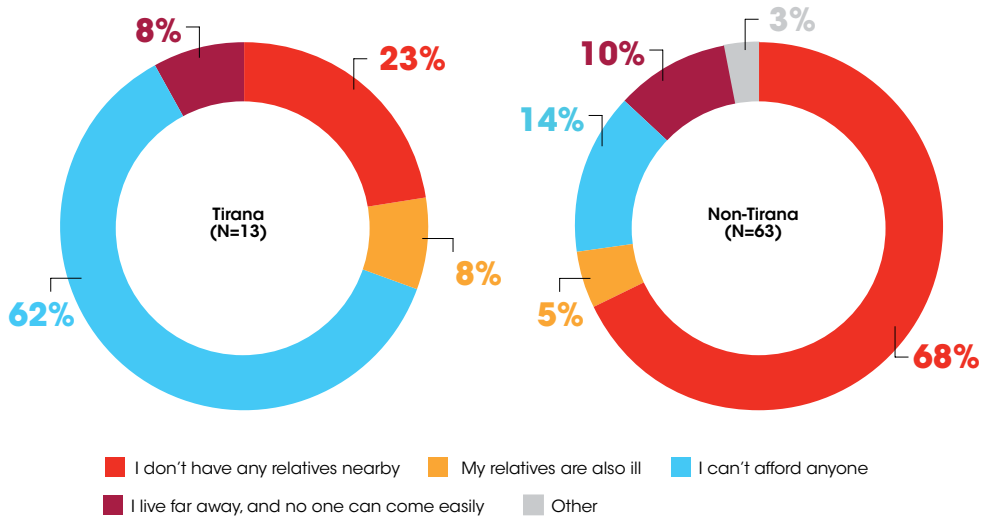
Societal Expectations, Financial Constraints, and Geographic Disparities

Among the 13% of older persons in need who lack caregiving support, the most cited reason was the **lack of nearby relatives (61%)**, followed by **financial constraints (22%)**, which reflect the inability to afford professional caregiving. Other reasons include **logistical challenges (9%)** and **relatives being ill (5%)**, with **3% citing miscellaneous barriers**.

Regional differences reveal distinct caregiving challenges. In **Tirana**, where caregiving options might be more available, **68% cite financial constraints** as the main barrier, compared to only **14% in non-Tirana areas**. Conversely, in **non-Tirana regions**, **68% report the lack of nearby relatives** as the primary issue, reflecting the impact of migration and geographic isolation.

The data underscores a systemic issue: whether due to geographic inaccessibility or financial unaffordability, the outcome is the same—13% of older persons in need remain without caregiving support. However, **financial constraints appear more significant**; when asked how much they could pay for private care, **84% of the respondents indicated they could not afford to pay anything,** underscoring the unaffordability of these services.

Figure 29. Why 13% of the older persons are left without care



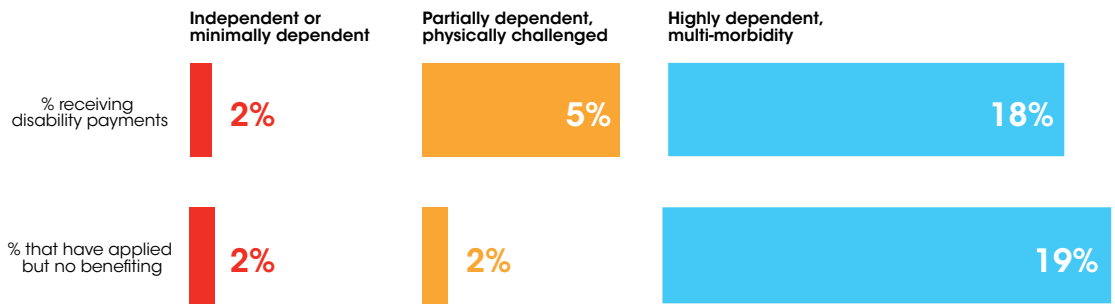
Ultimately, the data illustrates that without accessible and affordable caregiving options, families—especially those with limited resources—are unable to ensure the well-being of their older persons members, perpetuating a cycle of unmet needs. **The small sample size in Tirana, however, suggests the need for further research to validate and expand these findings.**

The Bureaucratic Burden of State Support

The findings on regional and financial barriers reveal interconnected challenges that families face in accessing caregiving support. Whether due to **geographic isolation in non-Tirana regions** or **financial constraints in urban centers like Tirana**, the inability to secure consistent caregiving support places significant strain on families. Together, these challenges illustrate systemic issues where **limited state support and insufficient alternatives add to caregiving gaps**.

Navigating state support systems for long-term care often adds to the challenges families already face. Disability payments, a potential relief for financial pressures, remain underutilized. Among highly dependent individuals, only **18% receive disability payments**, while **19% applied but were denied**. This reflects restrictive eligibility criteria and the challenges families face in accessing state assistance.

Figure 30. **Limited Access to Disability Payments**



For families in rural areas, these challenges are compounded by geographic barriers.

> Gjelina, who cares for her paraplegic husband, explained: "They dragged us around. Go to Shkoder, go there, go there, no this doctor has to see him, no that commission has to verify... Meanwhile, my husband cannot move that easily. The last time we went there at the office, he [my husband] told me: If they don't give it [the invalid status] this time, I'm not doing this again."

These experiences highlight the need for **streamlined processes** and **greater accessibility** to ensure that families are supported without undue burden.The challenges in accessing state support are closely linked to regional differences. In **non-Tirana regions**, the lack of formal caregiving services and geographic distance make caregiving more difficult, particularly when nearby relatives are unavailable. In contrast, families in **Tirana, while**

also financially constrained, may benefit from better proximity to services, highlighting the need for equitable distribution of caregiving resources across the country.This lack of dedicated services adds to the emotional and physical burden on families, emphasizing the need for investments in community-based and specialized care options to provide both respite and adequate support.

Challenges in Home-Based Care faced

The overwhelming reliance on family caregivers in Albania's long-term care (LTC) system is compounded by a lack of formal training, which significantly impacts the quality of care provided. Data from the survey highlights that **99% of home-based caregivers lack any formal training**, regardless of the dependency level of the older person they are caring for. This means that families, who are the cornerstone of caregiving, are left to manage complex medical, physical, and emotional needs without adequate preparation.

Family caregivers often find themselves navigating unfamiliar medical tasks, such as administering medications, monitoring chronic conditions, and assisting with mobility, without the necessary knowledge or skills. For instance, **88% of caregivers for highly dependent individuals provide medical assistance, such as administering injections or measuring blood pressure**, tasks that require some degree of training to ensure safety and effectiveness. This lack of training not only compromises the quality of care but also places significant stress on caregivers. Many caregivers report feeling overwhelmed and unprepared for the demands of caregiving.

> As Miranda, 53, from Tirana, explained: "At times it is difficult because you just don't know what to do. I used to get really nervous with her [my mother] because I expected her to behave as an adult as she had always behaved. It took me some time to realize that in that manner I wasn't getting anywhere. I had to change my communication with her to make her more cooperative."

Emotional and Physical Strain

The absence of training worsens the emotional and physical toll on family caregivers. As they juggle caregiving responsibilities with their own personal and professional lives, the lack of guidance often leads to burnout.

> Frederika, 26, from Vlore, shared her experience: "It is difficult [caregiving], especially because they [the family member in need] need it all the time. It's not something you do once or twice. And meanwhile, you also need to tend to your own life."

The lack of preparedness is particularly critical for caregivers of individuals with conditions such as Alzheimer's or autism, where specialized communication and behavioral management strategies are necessary.

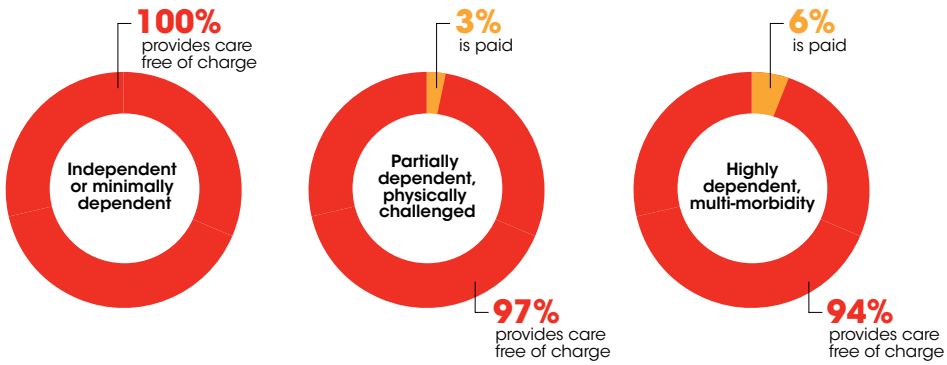
> Alma, 46, caring for her autistic son in Shkoder, highlighted this gap: "I need some specialized people who can help me. Somewhere where I can leave him for a few hours. ... I took him to a church community center here in Shkoder, but they didn't know how to deal with an autistic person. It needs to be a center specialized for them [people with autism], with specialized personnel who know how to manage and help them."

"Exploring Non-Family Caregivers" - Paid Caregiving: Minimum contribution

Paid caregiving and informal non-family caregiving represent critical yet limited components of Albania's long-term care (LTC) landscape. While families overwhelmingly shoulder the caregiving burden, these alternative forms of caregiving provide valuable insights into the gaps and challenges within the system. Focus group discussions with informal caregivers shed light on their roles, challenges, and aspirations, offering a more comprehensive view of the caregiving ecosystem. Among the **600 older persons surveyed**, only **12 cases involved paid caregivers**, with just **4 of these being government-funded custodial caregivers** (often family members receiving a stipend). This represents a **2% prevalence** within the sample.

While statistical analysis is not feasible due to the small number of cases, the data reveals a clear pattern: the prevalence of paid caregiving increases with dependency levels. For **minimally dependent older persons**, caregiving is entirely unpaid. Among **partially dependent individuals**, **3% rely on paid caregivers**, and for **highly dependent individuals**, this figure rises to **6%**. Despite this trend, paid caregiving remains negligible, with families continuing to bear the overwhelming burden of care, even as dependency needs grow.

Figure 31. Caregiving services: paid vs.free support



This minimal contribution reflects financial barriers, limited availability of trained caregivers, and cultural norms that prioritize family caregiving. However, even in the rare instances of paid caregiving, focus group discussions reveal that caregivers often provide essential physical, medical, and emotional support.

Informal Non-Family Caregivers: Focus Group Insights

Non-family caregivers, often operating without formal recognition or training, play a crucial role in supplementing family support. Focus group participants provided detailed accounts of the services they provide, the challenges they face, and their aspirations for formalization.

Services Provided

Accompaniment and Companionship: Many caregivers focus on emotional and social support, ensuring older persons feel connected and cared for. Light household tasks, such as preparing meals or running errands, are common.

> "I stay with her, cook, watch TV, talk about stuff, and go out for walks or to the coffee place. It's not a difficult job, to be honest." – **Alma, Informal Caregiver, Tirana**

Physical and Medical Support: For individuals with chronic illnesses or severe disabilities, informal caregivers often handle intensive tasks, such as personal hygiene, feeding, and administering medications. These responsibilities are physically demanding and emotionally taxing, leading to significant caregiver burnout.

> "I cook, clean, tend after him. He's paralyzed due to a stroke and doesn't move from his bed. I have to be available to him all day and night."
> – **Lume, Informal Caregiver, Tirana**

Challenges Faced by Informal Caregivers

Lack of Training: Focus group participants highlighted the absence of formal training as a major barrier. Most caregivers learn through experience or informal guidance, which limits the quality of care they can provide and increases stress.

> "The medical part I've learned along the way. I've tended to so many elders." – **Lumturie, Informal Caregiver, Tirana**

Physical and Emotional Strain: The irregular hours and lack of support exacerbate caregiver exhaustion. Emotional bonds with clients can also lead to psychological strain.

> "It's not just the physical fatigue—the irregular hours and lack of support make it emotionally draining too." – **Lume, Informal Caregiver, Tirana**

Aspirations for Training and Formalization

Training Needs: Caregivers expressed a strong desire for formal training in areas such as medication management, wound care, and emotional support for individuals with cognitive impairments.

> "I would like to have a certificate that proves I am trained. It would make us more credible and available for better job opportunities." – **Zamira, Informal Caregiver, Tirana**

Career Aspirations: Many caregivers aspire to formal employment, seeking benefits like social security and health insurance. Some are interested in working abroad, where conditions and pay are better.

> "If the opportunity arises, I would want to do this job abroad. It pays better, and the conditions should not be as hard." – **Alma, Informal Caregiver, Tirana**

Lack of State Support and Regulation

Lack of Benefits: Informal caregivers lack access to social security or healthcare benefits. Older caregivers fear losing income if formal systems impose taxes or restrict eligibility.

> "Sure, we're working now and earning something, but what about when we don't have the energy to work anymore? What happens then?" – **Liljana, Informal Caregiver, Shkoder**

Need for Regulation: Participants called for government intervention to standardize pay, working conditions, and time off.

