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Bywaters, P.

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Key Issues for Health Inequalities Research, UK and International Conceptions

Introduction

The Millennium Development Goals (United Nations 2000) reflect international agreement that inequalities in health are a major barrier both to improved population health and economic growth (Feacham 2000). The Ministerial Summit on Health Research in Mexico (World Health Organisation 2004, 1) stated that 'Research has a crucial but under-recognised part to play in …. improving the equitable distribution of high quality health services, and advancing human development.' In the UK, successive government commissioned reports and White Papers (for example, Acheson 1998; Wanless 2002; Department of Health 2004) have echoed this global emphasis on the significance of reducing health inequalities for meeting health, social and economic policy objectives.

Recently in the UK, theorising social work's engagement with health inequalities has begun to gain recognition as a distinctive and integral dimension of social work research both as a general topic (McLeod and Bywaters 2000; Bywaters and McLeod 2001) and through specific studies of , for example, domestic violence, service users' perspectives on palliative care or on mental health services for young people from Black and Minority Ethnic communities and the role of money advice services in contributing to better health (Williamson 2000; Croft et al 2005; Street al 2004; Borland 2004). But this remains a somewhat marginal and disparate focus of research and of practice.

In this paper I aim to outline some ways in which the international context or perspective can enhance our discussions of social work research on health inequalities and create both a new international research agenda and new research activity. To slightly amend what Hilary Graham wrote in the introduction of Understanding Health Inequalities (2001:3): 'his (seminar series) turns the spotlight on the link between social inequality and individual health. It does so by focusing on socio-economic inequality: on the fact that how well and how long one lives is powerfully shaped by one's place in the hierarchies built around occupation, education and income.' And because this is a social work research seminar series, the focus is on what can be done about health inequalities not only by policy makers but in practice and through research. I would like to think that these seminars are about changing things not just studying them.

Background

I want to begin with a brief reminder of what we are dealing with and its significance for people's lives. Despite overall rising life expectancy within the UK and internationally, inequalities in health both within and between countries have, in significant respects, continued to widen in recent years (Department of Health 2005; Task Force on Health System Research Priorities for Equity in Health, 2004; Labonte et al 2005). In the UK, a nearly two year gain in average life expectancy in the last ten years has been accompanied by a widening gap between the most advantaged (Kensington and Chelsea) and least advantaged (Glasgow) local authorities from around 9 years to around 11.5 years for boys (National Statistics 2006). According to the Director of Public Health in Birmingham, life expectancy for boys in the most advantaged wards in Sutton Coldfield is over 78 years. In the two least advantaged wards of Soho and Nechells it is 67.4 and 63.8 years respectively (Chambers 2005). When you think that the average life expectancy in Bangladesh is 63 years, according to the World Health Organisation (WHO) Annual Health Report (2005a), it gives you some sense of what it means to be a boy born in Nechells. Nechells has the life expectancy of a low income developing world country. In many areas of Sub-Saharan Africa, life expectancy has substantially worsened in the past fifteen years. As a result, the only seven countries with overall average life expectancy under 40 years are all from Sub-Saharan Africa, with several countries losing as many as 10 years of average life expectancy in a very short time (Sanders et al 2004). There are, of course, dimensions of difference which go beyond the links between place and economic status. For example, differences of gender and age are reflected in the Millennium Goals of reducing maternal and infant mortality (World Health Organisation 2005a). The 20 year difference in life expectancy for Aboriginal and Torres Straits Islander boys in Australia compared to the non-indigenous people, exemplifies profound world-wide differences between indigenous and non-indigenous peoples' health (Marmot 2005).

So what we are talking about in these seminars are matters of life and death, of pain and suffering, much of it avoidable and inequitably distributed. Illness affects people's quality of life before death and impacts on the quality of life of those they leave behind. No-where is this more apparent than in Sub-Saharan Africa where HIV/AIDS has created an epidemic of orphans. 'For poor groups within countries…untreated illness is a major barrier to both income generation and education, while spending on medical care is a major reason why many families in poor countries fall into poverty' (Sanders et al 2004, 760).

As Eileen McLeod has argued earlier, this pattern of poor or threatened physical and mental health going hand in hand with poverty and material disadvantage are the social characteristics which link the vast majority of social work service users, world wide. Ill-health and poor health chances have a major impact on service users' and carers' well-being and quality of life and are often the fundamental cause of their requirement for social work services (Becker 1997, McLeod and Bywaters 2000).

A number of connected arguments underpin this perspective (for an extended discussion see McLeod and Bywaters 2000).

