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Foundation for Equity and Research New Zealand

Report to UN Committee on the Elimination of Discrimination against Women (CEDAW)

UN Civil Society Organisation Shadow Report

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

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Shadow Report – Article 12 Health

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Cover Page Imagery:

A black background centred with a three-by-three grid of the nine lived-experience steering group authors of this report, flanked above and below by a banner of silver ferns (ponga) – a New Zealand native iconic species (*Alsophila tricolor*). The silver fern's graceful shape represents "strength, enduring power, and stubborn resistance." It symbolically links to the name and logo icon of the Foundation for Equity and Research New Zealand (FERNZ), representing new life, growth, strength, and peace—values that underpin their philosophy on equity and human rights. The FERNZ logo is in the top right corner.

The report authors, portrayed (from top left to bottom right) are:

Bernadette Jones – a distinguished Māori Health Academic and Director of FERNZ, also recognized as a Wahine Tangata Whaikaha Māori. Seated indoors with a serene backdrop of greenery framed by a wooden window, she has short grey hair and a calm, composed expression, reflecting her authority and commitment to advancing health equity for Māori communities, especially those with disabilities. Her dark blue top and patterned shawl add cultural elegance to her professional appearance.

Marama Parore – a respected Māori leader and advocate for Māori health and disability rights. She wears a traditional Māori cloak (korowai) with intricate red, white, and black patterns, greenstone earrings, and a moko kauae (traditional Māori chin tattoo). Her red and black feather-adorned hair and a richly patterned floral background highlight her pride and dignity in her leadership roles, including Chair of Pipitea Marae.

Meredith Perry – a physiotherapist and researcher specializing in long-term conditions and disability. Her work centres on person-centred care, therapeutic relationships, and co-produced solutions to health inequities. As a mother of two disabled children, her research is deeply informed by both personal and professional experience. She has long brown hair and a warm smile, set against a backdrop of intricate, patterned panelling that reflects a professional and inviting atmosphere.

Lara Greaves – an associate professor in politics at Victoria University of Wellington and a senior research fellow in statistics at the University of Auckland. She stands confidently with her arms crossed, wearing a dark olive-green blazer and a brown top. Her long, dark, wavy hair and slight smile add a friendly touch, set against a natural background of lush green palm leaves. As a Royal Society of New Zealand Rutherford Discovery Fellow, she focuses on improving democracy and participation in New Zealand, particularly for Māori and intersectional communities.

Mereana Latimer – a Māori and Cook Island Māori professional in public health and education policy, depicted in a pop-art-style portrait. The vibrant lime green and dark blue tones highlight her long dark hair and bright smile, conveying warmth and positivity. Wearing a floral-patterned top, the dynamic image reflects her advocacy work informed by her lived experience as Māori, Cook Island Māori, and Rangatahi.

Huhana Hickey – a prominent disability rights lawyer and advocate for accessibility and human rights. She has short hair and a friendly smile, wearing a moko kauae and a tattoo on her forehead, which symbolize her deep connection to Māori culture. Her simple dark blue top and natural, blurred background emphasize her strength and commitment to advocating for Māori, disability, and LGBTQI+ rights in her various leadership roles.

Tristram Ingham – a Clinical Epidemiologist and Deputy Head of Department at the University of Otago, Wellington. Seated in his power wheelchair against a backdrop of lush greenery, he wears a dark suit jacket over a light blue checkered shirt. His thoughtful expression reflects his expertise in health inequities, Māori health, long-term conditions, and disability rights. As Chair of FERNZ, he advocates for equitable healthcare governance and addressing systemic health challenges.

Vicky Robertson – an accomplished leader and former Chief Executive of the Ministry for the Environment, with experience in governance and public service. She has short styled blonde hair and a warm smile, dressed in a formal outfit with a collared shirt. The black-and-white photo emphasizes her engaged and approachable demeanour, reflecting her roles as an Independent Director and her previous senior positions in New Zealand's public sector.

Gemma Roache – a public health professional with expertise in epidemiology and biostatistics. She has long dark hair and a bright, engaging smile, dressed in a dark top with a green cardigan that exudes a professional yet relaxed disposition. Her friendly expression and presence align with her work in public health, focusing on community health, disease prevention, and program implementation, informed by her strong academic and practical background in health science.

