REVIEW OF THE

Primary Health Care for Travellers Projects (PHCTPS)

An Roinn Sláinte
Department of Health

HSE

Prepared for:

The National Traveller Health Implementation Group (NTHIG)

Prepared by:

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Members of the Working Group and Oversight Group for the Review provided guidance, clarification and feedback throughout the process, strengthening the quality and relevance of the findings.

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List of abbreviations

AITHS All-Ireland Traveller Health Study

CHN Community Health Network

CHO Community Health Organisation

DoH Department of Health

HSE Health Service Executive

LDC Local Development Company

NSIO HSE National Social Inclusion Office

NTHAP HSE National Traveller Health Action Plan 2022-2027

NTHIG HSE National Traveller Health Implementation Group

NTHN National Traveller Health Network

NTRIS National Traveller and Roma Inclusion Strategy

PHCTP Primary Health Care for Travellers Project

PHC Primary Health Care

RHA Regional Health Areas

SIM Social Inclusion Manager

SDOH Social Determinants of Health

TCHW Traveller Community Health Worker

THAF HSE National Traveller Health Advisory Forum

THU Traveller Health Unit

WHO World Health Organization

Foreword

We are pleased to introduce this independent review of the Primary Health Care for Travellers Projects, which was undertaken as part of the HSE Service plan commitment 2025 and also as a commitment under the National Traveller Roma Inclusion Strategy II. These projects play a fundamental role not only in supporting the HSE and other statutory agencies to address Traveller health inequalities, but also in enabling the wider society to respond more effectively to the social determinants of Traveller health, in partnership with Travellers and Traveller organisations.

The report examines the role, value and impact of the Primary Healthcare for Travellers Projects and sets out a clear path to improve how we deliver and support these projects into the future. In existence for more than 30 years, the projects are the building blocks upon which much of our engagement with Traveller health has been developed. We have both seen first-hand their impact on the lives of many Traveller families around this country and the vital role they play; as role models for their own families and their community. They have consistently demonstrated the importance of culturally appropriate, community-led approaches and partnership working in improving access to and experience of health services for Travellers.

This review represents an important milestone in the journey of these important projects. It provides a valuable opportunity to take stock of what is working well, to recognise the strengths and achievements of the model, and to identify where improvements are required to ensure the projects remain effective, sustainable and responsive to changing needs. Importantly, the report does not look back alone; it sets out a way forward to build, grow and further develop the projects so they can continue to impact in the future, in partnership with the HSE and the Department of Health.

There are significant learnings contained within this report, not only for the Primary Health Care for Travellers Projects themselves, but also for mainstream health services. We would encourage all within the health services and beyond to read this important report and consider recommendations in the context of their own role and wider health system.

We would like to acknowledge and thank, the staff working within the Primary Health Care for Travellers Projects, the HSE staff and the external partners who contributed their time, expertise and perspectives to this review. We would also like to thank the Oversight Group for the Review, and the report's author for their engagement and openness were essential to ensuring a robust and meaningful report.

The recommendations set out in this report provide a strong foundation for future action. Both the Department of Health and the HSE are committed to supporting their implementation and to working in partnership with all stakeholders to ensure that the Primary Health Care for Travellers Projects continue to evolve, strengthen and deliver on their vital role.

Jennifer Murnane O'Connor
TD Minister of State with responsibility for Public Health, Wellbeing & the National Drugs Strategy

Bernard Gloster
HSE CEO

Executive Summary

This report presents the findings of an independent review of the Primary Health Care for Travellers Projects (PHCTPs), undertaken under Action 27 of the National Traveller and Roma Inclusion Strategy II (2024–2028) and aligned with Goal 4 of the National Traveller Health Action Plan (2022–2027). The review was conducted between August and December 2025 under the oversight of a National Oversight Group. Its purpose is to examine the perceived role, value and impact of PHCTPs and advise on how they can be sustained and strengthened into the future to support ongoing monitoring and reporting.

PHCTPs operate at the intersection of primary health care and community development models. Central to the model is the peer-led role of Traveller Community Health Workers (TCHWs), who work within their own communities to support engagement with health information and services, to promote and advocate for improved Traveller health and to act as trusted intermediaries between Travellers and the health system.

Review approach

The review adopted a qualitative, participatory approach and involved extensive engagement with stakeholders at national, regional, and local levels. Data collection included national workshops with TCHWs, interviews and focus groups with Travellers, TCHWs, PHCTP coordinators, Traveller organisations, HSE staff, senior policy stakeholders, and academics, alongside qualitative surveys. Approximately 150 participants contributed.

This approach enabled a detailed examination of how PHCTPs operate in practice, how they are experienced by Travellers and other stakeholders, and how they are understood to contribute within the wider health system and policy context.

Key findings

There is strong consistency across stakeholder groups in how PHCTPs are described as functioning in practice. The peer-led model, long-term relationship-building and trust are consistently identified as defining features. These characteristics are widely viewed as central to effective engagement with Traveller communities, particularly in a context shaped by historical discrimination, mistrust of statutory systems, and structural disadvantage.

Stakeholders describe PHCTPs as signposting and supporting engagement with health information and services, facilitating navigation of complex systems, and strengthening confidence, advocacy and participation among Travellers. PHCTPs are also viewed as supporting mainstream services to work more effectively with Traveller communities through outreach, cultural mediation and system-level insight.

The review identifies a number of structural challenges affecting sustainability. These include funding insecurity, inconsistent terms and conditions, limited career progression pathways for TCHWs, lack of dedicated administrative support, and variation in approaches to monitoring and reporting across regions.

The review also finds that PHCTPs are described and understood differently across policy, operational, and community contexts. While this reflects the flexibility and responsiveness of the model, it has implications in terms of expected outcomes that could and should be monitored to demonstrate effectiveness. A clearer, shared articulation of the PHCTP model would support greater consistency while retaining local adaptability. It is also important as a means of providing focus to monitoring efforts going forward.

Implications for monitoring and future development

The findings point to the need for a monitoring approach that reflects the broad and complex nature of PHCTP work, including its relational, preventative, and community-based dimensions. Section 5 of the report sets out key considerations and building blocks for the development of an outcomes framework (such as a theory of change) as a foundational step towards developing a subsequent monitoring framework that is proportionate, meaningful, and aligned with the PHCTP model and its goals. Examples, templates, and resources are provided within the report.

However, further consultation and critical input is required to develop these frameworks, including structured engagement with PHCTPs and TCHWs, Traveller Health Units (THUs), the HSE, the Department of Health and policy decision-makers. Continued partnership and collaboration will be essential to developing a monitoring framework based on a shared understanding and future vision for the PHCTP model, supporting accountability, learning and informed decision-making.

Recommendations

Recommendation 1: Develop a standardised approach to reflect the work of PHCTPs

Develop a nationally agreed articulation of the PHCTP model to support shared understanding, clarify expectations and provide a foundation for monitoring and reporting, while allowing for local flexibility. A theory of change is a suggested approach; however several methodologies are discussed, and resources are provided for consideration.

Recommendation 2: Invest in workforce development to reach long term goals

Recognise the importance of workforce stability by prioritising investment in improved pay, hours, and terms and conditions for TCHWs. This should include clear and supported progression routes into appropriate roles and posts, including relevant mainstream roles. In parallel, continue to invest in education and training for TCHWs, recognising the skilled and demanding nature of their role.

Recommendation 3: Strengthen accountability, coordination, and partnership approach

Strengthen accountability, coordination and partnership arrangements across local, regional, and national structures to support consistency, clarity, and shared ownership.

Recommendation 4: Enhance infrastructure to support knowledge sharing

Enhance administrative, IT and organisational infrastructure to support knowledge sharing, peer learning and consistency of practice across PHCTPs.

Recommendation 5: Consider future approaches to monitoring and evaluation

Develop monitoring and evaluation approaches that are co-designed, proportionate, and aligned with the PHCTP model, combining qualitative and quantitative elements in ways that are meaningful for communities and policymakers. Consideration should be given to allocating sufficient and dedicated resourcing to support monitoring and evaluation activity, including staff time, training, data systems, and analytical capacity, to ensure that monitoring and evaluation requirements are realistic, consistent, and sustainable across PHCTPs.

Conclusion

This review finds that PHCTPs continue to be regarded as a highly valuable, responsive, and established mechanism for the improvement of Traveller health in Ireland. A shared understanding and collective vision for the model into the future is critical. Employment security and opportunities for career progression are essential to ensure stability and sustainability of the PHCTPs. Addressing structural challenges and strengthening monitoring arrangements, while maintaining the peer-led and foundational principles of the model will be central to supporting the future development of PHCTPs.

Section 1: Introduction

This section briefly sets out the background and purpose of the review and the wider policy context. It outlines the governance and oversight for the review and provides a summary of the structure of the report.

1.1 Background and purpose of the review

The Primary Health Care for Traveller Projects (PHCTPs) are a cornerstone of the State's strategy to improve Traveller health. Goal 4 of the National Traveller Health Action Plan (NTHAP) 2022–2027 commits to 'enhancing Travellers' access to culturally appropriate primary health care through investment in Traveller Health Units (THUs) and Primary Health Care for Travellers Projects (PHCTPs)' and includes actions to continue resourcing, expanding and supporting these projects, addressing staff recruitment and retention, and supporting Traveller health literacy (Actions 41, 43 and 45).[1]

The HSE National Service Plan, 2024 and Action 27 of the National Traveller and Roma Inclusion Strategy II (NTRIS II 2024–2028) mandate evaluation of the PHCTPs. The Department of Health requested that the HSE evaluate the impact of the PHCTPs, to ensure this critical infrastructure is effective in supporting delivery of the NTHAP and to inform future development. Furthermore, NTRIS II sets out the aim to: 'Develop a framework to review the PHCTPs in partnership with Traveller organisations and consider the role and impact of the PHCTPs on an ongoing basis to inform monitoring and need for future developments (NTRIS II 2024-2028)'.[2]

A National Oversight Group for the Review of the PHCTPs was convened in May 2025 followed by a competitive tendering process. See Appendix 1: Governance and Oversight for a list of members. The National Oversight Group, in collaboration with the National Traveller Health Implementation Group (NTHIG), commissioned an independent consultant to carry out a review of the PHCTPs between August 2025 and December 2025.

The **aim of this review** was to document the rationale, role, benefit, challenges and impact/responses to the work of the PHCTPs with a view to support ongoing monitoring and reporting.

The key deliverable is to produce a **report on the analysis of findings** including an outline framework for the monitoring of the achievements, challenges, enablers, gaps, and support needs for the strengthening, sustainability and future development of PHCTPs.[3]

1.2 Oversight for the review

A working group was established, consisting of a subset of members from the National Oversight Group for the Review of the PHCTPs, to collaborate with the independent consultant and act as an operational touchpoint. The group had representation from the HSE, Traveller organisations and THUs. Working group meetings were held on a weekly basis between July and October 2025.

The report was reviewed by the National Oversight Group for the Review with comments and feedback provided and integrated into the report. A final report was endorsed by the National Traveller Health Implementation Group in February 2026.

1 Department of Health and Health Service Executive (HSE) (2022) National Traveller Health Action Plan (NTHAP) 2022–2027. Dublin: Department of Health and HSE Social Inclusion.

2 Department of Children, Equality, Disability, Integration and Youth (DCEDIY) (2024) National Traveller and Roma Inclusion Strategy II 2024–2028 (NTRIS II). Dublin: Government of Ireland; DCEDIY (2024) National Traveller and Roma Inclusion Strategy II 2024–2028: Action Plan 2024–2026. Government of Ireland. Available at: https://www.gov.ie; HSE National Service Plan 2024. Dublin: HSE.

3 As stated in the Invitation to Tender for the Review of the Primary Healthcare for Traveller Projects (PHCTPs).

1.3 Structure of report

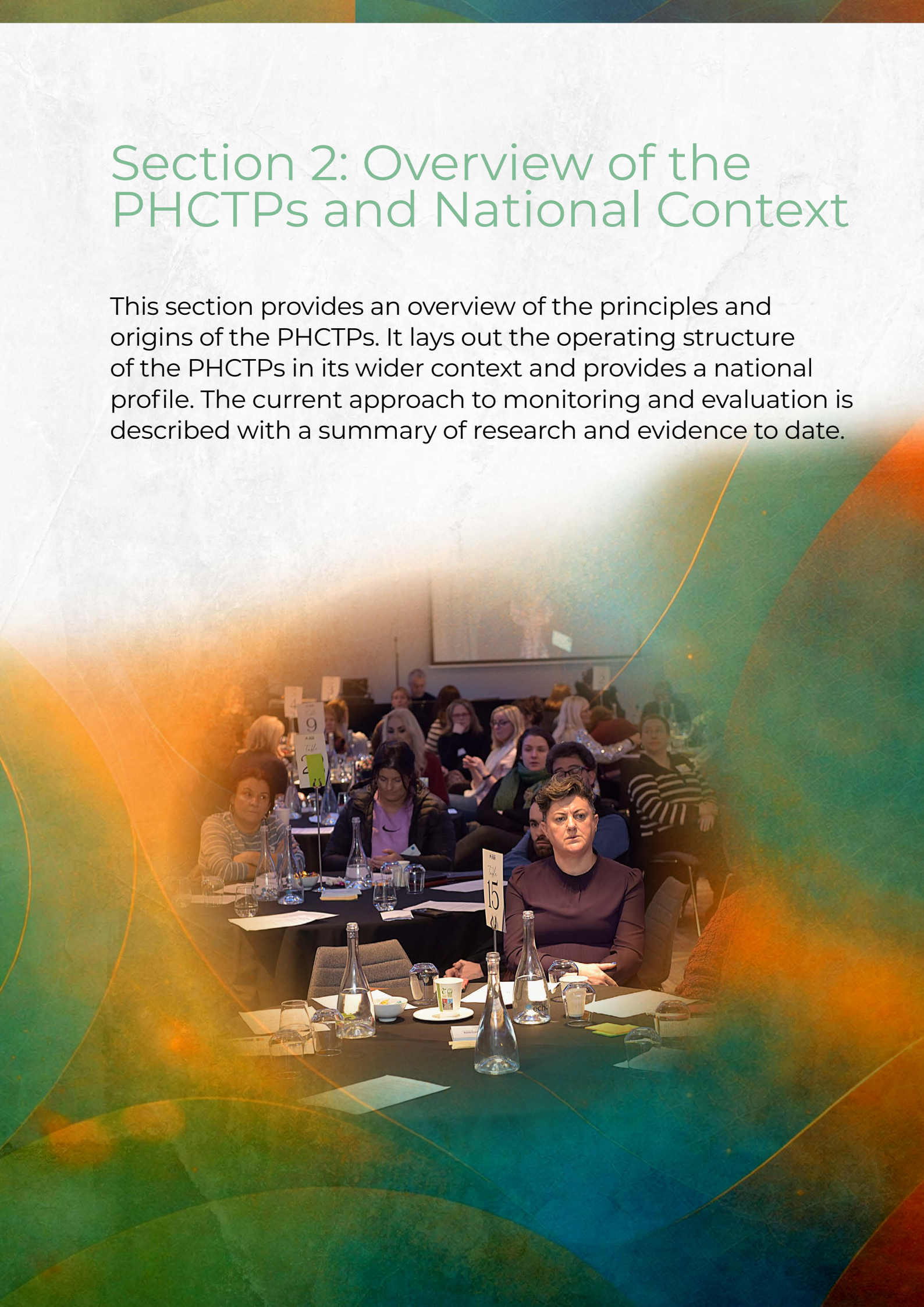
The report is structured under six sections as follows:

- **Section 1: Introduction** introduces the background, purpose, governance and oversight of the review, and outlines how the report is organised.
- **Section 2: Overview of the PHCTPs and National Context** provides an overview of the PHCTPs, including their principles, origins, operating structures and the wider national context for monitoring and reporting.
- **Section 3: Review Methodology** describes the methodological approach, including the review objectives, sampling strategy, data collection methods, analytical process, and strengths and limitations.
- **Section 4: Review Findings** presents the findings from the thematic analysis of stakeholder perspectives, structured around the value, role and impact of PHCTPs and their sustainability and future development.
- **Section 5: Outline for a Proposed Monitoring Framework** outlines a conceptual basis for a monitoring framework, discusses the challenge of measuring PHCTPs, and sets out key considerations for further development of a monitoring framework.
- **Section 6: Review Recommendations** provides recommendations arising from the review to support the strengthening, sustainability and future development of the PHCTPs.

The report is accompanied by appendices which provide further detail on governance and oversight arrangements, the review objectives and methods, workshop and survey outputs, and templates and resources for monitoring frameworks with illustrative and worked examples.

Section 2: Overview of the PHCTPs and National Context

This section provides an overview of the principles and origins of the PHCTPs. It lays out the operating structure of the PHCTPs in its wider context and provides a national profile. The current approach to monitoring and evaluation is described with a summary of research and evidence to date.



2.1 Principles

The PHCTPs are a peer-led model of community health grounded in participation, empowerment and social justice. They operate at the intersection of primary health care and community development, embodying a national policy commitment to improve health experiences and outcomes for Travellers.

The PHCTP model is informed by the original concept of **primary health care** (PHC) in the Alma Ata declaration and reiterated in the Astana Declaration 2018 linking to universal health care.[4] PHC emphasised values of access, participation, self-reliance and self-determination.[5] It takes a 'whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.'[6]

The PHCTPs draw from a model of **community development** taking a holistic approach that is grounded in the following principles:

- social justice and solidarity
- equality and human rights
- active participation, empowerment and collective action.[7]

As stated in NTHAP, 'Community development and community workers work to empower, enable and support communities to improve their quality of life. They work to address poverty and social exclusion, and to achieve rights and equality for marginalised communities including Travellers, women, migrants, minorities and others that experience poverty, inequality and social exclusion'.[8]

As determined by its original concept, a key component of PHC is the role of community health workers in delivering and supporting a range of preventive interventions as well as empowering and engaging communities in health-related activities. As part of the PHCTP model of primary health care, Traveller Community Health Workers (TCHWs) serve as peer workers who bridge the gap between their community and mainstream health services. PHCTPs train Travellers as community health workers enabling primary healthcare to be developed 'based on the Traveller community's own values and perceptions'.[9] In practice, TCHWs conduct outreach, health education, and advocacy. They raise awareness of issues such as immunisation, maternal and child health, mental health, support improved health literacy, help community members navigate health services and signpost to health services. Importantly, they work from an understanding of how broader social determinants of health—such as accommodation, education and employment—shape people's ability to access mainstream health and social services.

They also play a key role in developing culturally appropriate health information and materials, and in informing research and policy by bringing forward their communities' needs and priorities.

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4 World Health Organization (WHO) Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Geneva: WHO; 1978. https://www.who.int/publications/i/item/declaration-of-alma-ata; World Health Organization (WHO) Declaration of Astana. Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61

5 WHO and United Nations Children's Fund (UNICEF) (2018). A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization

6 Operational Framework for Primary Health Care: Transforming Vision into Action, WHO and UNICEF, 2020

7 The NTHAP has adopted the values and principles as outlined in the government report, 'Sustainable, Inclusive and Empowered Communities: A five-year strategy to support the community and voluntary sector in Ireland 2019-2024'.

8 Department of Rural and Community Development (2019) Sustainable, Inclusive and Empowered Communities: A Five-Year Strategy to Support the Community and Voluntary Sector in Ireland 2019-2024, cited in NTHAP.

9 Department of Health and Health Service Executive (HSE) (2022) National Traveller Health Action Plan (NTHAP) 2022–2027. Dublin: Department of Health and HSE Social Inclusion.

By being embedded in the community they serve, these peer workers build trust, cultural awareness, and continuity of contact that mainstream services often struggle to achieve. Their role is not just informational but also relational. It involves empowering the community, strengthening self-advocacy and self-determination, and ensuring that health interventions align with community needs and perceptions and are delivered in a culturally appropriate way, thereby reducing barriers of discrimination, mistrust, and inaccessibility.

There is substantial evidence to support the effectiveness of the community health worker model. Research across multiple jurisdictions suggests that community health workers can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection'.[10] In Brazil, the Family Health Strategy - in which community health workers are central - has been running at a national scale since the early 1990s and is reported to have led to sustained improvements in hospital admissions, hospitalisations, and mortality for chronic diseases, as well as improvements in immunisation and screening uptake.[11] More recently, there is a shift towards this model in the UK with NHS services beginning to report positive outcomes from their evaluations of CHW initiatives.[12] Research also suggests a positive return on investment for community health worker programmes and their effectiveness in responding to the social determinants of health.[13]

The PHCTPs work to establish a model of Traveller participation in the promotion of health, develop the skills of the Travellers in providing community-based health services, liaise and assist in creating a dialogue between Travellers and health service providers and clarify gaps in health service delivery and work towards reducing inequalities that exist in mainstream services. The PHCTP model approaches the problem of health inequality by recognising the multitude of factors that determine a person's health, understanding that health is largely produced outside of the health system. This is based on the Social Determinants of Health (SDoH) model developed by Dahlgren and Whitehead in 1991.[14]

WHO provides a useful definition of the social determinants of health equity as "the societal factors that give rise to social position and the association between social position; access to power, money and resources, and health. These include the conditions in which people are born, grow, live, work and age, together with structural determinants, such as the formal and informal rules of systems and institutions (including economic systems and commercial determinants), policies, culture and values (including classism, racism, sexism, ageism, ableism, xenophobia and homophobia).

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10 Harris MJ, Haines A. The potential contribution of community health workers to improving health outcomes in UK primary care. J R Soc Med. 2012 Aug;105(8):330-5. doi: 10.1258/jrsm.2012.120047. PMID: 22907550; PMCID: PMC3423132; Witmer A, Seifer SD, Finocchio L, Leslie J, O'Neil EH. Community health workers: integral members of the health care work force. Am J Public Health. 1995 Aug;85(8 Pt 1):1055-8. doi: 10.2105/ajph.85.8_pt_1.1055. PMID: 7625495; PMCID: PMC1615805; Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE, Odgaard-Jensen J, Johansen M, Aja GN, Zwarenstein M, Scheel IB. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. Cochrane Database Syst Rev. 2010 Mar 17;2010(3):CD004015. doi: 10.1002/14651858.CD004015.pub3. PMID: 20238326; PMCID: PMC6485809; Hayhoe B, Cowling TE, Pillutla V, Garg P, Majeed A, Harris M. Integrating a nationally scaled workforce of community health workers in primary care: a modelling study. J R Soc Med. 2018 Dec;111(12):453-461. doi: 10.1177/0141076818803443. Epub 2018 Oct 4. PMID: 30286301; PMCID: PMC6295943;

11 Rocha, R. and Soares, R.R. (2010), Evaluating the impact of community-based health interventions: evidence from Brazil's Family Health Program. Health Econ., 19: 126-158. https://doi.org/10.1002/hec.1607

12 Junghans, Cornelia & Antonacci, Grazia & Lennox, Laura & Harris, Matthew. (2022). Year One evaluation of the Community Health and Wellbeing Worker initiative in Westminster. See National Association of Primary Care (NAPC), CHWW Publications: https://napc.co.uk/chww/publications/

13 Kangovi, S et al (2020) Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment; Health Affairs 2020 39:2, 207-213; MHP Salud. Community Health Workers and Return on Investment (ROI). Available at: https://mhpsalud.org/programs/community-health-workers-roi/;

14 Dahlgren, G. and Whitehead, M., 1991. Policies and strategies to promote social equity in health. Stockholm: Institute for future studies, 27(1), pp.4-41.

They are influenced by historical context and operate over the lifespan. Societal factors are conditioned by their physical and technological environment, and changes in these environments are important constraints on or enablers of social change." In their report, WHO cite research that suggests that social determinants account for at least 50% of health outcomes and health inequities".[15] In this context, it is important to note that many Travellers live in areas characterised by wider social disadvantage. The Inverse Care Law (Tudor Hart 1971) describes how "the availability of good medical care tends to vary inversely with the need for it in the population served". A review of this in 2021 (Cookson 2021) describes how "socially disadvantaged people receive more health care, but of worse quality and insufficient quantity to meet their additional needs".[16] Poverty, discrimination, racism and stigma are also well-established sources of chronic stress, which is known to contribute to both mental and physical ill-health.[17] It is within this wider social ecosystem that PHCTPs operate to support improved health for Travellers.

2.2 Origins

In March 1994 the Department of Health published their national health strategy, Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s in which they outlined the health inequalities experienced by Travellers, in particular highlighting that life expectancy and general health status among Travellers is poorer than the general population. The DoH set out a strategic plan for developing and implementing a programme to address the particular health needs of Travellers.[18] This included the development of a Taskforce, which would include a joint study on Travellers' health with particular emphasis on access to appropriate health services. The strategy stated that, following the completion of this study, a number of initiatives would be undertaken including; a health education programme aimed specifically at Travellers; development of models of Traveller participation in health promotion and prevention; special arrangements to encourage and permit Travellers to avail of primary care services; simplifying services and providing better continuity of care from one health board area to another; better targeting of services at Travellers.

The subsequent Task Force Report (1995) provided a comprehensive overview of the range of health inequalities experienced by Travellers in Ireland. It recognised that if the gap between Traveller health and that of the majority population was to be bridged, there needed to be specific health programmes to target the needs of Travellers. It recommended the establishment of a National Traveller Health Advisory Committee at departmental level and of Traveller Health Units (THUs) at health board levels.

The first PHCTP was established in 1994 on a 12-month pilot basis in the Finglas/Dunsink area of Community Care Area 6. The project was a joint partnership initiative between the then Eastern Health Board and Pavee Point and was conceived as part of a shared vision between the Department of Health (DoH) and the Health Boards to take a community development approach towards supporting Travellers to access mainstream primary care services. The PHCTPs were set up as a means of providing a collective response to what key stakeholders in the Department and Health Boards recognised was an unacceptable

15 World Health Organization (2025) World report on social determinants of health equity. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/teams/social-determinants-of-health/equity-and-health/world-report-on-social-determinants-of-health-equity

16 Tudor Hart J. (1971) The inverse care law. Lancet 297(7696):405–412

17 Cookson R, (2021) The inverse care law re-examined: a global perspective. Lancet 397(10276):828–838. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00243-9/abstract

18 Department of Health (1994) *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s.* Dublin: The Stationery Office. ISBN 0-7076-0374-9.

gap between Traveller health and the majority population. As HSE Regional Executive Officer, Martina Queally explains:

> *If we consider the origins of PHCTPs, The Department of Health and the Health Boards at the time wanted to do something that would have a real benefit in terms of changing [Traveller's experience in accessing health services] at a fairly radical and fundamental level. And they believed, and I think they were correct in their belief, that community development approaches were probably the best way to do that in terms of working in real partnership and with the population they were serving.*
>
> **(Interview with Martina Queally, HSE Regional Executive Officer)**

The project trained Traveller women as Community Health Workers (CHWs) to provide culturally appropriate health promotion, advocacy, and liaison between Traveller families and health services. Originally, there were Public Health Nursing (PHN) posts, dedicated on a part time basis and based in projects who jointly coordinated alongside a co-coordinator from the host organisation, who had community development or community knowledge, and a background or experience working in partnership to oversee the PHCTP. In a number of areas there were/are additional dedicated Traveller PHNs whose role is to link with Travellers. This augmented Travellers engagement with the PHN service, and supported Travellers availing of the regular PHN service. The co-coordinator posts were lost over time, however a small number of the dedicated Traveller PHN positions are still in place.

