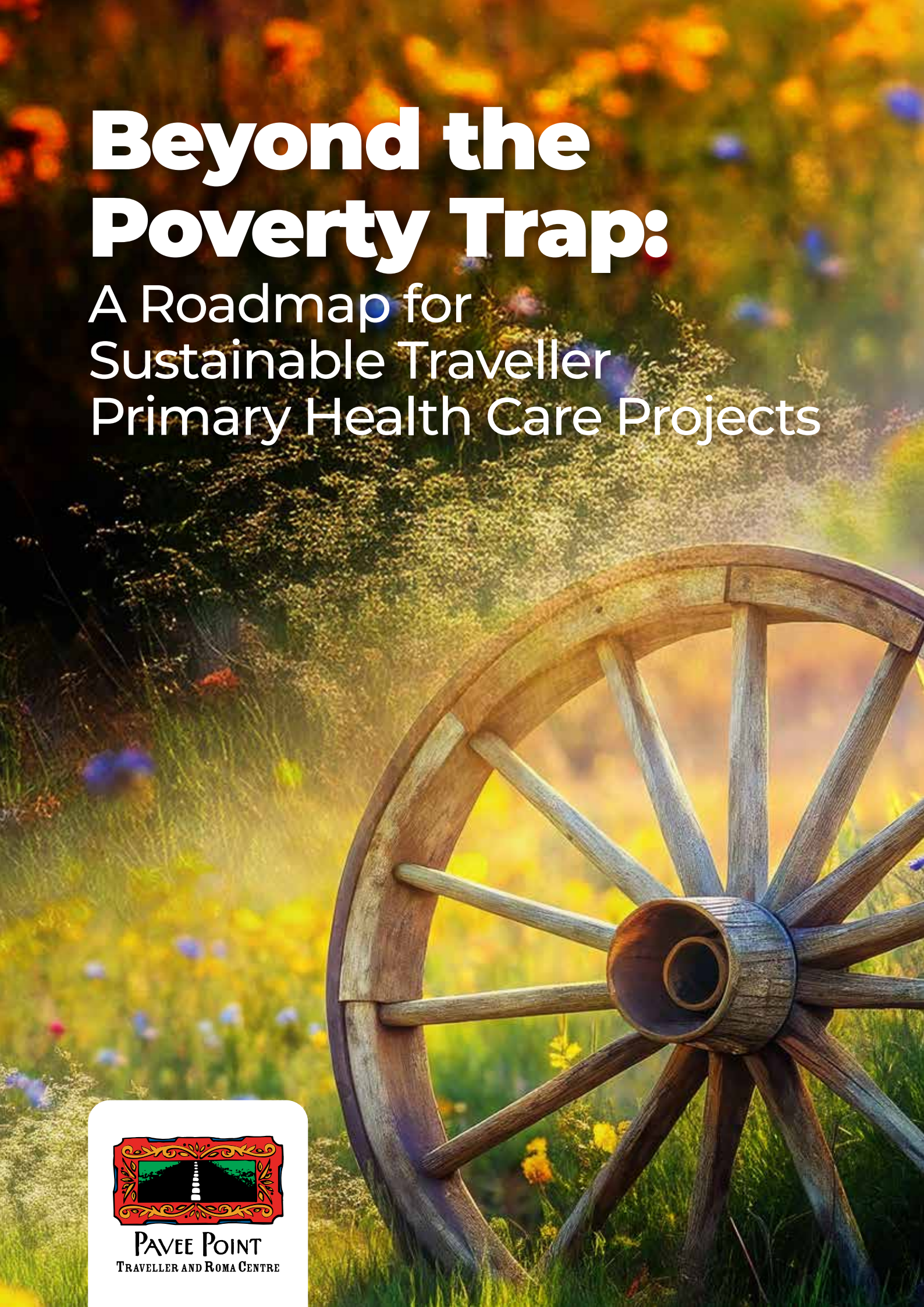
Beyond the Poverty Trap:

A Roadmap for Sustainable Traveller Primary Health Care Projects



Pavee Point
Traveller and Roma Centre

Dr. Stuart Stamp
Independent Social Researcher & Research Associate,
Department of Applied Social Studies, Maynooth University.

