

**Submission to the HSE on the future of  
Traveller Health Unit's  
From  
The THU in the Eastern Region**

**March 2006**

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## **Background**

### **Establishment of Traveller Health Units**

#### **The Task Force Report on the Travelling community**

The Task Force Report, which was published in July 1995, provided a comprehensive overview of the life situations of Travellers in Ireland and the range of inequalities they experience in their lives – including health. It was the first national report to acknowledge that mainstream health service provision had not met the needs of Travellers. Drawing from existing research and specially commissioned research, Section E of the Task Force Report provided an overview of the poor health status of Travellers. It recognised the need for specific health programmes that address and target the needs of Travellers, if the gap between Traveller health and that of the majority population was to be bridged.

#### **Travellers Health Statistics:**

*“From birth to old age those at the bottom of the scale have much poorer health and quality of life than those at the top. Gender, area of residence and ethnic origin also has a deep impact.”*

The Black Report, UK, 1980.

In 1983, the Travelling People Review Body proposed the regular and systematic collection of data on the health status of Irish Travellers. The publication of the 'Travellers Health Status Study - Census of Travelling People 1986', (HRB 1988:1) and 'The Travellers Health Status Study - Vital Statistics of the Travelling People' 1987, (HRB, 1989:2) gave rise to considerable concern about the health status of the Traveller community. These reports found that:

- ◆ Fertility rate of Travellers in 1987 was 34.9 per 1,000 - more than double the national average and the highest in the European Union.
- ◆ Travellers have more than double the national rate of stillbirths.
- ◆ Infant mortality rates are 3 times higher than the national rate.
- ◆ Traveller men live on average 10 years less than settled men.
- ◆ Travellers are only now reaching the life expectancy that settled people reached in the 1940s.
- ◆ Travellers of all ages have very high mortality rates compared to the Irish Population.
- ◆ Traveller women live on average 12 years less than their settled peers.
- ◆ Travellers have higher rates of morbidity for all causes of death

Since 1987, no National Studies have been conducted on Travellers health, but some research has been carried out in recent years, which would suggest that the health status of Travellers has not improved, and more alarmingly may have deteriorated. What we do

know for certain is that the gap between the health status of Travellers and settled people has widened. This is borne out by the following statistics:

- In the national census conducted in 1996, it found that only 1% of all Travellers were aged over 65 years of age compared to 11% of the settled population.
- In a study on Travellers using Tallaght hospital, it was found that only 2% of all the hospital patients were Travellers aged over 65 years, compared to 34% of hospital patients who were settled people aged 65 years+.
- The Irish Sudden Infant Death Association in their Annual Report 1999, found that the differential in the rates of Sudden Infant Deaths among Travellers was 12 times the rate among the settled population

To this end the Task Force Report recommended a National Traveller Health Advisory Committee be established at the Department of Health and Children and that Traveller Health Units be established in each health board. The role of the Traveller Health Unit was to prioritise Traveller health within each health board and to monitor and evaluate health service provision for Travellers.

The Report also emphasised the need for more information on the health status of Travellers to be available. Within this context, the Task Force made a series of recommendations related to health provision, a key one being that;

Each health board should establish a **Traveller Health Unit**. The brief of such a unit would include:

*Monitoring the delivery of health services to Travellers and setting regional targets against which performance can be measured;*

*Ensuring that Traveller health is given prominence on the agenda of the health board;*

*Ensuring coordination and liaison within the health board, and between the health board and other statutory and voluntary bodies, in relation to the health situation of Travellers;*

*Collection of data on Travellers' health and utilisation of health services;*

*Ensuring appropriate training of health service providers in terms of their understanding of and relationship with Travellers;*

*Supporting the development of Traveller specific services, either directly by the health board or, indirectly through appropriate voluntary organisations;*

*The health board Traveller Health units should have a committee drawn from the various sectors in the health board and from local Traveller and Traveller organisations. It should have a small staff attached to it. It should have a reporting relationship to each of the Programme Managers and to the new Directors of Public Health. These Units should incorporate existing inter-sectoral structures focusing on Traveller health issues at health board level.*

### ***THU in the Eastern Region***

The first Traveller Health Unit in the country was established in what is now the Eastern Regional Health Authority in 1999, this unit incorporated the three health boards in the Eastern Region, which included Dublin, Kildare and Wicklow. In this region there are 1,650 Traveller families (according to Dept of the Environment, Heritage and Local Government 2004) which means that approx 25% of Travellers live in this region. Crucial to the role of the Traveller Health Unit was the involvement and participation of Travellers and Traveller organisations.

The Task Force Report recognised the need for collaboration and partnership between health service providers and representatives of the Traveller community in order to identify and prioritise health issues within the Traveller community and to develop appropriate interventions. In this way it could be ensured that Traveller specific health programmes were effective in meeting the needs of the Traveller community in a sustainable, co-ordinated and cost effective manner.

Within the Traveller Health Unit in the Eastern Region it was agreed that real community involvement, listening and power sharing, were needed to make real and effective improvements in Traveller health. This was reflected in the make up of the committee, established among relevant sectors in the health board and local Travellers and Traveller organisations.