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EXECUTIVE SUMMARY

1. This Shadow Report has been prepared by the Foundation for Equity and Research New Zealand (FERNZ). With first-hand lived experience of inequity, FERNZ is dedicated to identifying and addressing health and social inequities for communities across New Zealand. This report examines persistent health inequities affecting Māori, Pacific, Disabled and Rainbow women in New Zealand, specifically through the lens of intersectionality. Since the last reporting cycle, the State Party has taken several positive actions to implement its obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). However, despite recommendations from this Committee and the introduction of health equity frameworks, significant gaps in health outcomes remain.

2. Māori and Pacific women face inadequate access to culturally competent healthcare, particularly relating to reproductive and maternal health, disproportionately higher rates of illness and lower life expectancy. Mental health inequities are also of critical concern, with insufficient or culturally unresponsive services to address the unique needs of intersectional communities. Rainbow communities experience higher levels of mental health distress and Disabled women often face additional barriers in accessing both physical and mental health services. Rural women, particularly from Māori, Pacific, Disabled and Rainbow communities also face additional challenges due to geographic isolation and inadequate or culturally unresponsive healthcare infrastructure.

3. A major issue highlighted in this report is the absence of comprehensive, intersectional health data. This lack of intersectional data and subsequent analysis means the State Party is failing to capture the compounded forms of discrimination and marginalisation that women experience. This is not only a breach of its obligations under the Te Tiriti o Waitangi (Treaty of Waitangi) but also a failure to meet its responsibilities under CEDAW. This hinders the development of effective and culturally responsive policies and the delivery of funding to address the unique challenges of women, particularly from Māori, Pacific, Disabled and Rainbow communities.

4. This report recommends stronger enforcement of health equity policies, the implementation of comprehensive cultural competency training and greater leadership by Māori, Pacific, Disabled and Rainbow communities in shaping health policies. Furthermore, we urge the

State Party to prioritise intersectional data collection and disaggregation, as previously recommended by this Committee, to inform and guide inclusive, responsive and equitable health interventions.

ACCESS TO HEALTHCARE

Persistent health inequities

5. Despite the introduction of health equity frameworks such as the New Zealand Health Strategy 2023 and the Whakamaua: Māori Health Action Plan 2020-2025, significant inequities in health outcomes for women remain deeply entrenched in New Zealand, particularly for Māori, Pacific, Disabled and Rainbow communities.[1,2]

6. Māori experience higher rates of illness, lower life expectancy, elevated rates of mental health issues and a higher prevalence of unmet health needs. This situation is further exacerbated by socio-economic factors that disproportionately impact these communities. Māori and Pacific women are more likely to experience economic hardship, racism, discrimination and barriers in essential services and culturally appropriate care. Many have reported that their voices are not heard or validated by healthcare professionals and decision makers and that they lack autonomy over their health and care. [3]

7. Māori and Pacific women are more likely to experience complications and adverse outcomes during pregnancy and childbirth and experience a higher infant mortality rate.[4] Rainbow children and youth are also disproportionately represented in New Zealand's care and child welfare systems and face much higher rates of disability, homelessness, discrimination and violence compared to their peers.[5] These intersecting and compounding layers of marginalisation exacerbate vulnerabilities that can follow across the life course. Yet there is limited understanding or focus on intersectional needs and experiences.[6]
8. Mental health remains a critical concern for Māori, Pacific, Disabled and Rainbow women. The availability of mental health services is often insufficient and the services that do exist,

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[1] Ministry of Health. (2023). Health and independence report 2023. Ministry of Health, New Zealand.

[2] Ministry of Health. 2020. Whakamaua: Māori Health Action Plan 2020-2025. Wellington: Ministry of Health.

[3] Ministry of Health. 2023. New Zealand Health Strategy. Wellington: Ministry of Health.

[4] Ministry of Health. (2023). Health and independence report 2023. Ministry of Health, New Zealand.