> "Somebody needs to do something about that because I'm sure many ladies still work like that because they are in need." – **Merita, Informal Caregiver, Tirana**

Impact on Families and Clients

Informal caregivers alleviate the burden on families by managing daily caregiving tasks, enabling family members to balance their responsibilities.

Emotional Impact: Caregivers provide crucial companionship, reducing isolation and improving the emotional well-being of older persons.

> "It is important to be there for them, not only physically but also to make them open their heart and feel good." – **Elodina, Informal Caregiver, Tirana**

PART 2. Institutional landscape of LTC supply in Albania

Desk review

Availability of Long Term Services Albania has made some progress in expanding long-term care (LTC) services, guided by legislative frameworks such as the **Law No. 121/2016 on Social Care Services, Strategy on Social Protection (DCM 152/2024)** and the **National Action Plan on Ageing (NAPA) 2020-2024**. The NAPA introduces a comprehensive series of measures and actions aimed at ensuring healthy aging and full coverage of health and social services for older persons in need. These efforts have facilitated the opening of new community day centers and the development of social care infrastructure. However, a closer examination of the distribution, capacity, and accessibility of these services reveals significant gaps and inequalities, particularly affecting older people populations in rural and underserved areas.

As of the latest figures[1], in Albania, 439 providers offer social care services or 13% more than in 2023, who ensure the functioning of 1,669 social care services or 56% more than in 2023 for 39,091 beneficiaries, individuals in need (11% more than in 2023). Compared to 2023, the share of elderly people receiving services has doubled, from 12% in 2023 to 23% in 2025, with 5,917 elderly people benefiting, compared to 3,600 in 2023. 80 services are dedicated specifically to elderly care.

[1] *The study "Mapping of Social Services in Albania, 2025" presents the distribution of social care services by typology, source of funding, beneficiary groups and type of provider institution, based on administrative data collected directly from the 61 municipalities of the country.*

Social care services for the elderly in Albania have seen modest improvements but remain inadequate and unevenly distributed across the country. Elderly individuals constitute approximately 18% of all service beneficiaries, placing them among the primary target groups alongside children with disabilities and economically vulnerable families. The most commonly accessed services for the elderly include parashoqërore (pre-social), community-based, family-oriented, and specialized support. However, residential services—vital for those without family support—are limited, with entire regions such as Kukës, Dibër, and Lezhë lacking key service typologies like residential or alternative care.

Public institutions are responsible for over half of the services provided to the elderly, with a growing role played by local governments in financing and managing community-based and mobile services. Despite this, only a few municipalities (e.g., Shkodër, Tirana, Gjirokastër) meet over 25% of local care needs. The rest—especially rural and

remote municipalities—remain underserved. Social Fund mechanisms have enabled the establishment of new services in some regions, but sustainability and institutional capacity remain key concerns. Many municipalities lack dedicated staff or coordination mechanisms (such as needs assessment units), undermining service quality and responsiveness.

Gaps and Policy Challenges

Although the number of care service providers has increased (439 as of 2025), and elderly beneficiaries are more numerous than in previous years, critical gaps persist. Services remain concentrated in urban areas, and their alignment with actual needs is insufficient. For example, only 12% of identified care needs are being met nationally. The report emphasizes the need for standardized assessment methodologies, expanded service types (particularly home-based and day care models), and sustainable municipal financing. Legal reforms and better integration between state, local government, and non-state actors are essential to ensure dignified aging and inclusive care for Albania's growing elderly population.

Currently, 36 community day centers serve approximately 3,000 older individuals, and residential care facilities now number 23, with a capacity of 705 older residents. These advancements reflect an increasing recognition of the growing needs of Albania's aging population and the importance of providing targeted support for elderly care.

Capacity and Workforce Limitations

In addition to geographic limitations, the LTC system faces significant capacity constraints. Residential care facilities, which are vital for individuals requiring round-the-clock assistance, can accommodate only a small fraction of those in need. Home care services, crucial for supporting the independence of older individuals, are severely limited, with only a handful of beneficiaries, reflecting an urgent need for expansion.

Furthermore, the LTC workforce remains under-resourced. According to the latest data [1], the formal **social care workforce** in Albania comprises approximately 3,700 individuals employed across public, private, and hybrid institutions, as well as within municipal roles. Among these employees, 78% (or 2,916 individuals) work directly within social care institutions, while the remaining 22% (837 individuals) support the broader social care system at the municipal level. The workforce is predominantly female, with women making up 81% of institutional staff, underscoring the reliance on women in caregiving and administrative roles.

Staffing requirements differ significantly depending on the care setting. Community day care centers, which typically serve healthier elderly adults, can operate with a lower staff-to-beneficiary ratio (currently 12 to 1). However, in residential care facilities, where residents often have more complex health needs, maintaining an adequate staff-to-resident ratio becomes crucial.

In public residential care institutions, the current staff-to-resident ratio averages approximately 1 staff member for every 7 - 8 residents, highlighting the need for additional personnel to provide sufficient care for residents with higher dependency levels.

Informal caregivers, predominantly women, play a vital but unrecognized, further highlighting the need for integration and support within the formal care system.

Financial Barriers

To date, 59 municipalities have benefited from the social fund, with the continuous assistance of the central government, national and international partners in the drafting of social plans (61 municipalities with social plans) where the needs for services have been identified and groups in need of services have been better targeted.

The number of social services for the elderly is 25 services, with a number of beneficiaries (cumulative number 11,639). Financial constraints also pose challenges to the LTC system. Although the **Social Fund** was established to support municipalities in providing social care services, it remains underutilized.

Municipalities often face difficulties in accessing these resources due to limited capacities for project design and application, as well as challenges in meeting co-financing requirements. This underutilization highlights the need for capacity-building initiatives to help municipalities better engage with funding mechanisms and improve the equitable distribution of resources across regions.

Role of Public-Private Partnerships

To address gaps in public service provision, partnerships with private and civil society actors have become increasingly important. Hybrid and non-public institutions now serve a significant share of beneficiaries, with non-public institutions supporting an average of 149 individuals per facility, compared to 61 in public institutions. Strengthening public-private collaborations could enhance service delivery, particularly in underserved areas, ensuring greater access and responsiveness to community needs.

Survey and Focus Group Methodology

To complement the desk review, this report employed primary data collection through an online survey and focus group discussions. The survey targeted heads of care institutions, aiming to explore the challenges, service provision, and operational dynamics of residential and day care centers for older persons in Albania.

It was conducted alongside focus groups with caregivers working in these institutions to provide a comprehensive understanding of the state of long-term care (LTC) facilities. The primary objective was to uncover systemic issues, including staff qualifications, financial constraints, and infrastructural needs.

Survey Approach

The survey was conducted online, targeting the directors of eligible institutions through shared links. To boost response rates and ensure diverse participation, follow-up calls were made. Furthermore, the Ministry of Health and Social Protection assisted actively in distributing the survey link to all government-funded facilities, ensuring broad participation from state-funded institutions.

The list of eligible LTC facilities was provided by the State Health Inspectorate (**Inspektorati Shtetëror Shëndetësor)**, and it included a total of 54 facilities (public and private) that provide care for older persons.To the online survey responded 30 institutions, representing roughly half of Albania's residential care facilities (12 out of 23) and 18 day/community centers out of 36.

Out of 12 residential care centers that responded, 6 were state-funded, 4 operated privately, and 2 followed a hybrid model. For day/community centers, 11 were state-funded, 2 operated privately, 3 followed a hybrid model, and 2 used other forms of ownership.

Focus Group Discussions were conducted with caregivers working in both institutional and home-based settings. These discussions provided qualitative insights into the lived experiences of caregivers, societal norms around caregiving responsibilities, and the challenges they face.The findings highlighted the gaps in training, systemic inefficiencies, and preferences for alternative LTC models.Full methodology can be found in annex A.

Main findings from the survey and focus groups

Following the methodological approach outlined above, this section summarizes the key findings from the survey with institutional leaders and focus group discussions. The insights gathered provide an overarching view of Albania's institutional LTC landscape, highlighting operational dynamics, systemic challenges, and caregiver experiences.

Residential care centers **primarily serve to highly dependent older persons, with nearly 50% experiencing cognitive impairments** such as Alzheimer's or dementia, while day/community centers focus mostly on social activities and basic physiotherapy programs for more independent clients.

Unmet Needs in Institutional Care:

A. **Dementia care** remain critically underprovided. Only 33% of residential centers offer dementia specialized care, despite 92% of residents requiring it. No day/community centers provides dementia care.
B. **Physiotherapy services** is similarly lacking, with just 25% of residential centers addressing the needs of individuals with disabilities.
C. **Lack of Home-Based Care Options**: A significant gap exists for older persons unable to access institutional care, particularly in rural and underserved areas. Institutional leaders and caregivers consistently highlighted this issue as a priority for systemic reform.

Staffing and Role Deficiencies: Residential centers rely heavily on caregivers (100%) and doctors (100%), with social workers and administrative staff playing supportive roles. However, specialized roles such as physiotherapists (0%) and psychologists (8%) are practically absent. Day/community centers fare slightly better in staffing social workers (94%) but still lack physiotherapists (17%) and psychologists (17%), limiting their ability to provide comprehensive care.

Lack of Specialized Training

A. Both residential and day/community centers face critical shortages in specialized training programs. Caregivers lack essential skills to manage cognitive impairments such as Alzheimer's and dementia effectively, as well as proper lifting techniques to reduce the physical strain associated with assisting older persons with disabilities.
B. **Impact on Caregiver Well-Being and Service Quality**: The lack of training exacerbates caregiver burnout and limits their ability to address the evolving needs of residents. Caregivers emphasized the need for targeted training, particularly for handling aggression or confusion in residents with cognitive impairments, as well as practical techniques to prevent workplace injuries.

Financial and Infrastructure Limitations:

A. Two-thirds of institutions identified **financial constraints as a primary barrier**, preventing infrastructure upgrades, procurement of assistive equipment, and competitive salaries for staff.
B. **Infrastructure Gaps**: Residential centers reported a critical need for modernized equipment and safer spaces, with 75% emphasizing the urgency of infrastructure improvements. Day centers highlighted the lack of dedicated spaces for therapy and social engagement as a pressing issue.

Emotional and Physical Toll: Caregivers frequently expressed feelings of being overwhelmed due to high workloads and inadequate tools, such as adjustable beds and lifting devices. Caregivers called for improved training programs, better tools to assist with daily tasks, and increased financial and institutional support to alleviate their burdens.

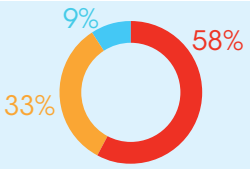
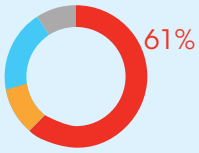
Partnerships with NGOs and Other Organizations: Most institutions reported collaborating with external organizations, but partnerships were often fragmented and lacked long-term impact. Institutions expressed the need for more structured collaborations focusing on training, financial support, and equipment provision.

Awareness and Community Engagement: Day/community centers emphasized the importance of partnerships to raise awareness and shift cultural stigmas around institutional care.

Detailed analysis

Sample profile: Institutional Roles and Challenges

Figure 32. Profile of residential and day/comm

	Residential Center	Day/Com.Center
Ownership type 100% State-Funded 100% Private Hybrid Other Forms		
# of older persons currently served	48	74
Average staff (total)	17.5	11.3
Ratio of older persons to staff	4.8	6.7
% of older persons with cognitive problems such as Alzheimer's, Dementia, etc	±50%	<20%

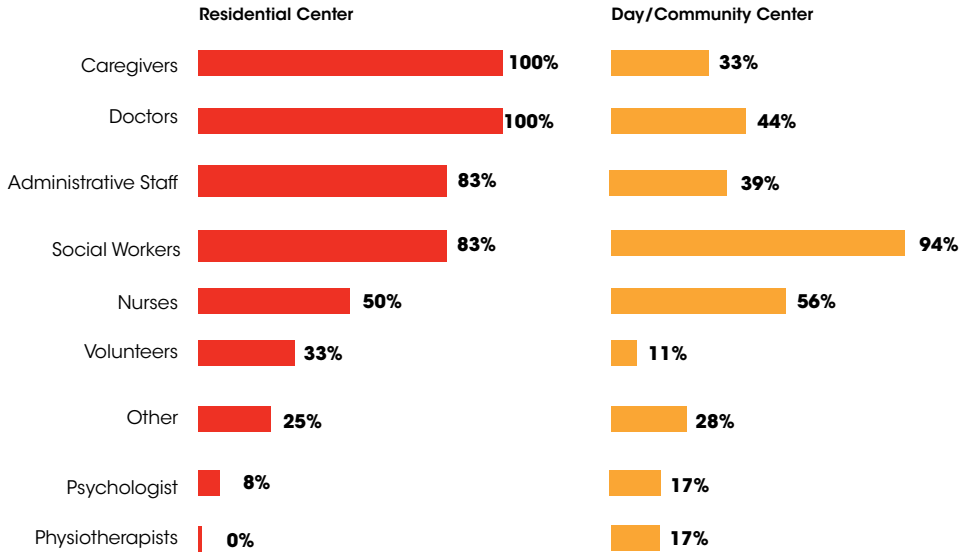
Residential care centers primarily serve **highly dependent older persons**, with nearly **50% of residents experiencing cognitive impairments** such as Alzheimer's or dementia. These centers provide **intensive physical and medical care**, accommodating an average of **48 residents**.The **staff-to-resident ratio is approximately 1 caregiver for every 5 residents**. A facility leader noted, ***"Every day, we address not only physical needs but also the deep emotional scars that come with losing independence."*** In contrast, day/community centers cater to **more independent older persons**, emphasizing **social activities and physiotherapy**. These centers support an average of **74 older persons clients**.The staff-to-client ratio is about **1 caregiver for every 7 clients**. A director in Tirana shared, ***"Our mission is to keep them connected, both socially and physically. But it's a constant struggle with the limited resources we have."***

*It is important to note that these figures represent **survey participants** and may not reflect the full distribution of LTC facilities in Albania.*

Staff roles involved

The composition of staff roles highlights distinct priorities in residential and day/community centers. Residential centers rely heavily on caregivers and doctors, with 100% of respondents employing these roles. Social workers and administrative staff also play crucial roles, with 83% of centers reporting their involvement. However, specialized staff such as physiotherapists and psychologists are notably absent or underrepresented, with only 8% of centers reporting the presence of psychologists and none employing physiotherapists.