Also crucial to the effectiveness of the Traveller Health Unit was its role in allocating and monitoring funding. Each Unit was allocated a specific budget and it meant that both health service providers and Travellers had a say in how funding was allocated.

Public representation, equity and empowered decision making at local level have been promised by the Minister for Health and Children in recent reforms of the health system. The Traveller Health Unit in the Eastern Region is the embodiment of exactly these principles.

In its first years, the Traveller Health Unit in the Eastern Region focused on research projects to identify Traveller health needs. It also began to raise awareness of the importance of culturally appropriate services to Travellers, and to build capacity in the Traveller community to work with the Unit.

### **Travellers Health – A National Strategy**

In 2002, the first ever National Traveller Health Strategy 2002-2005 was launched by the then Minister for Health and Children, Micheal Martin, TD. This represented a milestone in health policy and impacted significantly on the work of Traveller Health Units.

- The Strategy takes ‘achieving equity’ as its core principle within healthcare service provision and recognises the need to respect and acknowledge the distinct culture and identity of Travellers.
- It recognises that ‘equity’ means not only equal access to services but also ‘equality of outcomes’ for all sectors of the community.

- In order to achieve ‘equality of outcome’, the Strategy recommends an innovative approach so that the particular needs of Travellers can be met and outlines the role for Traveller Health Units in this approach.
- The Strategy strengthens the role of the Traveller Health Units in planning, monitoring and prioritising Traveller health within health boards.
- It stresses the importance of Traveller participation in the Units and recommends that each Unit should build Traveller capacity to work with the Units.
- The Strategy also proposes Traveller Health Units facilitate the development of similar partnership models at local level. It identifies Primary Health Care for Traveller Projects as the ‘cornerstone’ of the Strategy.
- These local projects, based on the principle of partnership and Traveller participation, have been credited with bringing ‘real and substantial’ benefits.
- The Strategy also recognises the impact racial discrimination has on Traveller health and the difficulties there are within the health service in taking account of differences between Travellers and the majority population.
- In this context it highlights a role for Traveller Health Units in promoting in-service training on Traveller culture for health service staff.
- Lack of data on Traveller health is also mentioned in the Strategy, which recommends how a question on ethnic group can be asked when collecting data. In the meantime it makes provision for a national study on Traveller health. It identifies a role for Traveller Health Units in accommodating this study, with the help of Travellers and Traveller organisations.
- And while the Strategy recommends how the workings of the Unit can be improved it reinforces Traveller Health Units as an integral part of a structure that can deliver effective, equitable and sustainable health care to Travellers.

## **The Future of the THU in the Health Service Reform Process**

Current reform of the health system provides the opportunity to achieve much needed positive measures in terms of Traveller health. Developed and empowered decision making at local level has been, correctly, identified by the Interim Health Executive as the key to delivering equitable healthcare and added value for money.

Up until now, health boards have provided services at local level and it is at this level that the Traveller Health Unit in the Eastern Region has been operating. At the time of its establishment it was felt that one Unit for all three health boards in the region would avoid duplication and provide better co-ordination.

In the future it is vital to Traveller health that the Traveller Health Unit in the Eastern Region continues its relationship with local health providers and continues to have direct input into the allocation of funds.

The Traveller Health Unit is a tried and tested structure, which provides a direct link between the Traveller Community and local health service providers. By ensuring the Traveller voice is heard, the Traveller Health Unit helps to ensure that local services are delivered to Travellers in a meaningful and sustainable way; ultimately providing the best value for money possible.

Without an ongoing real working partnership between Travellers and health service providers – health delivery to Travellers will continue, at best; to be a hit and miss affair.

The Traveller Health Unit in the Eastern Region is working well and is well placed to continue its work and contribute to the management and co-ordination of local services to Travellers by interacting with both proposed Health Service Executive offices in Dublin/North East and Dublin/Mid Leinster.

Relations have already been established with local health providers in both these regions and responsibility to a multi-executive as already exists, would allow the current work to continue with minimum disruption and maximum benefit.

Further Traveller representation at Health Service Executive level would also enhance the possibility of achieving improved outcomes for society's most neglected community.

## **Summary**

This submission is a distillation of the various views of THU members regarding the future of the THU structure within the HSE. Thirty individual interviews with THU members were carried out and two short focus groups held with both the Eastern Area Traveller Health Network and the National Co-ordinating Group of Area Traveller Health Networks.

There was a majority view expressed that the current regional structure of eight regional THUs should stay - at least as an interim measure - while the ongoing reforms of the HSE continue to bed in. It was felt that the structure worked well and while there was an acceptance that change would have to come there was a reluctance to dismantle the current format of the THU as much energy, time and commitment has gone into establishing the projects, priorities, work plan, trust and relationships of the unit. There was however an acknowledgement that the emerging structures of the HSE would have to be collaborated with to avoid problems into the future, while ensuring that the needs of Travellers continue to be voiced and responded to appropriately.