Initially, the focus of PHCTPs was on empowering Traveller women, many with low literacy, to conduct community-based surveys and communicate basic health education.[19] From this work, the TCHWs were able to capture the views of 85 families about their health needs and revealed significant health knowledge gaps, which was further confirmed by studies highlighting health disparities and in particular the All-Ireland Traveller Health Study (AITHS).[20] In response, the projects evolved from addressing basic health needs such as immunisation and antenatal care, to more complex issues affecting the community such as domestic violence, addiction, men's health and mental health.

Following the establishment of that first project in 1994, PHCTPs expanded rapidly to Blanchardstown and began to be set up throughout Ireland from the late 1990s. The peak number of PHCTPs was achieved in 2005 with 40 projects. However, due to austerity and a reduction in funding the number of projects has reduced and there are currently 31 PHCTPs in operation across Ireland.

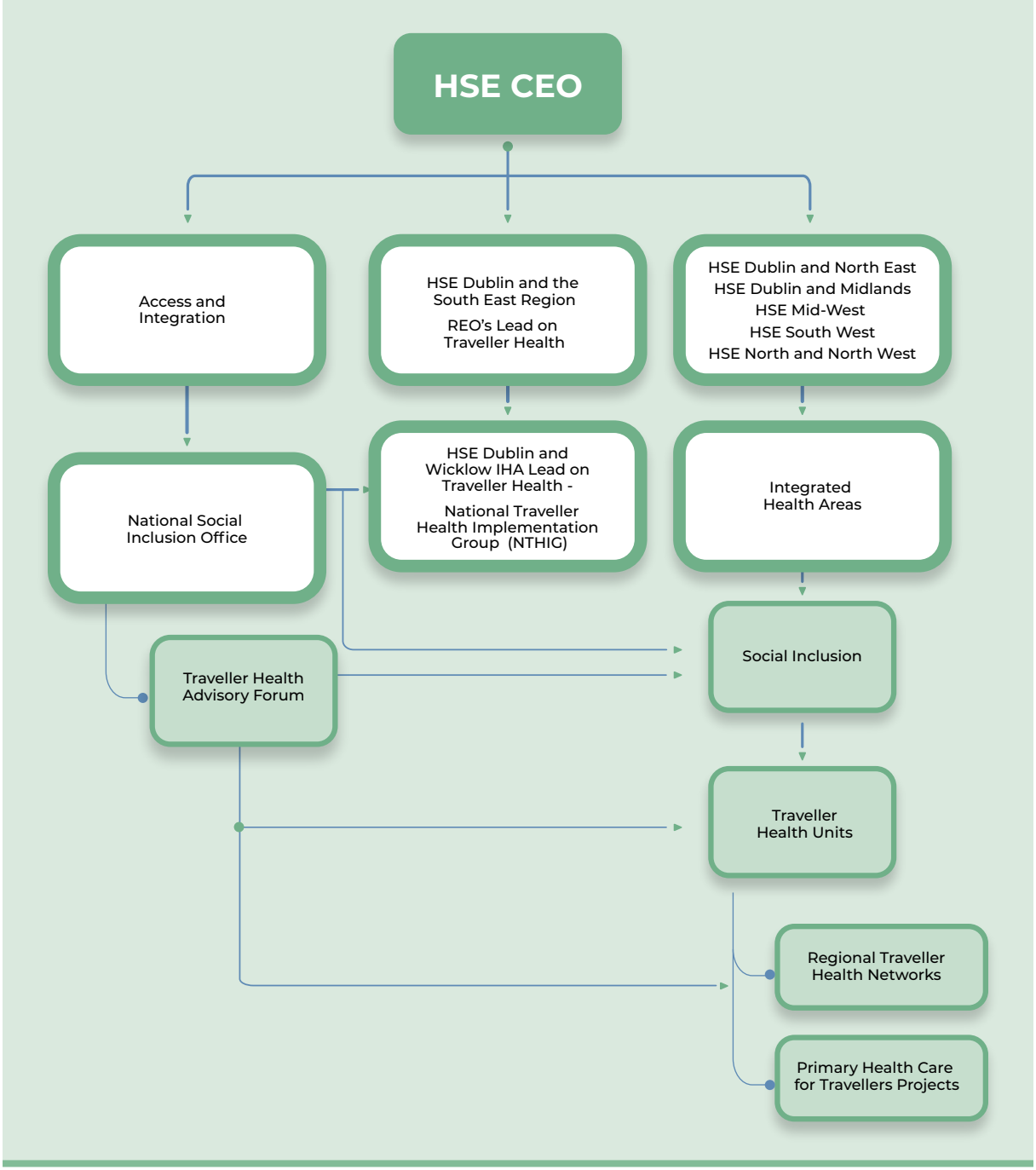
2.3 Operating structure

Figure 1 provides an overview of the national, regional and local structures that support Traveller Health, illustrating how PHCTPs are situated at the local level from which they extend out to the Traveller community.

19 Source: *Interview with former PHTCP coordinator*

20 Barry, J., Daly, L. (1986). The Travellers Health Status Study: a census of the Travelling People. Dublin: Health Research Board. Barry, J., Daly, L. (1988). The Travellers Health Status Study. Dublin: Health Research Board. Barry, J., Herity, B., Solan, J. (1989). The Travellers' health status study - vital statistics of travelling people, 1987. Dublin: The Health Research Board. All Ireland Traveller Health Study Team (AITHS) (2010) Our Geels: Summary of findings. Department of Health and Children, Dublin. (https://assets.gov.ie/18859/d5237d6119164631 89ecc1f9ea83279d.pdf)

Figure 1: National, regional and local structures that support Traveller Health



Source: National Traveller Health Action Plan (NTHAP)

The Department of Health (DoH)

The DoH provides leadership and policy direction to improve health experiences and outcomes for Travellers. It is jointly responsible with the HSE for the national Traveller health action plan. It promotes inclusion health measures for Travellers across various health policies including Sláintecare, mental health, drug services, maternity & neo-natal services, and women's health. The Dept works with Traveller organisations and government departments to support Travellers to lead inclusive, healthy and fulfilling lives through the National Traveller and Roma Inclusion Strategy.

HSE National Social Inclusion Office (NSIO)

NSIO is the HSE's specialist unit that aims to reduce inequalities in health and improve access to mainstream and targeted health services for under-served and socially excluded groups in Ireland, including Irish Travellers and Roma. In 2024, the NSIO received approximately 1% of the health budget (€222m). Within the NSIO, there are two Traveller Health Project Managers and an administrator working exclusively in Traveller Health. [21]

Traveller Health Units (THUs)

Regional Traveller Health Units (THUs) work in partnership with local Traveller organisations and PHCTPs. They were established on foot of a 1995 Task Force report on the Travelling Community.[22] They are mandated to monitor service delivery and regional targets, strengthen coordination across statutory and voluntary bodies, collect health data, support the training and mainstreaming of Traveller health within mainstream services, and develop Traveller-specific services where needed.

There are currently seven THUs across Ireland (aligned with former health board regions). The THUs are currently transitioning from operating at Community Health Organisation (CHO) level to the HSE's health regions.

National Traveller Health Implementation Group (NTHIG)

The National Traveller Health Implementation Group (NTHIG) was established to drive implementation of the National Traveller Health Action Plan 2022 2027, to direct, support and engage those involved in implementation, to monitor and report progress against expected outcomes to ensure delivery of the Plan and inform the design of RHAs in relation to Traveller health. The group meets eight times per year on average, sets up sub-groups when needed, and ensures accountability and progress on the 45 Actions outlined in the Plan. Membership of the group includes representatives from HSE National Social Inclusion Office, the National Traveller Health Network, Pavee Point Traveller and Roma Centre, Traveller representatives, Public Health, HSE National Mental Health, HSE National Finance and the DoH.

National Traveller Health Advisory Forum (THAF)

The overall purpose of THAF is to provide national coordination and support for Traveller health planning, delivery and monitoring. The Forum generally meets every 6 weeks and comprises HSE staff, Traveller Health Unit (THU) Coordinators, a Traveller organisation/ PHCP representative from each THU, and representatives from national Traveller organisations.

National Traveller Health Network (NTHN)

NTHN is a national forum for local Traveller organisations and PHCTPs throughout Ireland. The network was established in 1997 by Pavee Point.[23] NTHN provides a strong forum for the exchange of information on current and/or new policy developments and updates on health reforms and the implications related to Traveller health.

21 At time of writing, one of Traveller Health Project Manager roles was vacant.

22 Department of the Environment (1995) Report of the Task Force on the Travelling Community. Dublin: Department of the Environment.

23 The national networking of Traveller organisations is long established. The 1995 Task Force report identifies a range of coordination mechanisms to support this, including national resourcing and group development supports, structured networking between local organisations, and the development of national platforms to advance key issues.

The network also identifies any emerging issue, shares insights and learning and identifies models of good practice and initiatives. Collective responses to emerging issues as well as the development of Traveller-proofed health resources that are used by projects nationally, providing added value and national consistent approaches.

Traveller organisations

Local Traveller organisations play a central role in operating PHCTPs, providing community leadership and trusted relationships that enable effective engagement with Traveller families. They act as the bridge between the community and health services, supporting a Traveller-led approach to primary health care and ensuring Traveller voices shape priorities in developing and operating PHCTPs. As outlined in the 1995 Task Force report, while many of the activities of Traveller organisations are state funded, these organisations are autonomous and independent. They are organisations in which Travellers and settled people work together as equal partners, with the effective participation of Travellers as a defining feature. Advocacy on Traveller issues, alongside efforts to improve living circumstances and overall wellbeing, remains a core function of these organisations. [24]

Local Development Companies (LDCs)

In instances where a local Traveller organisation does not exist in an area, LDCs may be used to host PHCTPs. Typically, they provide broad organisational infrastructure and administrative support. While not Traveller-led, LDCs can provide strategic capacity and cross-sector partnerships. Currently the majority of PHCTPs are currently operated by local Traveller organisations, with a minority operated by LDCs and other groups.[25]

PHCTPs

Each PHCTP typically employs a range of staff, as follows:

- **Coordinator / assistant coordinator** who provide active and involved leadership of the PHCTPs ensuring that workplans are fully implemented, staff are supported and developed, finances are managed responsibly, and that all aspects of the programme remain grounded in a strong community-development ethos and the core values of the PHCTP.
- A team of **Traveller Community Health Workers** (TCHWs) on a part-time basis who engage with the Traveller community, health and social care services and relevant institutions in an advocacy role. They support advocacy and signposting in a range of health arenas (e.g. health education, child and infant health, immunisation, addiction, diet and exercise, health and wellbeing, women's health, men's health, mental health), as well as providing support around addressing the Social Determinants of Health

As shown in Figure 2, cumulatively PHCTPs employ around 307 TCHW (104 WTEs). They work on average 12 hours per week, mostly on minimum to living wage incomes with limited or no occupational pension entitlements. There is currently no dedicated resourcing for administrative posts for PHCTPs. As a result, organisations often absorb this workload by reallocating their own administrative capacity to handle routine administrative tasks such as financial management, HR processes, data handling and storage, and responding to information requests.

24 ibid
25 Stamp, 2025

Figure 2: Number of PHCTPs and workforce profile[26]

Number of PHCTPs:

- **There are currently 31 PHCTPs in operation across Ireland.**
  - 21 are operated by Traveller organisations
  - 9 are operated by Local Development Companies / C&V organisations
  - 1 Voluntary organisation
- **There are also 7 associated health initiatives that are funded to undertake Traveller health work.**

Workforce data across PHCTPs and associated health initiatives:

- **There are 34 Full Time Equivalent Coordinator posts (some projects have more than 1 FTE coordinator post and some coordinators work part time hours)**
- **There are 3.5 Full Time Equivalent Assistant Coordinators posts**
- **There are 104 Full Time Equivalent Traveller Community Health Worker posts with 307 Travellers employed**
- **There are 18.7 Full Time Equivalent posts**

2.4 Current approach to monitoring and reporting

The National Traveller Health Action Plan (NTHAP) sets out the vision for monitoring Traveller health in line with agreed actions considering the distinct health needs of Travellers and accountability for monitoring and evaluating: 'Monitoring ensures we can measure progress in this Plan using tools such as data and performance indicators and time scales. This also includes research and evaluation strategies. Strategies should explicitly take account of the distinct needs of Travellers and develop a set of clear accountability mechanisms to monitor and evaluate implementation progress'.[27]

Key Performance Indicators (KPIs)

Following the significant health inequalities evidenced in the AITHS in 2010, Traveller-specific KPIs were developed to capture awareness raising and signposting in relation to:

1. Cardiovascular disease
2. Type II diabetes
3. Positive mental health

In 2024, the target for each KPI was 20% of the Traveller population aged 15 and older, based on national census. PHCTPs met and exceeded this target in each area of type II diabetes, cardiovascular disease, and positive mental health, with 51%; 56% and 44% reached respectively. The HSE increased the Traveller KPIs to 25% in 2025, and all targets will be reviewed in 2026 with the HSE reforms.[28]

26 Source: HSE National Social Inclusion Office. Figures correct at time of writing.

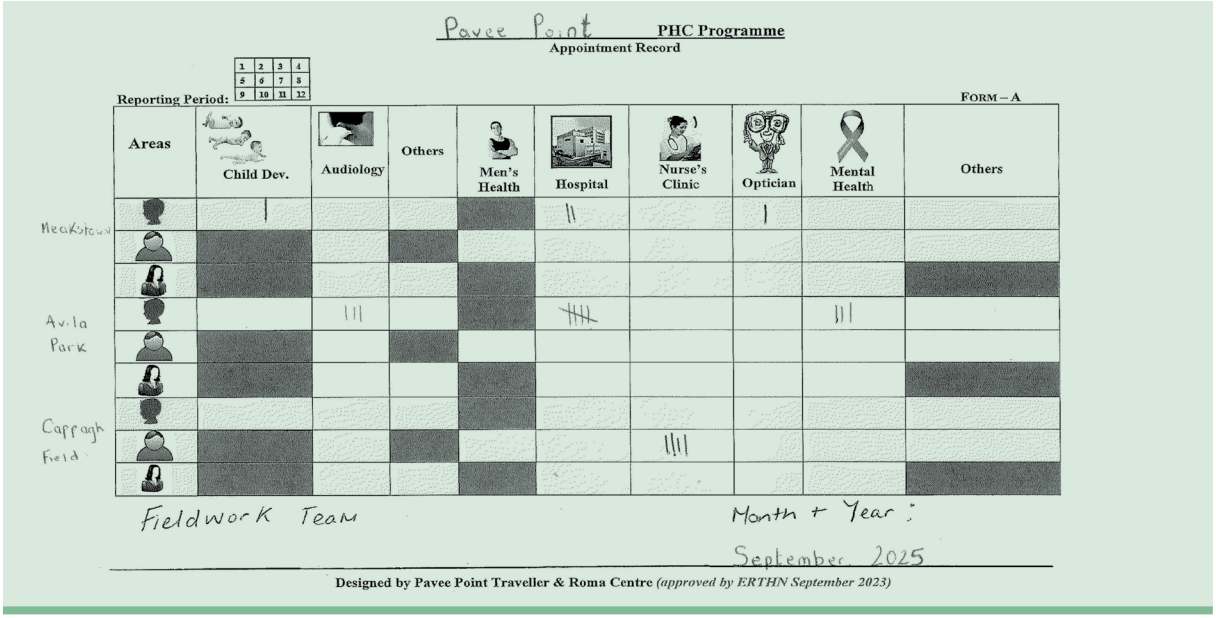
27 Department of Health and Health Service Executive (HSE) (2022) National Traveller Health Action Plan (THAP) 2022–2027. Dublin: Department of Health and HSE Social Inclusion

28 THAF (2025) National Traveller Health Advisory Forum Report: Summary of Key Activities of Primary Healthcare Projects for Travellers (PHCPTs) 2024.

Handheld records

TCHWs collect data on a range of indicators which may vary across PHCTPs but typically include incidences of disease, deaths and new births, attendance to antenatal care, health information and education sessions. Data is collected – often by hand – using records (referred to as "tally sheets") designed by TCHWs to overcome literacy issues for the workers.

Figure 3: Example of tally sheet for data collection by TCHWs in Eastern region



Activity data

The activities of the TCHWs 'takes many forms and is dictated by resources that are available within the local community, the target groups and the topic of health the fieldwork is addressing'.[29] It is influenced by several factors, such as:

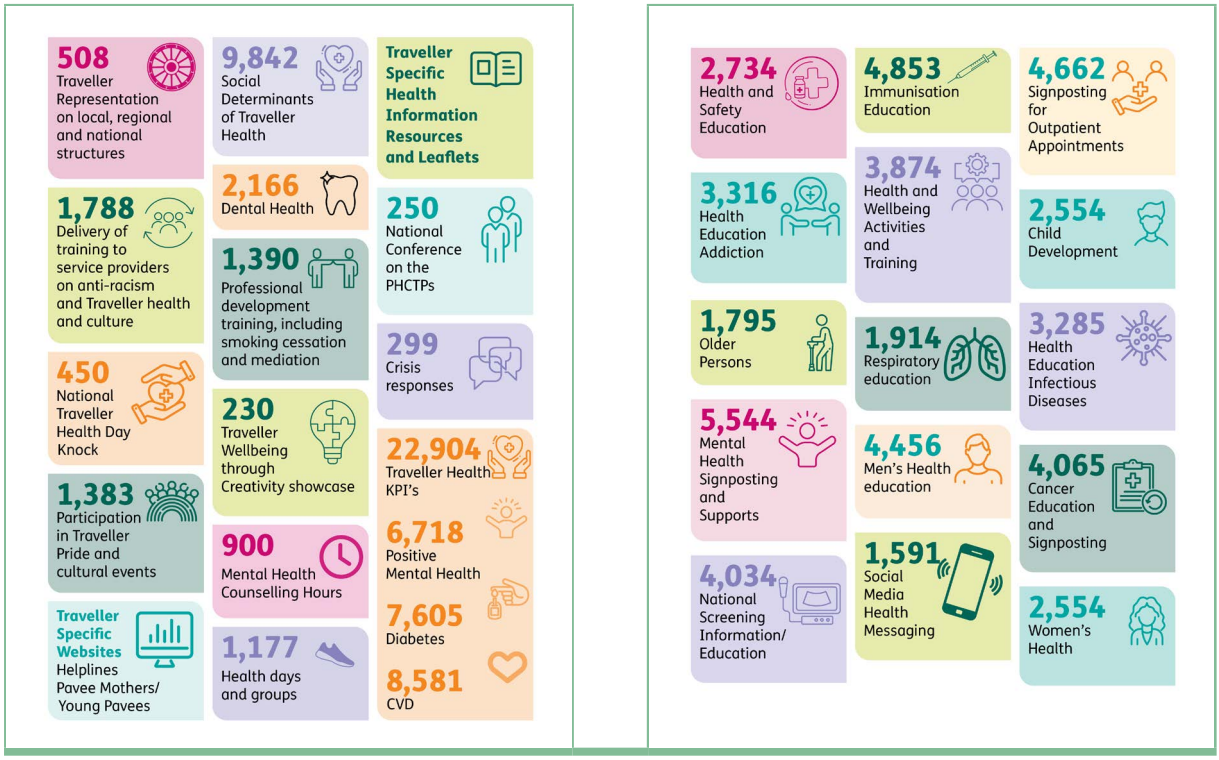
- Needs of the local population (which can vary between PHCTP)
- Services available in that area
- Needs of the service providers
- National health issues and emerging crises, e.g. responding to outbreaks of measles/ mumps/swine flu etc.

In 2025, a national report was compiled for THAF which captured the breadth of activity carried out by the PHCTPs during 2024.[30] The report provides a national flavour of the key activities reported by PHCTPs via THUs, as illustrated in Figure 4.

29 Eastern Region Traveller Health Unit (2009) Activities and work of Traveller Primary Health Care Projects in the Eastern Region Traveller Health Unit.

30 THAF (2025) National Traveller Health Advisory Forum Report: Summary of Key Activities of Primary Healthcare Projects for Travellers (PHCPTs) 2024.

Figure 4: Overview of PHCTP activities in 2024



The report highlights strategic achievements and ongoing efforts by the PHCTPs to promote culturally appropriate health provision and ultimately to reduce Traveller health inequalities.

THAF has committed to publishing an activity report annually and supporting the development of an agreed national reporting template for PHCTP data. At local levels, PHCTPs report activity data on quarterly and annual basis as part of funding arrangements. On a regional basis, depending on capacity, THUs publish their annual reports which contains activity data.

Subgroups

The NTHIG also convenes a number of associated working groups or subgroups (in areas such as KPIs, ethnic equality monitoring training, mental health, primary care, chronic diseases, etc.). Several relevant to this review include:

- **Ethnic Equality Monitoring (EEM) and Data** sub-group works to progress the implementation of the following actions from the National Traveller Health Action Plan (in line with NTHAP, Actions 10, 11 and 12)
- **HR workforce planning career progression** works to ensure that PHCTPs can attract and retain staff by addressing the barriers to recruitment and retention of staff. This involves developing a standard for pay and conditions that is consistently applied across the projects (in line with NTHAP Action 41).
- **Training sub-group** includes establishing an agreed baseline skills level for the PHCTPs workforce and developing appropriate tailor-made training solutions for TCHWs in the first instance, followed by Coordinators/assistant coordinators to meet baseline requirements (in line with NTHAP Actions 41, 43 and 45).

2.5 Research and evidence to date

The evidence base on PHCTPs spans three decades. Across this trajectory, the literature consistently reports that PHCTPs are an effective, culturally grounded model that improves Traveller engagement with health services, but persistent structural weaknesses continue to limit their potential. Early reports, such as the 1995 Project Report which provided a baseline survey, showed effectiveness and support for the model. The Task Force Report (1995) and the National Traveller Health Strategy (2002–2005) endorsed PHCTPs as the "cornerstone" of national Traveller health policy. Reviews from this period document improvements in health literacy, screening uptake, immunisation, maternal health, and service responsiveness.[31] They also highlight the cultural and relational role of TCHWs. Early warnings about inconsistent funding and lack of recognition for TCHWs also appear here.

Regional reviews, such as the Community Healthcare West report (2021), provide detailed insight into the model's everyday functioning and impacts.[32] These studies reaffirm strong community trust, improved access to mainstream services and cultural awareness within mainstream services, while documenting the emotional labour and "always-on" demands placed on TCHWs.

While the 2010 AITHS did not evaluate PHCTPs directly, it relied on them extensively for peer-data collection, reinforcing their reach and credibility. Evidence of impact in relation to health promotion is particularly strong within the study which found that 83% of Travellers reported that they received and responded to health information and advice from the PHCTPs and Traveller organisations. It also evidenced a higher uptake of screening among Travellers relative to the general population, for example:

- 25% of Traveller women had breast screening for cancer, compared with 13% of women in the general population
- 23% of Traveller women had a cervical smear test compared with 12% of women in the general population[33]

Evidence of the effectiveness of the TCHWs continues to grow. In 2020, the HSE published the National Covid-19 Traveller Service User Experience Survey in which respondents reported that their local Traveller project was the most highly used source to obtain information about Covid-19 (73%).[34] More recently, a national study of cancer awareness and attitudes among Travellers in Ireland (2025) reports that the key enablers to screening participation was speaking with the local Traveller Primary Health Care Worker (28%).[35]

Survey findings published by the European Union Agency for Fundamental Rights (FRA) highlight the persistent experience of discrimination among Roma and Travellers across Europe. In its 2020 survey, 65% of Travellers in Ireland reported experiencing discrimination because of their Traveller background in the previous 12 months (the second highest from the six countries surveyed), with 21% reporting discrimination when

31 McCabe C. & Keyes, F. (2005) A Review of Travellers' Health using Primary Care as a Model of Good Practice. Dublin: Pavee Point Travellers' Centre; Murphy, P. (2000) Primary Health Care for Travellers Project: Implementation Report 1996-1999. Dublin: Pavee Point & Eastern Health Board. Fay, R., Kavanagh, D. & Quirke, B. (1996) Primary Health Care for Travellers Project; Project Report for year ended October 1995. Dublin: Pavee Point & Eastern Health Board.

32 Gallagher, O. and Irwin, A. (2021) Community Healthcare West Peer-Led Traveller Primary Healthcare Programme Review; Quirke, B., Collins, M., Kavanagh, L. and Kelleher, C. (2023) *Review of the Primary Health Care for Travellers Projects (PHCTPs) in the Eastern Region.* Abstract presented at the 16th *European Public Health Conference*, 8–11 November 2023. European Journal of Public Health, 33(Suppl 2), ckad160.1126.

33 AITHS, 2010

34 National Social Inclusion Office (2020) National COVID-19 Traveller Service User Experience Survey. Health Service Executive.

35 HSE National Cancer Control Programme (2025) Summary of Findings: Cancer Awareness and Attitudes among the Traveller Community in Ireland. A co-designed study led by UCD in collaboration with Pavee Point Traveller & Roma Centre and the HSE National Cancer Control Programme (NCCP)

accessing health services in the previous five years. In 2024, the FRA repeated the survey and found that 75% of Travellers in Ireland reported discrimination in the previous 12 months—the highest rate among the countries surveyed and a 10-percentage-point increase since 2019—while 39% reported discrimination when accessing health services in the previous year.[36] This finding is consistent with the AITHS (2010) which reports over half (53%) of Travellers "worried about experiencing unfair treatment" from health providers, and the majority of service providers (67%) agreed that discrimination against Travellers occurs in the health services. The FRA also highlights that Travellers in Ireland are particularly affected by poor accommodation conditions, including leaking roofs, mould and damp walls, reinforcing the role of the social determinants of health in shaping outcomes. Notably, the collection of survey data underpinning the FRA reports was supported by the PHCTPs, providing a clear indication of the effectiveness and added value of the PHCTP model in building trust, access and participation.[37]

During the Covid-19 pandemic, the role of PHCTPs in raising awareness of public health guidance and supporting community-level responses was publicly acknowledged by the then Taoiseach, Micheál Martin, who recognised their contribution to mitigating the impact of Covid-19 within the Traveller community, stating "Your efforts in raising awareness of public health have contributed to mitigating the impact of the disease in the Traveller community."[38] Despite their impact, the TCHWs were excluded from receipt of the €1,000 Pandemic Special Recognition Payment (PSRP), often referred to as the "Covid bonus" for frontline health care workers.[39]

Despite evidence demonstrating the effectiveness of the model, Travellers continue to experience marked and persistent health inequalities compared with the general population. AITHS reported that suicide in the Traveller population was 6 times the rate of general population. Traveller men had 4 times the mortality rate of the general population and Traveller women had 3 times the mortality rate of the general population. Infant mortality was 3.5 times the national rate.[40]

More recent data indicate that these disparities have not been resolved. According to the 2022 National Census, Travellers continue to have a lower average life expectancy and higher fertility rates than the general population. Recently published analysis of administrative data from the Central Statistics Office (CSO) finds that the average age of death in 2023 in Ireland was 78.6 years for those reporting as White Irish, and just 58.5 for those reporting as White Irish Traveller. It also shows that suicide rates continue to be disproportionately higher. Over the five-year period 2019 to 2023, the average percentage of deaths for those who self-reported as White Irish was 1%, while for those who self-reported as White Irish Traveller, the average percentage of deaths due to suicide was around 9.4%.[41] This highlights how PHCTPs operate within an increasingly challenging structural context in which profound health inequalities persist.