Figure 33. Staff Roles involved

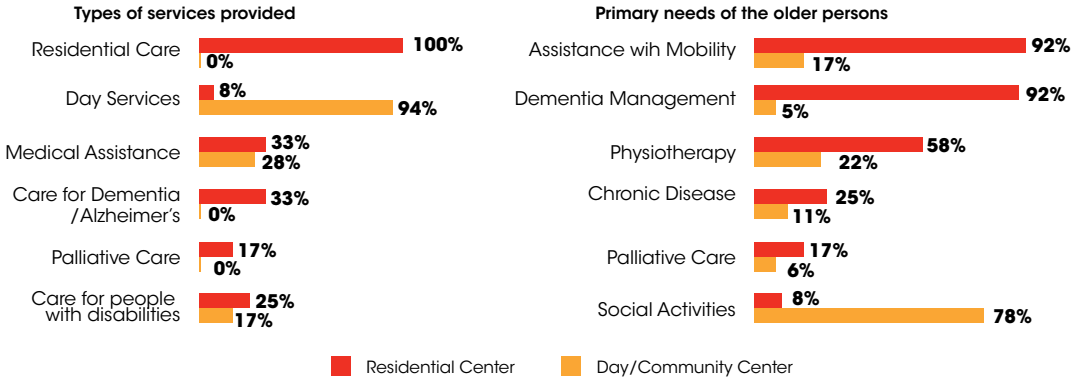


In day/community centers, the staffing structure reflects a greater focus on social integration and community engagement. Social workers are the most common role (94%), followed by nurses (56%) and doctors (44%). However, similar to residential centers, the lack of physiotherapists (17%) and psychologists (17%) limits the ability to meet the holistic needs of older persons clients. A respondent noted, ***"We do the best we can, but without specialized staff, certain needs go unmet."***

Service Gaps in Institutional Care

The survey uncovered a significant mismatch between the services offered by LTC institutions and the needs of their older persons clients. **Dementia management emerged as the most critical need,** with 92% of residential residents requiring this service. Yet, **only one-third of residential** centers provide dementia care, and no day/community centers offer it. This gap is particularly concerning given the rising prevalence of cognitive impairments among the older persons

Figure 34. Services provided and Primary Needs of the older persons by type of institution

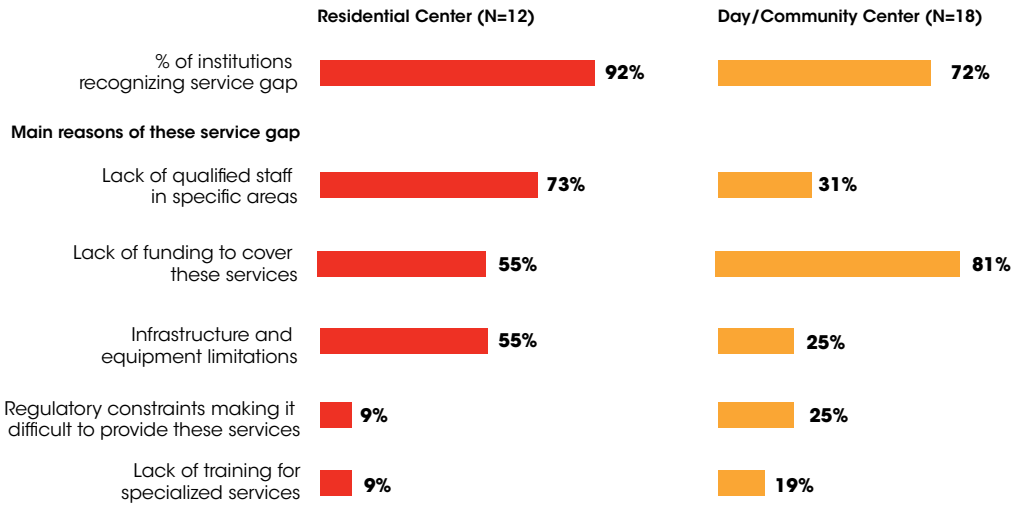


Physiotherapy and assistance with mobility ranked as the second most pressing needs. This inference stems from the service provision analysis, which indicates that only one-fourth of residential centers provide care for people with disabilities—a group that often requires mobility assistance and physiotherapy. While **92% of residential center residents and 58% of day/community centers** require mobility assistance, just **25% of institutions provide structured care for people with disabilities.**

For day/community centers, which primarily serve relatively healthier older persons, the absence of these services still limits their potential to address emerging needs. Interestingly, day centers in the "other" ownership category reported that one of the primary needs of the older persons is home service.

When institutional leaders were asked whether essential services were missing, 92% of residential centers and 72% of day centers acknowledged unmet needs. The reasons behind this inability to meet service demands include infrastructure limitations, financial constraints, and a lack of qualified staff. Among the services needed but currently not offered, physiotherapy and home services were frequently mentioned.

Figure 35. Barriers to meeting older persons care needs



Caregivers in residential facilities emphasized the often-overlooked need for emotional and social support due to overwhelming workloads and chronic staff shortages. One caregiver shared poignantly, ***"It would be good to have time to talk more with residents, but it takes us too much time just to cover their basic needs."***

This sentiment highlights a key service gap that isn't always reflected in institutional priorities but significantly impacts the well-being of residents.

The lack of specialized facilities for dementia patients also emerged as a pressing concern.

> Xhevrije, a caregiver with 26 years of experience in a public nursing home in Tirana, reflected, "Over the years I've worked here, cases of dementia and Alzheimer's have increased significantly. The state should consider opening a separate center specifically for Alzheimer's patients. It would not only make our work easier but also benefit the residents, as conflicts sometimes arise between those with the condition and those without."

In addition to institutional gaps, caregivers highlighted the unmet need for home-based services to support older persons unable to access day centers.

> As one caregiver from Durres expressed, "Older persons who live alone and can't come to us are left without support. We need more home-based care options."

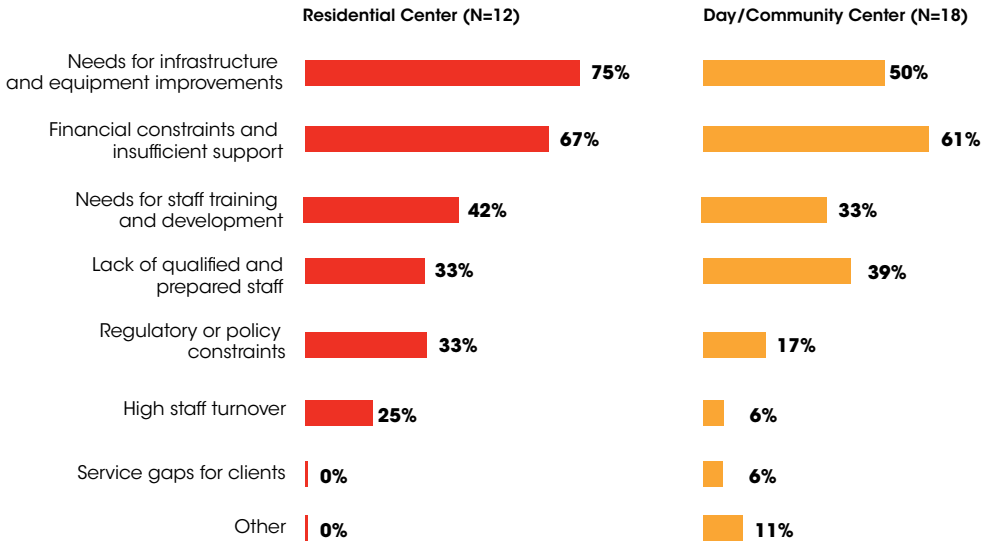
Caregivers, opinions made clear that the service gaps extend beyond physical care to include critical emotional and specialized support. Addressing these gaps requires both systemic reforms and targeted investments in caregiver resources and training.

The Financial Strain and Infrastructure Gaps

Financial struggles and infrastructure limitations are pervasive issues across Albania's LTC institutions, fundamentally hindering their ability to meet the increasing demand for quality care. When institutions were asked about the three biggest challenges they face, **two-thirds** of respondents cited financial constraints as a major barrier. These constraints prevent institutions from upgrading facilities, purchasing assistive equipment, and retaining skilled staff.

Infrastructure improvements are urgently needed, with **75% of residential centers** reporting a critical need for modernized equipment and safer spaces. Day centers echoed similar concerns, with **50% identifying infrastructure gaps** as a pressing issue. Beyond finances, the lack of staff training was emphasized, with **42% of residential centers** and **33% of day centers** struggling to address the evolving needs of older persons clients.

Figure 36. Challenges faced in providing quality service by type of institution



Institutions consistently highlighted the need for increased funding to expand their service offerings, improve infrastructure, and retain qualified staff. This financial strain has a direct impact on caregivers' ability to provide quality care, as seen in their daily challenges and emotional toll.

> One leader from Tirana remarked, "There's a growing demand for long-term care services, but funding and training aren't keeping up."
> Another leader emphasized, "Expanding capacity and investing in infrastructure are priorities".

Day centers, which primarily serve healthier older persons, expressed frustration with inconsistent policies and lack of local government support.

> "Local government could do more to help us," noted a respondent from Shkoder. Another from Pogradec added, "We need specialized centers for the abandoned, disabled, and older persons. We can't handle everything on our own."

Caregiver Perspectives on Equipment Needs

Caregivers experience firsthand the consequences of inadequate infrastructure and equipment.

> "We're physically drained because we don't have the tools to help us," shared a caregiver from Tirana, highlighting the absence of adjustable beds and lifting devices.

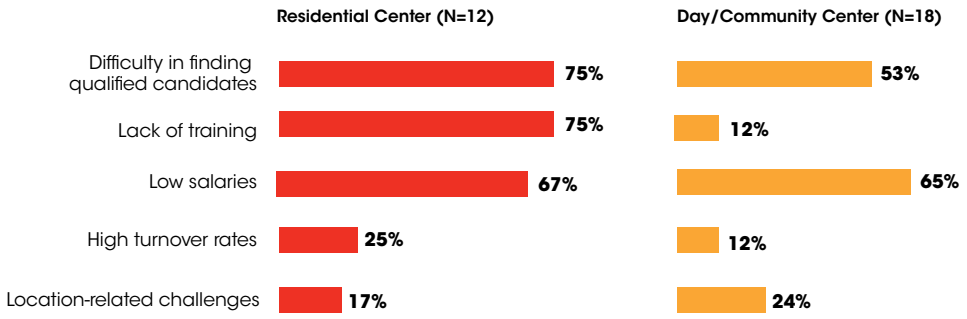
> Another caregiver noted, "There is still a need for equipment to assist with moving residents [with mobility issues]. Hospital beds with adjustable sections or small cranes to lift individuals with disabilities would reduce our physical exertion."

These inadequacies not only strain caregivers but also affect the quality of care they can provide. The lack of basic tools forces caregivers to improvise, often at the expense of their own physical well-being. ***"We're constantly improvising because we lack basic tools and spaces to do our jobs properly,"*** another caregiver explained.

Recruitment and Training Challenges

Staffing shortages represent a persistent obstacle across Albania's long-term care (LTC) institutions, fundamentally impacting their ability to deliver high-quality care. When institutions were asked about their biggest challenges in recruiting and retaining qualified staff, **75% of residential care centers** reported difficulties, while **53% of day/community centers** echoed similar concerns. These staffing shortages are not only numerical but qualitative, tied to low salaries, insufficient career development opportunities, and inadequate training.

Figure 37. Challenges faced in recruiting and retaining qualified staff by institutions



The most cited recruitment issues stem from low wages and a lack of professional growth opportunities. "It's not just about hiring people," explained a leader from Tirana. "We need qualified caregivers who understand the complexities of older persons care, and right now, we don't have enough of them." This sentiment is echoed by caregivers who feel undervalued despite their crucial role.