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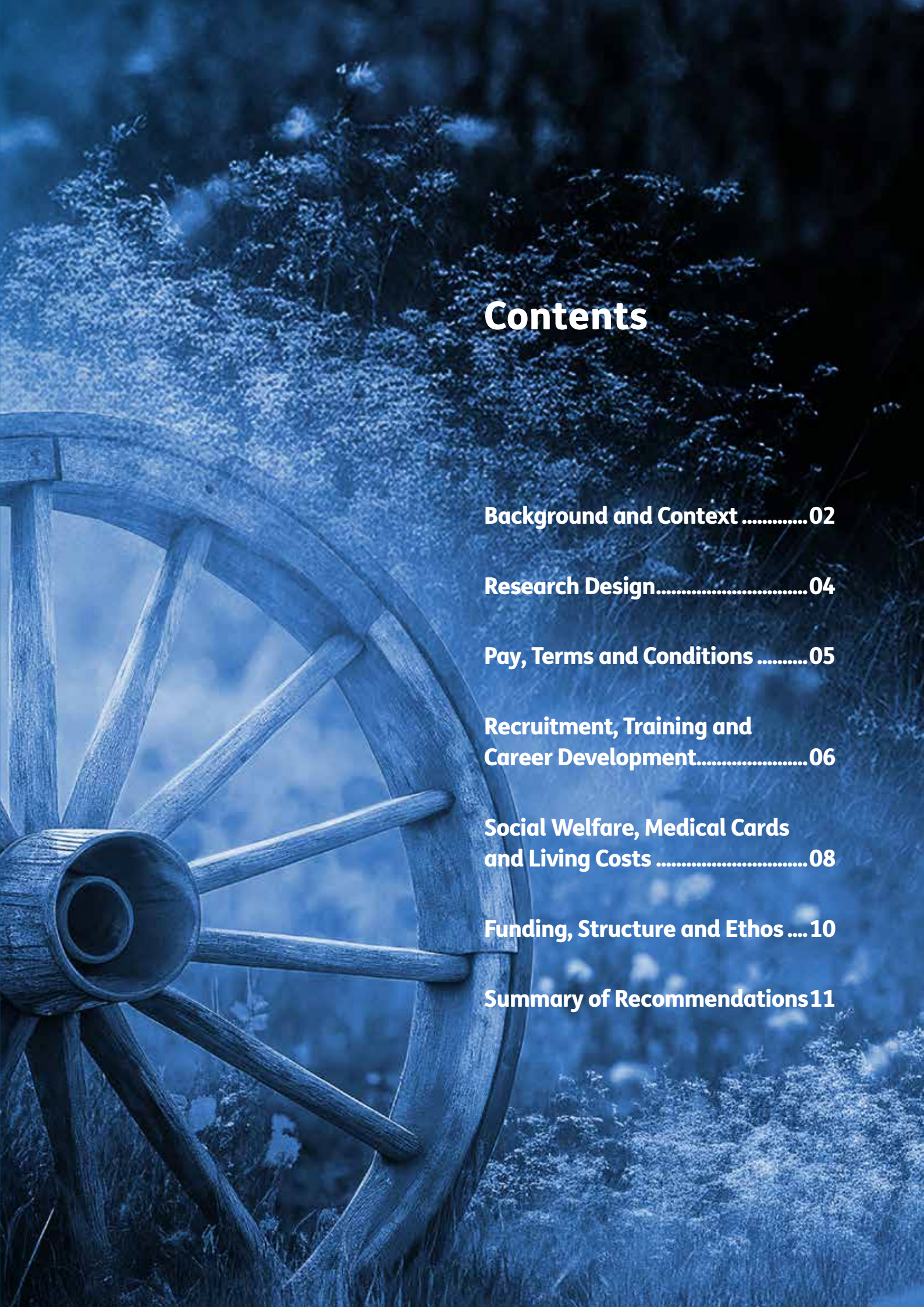


Contents

Background and Context

Travellers are one of the most socially marginalised communities in Irish society, marginalisation that manifests itself, among other deleterious consequences, in poor health outcomes and lower life expectancy relative to the population at large. As long ago as the 1980s, official reports were recognising such outcomes among Travellers. In more recent years, an increasing body of research—most notably the 2010 All Ireland Traveller Health Study (AITHS)—has focused more on what have now become known as 'the social determinants of health', namely the conditions in which people are born, grow, live, work, and age that can influence their health and wellbeing outcomes, and lead to health inequalities and disparities. These trends continue; according to the most recent Census (2022), Travellers are twice as likely as the general population to report their health as bad or very bad and to experience a long-lasting condition. Furthermore, the average life expectancy of Travellers continues to be significantly lower than that of the overall population.