36 European Union Agency for Fundamental Rights (2025). *Rights of Roma and Travellers in 13 European Countries: Perspectives from the Roma Survey 2024*. Luxembourg: Publications Office of the European Union.

37 European Union Agency for Fundamental Rights. (2020). *Roma and Travellers in six countries: Roma and Travellers Survey.* Luxembourg: Publications Office of the European Union.

38 Pavee Point (2021) Taoiseach Takes Time Out to Thank Travellers. Online [Available]: https://www.paveepoint.ie/taoiseach-takes-time-out-to-thank-travellers/

39 Stamp, S. (2025) *Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health Care Projects.* Dublin: Pavee Point.

40 AITHS, 2010

41 Central Statistics Office (CSO) Additional Insights into Deaths using Administrative Data 2023, CSO Frontier Series Output, 26 November 2025. Available at: https://www.cso.ie/en/releasesandpublications/fp/fp-aidad/additionalinsightsintodeathsusingadministrativedata2023/

The most recent phase of evidence has tended to focus on sustainability and system alignment. Preliminary findings from action research undertaken by Genio identified a number of challenges for PHCTPs — typical of peer worker roles — including access to clinical support, operating without clinical responsibility, capturing health impacts, limited supervision structures, recruitment and retention difficulties, managing professional boundaries, and navigating a complex and changing health system on minimum working hours. At the same time, the research identified clear examples of approaches that were working particularly well within the Traveller health sector, highlighting strengths in areas such as access, advocacy and signposting; the significance of PHCTPs during Covid; the role of PHCTPs as cultural mediators; and strong connections with mental health services and primary care.[42]

Responding to a call from NTHAP for a 'nationally consistent approach across' the PHCTPs, a report was commissioned in 2024 to develop a standard framework which described the vision, values, mission, strategy structure, and operational systems of PHCTPs.[43] This *Standard Framework for PHCTPs* synthesised thirty years of learning into a coherent model of practice, values and structure, and places PHCTPs within the broader context of Sláintecare, ECC and RHA reform.

A recent scoping report, *Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health* commissioned by Pavee Point demonstrates that the primary risk to the model now lies in workforce sustainability.[44] Low pay, limited hours, poverty traps, inconsistent terms and conditions, and the precariousness of medical card eligibility have created recruitment and retention challenges at scale.

The NTHAP highlights that Travellers experience poorer physical and mental health outcomes across the life course due to intersecting social determinants, including poverty, insecure and inadequate accommodation, racism and discrimination, and limited educational and employment opportunities. The Department of Health has endorsed the NTHAP as a mechanism for aligning its strategic priority to improve access to healthcare for socially excluded groups. Sláintecare similarly recognises that the health status of marginalised populations, including Travellers and Roma communities, is shaped and compounded by these wider social determinants.

Within this policy context, PHCTPs represent an established, community-embedded mechanism for addressing the social determinants of health through peer-led health promotion, system navigation and intersectoral working. The 2025 Sláintecare and Programme for Government further seek to strengthen this approach through the establishment of five projects within Sláintecare Healthy Community areas, aimed at tackling the social determinants of health affecting Travellers.[45]

42 Cahill L. & Lally, N. (2024) The role and function of the PHCTPs: Genio Action Research Findings. A summary paper submitted to the National Social inclusion Office (NSIO).

43 Crowley, N. (2024) *A Standard Framework for the Primary Healthcare for Traveller Projects (PHCTPs).*

44 Stamp, S. (2025) *Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health Care Projects.* Dublin: Pavee Point.

45 Government of Ireland (2025) *Path to Universal Healthcare: Sláintecare & Programme for Government 2025+.* Dublin: Department of Health, 14 May 2025.

Section 3: Review Methodology

This section of the report outlines the review aims, the methodological design employed for the review, the approach to data collection and analysis, and highlights strengths and limitations of the research. Please see Appendix 2 for a detailed and comprehensive breakdown of how each objective was addressed in terms of the review question, the methodological approach and the relevant section of the report where it is has been presented.

3.1 Review objectives

The National Oversight Group for the Review set out several objectives for the review (See Appendix 2). These can be broadly summarised as follows: [46]

- Document the impact of PHCTPs and TCHWs, including participation, empowerment, confidence, and progression, from the perspective of Traveller community members and other key stakeholders.
- Examine experiences of engagement with PHCTPs across HSE providers, voluntary organisations, academic institutions, Traveller Health Unit Coordinators, Social Inclusion Managers, and senior policy stakeholders.
- Explore perspectives from organisations hosting PHCTPs and assess PHCTP contributions to addressing social determinants of health.
- Review the PHCTPs to identify strengths, challenges, gaps, and future support needs.
- Produce a final report on the analysis of these findings including an outline framework for the ongoing monitoring of the achievements, challenges, enablers, gaps and support needs for their strengthening, sustainability and future development of the PHCTPs.

To help guide the review, these objectives were operationalised into the following consolidated **research questions**:

- What is the perceived value, role, and impact of the PHCTPs?
- How can the PHCTPs be sustained and strengthened into the future to support ongoing monitoring and reporting?

The review was approached as formative in nature with a focus on reviewing and documenting the context, experience and process of operating PHCTPs. The design employed qualitative, participatory methods and aimed to generate information, findings and recommendations that help to improve the PHCTPs and strengthen them into the future.

3.2 Sampling

Given the timeline of the review and factors associated with an external researcher accessing the Traveller community, the Working Group assisted with selection and recruitment of participants for the research. As is typical in qualitative research, a purposive sampling approach was used to select participants who had a depth of knowledge about PHCTPs and could provide rich insights.[47] The sample size (i.e. the number of participants recruited to take part in interviews and focus groups and surveys) is not guided by a need to be representative, but by the need to capture the breadth of possible explanations. Put simply, the researcher can stop recruiting participants once data saturation is reached (i.e. the point at which participants/cases no longer add new knowledge). In this sense, the spread and variation of the sample is more important than the number of participants.

46 Additional objectives and fieldwork were added to the review beyond what was included in the original tender or proposal - denoted in Appendix 2.

47 A purposive sample consists of individuals who have been intentionally selected because of their ability to elucidate a specific theme, concept or phenomenon. See: Robinson, O. C. (2014) Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, 11(1), 25– 41. https://doi.org/10.1080/14780887.2013.801543

3.3 Data Collection

Extensive stakeholder consultation was carried out and incorporated a range of qualitative methods, as illustrated in Figure 5.

Figure 5: Overview of stakeholder consultation conducted for the review

Method	PHCTPs*	Travellers	HSE	DoH	Wider Stakeholders (C&V, Academics)
Focus Groups	✓		✓		
Workshops	✓				
Interviews	✓	✓	✓	✓	✓
Qualitative Surveys	✓		✓		✓

In total, an estimated **150 participants** took part in the review either through qualitative surveys, interviews, workshops or focus groups. Representation from PHCTPs was particularly strong with **80 TCHWs** from across Ireland participating either through workshops and/or focus groups, and a total of 15 managers from PHCTPs (i.e. project coordinators / managers of Traveller organisations) through workshops, interviews, focus groups and/or surveys.[48]

National Workshops with TCHWs

All organisations that have a PHCTP were contacted by Pavee Point, on behalf of the National Traveller Health Network, to invite two representatives from each PHCTP to travel to Dublin to attend a national workshop. The first workshop with TCHWs was conducted on 9th September and a second workshop on 8th October 2025.

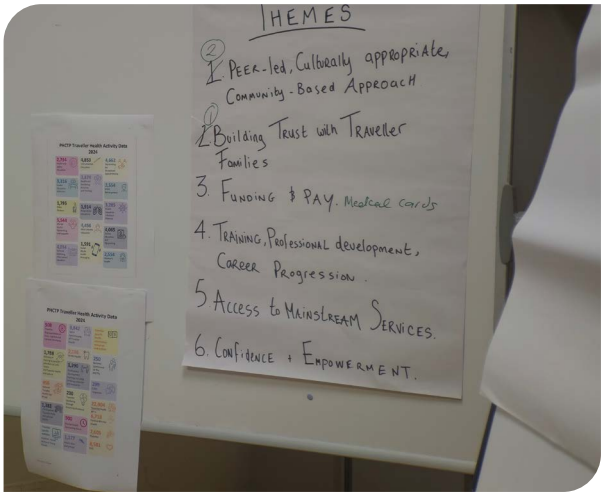
The theme of the first workshop was “looking back” with the aim of capturing the value and impact of the PHCTPs from its origins to date; the theme of the second workshop was “looking forward” with the aim of capturing how participants would like to see the PHCTPs in the future and which activities they perceived as most important. The second workshop was also an opportunity to present preliminary findings and themes to sense-check them with the participants.

48 Figures for TCHWs participation is presented as a best estimate. There was likely duplication between participants who attended the National Workshops and also took part in the focus groups at the rural and urban sites. The estimate of 80 TCHWs has attempted to control for potential duplication across methods.

For consistency, individuals who attended the first workshop were encouraged to attend the second workshop also. The workshops were participatory in their design incorporating:

- Photo elicitation
- Strengths, Weakness, Opportunities and Challenges (SWOC) analysis
- Spider graphs
- River of Life and Journey Mapping exercises
- Sense-checking of preliminary findings (themes)
- Reviewing and prioritising the activities of the PHCTPs and identifying the potential outcomes from those activities to inform the monitoring framework.

Peer researchers were largely used to facilitate the workshops and to take notes in each session. The peer researchers were typically TCHWs or staff from the PHCTPs or Pavee Point. Members of the Working Group also took part in facilitation or attended the workshop to provide support. Literacy challenges were taken into consideration so that the workshops were as accessible and inclusive as possible.



Key informant interviews

Several key informant interviews were conducted. The interviews were semi-structured with a focus on the participants experience and perspective on the following topics:

- Role, value and impact of the PHCTPs
- Current approaches to monitoring and suggestions for improvement
- Success / strengthening of PHCTPs into the future.

Purposive sampling was used to identify key informants who were invited to take part in interviews for the review.

The purpose of the review was explained to participants, as well as how the data would be used. A participant information leaflet was shared in advance and written consent obtained. Generally, key informants were given the choice of being named or de-identified. De-identification protects confidentiality and allows participants to speak openly, reducing personal or professional risk. However, in some cases key informants were contributing in a specialist capacity and either expressed a preference to be named based on their expertise or could not be reasonably and meaningfully de-identified through aggregation due to the specificity of their role. These were:

- Aisling Heffernan, HSE Integrated Healthcare Area Manager Dublin South and Wicklow and Chair of the National Traveller Health Implementation Group
- Dr Ciara Bradley, Associate Professor of Applied Social Studies, Maynooth University is a community work educator and social scientist, and a former community development worker with Galway Traveller Movement.
- Martina Queally, HSE Regional Executive Officer, Dublin and South East

This was discussed and agreed between the interview participant and the researcher at the outset of the interview. Interviews were conducted online using MS Teams and were recorded for accuracy and analysis. They lasted approximately 1 hour on average.

Interviews and focus groups with urban and rural sites

Two sites were selected as urban and rural cases. These sites were selected as existing models of good practice and identified by the National Oversight Group. They provided depth and further context for understanding how the PHCTPs operate, and to document the experience of staff and Travellers who engage with PHCTPs in those areas. They were not intended to be representative of the breadth of 31 PHCTPs currently in operation across Ireland.

Background interviews were conducted with managers at these PHCTPs at the early stages to help inform and shape the review. These sites also provided literature (e.g. reports, research, administrative documentation) that have been incorporated into this review.

To provide a “service user” perspective, Travellers with experience of engaging with PHCTPs and mainstream services were identified by the PHCTPs for short (30 minute) semi-structured interviews.

Interviews and focus groups at the urban and rural sites were conducted in-person, and were audio recorded for accuracy and analysis. The purpose of the review was explained to participants in advance, and how their data would be used and deidentified. A participant information leaflet was made available and written (or oral) consent was obtained.

Qualitative Surveys

Qualitative online surveys were conducted using MS Forms. Three customised surveys were designed for the following stakeholders groups:

(i) A purposeful sample of HSE staff from the urban and rural sites who had experience of engaging with the PHCTPs.

(ii) All organisations that have a PHCTP

(iii) A purposeful sample of academic representatives and C&V sector stakeholders with experience of engaging with the PHCTPs

An invitation and link to the survey was disseminated to stakeholders by the Working Group, HSE NSIO and Pavee Point to target the stakeholder groups. The survey was available for a period of approximately five weeks. The survey was conducted anonymously, and no identifying information was retained.

3.4 Thematic Analysis

Thematic analysis of qualitative data was carried out following Braun and Clarke's (2012) approach.[49] This involves an inductive approach - a "bottom-up" method for finding patterns across the dataset, which included:

- Fieldnotes from workshops
- Written materials from workshops (e.g. post its, flip chart notes etc)
- Transcripts from interviews and focus groups.
- Qualitative data from surveys (predominantly open text comments)

The data was coded by the researcher and themes were reviewed, defined and named. In line with an action research, participatory approach, the development of the themes was conducted iteratively and collaboratively with the Working Group and the TCHWs, as follows:

- Preliminary themes and topics were identified by the researcher from data collected at the first national workshop with TCHWs.
- These themes were presented to the Working Group who provided feedback and refinement.
- The themes were then presented to the TCHWs at a second national workshop and discussed in small groups as a means of "sense checking" and further development.
- The researcher used these preliminary themes to being to analyse and incorporate the remainder of the data gathered (e.g. focus groups with THU coordinators, key informant interviews, survey data etc).

Coding and analysis were conducted using the qualitative software package, MAXQDA.

49 Braun, V. & Clarke, V. (2012) Thematic analysis. In H. Cooper, P. M. Camic, D. L.Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds), APA handbook of research methods in psychology, Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological (pp. 57-71). Washington, DC: American Psychological Association.

3.5 Strengths and Limitations

There were several strengths of this research that should be highlighted:

- The multi-stakeholder design enabled a rich and comprehensive understanding of the PHCTPs nationally.
- Triangulation across workshops, site visits, interviews, focus groups, surveys, and documentary analysis strengthened the validity of findings and allowed convergence of evidence from multiple perspectives.
- The inclusion of a breadth of stakeholders including TCHWs, Traveller organisations, HSE staff, Local Development Company staff, HSE Social Inclusion Managers, THU coordinators, and other external stakeholders enabled diversity in experience and insight, helping to surface shared themes across groups
- Fieldwork and analysis were primarily undertaken by a single researcher[50], which ensured strong consistency and depth of insight. Feedback and consultation with the working group provided opportunities for cross-checking the design and preliminary findings.
- Participatory approaches, peer researchers and the support of Traveller organisations helped to build trust, reduce barriers to contribution, and enhance the authenticity of the data.

However, several limitations must be acknowledged:

- Time constraints and varying levels of capacity across organisations (owing to planned and/or unplanned community events such as illnesses or bereavement) may have affected participation meaning that some regions or groups are less represented than others.
- There were several recent and ongoing research projects and reviews that may have contributed to additional burden and research fatigue among participants.
- The research relied primarily on self-reported data, which may be influenced by social desirability or organisational sensitivities
- The absence of routine quantitative outcome data also restricts measurement of change over time. While the design prioritised depth and contextual insight using qualitative methods, these factors limit generalisability and highlight the need for a future monitoring framework that supports systematic data collection nationally.

50 With the exception of the THU focus group which was conducted by another consultant. In that instance, the lead researcher was debriefed and the recording and notes were reviewed.

Section 4: Review Findings

This section of the report presents findings from a thematic analysis of the qualitative data collected during this review, with a brief discussion towards the end. Descriptive findings from the National Workshops and the qualitative survey are presented in Appendix 3 and Appendix 4 respectively.

Thematic analysis was conducted on the full breadth of **stakeholder groups**, including:

- Travellers (refers to Travellers who have engaged with PHCTPs and use mainstream health services)
- TCHWs
- PHCTP coordinators and assistant coordinators
- Traveller organisations
- HSE staff (including senior level management/ leadership, mid-tier level and operational / clinical delivery level)
- Academics and Community and Voluntary (C&V) sector
- Department of Health

The **sources of qualitative data** included in the analysis were:

- Transcripts from interviews and focus groups
- Fieldnotes from workshops
- Written materials from workshops (e.g. post its, flip chart notes etc)
- Qualitative data from surveys (predominantly open text comments)

Presentation of thematic analysis

Six themes were identified based on the analysis and are presented around the key topics, as they relate to the research questions, which are (i) value, role and impact of PHCTPs, and (ii) sustainability and development of PHCTPs, including monitoring and reporting.

Figure 6: Overview of topics and themes

Topics	#	Themes
Value, role and impact of PHCTPs	**1**	Building trust through a peer-led model
	2	Confidence and empowerment of Travellers and TCHWs
	3	Addressing the Social Determinants of Health
Sustainability and development of PHCTPs	**4**	Precarious funding and employment structure
	5	TCHW role, scope and career progression
	6	Monitoring and reporting

It should be noted that the themes identified from the data are inter-related and will overlap. They are not intended to be mutually exclusive. PHCTPs are a complex programme operating within a complex setting. The themes developed and presented here are for clarity of reporting and are informed by the issues and topics that were emphasised by participants.

Frequency and weighting of responses

In presenting the qualitative data from the review, it should be noted that stakeholder responses are not quantified precisely. Response levels varied across the stakeholder groups. Some issues may have been mentioned by a relatively small set of participants; however, the weight of these issues and the "why" was taken into consideration in reporting the findings. For example, as the DoH requested this review, their perspective carried particular strategic significance for the future monitoring and strengthening of the PHCTPs. It is therefore important to note that, in line with good practice in qualitative research, the issues and themes explored in the interpretation of the findings were only partially informed by volume or frequency of responses.

4.1 Value, role and impact of PHCTPs

The first three themes examine the value, role and impact of the PHCTPs from the perspective of those most closely engaged with them. These themes draw primarily on the accounts of TCHWs and Travellers, as they are uniquely positioned to describe the day-to-day work of the PHCTPs and its effects on individuals and families. While insights from other stakeholders are incorporated, the most detailed and experience-based descriptions of impact come from these two groups, and their perspectives form the core evidence base for these three themes.

Theme 1: Building trust through a peer worker model

As identified in the AITHS, only 41% of Travellers expressed complete trust in health professionals, compared with 82% of the general population.[51] A central theme emerging from the review is the pivotal role of the peer worker model in establishing trust. This includes trust in the TCHWs themselves and in their role as intermediaries who support signposting to services. Crucially, this trust also extends outward, to build between Traveller communities and health professionals, and with mainstream services more broadly. It is important to consider the need and value of building trust in the context of the body of evidence indicating that Travellers experience significant discrimination when accessing health services.[52]

Establishing trust

TCHWs consistently reported that trusting relationships were fundamental to their work recognising that trust takes time to build, especially with new families or families in standard accommodation. Long-standing TCHWs described how they build trust over years. They spoke about how access and trust was developed in the early days of the PHCTPs by connecting with the children.

> *"You know you got the children friendly with you, right? [They] get friendly with you... that relationship with the children and with the fathers and mothers and the families, that's very important."*
> **(Focus group with TCHWs, Urban).**

51 AITHS, 2010

52 European Union Agency for Fundamental Rights (2025). *Rights of Roma and Travellers in 13 European Countries: Perspectives from the Roma Survey 2024.* Luxembourg: Publications Office of the European Union.; European Union Agency for Fundamental Rights. (2020). *Roma and Travellers in six countries: Roma and Travellers Survey.* Luxembourg: Publications Office of the European Union

Sustained and consistent engagement

TCHWs were keen to emphasise that consistent **follow-up** and follow-through with families was very important for building trust and confidence. TCHWs often live within the community and "on site" which means they are accessible, visible and responsive to the community around the clock.[53] As one manager of a Traveller organisation explained:

> *"The speed at which our team can react to a crisis - the community can reach us 'out of hours' in an emergency."*
> **(Survey of Organisations that have PHCTPs).**

The responsiveness of PHCTPs to crises was perceived by stakeholders as hugely beneficial but it was also recognised that this places significant demands on the TCHWs which will be discussed further under Theme 5: TCHW role, scope and career progression.

Peer model and reach

Participants described how TCHWs create safe, non-judgmental spaces where sensitive issues like mental health, suicide, and domestic violence can be discussed and where Travellers feel like they are understood and supported. As illustrated by a Traveller woman:

> *"For myself, I find that you're not being judged ... with the primary health care women, ...because you're getting judged so much when you go somewhere else mainstream. It's like ...you're always having to justify your culture. Where [as] these women [TCHWs] are coming in, and they're part of your culture and they totally understand where you're coming from. Now, we might have different ways of doing things, but there's still no judgement there. And you feel supported. And you do know that they're invested in you."*
> **(Interview with Traveller woman, Urban)**

This was echoed by TCHWs who described how they were uniquely placed as Travellers to adopt a non-judgmental approach and to understand the context and conditions within a family's environment:

> *"A settled person might go onto that site and look at it as an overall picture that this is very bad accommodation for children to be living in. But we go on [site] and we see the comfort, say, we can look [beyond] the puddle of water on the ground, that the children are well looked after..."*
> **(Focus group with TCHWs, Urban).**

The broad reach and access to Travellers is often cited as a benefit of the PHCTPs, as one TCHW commented:

> *"They [HSE staff] need us to bring them on sites. They'd never be able to walk onto the site and introduce [themselves]...You just you wouldn't have it. So, if anyone does want to go onto the sites, [its] through ourselves."*
> **(Focus group with TCHWs, Urban).**

53 Living within the community can refer to TCHW living in halting sites, group housing schemes and in some instances, at the side of the road.

Comparing their reach and access to HSE staff, TCHWs also point out that they *"get information that I don't think anybody else would be able to get"* (FG TCHW urban). The academics surveyed as part of this review also commented on the invaluable reach that TCHWs provided, as one respondent explains:

> *"They enabled us to collect important data from Travellers that would not have been possible otherwise. Following the training we provided, they efficiently and effectively co-ordinated the data collection and ensured that the data and informed consents were returned to us in a timely manner."*
> **(Survey respondent, Academic)**

It is arguably the trust that TCHWs have built with the individual and families that enable them to collect information. The TCHWs also described examples of where their local knowledge and networks helped HSE staff to identify families when needed, particularly where families had moved out of an area. Highlighting the value of their combined reach, local knowledge and local networks.

The DoH endorsed the peer model approach as a core principle of social inclusion, stating:

> *"I can understand why you would want to have Traveller peer workers in service delivery for marginalised groups…the department completely understands that. It's a principle for us. Service user involvement and peer working is part of that. [And we] fully buy into that…I think the Traveller projects embody that. It's the whole issue of cultural mediation, health mediation between a group that may be very disadvantaged [and] have certain suspicions against the health service structure. [We] completely support and agree to that."*
> **(Interview with DoH representatives)**

Privacy and confidentiality

In terms of the value of PHCTPs, Travellers consistently pointed out the professionalism of TCHWs in terms of maintaining privacy and confidentiality around their personal, family or health issues.

> *"Whatever I discussed with the primary healthcare women coming to my home, I never heard it from next door. It was always kept very confidential."*
> **(Interview with Traveller woman, Urban)**

This was explained as important in terms of establishing trust and openness:

> *"I've been open and honest with them because…I've never heard of any of my personal information coming back. You know, so I trust it. And also as a Traveller woman [there would] be certain issues that you can't really talk to anyone else about."*
> **(Interview with Traveller woman, Urban)**

This enables open discussions on sensitive topics like mental health, addiction, domestic violence, and gynaecological health, which Travellers would not readily share with others.

> *I wouldn't open up to them [HSE staff or member of settled community]. I wouldn't be able to sit and talk. I'd be more or less, 'Oh, yeah, there's somebody else coming, with something different thing to tell me'. But because it is Travellers that's working with us, we understand each other and we can talk freely the way that we like to talk to them, because we understand more…We understand our own language and we understand…Will you feel down today? Well, how are you today? But if a stranger came in, we'd sort of bypass that.*
> **(Interview with Traveller woman, Rural).**

This was also reported by TCHWs as an aspect of their professionalism that they recognised as valuable and imperative to how they do their work.

Trusted source of health information

Findings suggest that trust of the TCHWs extends to the health information and messaging that TCHWs share with Travellers. For example, in the case of improving vaccine uptake and addressing vaccine hesitancy:

> *So when it comes to the vaccines for the children, Travellers had an awful thing out there that [the vaccination] was causing autism. But as primary healthcare workers, we know it's not coming from the vaccines. We know there's children out there that never got vaccinated in their lives, and they have autism. And we are breaking that down now and explaining to the families, because they're not believing the nurses, they're not believing the government. They're not believing. But we are going in telling them. And they believe us, and they know that we wouldn't tell them lies.*
> **(Focus group with TCHWs, Urban).**

This suggests it is the value of TCHWs as a trusted source of health information, rather than the messaging in and of itself. Several participants also discussed this in the context of vaccine uptake during Covid-19 and cited the research suggesting that the vast majority of Travellers obtained information about Covid-19 through their local Traveller project.[54]

Psychosocial support

Participants collectively emphasised the role of the PHCTPs in addressing serious concerns like suicide, depression, and addiction. Again, the peer-led approach is reported to be a critical in, for example, TCHWs provided a culturally appropriate response at times of crisis, such as in the case of suicide, as one participant explained:

> *…Because you're a Traveller yourself, you can almost understand, and you can use different words to comfort and stuff like that. So, I think it is very important. You know what to say, and what you can't say.*
> **(Focus group with TCHWs, Urban).**

54 National COVID-19 Traveller Service User Experience Survey found that the majority (86%) of respondents reported that they accessed COVID-19 health information from Traveller organisations/THUs. Source: National Social Inclusion Office (2020) National COVID-19 Traveller Service User Experience Survey. Health Service Executive.

Relationship building with HSE Staff

A purposeful sample of HSE staff were surveyed across the urban and rural sites selected for this review. These respondents reported a lack of trust as a key barrier to engaging effectively with PHCTPs (and conversely cited building trust as a key enabler to effective engagement). As one respondent commented: *"[The PHCTPs are] slowly reducing the fear the Traveller community have with our health service", adding that the PHCTPs are "... slowly making the health service aware of Traveller's health needs, [and] the appropriate tools and resources to support [them]" (HSE Staff survey).* See Appendix 4: Summary of Qualitative Survey Findings for further description of findings for this group.

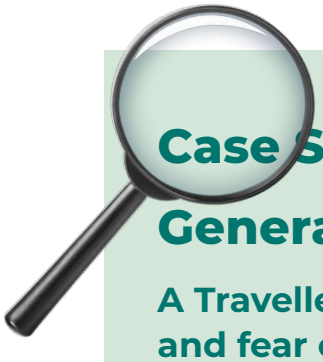
Generational trauma and mistrust

TCHWs pointed out the value of PHCTPs and the peer worker model in the context of Travellers experiences of institutional racism and discrimination within health and social care services in Ireland, and the **generational trauma** passed down within the community. In a discussion around HSE staff visiting the homes of Traveller families, one TCHW states:

> *"Travellers in general have an inbuilt mistrust of people pulling up and getting out of cars with this carry on, and [coming] into your house...if you come out with a pen and paper. If you come out with a bag that looks like computer [bag] or something like that...or even a strange car... [people think] she's up to no good. What's she doing with the information I'm giving her?"*
>
> **(National Workshop 1, Focus group 2 with TCHWs)**

Within this discussion, another TCHW further explained how their work provides an opportunity to potentially address some of that trauma, as TCHWs represent a trusted link between Travellers and mainstream health services:

> *"To my memory before [PHCTPs], you didn't have that link. Traveller community health workers and projects are now that link between organisations. There has been that much trauma, generational trauma within the health service towards Travellers, within the education institutions towards Travellers. The Travellers are fearful... I'm sure down through generations [we've all] had some experience with that. My own mother had [over 10] children and they were put into care. They were sexually, physically and emotionally abused in care. So, there's those traumas. So, when you see somebody getting out of their [car] with their briefcase...it's triggering. Its triggering."*
>
> **(National Workshop 1, Focus group 2 with TCHWs).**



Case Study Vignette #1: Generational trauma and mistrust

A Traveller woman described how deep-rooted mistrust and fear of judgment influence her decisions about engaging with mainstream health services. She explained that, as a community, past negative experiences and perceptions of authority figures create anxiety around speaking openly with HSE staff, particularly due to concerns that other agencies, such as Tusla the child and family agency — might become involved.