An analysis of the various views proposed as the way forward lent itself to a four level framework, with a national oversight THU, four regional consultative and decision making THUs, sub regional operational THUs and at local level Traveller Care Group Committees. The last two configurations of THU would dependent on the critical mass of Travellers in these catchments areas.

## **Rationale for submission**

The Eastern Region Traveller Health Unit (THU) was formed in 1998 with a brief to identify, prioritise and promote Traveller health needs. It has a membership of 21 and meets monthly. Mindful of the forthcoming structural changes within the HSE and how these changes will impact of the role and location of the THU it was decided to write a submission to the HSE formally setting out the view of the membership on its future role, structure and location within the emerging terrain of the HSE.

## **Methodology**

This submission did not seek to conduct either a review or evaluation of the Eastern Region THU. The approach of conducting individual interviews with each THU member was chosen as the most appropriate methodology. All THU members' perceptions, views and proposals for the future were captured and are synthesised here. A short series of questions was also put to the Eastern Region Traveller Health Network.

## **A national perspective**

The membership of the Eastern Region THU wished this submission to have as collective and national a perspective as possible and as such representatives of all the other seven THUs were invited to participate. Three THU chairs chose not to be formally

interviewed. Traveller representatives and organisations in all of the seven THU regions took the opportunity to put forward their views. Views on the future of the THUs were solicited at a national gathering of representatives of Area Traveller Health Networks.

### **Response of other care groups to HSE changes**

A quick audit of comparative regional representative structures yielded a mixed response to the structural changes in the health services. None of the other care groups have to date mobilised to the extent of submitting a formal submission, although there are meetings being held where changes and implications for the care groups are being discussed. A definite air of uncertainty is apparent with both non-statutory care group members and health staff reporting a degree of unease as to what the future will bring. The various developments at individual care group level is summarised briefly below.

#### ***Women's Health Advisory Committees***

The Women's Health Advisory Committees (WHACS) was a representative structure of health care professionals and representatives of regional women's groups and service users at health board level whose brief was to promote women's health initiatives at board level. This regional structure was a recommendation of the Plan for Women's Health 1996. It operated in all Health Boards for a number of years. More recently the WHACs have fallen into disuse, with only two WHACS continuing to meet regularly in Galway and the North East. Women's Health Development Officers have been recruited in most previous board areas and five of these officers submitted a position paper regarding the location and future structure best suited to forwarding women's health issues in the new HSE structures to the Director of Population Health in September 2005.

#### ***Violence against Women Regional Planning Committees***

The eight VAW Regional Planning Committees (RPCs) continue to be an active mechanism, which represents the needs and concerns of this specific population of need at previous board level. They meet quarterly and report to the Violence against Women National Forum. RPCs have not made collective response regarding future structural changes, which will impact on them. To date they have not made a collective submission or presented a position paper on their future although all HSE staff with the designated brief on Violence against Women are meeting the senior HSE official with this brief in November. There is a sense from the consultations regarding a new strategic plan for the RPCs that they wish to maintain the current geographic and structural boundaries.

#### ***The Regional Co-ordinating Committees for Disability***

There are two types of regional committees, called Regional Co-ordinating Committees for Intellectual Disabilities and for Physical and Sensory Disabilities.

Both types of committees continue to meet and will continue in their current format and structure until the end of 2005. There was a once off stakeholder meeting in May of this

year which discussed the future positioning of the committees, a report was compiled and is currently being considered as part of the ongoing strategic review of Disability Services which is due for completion by year end.

## **Eastern Region THU**

### ***Eastern Region THU achievements***

All participants were asked to list an achievement, which in their view made a difference to Traveller health and that they were proud of. Many chose the Primary Health Care Projects as an excellent model which has clear tangible outcomes translating into improved health status for Travellers - increased vaccination numbers, smears, health checks, developmental checks, more men attending GPs, health education, empowerment of Travellers, Traveller participation in health services from needs assessment to policy development, implementation, monitoring and evaluation, focus on environmental health, mental health etc. There was general agreement that these projects had a vital role to play in preventative health care, they were described variously as ‘positive ... transformative.... life changing.

Others chose particular projects such as the ethnic identifier and appointment system in Tallaght Hospital, the protocol in teaching hospitals on Traveller access to elective services and the various research and reports which have been commissioned.

“That it exists at all!” was an enthusiastic view mirrored by some members who thought that a key achievement was that the THU structure brought together various stakeholders looking for ‘pragmatic solutions despite different views’.

It was noted that the THU structure had resulted in Area Traveller Health Committees being formed to provide a support system at community level to resource Traveller participation in the THUs. This was viewed positively as a clear achievement as they provide a mechanism, which facilitates two-way communications between the regional level THU and more local groups.

### ***Eastern Region THU enablers***

THU participants were asked to identify what factors made the achievements of their THU possible.

### ***Dedicated support unit***

In the Eastern region the fact that Pavee Point was funded to act as a dedicated technical support structure to the THU was viewed as a definite contributor to the unit’s effectiveness, although a view was expressed that this could also be seen as a negative as the organisation was left ‘to get on with it’. The organisation’s capacity to articulate and analyse the structural barriers impacting on Travellers was praised as was their

commitment to support and drive the work of the THU. The model of the THU was described by one member as:

*An excellent model which could be replicated elsewhere*

### **Balance and representativeness**

Most people interviewed referred to the fact that the THU created a collective space to articulate and formalise responses to Traveller health problems and issues.