Against this persisting backdrop, a primary health care model has emerged internationally, including in Ireland, based on what is generally referred to as a community development approach, whereby supporting individuals and families with their family health needs is allied to addressing deep-seated, structural inequalities. This peer led model emphasises the participation and empowerment of marginalised communities in community-level programmes and activities, including by way of supporting social research. The combined individual, community and societal benefits of such interventions are evidenced and recognised widely and are supported by the academic literature.

In an Irish Traveller context, the first Primary Health Care for Traveller Project (PHCTP) was piloted in 1994-1995 to provide a culturally appropriate 'bridge' between Travellers and mainstream public health services by way of the employment of Traveller Community Health Workers (TCHW). This pilot established a model for Traveller participation in the promotion of health and the development of skills among the community. It further demonstrated its usefulness as a means of raising awareness around health initiatives and services within the community, creating dialogue between Travellers and health service providers, and highlighting gaps in health service delivery to Travellers.

The TCHW role represents a particularly deep and complex form of peer support. While 'peer' models in other sectors (e.g., mental health, criminal justice, homelessness) leverage lived experience to build trust and provide guidance, the TCHW role is multifaceted and combines lived experience, expertise and collective analysis and action of key issues. This approach is underpinned by the following principles and aims:

- **Community development:** The work of TCHWs is grounded in the following: a holistic approach; social justice and solidarity; equality and human rights; active participation; empowerment; and, collective action. It is further underpinned by a social determinants of health approach.
- **Mainstreaming:** Enhancing Travellers' access to culturally appropriate care and improving Travellers' equality of access, participation and outcomes in mainstream health services through a human-rights based approach.
- **Increasing trust and confidence:** TCHWs are from a community that has experienced profound historical mistrust of state services and systemic racism. Their shared ethnicity and understanding of key issues is vital for supporting Traveller access to - and effective engagement with - services and other statutory agencies.
- **Traveller-proofing:** TCHWs actively try to shape the health service in partnership with the HSE, by providing culturally appropriate health information and identifying new and emerging issues.

TCHWs are not simply 'peers'. Their effectiveness is dependent on their embeddedness within the community they serve. This distinction underscores the unique skills and value of TCHWs beyond a general advocacy or support function. Providing them with standardised, protective employment conditions is a necessary infrastructure for achieving health equity for all Travellers.

Following on from from the successful pilot in 1994-95, Pavee Point supported the establishment of a number of other PHCTPs which were rolled out across the country in subsequent years with funding support from Regional Health Boards, and have since been reconstituted by the Health Service Executive (HSE) by way of the Health Act 2004. The legal basis for current approved project funding is set out in Section 39 of the Health Act 2004, which covers grants to so called 'non-acute/community agencies' to provide services similar or ancillary to those provided through the HSE. In practice, the funding provided by the Department of Health to the HSE in respect of PHCTPs is channelled to these agencies by way of annual grants issued via the HSE's seven Regional Traveller Health Units (THUs) on the basis of individual Service Level Agreements (SLAs) or Grant Aid Agreements (GAAs). These agencies, which are predominantly Traveller organisations but, in the absence of Traveller groups in certain areas, also comprise Partnership Companies and other Non-Governmental Organisations (NGOs), act as employers, employ TCHWs and are accountable to the HSE for the funding they each receive by way of their SLAs or GAAs.

This incremental, project-by-project development has led to a fragmented ecosystem. While autonomy assigned via Service Level Agreements (SLAs) and Grant Aid Agreements (GAAs) allows projects to respond to local needs, it has also allowed differing pay rates, terms and conditions to emerge between TCHWs. The absence of a national standardised framework means that pay, hours, and conditions are ultimately dictated by the level of funding each individual project can secure from its Regional Traveller Health Unit (THU), rather than by the value of the work itself.

This structure creates inherent tension. Agencies must navigate competing priorities,advocating for their community's needs while operating within rigid or insufficient funding boundaries; delays in communication and decision-making, together with differing approaches, can also be an issue at regional level. Addressing the consequences of this model requires revisiting previous policy findings, particularly those from the National Traveller Health Advisory Forum (NTHAF). The THAF analysis further noted the inherent contradiction between the inflexibility of the welfare system and the flexibility required of those working in TCHW roles while simultaneously reliant on welfare support. It concluded with a series of recommendations designed to promote the recruitment and retention of TCHWs; these included automatic eligibility to full medical cards, changes to the social welfare system to prevent poverty traps, improved and standardised pay and conditions, career progression opportunities, and the development of consistent quality standards across projects. Although some developments are currently in train in relation to pay, conditions, career development and standardisation, recruitment and retention of staff continues to cause increasing concern across PHCTPs, hence the decision to carry out this scoping exercise which, is in essence, a follow on from the THAF analysis.