- Physical and mental health, illness and death - like the requirement for social care - are largely determined by social, economic, environmental and political factors.
- Social care services as well as health services play a vital role in health prevention, treatment and care.
- Self-care and informal care are crucial components of people's chances and experiences of health and illness and they are also inextricably patterned by social factors.
- The social consequences of ill-health impact on many other dimensions of people's lives, such as education, employment, and income, including through stigma and discrimination.

So entwined are the relationships between poor socio-economic conditions and poor physical and mental health, that addressing health inequalities can have valuable spin-offs for social work service users generally. As the White Paper 'Our Healthier

Nation' (Department of Health 1998: 12) put it, 'tackling inequalities generally is the best way of tackling health inequalities in particular.' Like Wilkinson and Marmot (2003: 9), I 'hope that by tackling some of the material and social injustices, policy will not only improve health and well-being but may also reduce a range of other social problems that flourish alongside ill health and are rooted in the same socioeconomic processes.'

Health Inequalities as a Human Rights Issue

An international perspective on health inequalities emphasises that this is an issue of human rights. This is built into the WHO's Constitution (WHO 2005b) which says that: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'

The WHO's web pages on Health and Human Rights argue that 'Promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked:

- Violations or lack of attention to human rights can have serious health consequences (e.g. harmful traditional practices, slavery, torture and inhuman and degrading treatment, violence against women and children).
- Health policies and programmes can promote or violate human rights in their design or implementation (e.g. freedom from discrimination, individual autonomy, rights to participation, privacy and information).
- Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights (e.g. freedom from discrimination on account of race, sex and gender roles, rights to health, food and nutrition, education, housing).' (WHO 2005c)

This understanding of what is involved in or meant by 'health' demonstrates the direct links between social work practice and health. It is not that we have to perceive or develop or justify the relevance of social work for people's health but that these issues overlap to a significant degree, that they are often one and the same brought together in a common interest in human rights and social justice. This is expressed in the IFSW definition of social work:

> 'The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.' (IFSW 2005)

The importance of a human rights perspective on health inequalities has not been central to discussions in the UK but is much more present internationally (Hunt 2003; Labonte et al 2005). Social work values require that social workers oppose unjust inequalities in health. In response to the injustice of differential life expectancies within and between Scottish cities, Watt wrote that 'dying before your time is the ultimate social exclusion' (1996: 1027), he could have said that avoidable, premature death involves the ultimate loss of your human rights.

Towards A Research Agenda

What Do We Know?

If social work research is to make its contribution to health inequalities research, it is perhaps useful to briefly outline what can be considered to be already known. In 'The Solid Facts', Wilkinson and Marmot (2003, 7) try to establish what has been 'most reliably established by research' about the social determinants of unjust health inequalities, what is sometimes called health inequity. They argue that there is a remarkable consensus amongst the experts they assembled that to tackle health inequalities what is needed is a more just and a more caring society, both economically and socially. To establish the basis for this, they say, in terms which could speak for social work's own mission, 'much depends on understanding the interaction between material disadvantage and its social meanings. It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters. As social beings, we need not only good material conditions but, from early childhood onward, we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful, and we need to exercise a significant degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness, which all rebound on physical health' (9).

They make a number of explicit claims for what is known. These include, first, that the social determinants affect people's health throughout life – with different ages mattering more in different societies and circumstances. For example, the radically reduced life expectancy of indigenous Australians is not primarily caused by a low infant mortality rate (albeit about double that for non-Aboriginal Australians), but by what happens thereafter. Pre-natal conditions, infancy and childhood are clearly crucial periods for laying down health chances, but advantage or disadvantage in adult life and old age (while influenced by childhood factors such as educational success) also act independently to affect patterns of illness and death.

Second, disadvantage has many and varied dimensions: inadequate family financial assets; poor educational opportunities and outcomes; insecure or hazardous employment; substandard housing; stressful family circumstances. We might include, particularly in an international context, other social resources including the presence or absence of war, endemic gender and ethnic violence and the absence of welfare provision.

Third, these disadvantages tend to concentrate on the same people at any given time while the health effects accumulate across the lifecourse, progressively reducing the chances of a healthy old age.

Fourth, 'social support and good social relations make an important contribution to health…. (But) the amount of emotional and practical social support people get varies by social and economic status. Inequality is corrosive of good social relations' Wilkinson and Marmot 2003, 22).

Fifth, the gradient of health inequality runs right across society. From a policy perspective Graham (2000) identified that tackling health inequalities across society is not just a matter of raising the level of health of the poor, or of reducing the gap between the poor and others, but of reducing inequalities across the whole strata of society and, we might add, between nations.

What Are We trying To Achieve?