*a good sounding board*

There was agreement that the 50:50 balance of HSE staff and Traveller representatives and organisations was a positive indeed critical success factor. Those working in the acute services noted the positive outcomes of the boundary crossing between primary health care and acute health services which had resulted in both improvements in health outcomes for Travellers and better procedures and more Traveller friendly systems in some hospitals Tallaght, Rotunda and Temple St. This joint working had helped build trusting relationships and respect.

Giving Travellers a direct voice was seen as important as it was felt that they brought direct insights into Traveller needs. It was noted as ironic by one member that certain HSE services were developing their capacity to respond to and understand the needs of non nationals while the poor health status of Travellers, an indigenous group had not been prioritised.

### **Seniority of HSE representatives**

The fact that heads of disciplines are THU members was welcomed as this ensured that these strategic post holders are meeting directly with Traveller representatives and organisations. The seniority of the HSE THU members was viewed positively as it conferred profile, status and budgetary influence. There was a shared sense that having had an ACE as chair meant that the THU was championed and profiled at a strategic level. The positive impact of the previous chair was mentioned, and their chairing, facultative skills and commitment were praised widely by THU members.

### **Partnership working**

The value and positive outcomes of partnership working was frequently cited as a key success factor in the THU's achievements.

*settled people there to support and do listen*

A majority view was expressed that despite the different mindsets THU members managed to coalesce around key issues and work towards overcoming prejudice and barriers. The good will factor was cited alongside the energy members were prepared to give to building a common understanding of what constitutes partnership working. The

commitment and willingness of HSE staff to flexibly meet the needs of Travellers in clinics etc., was seen as a good example of partnership working in concrete terms.

### **Joint training**

The joint training offered by the THU was generally welcomed with a minority view expressed regarding the analysis presented. A few members felt that the training was biased towards blaming settled people for the structural problems experienced by Travellers. Most other members felt that the training was illuminating and aided their comprehension of the depth of exclusion. Traveller representatives were positive about the training as they saw it as an opportunity for settled people to begin to see how structural barriers affect Travellers adversely. It was seen as an opportunity to build trust among THU members which aided their working relationships.

### **Eastern Region THU barriers to effective working**

#### **Diverse attitudes**

The various mindsets apparent in the THU membership were viewed as a barrier by some members. Despite the commitment to a common goal a lack of unified approach evident in the various mindsets and attitudes towards Travellers was noted by a small number of members as a block to progress 'different mindsets different agendas'. Others adopted a more pragmatic approach to the fact that there were differing attitudes.

#### **Language as a barrier**

The use of unfamiliar language posed a problem for some of the Traveller representatives who expressed the view that 'It's hard to say you don't understand'.

#### **THU's ability to change and respond**

The slow and uncertain pace of change was cited as frustrating as were the structural constraints of the HSE itself, which were not viewed as being able to adapt quickly to emerging needs.

#### **Strategic service planning**

The necessity for strategic service planning was seen by some as a barrier to flexibility and innovation - 'a stifled template' and not an organic response, while others viewed that process as a given and concentrated their energies on ensuring that the THU fed into the process to safeguard funding.

### **THU representativeness**

A small number of THU members noted the lack of representation from smaller Traveller organisations in their THU while acknowledging Pavee Point's commitment and contribution to the unit's effectiveness.

### **Attendance at THU meetings**

Poor attendance was cited by certain members of the THU as a negative aspect, which frustrated them as actions were sometimes not followed through on.

The fact that THU membership is an 'add-on' to full time posts has led to some members experiencing time constraints which has impacted on their capacity to attend meetings and to progress actions.

### **THU administration**

The administrative nature of how the THU operated was seen as a barrier and as bureaucratic by a few members - *'too many hoops to jump through'* and *'lots of admin/paperwork'*. The circulation of minutes had previously caused frustration and annoyance but this aspect had improved which was welcomed.

### **Consultation**

The challenges of consultation were seen by some health services staff on the THU as a barrier to progress 'at what point do you stop consulting and start doing?'. A HSE staff member noted that 'we're almost afraid to be prescriptive' and that relevant expert staff should be allowed to present a view and use this as a starting point for consultation instead of beginning with a blank sheet. An opposing view was proposed from the Traveller organisations' representatives who argued the efficacy of real consultation with Travellers to ensure that health services were appropriately designed and delivered to meet their needs.

### **Data**

The management information systems (MIS) deficits on ethnic issues was viewed as a barrier to effectiveness although the ethnic identifier pilot had worked in Tallaght Hospital, it was not proactively used in all possible locations.