Left: Traveller Community Health Workers. Photo: Derek Speirs.

Left: Ann Friel, Primary Health Care Coordinator, Donegal Travellers Project, in conversation with Missie Collins. Photo: Tommy Clancy.

Traveller Community Health Care Workers, (L-R) Molly Collins, Missie Collins, Nellie Collins. Photo: Derek Speirs.

Research Design

The context for this report lies in Goal 4, Action 41 of the National Traveller Health Action Plan (NTHAP, 2022-2027), namely to 'explore barriers to recruitment and retention of staff in Primary Health Care for Traveller Projects (PHCTPs)'. The research repsonds directly to Action 41 by asking, what are the current barriers and enablers to recruitment and retention of staff in Primary Health Care for Traveller Projects; and how might the former be overcome?

The research objectives set for this enquiry are threefold. Firstly, to identify the barriers, both perceived and actual, to PHCTP staff recruitment and retention, including systemic and personal factors which impact on current or potential TCHW decisions. Secondly, to identify good practice factors which would better enable both PHCTP staff recruitment and retention, including in terms of shared learning. And thirdly, to make associated policy and practice recommendations in respect of the short, medium and longer-term.

Six research methods are employed in order to meet these objectives. These are:

(i) a literature review;

(ii) a legislative and administrative review of the background to key social protection allowances and schemes, including medical cards;

(iii) secondary data analysis of survey data gathered in respect of the current PHCTP/TCHW landscape;

(iv) a series of key informant interviews with welfare experts and those working in Traveller health to identify potential poverty traps and barriers to entering employment and increasing work hours;

(v) a semi-structured questionnaire survey of key stakeholders to provide an opportunity for those who wish to do so to feed into this review, and; (vi) a number of focus groups, reflective of the stakeholder population, to enable key constituencies (namely employers, employees and funder) to feed into the research.

Four key themes emerge from these enquiries:

1. Pay, Terms and Conditions;
2. Recruitment, Training and Career Development;
3. Social Welfare, Medical Cards and Living Costs, and;
4. Funding, Structure and Ethos

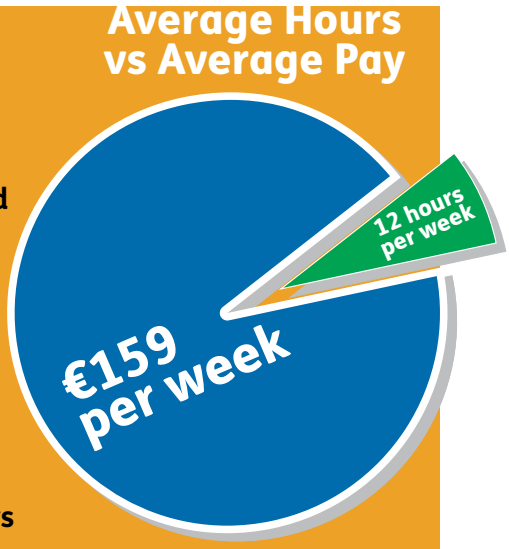
L-R Sheila, Nellie, Missie, Biddy, Bridgie, Molly & Ronnie outside Pavee Point. Photo: Derek Speirs.

1. Pay, Terms and Conditions

The first theme relates to pay, terms and conditions. Overall, while the role offers flexibility to Travellers and continued access to certain welfare benefits for some, for others, a combination of low pay and associated poverty traps leads to imparity of esteem, associated de-motivation, welfare dependency and working unpaid hours. Thus a move in train towards the creation of a framework for enhanced pay and conditions for all is welcome and necessary.

The quantitative findings here are informed by a survey of Primary Health Care for Traveller Projects (PHCTPs), administered in October 2023 on behalf of the National Traveller Health Advisory Forum's (THAF) Recruitment and Retention of Staff sub-group and the National Traveller Health Implementation Group's (NTHIG) HR Training and Education sub-group.

The survey paints an indicative picture of the Traveller Community Health Worker (TCHW) landscape in terms of employees, vacancy rates and the organisations which employ them. The results reveal that each project employs six workers on average, ranging from 1 or 2 TCHWs to 11 or more, with vacancy rates being considerably higher than the national average in percentage terms.