Equity in health, as defined by the WHO Task Force whose paper fed into the World Ministerial Summit on Health Research in Mexico 2004, ‘reflects a concern to reduce unequal opportunities to be healthy associated with membership of less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization’ (Braveman 2003 in Task Force 2004, 7). The Task Force argued that existing knowledge suggests giving priority to (1) integrated action to develop healthier social, economic, political and physical environments; (2) improved access to appropriate universal social care and health systems; and (3) interventions where ill-health and suffering is greatest and resources to address it are least.

How Can Research Contribute?

While greater knowledge of the fundamental causes of health inequalities remains a research priority, one factor in favour of greater social work research activity is that, the focus of attention in health inequalities research internationally has increasingly begun to shift towards a concern to establish a research base for effective measures to reduce unfair inequalities in health (Macintyre 1997; Gwatkin 2000, Graham 2004). ‘(R)esearch in the health equity field has, until recently, been devoted mostly to describing the inequalities and much less to explaining them and proposing interventions to address the inequalities’ (Task Force 2004 19).

As part of that agenda, the WHO’s Task Force recommended that closer attention be given to the micro-politics of health inequalities:

- the details of institutional policies and practices,
- the workings of health care and interlocking systems, and
- individual choices that are the transmission mechanisms between the underlying structures of social inequalities and health outcomes.

Both social work practice, operating in inter-agency and inter-professional settings, and social work research, which is interdisciplinary in nature, are primarily concerned with the relationships between individuals and their social context and with the application of forms of practice to reduce the causes and consequences of embodied human suffering. Significant benefits for research and practice, and in alleviating suffering, would accrue from the development of international collaborative research programmes that lead to a better understanding of the theoretical, methodological and substantive issues involved in researching such relationships.

The five research priorities identified in the Task Force report, applied to social work, provide a possible framework for our research agenda.

1. *Global factors that affect health equity*

Social work practice in response to health inequalities is clearly influenced by global developments, for example, in economics, social policy, technology, migration, conflict and climate change. Social workers respond to both ‘man-made’ and ‘natural’ disasters, such as war, terrorism, famine, de-forestation, global warming and earthquakes, including last year's tsunami and Pakistani/Kashmiri earthquake (Harrell and Zakour 2003). Social work is involved in pandemics, such as HIV/AIDS, cancer or heart disease, and front line work with asylum seekers, refugees, displaced persons and migrants, dealing with issues of health prevention, care for people who are sick and dying, and the social consequences of illness, such as the care of children who lack responsible adults. However, the impact of neo-liberal economic policies on widening social and health inequalities has rarely been addressed in social work practice but arguably has 'contributed to the rapid spread of infectious diseases, and increased adoption of high risk lifestyles, systematically undermined the public provision of essential services and food self-sufficiency, and reduced the authorities and capacities of states to protect public health' (Task Force 2004:11) Research questions include: how do global economic, political and environmental events impact on the health of social work service users? What forms of local social work action provide relatively effective responses to global forces? How can local communities gain or regain a degree of influence over the global factors affecting their health?

2. *The specific societal and political structures and relationships that differentially affect people's chances to be healthy.*

The distribution of power, wealth and risk within society has a major impact on the determinants of health (Davey Smith 2003). Both formal social arrangements, such as the extent and nature of welfare provision, including social care, and informal patterns, such as gender norms or social relationships within and between communities have the potential to increase, reduce or mitigate inequalities in health. Social workers characteristically operate in these inter-organisational and cultural spaces and alongside services users taking action for their own health, for example through the local manifestations of social movements (McLeod and Bywaters 2000). Research concerns include the impact of systems of rationing and eligibility for social care on health outcomes; the relevance of key policy concepts such as social inclusion and social cohesion for service users' health; measures to counteract endemic violence and the impact of anti-discriminatory legislation and policy on access to resources and services, for example, by indigenous peoples.

3. *The inter-relationships between individual factors and social context.*

The key fault line in policy and practice for tackling health inequalities lies between an emphasis on individualised risk factors and behaviours and on the impact of social context and social position across the life course (Department of Health 2004; Davey Smith 2003). There remains much to be learned about the 'pathways by which disadvantaged social positions translate into ill-health' (Task Force, 2004,15; Whitehead et al 2000) and it is in understanding these interpersonal and everyday experiences of inequality, linked to identity, that social work research can make a particular contribution. For social workers, these have been perennial issues of resonance not just in relation to illness but to a wider range of phenomena including interpersonal and institutional violence, abusive relationships, substance misuse and self-harm (Gibson 2003). Social workers are interested in the mechanics of marginalisation including unequal access to information, knowledge and skills, in factors that make for resilience in individuals and communities, and in lifecourse perspectives on health and social inequalities (Bywaters forthcoming).