### **THU finances**

This aspect of the THU operations generated strong views. There were negative opinions expressed regarding previous cash flow, decision making and bureaucratic delays which had hindered prompt payments to Traveller projects identified for funding under the THU work plan. Health services decision-making processes were criticised for creating delays and problems for small voluntary projects. For example a decision to fund a particular project would be agreed at the THU but the actual generation of that funding - often a

crucial cash flow issue for a small voluntary organisation - would be delayed causing serious problems and a negative perception and experience of the THU. There was agreement that the system to date had created a 'blame game' where Pavee Point was seen as holding back funds while Traveller organisations were themselves sometimes at fault for submitting information too late. There was an acceptance that the computerisation had improved the cheque generation turn around as had the monthly payroll system introduced since March 2005.

Despite these improvements concerns were raised about the membership and mandate of the finance group. The finance group is comprised of the Chairperson of the THU, the finance/administrator, the Thu coordinator, and a representative of the hospitals, the HSE and the Traveller organisations. This committee make recommendations in relation to financial allocations, which then have to be approved and ratified at a full THU meeting. The historic financing of the THU was mentioned as a problematic issue. The Traveller representatives and Pavee Point expressed dissatisfaction that the HSE cannot account for the totality of the budget allocated to the THU. That there were still monies unaccounted for was a source of disappointment as was the fact that if funds were not used within a particular time frame that they were absorbed back into unit budgets and lost to the THU.

#### ***Aspects of the Eastern Region THU to retain***

- ✓ Ensure the 50:50 balance of Travellers and Traveller organisations and health services staff continues
- ✓ Retain representation of different divisions within the HSE particularly the acute hospitals
- ✓ Keep the partnership approach to decision making, problem solving and planning
- ✓ Continue to commission research
- ✓ Rotate the chair role
- ✓ Chair to continue to be an ACE - proven chairing skills a critical competence
- ✓ Continue to capacity build Travellers to represent their communities
- ✓ Keep monthly meetings
- ✓ Continue training in THU to ensure understanding of structural barriers facing Travellers
- ✓ Select a smaller number of priorities to achieve - access to appropriate mental health services and implementation of recommendations of the research reports i.e. Environmental Health, Child Care and Hospital services.

#### ***Aspects of Eastern Region THU to discard***

- Meetings in Naas a problem – meetings should be held in central venues
- Large membership hinders effectiveness

## **Eastern Region THU - the future**

The following is a distillation of the various views captured regarding the future structure of the ERHA THU and THUs nationwide. A strong sense of frustration at the uncertainty which the slow roll out of the HSE structural changes is having on the impetus around the THUs was strongly expressed by participants. A majority of those spoken to wanted to leave the structures as they are for at least a year, eighteen months, until the end of 2007 - the length of time proposed varied. Others, usually health services staff, wanted to move quicker than that to the new structural reality, as soon as it became apparent, in order to avoid confusion and dissipation of energy and momentum.

There was a genuine confusion and frustration, expressed by both statutory and non-statutory members, at the degree of paralysis the uncertainty regarding the future was creating.

All of the non statutory members consulted for this submission wanted an assurance that their THUs would not be dismantled as they valued the trust and relationships which had been built up by the partnership approach espoused by their THUs. They also felt a degree of anger that change was being forced onto the current THU structure which they perceive to be working well.

*don't dismantle what's working well make it stronger*

Some of the statutory members felt that there was no point in trying to keep the old boundary configurations as they felt this would prolong the confusion regarding the reforms. Clear terms of reference were advised for all future THU configurations.

It became apparent during the analysis of the thirty interviews and two focus groups that the role and architecture of the THUs lend themselves to being operational at various levels within the HSE.

The variety of proposals suggested by participants formed a THU framework with four layers, operating at four distinct levels with four distinct roles all. This four layered framework came about as a natural response to the problem of the 'local committee being too local and the national too far away.

## ***Eastern Region THU recommendations***

### **Process**

- ✓ Continue to invest and support the processes which support partnership working
- ✓ Keep collective approach to problem solving, partnership, genuine participation
- ✓ Continue the shared involvement in decision making in relation to policy and funding allocation

- ✓ Create and retain good links and communication systems between social inclusion care group managers and regional managers
  - ✓ Resource and prioritise joint training for THU members
  - ✓ Hold quarterly THU meetings
- Strategy
- ✓ Develop monitoring role at oversight, national, level give direction and leadership
  - ✓ Be more focused in strategic priorities - smaller number of key priorities.
  - ✓ Use evidence based planning
  - ✓ Share paediatric hospital representative role among relevant hospitals
  - ✓ Use sub groups more strategically - strategy and policy sub group, operations, research, finance sub groups
- Capacity building
- ✓ Develop real relationships and effective communications system with National Care Group Team and the Director for Social Inclusion
  - ✓ Fund community development workers for Traveller organisations as a pre development stage to ensure active and value adding participation on THU itself
  - ✓ Fund and resource Eastern Regional Traveller Health Network to continue its work as the communications conduit between THU and Traveller organisations
  - ✓ Training on community development principles and partnership working
- Structure
- ✓ Leave current structure as is and review in 2007
  - ✓ THU must be accountable into senior reporting structures at high level
  - ✓ Northern Area and North East should have their own sub regional THUs as they have different Traveller populations with different health needs and issues. These two areas have different expertise, administrative systems including IT compatibility, etc and need different THUs to reflect this diversity.
  - ✓ There should be one THU across the Dublin area as splitting Dublin would be very complicated. A structure which ‘fits the reality of people’s lives is needed’