[5] Oranga Tamariki Evidence Centre (2023). Rainbow children in care. Understanding how Oranga Tamariki can better support rainbow children and youth. Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

[6] Roy, R., Greaves, L. M., Peiris-John, R., Clark, T., Fenaughty, J., Sutcliffe, K., Barnett, D., Hawthorne, V., Tiatia-Seath, J., & Fleming, T. (2020). Negotiating multiple identities: Intersecting identities among Māori, Pacific, Rainbow and Disabled young people. The Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand.

frequently fail to meet the specific needs and aspirations of intersectional populations. Stigma, discrimination and a lack holistic and sustained interventions perpetuates the cycle of inequity that disproportionately affects marginalised groups.[7] For many decades, these communities have consistently called on the State Party to address the lack of control, co-design and co-governance in the services provided to their own communities. While targeted initiatives, such as maternal health programs and increased funding for mental health have been introduced, measures often fall short of addressing the underlying systemic issues that perpetuate inequities for women.[8,9]

Intersectional data

9. In its previous Concluding Observations, this Committee expressed concern about the deficiencies in compiling, analysing and processing reliable statistical data about women, particularly regarding intersections between women belonging to more than one marginalised group. This Committee recommended that New Zealand establish a centralised system for the collection, analysis and dissemination of such comprehensive data, disaggregated by sex, age, disability, ethnicity, location, gender identity, sexual orientation and socioeconomic status.[10]

10. Current health data and subsequent health policies, often fail to capture the overlapping and compounding forms of discrimination that women experience particularly for Māori, Pacific, Disabled and Rainbow communities. Despite the State Party acknowledging that some groups of women, particularly Māori, Pacific, migrant and pan-ethnic women, disabled women and women from Rainbow communities face intersecting discrimination; a critical gap within New Zealand's healthcare system is the collection, analysis and utilisation of intersectional health data. [11,12,13]

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[7] Roy, Rituparna & Greaves, Lara & Fenaughty, John & Fleming, Theresa & Clark, Terryann. (2023). Mental Health and Wellbeing for Young People from Intersectional Identity Groups: Inequity for Māori, Pacific, Rainbow Young People, and those with a Disabling Condition. New Zealand Journal of Psychology. 52. 12-40.

[8] Dawson, P., Jaye, C., Gauld, R. et al. Barriers to equitable maternal health in Aotearoa New Zealand: an integrative review. Int J Equity Health 18, 168 (2019). https://doi.org/10.1186/s12939-019-1070-7

[9] Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission. 2024. Kua Tīmata Te Haerenga | The Journey Has Begun—Mental health and addiction service monitoring report 2024: Access and options. Wellington: Te Hiringa Mahara.

[10] United Nations. (2018). Concluding observations on the eighth periodic report of New Zealand: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (CEDAW/C/NZL/CO/8). https://documents.un.org/doc/undoc/gen/n18/238/12/pdf/n1823812.pdf

[11] Ministry of Health. 2023. New Zealand Health Strategy. Wellington: Ministry of Health.

[12] Government of Aotearoa New Zealand, 2023. United Nations Convention on the Elimination of All Forms of Discrimination against Women Ninth Periodic Report by the Government of Aotearoa New Zealand.

[13] Green, M. A., Evans, C. R., & Subramanian, S. V. (2017). Can intersectionality theory enrich population health research? Social Science & Medicine, 178, 214-216. https://doi.org/10.1016/j.socscimed.2017.02.029

11. Intersectionality is crucial in understanding how sexism, racism, ableism and other forms of discrimination intersect to create compounded disadvantage. For example, colonial concepts of disability have historically shaped the way health data is collected, often overlooking the specific needs and aspirations of Māori with disabilities. The reliance on Western, deficit-based models of health, can result in medical and social models being used to measure funding, inform policy decisions and subsequent eligibility for services that fail to capture the full scope of need.[14,15]

12. In New Zealand, gender, sex, variations of sex characteristics, or sexual orientation are expressed through a wide spectrum of identities, rooted in cultural and community-specific terms. For example, Māori have long recognised intersectionality, through concepts such as Mana Wāhine and Mana Takatāpui which broadly translates to the status of women and the status of LGBT+ communities, although these terms have no direct translation.[16] Similarly, Pacific cultures embrace diverse gender and sexual identities within their own unique cultural frameworks.[17] These culturally specific identities highlight the deep significance of diversity and reinforce the need for policy action that acknowledges, respects and empowers these intersectionalities.[18]