> A caregiver from a public nursing home in Tirana, shared, "We're overwhelmed. Our wages are still low. It would be good if they gave us a wage increase, as the work is so overwhelming."

Barriers to Training and Development

Training gaps emerged as a recurring theme, impacting not only staff recruitment but also their ability to evolve and deliver higher-quality services. When asked about the main barriers to training staff, such as caregivers and assistants, institutions provided a detailed snapshot of the structural and logistical challenges they face:

Lack of Time for Training: **58% of residential centers** and **28% of day/community centers** identified time constraints as a significant hurdle. Caregivers are often overwhelmed by their daily responsibilities, leaving little room for professional development.

> One director from Shkoder noted, "Most of our staff don't have the opportunity to attend training because they can't leave their daily responsibilities."

High Cost of Training Programs: **42% of residential centers** and **56% of day/community centers** reported financial barriers to accessing training programs. The expense of specialized courses, coupled with limited institutional budgets, restricts opportunities for upskilling.

Geographical Barriers: **39% of day/community centers** cited the challenge of accessing training centers due to their location, suggesting that many facilities in remote areas struggle to send staff to urban hubs where most training sessions are conducted.

> "Most of our staff don't have the opportunity to attend training because they can't leave their daily responsibilities," noted one director.

Caregivers consistently emphasized the need for specialized training in managing residents with cognitive impairments.

> Renato, a nurse from Shkoder, shared, "We often deal with residents who are confused or aggressive, especially those with cognitive impairments. Training is needed as a tool to manage these extreme situations."

Training in lifting techniques and proper ergonomics was also identified as critical to reducing physical injuries among caregivers.

> "The physical toll of this job is huge," shared a caregiver from Tirana. "I would like some training in lifting techniques or some way of moving someone without hurting your back."

Bridging the Gap

Institutional leaders called for a multifaceted approach to address staffing and training challenges. Investments in competitive salary structures and targeted training programs were frequently mentioned.

> A leader from Lezha suggested a co-financing model to address financial constraints: "If the government could cover 50% of our costs, we could focus more on improving staff skills and infrastructure."
>
> Caregivers, too, expressed hope for systemic change. A caregiver in Tirana, remarked, "I've studied for four years in long-term care, but even with training, we need better tools and more support to keep going."

The Human Impact of Financial Strain and Training Gaps

Caregivers provided a candid view of how these challenges play out in their daily roles, often highlighting the compounding effects of financial strain and inadequate training. Many reported juggling multiple responsibilities due to understaffing and a lack of specialized personnel.

> "We're stretched thin," shared a caregiver from a public nursing home in Tirana. "We're expected to handle everything, from physical care to emotional support, with little training to prepare us."

> The lack of tools and resources further compounds their workload. Zamira, a caregiver from Tirana, noted, "Assisting individuals with disabilities and mobility issues is one of the hardest parts of the job. I once took a private course on caring for disabled people, and it made a huge difference in my skills."

These comments reflect a growing concern about the sustainability of caregiving roles under current conditions.

Caregivers also highlighted the emotional toll of their work. Beyond physical strain, they often assume the roles of nurses, counselors, and companions, stretching their professional boundaries.

> "We're overwhelmed," explained Marjana, a caregiver from Tirana. "It would be good if they gave us a wage increase, as the work is so overwhelming." The absence of tools such as adjustable beds, lifting devices, or specialized training exacerbates this burden.

From assisting residents with cognitive impairments to managing medical emergencies, caregivers frequently encounter situations that require expertise beyond their initial training.

> As Manjola, a nurse from a private nursing home in Tirana, pointed out, "Caregivers need more training in medical assistance tasks—tending to wounds, administering medications, and performing basic nursing tasks. Without this, the workload for nurses becomes unsustainable."

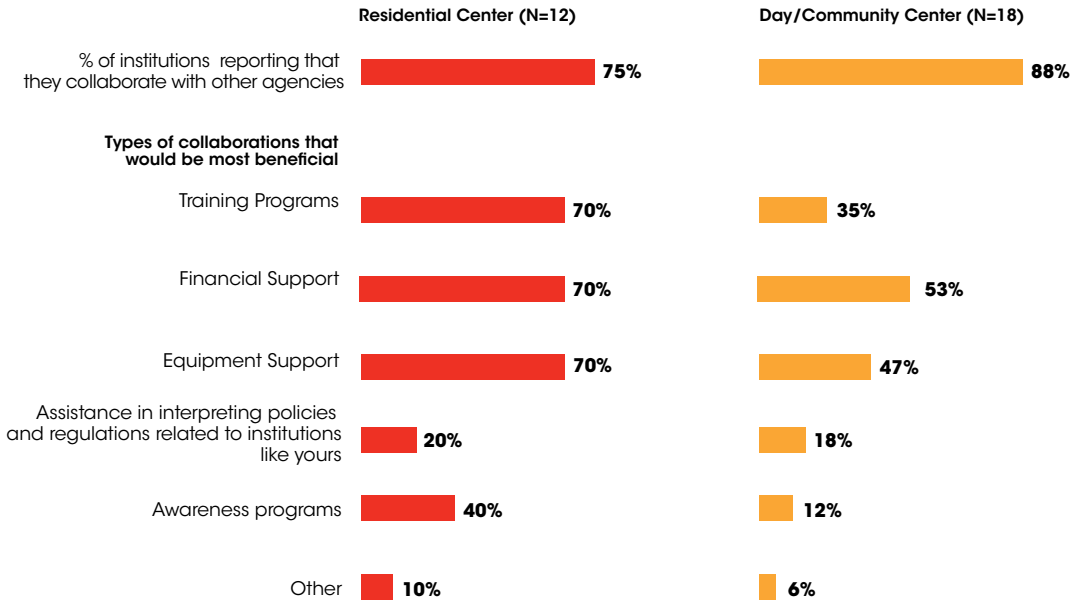
This intersection of financial constraints, inadequate training, and limited resources underscores the urgent need for systemic reforms to support both caregivers and the older persons population they serve. Recognizing and addressing these challenges will not only enhance the quality of care but also improve job satisfaction and retention among caregiving staff.

Collaboration: Strengthening Partnerships for Impact

Collaboration with NGOs, government agencies, and other organizations offers immense potential to strengthen LTC institutions, but the current efforts appear sporadic and inconsistent. The survey revealed that **75% of residential centers** and **88% of day/community centers** reported collaborating with external organizations. While this shows

promise, both caregivers and institutional leaders emphasized the need for more structured and impactful partnerships.

Figure 38. Collaboration with other organization



> Local leaders stressed the importance of policy support. One from Kamëz suggested, "Preparing caregivers for home-based care and creating more day centers would improve active aging opportunities."

The types of collaborations identified as most beneficial reflect the critical gaps in services and resources:

A. **Training Programs** were highlighted by **70% of residential centers** as essential for improving staff capacity, while only **35% of day centers** emphasized this need.
B. **Financial Support** was a top priority for **70% of residential centers** and **53% of day centers**, underscoring the financial constraints that institutions face.
C. **Equipment Support**, cited by **70% of residential centers** and **47% of day centers**, reflects the acute need for modern tools and resources to enhance care delivery.

While existing collaborations have demonstrated potential, they remain fragmented and often fail to address the systemic challenges faced by LTC institutions. Institutional leaders

advocated for a more coordinated approach to partnerships, with clear objectives and sustainable funding models. "It's not enough to have one-off programs," said a director from Lezha. "We need a framework that ensures continuous support, whether it's financial, technical, or operational."

Expanding partnerships to include private sector stakeholders, universities, and international organizations could provide a more holistic support system. Collaborative networks can foster innovation, improve service delivery, and empower both caregivers and institutional leaders to address the evolving needs of older person clients effectively. Institutions expressed the need for partnerships that align with their long-term goals.

> A leader from Pogradec highlighted the importance of structured collaboration: "We need partners who understand the systemic issues we face and are willing to invest in sustainable solutions, like co-financing initiatives or capacity-building programs."

> Day/community centers specifically pointed out the potential of partnerships to enhance community engagement and awareness. One respondent noted, "Awareness programs that involve families and local communities can shift cultural stigmas around institutional care."

Conclusion on LTC institutions

This assessment of Albania's long-term care (LTC) institutions reveals a complex web of challenges spanning service provision, infrastructure, staffing, and financial constraints. Residential and day/community centers, while vital to the country's care ecosystem, operate under significant strain, leaving critical gaps in their ability to meet the diverse and evolving needs of the older persons population.

Key findings highlight the pervasive disconnect between the services offered and the needs of older persons, particularly in areas such as dementia care and mobility assistance. While institutions recognize these gaps, systemic barriers—ranging from financial constraints to inadequate training and infrastructure—continue to hinder progress. The lack of specialized staff further exacerbates these issues, limiting the scope and quality of care provided.

Caregivers bear the brunt of these systemic shortcomings, often juggling multiple roles with insufficient resources and training. Their experiences underline the urgent need for targeted investments in training programs, modern equipment, and comprehensive support systems. Institutional leaders echoed these concerns, advocating for sustainable funding models, enhanced collaboration with government bodies, and policy reforms to strengthen the LTC framework.

Current Landscape of Vocational Training for LTC Caregivers in Albania

The vocational training landscape in Albania provides foundational resources for long-term care (LTC) caregivers but requires significant enhancements to meet current and emerging demands.The following section outlines the existing training programs provided by key institutions and organizations, along with their potential to bridge critical gaps in the LTC sector.

Institutional Training Programs

National Employment and Skills Agency (AKPA)

AKPA serves as the cornerstone of vocational education in Albania, offering foundational and advanced courses in caregiving.These programs focus on **old people care**, **childcare**, **disability support**, and **social caregiving** emphasizing practical skill development to prepare participants for diverse caregiving roles in institutional and home-based settings.

Training Programs Overview

Designed to prepare participants for caregiving roles in both institutional and home-based settings, AKPA's training programs dedicate 70-80% of their curricula to hands-on learning, ensuring graduates are well-equipped to meet the real-world demands of caregiving professions

Figure 39. **Overview of training programs**

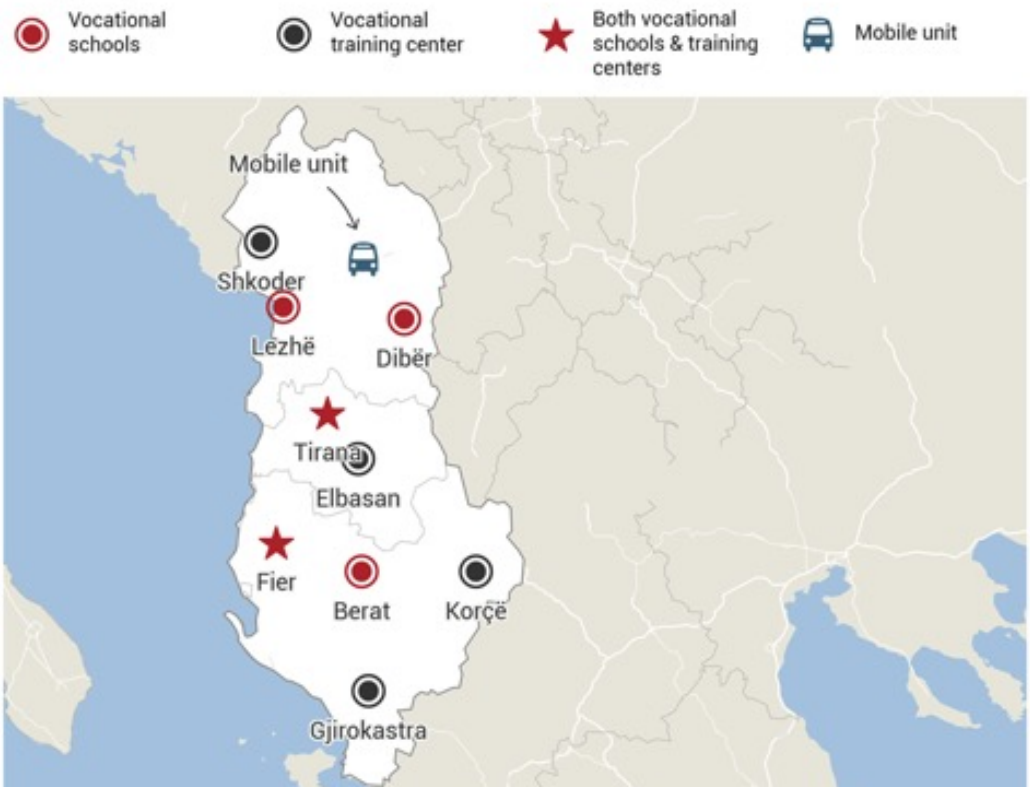
Training Program	Duration (Hours)	Practical Training (%)	Employment Opportunities
Old people Caregiver	250	80	Nursing homes, home care services, hospitals, self-employment
Caregiver for People with Disabilities	250	70	Disability support centers, NGOs, independent caregiving
Social Caregiver	260	70	Shelters, day-care centers, home-based caregiving
Childcare Caregiver	240	80	Private childcare businesses, self-employment

AKPA's programs cater to a wide range of employment opportunities, enabling participants to work in **nursing homes, hospitals, NGOs, day-care centers**, and private caregiving businesses. Additionally, the programs support pathways for **self-employment and entrepreneurship**, allowing graduates to establish their own caregiving enterprises. Key training offerings include old people care, disability support, social caregiving, and childcare, with program durations ranging from 240 to 260 hours, all with a strong focus on practical application.