> *"Well, if HSE staff called into my home for some reason - due to the past of where Travellers have been treated - I'd feel that they were judging me. And they might never be. It's just all of that authority because they're in a certain government position. Like if Tusla came into my home I'd be the same...*
>
> *There's a fear. And it's not that they're here to judge you, it's just that we have a misunderstanding of why they're coming into the home...Even if they're coming in about health, I don't think I'd open myself up as much because I might be afraid. In case they say, look, are you fit enough even to look after your children if you're that sick?*
>
> *Where[as] I can have that conversation with [TCHWs] and I can say 'I'm worried about such a thing', and 'would you think I should tell my doctor?'...*
>
> *If the HSE did come into my home, I'd be afraid that they'd bring in other agencies into my home and judge me. That's the way I would feel."*
>
> **(Interview with Traveller woman)**

This case study vignette highlights how perceptions of risk and institutional authority can act as barriers to help-seeking behaviour and general engagement with health and social care providers.

This woman's account illustrates the extent to which fear of judgment by authorities pose a barrier to building trust and engagement with mainstream health services. This example highlights why trusted peer-led relationships within PHCTPs are critical for creating safe spaces to discuss sensitive health concerns and for Travellers to seek support.

Theme 2: Confidence and empowerment of Travellers and TCHWs

As outlined in *A Standard Framework for the Primary Healthcare for Traveller Projects (PHCTPs),* the PHCTPs work to 'build the knowledge, skills, consciousness, analysis and confidence within the Traveller community, that would support Traveller involvement in advocating on and engaging with health issues and the social determinants that influence their health and create the conditions for their self-determination over their own health'.[55]

Indeed, many participants in this review described how PHCTPs have played a role in increasing confidence and empowerment within the Traveller community and how this has enabled greater self-determination over their health and in their engagement with health systems.

Internalised stigma

A former PHCTP coordinator, remarked that in the past when Travellers encountered a health professional they didn't understand, they would blame themselves. However, since the establishment of the PHCTPs, she has observed that:

> *"[Travellers have] learned that health is about them and they shouldn't be apologising because they didn't understand. The person explaining has to use a language that is understood by people."*
> **(Interview with former PHCTP Coordinator).**

Indeed, a Traveller woman echoes this when describing how she has learned to engage with mainstream services. She describes her willingness to self-advocate to ensure she can access clear and appropriate health information, despite carrying a sense of fear or suspicion of mainstream services:

> *"It gives you encouragement to go to your doctor to say, look, you're like anybody [any] patient coming through that GP services. You're allowed to ask a question. Don't be afraid and build up your confidence...It actually builds up your confidence. Because like sometimes you might go into a service, especially clinical, and you feel a bit paranoid for some reason because you're a Traveller, you just carry that with you. But I find because you're talking to women [TCHWs] that talk about health and it gives you that much confidence to say, 'look, I'm the same as this person sitting next to me, you're going to have an issue as well. You're going into doctor, so speak up'!"*
> **(Interview with Traveller woman, Urban)**

Role models

A key benefit of the PHCTPs cited by participants was how TCHWs act as role models in the community helping to build the confidence of Travellers. As one TCHW remarked this confidence within the community has grown over time:

> *"We're in a better place than we were going back when [the PHCTPs] started because of the engagement, the confidence within the Traveller community, the confidence that the women have built up*

55 Crowley, N. (2024) *A Standard Framework for the Primary Healthcare for Traveller Projects (PHCTPs).*

within it, that have gone into different roles [such as] community development, leading out different programmes, you know, being more confident and able to speak for themselves. Many years ago... when you go into a room and you might have one or two Travellers there, [they] wouldn't say anything because we were overpowered at all times. The confidence wasn't there. But now the confidence has been built and you see a lot more younger [Travellers] engaging as well, which is needed. So I really think without the primary healthcare projects, Travellers would be lost."

(National Workshop 1, Focus group 1 with TCHWs)

Participants across stakeholder groups described how TCHWs have become role models and leaders within Traveller organisations and their community. As one THU coordinator explains, '[TCHWs] are central as not just a link person to other Travellers, but in terms of empowerment and leadership within the organisations' (THUC focus group). HSE Regional Executive Officer, Martina Queally reflects on the impact of the PHCTPs that she has observed over her career spanning frontline services to senior management, including former Chair of NTHIG, remarking that:

"*[Over the course of my career], from my perspective...working as a frontline clinician right up to senior management, when I visit the primary health care projects, the Traveller women and men working on the projects are well able to speak for themselves and articulate and advocate on behalf of their communities.*"

That was not the case 20 years ago. They're quite comfortable attending meetings and addressing issues that are pertinent to their community. That's a sea change." (Interview with Martina Queally, HSE Regional Executive Officer)

Education, as part of the career development of TCHWs, plays an important role in the empowerment of Travellers and contributing to the development of role models within the community. As Martina Queally adds:

"*The HSE has worked with Traveller organisations to create opportunities for education ...here in the East with Maynooth University [if you] talk to the Travellers who have participated in education and some who have completed third level, that changes the experience. It creates a set of circumstances for other younger Travellers when they can aspire to that.*"

(Interview with Martina Queally, HSE Regional Executive Officer)

TCHWs themselves strongly expressed the value of obtaining qualifications and training throughout their career, pointing out the ripple effect this has within their family and community:

"*Even with our professional development ourselves and doing training ourselves, it's a ripple effect to our own family, to our own community... because then people in our own community know education is power.*"

(Focus group with TCHWs, Rural)

This development of role models is important not only in terms of aspiration and empowerment within the Traveller community, but also as a means of challenging stereotypes and discriminatory beliefs held among health and social care professionals and the wider population. As one survey respondent stated:

> *"The TCHW team are role models - working, independent, furthering education, gaining recognition for their expertise within and external to our community...The impact a knowledgeable, skilled team make at meetings with key stakeholders cannot be underestimated.*
>
> *Some service providers have never met a professional Traveller woman. We are challenging stereotypes, low expectations and outdated and discriminatory beliefs that all Traveller women are weak, uneducated, oppressed. This helps the service providers relationship with their Traveller clients - they learn to treat everyone as an individual rather than a homogenous group."*
>
> **(Representative from a Traveller Organisation, Survey of Organisations that have PHCTPs)**

Participants described how PHCTPs empower individuals to advocate for their rights, challenge discrimination, and make informed decisions about their health. TCHWs described empowerment through their role, acting as advocates and leaders within their communities and in interactions with external bodies. They actively participate in committees and forums at local, regional, and national levels to represent Traveller issues. It should be noted, however, that tokenistic representation was identified as a potential challenge in this context, with concerns that issues raised by the Traveller representative are not always meaningfully engaged with or acted upon. Nonetheless, the ability to play an active role in influencing policy, and challenging discrimination is an important part of the PHCTPs and demonstrates its value for Travellers, the health system, the wider community and society.

Case Study Vignette #2:

"Getting to the front door" - Building confidence to access mainstream services

The following vignette illustrates how TCHWs built up a Traveller women's confidence, trust and knowledge over time which resulted in her feeling encouraged to seek screening and care within mainstream health services:

> *"With the primary health care women coming to my home, it was very ideal because...there was a little bit [of] embarrassment there sometimes about certain tests that a woman would have to go [for] and come to a certain age. So especially the smear test and a breast examination, I [was] very fearful about them.*

But when the primary care women came in and I had my own little private chat in my own home, where I felt safe and I knew the women, I built up a relationship with them coming into my home. I was kind of brave enough to say, 'Girls, will you explain to me what is a smear test?' And that's going back about 15-20 years ago. But I had the confidence because I knew them.

I was the very same with getting a breast examination. And I remember going on the bus one time with [TCHWs] for a breast examination. The first time it was kind of ever set up. And they actually did find when I eventually got to the doctors...they referred me to the hospital because they found a lump...It was a frightening experience. But to cut a long story short, one: I wouldn't have ever went and found that lump, and two: it wasn't cancerous, thank God! But there was a good ending to it. I did get a biopsy done. [It] had to be taken away. I look back at that as a very good story to tell.

I would have kept that worry in me that the doctor would have found a lump, and I wouldn't have done nothing about it. It would have been left here. So for me, it was the actual encouragement that I got off the [TCHW] women."

(Interview with Traveller woman)

This woman's experience reflects how effective engagement in preventative care is driven not only by clinical expertise or even the availability of screening, but by the broader context in which the preventative care is provided. This is achieved well before the woman ever considers getting a breast examination through TCHWs developing a supportive and trusted relationship with her over time.

The following narrative provides a HSE perspective on the value of the careful and complex work that TCHWs do to reduce barriers to accessing services:

"*The HSE has Enhanced Community Care programmes targeting cardiac disease diabetes and respiratory disease right across the country. We know that Travellers experience higher levels of chronic disease and while, without an ethnic identifier, it's very difficult to say how many Travellers access these services, I am aware of one instance where the Social Inclusion Manager worked with the local chronic disease hub and the PHCTPs to encourage Travellers to attend. The challenge was to support the Traveller community to overcome significant fear regarding attending the clinic and the peer-to-peer support was critical to overcome this barrier. Starkly, all but one of the people who attended needed to be seen.*

This is not quick work. Sometimes when I hear people talking about access and I hear them talking about signage or booking of appointment times being made easier or service information being easier and simpler to read/understand - these are all

really important activities that serve the whole population, whether it's the structural environment of your buildings; ease of reference around navigating a building; or flexibility and ease of appointment times. The people, systems and signage that support service users navigating a building are really important but they're simply the front door access issues.

The more fundamental issues are around trust, around understanding the level of need and structural barriers experienced by some populations. And that's where the Traveller Primary Health Care Projects are really important. It's complex work.

Similarly, broad high-level population campaigns which are mobilised to target large populations around lifestyle factors such as nutrition or exercise or smoking, require more in-depth targeted approaches to work with a population that are disadvantaged not just Travellers, but including Travellers.."

(Interview with Martina Queally, HSE Regional Executive Officer).

Theme 3: Addressing the Social Determinants of Health

The PHCTP model recognises that health of Travellers is inextricably linked to social determinants of health (SDoH) such as accommodation, education, employment, and the pervasive issue of racism and discrimination of Travellers. As one Social Inclusion manager stated:

> "*You cannot look at supporting better health for Travellers unless you're dealing with issues of accommodation, dealing with the issues of racism and prejudice, dealing with issues of education and employment.*"
>
> **(Focus group with Social Inclusion Managers).**

A TCHW outlines how a person's environment clearly impacts their health, providing an example of Traveller woman struggling with lung disease while trying to find a home with both heat and electricity:

> *We had a woman that was living up the road in an unofficial site with COPD and no electricity for a machine...Like she was housebound. She couldn't get out, and she ended up dying. No ambulance could get up the road. And only for we were going up and we ended up trying. She was on an official site...They were there for the last 60 years, so there couldn't have been moved off it. But the council wasn't having nothing to do with it yet. This woman was very, very sick. Well, we ended up being able to get a caravan more suitable, but it wasn't more suitable because there was no heat...and there was no place for the heating. So she ended up coming back into her [old] home because there was a stove for the night to keep her warm.*
>
> **(Focus group with TCHWs, Urban).**

Rights-based approach

A rights-based approach which addresses the social determinants of health was fundamental to this original vision of the PHCTPs, as one manager of a Traveller organisation explains:

> *"[We held an] unambiguous position in relation to working to realise Traveller rights across all the social determinants and social policy areas, because at the time and, similar today, the experience of discrimination and racism was chronic and it needed to get addressed. Access to services was one of these areas and the poor health status was a driver in positioning ourselves…to do something in relation to addressing health inequities."*
>
> **(Interview with Manager of a Traveller Organisation)**

Racism and discrimination across services

According to the All-Ireland Traveller Health Study (AITHS), approximately half of Travellers report experiencing discrimination in their daily lives.[56] More recent evidence from the European Union Agency for Fundamental Rights (FRA) indicates that experiences of discrimination among Travellers are increasing, including in access to health services. In 2024, 39% of Travellers in Ireland reported experiencing discrimination when accessing health services in the previous year—an 18-percentage-point increase since 2020. Addressing racism and discrimination is therefore a critical focus of the work of the PHCTPs, reflecting the need to recognise and respond to the cultural and social conditions in which health and healthcare interactions take place.[57] Addressing racism and discrimination is therefore a critical focus of the PHCTPs' work, reflecting the need to recognise and respond to the cultural conditions in which health and healthcare interactions take place. Participants explained how the delivery of **anti-racism** training to the HSE and mainstream services was highly valued as a means of building capacity within the health system to deliver culturally appropriate services. This training was cited as an important part of the work of PHCTPs.

Addressing racism and discrimination is fundamental to the mission of PHCTPs. As a manager from a Traveller organisation explains there is strong evidence and an understanding internationally that racism is a root cause of the exclusion of Travellers from health services:

> *"We can't continue to accept the lack of cultural [awareness] that leaves a person leaving a service feeling that they have not been treated with respect and dignity. And sadly, that's not only…It's not any one service. This is across the whole public service. I'm afraid that we're not getting to the root cause of what is causing the exclusion of the Traveller community…the root cause is racism and discrimination."*
>
> **(Interview with Manager of a Traveller Organisation)**

56 AITHS, 2010

57 European Union Agency for Fundamental Rights (2025). *Rights of Roma and Travellers in 13 European Countries: Perspectives from the Roma Survey 2024.* Luxembourg: Publications Office of the European Union; European Union Agency for Fundamental Rights. (2020). *Roma and Travellers in six countries: Roma and Travellers Survey.* Luxembourg: Publications Office of the European Union.

Dr Ciara Bradley – academic and educator in community development - explains the value of the PHCTPs is in their social determinants approach and the "broader understanding of education, accommodation and racism" that TCHWs have in approaching health. How this works in practice is explained by one of the TCHWs:

> *"...[we are] checking the family sees anything needs to be done. Then they give you the information. Well, look, I need support around maybe education, accommodation. That's when we then go back and [signpost to mainstream services]for them...But they allow us to do it and pass on their information...So they can have the conversations themselves, instead of us doing the talking for them. So when they connect with that person, or we bring that person, they then have that relationship."*
>
> **(National Workshop 1, Focus group 3 with TCHWs).**

As illustrated in the quote above, an aspect of self-determination and self-advocacy is built into the TCHWs practice. The interaction may have begun by focusing on health (e.g. a visit to a family to provide health information) but if other issues become the focus or a priority for the family, the TCHW will support the family to access and link with the relevant service or support. Some of the inherent complexities of PHCTPs operating within the model, in terms of the scope of their role and boundaries of their work, is discussed further under Theme 5: TCHW role, scope and career progression.

4.2 Sustainability and strengthening of PHCTPs

It is worth noting that there have been strong and persistent calls for action over many years to address issues in relation to the sustainability and development of PHCTP. The pay and conditions of TCHWs have been routinely highlighted as a source of concern, and recommendations have been made by THAF to address medical card entitlements for TCHW workers repeatedly.[58] In 2024, a scoping exercise was conducted to evaluate both current barriers and enablers to the recruitment and retention of TCHWs which found 'This initiative [PHCTPs] has proved to be both important and impactful; it also requires considerable flexibility, but because of limited pay, most staff are constrained in terms of working hours and career development by poverty traps, coupled with the inability of the projects which employ them to offer better terms and conditions.'[59]

Themes 4 and 5, presented below, capture issues related to funding and employment conditions consistent with the findings of the 2024 scoping exercise. The perspectives and insights from the participants provide further depth to understanding these issues and the working conditions in practice. Theme 6 captures perspectives on current approaches to monitoring and suggestions for improvement.

Theme 4: Precarious funding and employment conditions

A central theme identified from the data analysis is the precarious nature of employment and the chronic underfunding of PHCTPs. This was recognised by all stakeholder groups as a major challenge to the sustainability and strengthening of the PHCTPs. Organisations who have a PHCTP (e.g. Traveller organisations and Local Development companies)

58 National Traveller Health Advisory Forum (2017) *Traveller Primary Health Care Projects: Recommendations for Improved Terms and Conditions*, produced by the National Working Group: Ronnie Fay, Josephine Fogarty and Jimmy Todd, December 2017

59 Stamp, S. (2024) Scoping Exercise on Supporting the Recruitment and Retention of Traveller Community Health Workers in Primary Health Care for Traveller Projects. Pavee Point Traveller and Roma Centre.

were asked to rank priorities actions to support PHCTPs in the future. From a list of eight priorities, addressing Terms and Conditions (T&Cs) for PHCTP staff was ranked highest; followed by the retention of medical cards for TCHWs. See Appendix 4: Summary of Qualitative Survey Findings.

Minimum wage

There are several aspects of the PHCTP operating model that describe a poverty trap for TCHWs and were strongly expressed by participants in this review. Currently, one third of TCHWs are on minimum wage and the average rate of pay is €15.20. Many TCHWs report dissatisfaction with minimum or low wages for extended periods, and with inconsistency in wages across the country. As a Social Inclusion Manager remarks, "if this was done now, the way it was done back in the day, I wouldn't … dream of putting [TCHWs] on minimum wage. I just wouldn't" (Focus group with Social Inclusion Managers).

Medical cards

Financial precarity for TCHWs is made worse by the fact that increased income often leads to the loss of essential medical cards, meaning working more hours becomes financially unviable for TCHWs. Participants repeatedly highlighted the persistent call for access to medical cards explaining:

> *"It keeps Travellers in the poverty trap. Not enough hours but can't go full time because of the medical card. And even families with part time [hours] are losing the medical card. And we talk about health inequalities!"*
> **(Focus group with TCHWs, Rural).**

The lack of medical cards was discussed by TCHWs and other stakeholders in the context of the risks that the workers take in their exposure to infectious diseases in their day-to-day working environment. The Covid-19 pandemic was often cited as an example of where TCHW became "our frontline workers" and went to sites when HSE staff would not or could not. Despite not receiving the "Covid bonus" for frontline health care workers, one TCHW remarked, "only for the likes of us was able to do that… there was no HSE around" (Focus group TCHW urban). As one Traveller woman observed:

> *"I've seen these Traveller women [TCHWs]…going out there into sites where people couldn't isolate because they didn't have the facilities to isolate. And these [TCHWs] were going out into these sites putting themselves [and] their own health at risk. But yet they had the community in mind to go and make sure everything was all right. And then [challenged] councils and tried to fight for better services and facilities. So they're out there. They're our frontline workers. But I don't think they got the recognition that they deserved."*
> **(Interview with Traveller woman, Urban)**

This participant talks about "having the community in mind" referring to TCHWs doing their work because they are intrinsically motivated to improve the health and wellbeing of Travellers, discussed further under Theme 5: TCHW role, scope and career progression.

Retirement and recruitment

The lack of pensions and retirement packages was also highlighted as a critical concern, with long-serving workers facing retirement with no financial security or being forced to continue in their roles as they age:

> *If you look at HSE they can get retirement packages. They can go out and go back into HSE after three years. Our primary health care workers, [have] no pensions, no retirement package. So if them women is here 36 years, which they are, obviously as you get older you struggle more to get out and you slow down. But if they want to retire tomorrow morning. They have to go out that door with no pension.*
>
> **(Focus group with TCHWs, Urban).**

Recruitment and retention of TCHWs was cited as an increasing challenge for PHCTPs in given the poverty trap described. Participants expressed how recruiting young people to join the PHCTP workforce is becoming increasingly challenging given how disincentivising the current employment structure and conditions are for Travellers. Overall, this environment is reported to lead to high turnover and recruitment difficulties within the PHCTPs with many workers on short-term contracts and lacking job security.[60]

Uncontracted hours

Participants highlighted that many TCHWs work significantly beyond their contracted hours without additional compensation, often responding to crises outside of official working times. TCHW accessibility within the community where they typically live in the same environment that they work in. As one TCHW explains:

> *We need to point out that primary healthcare workers never switch off because you live in [and] work in the community. You could go down to the shop, you could meet somebody down around the post office that could pull you up and ask you something. You have to talk and share information with them.*
>
> **(Focus group with TCHWs, Urban)**

> *We can say we're finished at 5pm, but what do you do? You destroy the trust, you destroy the relationships. And if people can't get you... we live in the community. We work in the community. They [contact us] on our private Facebook page or social media...That's the reality.*
>
> **(Focus group with TCHWs, Rural)**

This flexibility and responsiveness, while beneficial for the community can have an impact on their personal lives and their ability to "switch off". In terms of crisis responses, one TCHW explains the dilemma of maintaining trust by being responsive and available in the community outside of work hours:

> *People come to your doors all hours, like, if there's a crisis on ...I have family friends, and you'd never turn them away. Like, even though you were at home and ...your work was finished, like, you'd never turn anyone [away].*
>
> **(National Workshop 1, Focus group 1 with TCHWs)**

60 Stamp, 2025

Planning, funding and management

At local level, participants identified a lack of long-term, sustained investment as problematic and posed a barrier to longer term planning and implementation. As one participant summaries:

> *"We've got the National Traveller Health Action Plan so the work is left to deliver on, but no extra money, there's no extra funding. We're given a plan [to] deliver...[and] there has been a bit of money here [and there], but [its] not sustainable over the long term."*
> **(Focus group with TCHWs, Rural)**

The NTHAP was supported by both recurring and once off funding. The CEO of the HSE previously confirmed that projects that have been evaluated as being successful should be regularised with recurring funding.[61] HSE Regional Executive Officer Martina Queally describes year-to-year funding as "a real problem" noting that recurrent funding would represent a

> *vote of confidence that says we are going to support this."*
> **(Interview with Martina Queally, HSE Regional Executive Officer).**

The importance of securing sustainable funding was noted by respondents in the academic and community and voluntary sector survey, as one academic states:

> *"By securing sustainable funding to expand capacity, embedding their work more strongly in national health and social care strategies, and creating more structured partnerships with higher education and service providers. They could also strengthen their impact through increased research collaboration, advocacy on systemic inequalities, and supporting pathways for Traveller participation in professional roles."*
> **(Survey of Academics and C&V sector)**

Short term contracts are a feature of the PHCTPs since its establishment over 30 years ago and reflects a structurally precarious funding model. As one THUC coordinator explains:

> *"People are in the job now, some of them are in for 25 years, but have never had more than 12-month contract."*
> **(Focus group with THU coordinators).**

The need for TCHWs to be responsive to crises while also delivering a planned programme of work was also highlighted as a challenge for PHCTPs. For example, a Social Inclusion Manager explains:

> *"If [TCHWs are] dealing with a family with an attempted suicide, everything else stops. Breast checks stop, vaccination stops, screening stops, diabetes training and awareness stops, until that crisis is over."*
> **(Focus group with Social Inclusion Managers).**

61 HSE (2023) Internal memorandum from the HSE Chief Executive on National Traveller Health Implementation Group (NTHIG).

THU coordinators described some of these structural issues as they relate to planning and funding allocation, particularly in the context of the HSE's transition from CHOs to RHAs. A strong management infrastructure was also highlighted as integral to the continued employment of TCHWs, as a THU coordinator states:

> *"I think our projects are starting to really find that, that they are getting funding for workers, but they can't take on any more workers until they actually get the support to have a strong management structure to support the [PHCTPs] going forward."*
> **(Focus group with THU coordinators)**

The DoH suggested that there was a need to have a clear ambition for the PHCTPs, remarking, *'how do we see these [projects]? What's the model we want to have? How do we see us growing this and developing it?*. The need for a shared or aligned ambition for the PHCTPs is highlighted by HSE Regional Executive Officer, Martina Queally, who stated *"I think we are ambitious, but I think we need to align our ambition"*.

While there are clearly substantial challenges faced by PHCTPs and TCHWs in terms of working conditions and funding, despite this they continue to deliver their programmes of work and respond to their community to support the health and well-being of Travellers. As a TCHW states:

> *"This is how important this work is to Travellers, because there's obstacles put in our way with pay. There's obstacles [are put in] our way with medical cards. There's obstacles put in our way with no pay for [PHCTP staff] when they [retire]. But yet there's young Traveller women trying to get on to the [PHCTPs] because we know about our own health needs. And if that doesn't say how important the work is, even if the settled community, the HSE, the government departments doesn't see."*
> **(Focus group with TCHWs, Urban)**

Within a challenging funding environment, the persistence of TCHWs to address health inequalities for Travellers, and a deep commitment to the work of the PHCTPs is evident throughout the responses collected in this review.

Theme 5: TCHW role, scope and career progression

As the PHCTP model has matured over time, questions of visibility, status, parity, and structural support within the wider health system have emerged. This theme explores views and perceptions of the positioning of TCHWs within national health structures, the resources allocated to the PHCTPs, and how career pathways (or lack thereof) influence their strength and sustainability.

Professional recognition and motivation

For TCHWs, the lack of funding of PHCTPs was seen to reflect a lack of professional recognition of their role and the PHCTPs more generally. They expressed a feeling they are doing "double the work" for "pennies", highlighting a profound disconnect between their contribution and a lack of renumeration for the work they are uniquely placed to do. Discontent in relation to pay and funding were consistently expressed by the TCHWs throughout the review. However, TCHWs explained how they "loved" their jobs and gained a deep sense of satisfaction from helping their community.