4. *Health (and social) care system factors that influence health equity.*

The availability and distribution of health and social care services have a potentially important role to play in reducing inequalities in health and their impact. Social workers are interested in how such services impact on the daily lives of individuals and households that are at risk of or living with poor health and in the potential for different models of service provision to reduce or exacerbate health inequalities (Sulman and Savage 2001). Research issues include the differential impact of systems and system reforms on different population groups, equalising power relations between professionals and service users, and interdisciplinary working (Beresford, 2001; Shera et al 2002; Whiteside 2004).

5. *Documenting and widely disseminating effective policy interventions to reduce health inequity.*

For social work, as for health equity interventions generally, there is a paucity of evidence about the impact of social work policy and practice, both separately and as members of inter-professional teams. Issues include methodological problems in evaluating social interventions, including anti-poverty strategies, ethical/political considerations, and paying greater attention to ensuring that research evidence and application develop in step.

Making it Happen

At the start of these seminars, then, I would want us to be ambitious about our task. It seems to me to fall into a number of categories.

Conceptual and Theoretical issues:

Research on health inequalities requires that we consider how to define a number of key terms. First, is how we understand inequality, its relationship to equity, to social work values, to the more usual focus in social work recently on discriminatory or oppressive social relations. The Task Force argues that a focus on creating equal opportunities will inevitably increase differences between social groups because of a differential capacity to take advantage of opportunities. So arguably we need to adopt equality of outcomes as the measure of choice for the impact of interventions. Second, we need to explore the lay and professional concepts of health and its relationship to the social; the relationships between physical and mental health, between health and disability, between health care and social care, health and development, social work and related professions. Third, there is the nature of lifecourse understandings of health chances and health experience and the relationship of these to understandings of social inequalities more generally; how cross cutting social structural factors such as ethnicity, gender, disability or sexual orientation affect health chances and access to health services. Fourth, in policy terms, Graham’s (2001) distinction between addressing the poorest, narrowing the gap and population wide interventions warrants exploration in practice. Fifthly, we also need to develop better ways of linking the study of local phenomena to globalisation processes that control and constrain them (Sanders et al 2004).

Methodological issues:

In order to carry out this research agenda we will require parallel methodological development. Questions to explore include what we mean by international research: international in focus, in relevance, in the composition of the research team, in analysis, in resulting action? Are we talking about collaborative, comparative, parallel or cumulative research projects? A couple of our international contributors are interested in how epidemiological research approaches can be applied to social work (Whitehead 2004). Social work has been better than some disciplines at exploring the ethical issues of participatory and action research approaches. We may need to develop ways of managing this across international boundaries. We will also want to take part in debates about whether evidence based practice approaches can be developed that are compatible with equity (Sanders et al .2004, Rogers 2004)

Ethical and Political issues

Such methodological issues are closely allied to ethical and political considerations. For example, how do we value different kinds and sources of knowledge about health inequalities? How do we encompass difference in perceptions of health and illness, life and death, for example between groups and populations with different approaches to spirituality? Some questions bear on the international role of social work. What action can social work take nationally and internationally based on research?

Substantive Issues

We may also hope to clarify through these seminars what are the central substantive issues that we as researchers should address. What should be the breadth of our concerns? What are the range of health threatening social inequalities which we would wish to include? What are the sharpest aspects of health inequalities on which we should focus attention? Who should decide these priorities?

Practical Issues

Finally, I would hope that through these seminars, in the relationships that are set up as well as the meetings themselves, we could begin to address together a number of practical issues. How can we secure funding for social work research on health inequalities? How do we develop the capacity to be able to create and sustain substantial research programmes? Do we have the expertise, the workforce, the governance structures? How do we create the conditions for effective national and international collaborations and what obstacles do we face? What links and alliances should social work be making with other civil society bodies, other professions and disciplines who share some of our concerns: at an international level the World Social Forum, People’s Health Movement, Global Forum for Health Research. How do we create the structures and activity within social work to be able to achieve a more globalised perspective on unjust social conditions and a greater ability to act upon them? Is IFSW or IASSW adequate to the task?

Conclusion

That seems to me to constitute a more than demanding agenda. Personally, I am particularly excited by the international dimension of these seminars. There seem to me to be a number of key reasons for adopting this international perspective. Many of the forces which act to create and maintain health inequalities are multi-national or global and cannot be understood or acted against effectively from a single country. Comparative and collaborative work can shed new light on familiar problems and tried solutions. We seem to me to need all the help we can get with this agenda and we ought to gain strength from each other. And finally, I believe that social work needs to learn how to act in a globalised world.

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