The range of working hours reported varies from 5 to 39 hours per week, with the most cited number of hours worked being 12 per week. This is also the average weekly figure among the TCHW distribution surveyed. Almost 90% of workers work fewer than 17.5 hours per week, which we take for the sake of argument to be the conventional part-time norm on the basis of a 35-hour working week. By comparison, PHCTP co-ordinators are more likely to be employed on a full-time (or close to full-time) basis. Only a minority of projects (less than a third) offer assistant co-ordinator positions.

Indicative rates of pay range from the minimum wage to around double it, with around a third of TCHWs on or around the minimum wage and almost 40% receiving a living wage or in excess of it. A strong sense emerged of a largely static situation, however, over a considerable period of time. When working hours are combined with rates of pay, the average TCHW earns around €159 per week. Inconsistency also emerges around annual leave and pension entitlements. In terms of the former, the majority of employees receive annual leave entitlements in excess of the statutory minimum, albeit not in line with HSE HR Circulars on standardisation of annual leave arrangements. This is due to work hours in excess of contracts and additional annual leave being taken to compensate these additional hours. Less positively, at the time of writing, a considerable majority of TCHWs do not have employer supported pensions or are not in a position to avail of it given their low income. Several instances were cited of TCHWs leaving work after 20 to 30 years with no occupational pension entitlement at all. This is an issue which is also emerging across the community and voluntary sector more broadly.

The qualitative responses on these various issues suggested a desire to move away from welfare reliance but that the poverty-trap issue continues to prevent workers from taking on hours that would adversely affect welfare and medical card entitlements. Concerns were also expressed about non-receipt, by some, of an agreed cost-of-living increase for those working in Section 39 organisations, together with

disappointment about what appears to be the exclusion of TCHWs from receipt of the €1,000 "Pandemic Special Recognition Payment" (PSRP), often referred to as the "Covid bonus" for frontline health care workers, based on the particular additional risks they faced during the pandemic. Cumulatively, disparities and issues around pay and conditions are leading to adverse impacts on morale among some staff, who see peers doing essentially the same work being paid more and receiving more favourable conditions in terms of pensions and leave as a result of their contractual status. A related issue concerns the fact that people working for considerable periods of time can often find themselves on exactly the same rate of pay as someone new to the role.

Important context here is that TCHWs are from the community and live within the communities in which they work, hence they can be called upon to work more than their contracted hours should a particular need or crisis arise, a situation exacerbated by the poor health outcomes for Travellers described earlier. Attendance at meetings or training events can also push people up to or above their weekly limit and given work demands and the fact that workers live in their community means they are not in a position to take time off in lieu (TOIL).

2. Recruitment, Training and Career Development

The second theme concerns recruitment, training and career development; here, a varied picture emerges comprising employment opportunities—albeit often limited—for some, but more commonly one where workers can become 'stuck' for long periods of time, often until they cease work. Again, there are positive developments in train, in terms of accreditation, the recognition of prior learning and consideration of career pathways. These need to be expedited and supported.

As alluded to earlier, the vacancy rate for TCHWs is higher than the national average for job vacancies in general; this is despite the ostensibly large pool of potential workers given high unemployment rates among the Traveller community as a whole. However, the situation is far from uniform across the country, and while examples were cited of certain projects not being able to recruit staff, in other areas there seemed to be few or no problems at all in this regard. More broadly, references were often made to recruitment becoming a big issue in the community and voluntary sector more generally and not just within certain PHCTPs.

More positively, there was a general sense that TCHWs get a personal sense of achievement from the work that they do, and the community health outcomes and impacts it brings. This job satisfaction element can have additional benefits both in inspiring others to want to become part of the projects—particularly where alternative employment opportunities may be limited—and encouraging those already involved to want to do more. Several good practices also emerged in relation to staff recruitment groundwork, including the use of promotional flyers, online and 'in person' information sessions (where prospective applicants could find out how their welfare benefits would be impacted), and interview/CV preparation sessions to broaden the pool of potential workers.

Less positively, a number of barriers which inhibit recruitment were identified. One of these relates to the costs (especially in rural areas) associated with running a car, principally insurance, fuel, and maintenance. Another, more indirect barrier, concerns a failure on the part of the State to properly value TCHWs and the work that they do. Not feeling valued in this sense can lead to a lack of self-acknowledgement among some TCHWs in terms of their role, which can give off discouraging signals to potential recruits within the community; it can further inhibit personal and employee development, and indeed deepen the marginalisation of Travellers within a broader employment context.