As one TCHW states:

> *It's a job you'd have to love. And just because it's our own people. Obviously, we love our own people. And we know that they're on the back burner the whole time. So you are trying to help them and you're trying to speak for the ones that can't speak for themselves. But there's no one else going to be able to do that. Only our community, for our community.*
>
> **(National Workshop 1, Focus group 4 with TCHWs)**

However, frustration with a lack of perceived value of the PHCTPs was expressed, as one TCHW remarked:

> *We're always on the outside, banging down the doors of the health system…That shouldn't be the situation. 25 years on from the primary health care establishment, we should have a situation where the role and the value of primary health care workers and the primary health care teams within the […] community are actually seen as a valuable commodity in terms of the development of preventive health care at a local level, but that's not the case.*
>
> **(National Workshop 1, Focus group 1 with TCHWs)**

However, the national conference to mark 30 years of PHCTPs in 2024 was cited as an important milestone in celebrating the work of the PHCTPs and a clear demonstration of its value and impact.[62]

Role boundaries and scope creep

Participants described how the scope of the TCHW role has evolved and expanded since the inception of the PHCTPs in 1994. Initially focused on basic health education and primary care, the responsibilities of TCHWs have expanded and now encompass a wide array of complex social and health issues. Often PHCTPs need to respond to emerging issues within the community without additional resources. This includes addressing violence against women, addiction, education supports, suicide intervention, mental health, and general well-being. TCHWs explained how they are often faced with a broad spectrum of work within primary healthcare and beyond it. They are driven by an imperative to support their communities and address the social determinants of health while confronted with gaps in existing services and being under resourced. Consequently, this potentially stretches the scope of TCHWs role. As one HSE staff member comments:

> *[TCHWs] work tirelessly to engage with their communities often outside the hours of employment. They are an anchor for the community and as such are essential to the overall health and wellbeing outcomes of the community. If the wider social determinants of health, first and foremost accommodation, could be addressed their capacity to improve health outcomes would be immeasurable. As it stands the PHCTP's are constantly fighting fires around advocacy, accommodation, mental health, education and access to services. These teams go above and beyond and should be resourced accordingly.*
>
> **(Survey of HSE staff)**

62 See: HSE NSIO, Celebrating 30 Years of Primary Healthcare for Travellers Projects https://www.hse.ie/eng/about/who/primarycare/socialinclusion/travellers-and-roma/irish-travellers/traveller-projects-and-resources/celebrating-30-years-of-primary-healthcare-for-travellers-projects.html

This is compounded by a perception among the wider Traveller community that the TCHWs role, as a bridge or intermediary with HSE services, applies to all public services and local government and consequently PHCTPs become a "stopgap for everything". As a TCHW explains:

> *"When it comes to primary health care projects, we seem to be the stopgap for everything. And you have to resolve the issues. Like when we go on to a site, Travellers have an expectation, even if you're going out with public health information, that because the roof is leaking, you'll be able to ring the council for them, when in fact you should have that joined up networks that are available to kick in when something else isn't delivering or something is in their brief. But we just don't have it with Traveller services."*
>
> **(National Workshop 1, Focus group 1 with TCHWs)**

This link role was also reported between TCHWs and external organisations and agencies where, for example, access to Travellers is required, the first point of contact is typically the PHCTPs even in instances that do not relate to primary healthcare or the work of the PHCTPs.

The issue of a standardised role definition, training and job description has been highlighted by the DoH and others:[63]

> *"A better structure could be there to standardise this role across the country to ensure that the [TCHWs] are trained to a certain extent or can be afforded training to a certain extent."*
>
> **(Interview with DoH representatives)**

At a health systems level, the PHCTPs have adapted and responded to the needs of Travellers over time, however this may have shifted the model to a less targeted approach. This expansion of duties, often undertaken by a small, part-time workforce, places immense burden on staff and coordinators who are insufficiently resourced. As a Social Inclusion Manager describes:

> *"The work that they [TCHWs] did at the very beginning, which would have just been purely primary care, breast check screening, diabetes, cardiovascular. They're now being pulled in all sorts of directions. They're being pulled into suicides. They're being pulled into health and well-being, smoking cessation, Making Every Contact Count … the [increasing] demands and the requirements to improve health outcomes for members of the Traveller population. As we [HSE] get much better [at] delivering services to the rest of the population, more and more demands are being made on a small cohort of people who mainly work part time."*
>
> **(Focus group with Social Inclusion Managers).**

63 This is echoed in a recent scoping exercise on pay and conditions of PHCTPs which concluded by recommending 'Standardised job descriptions and roles, including renumeration and rates of pay, underpinned by community work and human rights principles', see Stamp, S. 2025.

While advocating for essential facilities like water and electricity is essential in terms of addressing the social determinants of health, ideally TCHWs should be able to refer these families to a relevant support worker in their area (e.g. a Traveller Accommodation worker etc). However, if there are no relevant workers in post in that area - or if relationships with local authorities or services are poor, and/or they are unresponsive - this presents a gap that TCHWs are likely to feel a strong need or motivation to try to fill.

Several participants called for parity of esteem with HSE colleagues or indeed new roles that define clearer clear parameters around the role. As one Social Inclusion manager comments:

> *"TCHWs deserve parity of esteem for the breadth of work that they do, or they deserve to actually have new roles created, where actually you're coming in and you know you're only dealing with health and well-being, or you know you're only dealing with core primary care, or you know you're being skilled and trained up to deal with some sort of emergency, crisis mental health work."*
>
> **(Focus group with Social Inclusion Managers).**

Career progression and qualifications

Currently, TCHWs are provided with a range of internal, external and mandatory training and supports including, for example, induction training, Continued Professional Development (CPD) training, mentoring programmes and support where possible to access to career progression opportunities.[64] However, concerns were strongly expressed by stakeholders about a lack of clear career progression pathways and qualification routes for TCHWs. The DoH also expressed concern around the responsibility to provide a defined career path or qualification route for TCHWs. While there are many cases of TCHWs who have progressed to university level training and gone on to secure professional roles in mainstream services, for example, in primary school teaching and other areas. This is not yet formalised and embedded in the PHCTP model. [65]

The loss of previous funding for intensive training and induction, such as from FÁS schemes, has created gaps. A former PHCTP coordinator explains how projects used to be able to access FÁS training for up to three years. This would typically cover practical and theoretical training in areas such as first aid, immunisation, and communication. It would be based on repeated instruction rather than relying on reading and writing skills. This training *"gave you that cushion before [TCHWs] came off training and became fully qualified community health workers"*. However, since FÁS dissolved in 2013 *"it's much more complicated now to get that training budget" (Interview with former PHCTP Coordinator).*

While some internal progression has occurred, such as Travellers becoming project coordinators or assistant coordinators, there is a strong call among TCHWs for career pathways into the Health Service Executive (HSE) and into mainstream healthcare settings, as one worker explains:

64 See Crowley, N.

65 Recent examples include several graduates who obtained a Level 7, Community Development qualification with Maynooth University, supported by HSE; 2 of these were TCHWs, 1 was a PHCTP coordinator and 4 were Traveller health workers; this was preceded by a return to learning programme funded by HSE and is a commitment in the NTHAP.

> *A lot of Travellers are coordinators [now]. One time ago that wasn't the case. You had always a settled person running a primary healthcare project. So it's a great thing to see that your assistant coordinators and coordinators and also your people in manager roles now as well within some of the projects as well, that's progressing. But we need to see real change as well…[but] not everybody wants to be a primary healthcare worker for the rest of their life.*
>
> **(Focus group with TCHWs, Urban)**

The absence of wage scales and yearly increments further disincentivizes staff and devalues their experience and the wealth of knowledge they have accumulated over many years in the role. While the DoH point to a "lack of ambition" in terms of driving qualification routes forward, the chair of NTHIG sets out a vision:

> *We need a whole career structure…here is maybe the opportunity to formalize different levels of training that they can be adapted according to people's literacy skills…And you know that everybody there should be at an entry level that's appropriate. I know people have spoken about other peer worker pay scales throughout the HSE, but look at an entry level that's appropriate, not hitting them with [a] poverty trap level. And that there's a whole career structure, so that somebody who is getting a degree or a master's can move into more senior roles, specialist roles, just as you would if you were a therapist or something else in the HSE.*
>
> **(Interview with Aisling Heffernan, Chair of NTHIG).**

In this regard, she remarks that she requires the DoH to be "very on board" to support this goal into the future to achieve this (Interview with Aisling Heffernan, Chair of NTHIG).

It would appear that there is consensus between PHCTPs, HSE and DoH, that training and qualifications of TCHWs needs to be addressed and resourced as a means of providing opportunities for career progression of TCHWs. In the context of standardising training, the DoH remark that suggesting short term courses and micro-credentials delivered by academic institutions, *"would be something practical and tangible that we could offer"* (DoH) and could be aligned with a HSE grade to enhance career progression for TCHWs.[66]

While TCHWs complete a range of professional development training, there is a vision for third-level accreditation and blended learning modules for health workers. The DoH suggest using a micro-credential model, to provide better skills, knowledge, and career development. There are challenges to standardisation of qualifications and training which include accessibility for workers across the country, the content and delivery approach (emphasising community development), and the crucial need for recognition of prior learning and experience for long-standing staff. As academic, Ciara Bradley points out:

> *Given the state of education [of Travellers] in this country…in terms of primary and secondary education and the deficits there, they have to be addressed in tandem with any other initiatives that are taken on.*
>
> **(Interview with Dr Ciara Bradley, Maynooth University).**

66 Examples cited by DoH included: Communication and Interpreting in the Irish Healthcare System (UL), Certificate in Peer Support (Mental Health) (DCU)

HSE Social Inclusion Managers and THU coordinators pointed out there is also a recognised need for training to upskill workers for the breadth of their expanded roles and for support around mental health, planning, reviews, and management supervision in line with the role and responsibilities of a TCHW.

Theme 6: Monitoring and reporting

Feedback captured from participants on monitoring of the PHCTPs reveals a complex setting marked by significant challenges in data collection and impact assessment, alongside a strong consensus that current practices are not fit for purpose to adequately capture the PHCTP model and its activities.

Current monitoring and reporting

There was widespread agreement among participants that current monitoring practices of the PHCTPs are insufficient and do not accurately reflect the breadth and depth of work undertaken. The current Key Performance Indicators (KPIs) collected to capture cardiovascular disease, type II diabetes and positive mental health are consistently criticised for being too narrow, imposed, and failing to capture the diverse activities and qualitative outcomes of the projects. The focus on KPIs as a mechanism for capturing the work of PHCTPs further compounded a feeling that the efforts of PHCTPs were not fully valued and created a sense that the core principles of the model were not recognised. As one TCHW stated:

> *"Primary health care projects are set up to work on the social determinants, underpinned by community development. We were not set up to work on KPIs... it's really important that we capture data, but the qualitative work needs to go alongside it because nobody can do the jobs that primary health care project does."*
>
> **(Focus group with TCHWs, Rural)**

Pointing out that KPIs have only been initiated since around 2010. "There was no such thing as KPIs" until after the AITHS. The THU coordinator notes that KPIs often only measure *"busyness"* rather than outcomes, and ultimately *"break the hearts of all the community health workers"*. As one THU coordinator explains:

> *"I can honestly say I have no idea how we measure our outcomes, because we don't...those KPIs make no sense. They're just asking how busy you are."*
>
> **(Focus group with THU coordinators)**

The issue of how activity data is calculated, consistency of data collection, and whether it is self-reported was also raised by THU coordinators and SIMs. The disproportionate expectation for extensive reporting given limited resources and fragmented IT systems was reported to further exacerbate monitoring challenges. While arguably KPIs and activity data primarily measure "busyness" rather than impact, some stakeholders expressed they are a positive step to show the breadth of the work of the PHCTPs, and the number of contacts made through the PHCTPs. As the Chair of NTHIG remarks *"there's something powerful in that as a first step" (Interview with Aisling Heffernan, Chair of NTHIG).*

The DoH highlights that HSE activity reports and KPIs are high-level, lacking specific details on the nature of the interventions, how they influence outcomes on Traveller's health and a *"full pathway through the health service"*.

> *"...On the interventions, [its] not in the KPIs and it's not really in the activity report. So it's hard to know. [The] information [that is] given to Travellers...was that just a leaflet? Was that a proper discussion? Was it a preventative discussion?...What might be your next steps? How did that really impact the health status of the Traveller community? Because [in] the end, that's our shared goal here. We're looking to improve the health status and it's hard for us to discern from these very high-level numbers."*
>
> **(Interview with DoH representatives)**

While there is a shared objective to improve the health status of Travellers, the respective roles of PHCTPs and the HSE within the care pathway are not always clearly distinguished. PHCTPs primarily support access to and engagement with the "front door" of services, while responsibility for progression through mainstream health services sits with the HSE. Greater clarity on this division of roles would strengthen future monitoring and evaluation of the PHCTPs. As the DoH add:

> *"At the end of the day, we know that the health status is not improving and that's a really important metric that we need to work on essentially."*
>
> **(Interview with DoH representatives)**[67]

A respondent from the survey of academics explicitly outlines some of the specific and important contributions of the PHCTPs from their experience of engaging and working with them, stating:

> *"The PHCTPs provide trusted links with the Traveller community, enabling genuine engagement and co-production. They strengthen capacity through education and training, amplify Traveller voices in health and social care, and address barriers to inclusion by building relationships between communities, practitioners, and institutions."*
>
> **(Survey of Academics and C&V sector)**

This highlights the depth of work carried out through the PHCTPs including but not limited to accessing mainstream services, as means of improving the health and well-being of Travellers.

67 As noted by Jim Walsh, Principal Officer with responsibility for Traveller health in the Department of Health, at a recent Joint Committee on Key Issues Affecting the Traveller Community (15th Jan 2026), "turning the tide of life expectancy will take a number of years." He explained that the emphasis on early intervention for Traveller children, through programmes such as Brighter Beginnings, is intended to build strong foundations over time and ultimately help to "turn the tide of health inequalities." See: https://www.oireachtas.ie/en/committees/34/committee-on-key-issues-affecting-the-traveller-community/

Accountability for measurement and reporting

The question of accountability for measuring health outcomes is highlighted by a manager of a Traveller organisation who emphasises that the onus should be on the HSE to report health outcomes, not the PHCTPs who are under resourced and not set up to do so:

> *"The people who have to get bigger results in dealing with diabetes are the health services themselves...and use us [PHCTPs] then as a mechanism to get that improvement...Do not be putting the pressure on a low resourced budget to get the health results, when in actual fact it should be the HSE services are tasked with 'Why aren't you getting better results for the Traveller community across all the health departments?"*
>
> **(Interview with Manager of a Traveller Organisation)**

A significant issue here is the disconnect between the often informal, invisible, "out of hours" and crisis-driven work performed by PHCTP staff and the limited opportunities to report that at a higher level currently. This may contribute to a lack of professional recognition, and overall perception of the work of PHCTPs being undervalued.

Furthermore, the lack of standardisation and centralisation across the numerous PHCTPs makes effective monitoring and a unified understanding of their inputs and activities more challenging. As the Chair of NTHIG explains:

> *"I think there's inconsistent approach[es] across the country and different mechanisms for employing or working with the projects and with the workers...different projects maybe focus more on different aspects of services. They'll obviously have different resources available to them as well. The metrics are quite limited."*
>
> **(Interview with Aisling Heffernan, Chair of NTHIG**

The establishment of PHCTPs and their implementation has happened at different rates across Ireland since the mid-1990s. They are currently staffed and resourced at different levels. From a monitoring perspective, this presents a challenge in terms of fidelity of the implementation of the model and being able to generate a consolidated monitoring system that can capture variation at the local level.[68]

The situation as described by many stakeholder groups across this review, presents a dilemma of not having appropriate resourcing in place currently to support the PHCTPs, but nonetheless needing to show successful outcomes from existing funding to secure further investment and growth. Indeed, the DoH clearly outlines their position in terms of funding needing to be linked to "tangible" outcomes, stating that:

> *"What is the outcome of this funding? And that for us is the dilemma."*
>
> **(Interview with DoH representatives)**

The Chair of NTHIG recognises this issue for the DoH, understanding there is a need to evidence the effectiveness of the PHCTPs in order for the department to build their case with the Department of Expenditure and Reform and that currently the DoH "doesn't have a whole lot of data to argue the case" (Interview with Aisling Heffernan, Chair of NTHIG).

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68 Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, Hensley M. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011 Mar;38(2):65-76. doi: 10.1007/s10488-010-0319-7. PMID: 20957426; PMCID: PMC3068522.

However, she and other stakeholders also highlight the need for greater engagement from the DoH in their participation and representation on Traveller health governance and oversight groups. For example, as one TCHW states in relation to NTHIG:

> *"We have people from the HSE [on NTHIG], but we need people from the Department of Health where they have the power and they have the say to do things and to support us. We do not have that since 2012."*
>
> **(Focus group with TCHWs, Urban)**

Adding that partnership is required to take action to improve Traveller health and *"We cannot do it alone"* (Focus group TCHW urban). However, holding other agencies and central government departments to account is remarked upon. Some stakeholders expressed discontent in terms of the commissioning of this review, as one TCHW states:

> *"I would even question why the [PHCTPs are] being reviewed when all these different departments has a responsibility. Why are they come questioning us?"*
>
> **(Focus group with TCHWs, Urban)**

Another participant highlights that, if we are tackling Traveller health through a SDoH lens, then the responsibility for the health and wellbeing of Travellers extends beyond the HSE:

> *"I have to...praise the fact that [over] the last 30 years the HSE have seen fit to keep this funded, when I think other departments...should be held to account for not funding the sector to the similar extent that the HSE do. Same way in accommodation. Who's responsible for that? HSE can't be responsible for everything."*
>
> **(Interview with Manager of a Traveller Organisation)**

Defining PHCTPs

As discussed earlier in this report, the original focus of the PHCTPs has evolved over time in response to the needs of Travellers. As a manager of Traveller organisation reflects:

> *"You might want [PHCTPs] to be something in 20, 25 years but it wasn't designed to be that. So you can't just suddenly expect it to adapt to that if that's not what its original role and if people are forgetting or confused about the original role."*
>
> **(Interview with Manager of a Traveller Organisation)**

The DoH suggest the PHCTPs – originally conceived of as projects – have become a "catch all" and would welcome an approach providing greater focus.[69] The majority of stakeholders emphasised the importance of retaining the model's focus on the social determinants of health, advocacy and a rights-based approach. Defining the scope of the PHCTPs is therefore an area requiring careful balance as the PHCTPs develop, and particularly in terms of a focus for monitoring and evaluating the PHCTPs into the future.

69 Examples of good practice in programme monitoring were cited by the Department of Health, including: *Brighter Beginnings* programme for Traveller children, a three-year initiative, aligned with actions in the NTHAP, delivered in partnership with Traveller organisations to develop culturally appropriate solutions to improve Traveller infant and child health; The *Sláintecare Healthy Communities Programme* which is currently working to address the social determinants of health for Travellers. There are five projects established under this call and the programme of work will align with the objectives of Healthy Ireland, Action 26 of NTRIS II as well as complement the NTHAP; *Traveller Women Experiencing Homelessness* works with Traveller women who are at risk of homelessness and is a collaboration between the DoH, HSE and the Genio Trust and is funded by the Women's Health Fund.

Measuring "quality" outcomes and impact

A major hurdle is the difficulty in measuring qualitative outcomes such as building trust, increasing Traveller voice, advocacy work, and improved well-being. While the DoH refer to these as "intangible" adding that "we need to see the behaviour that comes out of building trust", others argue that robust and well-established methods do exist for monitoring the qualitative dimensions of PHCTPs. The challenge of measuring PHCTP impact is explored further in Section 5, which outlines approaches drawn from the monitoring and evaluation of comparable community development models.

THU coordinators highlighted a barrier to reporting outcomes whereby PHCTPs provide information and signposting to services, but the mainstream services themselves often fail to collect data on Traveller attendance, making it hard for PHCTPs to demonstrate their impact. Participants explained that systemic issues like racism and discrimination, which are root causes of exclusion, are also not adequately monitored by public bodies despite the Public Sector Equality and Human Rights Duty.[70] The HSE National Service Plan 2026 states that a priority action for 2026 is to implement the Public Sector Human Rights and Equality Duty in the HSE.[71]

The need for an ethnic identifier is a recurring issue, with many stakeholders emphasising its crucial role in advancing monitoring and evaluation of PHCTPs. Participants strongly advocate for its implementation to monitor access, participation, and impact for Travellers, and to influence policy change. The Chair of NTHIG notes a broad eagerness at senior management level within the HSE to move towards an ethnic identifier but acknowledges it as a long-term goal due to complex issues like fragmented IT systems and the lack of a national standard. The THU coordinators further highlighted that even where an identifier exists, staff often lack training on its use. The DoH questions the lack of an ethnic identifier for Travellers as an ongoing obstacle, arguing that administrative data is sufficient. The DoH recognise that improved health outcomes are *"really down to the [HSE] services"* but again, want to understand the pathway from the intervention at the PHCTP level through to the service. While administrative data can indicate levels of activity or service use, it is limited in its capacity to evidence outcomes or explain how change occurs. For example, the DOH express a wish to understand how:

> *"[As a result of PHCTPs] Travellers would have a better experience of services, more likely to use services, more likely to take on board the measures that help to reduce some of these illnesses."*
> **(Interview with DoH representatives).**

An ethnic identifier could provide the HSE with robust, disaggregated data to support tracking and measurement of service user experience and service uptake. At the time of writing, HSE senior leadership is considering a paper on the ethnic identifier, addressing the infrastructure, training and promotional requirements necessary to support effective implementation.[72] For future monitoring and evaluation purposes, however, clearer delineation between PHCTPs and mainstream HSE services will still be required to enable integration without losing analytic clarity, particularly in relation to which direct and indirect outcomes can reasonably be attributed to the work of PHCTPs.

70 Contained in Section 42 of the Irish Human Rights and Equality Commission Act 2014. See: https://www.ihrec.ie/public-sector-duty

71 See HSE National Service Plan 2026: https://about.hse.ie/publications/hse-national-service-plan-2026/

72 See: Oireachtas Joint Committee on Key Issues Affecting the Traveller Community (2026) T*opic: National Traveller Health Action Plan and Report on the Traveller and Roma Mental Health Working Group*, 15th January 2026. Houses of the Oireachtas. Available at: https://www.oireachtas.ie/en/committees/34/committee-on-key-issues-affecting-the-traveller-community/

4.3 Discussion

Value, role and impact of PHCTPs

The findings of this review strongly reinforce the central importance of the peer-led model within the PHCTPs. Trust, cultural understanding and expertise are core enablers of meaningful engagement between Travellers and health services, particularly in the context of historical trauma, structural discrimination, and multigenerational mistrust of mainstream systems. The peer worker aspect of PHCTPs was consistently highlighted by participants as a significant strength and foundation of the model's effectiveness. It was described as a mechanism for building trust with families, to an extent that mainstream services would struggle to achieve according to the participants. This is important because trust in health professionals is associated with improved health outcomes.[73] The work of TCHWs extends far beyond traditional health promotion, encompassing psychosocial support, crisis response, advocacy, navigation of complex services, and addressing the social determinants of health. This breadth of contribution plays a critical role in strengthening empowerment, building confidence within the Traveller community, and challenging stigma and negative stereotypes. In this respect, PHCTPs function not only as a health intervention, but as a community development and rights-based approach that enhances equity, voice, and participation.

However, much of the value delivered by PHCTPs remains largely invisible within current monitoring structures, which fail to capture qualitative outcomes such as trust, empowerment and Traveller voice. The reliance on current KPIs and activity counts, and the absence of an ethnic identifier at scale, contribute to a persistent lack of visibility of the programme's full impact and may reinforce negative perceptions within the wider health system regarding the contribution of PHCTPs. There is a clear argument for developing a monitoring framework that reflects the complex and relational nature of the work, aligns with community development principles, and captures outcomes that matter to Travellers and to the health system.

Sustainability and Development of PHCTPs

Findings highlight significant concerns regarding long-term sustainability of the PHCTPs, driven by precarious employment conditions and funding. A recent report *'Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health Care Projects'* highlights many of these issues and underscores the need to address barriers to recruitment and retention of staff in PHCTPs in relation to pay, terms and conditions; recruitment, training and career development; social welfare, medical cards and living costs; and funding, structure and ethos.[74] The findings from this review corroborate much of the findings from that report that pay stagnation, lack of pension and progression routes, and poverty traps associated with medical card loss have created substantial barriers for PHCTPs and present a significant obstacle to the sustainability

73 Birkhäuer J, Gaab J, Kossowsky J, Hasler S, Krummenacher P, Werner C, Gerger H. Trust in the health care professional and health outcome: A meta-analysis. PLoS One. 2017 Feb 7;12(2):e0170988. doi: 10.1371/journal.pone.0170988. PMID: 28170443; PMCID: PMC5295692; Ewald L, Bellettiere J, Farag TH, Lee KM, Palani S, Castro E, Deen A, Gillespie CW, Huntley BM, Tracy A, Haensch AC, Kreuter F, Weber W, Zins S, Motte-Kerr W, Li Y, Stewart K, Gakidou E, Mokdad AH. Association Between Trust in Health Care Professionals and Health Care Access: Insights From an Online Survey Across 21 Countries. Int J Public Health. 2025 Apr 10;70:1607884. doi: 10.3389/ijph.2025.1607884. PMID: 40276462; PMCID: PMC12018240. Ausserhofer D, Wiedermann CJ, Barbieri V, Lombardo S, Gärtner T, Eisendle K, Piccoliori G, Engl A. Health Information Mistrust Is Directly Associated with Poor Sleep Quality: Evidence from a Population-Based Study. Healthcare (Basel). 2025 Jun 10;13(12):1385. doi: 10.3390/healthcare13121385. PMID: 40565412; PMCID: PMC12193538.

74 Stamp, S. (2025) *Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health Care Projects*. Dublin: Pavee Point.

and strengthening of PHCTPs into the future. Furthermore, this review finds that the disconnect between role expectations and available resources has resulted in role creep, unmanaged workload expansion, and uncontracted out-of-hours labour that risks burnout and loss of staff and weakens progress and development of PHCTPs.

Without clear career pathways and standardised role structures, significant opportunities to retain expertise and strengthen leadership within Traveller communities are being lost. Likewise, fragmented and inconsistent monitoring systems hinder the ability to demonstrate impact and secure future investment, creating a cycle in which inadequate data justifies inadequate funding. Addressing sustainability will require structural change: long-term, secure funding; appropriate remuneration and supports; integration into mainstream governance; and development of a monitoring and reporting model that captures the complexity and social value of PHCTPs. The persistence and commitment of TCHWs in the face of systemic obstacles underscores both the importance of the programme and the urgency of reform.

Section 5: Outline for a Proposed Monitoring Framework

This section outlines the context and challenges of monitoring community development and social inclusion programmes and considers the relevance of these challenges for PHCTPs. It identifies the building blocks to develop a monitoring framework and offers suggested approaches. It is complemented by a range of resources and templates in Appendix 5.

Based on the stakeholder consultation and feedback, potential indicators are suggested. Worked examples are provided with the intention of being illustrative rather than prescriptive. This section of the report also discusses the limitations and assumptions around any potential monitoring frameworks or systems to be developed.

5.1 Conceptualising and defining PHCTPs

This review identifies a lack of consensus around whether it is appropriate to define PHCTPs as a "project"; several terms are used interchangeably among different stakeholder groups to describe PHCTPs, such as "project", "programme", "model of practice", "service". TCHWs are clear to assert that PHCTPs are not a service, in terms of being distinct from mainstream health and social care services, and from a medical or clinical model. TCHWs clearly express that they do not deliver primary care services, rather their role is to signpost and raise awareness, such as in health promotion and education. NTHAP identifies an objective of PHCTPs is 'to develop the skills of Travellers in providing community-based health services' [emphasis added]. However, the meaning of 'providing services' in this context is not well defined. It is unclear whether this refers to, for example, health promotion and education activities delivered by TCHWs as a service. This kind of ambiguity in terminology may contribute to confusion about how PHCTPs are conceptualised both internally and externally.

A project is commonly understood as a specific, singular endeavour with a defined start and end, undertaken to create a specific product, service, or result to deliver a tangible output. Projects begin and end. They are timebound, temporary, small in scope, with clear objectives and outputs, delivering discrete pieces of work. They are often innovative or piloted and funding is typically short-term. PHCTPs were originally funded as pilot projects in the Eastern region and have grown and evolved beyond their project phase. Therefore, conceiving of them as "projects" may underplay their longevity and their long-term ambitions and goals.