Geographical Presence

Geographically, AKPA's reach spans across Albania, with five vocational schools located in Dibër, Lezhë, Berat, and Fier, and eight vocational training centers operating in Shkodër, Gjirokastër, Elbasan, Korçë, and Durrës. Tirana and Fier serve as strategic hubs, hosting both vocational schools and training centers to maximize accessibility and support. To further address the challenges of reaching rural and remote areas, AKPA has implemented an innovative mobile training unit. This initiative brings on-site training to underserved communities, ensuring that even those in the most isolated regions have access to caregiving education and opportunities.

Figure 40. Vocational training centers

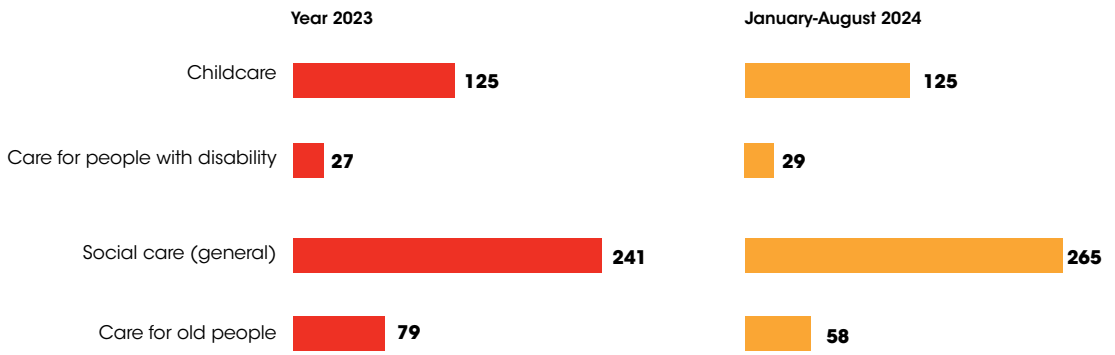


Enrollment and Participation Trends

Participation in AKPA's programs has shown steady growth, reflecting their importance and relevance. In vocational schools, **546 students in health and social services** were enrolled during the 2023-2024 academic year, with an increase to **581 students** for 2024-2025. Training centers recorded strong participation in various caregiving sectors, with

186 caregivers for 2023-2024s completing old people care training, **453 for year 2023-2024** engaged in childcare programs, **56 individuals** specializing in disability support, and **766 for year 2023-2024** pursuing social caregiving programs between 2023 and the first eight months of 2024.

Figure 41. Course registration in AKPA centers



Trends in participation reveal stable interest in childcare training, with **125 participants** registered in both 2023 and early 2024. Disability support programs saw a slight increase, while social caregiving programs experienced the highest growth, rising from **241 participants** in 2023 to **265 in 2024**, reflecting their broad applicability. However, a decline in elderly care training from **79 to 58 participants** signals a need for targeted outreach to promote this vital program.

By continuing to innovate and expand its offerings, AKPA is well-positioned to meet the evolving needs of Albania's health and social care sectors.

Caritas Albania

Caritas provides targeted training programs for caregivers focusing on home-based care and dementia management. The courses emphasize non-institutional caregiving, aiming to meet the needs of older persons who remain in their homes. Training locations include Tirana, Lezhë, and Korçë. Although its short-term modules (1-3 months) are impactful, Caritas primarily serves urban caregivers. **Training focus**: Short-term, practical modules.

Red Cross Albania

The Red Cross specializes in short-term, emergency-focused training, equipping caregivers with critical first aid, wound care, and mobility assistance skills. With its nationwide presence, this organization stands out for its ability to reach a broader audience. **Accessible programs**, often free or low-cost.

Ryder Albania

Ryder Albania offers advanced, specialized training, targeting experienced caregivers looking to deepen their expertise. Courses in physiotherapy and palliative care provide critical skills for addressing complex patient needs. Currently Operating primarily in Tirana

and Fier. However, its limited reach and focus on experienced participants create gaps for novice caregivers and rural populations.

Observations and Challenges

A. **Urban Concentration**: Most training providers operate in urban centers, leaving rural caregivers with limited access to resources.
B. **Financial Barriers**: While some programs are free for registered unemployed individuals, travel and associated costs deter broader participation.
C. **Specialized Training Needs**: Programs in dementia care, physiotherapy, and ergonomic techniques are still underdeveloped, despite their importance.

This landscape reveals both opportunities and challenges for Albania's efforts to build a skilled LTC workforce, underscoring the need for expanded accessibility, targeted specialization, and better alignment with caregivers' and patients' needs

CHAPTER 3

CONCLUSIONS AND RECCOMENDATIONS

Conclusions

The findings from this report reveal an urgent need to address the growing challenges faced by Albania's aging population and the gaps in its long-term care (LTC) system. Albania's long-term care (LTC) system is at a critical juncture, as the needs of its aging population outpace the existing supply of caregiving services. This report highlights several key findings that underscore the urgency of addressing these challenges:

A. Demand for Care Outweighs Supply

The aging population, representing nearly 20% of Albania's total population, has created a significant demand for both formal and informal caregiving. A substantial proportion of older individuals—particularly those in rural areas—are left without adequate support. Older adults living alone with partial or high dependency have more complex health and social needs, that are currently not being met. Nearly 13% of older persons in need of care lack any form of caregiver, reflecting the systemic gaps in service availability.

B. Need for tailored interventions

Highly dependent older adults face the greatest need for intensive, continuous care, particularly in mobility assistance, personal care, and overall well-being. In contrast, the Partially dependent older adults require some support, though to a lesser degree, and could benefit from rehabilitation and assistive technologies aimed at preserving their autonomy and preventing further escalation of dependency.

C. Overdependence on Family Caregivers

Family caregiving remains the cornerstone of Albania's LTC system, with 95% of care provided informally. This reliance on family members places an immense physical, emotional, and financial burden on caregivers, particularly women, who represent 67% of primary caregivers.The absence of formal training and support mechanisms for family caregivers further exacerbates these challenges.

D. Limited Formal and Institutional Care Options

Institutional care services, including residential facilities and day centers, are underdeveloped. Many municipalities, particularly in rural and underserved areas, lack any LTC facilities. Even existing institutions face significant barriers, including inadequate infrastructure, a shortage of trained staff, and limited capacity to provide specialized care for conditions like dementia and mobility impairments. Older adults themselves were highly unwilling to consider an institutional arrangement, indicating their preference for home-based care, but also the shortfalls in quality of institutional service provision so far.

E. Unmet Needs in Home-Based Care

Home-based care services are nearly non-existent, despite being a practical solution for the majority of older individuals. Even though there is a legal provision guaranteeing a care assistant for persons with disability, this provision is largely not implemented for older adults, even the ones highly dependent, owing to lack of information but also

struggling bureaucratic procedures. Up to three-quarters of older persons in need could be effectively served with properly structured home services and expanded day centers, highlighting a missed opportunity for cost-effective care delivery.

F. Financial and Infrastructure Challenges

Financial constraints affect all levels of caregiving, from families struggling to meet out-of-pocket expenses to institutions unable to upgrade facilities or retain staff. More than 1 out of 10 older adults from the sample live with less than 10,000 ALL per month, while 2 out of 3 of them have income up to 30,000 ALL. More than half of this income typically is used to meet health needs, which makes older adults and their families more prone to "health-induced poverty". State support programs, while helpful, remain underutilized due to bureaucratic hurdles and limited awareness.

G. Social and Emotional Well-Being is Overlooked

Older persons face high levels of social isolation and emotional distress, particularly those in the highly dependent group.The limited availability of community engagement programs and emotional support services further compounds these challenges, leaving significant gaps in holistic care.

These findings underscore the need for a paradigm shift toward a more inclusive, professional, and sustainable LTC system in Albania—one that balances formal care services with support for informal caregivers, expands infrastructure, and leverages community and home-based care solutions.

Recommendations

To address these challenges and create a more inclusive and sustainable LTC system, the following recommendations are proposed:

1. Develop and Scale-Up Home-Based LTC Services

- Establish a centralized application and assessment process through municipalities, where elderly adults or family members can apply for home care. Municipalities will assess the applicant's needs using a standardized tool to determine service frequency and type.
- Provide personalized home care services based on needs, including personal care (bathing, dressing, feeding), household assistance (shopping, meal preparation, cleaning), transportation to medical appointments, and medication management.
- Deploy mobile health units to offer periodic medical check-ups and basic interventions, especially in rural areas.
- Introduce respite care programs to support family caregivers by providing temporary professional caregiving assistance.
- Expand the collaboration between social protection and health system to ensure a comprehensive coverage of both health and social care needs of older adults.
- Leverage families and economically vulnerable individuals to expand the home care workforce:

- Train and employ family members or individuals receiving economic aid as certified caregivers.
- Integrate these individuals into home-based care programs, ensuring they are compensated and professionally supported.

2. Expand the Network of Day and Community Centers

- **Increase the number of centers** in underserved areas, ensuring that every municipality has at least one accessible center.
- Enhance services to include **physiotherapy, mobility training, social activities**, and practical support such as meal provision and transportation.
- Operate centers with **flexible schedules** to accommodate the needs of semi-dependent elderly adults and their families.
- Increase awareness about the existence of these centers in both urban and rural areas.

3. Professionalize the Caregiving Workforce

- Develop a **national training program** to provide **structured, accessible, and specialized training** for both **family and institutional caregivers**. This should be led by **AKPA (National Employment and Skills Agency)** in collaboration with **health and social care institutions, vocational schools, and NGOs**. Training should be offered **free of charge** for family caregivers and **subsidized for institutional caregivers**, ensuring accessibility for all.
- **Family Caregivers: Basic Training for Everyday Care**
  - Given that 99% of family caregivers lack formal training, short, time-efficient courses should focus on basic caregiving skills, dementia care, safe lifting techniques, and mental health support, delivered through community centers, mobile units, and online platforms to reach remote areas.
- Institutional Caregivers: Specialized and Advanced Training
  - For institutional caregivers, where staffing shortages and lack of specialized roles persist, training must prioritize dementia and Alzheimer's care, physiotherapy basics, and safe patient handling, with mandatory onboarding training, continuous professional development, and refresher courses.

4. Strengthen Vocational and Training Schools

- **AKPA Vocational schools**, enrolling **550-600 students annually and AKFPK responsible for training curricula development** should expand their curricula to include **dementia care, rehabilitation, palliative care with more modules on hands-on training and financial incentives** to encourage LTC specialization.
- Diversify the workforce: Encourage the involvement of men in these trainings and in the caregiving profession, by promoting positive role models or other international best practices.
- Certification and Career Development
  - Establish, a tiered certification system (Basic, Advanced, and Professional) to formalize caregiving roles, create structured career pathways, and incentivize workforce retention
  - Offer competitive salaries and benefits to attract and retain caregivers, including social security, health insurance, and opportunities for career advancement.

5. Strengthen Financial and Institutional Support

- Create **subsidized care programs** to assist low-income families in affording home-based or institutional care services.
- Simplify and streamline the **application process** for disability benefits and caregiving allowances to improve accessibility.
- Increase government funding for the **expansion of LTC facilities** and the purchase of medical equipment.

6. Modernize Infrastructure and Leverage Technology

- Upgrade **residential and day centers** with adjustable beds, mobility aids, and safety features. Develop specialized centers for dementia and complex care needs.
- Implement **digital health platforms** for telemedicine consultations, caregiver scheduling, and resource allocation to improve service delivery efficiency.

7. Promote Public-Private Partnerships

- Collaborate with **NGOs and private providers** to expand mobile care units, establish new community centers, and train caregivers.
- Develop public-private partnerships to **co-finance facility upgrades** and expand service offerings in underserved areas.
- Explore innovative models in care economy that will contribute in the provision of care services, such as the establishment of social enterprises in this sector.

8. Enhance Social Inclusion and Emotional Support

- Organize **community engagement programs** such as intergenerational activities, volunteer networks, and social events to reduce isolation.
- Establish **counseling and peer-support programs** for elderly individuals and their caregivers, focusing on emotional and mental well-being.