13. For State Party policies to be effective, they must be informed by culturally responsive, multifaceted data that reflects the diverse realities of all women in New Zealand, particularly those who face multiple forms of discrimination. This requires not only the collection of intersectional data but also a commitment to analysing and using this data to drive policy decisions that are attuned to the needs and aspirations of marginalised communities.[19]

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[14] Ingham TR, Jones B, Perry M, King PT, Baker G, Hickey H, Pouwhare R, Nikora LW. The Multidimensional Impacts of Inequities for Tāngata Whaikaha Māori (Indigenous Māori with Lived Experience of Disability) in Aotearoa, New Zealand. Int J Environ Res Public Health. 2022 Oct 19;19(20):13558. doi: 10.3390/ijerph192013558. PMID: 36294138; PMCID: PMC9602565.

[15] Greaves, L. M., Latimer, C. L., Muriwai, E., Moore, C., Li, E., Sporle, A., Clark, T. C., & Milne, B. J. (2023). Māori and the Integrated Data Infrastructure: An assessment of the data system and suggestions to realise Māori data aspirations [Te Māori me te Integrated Data Infrastructure: He aromatawai i te pūnaha raraunga me ngā marohitanga e poipoia ai ngā wawata raraunga Māori]. Journal Name, Volume(Issue), 190-206. https://doi.org/10.1080/03036758.2022.2154368

[16] Pihama, L., Smith, L. T., Simmonds, N., Seed-Pihama, J., & Gabel, K. (Eds.). (2019). Mana wahine reader. Volume I: A collection of writings 1987-1998. Te Kotahi Research Institute.

[17] Thomsen, P., McLean-Osborn, S., Ainea, H., & Verner-Pula, A. (2021). Examining the state of health research on Pacific Rainbow Communities in New Zealand: Literature review. Pacific Health Dialog, 21(7), 449-457. https://doi.org/10.26635/phd.2021.605

[18] Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019) Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand. Transgender Health Research Lab, University of Waikato: Hamilton NZ.

[19] Ker A, Gardiner T, Carroll R, Rose SB, Morgan SJ, Garrett SM, McKinlay EM. "We Just Want to Be Treated Normally and to Have That Healthcare That Comes along with It": Rainbow Young People's Experiences of Primary Care in Aotearoa New Zealand. Youth. 2022; 2(4):691-704. https://doi.org/10.3390/youth2040049

RURAL WOMEN

Access to healthcare in rural areas

14. Women living in rural areas of New Zealand, particularly from Māori, Pacific, Disabled and Rainbow communities, face significant and multifaceted challenges in accessing healthcare. Geographic isolation often means limited access to even basic health services and inadequate transportation infrastructure makes reaching urban centres for specialised care both time-consuming and expensive. This can result in long wait times and interrupted continuity of care.[20]

15. In addition to geographic isolation, rural women's health is influenced by socioeconomic factors and the historical marginalisation of Māori and other groups. For decades, the dominance of farming and landowner interests has overshadowed the pressing health needs of these communities, particularly in delivering culturally appropriate care. Improving rural health requires dismantling the systemic inequities that have long excluded these communities from equitable healthcare access and ensuring services are culturally aligned with needs and aspirations.[21]

16. While the State Party has introduced initiatives such as mobile health clinics and travel subsidies, these measures fail to fully address the structural barriers that persist. Compounding these challenges is the shortage of healthcare professionals trained to provide culturally competent care, particularly for Māori and Pacific women. As a result, many individuals experience significant delays in accessing care, only reaching acute services when their health deteriorates to crisis levels, contributing to a cycle of unmet needs and frustration.[22]

Telehealth and mobile health services

17. There are many examples of health innovation during the COVID-19 pandemic, where strong social networks and a collective sense of responsibility promoted community strengths, knowledge-sharing and support to help people stay safe and socially connected. For example, Māori communities in particular, demonstrated significant leadership through grassroots, wrap-around welfare responses to address health and wellbeing needs,

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[20] Ministry of Health. (2023). Health and independence report 2023. Ministry of Health, New Zealand.