5.2 The challenge of measuring PHCTPs

PHCTPs are rooted in community development and built around participation, empowerment, and collective action. As discussed, they use a social determinant of health approach to understand and address inequities in Traveller health. They are democratic and consensus based. The *'Standard Framework for Primary Health care for Travellers Projects (PHCTPs)'* aligns PHCTPs with the All-Ireland Standards for Community Work (2016) and positions community development values as the foundation for the vision, strategy, and operational practice of PHCTPs.[75] Community Work Ireland defines community development as: 'a developmental activity comprised of both the task and process. The task is social change to achieve equality, social justice and human rights. The process applies principles of participation, empowerment, and collective decision making in a structured and coordinated way'.[76]

Researchers have highlighted the key challenges related to monitoring and evaluating community development programmes emphasising that it is 'extremely difficult to capture the impacts of activities and spending that occur at the community level' due to their long-term, non-linear nature and the absence of suitable measurement tools.[77]

75 All Ireland Endorsement Body for Community Work Education & Training (AIEB) (2016) *All Ireland Standards for Community Work.* Galway: Community Work Ireland, cited in Crowley, N. (2024).

76 All Ireland Endorsement Body for Community Work Education and Training (AIEB) & Community Work Ireland (2016) All Ireland Standards for Community Work. Online, Available: https://www.cwi.ie/wp-content/uploads/2016/03/All-Ireland-Standards-for-Community-Work.pdf

77 Mc Ardle, O. and Murray, U. (2020). Fit for measure? *Evaluation in community development. Community Development Journal,* 56(3), 432–448. doi:10.1093/cdj/bsaa005

They also recognise the challenge of capturing outcomes related to both task and process dimensions, i.e. capturing both what is achieved (task) and how it is achieved (process). As discussed in the Findings section of this report, the burden of responsibility to report health outcomes should not be limited to the PHCTPs. In order to support the future monitoring and evaluation of PHCTPs, it may be helpful to clarify outcomes in terms of process outcomes (empowerment, participation, trust) and health system outcomes (service access, coordination, and impact on social determinants of health) and importantly, who is responsible and accountable for reporting and delivering on these outcomes and their contribution to these outcomes at various points along the service user journey.

There are emerging attempts within policy circles to measure community development and wellbeing.[78] In 2019, the ESRI produced a report commissioned by the Department of Rural and Community Development (DRCD)[79] and Pobal, to make recommendations on a framework for evaluating the SICAP social inclusion programme 2015-2017.[80] Following an extensive review of the literature, they asserted that evaluation approaches generally use very broad aggregates that are not linked to any particular policy intervention, concluding that there were no formal evaluations to estimate the counterfactual impact of community development policies in either the academic or policy literature. They suggest that in any assessment of community development, there needs to be an overall framework to guide decisions around the metrics with a clear statement of the programme objectives, which are then linked explicitly to inputs and outcome variables that the policy should be influencing.[81] In terms of PHCTPs, this could be helpful in terms of monitoring, whereby the specified processes and outcomes are related to the policy goals.

Conventional, indicator-driven monitoring frameworks often fail to capture emergent process outcomes such as confidence and trust, which this review identifies as central to the PHCTP model. In 'Beyond the Numbers: How qualitative approaches can improve monitoring of humanitarian action', the authors argue that quantitative metrics alone overlook the complexity of social change and recommends combining numeric and narrative evidence to strengthen accountability and learning.[82] Participatory methods — such as Most Significant Change (MSC), Outcome Harvesting and Outcome Mapping — offer ways to document meaningful change from the perspective of participants.[83] They can be combined with quantitative methods to capture impact data and explore causality and contribution: 'More can be achieved with participatory methods than only group-based data collection of impacts on programme participants – causality can also be investigated in interviews and focus group discussions. Discussion methods using impact or causal flow diagrams can help to establish respondents' understandings of key factors that have contributed to the impacts they identify. When combined with [impact data], these methods can elicit qualitative and quantitative information within the same discussion, including around the relative contribution of different causes'.[84]

78 Examples include the Community Tool Box, developed by the University of Kansas Work Group for Community Health and Development, and the Happy City Index, developed by What Works Centre for Wellbeing, UK.

79 Currently the The Department of Rural and Community Development and the Gaeltacht

80 Whelan, A., McGuinness, S. and Delaney, J. (2019) Valuing Community Development through the Social Inclusion Programme (SICAP) 2015–2017: Towards a Framework for Evaluation. Research Series No. 77. Dublin: The Economic and Social Research Institute (ESRI). Available at: https://doi.org/10.26504/rs77.

81 Ultimately, a "distance-travelled tool" was developed to improve the process of measuring the effectiveness of support from programmes like SICAP https://www.gov.ie/en/department-of-rural-and-community-development-and-the-gaeltacht/publications/my-journey-distance-travelled-tool/

82 Sundberg, A. (2019) Beyond the Numbers: How qualitative approaches can improve monitoring of humanitarian action. ALNAP Paper. London: ODI/ALNAP'.

83 McArdle and Murray, 2020; Davies and Dar, 2005; Measure Evaluation, 2020; Smith, R. 2023. A Guide to *Participatory program monitoring with Most Significant Change, Outcome Harvesting, and Outcome Mapping.* Atlanta, GA: CARE USA. Applied example in Irish context: YoungBallmun, 2015

84 Guijt, I. (2014). Participatory Approaches, Methodological Briefs: Impact Evaluation 5, UNICEF Office of Research, Florence.

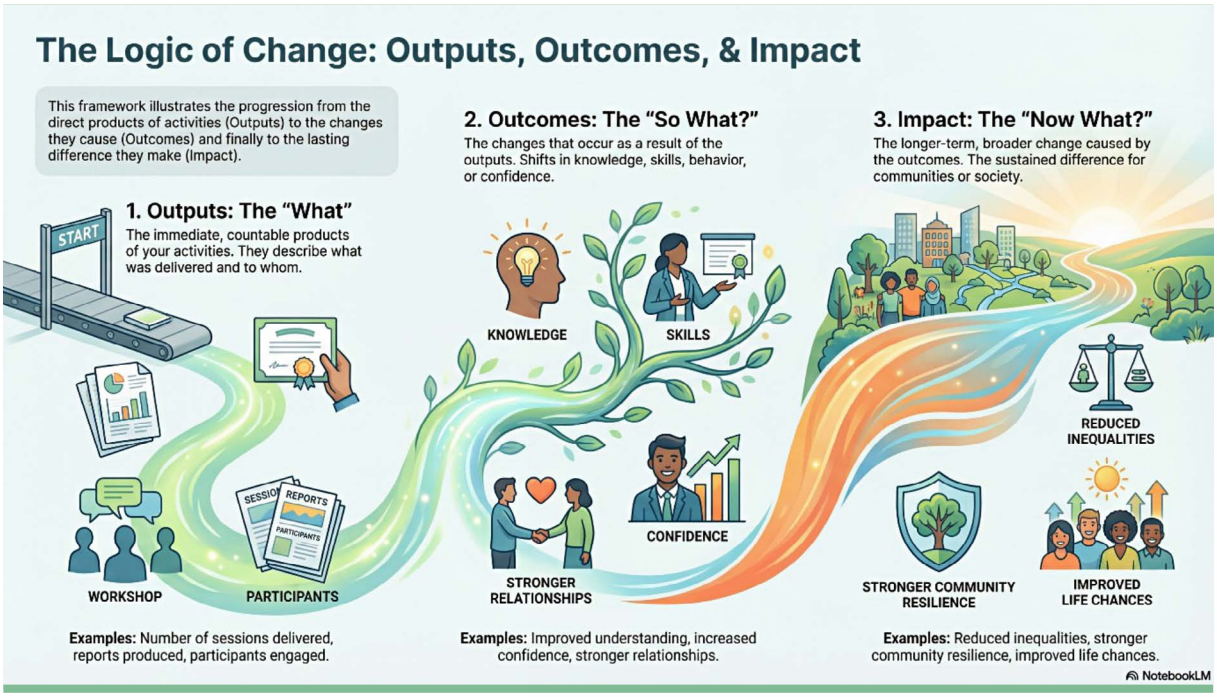
These approaches are consistent with the ethos of PHCTPs and could underpin a monitoring framework that reflects both measurable health improvements and Traveller-defined outcomes of empowerment and equity.

5.3 Building blocks for a monitoring framework

While there is no "silver bullet" that will capture and adequately measure the full complexity and extent of the PHCTPs and their highly valuable, and often invisible labour, there are practical steps that can be made towards clarifying and articulating the value of the PHCTP model and improving current approaches to monitoring. Monitoring can be defined as the ongoing process by which stakeholders obtain regular feedback on the progress being made towards achieving their goals and objectives.[85]

The development of a *Standard Framework for PHCTPs* provides a helpful extrapolation of good practice and clarifying the goals and objectives of the PHCTPs.[86] A next step is to build on this work with clear objectives and link them to inputs and outcomes that the policy (e.g. NTHAP, NTRIS II) should be influencing. This process might involve articulating distinct or discrete projects or an overall programme of work including the "what" (outputs), the "so what" (outcomes) and the "now what" (impact), as illustrated in the Logic of Change framework presented in Figure 7.

Figure 7: The Logic of Change



Source: Dr Naomi Tyrrell, Research Your Way Ltd

85 UNDP Handbook for Monitoring and Evaluation

86 Crowley, N. (2025) *A Standard Framework for the Primary Healthcare for Traveller Projects (PHCTPs)*

In any case, the process requires thinking critically about desired change and what is required to bring it about in order to answer the following questions:

- What precisely do we want to see changed?
- How will this change occur? What will make change happen?
- Who needs to be involved?
- What resources are needed?
- What conditions need to be in place, and what will influence these conditions?
- How will we monitor and evaluate the changes?
- How will we use the information obtained from monitoring and evaluation?

A range of resources are provided in Appendix 5: Templates and resources that can be used as tools to develop an approach to describing the logic or theory of change for PHCTPs.

5.4 Articulating underlying assumptions and outcomes

Stating assumptions about a programme helps to articulate the positive changes stakeholders would like to see from that programme and working backwards to map the prerequisites for these changes. There are several frameworks that can help to structure this thinking, such as Theory of Change, Logic Model, Contribution Analysis, Causal link monitoring. Further resources and templates are provided in Appendix 5, which also includes a worked example of a theory of change for PHCTPs for illustrative purposes.

Generally, these kinds of frameworks help stakeholders to work together to describe the logic, principles and assumptions that connect what an intervention, service or programme does, why and how it does it, and its intended results.[87] Importantly, it helps to clarify assumptions about the changes stakeholders expect to see as a result of a programme, over the short, medium and long term. These kinds of outcome frameworks help to strategically target data collection on meaningful outcomes which can reduce the data collection burden. And in the case of PHCTPs, may help to improve the understanding and recognition of the value and contribution of PHCTPs to influence outcomes for Travellers.

This is particularly relevant given the extensive administrative requirements placed on Traveller organisations in particular, who may have limited resources in place to support data collection. The assumptions stage is generally a good time to ask: “If we achieve the positive result we have identified, will we in fact see the longer term benefits or effects that we want?” “What are we assuming?” and “Do our assumptions differ?” In this process of thinking through the assumptions being made about the context, environment and actions that relevant stakeholders should take, useful ideas may emerge that could inform advocacy and other efforts aimed at encouraging action by others.

Process for collaboration and consensus

Developing a framework that involves clarifying assumptions as they relate to changes as a result of the PHCTPs is a crucial first step in monitoring PHCTPs. Any further effort to improve monitor PHCTPs requires agreement from all stakeholders groups on what changes we expect to see (outcomes we expect to achieve) as a result of PHCTPs.

87 Ghate, D. Developing theories of change for social programmes: co-producing evidence-supported quality improvement. Palgrave Commun 4, 90 (2018). https://doi.org/10.1057/s41599-018-0139-z

The findings of this review have helped to identify some of the expected changes and areas that should be monitored into the future. However, further consultation and critical input to develop a monitoring framework is required from PHCTPs, Traveller Health Units (THUs), the HSE, DoH and policy decision-makers.

It is important to emphasise that an outcome framework is **not a panacea** for complex community development programmes, such as PHCTPs. As Motherway (2006) states, 'There is no simple, universal, magic solution to the challenge of measuring community development impacts'.[88] The process of "articulation" of a programme in this context can be 'as fraught with difficulties as it is full of promise'.[89] However, the process is useful especially as a collective and collaborative endeavour that brings key stakeholders at all levels around the table to consider the assumptions and expectations of a complex programme or initiative.

Especially relevant is how it can help to surface points of confusion, misunderstanding or misconceptions between stakeholder groups and identify points of fuzziness and tension in the programme theory: 'The process can reveal where thinking is fuzzy — where logic or linkages are weak — and surface biases and divergent views about how change is expected to happen, especially among those with different positions or levels of authority. The process also helps to ensure different views are explored and addressed. In the life cycle of a strategy, the earlier these points of fuzziness or tension are resolved, the better'.[90]

This process can be especially useful for delineating and reaching agreement about what is sometimes called the **"messy middle"** — that is, the interim or **medium-term changes** that are expected to occur within a complex, large-scale social change programme. This is especially relevant to PHCTPs who draw from models of community development and primary health care. Since changes in systems or social structures are frequently qualitative and can be hard to name or identify, the process of clarifying interim outcomes is often at the heart of theory of change development.

Finally, an inclusive theory of change development process promotes equity by helping groups surface and probe differing beliefs and assumptions. The process often sparks important — if sometimes uncomfortable — conversations. Those conversations can help increase awareness of ways the theory of change upholds and advances equity, or risks not doing so. The process also can strengthen collective work by enhancing the level of commitment and buy-in among many stakeholders. The findings from this review indicate a need for collective reflection on the intended outcomes of the HCTPs, particularly at the medium-term level, and on how PHCTPs contribute to or can reasonably be attributed to these outcomes.

Theories of change become most valuable when they are regularly used and reviewed in line with changing assumptions about the programme. Instead of being viewed as a static narrative or visual product, theory of change products can become dynamic, living tools that support ongoing reflection and learning. Appendix 6 contains a list of resources to help with the development of complex programme logics.

88 Motherway, 2006: 36

89 Connell and Kubisch, 1998: 21

90 Annie E. Casey Foundation. 2022. *Developing a Theory of Change: Practical Guidance.* Baltimore, MD: Annie E. Casey Foundation

5.5 Measurement levels and indicators

Beneficiaries

Any approach to measurement of the PHCTPs should consider the various levels at which change is happening as a result of PHCTPs and those who benefit from its outcomes (i.e. "the beneficiaries"), such as the individuals and families from the Traveller community who engage with the PHCTPs, Traveller and non-Traveller staff who work in the PHCTPs, health and social care professionals who engage with the PHCTPs, and wider stakeholders in research and policy spaces. In the context of PHCTPs, and within a SDoH model, the interplay of stakeholders and levels is particularly complex.

The European Community Development Network's (ECDN) common framework for community development provides a helpful lens for thinking about the types of change PHCTPs may contribute to. As they explain, 'Community development outcomes are changes which occur at various levels - at the community level, at the policy or structural level and at the broader level of ideology and culture'.

Figure 8: Outcome levels for community development (ECDN)

Community level	Policy, structural and governance level	Themes
People have a better quality of life through concrete physical change to the lives of communities **Increased community leadership through more people becoming involved in community activity** **Strengthened community capacity i.e. communities are pro-active and resilient;** **Better community experience, i.e. strong mutual trust and solidarity; increased community capacity to attract/ generate funds**	Community networks are formed where strengthened alliances reflect collective interests Communities participate & are assertive and influential in decision making at local, national, European level Community issues on the agenda of decision makers Communities design and control their own solutions Changes are evident in practice,/policy /legislation at local, national and European level	Decision makers and public institution staff have a well-informed understanding of and approach to marginalised groups Transparency is evident in how decisions are made Services and structures respond more effectively to the needs of communities Participatory spaces reflect genuine participation and sharing of power of marginalised and minority groups in decision-making

Source: European Community Development Network for the European Commission

The ECDN explain that these levels are connected and explain that 'in order to transform the concerns and realize the interests of communities, the ambition of community development is to achieve outcomes which address the causes of issues as well as their consequences'.[91]

Suggested indicators

Indicators help to measure progress and achievements, as understood by the different stakeholders. They help to track intended results and can be considered as signposts of change. From the extensive consultation carried out as part of this review, the following metrics were identified to be considered for future monitoring of the PHCTPs:

- **Trust and empowerment:** Metrics should assess the level of trust built between peer workers, the community, and mainstream services; the increased confidence of Travellers in accessing services and their empowerment to advocate for their own health and rights. This can be captured through qualitative surveys, interviews and impact case studies, including staff and Traveller narratives.
- **Job quality:** job quality is a multi-dimensional concept that covers both subjective and objective measures, such as earnings (pay and other rewards); prospects and terms of employment (job security and career progression); intrinsic job quality (skills, social and physical environment, work intensity); health and safety; work–life balance; representation and voice. There are several models and frameworks developed internationally that can be drawn from in order to develop indicators in the context of PHCTPs.[92]
- **Advocacy and policy influence:** Measuring the impact of PHCTPs' advocacy work on policy change, service delivery and cultural awareness within mainstream institutions is important. This could include quantitative reporting on PHCTP representatives' engagement, promotion and representation on local and national committees, as well as the time TCHWs spend with families undertaking research and advocacy, and engaging with researchers and policymakers. However, monitoring should also capture the quality of these engagements and, where possible, their contribution to advocacy and policy outcomes (e.g. successful interventions related to the social determinants of health or the adoption of anti-racism policies).
- **Service uptake and early intervention:** Existing efforts to track increased uptake of preventative health services (e.g. vaccinations, screenings) and earlier engagement with healthcare can demonstrate impact. Increased focus and effort on capturing outputs may be useful. However, it should be noted that the absence of a universal ethnic identifier remains a significant barrier to robust quantitative impact assessment.
- **Health and wellbeing:** There is a strong focus in PHCTPs on delivering activities that support the general health and well-being of Travellers. Many creative and arts-based initiatives were mentioned in this context as a means of building community and celebrating Traveller culture. Studies have shown perceived health to be a good predictor of subsequent mortality and that engagement in the arts, culture and sports at any age is good for both mental wellbeing and physical health.[93]

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91 European Community Development Network for the European Commission (2014) Community development in Europe: towards a common framework and understanding. Online, available: https://ccednet-rcdec.ca/resource/community-development-in-europe-towards-a-common-framework-and-understanding/

92 Warhurst, C., Wright, S. & Lyonette, C. (2017) Understanding and measuring job quality: *Thematic literature review.* London: Chartered Institute of Personnel and Development.; International Labour Organization (ILO). 2020. *Measuring job quality: difficult but necessary*. ILOSTAT, 27 January. Available at: https://ilostat.ilo.org/measuring-job-quality-difficult-but-necessary/; Eurofound. 2015. *Towards 'better jobs': Eurofound's approach to measuring the quality of work.* [online] 13 March. Available at: https://www.eurofound.europa.eu/en/publications/all/towards-better-jobs-eurofounds-approach-measuring-quality-work

93 Included in Healthy Ireland Outcomes Framework: https://assets.gov.ie/static/documents/healthy-ireland-outcomes-framework-first-report-september-2022.pdf

- **Racism and discrimination:** There is a wealth of research to suggest that racism is linked to poor health outcomes.[94] While continued efforts to report outputs such as the number of anti-racism training sessions held, and number/types of participants, evaluation of the outcome of this training in terms of changes in the practices of health professionals is important to capture. There are useful models for evaluation in this regard that capture changes at incremental levels over time (learner's reaction to the training, changes in attitudes, increased knowledge and skill, changes in behaviour and organisational practice, and ultimately changes in the benefit to service users).[95]

As the UN Development Programme Handbook on Planning, Monitoring and Evaluating for Development states, there are a number of considerations when developing indicators:

- '**Who** sets indicators is fundamental, not only to ownership and transparency but also to the effectiveness of the indicators. Setting objectives and indicators **should be a participatory process.**
- A **variety** of indicator types is more likely to be effective. The demand for objective verification may mean that focus is given to the quantitative or simplistic at the expense of indicators that are harder to verify but may better capture the essence of the change taking place.
- The **fewer** the indicators the better. Measuring change is costly so use as few indicators as possible. However, there must be indicators in sufficient number to measure the breadth of changes happening and to provide cross-checking'.[96]

Qualitative and quantitative methods

Traditionally, outputs are typically measured using quantitative metrics, for example, capturing not only the number of interventions but also the type and the duration of interventions (e.g. "dosage"). To date, consistent collection of this information has enabled the HSE and PHCTPs to capture the breadth of activities across the PHCTPs. Information on gender and age bands may add further insight. However, the key focus in strengthening the monitoring of PHCTPs should focus on identifying outcomes, with a follow-up step then focusing on the most appropriate methods to capture those targeted outcomes.

The data to measure outcomes from PHCTPs should come from a variety of sources and includes both quantitative and qualitative elements. As outlined in Section 5.2, it is widely acknowledged that it is difficult to demonstrate impact, particularly in community development models. Some innovative examples are described in Case Study Vignette #3 below. 'Hard' outcomes are more readily demonstrated, whereas engagement with people, communities and groups often leads to 'soft' change that is more difficult to evidence. These types of outcomes lend themselves to being demonstrated and evaluated through qualitative research. It is recommended that that a mix of qualitative and quantitative methods are used to inform monitoring and evaluation of the PHCTPs.

94 https://pmc.ncbi.nlm.nih.gov/articles/PMC4580597/; NTHAP, 2022

95 Carpenter, J. (2011). Evaluating Social Work Education: A Review of Outcomes, Measures, Research Designs and Practicalities. Social Work Education, 30(2), 122–140 https://doi.org/10.1080/02615479.2011.540375

96 UNDP Handbook

Case Study Vignette #3: Measurement Examples

The following examples provided by a THU coordinator highlight useful approaches to measurement that were simple and culturally appropriate:

The THU coordinator explains how they developed a traffic light system to record Travellers readiness to engage with screening services:

> *So when the [TCHWs] were [working on the] programmes, the screening programmes - breast check, cervical check in particular - they just made a small note of how ready the person was to engage with it. And over time, we saw an improvement. We saw fewer reds, a few more oranges, and definitely more greens. And it was such a simple way to measure attitude and readiness to engage.*
>
> *It's not the job of the community health workers to be bringing people to screening programs or seeing how they've gotten [on]. Plus they're every five years or every three years, and it keeps changing.*

> *I think if we just break it down into simple that works for me, and if we imagine it has to be implemented by Traveller Community Health Workers who worked 12 hours a week and have enough going on. So simplicity is handy.*
>
> **(THU Coordinator, Focus group)**

The following in another example from an asthma project:

> *This was a number of years ago, and...promotion around asthma was a KPI. We did all the ...training. [But] we were given no guidance of how to assess the work. So what the [TCHWs] did was, when they went out at the beginning of the year, they asked the simple question - if there was somebody with asthma in the house - how many times in the last month did you use the blue inhaler? Because we learnt in the training, if you're using your blue inhaler more than a couple of times a week, your asthma is out of control.*
>
> *...They went back a number of months later and asked the same question, and the idea was to see, was there a shift in the amount of use? Because if...people are using the brown inhaler more, they're going to need that blue inhaler less. Because what we found is people were more relying on the blue inhaler, which is the responding, rather than the preventing. So we can look at simple measures like that, and they're very easy to capture.*
>
> **(THU Coordinator, Focus group)**

5.6 Considerations, assumptions and limitations

The following provides some considerations, assumptions and limitations in relation to developing a monitoring framework, that may be useful to explore:

- **Underlying motivations:** The purpose and motivation of monitoring PHCTPs should be considered. For example, is it primarily to satisfy funding requirements, or policy/ implementation requirements? Is it for learning and improvement? Is it to clarify accountability? Is it to support future evaluations?
- **Scope of the monitoring framework:** A theory of change, or similar, would help articulate how PHCTP goals, activities and outcomes are linked. However, as highlighted in this review, many mid- to long-term outcomes sit beyond the direct scope of the PHCTPs and are instead shaped within mainstream services. For monitoring purposes, consideration should therefore be given to clearly delineating the monitoring requirements for PHCTPs, distinct from those of HSE mainstream services.
- **Investment in monitoring and evaluation:** Monitoring and evaluation requires both human and financial investment. Comprehensive monitoring systems for complex interventions can be resource heavy and expensive, particularly in terms of design and set-up. THUs and PHCTPs will require appropriate resources and support to effectively monitor. Larger, more complex programmes require more monitoring and evaluation resources (data systems, training to use those systems, multiple stakeholder interviews or consultations, longitudinal follow-up). A programme with many measurement points (monthly or weekly data) and one that requires more qualitative measurement will cost more than one with simple annual measures. Clarification of the resources to be invested in future monitoring and evaluation of PHCTPs needs to be considered when further developing a monitoring framework.
- **Collective representation:** Buy-in and a sense of accountability from key actors is imperative. To this end, it will be vital to ensure there is appropriate representation and meaningful participation in the process of developing future monitoring systems. A stakeholder engagement plan may be considered as a useful tool to support the development of an outcomes framework, and may help to ensure buy-in, incorporate diverse perspectives, and improve the likelihood of achieving the desired long-term impacts. See Figure 9: Functions and Principles of Monitoring & Evaluation in Appendix 5.
- **Adaptability:** Outcome frameworks often involve producing a visual model which can imply a neat, predictable, linear progress to achieving change. However, progress often emerges incrementally, and unevenly. Any single diagram cannot easily capture setbacks, external pressures, or emergent outcomes that are central to community development approaches. Any framework used to capture the outcomes of PHCTPs should not be intended as a form of national standardisation to be used for compliance or regulation. Rather it may help to express consensus on agreed goals, standards and outcomes within the PHCTPs. It should function as a living tool that evolves alongside the programme. It can be strengthened through iterative review cycles that actively involve TCHWs, Traveller organisations, THUs and other key partners.
- **Develop and pilot at local level:** A co-designed theory of change or similar, would provide a foundation for developing a monitoring framework. The monitoring framework could then be piloted at local level and further refined. An evaluation of its implementation should assess the acceptability, appropriateness and feasibility of the monitoring framework, particularly for local level stakeholders.

- **Reduce burden:** It should be easy to use and enhance the planning and implementation process rather than detract from it. It should help to streamline reporting and data collection rather than overwhelm organisations.
- **Unintended consequences:** Consideration should be given to whether programmes generate unexpected or negative effects. For the PHCTPs, examples might include the poverty trap created by the employment structure for TCHWs, and the risk of over-work and blurred boundaries where TCHWs live within the communities they support—a potential challenge implicit in the peer worker model. There may also be other indicators not currently assessed or analysed, such as the relative proportion of Travellers *withdrawing* from a service over time. It would be important to uphold data protection principles between agencies and ensure that quality improvement efforts are separated from compliance and monitoring functions, the potential to use existing data to more objectively assess quality should be explored. An ethnic identifier would likely be essential to extract useful data in this regard.
- **Expectations on causality and impact:** Travellers may take part in numerous programmes and be the recipient of multiple services. It would not be possible or realistic to directly attribute any *single* programme to Traveller health outcomes overall. There is an inherent "muddiness" to proving causality in a model of community development, such as PHCTPs. Research suggests we need to accept some uncertainty about measurement, 'we must recognize that determining definitively the extent to which a government program contributes to a particular outcome is usually not possible, even with a carefully designed evaluation study. We might be able to provide considerable evidence regarding a program's impacts and might be able to significantly increase our understanding of how a program is influencing a certain outcome, but in most cases of any complexity, there will not be a 100% guarantee. Rather, we need to talk of reducing our uncertainty about the contribution of the program', adding that, '...we can almost always gather additional data and information that will increase our understanding about a program and its impacts, even if we cannot "prove" things in an absolute sense. We need to include softer and qualitative measurement tools within our concept of measurement in the public sector'.[97] In this sense, it may be worth considering the PHCTPs in terms of their contribution rather than attribution towards improving Traveller health.[98]

97 Mayne, J. (2001). Addressing attribution through contribution analysis: Using performance measures sensibly. *Canadian Journal of Program Evaluation*, 16(1), 1–24; Mayne, J. (1999). *Addressing attribution through contribution analysis:* Using performance measures sensibly (discussion paper). Ottawa, ON: Office of the Auditor General of Canada.