***Eastern Region THU finance related recommendations***

- Keep financial issues separate from the strategic and policy work of THU
- Agree specific criteria for funding
- Ringfence THU budget for more transparency
- Set up joint company to manage funds – this applies to the Eastern Region THU alone
- Finance sub committee to have full control and accountability for total THU budget

- Restore base budget back - the target for expenditure in the Traveller Health Strategy has not been met yet
- Wider representation on finance sub group
- Resource Travellers to be competent and confident on the financing area
- Streamline cheque generating and payment mechanism
- Presentation of an updated balance sheet every quarter to the finance sub-group

### **Generic THU recommendations**

- ✓ Leave the current THU structure as is for at least a year
- ✓ Set up a more formalised mechanism whereby all THUs share their learning
- ✓ Each LHO and relevant discipline to have representatives on the Sub regional cluster level THU
- ✓ Keep the 50:50 balance on all THUs
- ✓ LHO managers should be on THU to embedded it more as this would mean less transaction costs
- ✓ Widen representation to include other key stakeholders such as local authorities and Department of Education and Social, Community and Family Affairs
- ✓ Co-ordinators of Primary Health Care Projects or the development co-ordinators and the PHN co-ordinators should be members of the cluster level sub regional level

## **The Future**

### **Existing Traveller Health Structures**

As well as taking cognisance of the new HSE structures we need to consider the Traveller Health Structures that have been developed and resourced. Travellers participate in PHC steering groups, which operate at LHO level and are partnership committees between Travellers and the HSE. Depending on the density of population there may be more than one PHC steering group in a LHO area. In the absence of PHC project, this partnership role is fulfilled as appropriate by the local Traveller organisations. Each LHO area with a significant Traveller population has a Traveller Area Health Committee (See terms of reference for these committees attached) At regional level, co-terminus with the existing THU regions there are Regional Traveller Health Networks, which are a structure to support local Traveller organisations working in Health. These regional networks (TOR attached) are used to elected representatives on to the THU and ensure they have a mandate and a feedback mechanism to local groups. At national level there is a National Traveller Health Network, which includes reps of all Traveller organisations involved in health around the country, they provide the reps, mandate and feedback mechanism for Traveller representatives on the National Traveller Health Advisory committee. These regional networks have also been identified as the clear mechanism that will be used to provide training and support for the participation of Travellers in the forthcoming national needs assessment and health status study.

## **Proposed New Structures**

### *National THU*

This national THU would operate as the equivalent of the National Traveller Advisory Committee but would be located within the HSE to ensure Traveller issues are driven strategically, programmatically and operationally. It would ensure that the needs of Travellers would be fed strategically into the national service plan to ensure access to funds and insertion into relevant strategies and objectives.

It is proposed that this structure will operate at national level in partnership between the HSE and representatives of national Traveller organisations and will work in parallel with the National Traveller Health Advisory Committee and its sub-committees in the Department of Health and Children. The proposed terms of reference could include:

- Monitoring the implementation of the National Traveller Health Strategy.
- Set guidelines and principles to inform the allocation and accountability of the National Traveller Health Budget
- Ensure effective management and operation of the regional and sub-regional THU structures.
- Support the National Needs Assessment and Health Status study and promote the implementation of the ensuing findings.
- Set up monitoring systems to assess equality of access, participation and outcome for Travellers to health services.

This is just an example of some of the TOR for this National THU, it is envisaged that this committee would link with the other national health offices i.e. National Hospital Office and Population Health. It would also link with other relevant national committees to act as advocates and address the social determinants of Travellers Health.

This national THU should prioritise the delivery of the All Ireland Study as this will be a key strategic management information tool to inform future design and delivery of Traveller health services.

### **Regional THU**

There was an almost even split between those who saw four regional THUs with a consultative and decision making brief as sufficient and those who wanted to retain the current number of eight. Whether or not four or eight was the quantity in question those spoken to wanted these regional THUs to have a strategic brief, they also wanted these THUs to support and champion activities at sub regional and local level. There was a sense that these THUs should also have a monitoring and evaluation role that they should

engage in planning and feed up the emerging trends and needs identified at sub regional and local level to the NATIONAL THU.

Those opposed to regional THUs as the only THU structure cited long distances to attend meetings and felt that this would create barriers for many to stay involved. There was a concern at the geographic vastness of some of the regions - the Carlow to Kerry area was offered as an example of how difficult it would be to represent successfully the views of Travellers in this large catchment zone. Likewise in the Eastern region the challenge of meet the diverse needs of both urban and rural Travellers was cited as was the issue of population density, with over 25% of the Traveller population living in that region. To support the regional THUs a sub regional layer was thought to be value adding.