[21] Pomeroy, A. (2022). Reframing the rural experience in Aotearoa New Zealand: Incorporating the voices of the marginalised. Journal of Sociology, 58(2), 236-252. https://doi.org/10.1177/14407833211014262

[22] Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission. 2024. Kua Tīmata Te Haerenga | The Journey Has Begun—Mental health and addiction service monitoring report 2024: Access and options. Wellington: Te Hiringa Mahara.

particularly for high-risk and hard to reach populations.[23] There was also increased State Party funding to provide digital access to health information, online health appointments and mobile health services during this period.[24]

18. For many individuals, telehealth offered a convenient and accessible option, especially for those with mobility challenges in rural New Zealand. However, telehealth is not a one-size-fits-all solution. While it benefited some, it also presented barriers for others, underscoring the need for a nuanced approach that considers the diverse needs of all women, in particular Māori, Pacific, Disabled and Rainbow communities.[25] Much of the telehealth innovation has subsequently been rolled back post-pandemic.

POLICY MEASURES TO ELIMINATE DISCRIMINATION

Persistent and systemic challenges

19. In New Zealand, health inequities continue to impact women, particularly those from Māori, Pacific, Disabled and Rainbow communities. Many of these inequities have been created over time by a system that has failed to respond to the diverse cultural needs of the population. Despite existing health equity frameworks, significant barriers persist, leading to inequities in access to essential healthcare services and health outcomes. These barriers are not just physical but also cultural, with many facing difficulties in finding healthcare that respects, understands and empowers unique identities and experiences.[26]

Intersectional policy opportunities

20. Intersectionality, when applied to data collection and policy analysis, offers the potential to uncover not just compounded disadvantages but also unique strengths that arise from the intersection of multiple identities. For example, within Māori culture, strength-based perceptions of disability and a collectivist approach to social responsibility may help mitigate the disadvantages associated with disability. This perspective, however, remains underexplored in current research. Embracing intersectionality in data collection could

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[23] Cassim, S., & Keelan, T. J. (2023). A review of localised Māori community responses to Covid-19 lockdowns in Aotearoa New Zealand. AlterNative: An International Journal of Indigenous Peoples, 19(1), 42-50. https://doi.org/10.1177/11771801221124428

[24] Ministry of Health. 2023. New Zealand Health Strategy. Wellington: Ministry of Health.

[25] Health Quality & Safety Commission. (2021). The health care experience of disabled people during COVID-19: Summary of findings from the COVID-19 patient experience survey (Te wheako tauwhiro hauora a te hunga hauā i te wā KOWHEORI-19: He whakarāpopototanga o ngā kitenga o te tiro whānui KOWHEORI-19). Health Quality & Safety Commission, Wellington, New Zealand.

[26] Ministry of Health. 2023. New Zealand Health Strategy. Wellington: Ministry of Health.

reveal opportunities for more holistic and culturally responsive approaches to addressing inequities.[27]

21. Incorporating the leadership and decision-making of Māori, Pacific, Disabled and Rainbow women into State Party policies and funding structures is critical to addressing the root causes of health inequities. Rather than limiting engagement to advisory roles, these communities must have governance and control over health interventions that impact them. Effective solutions require genuine, sustained collaboration, ensuring communities have the power to shape policies that reflect needs and aspirations, fostering a healthcare system that is truly equitable and culturally responsive.[28,29,30]

RECOMMENDATIONS

22. To effectively address the health needs of women in particular from Māori, Pacific, Disabled and Rainbow communities, it is crucial that the State Party prioritises the inclusion of comprehensive intersectional health data in all state health reports and policies. This should include disaggregating data by ethnicity, disability, gender, variations of sex characteristics, or sexual orientation and geographic location.

23. Furthermore, health policies and interventions should be led by Māori, Pacific, Disabled and Rainbow communities, ensuring their voices shape health interventions. Collaboration with non-government organisations and community organisations is essential to gather qualitative data and case studies, which will inform recommendations and advocate for increased funding and support for culturally competent care and mental health services.

24. We recommend a focus on provision of disability responsiveness training within the health sector, and bringing together groups of disabled women as individual health service users.