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Legislation

- Law 57/2019 on Social Assistance
- Law no. 121/2016 "On Social Care Services"
- Law no. 10107/2009 "On Health Care"
- Law no 138/2014 "On Palliative Care"
- Law no. 44/2012 "On Mental Health"
- Law no 93/2014 "On the inclusion and accessibility of persons with disability"

Strategies and action plans

- National Action Plan on Ageing 2020-2024
- National Action Plan for Persons with Disability 2021-2025
- National Strategy for Social Protection 2024–2030
- National Employment and Skills Strategy 2023-2030

Annexes

Annex A. Methodology for Survey on Long-Term Care (LTC) with people older than 65+ in Albania

Sampling Methodology

The survey utilized a multi-stage stratified cluster sampling methodology, designed to yield statistically representative data for Albania's elderly population (65+).The approach involved three distinct stages:

Step 1: Selection of Primary Sampling Units (PSUs)

Sampling Frame: The sampling frame comprised geographic areas corresponding to polling areas associated with Voting Centers (VCs). Although VCs were used for reference, actual clusters were defined by the geographic boundaries of the polling areas themselves. Each polling area is exhaustive, mutually exclusive, and representative within administrative divisions, ensuring comprehensive territorial coverage.

Stratification: Stratification was performed by:

- **County:** Interviews were proportionately allocated across Albania's 12 districts based on the population density of individuals aged 65+ as of census 2023
- **Urban and Rural Division:** Further stratification was applied by urban and rural classifications, with proportional representation based on demographic distributions.

From Albania's total of 33 municipalities (out of 61) and 57 administrative (out of 373) units were randomly selected for inclusion in the survey.

Selection Procedure for PSUs: The selection employed Probability Proportional to Size (PPS) sampling using SPSS Complex Sample Module. PSUs were chosen systematically based on the Measure of Size (MOS), specifically the population size of individuals aged 65 and above. Larger units had proportionally higher selection probabilities.

Step 2: Household Selection

Upon identifying each PSU, enumerators used systematic randomization to determine starting points. SPSS software's RV.UNIFORM function provided random numeric values specifying distances (0 to 250 meters) and directions (North, North-East, East, South-East, South, South-West, West, North-West) from a defined central reference point within each PSU.

Enumerators located these randomly determined starting points and employed a systematic random sampling method, approaching every nth household until meeting the target number of interviews per PSU. For instance, enumerators selected every 10th household if ten interviews were required within a PSU of approximately 100 households.

Step 3: Respondent Selection

Eligible households were identified based on two primary screening questions:

- Presence of individuals aged 65 or older.
- Presence of individuals aged 65+ who require assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

In households with multiple eligible respondents, the final participant was selected using the "most recent birthday" method, ensuring unbiased respondent selection.

Data Collection Procedure

Interviews were conducted face-to-face utilizing Computer-Assisted Personal Interviewing (CAPI) technology. Enumerators were equipped with portable digital tablets installed with KOBO-Toolbox software—an Android-based platform optimized for efficient, reliable, and secure field data collection. GPS location tracking and automatic timestamp recording facilitated adherence to sampling protocols and precise data validation.

Sample Size and Margin of Error

While approximately 800 interviews were conducted overall, 600 interviews fulfilled the analytical inclusion criteria, specifically focusing on elderly individuals needing assistance. According to the 2023 INSTAT Census, Albania's elderly population totals approximately 473,104 individuals. With a 95% confidence interval, the calculated margin of error for the analyzed sample (n=600) is ±4%.

Data Quality Assurance and Verification

To ensure high data quality and integrity, daily verification and cleaning procedures were implemented by a dedicated data management team. An independent quality control team also performed verification by re-contacting a randomly selected subset (15-20%) of respondents via telephone. This approach validated data accuracy, respondent authenticity, and methodological rigor.

Weight Calculation and Adjustments

Sampling weights were calculated to correct for unequal probabilities of selection at various stages (PSU, household, and respondent). Weights were derived based on the inverse of inclusion probabilities at each stage, ensuring data representativeness. Additionally, post-stratification adjustments were applied to align the sample with demographic characteristics (region, urbanity, gender, and age) of the target population. Non-response adjustments were also integrated, based on recorded unsuccessful interview attempts.

Annex B: Methodology for segmenting the older persons population

The primary goal was to identify meaningful patterns in the data that could guide tailored care interventions. A clustering methodology was applied, with variables capturing chronic illnesses, assistance required with Activities of Daily Living (ADLs), and Instrumental Activities of Daily Living (IADLs). The final model used **k-means clustering** to classify individuals into three distinct groups.

Included Variables

1. **Illnesses**
   - Included: Alzheimer's/Dementia, Parkinson's Disease, Multiple Sclerosis, Arthritis, Diabetes, Chronic respiratory issues (e.g., COPD), Chronic pain, Cancer, Kidney Disease, Physical disability, and Mental health disorders.
   - **Excluded:** Cardiovascular disease was excluded after initial exploratory analyses as it did not contribute significantly to differentiating the clusters, as indicated by the ANOVA tables and factor analysis results.

2. **Activities of Daily Living (ADLs)**:
   - Bathing or showering
   - Dressing
   - Eating
   - Getting in and out of bed or a chair
   - Using the toilet
   - Walking or moving around

3. **Instrumental Activities of Daily Living (IADLs)**:
   - Managing medications
   - Preparing meals
   - Paying bills
   - Doing housework (cleaning, laundry, etc.)
   - Shopping for groceries or personal items
   - Transportation (driving or using public transport)

All variables were dichotomized to indicate whether assistance was required or not.

Clustering Procedure

The clustering procedure employed an exploratory analysis to uncover the underlying structure of the data and identify meaningful patterns. Factor analysis was conducted to group variables into clusters that corresponded to distinct dependency levels and multimorbidity profiles. This was followed by an ANOVA test to assess the significance of each variable in distinguishing between clusters. Variables with low or insignificant F-values, such as cardiovascular disease, were excluded to enhance the robustness of the clustering process. While prevalent in the dataset, cardiovascular disease did not significantly contribute to cluster differentiation, as evidenced by a low F-value in the ANOVA table and its lack of distinct association with specific clusters during factor analysis

Next, k-means clustering was selected as the method for grouping the data due to its efficiency in creating well-defined, non-overlapping clusters. This algorithm iteratively minimized within-cluster variance to ensure optimal groupings.

Finally, the number of clusters was determined based on both interpretability and practicality.Three clusters were chosen, as they aligned closely with real-world dependency levels and care needs, ensuring the results were actionable and relevant for analysis.

Statistical Validation

The final clustering solution was validated using:

- **ANOVA**: Confirmed significant differences between clusters across key variables.
- **Robustness Checks**: Repeated clustering after excluding different subsets of variables to ensure consistency in results.
- **Checking all variables**

Annex C: Methodology for Focus Group Study on Long-Term Care (LTC) in Albania

Study Objective

The principal objective of this study is to provide an in-depth understanding of the caregiving landscape in Albania by examining the roles, responsibilities, and challenges faced by caregivers across different caregiving settings. The study seeks to achieve the following:

- **Identification of Key Caregiving Skills**: Understanding the skills caregivers need to effectively perform their roles, along with identifying gaps in knowledge that may hinder caregiving efficacy.
- **Assessment of Training Needs**: Evaluating caregivers' access to formal training and support, as well as their interest in further training opportunities to enhance their caregiving capacity.
- **Evaluation of State and Community Support**: Analyzing the support mechanisms provided by the state and local community, and understanding caregivers' perceptions of the adequacy of these resources.
- **Understanding Caregivers' Aspirations**: Exploring caregivers' aspirations regarding their roles and the changes they believe are necessary to improve caregiving quality, their personal well-being, and the overall quality of care in Albania.

Focus Group Design

This study adopted a qualitative research design, utilizing focus groups as the primary method of data collection to explore the perspectives of different caregiving groups in the context of long-term care (LTC) in Albania. Three distinct caregiver categories were targeted:

- **Institutional Caregivers**: This group was further divided into two subgroups based on the type of institution:
    - **Public Institutions**
    - **Private Institutions**

- **Informal Caregivers**: This group encompasses both paid and unpaid family caregivers who provide care in private settings.
- **Family Caregivers**: Family members who are directly involved in providing care to their loved ones at home, further subdivided based on living arrangements:
    - **Co-living Family Caregivers** (those living with the care recipient)
    - **Non-co-living Family Caregivers** (those not living with the care recipient)

Each focus group was designed to reflect the diversity within each caregiving category, ensuring a broad spectrum of caregiving experiences and challenges were represented. The division of groups into specific categories allowed for a nuanced understanding of the role each caregiver group plays and the unique challenges they face, influenced by institutional setting or family dynamics.

Participant Selection

Participants were carefully selected to ensure the inclusion of a diverse representation of caregiving experiences across the different caregiving categories. The selection process aimed to achieve a balanced representation based on caregiving role, setting, and geographical location. Participants were drawn from both urban and rural areas to ensure geographic diversity and capture a range of caregiving challenges present in different regions of Albania. Special attention was given to selecting individuals who are currently in caregiving roles to ensure the relevance and accuracy of their input.

Group Composition

The following table provides a detailed breakdown of the groups involved in the focus groups study, including the number of participants, specific caregiving roles, and the locations where the focus groups were organized:

Nr	Group Type	Specifics	No of Participants	Participants Residence	Organised on
1.	Institutional Caregivers	Public Institutions	6	Tirana, Lezha	11.11.2024
2.	Institutional Caregivers	Private Institutions	6	Tirana, Shkodra	14.11.2024
3.	Informal Caregivers	Caregivers	6	Tirana, Shkodra	12.11.2024
4.	Informal Caregivers	Caregivers and Nurses	7	Tirana	12.11.2024
5.	Family Caregivers	Non co-living	7	Tirana, Vlora, Fier Korca	13.11.2024
6	Family Caregivers	Co-living	7	Tirana, Shkodra, Vau-Deje, Korca	13.11.2024

Focus groups guide

The focus group discussions were guided by semi-structured questionnaires, which allowed for both flexibility and in-depth exploration of key themes. The semi-structured format ensured that participants could freely express their experiences and challenges while addressing the specific objectives of the study. The primary topics covered in the questionnaire included:

- **Caregiving Tasks**: The range of tasks caregivers perform, including physical care, emotional support, and medical assistance.
- **Skills Required**: The competencies and knowledge caregivers believe are necessary to perform their roles effectively.
- **Training and Resources**: Access to and availability of formal training opportunities, as well as the caregivers' perceived need for additional training.
- **Challenges**: Specific challenges caregivers face in their roles, including but not limited to emotional, physical, and logistical difficulties.
- **Support Mechanisms**: Availability and effectiveness of formal and informal support networks, including community resources, healthcare systems, and social services.
- **Long-term Aspirations**: Caregivers' hopes for the future of caregiving in Albania, including changes they believe are necessary to enhance the quality of care.

Where

Focus group discussions were facilitated in dynamic group settings to encourage the exchange of diverse viewpoints and shared experiences. Facilitators used open-ended questions to promote natural, organic dialogue among participants, which ensured a comprehensive understanding of the issues at hand.

The discussions were designed to capture both individual and collective insights into caregiving in Albania. The facilitator's role was to guide the conversation, encourage participation from all members, and keep the discussions focused on the key themes of the study while allowing for the free expression of ideas.

Analysis Approach

Data from the focus group discussions were transcribed and analyzed using thematic analysis. Thematic analysis allows for the identification of recurring patterns, themes, and trends within the data. The analysis focused on:

- **Key Themes and Patterns**: Identifying common threads that run through the caregivers' experiences, and examining how these themes differ across the various caregiving categories.
- **Contrasting Perspectives**: Analyzing the contrasting views between caregiving groups (e.g., institutional vs. informal caregivers) to understand the varying challenges and needs of each group.
- **Caregiver Aspirations and Needs**: Synthesizing the feedback on caregivers' aspirations and the changes they believe are necessary for improving caregiving in Albania.

By systematically analyzing these areas, the study aims to provide a comprehensive, evidence-based understanding of the caregiving situation in Albania, offering insights that can guide future policy, training, and resource allocation for LTC.

Annex D. Methodology for Survey on Long-Term Care (LTC) Institutions in Albania

Study Objective

This survey was conducted as part of a broader effort to assess the state of long-term care (LTC) in Albania, focusing specifically on institutional care. The primary aim was to investigate the operational dynamics, challenges, and service provision in residential care facilities and day/community centers for older persons. The study aimed to uncover systemic issues within these institutions, including staff qualifications, financial constraints, and infrastructural needs. The survey was conducted alongside focus group discussions with caregivers to provide a comprehensive understanding of the LTC system in Albania.

Survey Approach

The survey was conducted online during the month of November 2024, targeting the directors of eligible residential care facilities and day/community centers. The survey was designed to gather both quantitative and qualitative data on operational issues, staffing, funding, and infrastructure. To boost participation and ensure a broad range of perspectives, follow-up calls were made to encourage completion.

Furthermore, the Ministry of Health and Social Affairs assisted actively in distributing the survey link to all government-funded facilities, ensuring broad participation from state-funded institutions.

The list of eligible LTC facilities was provided by the State Health Inspectorate (**Inspektorati Shtetëror Shëndetësor)**, and it compiled a total of 54 facilities (public and private) that provide care for older persons. However, 4 of these institutions were no longer functional, and contact information for 5 other institutions was incorrect, which limited the final sample.

The survey received responses from 30 institutions, representing approximately half of Albania's residential care facilities and day/community centers: This sample ensures a diverse representation of institutional care models in Albania, providing a well-rounded view of the current LTC system.