### **Sub- regional/Cluster THU**

An underpinning sub regional structure - at Local Health Office (LHO) and county level - could be developed to ensure that emerging local Traveller issues and needs were identified and responded to. As there are 32 LHOs a realistic approach to this could be to create clusters of local Traveller Care Committees as each care area may not have the critical mass and or capacity to run a THU at that micro level. This sub regional THU could be made up of a clustering of LHOs depending on the critical mass of local Traveller populations. These clusters would have an operational focus delivering projects, participating in research, sharing learning etc. The clusters could combine to ensure that they have representation on their regional THU. Where there is a critical mass of Travellers at Local Health Office level, Traveller Area Health Committees have been established.

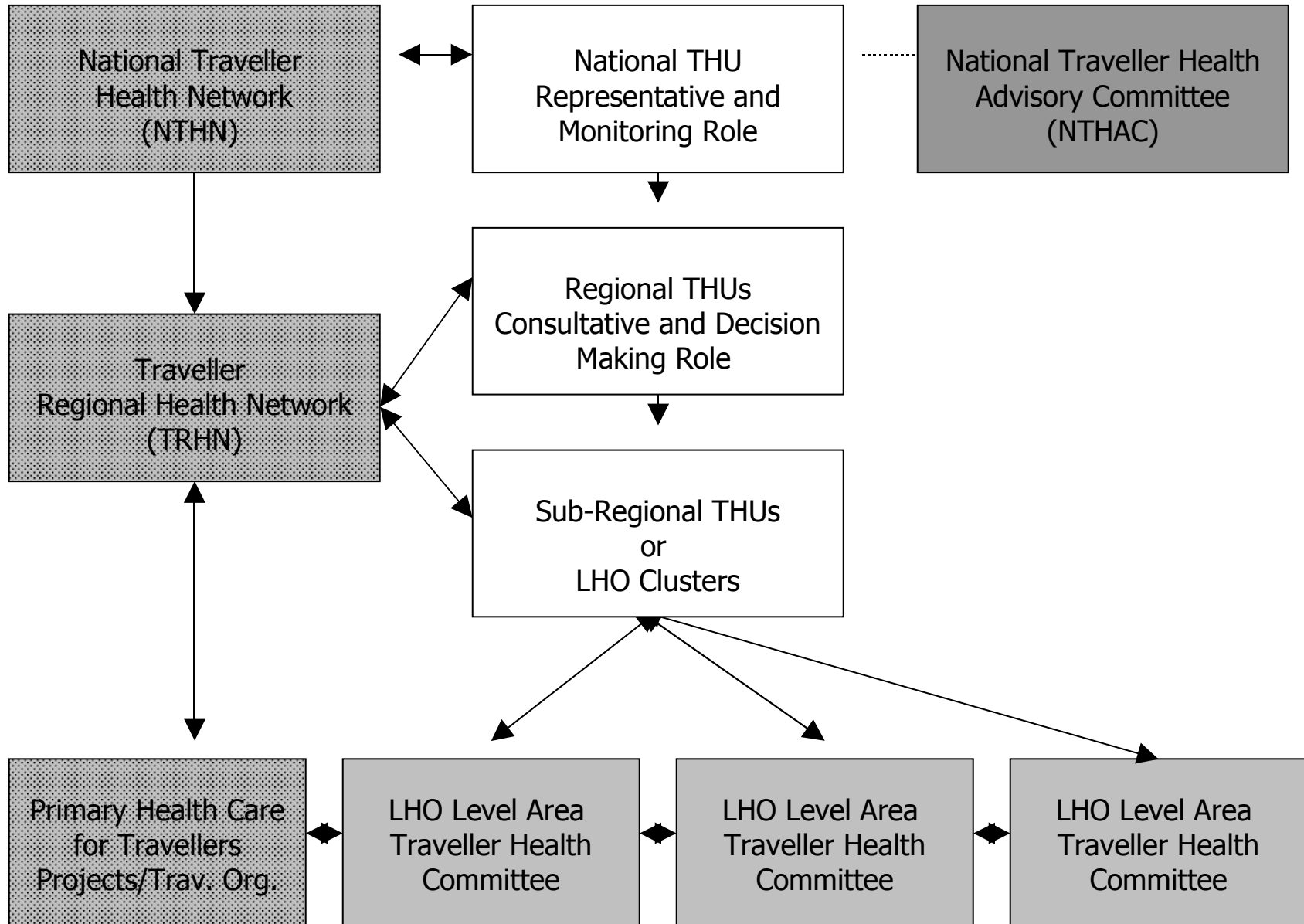
### ***Traveller Area Health Committees – at LHO Level***

There was a clearly expressed fear that if the Traveller remit was subsumed into the social inclusion brief at LHO level that it would be dissipated, would lose its funding and would end up competing with other care group populations of need. Therefore it was felt that separate Traveller Care Committee groups could be established and managed by a LHO general manager with strong links to the local social inclusion manager and Traveller organisations in the area. This Traveller Care Committee could have a micro focus on local needs.

### **Conclusion**

This is a proposed framework to facilitate the effective participation of Travellers in the new HSE structures. This document is to promote discussion and debate nationally and within the regions on the future role of Traveller health structures. There is a need for further thought and discussion on the new organogram and particularly on the most effective level for decision-making.