98 There is a body of literature in the field of evaluation and impact studies which lays out the distinction between attribution and contribution. The term 'causal attribution' refers to a direct causal link. The term 'causal contribution' can be used to recognise multiple contributing factors that produce results and may be better suited to model such as PHCTPs: https://www.intrac.org/app/uploads/2024/12/Attribution-and-Contribution.pdf; https://www.betterevaluation.org/frameworks-guides/communication-for-development/tasks/understand-causes/investigate-causal-attribution-contribution

Section 6: Review Recommendations

This final section of the report presents five key recommendations to strengthen and support the PHCTPs into the future.

Recommendation 1:
Develop a standardised approach to reflect the work of PHCTPs

It is recommended that a standardised approach to capture the work of the PHCTPs is developed, as a foundation for monitoring, evaluating and learning into the future. Monitoring of PHCTPs should move beyond narrow quantitative activity counts to include meaningful qualitative assessments that reflect the complexity of community development, trust-building and empowerment, as outlined in the findings of this review. Current practices, which rely heavily on KPIs related to raising awareness and signposting in three very specific areas (cardiovascular disease, diabetes and mental health), are widely regarded as inadequate for demonstrating the full value and impact of the PHCTP model. In order to support a more appropriate monitoring approach, a first step is for key stakeholders to participate in a **collaborative process to develop an outcomes framework.** This process could help to clarify and agree relevant and/or targeted outcomes for the PHCTPs, and articulate a **pathway of change** to influence these outcomes. This may help to provide a unified understanding of programme objectives at local and national levels among a diverse group of stakeholders. A stakeholder engagement plan is a useful tool in this regard also.[99]

The PHCTP monitoring framework should incorporate **standardised core domains** aligned with national policy priorities, while allowing **local flexibility** to reflect the diverse contexts and priorities of Traveller communities. International good practice in community development evaluation offers valuable methodologies—including Most Significant Change, Outcome Mapping, Outcome Harvesting, Ripple Effect Mapping, and Learning, Evaluation and Planning (LEAP)—which emphasise qualitative insight, collaborative learning, and evidence of change over time. It should be noted some of these approaches will be suited to routine monitoring, while others will be more appropriate for evaluations.[100]

Recommendation 2:
Invest in workforce development to reach long term goals

There is consensus across the stakeholder groups who participated in this review that low pay, limited career progression and inconsistent employment conditions currently undermine the value of TCHWs and that these issues are an urgent priority. Improving **salary structures, longer term contracts** and **benefits** (such as medical card, pensions, maternity supports) are essential steps to recognising the professional expertise of TCHWs and retaining a stable workforce that can build on progress towards the long-term goals of the PHCTPs.

Central to this is the need to clearly **define the roles and boundaries** of TCHWs and Project Coordinators, supported by national role descriptions and competency frameworks that align expectations, workload and remuneration. It is recommended that pathways to accredited **training and qualification** for TCHWs are improved and current obstacles to funding and implementation are resolved as a priority. In addition, Recognition of Prior Learning (RPL) and experience[101], the development of mechanisms to share, capture and retain knowledge when experienced staff leave or retire may be helpful to the PHCTPs.[102] A THAF subgroup have been established and is working to resolve issues related to HR workforce planning career progression and training which will continue into 2026.

99 See: https://analysisfunction.civilservice.gov.uk/policy-store/the-analysis-function-theory-of-change-toolkit/#section-7

100 See: Sundberg, A. (2019) Beyond the Numbers: How qualitative approaches can improve monitoring of humanitarian action. ALNAP Paper. London: ODI/ALNAP.

101 Recognition of Prior Learning (RPL) refers to the formal recognition by higher education institutions of the knowledge, skills, and experience students already have, even if they were gained outside traditional education.

102 Anne Burmeister, Jürgen Deller, Knowledge Retention From Older and Retiring Workers: What Do We Know, and Where Do We Go From Here?, Work, Aging and Retirement, Volume 2, Issue 2, April 2016, Pages 87–104, https://doi.org/10.1093/workar/waw002

Improved clarity on the role of the TCHWs must be accompanied by investment in **adequate staffing** to support Traveller health, including specialist posts such as men's health, mental health, drug and alcohol, accommodation and family support workers, enabling TCHWs to focus on their core responsibilities in primary health care rather than acting as a default response to gaps in other services. As described in the findings of this report, the SDoH model makes this need more acute.

Given the nature and context of the work that TCHWs do, particularly in relation to crisis response and the continued high incidence of suicide among the Traveller population, **psychosocial and wellbeing supports** for workers should be considered akin to Employee Assistance Programmes, alongside existing creative wellbeing programmes such as CEART.[103] The suitability of staff support programmes, including their cultural appropriateness and adequate resourcing, would also need to be considered.

Improving working conditions also requires investment in **administrative capacity and infrastructure**. Many PHCTPs operate without dedicated administrative posts, diverting frontline workers into reporting and data management tasks. Adequate administrative resourcing, coupled with a national, literacy-accessible IT system to standardise data collection and support meaningful monitoring, is essential to demonstrate impact, strengthen programme planning and secure future investment.

The above mirrors many of the key recommendations from the recent report *'Beyond the Poverty Trap: A Roadmap for Sustainable Traveller Primary Health Care Projects'* which recommends nationally consistent and standardised approaches to PHCTPs in terms of operational aspects of recruitment, training and job descriptions. It calls for affirmative action measures to address social welfare, medical cards and living costs and contains several recommendations related aspects of funding, structure and ethos which are echoed in this review.[104]

Recommendation 3: Strengthen accountability, coordination and partnership approach

With regard to monitoring PHCTPs, there is a need to clarify accountability and define the respective responsibilities of PHCTPs, the HSE and other public services. Developing a shared **outcomes framework** will help establish a clear understanding of the PHCTPs' role within the wider primary care system, distinguishing the outcomes for which PHCTPs are responsible from those that sit with mainstream HSE services, and the DoH. This clarity is essential to prevent inappropriate role expectations, reduce scope creep, and support meaningful monitoring and resource allocation.

Improved partnership and communication between PHCTPs, the HSE and the DoH is critical to strengthen and progress the PHCTPs into the future. Stakeholders emphasised the importance of stronger coordination across projects and consistent engagement from central government partners. Establishing formal mechanisms for relationship-building, shared planning and decision-making would help build consensus, strengthen trust and ensure that programme ambitions are jointly owned rather than carried by PHCTPs alone. The process of developing an outcomes framework may assist with building consensus and establishing a shared understanding between HSE, DoH, Traveller organisations and wider stakeholders on how PHCTPs contribute to outcomes for Traveller health and wellbeing.

103 https://www.paveepoint.ie/launch-of-traveller-wellbeing-through-creativity-programme/
104 Stamp, S. 2025

Recommendation 4:
Enhance infrastructure to support knowledge sharing

A stronger, more connected infrastructure is needed to enable shared learning, knowledge exchange and consistent practice across PHCTPs. This should include investment in shared **digital systems** and software, along with **capacity building** to ensure organisations can use them effectively.

National **repositories of resources**, standard templates for SOPs, SLAs, tenders and job descriptions could support programme fidelity while allowing adaptation at a local level as needed. Structured mechanisms to identify and **share good practice** through established networks—such as THUs and national PHCTP forums—should be expanded, supported by local needs assessments and peer-learning opportunities that are accessible and regular.

Monitoring and evaluation should be reframed as a **mechanism for learning, reflection and improvement** at the local level, rather than solely a reporting requirement for funders. Organisations should be supported to use data to understand what is working, what needs improvement and why, and to generate knowledge for the wider programme. It is hoped that collaboration, learning and shared problem-solving will strengthen coherence across sites and enhance the collective capacity of PHCTPs.

Recommendation 5:
Consider future approaches to monitoring and evaluation

Investment in monitoring and evaluation should be **planned and budgeted** proportionately, recognising its essential role in evidencing impact and driving programme improvement. This requires dedicated resources for data systems, staff time and specialist evaluation expertise, rather than positioning monitoring as an add-on to current operations. Dedicated budget would help to endorse the view that evidence, learning and accountability are core to the PHCTP model and integral to sustainable programme development. Evaluation tenders should be **developed collaboratively** with key stakeholders, particularly commissioners, and funders such as the DOH, should be engaged as active partners in the evaluation process to ensure relevance, shared ownership and a strong commitment to evaluation findings.

There is significant value in commissioning a focused **literature review** to examine monitoring and evaluation approaches used in comparable community health worker programmes in other jurisdictions, particularly those working with marginalised or minority groups. This would help identify international exemplars, transferable learning and pitfalls to avoid. Alongside external evaluation, capacity for self-evaluation should be strengthened within PHCTPs, enabling ongoing reflection, learning and adaptation at local level.

Alongside external evaluation, capacity for **self-evaluation** should be strengthened within PHCTPs to support ongoing reflection, learning and adaptive improvement at local level.[105] This combined approach will enable the programme to demonstrate value more effectively, build credibility with funders and partners, and ensure future investment is grounded in strong evidence and shared understanding.

105 Health Service Executive (2019), National Quality Improvement Team Self-Evaluation Guide Dublin: National QI Team Health Service Executive https://www.hse.ie/eng/about/who/nqpsd/qps-education/national-qi-self-evaluation-guide.pdf

Conclusions

This review finds that, among the participants who took part in the research, the PHCTPs were viewed as a trusted, culturally appropriate mechanism for providing Traveller families with health-related information, signposting, support and advocacy. The peer-led approach was consistently described as central to this, with PHCTPs providing access, continuity and reach that mainstream services would find difficult to achieve. It is estimated that as little as 20% of a person's health is linked to access and quality of care, with 80% related to other factors such as behaviours and socioeconomic conditions.[106] This review evidences this in its description of the careful, considered work TCHWs do over many years to build relationships and trust with families, well before they ever consider or have a need to engage with mainstream health services. In order to recognise and measure the value of PHCTPs, there is a clear need to focus on these aspects of TCHWs work that contribute and influence health outcomes for Travellers.

The work of PHCTPs is broad and spans health education, navigation of mainstream services, crisis response and advocacy and support around social determinants of health. While the diverse outcomes of their current work are not routinely measured, stakeholders report that their work improves Travellers' confidence, awareness, and engagement with services, alongside building strengthened relationships between Travellers and health providers.

The review identifies several factors that currently limit sustainability. These include structural funding constraints, inconsistent employment structures and conditions, barriers to career pathways for TCHWs, and increased expectations placed on projects without sufficient resources. Recruitment and retention challenges are directly linked to the current employment model, and variations across regions create further inconsistency. Strengthening sustainability will require more stable long-term funding arrangements, clearer role definitions, investment in workforce development, and improved alignment between PHCTPs, wider HSE structures and the DoH.

This review highlights a sense of frustration among stakeholders that existing monitoring arrangements capture only a narrow set of activities and do not reflect the full scope of PHCTP work. Current KPIs provide limited insight into outcomes, and the absence of a national monitoring approach limits the PHCTPs ability to track change over time and demonstrate the impact they are having "on the ground".

Stakeholders expressed a clear preference for a monitoring framework that is proportionate, feasible and recognises both quantitative and qualitative dimensions of the work, including trust, confidence, cultural mediation and support around social determinants of health. While this review provides some guidance and insight into what a monitoring framework that captures the value of PHCTPs should look like, there is further work to do to clarify assumptions and agree on core outcomes that will underpin a monitoring framework. Again, this will require collaboration across PHCTPs, Traveller organisations, THUs, the HSE, DoH and other partners.

Taken together, the findings from this review indicate that PHCTPs play a distinctive and valued role in Traveller health but are operating within structural and system constraints that limit their ability to show long-term effectiveness. Clearer national direction, improved resourcing, and stronger workforce supports would help align the model with national policy goals and support more coherent planning, monitoring and reporting into the future.

106 Institute for Clinical Systems Improvement, 2015 cited in HSE Public Health Strategy 2025 -2030: Achieving the best possible health for everyone in Ireland https://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/hse-public-health-strategy-2025-2030.pdf

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Appendices

Appendix 1: Governance and oversight

Membership of the National Oversight Group for the Review of PHCTPs

- Jackie Austin, Director of Public Health Nursing, Dublin North County
- Thelma Birrane, Social Inclusion Coordinator, HSE West
- Mary Brigid Collins, PHCTP Coordinator, Pavee Point Traveller and Roma Centre Primary Healthcare for Travellers Project
- Concepta De Brun, HSE Social Inclusion Specialist, Dublin
- Ann Friel, Donegal Travellers Project,
- Lynsey Kavanagh, Co-Director of Pavee Point Traveller and Roma Centre
- Sandra McDonagh, CEO, Offaly Traveller Movement
- Siobhan McLaughlin, Coordinator Donegal Travellers Project
- Mary Nevin, Project Coordinator Longford Primary Healthcare for Travellers Project,
- Ellen O'Dea, Head of Service, HSE Health and Wellbeing, Dublin North
- Diarmuid O'Donovan (Chair of Oversight Group for the review of PHCTPs), Director of National Health Improvement with HSE Public Health
- Chrissie O'Sullivan, Coordinator, Cavan Traveller Movement
- Brigid Quilligan, Project Manager, Kerry Travellers Project
- Jimmy Todd, Traveller Health Unit Coordinator, HSE Midlands
- Brigid Quirke, Project Manager, HSE National Social Inclusion Office[107]
- Michelle Kearns, Project Manager, HSE National Social Inclusion Office

107 Until retirement at end of August 2025

Appendix 2: Review objectives, questions and methods

Figure 10: Review objectives, questions, methods and location in report

#	Objective	Review Question(s)	Method/approach	Location in report
1	Document levels of participation, empowerment, progression, self-esteem and confidence of the **Traveller Community Health workers.**	What are the levels of participation, empowerment, progression, self-esteem, and confidence among TCHWs? What works or does not work? And why? What needs to be changed / improved?	**Workshops** with TCHWs, and focus groups across two sites, incorporating photo elicitation or similar. Where possible, draw from any existing case studies or feedback for secondary analysis.	Section 4: Review Findings Appendix 3: Summary of National Workshop outputs
2	Document views of the role and benefit of the TCHWs/PHCTPs with **Traveller Community members.**	How do members of the Traveller community view the role and benefits of the PHCTPs? What does it mean for them, their families and community? How / has their experience changed over time? What works / does not work?	**Interviews with Traveller community** members across two sites (urban and rural)[108] Where possible, draw from any existing case studies or feedback for secondary analysis.	Section 4: Review Findings
3	Explore experience of **HSE providers** in engaging with the PHCTPs.	What are HSE service providers' experiences of working with PHCTPs? What works, or does not work, and why? What are the challenges and solutions	Online survey of a sample of HSE staff who have worked with PHCTPs across the urban and rural sites selected for the review.	Section 4: Review Findings Appendix 4: Qualitative Survey Findings
4	Outline experience of **voluntary organisations and academic institutions** of engaging with the PHCTPs.	What is the experience of voluntary and academic institutions in engaging with PHCTPs? What works, or does not work, and why? What are the challenges and solutions?	Online **survey** of a sample of representatives from community and voluntary organisations, and academic institutions who have worked with PHCTPs. ***Key informant interview*** *with a representative from an academic institution with specialist expertise in community development and experience of collaborating/ engaging with PHCTPs**	Section 4: Review Findings Appendix 4: Qualitative Survey Findings
5	*Explore experience / perspective of **Traveller Health Unit** coordinator and **Social Inclusion Managers****	What is the perspective of THU coordinators and SIMs in terms of the impact, role and value of PHCTPs? In terms of monitoring, what works, or does not work, and why? What are the challenges and solutions to strengthening and sustaining the PHCTPs into the future?	***Focus groups*** *with Regional Traveller Health Units and Social Inclusion Managers/GMs**	Section 4: Review Findings
6	*Explore experience / perspective of **key informants** at a senior strategy / policy level**	What is the perspective of senior strategy and policy level stakeholders of the impact, role and value of PHCTPs? In terms of monitoring, what works, or does not work, and why? What are the challenges and solutions to strengthening and sustaining the PHCTPs into the future?	*Semi-structured **key informant interviews** with representatives from DoH, Chair of NTHIG, HSE REO, HSE**	Section 4: Review Findings

108 Following consultation with Working Group, it was agreed that semi-structured one-to-one interviews would be more appropriate than the focus groups originally proposed for this stakeholder group.

7	*Explore experience of **organisations that have PHCTPs** (e.g. Traveller organisations and Local Development Organisations)**	What is the experience of organisations that have a PHCTPs? What works, or does not work, and why? What are the challenges and solutions? What is the perspective of the key informant in terms of the impact, role and value of PHCTPs? In terms of monitoring, what works, or does not work, and why? What are the challenges and solutions to strengthening and sustaining the PHCTPs into the future?	*Online survey of organisations that have PHCTPs* *Semi-structured key informant interviews with representative from a Traveller Organisation that has a PHCTP and a former PHCTP coordinator*	Section 4: Review Findings Appendix 4: Qualitative Survey Findings
8	Outline engagement with key stakeholder by the PHCTPs regarding impact on **social determinants of health.**	How have PHCTPs influenced social determinants of health (e.g. accommodation, education, racism)?	**Workshops** / Focus groups and participatory methods with TCHWs, Traveller community members, and other stakeholders, will explore how PHCTPs address issues such as accommodation, education, racism, and employment.	Section 4: Review Findings Appendix 3: Summary of National Workshop outputs
9	Review of findings from **Genio's** ongoing action research project	What relevant insights arise from the Genio action research project?	**Desk-based review** and high-level integration of the Genio project findings into the analysis, ensuring relevant insights are reflected in the overall evaluation without additional primary fieldwork.	Section 3: National and local context of the PHCTPs
10	Review of the PHCTPs with regard to the **PHCTPs standard framework** to identify highlights as well as gaps and future support needs.	What are the gaps and strengths of the standard framework? Is the (existing) standard framework appropriate, acceptable and feasible for monitoring and reporting on PHCTPs?	**Desktop review** of the existing standard framework and related documentation. Standard framework for PHCTPs incorporated into **online qualitative survey** with stakeholders.[109]	Section 4: Review Findings Appendix 3: Summary of National Workshop outputs
11	Identify the strengths, challenges, gaps and future supports required for their **development and sustainability**	How can a monitoring framework support ongoing monitoring of achievements, challenges, enablers, gaps and support needs for the strengthening and sustainability of PHCTPs?	**Thematic analysis** of data collected through focus groups, and open text comments in survey questionnaires to capture feedback on the standard framework, and identify system strengths, challenges, and required future supports.	Section 4: Review Findings Section 5: Outline for a Proposed Monitoring Framework Section 6: Review Recommendations
12	Report on the **framework** developed for the identification, collection and ongoing collation of core activity data from each of the PHCTPs to document the range of work that is undertaken by the projects.	N/A	Building from the standard framework, develop a practical **monitoring framework** informed by document review, participatory input from TCHWs, and consultation with HSE and voluntary sector stakeholders. This will detail feasible mechanisms for ongoing data collection and collation.	Section 5: Outline for a Proposed Monitoring Framework Section 6: Review Recommendations
13	Produce a **final report** on the analysis of these findings including an **outline framework** for the ongoing monitoring of the achievements, challenges, enablers, gaps and support needs for their strengthening, sustainability and future development of the PHCTPs.	N/A	Final report will synthesise all qualitative and documentary data, integrating participatory findings and a co-developed **outline monitoring framework**, aligned with best practice and community insights.	Section 4: Review Findings Section 5: Outline for a Proposed Monitoring Framework & Appendix 5: Templates and resources Section 6: Review Recommendations

**Signifies added objectives and fieldwork beyond the original proposal*

109 A modification was made to the original design of the review in terms of how to incorporate and build from the PHCTP Standard Framework. In its current form, that framework was more suitable for the purposes of a desktop review and to inform an understanding of the model, rather than for direct assessment or evaluation with stakeholders. Instead, the Activity Report (2024) was reviewed with TCHWs in National Workshop #2 to inform the activities contained in Section 5 of this report.

Appendix 3: Summary of National Workshop outputs

National workshops were conducted with representatives from PHCTPs, primarily TCHWs on 9th September and 16th October 2025 at Pavee Point in Dublin, with 63 and 65 attendees respectively (See Section 3: Review Methodology).

The following captures the participants reflections of the journey of the PHCTPs from its beginning in the 1990s to date, and importantly their vison for the PHCTPs in the future.

1.1 'River of Life' and Future Journey of PHCTPs

What has been the journey of PHCTPs?

The journey of Primary Healthcare for Travellers (PHCTPs) has evolved significantly since the early 1990s, growing from a foundation of community empowerment to a multifaceted role encompassing advocacy, cultural mediation, and addressing systemic inequalities.

Despite their increasing contribution and remit, PHCTPs face persistent challenges such as inadequate pay, lack of benefits, and the need for greater professional recognition and clear career progression opportunities.

LOOKING BACK

Early Years (1990s): Foundation and Empowerment

- The PHCTP journey began in 1992 with a focus on Travellers taking ownership and empowerment within their communities.
- Early projects aimed at helping their own people—men, women, and children—on the ground.
- Focus on targeted initiatives such as dental health, especially for children
- Early workers faced challenges, including experiencing racism for the first time and difficulties in the initial years of their work.

Growth and Formalization (2000s): Reach and knowledge

- 2000s saw the PHCTPs expand their reach and develop training.
- "Citizen Traveller" initiative established in 2000 to encourage a better understanding between Travellers and settled people through public education and awareness programmes.
- Training programs became more prevalent, with Donegal offering training in 1999
- By 2001, the Fingal project alone had 16 women employed as TCHWs
- In 2004 PHCTP workers completed FETAC Level 5 community health training
- TCHWs worked as peer researchers for All Ireland Health Study (AITHS), published in 2010, providing an improved understanding of the health status of Travellers.

Challenges and Advocacy (2010 to date): Recognition and Systemic Issues

- Issues such as inadequate funding, lack of travel budgets, and the "poverty trap" where working more hours led to reduced benefits or loss of medical cards became prominent
- Recognition of ethnicity in March 2017 was a significant milestone
- Despite their crucial work, including during the Covid-19 pandemic, they often did not receive recognition or pandemic payment.
- Need for progression routes, investment in training, and higher-paid jobs, with employment opportunities provided by the HSE, was strongly voiced
- PHCTPs also highlighted the ongoing issue of racism and discrimination, emphasizing their role in challenging it.

MOVING FORWARD

Short-Term Vision (2026 - 2029): Investment, Standardisation, Coordination

- Continue to advocate for equality and social justice
- Poverty trap is addressed where TCHWs can take on more hours, and where more staff are being employed within the PHCTPs, particularly to make it more attractive for younger generations to take up TCHW roles.
- Improved pay and conditions, including contributions such as pensions and maternity benefits (and maternity cover) are provided and the provision of medical cards to TCHWs. Sustained funding and longer-term employment contracts.
- Sense of recognition, appreciation, linked to receiving these benefits
- Call for standardisation in terms of:
  - TCHW role and job description
  - Training (as well as recognition of prior learning)
  - Pay and conditions for staff providing guaranteed benefits, particularly medical card and pension
  - Approach to cultural awareness training
- Build capacity of TCHWs to collect data, particularly around digitisation of data collection.
- Counselling and wellbeing support for the workers
- Collaboration between communities, government departments and HSE is also sought, as well as the capacity of PHCTPs to partner with these stakeholders.
- Better coordination and communication between projects
- Services will be more culturally informed
- *"In 5 years we want to see standard approaches to things, clear strategy and better coordination between the projects"* (TCHW, National Workshop 2)

Long-Term Vision (2030-2035): Permanent Roles and Full Integration

- By 2030, the vision for PHCTPs includes permanent roles with benefits, such as pensions and medical cards, and Traveller supports based within the community
- Progression to full time roles in mainstream health services, with potential for internships, and routes to nursing and medicine
- TCHW role more attractive for younger generation, "you can get the same pay in McDonalds"
- Better ways to capture complexity of community work – "All HSE want is KPIs – need to capture work better + the complexity"
- More respect and recognition for the TCHW role and the limits of the role
- Additional training - specialised areas: child welfare, education of developmental delays
- Mandatory antiracism training
- Better representation at local level
- More participation / accessibility for peer learning between TCHWs - *"Don't just meet in Dublin, maybe hold some bigger forums for the workers"*
- Government playing their part in tackling discrimination

In summary, the future vision for PHCTPs expressed by TCHWs aims for:

- Proper investment and sustained funding to end the current poverty trap, with improved pay, conditions, benefits (pensions, maternity supports, medical cards), and longer-term contracts.
- National standardisation of roles, training (including RPL), pay and conditions, and cultural awareness/anti-racism training.
- More staffing and clearer career pathways, including routes into mainstream health roles such as nursing and medicine.
- Projects as Traveller-led, culturally informed, and strongly connected to communities.
- Better coordination, communication, and collaboration across projects and with Government/HSE partners.
- Stronger recognition and respect for the complexity and impact of TCHW work, supported by improved data collection and digital systems beyond narrow KPIs.
- Wellbeing supports for workers, including counselling.
- Expanded peer learning opportunities and more accessible national forums.
- Increased representation and government commitment to tackling discrimination.

1.2 Strengths, Weaknesses, Opportunities, Challenges

The purpose of this SWOC analysis was to develop a shared understanding of what is working well within the current Primary Health Care for Traveller Projects (PHCTPs), what challenges are limiting their effectiveness, and where opportunities exist to strengthen and sustain the programme into the future. The scope of the SWOC focused on identifying internal strengths and weaknesses and external opportunities and threats affecting PHCTPs. The exercise was conducted with approximately 60 representatives from PHCTPs across Ireland during a national workshop. Participants were divided into four small groups for discussion and SWOC analysis drawing on lived and professional experience.

STRENGTHS
Peer-led model: culturally appropriate, community-based approach
Trust and long-term relationships with Traveller families;
Confidence and **empowerment** of Travellers
Improved health outcomes: participation of Travellers, identifying health needs / issues of community; improved life expectancy
Addressing/modelling **a social determinant of health approach**
Building relationships and breaking down barriers between Travellers and mainstream services and other organisations
Community development, intergenerational engagement, community pride
Professional development of PHCTP staff - Staff gaining skills and training.

WEAKNESSES
Funding and pay: Chronic underfunding, low wages, lack of parity with HSE, no pensions, insecure posts, year-to-year funding
Poverty trap: Loss of medical cards or welfare if hours increase; part-time hours enforced.
Limited progression: Few routes into HSE or mainstream employment; prior learning/experience often not recognised
Overwork & blurred boundaries: Always on call, "never off the clock"; people coming to doors outside hours; exposure to trauma.
Role creep & lack of recognition: Services offload work (e.g. accompanying PHN on site); TCHWs not seen as equal professionals
Lack of consistency: Variation across projects in pay, terms, support
Recruitment & retention issues: Staff leaving, not replaced; lack of younger people entering / ageing staff
Vulnerable to wider systems failures: Frustration when councils/services don't act on issues flagged.