Data Collection

Data were collected via an online survey platform, with the survey link distributed to the directors of the selected institutions. The survey included both closed and open-ended questions to capture a wide range of information, including:

- **Operational Dynamics**: Insights into the daily operations, staffing, and service provision within the institutions.
- **Staff Qualifications**: Data on caregiver qualifications, training opportunities, and challenges related to maintaining a skilled workforce.
- **Financial Constraints**: Information on funding sources, budget allocations, and financial barriers to providing adequate care.
- **Infrastructural Needs**: Insights into facility conditions, including accessibility, maintenance, and space limitations.
- **Challenges and Systemic Barriers**: Directors were asked to identify key operational and systemic challenges affecting service delivery and care quality.

Analysis

Once the data were collected, both quantitative and qualitative analyses were conducted:

Quantitative Analysis: Responses to closed-ended questions were analyzed through SPSS to identify trends and patterns in the operational and financial aspects of LTC institutions. This included examining the distribution of care models (state-funded vs. private vs. hybrid) and identifying key operational metrics.

Qualitative Analysis: Open-ended responses were analyzed thematically to identify recurring issues and challenges related to staffing, training, financial constraints, and infrastructure. This helped uncover systemic barriers and issues that might not be immediately visible through quantitative data alone.

Integration with Focus Groups: The survey results were complemented by focus group discussions with caregivers working in these institutions. These discussions provided deeper insights into the lived experiences of caregivers and the older persons they serve, allowing for a more holistic understanding of the LTC system in Albania. The combination of survey data and caregiver feedback will help address both operational and systemic issues within the LTC framework.

Annex E. Research instruments

Questionnaire

Assessment of long-term care needs

Hello, my name is _____. I am an interviewer from _____, an organization that is implementing a Long-Term Care project in Albania, supported by UNDP. I would like to ask you some questions about your various needs, such as physical, medical, social, emotional and financial. Also, if you have a guardian, I would like to ask him/her some questions as well. The purpose of this study is to collect data throughout Albania about the different needs of the elderly and the challenges they face to meet them. There are no right or wrong answers, we are only interested in your personal experience and perceptions. Your responses are anonymous and confidential. They will only be published as a set of responses, without any information that can identify you. Your participation is voluntary, you are not obligated to participate in this survey. However, your input is valuable to us. If you agree to participate, you may not answer any questions you do not wish to answer, or you may withdraw your participation at any time without penalty.

Selection questions

F1. Are you or any member of your household living in this household over 65?

1. Yes (go to P. 02)
2. No (this questionnaire ends here)

F2. Do you regularly need help with daily activities such as bathing, dressing, eating, moving, administering medications, or housework?

1. Yes (go to P.1.1)
2. No (this questionnaire ends here)

Include in the sample individuals who answer **"Yes" to both questions.**

ID. Interview code: _____
TEL: Phone number of the respondent: _____
D1. Region
D2. District
D3. Municipality
D4. Administrative Unit
D5. City/Village
D6. Urban/Rural

Section 1. Family composition and environmental needs

Category	Question	Answer alternatives
Demographic data	D.7. Your age	_____ (write the correct age)
	D.8 Age group (for control)	1) 65-69 2) 70-74 3) 75-79 4) 80-84 5) 85+ 99) ND/NP
	D9. Gender	1. Man 2. Woman
	D10. Education	1. No education 2. Primary education (4 years) 3. Lower secondary education (7 or 8 years) 4. Upper secondary (4 years) (high school or vocational school) 5. Higher education 99) ND/NP
	D11. Your status	1. Single 2. Married 3. Live together with a partner 4. Widow/er 5. Divorced

Category	Question	Answer alternatives
Family composition	Q12. Who do you currently live with? (MULTIPLE)	1. Alone >> Continue to D14 2. With spouse >> D13 3. With my children >> D13 4. With extended family (e.g. grandchildren) >> D13 5. With other relatives >> D13 6. With others (please specify _____) >> D13
	D13. How many people live with you?	_____ (not including the interviewee)
	D14. How many children do you have?	_____ (mark 0 if no children)
	D15. How often do relatives visit you?	1. Every day 2. Every week 3. Every month 4. Rarely 5. Never
	D16. Do your children or other relatives live nearby?	1. Yes, in the same house 2. Yes, close by 3. No, they live far away
	D17. What type of house/apartment do you currently live in?	1. My personal house 2. Rented apartment 3. Other (Please specify _____)
Housing	P1.1. Do you think the house you currently live in is safe for you considering your difficulties?	1. Yes, very safe 2. Mostly safe 3. Somewhat safe 4. Not at all safe 99) DNW
Transportation	P1.2. Do you have access to public transportation to make doctor's appointments, go shopping, etc.?	1. Yes, and I use it regularly 2. Yes, but I don't use it 3. But, but it's not convenient, so I don't use it 4. Yes, but I use it rarely 5. No, I don't have access to public transport 99) DNW
Community services	P1. 3. Are there day care centers for the elderly in the area where you live?	1. Yes, and I go often 2. Yes, but I don't go 3. There is no such center 4. I don't know what day care centers are 99) DK/NA

Section 2. Physical Abilities AND Medical Care Needs

Chronic diseases and other chronic conditions	
P2.1. Do you have any of the following chronic diseases? Please select <u>ALL</u> types of diseases you have): (MULTIPLE)	a. Alzheimer's or Dementia b. Parkinson c. Multiple sclerosis d. Arthritis (Osteoarthritis, Rheumatoid Arthritis) e. Cardiovascular disease (eg heart disease, hypertension) f. Diabetes (Type 1 or 2) g. Chronic breathing problems (e.g. chronic lung disease, asthma) h. Cancer i. Kidney disease j. Chronic pain (eg fibromyalgia, chronic back pain) k. Physical disability (eg mobility problems, limb amputation) l. Mental health disorder (eg, depression, anxiety, schizophrenia) m. Other (Please specify): _____ 88. I have no chronic disease 99) ND/NP

Category	Question	Answer alternatives
Activities of daily living	P2.2. Do you need help with any of the following activities? (Circle **ALL** the alternatives the person needs): (MULTIPLE)	a. To take a bath or shower b. To get dressed c. To be fed d. Getting up or lying/sitting in bed or a chair e. To use the toilet f. To walk or move X. I do not need help with any of these activities
	P2.3. Do you need help with any of the following activities? (Check **ALL** cases where the person needs help): (MULTIPLE)	a. To manage medications b. To prepare meals c. To pay bills d. To do housework (cleaning, washing, etc.) e. To buy food or personal items f. For transport (driving a car or using public transport) X. I do not need help with any of these activities
	For what do you regularly need help?	_____-

Category	Question	Answer alternatives
	P2.4. How often do you go to the doctor (eg, visits to the family doctor or other doctors or nurses)?	a. Once a year b. Every 6 months c. Every two months d. Every month e. Every week f. More than once a week 99) DK/NA
Medical Care	P2.5. Do you take any prescription medication?	a. No b. 1-2 medications c. 3-5 medications d. More than 5 medications 99) DK/NA
	P2.6. Do you have the necessary medical equipment (eg blood pressure monitor, oxygen) in your home?	a. Yes, all necessary equipment b. Some equipment, but more needed c. No, I do not have access to the necessary equipment d. I don't need medical equipment at home 99) DK/NA
Social care	P2.7. What benefit or service do you currently receive from the state (from the social protection system)? (Circle **ALL** the alternatives the person gets) (MULTIPLE)	a. None b. Social pension c. Disability allowance d. Payment for care by a third person/family member e. Care at home f. Free meals g. Other (Please specify_____) 11.99) DK/NA
	P2.8. Have you applied for social security programs, such as those mentioned in the question above, but are not currently receiving them?	1. Yes, I have applied but I am not benefiting 2. No, I have not applied 3. I have no information about these programs 99) DK/NA
	Q 2.9. Have you received any services through digital platforms?	1. Yes 2. No 99) DK/NA
	Q. 2.10 Would you be willing to receive services through digital platforms?	1. Yes 2. No 99) DK/NA

Section 3. Social and emotional needs

Category	Question	Answer alternatives
Social interaction	P3.1. Are you satisfied with the amount of social interaction you currently have?	1. Very satisfied 2. Satisfied 3. Neutral 4. Dissatisfied 5. Very dissatisfied 99) DK/NA
Emotional support	3.2. Do you have someone who gives you emotional support or comfort when you need it?	1. Yes, always 2. Yes, sometimes 3. Rarely 4. No 99) DK/NA
Emotional Wellbeing	Q 3.3. How often do you feel anxious or stressed?	1. Never 2. Rarely 3. Sometimes 4. Often 5. Always 99) Dk/NA
Community involvement	Q 3.4. How often do you participate in social activities, community groups or engage in activities you enjoy (hobbies)?	1. Every day 2. Every week 3. Every month 4. Rarely 5. Never 99) DK/NA

Section 4. Financial needs and potential of families to engage private services

Category	Question	Answer alternatives
Income level	Q 4.1. What are your sources of income? (Check **ALL** alternatives that constitute a source of income) MULTIPLE	1. Pension 2. Personal savings 3. Family support 4. State aid 5. Income from rental property (house, land, etc.) 6. I have no regular income 7. Other, please specify_____ 99) DK/NA
	Q 4.2. What is the level of your personal monthly income approximately?	1. Less than 10,000 ALL 2. 10,000 – 30,000 ALL 3. 30 000 - 600 00 ALL 4. 60 000 – 100 000 5. More than 100 000 ALL 6. I don't know my personal monthly income 99) DK/NA
	Q 4.3. Does your family help you with money to buy medicine, food or other needs?	1. Yes, regularly 2. Yes, occasionally 3. No 99) ND/NP
Monthly expenses	Q 4.4. What percentage of your monthly household income is spent on basic expenses (eg food, water, electricity, etc.) and how much do medications and other health care services cost?	A. Basic expenses _____ (%) B. Medications and other health care services _____ (%)
	Q 4.5. Do you have enough income from a pension, family allowance, government assistance, property or other sources to help you employ someone to look after you?	1. Yes, I have enough income 2. Yes, but my income is limited 3. No, I don't 99) DK/NA
Savings and other assets	Q 4.6. How much money per month can you afford to get the care you need privately?	]1. None 2. Less than 10,000 ALL 3. 10,000 - 30,000 ALL 4. 30,000 - 50,000 ALL 5. More than 50,000 ALL 99) DK/NA

Category	Question	Answer alternatives
Residential services	4.7. Have you considered going to a residential facility for the elderly (asylum)?	1. Yes 2. No

Caregiver Information Module

1. Caregiver profile	K1. Do you currently have someone who cares for you/helps you? (circle all who offer assistance) (MULTIPLE)	A. Yes, wife/husband B. Yes, the children C. Yes, another relative (nephew, niece, etc.) D. Yes, a person outside the family E. **No - I don't have anyone (close the interview**)
	K1_no : What are the reasons you don't have anyone taking care of you? Close the interview	1. I don't have any relatives around 2. My family members are sick themselves 3. I can't pay anyone 4. I live far away and no one can come easily 5. Other _____
	K1_Ref: Who is the main person who takes care of you?	1. husband 2. The girl 3. The boy 4. grandson 5. granddaughter 6. Another relative 7. A non-family person 8. Other_____
	K_ans. If the person who cares is present, ask them yourself, otherwise ask the person in need **Who is the person answering the interview?**	1. The person who needs care 2. The guardian himself
	K_age. How old is the person who takes care of you?	1. 18-35 2. 35-50 3. 50-65 4. 65+ 99) ND/NP
	K_gen. Caregiver's gender Interviewer: don't ask about gender, but understand from the answers above	1. man 2. The woman

	K_edu. EDUCATION	1. PRIMARY 2. 8-year old 3. The middle one 4. High 99) ND/NP
	K2. Does the person who cares for you live with you?	1. Yes, live with me 2. No, but it comes every day 3. No, but he comes a few times a week 4. No, it comes from time to time, 99) I don't know/No answer
3. Services provided by the guardian	K3. How does the caregiver help you, what does he do for you?	A. He washes me, wears me, combs me B. cooks C. He gives me medicine/does injections D. He cleans the house E. Do the shopping F. Take me to the doctor G. It keeps me company H. It helps me to move I. Measures blood pressure/ diabetes/heals wounds J. Pays the bills K. Other (please specify) _____
4. Qualifications of the guardian	K4. Has the person taking care of you completed any nursing or other similar course in elderly care?	1. Yes, Nursing 2. Yes, physiotherapist 3. Yes, to help people with disabilities 4. Other_____ 99. I don't know/PP
Caregiver Compensation	K5. Is the caregiver paid for his/her services?	1. Yes, it is paid 2. No, it provides free care (**close the interview**)
	K6. Who pays the babysitter?	1. Me myself, with my savings and income 2. My children 3. State/municipality 4. Other_____ 99. ND/PP

