Happy tenth anniversary! Welcome to the first issue of our tenth volume. Running for ten consecutive years, our journal is now recognized as one of the leading peer-reviewed publications dedicated to human rights issues impacting on health and social care internationally.

This issue also marks my fourth year as the Journal’s Editor-in-Chief. Before I introduce you to this exciting new edition, I want to thank my predecessors as well as my Editorial Board and our publisher for supporting me to reach this important milestone. I also want to thank you, the reader, for your interest in our work. If you are indeed reading this, it means that we share the same vision with us for a more equal, fair and rights-based treatment in health and social care. As a thank you and in acknowledgement of our growing readership, we have decided to increase our issues’ peer-reviewed research papers from five to six, while also accepting book reviews, literature reviews and case studies. We also remain committed to keeping our unique focus on combining practice with the highest academic research.

I have always believed that the best arguments for practice and policy reform are those that are founded in evidence. Therefore, it is a true honour and pleasure to serve as this Journal’s Editor-in-Chief. It is also with pride that I reach the tenth anniversary milestone with you, and indeed hope that together we will continue making a real contribution to academia, policy and practice internationally for another ten years.

A key issue that remains unaddressed internationally is the acknowledgement of an ingrained gender bias in the manner in which we deal with health issues. In 2016, our journal published two special issues dedicated to gender related healthcare matters. Volume 9, Special Issue 1 (by Guest Editor Dr Daniel Riesel) looked at Female Genital Mutilation (FGM), while Volume 9, Special Issue 4 (by guest Editor Dr Ritu Mahendru) was titled “Gender-based violence and health”. It is, therefore, my pleasure to open the first issue of Volume 10 with “Don’t Judge Me: Narratives of living with FGM”. The paper is based on research that was conducted through a creative narrative approach which included the sharing of personal stories, the creation of pottery models and the sharing of artefacts. Six women who are living with FGM agreed to take part in a participant-led arts workshop in order to explore their experiences and impact of FGM on health and wellbeing. The composition of the workshop encompassed the creation of a persona and sharing artefacts. The findings suggest that there is further scope for research and practice development which examines the impact of education on professional’s approaches to FGM. There is a paucity of studies which have explored women experiences of living with FGM and the impact on health and wellbeing and thus this paper is important in that it opens the debate for further research in the area.

The second paper is titled “Religious differentials in morbidity prevalence and healthcare seeking behaviours among older persons in India”, and aims to bridge the gap in understanding differences in morbidity prevalence rates and utilization of healthcare services among older adults between religion groups in India. Multivariate logistic regression models were fitted to examine the association between socio-demographic conditions and morbidity prevalence and healthcare seeking behaviours between Hindus and Muslims. The paper concludes that morbidity prevalence rate was higher among older Muslims. In trying to understand this difference, the research suggested that income had no association with the burden of disease. In fact, despite of low socio-economic status, Muslim older persons were more likely to seek treatment for ill-health compared to Hindu older persons, but spent less money for treatment. The findings shed light at an important policy areas not only for India but also internationally.
The third paper, “Type 2 diabetes prevention & self-management among Nicaraguan ethnic minorities” explores the physical and medical environments as well as the individual factors in a sample of ethnic minority adults with at-risk for type 2 diabetes (T2D) on the Atlantic Coast of Nicaragua. The study used a cross-sectional, descriptive design guided by community-based participatory research. Three coastal communities were sampled. For many participants, fresh vegetables and fruit were reported as ordinarily available, but difficult to afford. A majority reported prescribed medication(s) were available without difficulty although most indicated difficulty affording them. A minority of participants with T2D reported receipt of diabetes education. Participants at-risk for T2D were less frequently instructed, by a provider, to follow an exercise programme, or meal plan. These are significant new findings that can inform the development of community-based clinics to address the problem of T2D locally. We are proud to report that this is the first quantitative assessment of the T2D problem among diverse ethnic groups in Nicaragua’s underserved Southern Atlantic Autonomous Region.

The following paper “Implicit bias in US medicine: complex findings and incomplete conclusions” takes a bold step in understanding the unconscious attitude of a provider’s perception of a patient based upon perceived race or ethnicity. The paper hypothesized that this hidden bias affects clinical decisions, provider-patient interactions and patient health. The paper critiques the relevant works over the past 15-years while highlighting its strengths and weaknesses. The authors conclude that the US-providers hold an anti-black implicit bias negatively affecting patient-provider communication and patient satisfaction. However, they do accept that the reviewed studies do not show that this bias consistently negatively affects diagnosis and treatment regimens of black patients in comparison to white patients. My own view as a researcher in the area of equality is in agreement with the authors’ conclusion that there is a significant dearth of implicit bias literature addressing the care of other patient groups of colour. Therefore, I call for further research to be done in this area and will be looking at proposals from Guest Editors who are interested in editing a special issue on the topic.

The subsequent paper “Geographical perspective of modelling primary healthcare accessibility” measures the spatial accessibility of primary healthcare facility in Ghanaian rural areas by determining the barriers to healthcare accessibility in the Amansie Central district. The paper is based on original research that adopted network and proximity analyses on digitized data such as road networks, settlements, population, district boundary, natural resources and site location. In all, 31.2 per cent of the district population had no access to healthcare facility. Transportation was identified to be one of the major hindrances to healthcare accessibility and this was as a result of poor road network in the district. The study proposed additional sites for siting new health facilities based on criteria such as population, distance, centrality and existing infrastructural development. If these recommendations are adopted, then we would expect to improve healthcare accessibility and utilization by increasing total coverage closer to 100 per cent.

Finally, “Young service users from refugee backgrounds” examines barriers to accessing mental health services from the perspective of young people of refugee background who have been service users. I was particularly pleased to edit this paper given my passion in youth-led and user-led research. The paper adopted a qualitative methodology that involved 16 young people who had been refugees and who had attended mental health professionals in Australia. A key finding was that stigma about mental health problems was particularly prominent. Many believed a high level of disturbance was the threshold for entering services, and for some there was no knowledge of such services’ existence. Options for assistance other than mental health services were often preferred, according to young people’s explanatory models. Apprehension was expressed that sessions would be uncomfortable, distressing, or ineffective. The desire to be self-reliant functioned as a further barrier. Finally, structural obstacles and social exclusion deterred some young refugees from accessing services. The findings of this important paper highlight the need for service providers to be equipped to provide culturally sensitive, responsive services that ideally offer both practical and psychological assistance. Potential referrers, including health professionals and community leaders, could facilitate increased access if trained to recognize and address barriers.
Finally, findings indicate potential content for awareness-raising initiatives for young refugees about mental health problems and services.

The tenth Volume will be a special one with several issues dedicated to addressing current knowledge gaps and persistent inequalities. I am always keen to hear from our readers and, of course, consider new submissions. Experienced researchers interested in acting as guest editors are welcome to contact me directly with ideas for special issues. We also have an open call for reviewers. I hope that this issue and our celebratory tenth anniversary volume will provide you with new insights, ideas and evidence that you will use to progress human rights whether you are a practitioner, researcher or policy maker.