25. *Intersectional Data:* The State Party should prioritise the inclusion of comprehensive intersectional health data in all national and regional health reports and policies. This

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[27] Ingham TR, Jones B, Perry M, King PT, Baker G, Hickey H, Pouwhare R, Nikora LW. The Multidimensional Impacts of Inequities for Tāngata Whaikaha Māori (Indigenous Māori with Lived Experience of Disability) in Aotearoa, New Zealand. Int J Environ Res Public Health. 2022 Oct 19;19(20):13558. doi: 10.3390/ijerph192013558. PMID: 36294138; PMCID: PMC9602565.

[28] Cole, E.R. & Duncan, L.E. (2023) Better policy interventions through intersectionality. Social Issues and Policy Review, 17, 62–78. https://doi.org/10.1111/sipr.12090

[29] Green, M. A., Evans, C. R., & Subramanian, S. V. (2017). Can intersectionality theory enrich population health research? Social Science & Medicine, 178, 214-216. https://doi.org/10.1016/j.socscimed.2017.02.029

[30] Johnson DE, Fisher K, Parsons M. Diversifying Indigenous Vulnerability and Adaptation: An Intersectional Reading of Māori Women's Experiences of Health, Wellbeing, and Climate Change. Sustainability. 2022; 14(9):5452. https://doi.org/10.3390/su14095452

includes disaggregating data by ethnicity, disability, gender, variations of sex characteristics, or sexual orientation and geographic location to better understand and address the health needs of marginalised women.

26. *Strengthening Policy Reform:* Implement stronger enforcement mechanisms and accountability measures in health equity policies. This should include mandatory cultural competency training for healthcare providers and policymakers to address structural discrimination and support the health needs of intersectional populations. Adequate resources should also be allocated to ensure equity-focused strategies are implemented and sustained over the long term, with regular community engagement serving as both an informational and accountability mechanism.

27. *Accountability:* The State develop specific outcome measures for this group that are tracked over time at the Cabinet level, that public sector Chief Executives are held accountable to for these as a collective with a lead agency; that funding is pooled across agencies to deliver on these outcomes.

28. *Enhancing Community Engagement:* Collaborate with non-government organisations and community organisations to gather qualitative data and case studies that highlight the health inequities and views of marginalised women. Use this information to develop policy recommendations and advocate for increased funding and better access and support for culturally competent care and mental health services tailored to the needs of Māori, Pacific, Disabled and Rainbow women.

<u>Questions for the State Party</u>

29. *Data collection and analysis:*
    (a) How does the State Party plan to address the existing gaps and barriers in intersectional health data collection and analysis?
    (b) What steps will be taken to ensure that this data is effectively utilised to inform policy decisions and improve health outcomes for marginalised women, especially those from Māori, Pacific, disabled and rainbow communities?

30. *Cultural competence in healthcare:*
    (c) What measures are being implemented to enhance cultural competencies within the healthcare system?

(d) Specifically, how will the State Party ensure that healthcare providers receive adequate training to address the unique needs of Māori, Pacific, disabled and rainbow women, to address structural discrimination and improve access to culturally appropriate care?

31. Policy accountability:

(e) Can the State Party outline the mechanisms in place to ensure accountability in the equitable implementation of health policies?

(f) How will these mechanisms be strengthened to better address the persistent health inequities faced by women from marginalised communities?

(g) How will the State Party ensure that healthcare reforms, such as the disestablishment of Te Aka Whai Ora, Māori Health Authority supports improved health outcomes for Māori, Pacific, Disabled and Rainbow women in New Zealand?

32. Community involvement:

(h) How does the State Party plan to involve marginalised communities, particularly Māori, Pacific, Disabled, and Rainbow women, in the development and evaluation of health policies?

(i) What steps will be taken to ensure that their voices are not only heard but actively shape the policies intended to address their needs?

(j) How does the State Party intend to devolve to community both decisions on priorities for their community but also delivery of interventions?

(k) Can the State Party identify the number and proportion of healthcare leadership and governance roles held by Māori, Pacific, Disabled, and Rainbow women? If not, what definitive actions is the State Party prepared to commit to, in order to collect and report these data?

(l) What steps is the State Party taking to address inequities in representation of marginalised populations of women within all levels and roles of the healthcare workforce?

(m) What steps will be taken to remove barriers to marginalised populations of women from active involvement in healthcare? For example, the State Party is planning a review of the Health Practitioners Competence Assurance Act 2003 that systematically discriminates against disabled women.