	K5.2 How much is the guardian paid per month (if paid)?	1. Less than 10,000 ALL 2. 10,000-20,000 ALL 3. 20,000-30,000 ALL 4. More than 30,000 ALL 5. ND/PP
	K6. Do you pay social and health contribution + salary?	1. yes 2. not 99. ND/PP
	K7. How many hours a week does your carer help you?	1. Less than 10 hours 2. 10-20 hours 3. 20-40 hours 4. More than 40 hours 99. ND/PP
	K8. How did you find your current carer? (Circle ALL the alternatives that are true)	A. Recommendation from a family member/friend B. Referral from the doctor C. Online D. Agency or company that provides babysitters E. Other, (please specify) _____ 99. ND/PP
	K9. Is the paid caretaker present?	1) yes 2) No (**close the interview**)
	Ask the following only if the caregiver is paid and present	
Challenges as a caregiver	KS1. What are **the THREE biggest challenges challenges** you face in your role as a caregiver? (Circle the THREE MOST IMPORTANT things the person says)	A. The work is very physically demanding B. I feel tired and stressed from this job C. I don't know what it takes to care for the person (lack of training) D. I don't have enough equipment or medical help E. I don't have enough time F. I don't get paid enough G. I feel alone in this job, H. I have difficulty communicating with the person I care for I. Other (please specify): _____ 99. ND/PP
Future perspective	KS2. Do you plan to continue working as a carer in the next 6-12 months?	1. yes 2. No >> Ask KS3 99. ND/PP

	KS3. IF not, why are you considering leaving care? (See ALL the reasons the person gives)	1. I feel tired and stressed 2. Low payment 3. Better job opportunities elsewhere 4. Family or personal reasons 5. Other (please specify) _____ 99. ND/PP
Caregiver skills	KS4. Do you have any formal training in the following areas? (Check all that apply)	A. First aid and CPR B. Dementia care C. Palliative care D. Wound care E. Care for persons with limited mobility F. Care for people with memory problems G. Medication care H. Medical equipment management (eg feeding tubes, oxygen tanks) I. Other (please specify) 99. ND/PP
Invitation to focus groups	We would be interested in inviting you to a wider discussion with other people who do the same work as you. Would you like to participate? Your participation will be rewarded.	1. yes 2. not
	If so, Name	Name_____ Phone_____

Thank you for your participation!

Interview guide

Central government representatives, CSOs

Welcome and introduction. Explanation of the purpose of the interview.

- Gender M F
- What is the name of your institution and of the sector you work? _____
- What is your role and responsibilities in this sector? How are they relevant to LTC?

1. General information about the system

- What is the role of the institution you represent in designing and implementing system-wide policies, laws or other strategic documents related to LTC? Probe for:
    - Are these sufficient to enable the provision of quality services? If not, what are the legal gaps?
    - Are there any other responsible ministries or agencies that play a role in this sector? Could you describe their responsibilities?
    -
- With what institutions/sectors do you collaborate at central and local level for the design and delivery of LTC services? What are their specific responsibilities? Probe for:
    - How are they delivered?

2. Accessibility

- What are the eligibility criteria for accessing and receiving each of the benefits and services relevant to LTC for the different groups in need for these services (older persons, persons with physical or psychosocial disability, palliative care, or other chronic conditions)? Probe for:
    - How, if at all, these services and benefits are sequenced to continuously meet the needs of people and their caregivers as they age?
    - Are there any gaps in this sequence of services and benefits? (e.g. people staying to long in a hospital because of the discontinuation of service in their homes)

- What are the barriers in accessing these services faced by older persons? Probe for:
    - Are there any differences between urban and rural areas, such as waiting lists in urban areas or transportation in rural?

3. Availability and coverage

- What are the differences, if any, between urban and rural areas in terms of demand for LTC services? In terms of supply?
- What are the current solutions to the potential geographical disproportional distribution of LTC services?

- What benefits or services are lacking/limited for meeting all the needs of older persons, persons with disability, persons in need of palliative care, or with other chronic conditions in need for LTC (e.g. home care services, specific sections

in the hospitals for long-term care, nursing homes, assisted living, respite care, community based services, vouchers or others)? Probe for:
    - Persons with dementia/Alzheimer
    - Persons with physical disability (children and adults)
    - Persons with mental disability (children and adults)
    - Persons with terminal illnesses
    - Other chronic conditions

- What are the major challenges with respect to overall services' availability and coverage?

- What are the major challenges with respect to people's demand for services?

4. Affordability

- What are the main challenges faced by the families to afford public services? Are there any hidden costs in their provision? Probe for:
    - Does a family/person in need for LTC services have to co-pay for certain services? If yes, what it the percentage of co-payment?

- What are the differences between urban and rural areas?

- What about the services provided by the private sector?

5. Human resources

- What is the current situation of LTC workforce? Probe for:
    - Attractiveness of the sector
    - Influx in the professions of LTC such as nurses, doctors, care assistants or others
    - Skills needed and skills mismatches
    - Staff retention

- Where do you find unmet needs currently in terms of human resources available and skilled to provide quality LTC services?

- What are the prerequisites to become a care provider? Probe for: degree, training, induction phases, if any?

- What are the requirements for continuous professional development?

Closing questions:

- *Are there any other issues important to discuss about LTC services that are not mentioned here?*
- *Do you have any question for me?*

Thank you!

Focus group discussion guides

Focus Group 1: Institutional Caregivers (Nursing Homes, Residential Facilities)

Objective: To understand the challenges, skills, and services provided by institutional caregivers, focusing on care quality, training needs, and state support.

Detailed Questions:

1. **Types of Services Provided**:
    - **Q1**: Can you describe the range of services provided in your institution (medical, personal, emotional care)?
        - **Probe**: Are there any specific services (e.g., mental health support) that residents need but that the institution currently doesn't provide?
    - **Q2**: How do you coordinate with other healthcare professionals (doctors, nurses) to ensure comprehensive care for residents?

2. **Skills Required**:
    - **Q3**: What specific skills do you find most critical in your daily work with residents?
        - **Probe**: How do you manage communication challenges with residents, especially those with cognitive impairments?
    - **Q4**: Do you feel confident in managing emergency situations, such as sudden medical deterioration?

3. **Training Needs**:
    - **Q5**: In which areas do you think more training is required for institutional caregivers to improve the quality of care?
        - **Probe**: Have you received training on topics like dementia care, end-of-life care, or emergency response? If not, how would such training benefit your work?
    - **Q6**: How frequently do you have access to training or professional development opportunities?

4. **State Support**:
    - **Q7**: What role does the government play in providing funding or resources to your institution?
        - **Probe**: Are there gaps in state support that affect the institution's ability to deliver quality care?
    - **Q8**: Do you receive any specific guidance or regulations from the state regarding caregiving standards, and are they helpful?
    - **Q9**: What is the perception of the residents and their families about state support? Probe:
        - Do they expect that their needs will be fully met by the state?
        - Are they/have they been proactive before coming in your institution to find solutions to meet their needs? Which were those solutions?

5. **Long-term Career Aspirations**:
    - **Q10**: Do you see yourself continuing in this field long-term? What career growth opportunities exist within institutional care?
        - **Probe**: What factors (e.g., pay, working conditions) influence your decision to stay in or leave this field?

6. **Systemic Challenges**:
    - **Q11**: What systemic changes would improve the quality of institutional care in Albania?
        - **Probe**: How do staffing shortages, regulatory challenges, or other systemic issues impact your daily work?

Focus Group 3: Tirana-based Informal (Paid) Caregivers

Objective: To explore the challenges, skills, and support needs of informal caregivers providing paid care in Tirana, focusing on their access to training, state support, and future aspirations.

Detailed Questions:

1. **Types of Services Provided**:
    - **Q1**: What is the condition your client has that made him/her to ask for your services? What types of caregiving services do you provide to your clients?
        - **Probe**: Do you provide personal, medical, or emotional support, and how do you manage these different roles?
    - **Q2**: Are there any services you feel your clients need but that you are unable to provide? Do they receive these services from other caregivers/ institutions? Which ones?

2. **Skills Required**:
    - **Q3**: What are the most important skills for informal caregivers in Tirana?
        - **Probe**: How do you handle complex medical tasks, such as medication management or wound care, if needed?
    - **Q4**: How confident are you in providing emotional support to clients and their families?

3. **Training Needs**:
    - **Q5**: Have you received any formal or informal training in caregiving? What types of training would be most helpful to you?
        - **Probe**: How easy is it to access caregiving training programs in Tirana?
    - **Q6**: Do you feel there is enough emphasis on training informal caregivers to meet professional standards?

4. **State Support** and Family support
    - **Q7**: Does the government offer any support services or financial assistance for informal caregivers in Tirana?
        - **Probe**: What kind of state-provided services (e.g., respite care,

financial support) would help you in your role?
- **Q8**: How does the lack of state support affect your ability to provide high-quality care?
- **Q9**. Do the clients and their families you serve receive any kind of state support? If not, in your knowledge, what are their expectations about state support?
- Q10. What is the relationship of the persons in needs with their families? Do they visit them often? Based on your knowledge, do they support them financially?

5. **Future Aspirations**:
   - **Q11**: Do you plan to continue working as an informal caregiver, or would you like to transition to a formal role?
     - **Probe**: What barriers are preventing you from moving into a formal caregiving role, if any?

6. **Challenges Specific to Tirana**:
   - **Q12**: Are there challenges unique to caregiving in Tirana (e.g., cost of living, competition with formal caregivers)?
     - **Probe**: How does living and working in Tirana affect the support you can provide to clients?

Focus Group 4: Non-Tirana Informal (Paid) Caregivers

Objective: To understand the unique challenges faced by informal caregivers working in regions outside Tirana, focusing on access to resources, training, and state support.

Detailed Questions:

1. **Types of Services Provided**:
   - **Q1**: What is the condition your client has that made him/her to ask for your services? What types of caregiving services do you provide, and how do they differ from those in urban areas?
     - **Probe**: Do you find there is a lack of essential services (e.g., healthcare, social services) for your clients in rural areas?
   - **Q2**: How do you manage tasks that require specialized skills, such as medical care, in regions where there may be fewer healthcare professionals?

2. **Skills Required**:
   - **Q3**: What skills do you find most critical for caregiving in non-Tirana areas?
     - **Probe**: Are there specific challenges in rural caregiving that require different skills compared to urban caregiving?
   - **Q4**: How do you ensure that you meet the needs of clients when you lack certain skills or resources?

3. **Training Needs**:
   - **Q5**: How accessible are training programs for caregivers in rural or smaller urban areas?
     - **Probe**: What kinds of training programs would you like to see

introduced to your region?
- **Q6**: How could the government or NGOs help improve access to training for informal caregivers in non-Tirana regions?

4. **State Support**:
   - **Q7**: What role does the state play in supporting informal caregivers in your area?
     - **Probe**: Are there government services or benefits that you can access as a caregiver, and if so, are they sufficient?
   - **Q8**: What additional support would you like to see from the government?
   - **Q9**. Do the clients and their families you serve receive any kind of state support? If not, in your knowledge, what are their expectations about state support?
   - **Q10**. What is the relationship of the persons in needs with their families? Do they visit them often? Based on your knowledge, do they support them financially?

5. **Rural-Specific Challenges**:
   - **Q11**: What specific challenges do you face as a rural caregiver that urban caregivers might not encounter?
     - **Probe**: How do transportation, healthcare access, and local resources affect your caregiving ability?

Focus Group 5: Co-living Family Caregivers

Objective: To explore the experiences of family caregivers living with the individuals they care for, focusing on their caregiving responsibilities, skill needs, and state support.

Detailed Questions:

1. **Types of Services Provided**:
   - **Q1**: What is the condition your family member has that he/she is in need for care?
     - **Probe:** How would you describe the level of dependency of your family member in a daily routine?

   Q2. What are the main caregiving tasks you perform daily?
     - **Probe**: Do you feel there are services your family member needs but that you are unable to provide? If yes, how do they receive these services?
   - **Q3**: How do you balance personal care, emotional support, and medical tasks in your role?

2. **Skills Required**:
   - **Q4**: What caregiving skills have you developed over time, and what skills do you feel you lack?
     - **Probe**: Do you feel confident in managing medical care (e.g., medications, physical therapy), and if not, what training would help?

3. **Training Needs**:
    - **Q5**: Do you think family caregivers like yourself should receive formal training?
        - **Probe**: What specific areas would you like training in (e.g., medical care, mobility assistance, emotional support)?
    - **Q6**: Are there any barriers to accessing training in your area, and how could this be improved?

4. **State Support**:
    - **Q7**: Does the government provide any services to help you in your caregiving role?
        - **Probe**: Have you accessed any state-provided respite care, financial assistance, or healthcare services, and how helpful were they?
    - **Q8**: What additional services should the government provide for family caregivers?
    - **Q9**. Does your family members receive any kind of state support? If yes, what type of support?
        - **Probe**: How easy/difficult it is for you to access the specific benefits or services provided by the state?
        - Are they sufficient to meet the needs for your family member?
    - Q10. Are you of your family member in need aware of any community centers or other services for older people in you area? Does your family member attend any of them?

5. **Emotional and Physical Toll**:
    - **Q11**: How does caregiving affect your emotional and physical well-being?
        - **Probe**: Do you feel supported in managing caregiver stress or burnout, and what additional support do you need?