OPPORTUNITIES
Training, professional development, career progression: including standardised and compulsory training
Networking & collaboration: with other PHC projects, wider agencies, other professionals.
Advocacy & lobbying: Opportunity to influence policy on Traveller health, accommodation, and discrimination.
Professional recognition & Respect: to be seen / treated as a respected, professional workforce. Outcomes of work to be recognised

CHALLENGES
Funding and resourcing of PHCTPs: underinvestment in staff pay and conditions; lack of sustained funding to support programme planning;
Work overload: Expected to address wide range of issues (health, accommodation, education, youth) beyond remit; mission drift/creep
Staffing: Ageing workforce, lack of new recruits to replace staff, retention problems because of "poverty trap" inherent in role (i.e. staff leaving or reducing hours to protect entitlements), lack of men in workforce
Recognition & respect: Struggle to be seen as professionals; services don't always take PHCTPs / TCHWs seriously
Community engagement: Challenges in reaching more vulnerable families with complex needs; building trust with new families
Trauma exposure: High emotional toll of work, including suicide, DSGBV.
Geographical spread: Wide areas to cover, travel costs not supported.

1.4 Key Activities and Outcomes

This section summarises a workshop exercise where participants discussed current activities of Primary Healthcare for Traveller Projects (PHCTPs), identified missing activities, prioritized important contributions, and outlined their outcomes.

In small group workshops, TCHWs were shown or read a summary of activities conducted by the PHCTPs in 2024. They were asked to prioritise the most important activities (i.e. the activities that create positive changes for Travellers) in their day to day. Their feedback can be summarised as follows:

- **Psychosocial support:** participants emphasised mental health and crisis responses, particularly suicide.
- **Training and education:** Building cultural capacity through anti-racism / TCAT training
- Addressing **Social Determinants of Health:** Activities related to accommodation, education, and employment were recognised, often under the broader category of "Social Determinants of Traveller Health".
  - Emphasis on accommodation support in particular e.g. either needing to refer families to appropriate an accommodation worker (if available) or advocating for families with local councils.
  - Advocacy around rights, assisting at appointments, and addressing discrimination were also discussed
- **Community engagement:** Activities like Traveller Wellbeing through Creativity showcases, National Traveller Health Day events, and family events were highlighted for their role in community building and cultural pride.

TCHWs were asked to identify what activities are missing from their current programmes of work, that they feel should be included. The following is a summary of key feedback:

- **Informal / out-of-hours activities:** Participants emphasised the considerable informal work they do, such as responding to a "call to the door" for informal support and engagement. This responsiveness was considered by the TCHWs to foster trust and connection within their communities and as such, was integral to achieving impact.
- **Accommodation support:** Despite being identified as missing from data, its importance was underscored, with participants questioning if it should be a core role and reflected in activity data.
- **Specific health areas:** Disability support (including deafness, autism, dyslexia, ADHD), family response, and specific work with older persons were identified as missing or underrepresented.

Outcomes from Activities

The outcomes described by participants demonstrate a wide-ranging positive impact:

- **Improved mental health and reduced stigma:** Psychosocial support leads to better mental health, increased confidence to access services, and a breakdown of stigma around mental health and diagnoses.
- **Increased engagement with services:** Activities like signposting, health education, and community events result in more Travellers engaging with mainstream health services, attending appointments, and seeking help.
- **Enhanced awareness and informed decision-making:** Workshops and educational initiatives lead to greater awareness of health issues and improved health literacy (e.g., diabetes, cancer screening), available services, and empower individuals to make informed decisions.
- **Stronger community and cultural pride:** Family and cultural events foster a stronger sense of community, develop pride in Traveller culture, and encourage people to discuss previously taboo issues.
- **Support and empowerment:** Persistent follow-up and advocacy make individuals feel supported and not alone, leading to empowerment.

Overall, the workshop highlighted the critical role of PHCTPs in bridging gaps, building trust, and empowering the Traveller community, often through activities that are not formally captured but are deeply impactful.

Appendix 4: Summary of Qualitative Survey Findings

Findings from three surveys (HSE staff, Organisations that have PHCTPs, Academic/ Voluntary orgs) are presented in this appendix.

Figure 11 below outlines the sample collected for this predominantly qualitative survey across several stakeholder groups, as follows:

Figure 11: Survey responses and response rates

	Targeted (n)	Responses (n)	Response rate (%)
Organisations that have PHCTPs	22	11	50
HSE staff	37	19	51
Academics / C&V	31	15	48
Total	**90**	**45**	**50**

A note on interpreting qualitative survey findings

Qualitative surveys were conducted to generate primarily qualitative data, mostly through open text comments, which are integrated into the corpus of qualitative data presented thematically in the Findings section of this report.

Qualitative survey findings, as detailed below, should be interpreted as a reflection of the depth and diversity of participants' experiences rather than numerical consensus. Qualitative surveys are not intended to be treated quantitatively and are therefore not presented as such. The findings characterise the perspectives of the respondents, highlighting common patterns and meaningful insights. They are not intended to represent statistical generalisation.

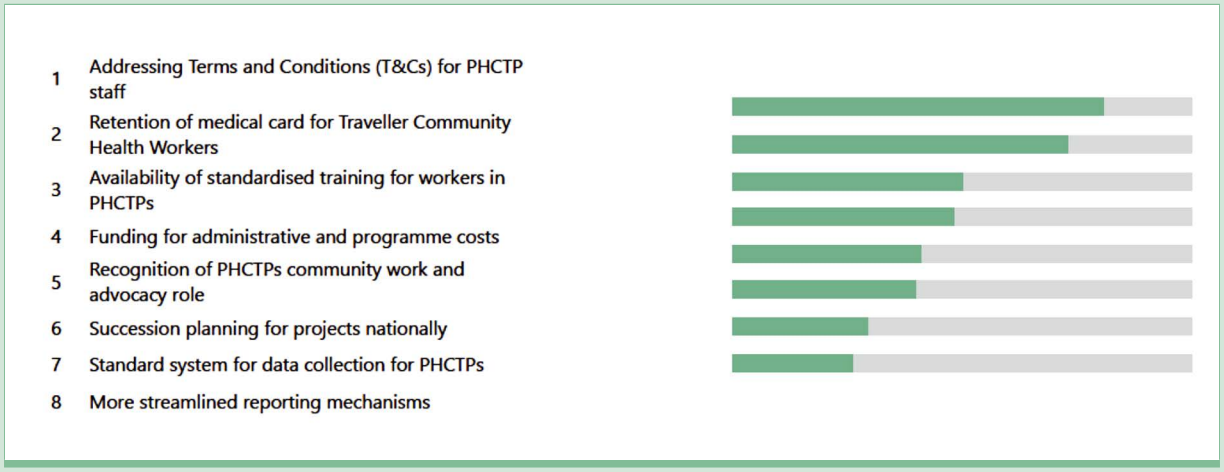
2.1 Organisations that have a PHCTP

The survey for "Organisations that have PHCTPs" was targeted at Traveller organisations, relevant community / voluntary organisations and Local Development companies which produced **11 respondents** in total.

- Of the 11 responses, 10 were Traveller organisations and 1 was a Local Development company.
- The majority of respondents reported that they had a PHCTP for more than 10 years suggesting extensive depth of experience within the sample based on mature PHCTPs programmes.
- Respondents were predominantly managers / coordinators.
- Most organisations were located, and reported to conduct their work in, urban or mixed urban/rural areas, with none reporting to be or work in a rural area only.
- Respondents either strongly agreed or agreed that PHCTPs were beneficial to their organisation, with the benefit of **'supporting Traveller families across a wide range of issues'** ranked as the most important contribution.
- In terms of the factors that help or support the organisation to have a PHCTP, there was strongest agreement that **'commitment and goodwill from PHCTP staff'** was the most important factor.
- There was **weaker agreement around structural support** in relation to 'support and guidance from the PHCTP steering group' and 'support and guidance from the THU unit', and 'regional and national networks of PHCTPs'.
- The organisations reported that the outcome achieved to the greatest extent was that PHCTPs 'provide opportunities for direct community work with and by Travellers at local and national levels'.
- They ranked the following outcomes highest in terms of being achieved to a *'great or moderate'* extent:
  - Supports and reinforces **empowerment** of Travellers working in PHCTPs
  - **Collaboration** between Traveller organisations, health sector and other organisations
  - Enhanced **access for service providers** to Travellers
- 'Commitment and support of PHCTP from other agencies (education, employment etc)' and 'Improved **health status**' while still positively reported were relatively less achieved than other outcomes.

- In terms of organisational challenges, there was strongest agreement that the main challenge is '**recruitment and retention of staff / pay and condition of workers**'. Respondents reported strong agreement that the organisations are challenged by 'complex and difficult issues faced by Travellers' and 'resources and uncertainty about the future'.
- Respondents were asked to rank eight priority actions to support PHCTPs into the future. '**Addressing terms and conditions for PHCTP staff**' was the highest ranked action, followed by the retention of the medical care for TCHWs.

Figure 12: Ranking of priority actions to support PHCTPs into the future (by organisations that have PHCTPs



2.2. HSE Staff with experience of engaging with a PHCTP

A purposeful sample of HSE staff with experience of engaging with PHCTPs were targeted across the two urban and rural sites selected for this review, generating a total of **19 respondents**.

- Respondents represented roles across HSE senior level management, mid-tier level and operational / clinical delivery level. They represented areas of work across Traveller health, mental health, child and maternal health, public health, health promotion, drug and alcohol.
- Most respondents reported to carry out their work in an urban area, or in a mix of urban/ rural areas.
- Respondents were generally positive about the extent to which PHCTPs were currently **achieving their aims and outcomes**, as set out by THAF.[110]
- Respondents highlighted the strong impact of PHCTPs in **empowering TCHWs, building trust, and improving access** to culturally appropriate health services.
- They regarded the **peer-led model** as a successful approach, but with limited resources, inconsistent partnership with the HSE, and variation between projects constraints and the ability of PHCTPs to reach their full potential.

110 PHCTP aims and objectives are: Highlighting gaps in health service delivery and working towards reducing inequalities that Travellers face in established services; Establishing primary healthcare as a model of good practice to address Travellers' health; Liaise and assist in dialogue between Travellers and health service providers; Develop the skills of Travellers in providing community-based health services (Source: NTHAP, 2022).

- In terms of outcomes, the HSE staff saw the following outcomes as being achieved to a great or moderate extent:
  - **Collaboration** between Traveller organisations, health sector and other organisations
  - Creates conditions for **Travellers' right to health** to be understood and realised
  - Challenging **racism** and supporting better understanding of Traveller **health needs** within the mainstream
- Similar to the Organisations that have a PHCTP, HSE staff suggest that 'Commitment and support of PHCTP from **other agencies** (education, employment etc)' is relatively less achieved. PHCTPs creating 'conditions for **systemic issues** affecting Travellers to be addressed an individual and community level' was also reported to be relatively less achieved.
- Some additional outcomes suggested by these respondents were:
  - Stronger trust, outreach and engagement between Travellers and the health system.
  - Increased training and employment pathways
  - Greater focus on priority needs (women's health, mental health, infant and child health)
  - Translation of advocacy into measurable outcomes.
- HSE Staff described their experience of **barriers and enablers** to engaging effectively with PHCTPs, summarised as follows:

Figure 13: Key barriers and enablers to engaging effectively with PHCTPs among sample of HSE Staff with experience of engaging with PHCTPs

Key barriers	Key enablers
Funding / under resourcing of PHCTPs	Relationship building and collaboration
Lack of trust	Building trust
Stretched staff and competing priorities of PHCTPs	Cultural awareness of HSE Staff

- In terms of monitoring and current data use, many respondents noted limited or no usable data to support service planning or monitoring outcomes for Traveller inclusion.
- Where data is used, it tends to focus on activity tracking, engagement numbers, contractual compliance, and specific public health surveillance or programme-specific datasets.
- Regarding monitoring of the PHCTPs, respondents highlighted significant barriers including fragmentation, regional inconsistency, and the absence of ethnic identifiers, which limit their ability to evaluate impact or target need.
- Respondents suggested additional data to support them to achieve their goals and objectives in the future in relation to Traveller inclusion, such as:
  - Consistent use of an ethnic identifier and accurate demographic data to improve visibility and tracking
  - A standardised national data framework with digital reporting tools.
  - Better data on health messaging, service uptake, outcomes, and system impact and specific data on priority areas such as mental health and Traveller women's health (maternity, gynaecology, menopause)

- The most **important contributions** of the PHCTPs were reported as:
  - Sharing information (such as health information, and information about the community's issues and needs)
  - Peer-led access and building trust
  - Providing unique cultural knowledge and lived experience to support the development and implementation of culturally appropriate services and work in the community
- Suggestions for how PHCTPs could **strengthen their impact** in the future were:
  - Increased and sustainable funding, including full-time employment for TCHWs and additional specialist staff (particularly in men's health, accommodation and youth health work).
  - Stronger governance, oversight, and professional recognition/visibility of PHCTP work.
  - Expanded geographic coverage of PHCTPs and THUs, with regular engagement and more efficient ways of working.
  - Improved data, evidence, and record-keeping to demonstrate outcomes and strengthen collaboration and co-production with the HSE.
  - Greater Traveller representation and leadership, alongside action on systemic barriers (accommodation, medical cards, racism, social determinants).
  - Embrace digital tools and innovations to support activity reporting and service delivery.

2.3 Academics and Community & Voluntary (C&V) Organisations with experience of engaging with a PHCTP

A sample of representatives from **academic institutions** and **C&V organisations** with experience of engaging with a PHCTP were targeted. The C&V sector organisations included national health charities and local community organisations providing condition-specific support. The survey yielded a total of **15 respondents**, with a breakdown provided in the table below.

Figure 14: Respondents by organisation type (n)

Academic Institution	5
Community / voluntary organisation	6
Other (commercial, state agency)	4
Total	**15**

- Most respondents reported to be 'very familiar' with the PHCTPs and had engaged with PHCTPs through research collaboration, training (e.g. anti-racism / cultural awareness training), or as part of supporting specific health promotion campaigns.
- Most had learned about PHCTPs through their professional networks.

- The majority reported that their engagement with the PHCTPs had supported them 'to a great extent' to achieve their goals and objectives in Traveller health with the majority reporting to be 'very satisfied' with their engagement.
- Improved their experience?
- The key benefits of engaging with the PHCTPs were in relation to access and reach of the TCHWs. For example, as one respondent explained "the existing system" allowed them to implement an intervention "on top of an existing programme rather than invent something else" which was more efficient and more effective. Another respondent described the benefit of PHCTPs for research in terms of data collection, recruitment, co-design of research instruments, and also direct participation in research as respondents/ participants.
- Respondents reported that PHCTPs were the most effective way to do their work and could not identify any more suitable alternatives to accomplish the work or objectives they had set out to do.

Figure 15: Barriers and enablers to engaging effectively with PHCTPs among sample academics and C&V organisations

Key barriers	Key enablers
Stretched staff and competing priorities	Collaborative / partnership approach of PHCTPs
Funding / under resourcing of PHCTPs	Engagement (e.g. in-person, follow-up, meeting workers "on the ground")
Cultural awareness of our organisation	Respect (e.g. respectful engagement, mutual respect)

- In terms of what would improve their experience of engaging with PHCTPs, respondents cited increased time and resources for PHCTPs.
- The most important contributions of PHCTPs were reported as:
  - Building cultural awareness through TCAT / anti-racism training
  - Relationship building and partnership approach
  - Increased Traveller representation (e.g. Traveller "voice")
  - Health promotion / raising awareness of health issues
- In terms of what could strengthen the impact of PHCTPs in the future, respondents suggested:
  - Increased funding and resourcing of the PHCTPs
  - Advocacy and inclusion of Travellers in decision-making at a national level
  - Enhanced career, training and professional development opportunities.

Appendix 5: Templates and resources

The following provides a selection of resources that outline approaches and techniques for developing appropriate frameworks for measuring outcomes as part of monitoring, evaluation and learning:

Type	Source
General guidance	UNDP Planning for monitoring and evaluation: https://www.undp.org/turkiye/publications/undp-handbook-planning-monitoring-and-evaluating-development-results
Theories of change / outcomes mapping	Valters, C. (2015) Theories of Change Time for a radical approach to learning in development: https://media.odi.org/documents/9835.pdf Annie E Casey Foundation: https://www.aecf.org/resources/theory-of-change Center for Theory of Change: https://www.theoryofchange.org/ Rogers, P. (2014). Theory of Change, Methodological Briefs: Impact Evaluation 2, UNICEF Office of Research, Florence: https://www.betterevaluation.org/sites/default/files/Theory_of_Change_ENG.pdf Better Evaluation: https://www.betterevaluation.org/frameworks-guides/rainbow-framework/define/develop-programme-theory-theory-change
Most Significant Change (MSC)	https://www.betterevaluation.org/methods-approaches/approaches/most-significant-change
Examples of M&E frameworks	https://www.ncvo.org.uk/help-and-guidance/strategy-and-impact/impact-evaluation/planning-your-impact-and-evaluation/monitoring-and-evaluation-frameworks/examples-of-monitoring-and-evaluation-frameworks/
Causal link monitoring	https://www.betterevaluation.org/methods-approaches/approaches/causal-link-monitoring
Contribution analysis	https://www.betterevaluation.org/methods-approaches/approaches/contribution-analysis Apgar, M. Hernandez, K. and Ton, G. (2020) Contribution analysis for adaptive management. https://media.odi.org/documents/glam_contribution_analysis_final.pdf
Rainbow framework	https://www.betterevaluation.org/frameworks-guides/rainbow-framework
Planning Tool	https://www.ncvo.org.uk/help-and-guidance/strategy-and-impact/impact-evaluation/planning-your-impact-and-evaluation/monitoring-and-evaluation-frameworks/developing-a-monitoring-and-evaluation-framework/#use-a-planning-tool
Distance-travelled tool	https://www.gov.ie/en/department-of-rural-and-community-development-and-the-gaeltacht/publications/my-journey-distance-travelled-tool/
Scottish Community Development centre - resources	https://www.scdc.org.uk/our-work/resources
Community Development Health Network, Northern Ireland	https://www.cdhn.org/sites/default/files/downloads/ImpactReport_22_0_1.pdf

Figure 16: Action plan mapping

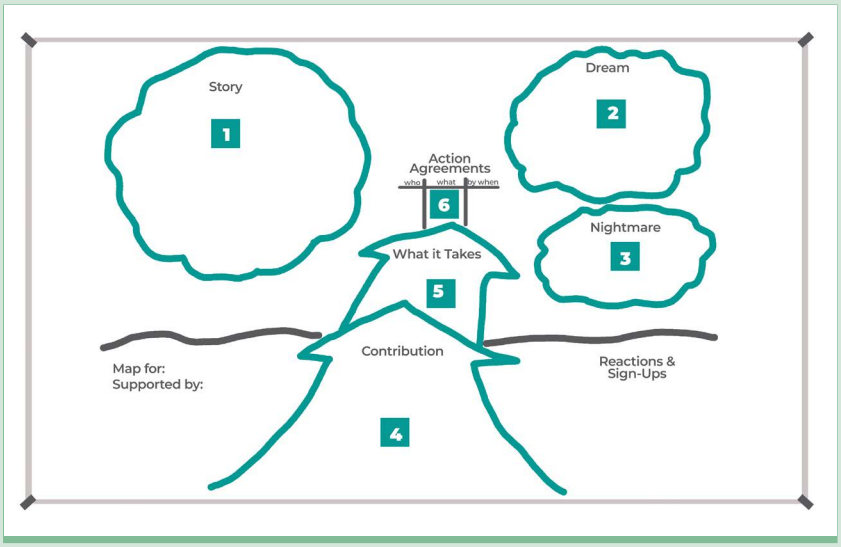
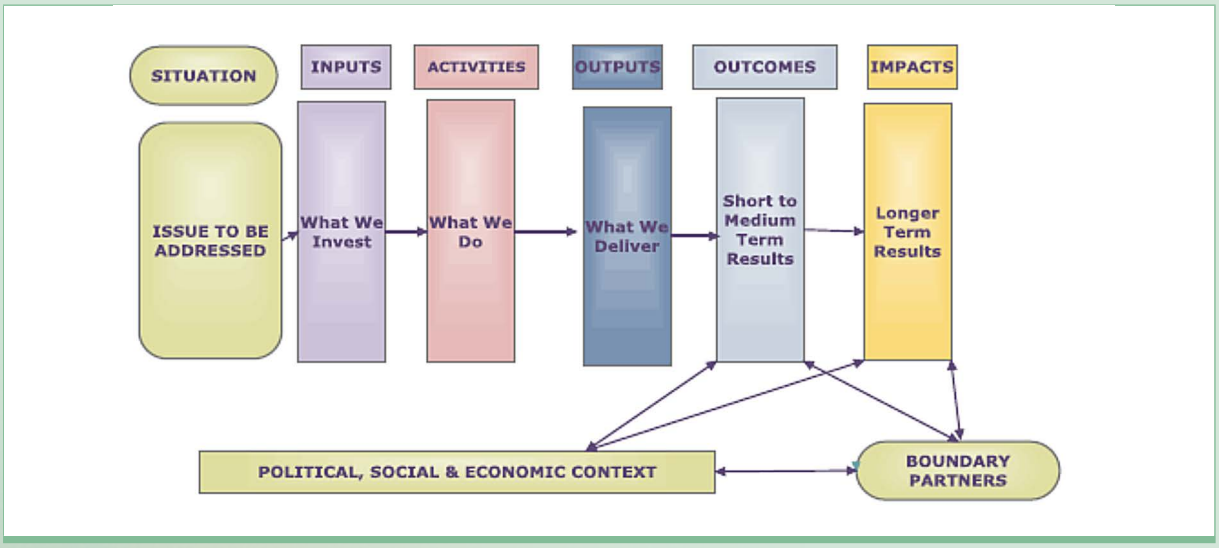


Figure 17: Diagram of a Programme Logic Model



Source: Anne Markiewicz and Associates, (2014) Core Concepts in Developing Monitoring and Evaluation.

Figure 18: Functions and Principles of Monitoring & Evaluation

Monitoring and Evaluation should generally support the three main functions of:

- Accountability to funding bodies and key stakeholders;
- Project management; and
- Facilitation of learning to achieve results.

Monitoring and Evaluation should include the main principles of:

- Positioning Monitoring and Evaluation at a point within the organisation where it is referred to during organisational decision making and resource allocation processes
- Use of Multi-Method Data Collection for the establishment of progress toward or achievement of processes (outputs) and impacts (outcomes)
- Mindful Stakeholder Involvement and Engagement in both the design and implementation of the Framework
- Use of Stakeholder Perceptions of change and/or validation of the program logic
- Use of Systematic Reporting of progress toward achievement of outcomes and impacts including identification of successes and failures
- Adoption of a Learning Strategy to analyse and reflect on the data generated by the Framework

Central steps and stages in developing a monitoring and evaluation framework include:

- **Developing a Stakeholder Engagement Strategy: Who is to be involved in the process and how?**
- **Developing a Program Logic: Outlining diagrammatically what the program has been established to achieve**
- **Developing Evaluation Questions: Agreement about what is to be known about how the program operates**
- **Producing a Monitoring Plan: Identifying how to answer the evaluation questions through monitoring processes and the development of associated indicators and targets**
- **Producing an Evaluation Plan: Identifying how to answer evaluation questions through formative and summative evaluation activities**
- **Developing an Evaluation Methodology: Identifying how to implement the evaluation and what evaluation methods can be used to collect required data**
- **Developing an Evaluation Rubric: Agreement about the criteria for measuring success or good practice**
- **Developing a Data Collection and Analysis Strategy**
- **Developing an Implementation, Reporting, Learning and Reflection Strategy**
- **Developing Data Collection Instruments and Tools to capture the required data**

Source: Anne Markiewicz and Associates, (2014) Core Concepts in Developing Monitoring and Evaluation.

Resources and editable template available here: https://www.betterevaluation.org/tools-resources/developing-monitoring-evaluation-frameworks-framework-template

Figure 19: Worked example of a Theory of Change as applied to PHCTPs (for illustration only) [111]

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
TCHW workforce PHCTP Project coordinators / Assistant coordinators HSE/DoH/THU funding	**Health education & promotion** (e.g. Delivery of culturally appropriate health information and sessions) **SDoH interventions** (e.g. activities related to support in access to accommodation, education, environmental health and employment) **Crisis response** (e.g. urgent and critical psychosocial responses; disease outbreaks) **Anti-racism & cultural mediation** (e.g. Anti-racism/TCAT training for service providers; mediating cultural understanding between services and Travellers) **TCHW training & development** (e.g. Capacity building and on-the-job training for TCHWs; literacy support; higher education) **Advocacy** (e.g. Supporting Travellers to navigate mainstream services and resolve access barriers at an individual level; local and regional representation for the Traveller community; advocacy for Traveller inclusion in health policy and governance at a national, systems level).	**Health education workshops / sessions** (e.g. Number and type of health education activities delivered; vaccination, screening, prevention etc). **Signposting & referrals to mainstream health services** (e.g. Counts of completed referral/support actions) **SDoH actions** (e.g. Recorded accommodation, education or welfare interventions – referral to supports, follow-up with families, calls/letters to councils and other services etc). **Crisis response** (e.g. number of responses, family visits, follow-up with families; contacts with services; support / debrief for the TCHW) **Anti-racism training sessions** (e.g. Number of sessions provided; short- and long-term feedback from sessions to assess impact) **TCHW training & development** (e.g. Training and induction completed by staff, CPDs and other completed training, staff satisfaction with training, support and materials provided, level and frequency of support, interventions to provide access and support to higher education; qualifications attained) **Advocacy** Engagement of PHCTPs in Traveller representation at local, regional and national forums. Counts of completed referral/support actions) **Feedback from Travellers who engage with PHCTPs** (qualitative methods)	**Short term:** · Increased health training and information · Increased knowledge among Travellers (e.g. Travellers demonstrate greater awareness of key health issues) · Improved reach and access of H&SC staff to Traveller community · Increased knowledge and awareness among service providers of delivering culturally appropriate health care to Travellers (e.g. satisfaction with the TCAT/anti-racism training; acquisition of knowledge and skills) · Improved professional recognition of value of TCHWs · Improved job quality among TCHWs etc... **Medium term:** · Increased Traveller confidence and trust in engaging with TCHWs · Increased Traveller confidence and trust in engaging with health providers (e.g. Travellers demonstrate greater confidence in their right to access services, self-advocacy, self-determination, and greater trust in service providers and health system). · Increased Traveller uptake of mainstream health and social care services. · Better service provider understanding of Traveller culture and health needs (e.g. application of TCAT / anti-racism learning on the job) · More culturally appropriate and responsive services. · Enhanced Traveller participation in local and regional health structures. · Stronger partnerships between PHCTPs, THUs, and mainstream services. · Improved employment stability and professional recognition for TCHWs. · Better service provider understanding of Traveller culture and health needs. **Long-Term (5+ years):** · Measurable reduction in Traveller health inequalities. · Improved health literacy, prevention, and wellbeing across Traveller communities. · Better service provider understanding of Traveller culture and health needs (e.g. application of TCAT / anti-racism learning on the job) · Culturally safe and anti-racist health system (e.g. principles of TCAT / anti-racism embedded into organisational goals of service) · Equitable health outcomes across social determinants of health. · Sustained Traveller participation in health policy and governance.

111 This worked example is included for illustrative purposes only and is intended as a starting point for further development. In line with best practice, a Theory of Change should be co-produced with relevant stakeholders, including Traveller organisations, HSE, DoH and relevant partners.

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