Further barriers to hiring TCHWs relate to basic and digital literacy difficulties, lack of confidence and absence of work experience. In this regard, the need to address broader issues relating to employment was also referenced. This includes improving Traveller education and literacy in an applied sense,

increasing cultural awareness among non-Travellers involved in social care, community and youth work programmes to encourage Traveller engagement in such courses, and addressing systemic racism and discrimination in the workplace to create inclusive environments, thus broadening the potential fields of employment available to Travellers. In terms of the latter, examples were cited of the employment entry bar being pitched at too high a level in educational terms to enable Travellers to apply for certain roles. The importance of developing alternatives to formal qualifications in the form of RPL – Recognition of Prior Learning – was referenced by several respondents in this regard.

As regards training, three categories emerged, namely: introductory training, ongoing/refresher training and further (skills development) training. In terms of the former, while introductory training is provided to new staff, there is currently no standardised induction programme for these entrants, although work is underway towards this goal as part of a wider standardisation process. It would be important that such training is accredited, given the 'value' issue alluded to above.

Further, there is clearly a division between Traveller and local development company projects. Respondents involved in the former often referred to the inadequacy of training budgets and cuts to these over time, primarily as a result of austerity policies during the previous decade which had affected services for Traveller organisations more broadly. In comparison, there was relatively more positive feedback from LDC representatives; the contrasting responses here point to a considerable degree of disparity between projects of different types.

Against the above backdrop, several respondents took the opportunity to propose changes that they felt would improve staff training and development. For example, these could comprise incorporating inputs on transferable digital skills, including data inputting. In addition, the creation of mentoring and apprenticeship opportunities was also suggested to equip Travellers with the practical tools they need to succeed in the workforce. As with introductory training, there is a clear desire to move towards validated or accredited ongoing training to facilitate transferable skills development.

Limited opportunities for career development also emerged, both within and outside of the projects, with the limited number of assistant co-ordinator and full-time positions emerging as factors here. Given the restricted opportunities available for career progression within PHCTPs, there was much discussion around career development outside of the projects, albeit within a staff retention framework of increasing possibilities within the respective Traveller, LDC or NGO employer organisations more broadly. The main issues to emerge here concern job security and certainty, the risk of embarking on less secure employment (for example in a pilot), and the fear of being unable to return to a 'safer' TCHW role should things not work out. As it stands, there appear to be limited or no opportunities for secondment, career breaks or leave of absence for example.

Mary Collins, Missie & Tess Collins and Bridgie Collins.
Photo by Derek Speirs.

Launch of Breast Cancer Awareness materials.
Photo by Derek Speirs.

3. Social Welfare, Medical Cards and Living Costs

The third theme to emerge is a financial one in terms of how the various criteria of our social welfare, medical card, and related means-tested payment systems can potentially impact on the living costs of TCHW households contemplating taking on additional working hours. For some, a balance can be struck facilitating income, medical card and secondary benefit retention, thereby increasing their ability to achieve or sustain a minimum essential standard of living. However, others face poverty traps and negative financial impacts, including on other household members and in meeting basic living costs.

Loss or downgrade of full medical card entitlements and of the financial security and re-assurance it brings is the most critical barrier to the recruitment and retention of TCHWs. There is a strong argument for its retention by workers on public policy grounds, with such an amendment necessitating administrative as opposed to legislative change. In addition, the complexity and convoluted nature of means testing across the social protection system in its broader sense renders it difficult for workers and prospective employees to work out how increased income will play out on their overall family finances. A mechanism for facilitating access to reliable, household-specific information as regards welfare and work 'in the round' is thus recommended.

Turning first to the social welfare or income maintenance aspect: current or potential TCHWs contemplating additional hours or income are likely to face difficult decisions in terms of means-tested assistance payments or allowances. These choices have to be made against the backdrop of a complex, highly centralised and siloed, decision-making welfare system, which is difficult for anyone to navigate, designed to activate claimants and to discourage welfare dependency. A further dimension is that while the Irish social welfare allowance system incorporates additional payments for child and adult dependants—and thus recognises that households and families of different sizes and compositions have differing needs—waged labour does not; hence, moving from welfare to work can entail a serious income hit unless the person in question has a relatively high paying job.

Photos of the Primary Health Care for Travellers Conference 2024. Photos: Tommy Clancy

This complexity is further compounded by differing types of welfare payment having different eligibility criteria in terms of part-time hours and earnings 'ceilings'; impacts on secondary benefits and the income of other household members can also vary depending on the payment or allowance concerned. Moreover, inconsistencies in information provision and practice were identified, as was a reluctance on the part of Travellers (for various understandable reasons) to query or challenge official decisions. This combination of factors can lead to considerable demands on PCHTP employers who may be called upon to support TCHWs experiencing welfare related issues.

