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There are a number of groups that are

especially vulnerable in terms of susceptibility to influenza and barriers to accessing vaccinations. This may lead to larger problems in case of a pandemic; for example, in the H1N1 2009 outbreak in Australia, indigenous Australians, a hard to reach group, were overrepresented in rates of hospitalisation (Seale et al 2010). Hard to reach groups may have adverse health outcomes, and the complex interplay of gender and social and economic marginalisation makes this a particular issue for women (Davidson et al 2011). There are a number of minority groups in society which have adverse health outcomes and where women are particularly affected, such as the Roma community, Irish Travellers, isolated immigrant communities, and those in lower socioeconomic groups. Gender is one of the most critical variables in terms of health outcomes; women in hard to reach groups are therefore particularly marginalised. For example, older people are more likely to be poor than other groups, and women are more likely to be poor than men (Davidson et al 2011).

There are approximately 2.8 million Roma across the EU (Fundacio?n Secretariado Gitano Health Area 2009). The Roma have a disproportionate burden of communicable diseases, which is linked to their overall living conditions, health inequalities, health perceptions and behaviours, and ingrained discrimination (ECDC 2011). The social exclusion and deprivation in which many Roma live contributes to under-vaccination or a complete lack of vaccinations, in a population which is already at disproportionate risk from an illness such as influenza.

One study found that 28% of Roma children in the EU do not follow any child vaccination programme ? the figure is as low as 2.6% in the Czech Republic but a massive 45.7% in Romania, which also has the highest population of Roma at 1, 050,000 (Fundacio?n Secretariado Gitano Health Area 2009). Among obstacles noted regarding Roma health prevention was negative attitude and mistrust between Roma and public institutions,

low health literacy and poor access to health information, poor understanding of the risks of infectious diseases, and negative perceptions towards Roma from healthcare staff (ECDC 2011).

For Roma women, this difficult situation is even worse, as they are more likely to experience social exclusion than Roma men. They suffer the added disadvantages of limited access to education, employment, health services and social services, and are discriminated against on the basis of both ethnicity and gender (European Commission 2010). The Traveller community in Ireland is another example of a hard to reach group. Compared to the general population, Travellers have a considerably higher mortality in all ages, both male and female. Travellers have excess cardiovascular morbidity, which puts them in the risk zone for influenza, both seasonal and pandemic (UCD 2010). Although almost 95% of Traveller children have received vaccinations at the age of 5, Traveller children are nearly four times as likely to die as infants (children aged under 1) as the settled community. Overall, Traveller mortality is 3.5 times higher than in the settled community (UCD 2010).

Traveller women, much like the Roma women, face the double discrimination of both gender and minority status. Traveller women suffer disproportionally with depression and the level of non-accidental injuries, chiefly through domestic violence, is also very high in Traveller women (Pilson 2011). Pilson argues that a traditionally patriarchal culture persists in the Travelling community at the expense of female autonomy ? this is evident in a healthcare setting, where Traveller men may attempt to represent a family or a woman on health issues.

In communities such as the Roma or the Travellers, the barriers to health are many and the overall poor health performance of the communities makes the issue even more urgent. Coordinated efforts from local to EU level are necessary to create an environment

where efforts from both health and social areas improve access to health, and health-seeking behaviour. This is especially relevant for the women of these groups. Davidson et al explain that ?engaging in strategies to increase educational attainment in women and policies that address violence against women are important in redressing the social and economic inequities that contribute to adverse health outcomes? (Davidson et al 2011, p. 1038). Thus, a multi-pronged approach may address a number of issues at the one time.

Lower socioeconomic status tends to be associated with higher morbidity and mortality rates. Endrich et al (2009) found that social inequalities exist in the context of influenza vaccination; however, this was not true of all 11 European countries analysed in their study. As for gender, they found being male increased the chances of being vaccinated in France, Italy, Spain, UK, Czech Republic, Poland, and Portugal, but did not have any effect in Germany, Austria, Finland and Ireland (Endrich et al 2009). The various countries in the EU are thus demonstrably not homogenous in their experience in terms of vaccination.

Damiani et al (2007) also highlight the varying results that studies on socioeconomic disparities in influenza vaccination show; some find that certain variables, for example educational level, household income, and age group, influence vaccination rates, while in some findings, they do not. However, regardless of this, Damiani et al argue that an integrated interdisciplinary programme should exist where a systematic surveillance of trends in influenza uptake by socioeconomic groups is implemented: this would allow policy makers to identify trends and barriers limiting equitable uptake of influenza vaccinations.

Lorant et al found in their 2002 study that influenza immunisation in Belgium was less likely between the bottom and third socioeconomic quintile of their sample. This result was reached by adding a variable termed ?concentration of needs?, which

reported that needs are more prevalent in lower socioeconomic groups. They define needs as ??use (health care or prevention) predicted by health status or sex-age group? (Lorant et al, 2002, p. 511), where the health care use or prevention was predicted by health status. By introducing needs into the variables analysed, they found a significant inequity gradient in prevention and health care where ignoring the distribution of needs for preventive care may ultimately conceal inequity in the provision, as needs are concentrated among the less well off. In terms of health seeking behaviours of different socioeconomic groups, Lorant et al (2002) argue that more research needs to be done in the area, and that socioeconomic inequality in prevention can be explained by differences in help seeking, information gathering, and beliefs.

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