# Proposed New Traveller Health Structures



# Appendix One

## Terms of Reference for Traveller Area Health Committees Meetings

### Principles:

- The core values and principles should reflect those that underpin the National Traveller Health Strategy (see NTHS Chp2)
- The Committee should be set up and managed through a joint partnership between the Health Board, Travellers and Traveller organisations.
- Pro-active participation by Travellers is key, additional Traveller representatives may need to attend to mentor & capacity-build Travellers.
- All committee members should have a commitment to improving the poor health status of Travellers and Health Board representatives may need particular training to further develop their analysis of the issues.
- The Committee should be empowered to support the implementation, monitoring and evaluation of the recommendations from the National Traveller Health Strategy (N.T.H.S.) at an appropriate level.
- The Committee should build a community development approach. It is essential that this should incorporate a permanent role for peer led services and develop new roles for travellers within the health services, as planners, service providers and promoters.

### Terms of Reference:

- To provide a forum where all parties can meet to discuss and take action aimed at improving Travellers health status.
- To implement, monitor and evaluate the relevant actions, priorities and outcomes of the N.T.H.S. as outlined in the regional Implementation Plan, at a local level.
- To ensure that resources for Traveller health are allocated and managed effectively and appropriately.
- To link in with the service planning process and to ensure that all local strategies and policy documents are proofed to include Travellers.
- To ensure participants represent and are accountable to their organisation and disseminate information and allocate actions, as appropriate, to the relevant individuals in their organisation / Health Board.
- To provide two-way communication between Travellers and Traveller groups, the Health Board, The Traveller Health Unit and the Eastern Regional Traveller Health Network.

### Chairperson:

Democratic process where the Committee elects the chairperson and the role is rotated six monthly, between partners.

### The Chairperson should have:

Good experience of working with Travellers, an analysis of Traveller issues and a commitment to progressing Traveller health.

The Chairperson and Committee should have decision-making capacity within their organisations.

## **Membership**

- The Committee should be small in number and provide equal representation from Traveller Organisations and Health Board staff.
- In order to ensure appropriate levels of participation the Committee should include at least 3 Traveller representatives per Traveller project, at least 2 Travellers.
- Whilst it would be useful to obtain a gender mix, it may not be possible to obtain a balance when there are currently few Traveller men engaged in projects.
- Capacity building and training, for example on the N.T.H.S. and on barriers to Traveller health, participation, structure of health boards, should be provided to all members to ensure a common understanding of the Committee and role of members.
- Co-opting expertise to deal with local issues may be necessary on an ad hoc basis.

## **Suggested members:**

- Local Traveller Organisations
- Local Traveller Community representatives
- CCA General Manager and relevant staff members
- Local Traveller Health Unit Representatives
- PHC project Steering Committee members

## **Reporting:**

A quarterly report, financial report and update on progress in all areas should be provided to Committee members.

## **Appendix Two**

### **Terms of Reference for Regional Traveller Health Networks**

#### **Mission Statement**

**We are a network of Travellers & Traveller organisations and other NGO's working with Travellers, who are committed to addressing health inequalities experienced by Travellers and, using a community development approach, to improve and promote Travellers health in our region.**

#### **Membership of network**

Membership is for individual Travellers; Traveller organisations and other NGO's working with Travellers using a community development approach and with a commitment to improving Traveller health within the Traveller community in our region.

Community Development co-ordinators of PHC programmes and assistant co-ordinators should attend meetings.

#### **Network meetings**

There are a number of jobs in this area, these are as follows: -

#### **Coordinator/Convenor**

The role of the co-ordinator is to facilitate the development of a funding proposal with the members and then draw down monies from the regional THU to resource the activities of the network. The convenor also sends out minutes, maps of where next meetings are responsible for reporting on finances. This position may rotate within the network, on an annual basis.

#### **Host**

A different group may host the meetings each time. The host group are to organise a venue, chair the meeting and provide a light lunch. Meetings will be run on average every 4 -6 weeks in advance of THU meetings. If a group incurs expenses from hosting meetings invoices and receipts should be given to the convenor so as they can be reimbursed.

#### **Terms of Reference for Regional Traveller Health Network (RTHN)**

- To provide a forum for advocacy, networking, support and information exchange between Travellers and Traveller organisations in the region.
- To promote the adoption of a community development approach to Traveller health through Primary Health Care and/or peer led initiatives to address Traveller health inequalities as recommended by the National Traveller Health Strategy
- To provide space for Travellers and Traveller organisations to discuss and debate health issues in order to develop collective health agendas for their region.

- To ensure the development of a mandate and feedback mechanism for TRHN representatives to act as advocates on behalf of Travellers' health in the region and to provide a mechanism for better two-way communication between Travellers/Traveller health organisations and the THU.
- To work collectively towards ensuring the implementation of the National Traveller Health Strategy and other relevant strategies.
- To advocate, influence and impact on policy development and implementation
- To identify and resource training, capacity building and skills development for network members.
- To link with special interest groups e.g. to ensure representation on the regional Violence against Women committees, Local area Traveller health committees and the local Traveller accommodation consultative committees etc.
- To develop appropriate regional working groups to advance issues identified by the network.