Projects can also be impacted by concerns relating to medical card entitlement among staff or prospective employees. The context here is primary legislation in the form of a series of Health Acts which provide for full entitlement to medical services if a person's assessable income (as defined) is below the specified threshold relative to household size and composition. This threshold—which has not been updated for several years –also factors in housing, childcare and travel costs, as well as other essential costs (as defined) which would push a household into 'hardship'. The calculation is thus a far from straightforward one. Entitlement to a full medical card provides free access to a range of medical services and tests, together with a range of non-medical benefits relating to school-related expenses. If a person's assessable income is above the relevant limit, they may be entitled to a so-called GP Visit card depending on whether they fall within a somewhat higher income threshold; this lower category of medical card, as the name suggests, covers GP visits only.

Loss, or fear of losing, full entitlement transpired to be a major issue for prospective and current TCHWs, both in terms of the sense of security it provides and the financial implications associated with increased health and medical costs. There was palpable worry and concern about potential and actual loss or downgrade of medical card entitlement both for workers and their dependent household members, which was referred to as 'ingrained fear'. Retention of the medical card was the key reason so many THCWs took on fewer hours for fear of straying beyond the means test limits; it can also prevent people from entering into employment in the first instance. A further problem concerns lack of clarity about how part-time employment affects medical card entitlement, particularly where a continuing welfare payment is involved.

Context here is important, and there were frequent references by respondents to the prevalence of poor health outcomes among the Traveller community as a whole. Against this backdrop, the financial and psychological benefits of full medical card entitlement are such that giving them up is a risk that many are clearly and understandably unwilling to take, even if it means going without extra weekly income and thereby experiencing a lower standard of living. The overwhelming consensus among respondents is that TCHWs should be able to retain their full medical cards while in PHCTP employment to cover both themselves and their dependants. Such an administrative change would remove a major barrier to recruitment and retention of workers and to the taking on of extra hours.

Finally in terms of other financial aspects pertaining to TCHWs, a number of respondents made reference to increased costs of living and the likely impact of extra waged income on increased rent costs, due to the various differential rent scheme criteria in operation across the country. A further context to financial decision-making among TCHWs relates to the widespread experience of financial difficulties among Travellers resulting from social and financial exclusion within society, a situation evidenced by an emerging body of research.

4. Funding, Structure and Ethos

The fourth and final substantive theme to emerge from the scoping exercise concerns the underlying funding, structure and ethos of the PHCTPs, and the long-term sustainability of the projects. The overriding consensus is that the funds currently provided are inadequate relative to the needs of the community and the expectations placed on workers. Furthermore, while, in principle, autonomy is assigned to local projects by way of Service Level Agreements (SLAs) and Grant Aid Agreements (GAAs), in reality the autonomy granted is often limited. The scarcity of increased core funding in the context of rising costs of living restricts both project and staff development, forcing organisations into a cycle of short-term planning and limiting their capacity for strategic innovation.

Overall funding for Traveller health has been fixed in the ballpark region of €10 million, with some once-off funding measures allocated to Traveller health over the years for some considerable time, while the number of projects and funding levels per project vary across THUs regionally. The overall perspective which came through was that the projects are not sustainable in their current form –given low working hours and high welfare dependency among the workforce – and that extra funding is the catalyst to enable them to meet the needs both of their target communities and the staff working in them. A further rationale is that it would cost the health services a lot more by way of investment to carry out the types of service provided by TCHWs, engage with the community, and develop the same levels of trust.

As it stands, current funding levels are to ensure adequate and appropriate terms and conditions for staff, including occupational pensions. They are also constraining recruitment, retention, rural coverage, training, development, planning, and motivation. Inadequate funding is further engendering a widespread sense of frustration and resignation, which came through in the qualitative dimensions to the research. Among the suggestions here are to move towards multi-annual as opposed to annual funding, with budgets being more up-front than is the case at present. Examples were cited of new 'ad hoc' budget lines being decided centrally rather than in response to locally identified needs, including stipulations that the related funding must be spent by a certain date. Instances were also referenced of current budgets not being used up on account of projects not being able to recruit workers on the existing terms and conditions available; the corollary of this is that the following year's budget may be reduced when money has to be returned.

As regards structure, while the use of local Traveller organisations and development companies allows for flexibility and is to be commended, improved standardisation – for example in terms of pay, terms, conditions and training– would better promote a sense of cohesion; in this regard, Regional Traveller Health Networks could be further resourced and strengthened to enhance peer support, collective action and sharing of materials. There is a need for a national driver to support and resource this work, with the overall trajectory should be towards creating sustainable projects and career progression.

In conclusion, while the evidence in terms of project impacts is robust and persuasive, the underlying ethos and approach behind the initial PHCTPs appears to have drifted away from a community development grounding, to some extent, and more towards a service delivery model, albeit one still containing an advocacy element and based on peer-led principles. A mutually agreed statement or re-statement of these core values would thus be a useful bedrock for future development. From the evidence gathered, a working set of principles might consist of the following: parity (between projects); community development (from the ground up rather than the top down); human rights (supporting individuals and community advocacy); independence (the ability to advocate and challenge policy and practice); complimentary approach (to state health services); flexibility (in being able to respond to local need); and, autonomy (albeit within a standardised basis or framework).

The original community development ethos of the PHCTPs, grounded in empowerment, advocacy, and challenging inequality, is what makes the TCHW model so effective. To dilute this into a pure service-delivery model would be to lose its core value, given its growing importance within health policy. The recommended principles of parity, independence, and flexibility are essential to protect the unique 'culturally-specific' health role of the TCHW and to ensure the model remains peer-led and community-driven, rather than being predominantly state-directed.

SUMMARY OF RECOMMENDATIONS

Recommended Actions

The following recommended actions have the potential to strengthen and sustain PHCTPs into the future in line with key policy commitments from the HSE and Department of Health as reflected in the National Traveller Health Action Plan and the National Traveller and Roma Inclusion Strategy II. All stakeholders, including THUs, Traveller organisations/PHCTPs, Traveller Community Health Workers and service providers, placed much energy and trust in this research and there is an obligation to translate the evidence of its findings into urgent action. Working in partnership with, and across, government departments and agencies, is required in order to address key issues outlined in this report including recruitment and retention, workforce planning, welfare and poverty traps, education and training.

1. Nationally consistent and standardised approaches to PHCTPs required

The development of an agreed PHCTP standardised framework in partnership with Traveller organisations/PHCTPs and the HSE, that reflects learning to date and best practice. This includes:

- **Standard operation procedures including principles, values, reporting, data collection and required staffing for PHCTPs**
- **Standardised job descriptions and roles, including renumeration and rates of pay, underpinned by community work and human rights principles'**
- **Accredited training and career progression, including pre-training to address recruitment and retention issues and RPL for lifelong learning to acknowledge the (transferable) value of gained experience as TCHWs**
- **Recruitment procedures and approaches**
- **Investment in PHCTPs nationally is required to develop and implement the standardised framework, including the need for investment in data collection, training budgets, programme and travel costs.**

2. Affirmative action measures required to address social welfare, medical cards and living costs

- **DoH to undertake an affirmative measure and make an administrative amendment to the medical card assessment criteria (or)to enable TCHWs (i.e. a Traveller working in a PHCTP) to retain their full medical cards to cover both themselves and their dependants.**
- **DSP to amend the employment rule for Jobseeker's Allowance (JA) from a daily one to an hourly one**
- **DSP to amend the JA earnings disregard from a daily to an hourly one and increase it**
- **Traveller organisations/PHCTPs to support and encourage increased use of online benefit estimation and living expense calculation tools**
- **HSE to develop and resource a technical support facility for PHCTPs and TCHWs to assess the impacts of taking on part-time employment and increased wages or hours 'in the round'.**

3. Funding, structure and ethos

- **HSE to support and resource regional Traveller health networks to strengthen peer support/learning, collective action and facilitate materials' sharing between projects; and to protect these structures as part of ongoing HSE reforms**
- **NTHIG to explore how the six newly reformed HSE regions will impact on the THUs, including in terms of funding**
- **Develop a mechanism for collating feedback on PHCTP outcomes and impacts nationally (for example, by way of a national annual report through THAF)**
- **DoH and HSE to fully resource PHCTPs in line with NTHAP and NTRIS II commitments**
- **DoH and HSE to ensure that sufficient funding is made available to THUs/projects to ensure that the terms and conditions offered to staff are appropriate to the role and include provision for pensions**
- **Traveller organisations/PHCTPs should ensure additional or voluntary hours worked are recorded on an ongoing basis**
- **HSE to consider re-thinking staff hours in Full Time Equivalent (FTE)/Whole Time Equivalent (WTE) terms.**

Pavee Point Traveller and Roma Centre
46 Charles Street Great, Mountjoy, Dublin, D01 XC63

www.paveepoint.ie