Submission on the draft of the Eighth Periodic Report.

United Nations Convention on the Elimination of All Forms of Discrimination Against Women.

January 2016

Submitted by: Dr Sandy Hall

Policy Analyst

Women's Health Action Trust

PO Box 9947

Newmarket

Auckland 1149

January 31st 2016

Email address: info@women.govt.nz

Women's Health Action is a women's health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to inform government policy and service delivery for women. Women's Health Action is in its 31st year of operation and remains on the forefront of women's health in Aotearoa New Zealand.

We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women's health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women's sexual and reproductive health and rights and body image.

We welcome the opportunity to give feedback on the draft report.

Introduction

WHA is particularly concerned with the health of women and girls and has undertaken investigations into many issues affecting women's health. In particular over the last year we have developed evidence based papers regarding the development of a women's health strategy, the health issues affecting older women in Aotearoa New Zealand, along with our work on the Body Image Leaders and Nourish programmes and the Big Latch On and breast feeding friendly workplaces.

As we have a particular focus on women's health we have not commented extensively on some topics including women in leadership, pay equity or personal finances or the situation of women in the Pacific Islands as others submitters have more expertise in these fields.

We have commented on the effects of poverty on women's health and in general and believe more needs to be done to address economic disparities and structural inequities that affect women in Aotearoa New Zealand. We also note that women are not a homogenous grouping, and many face multiple barriers to full and equal participation in all aspects of society. The gaps in all of the available indicators between Pakeha and Māori women in New Zealand including health outcomes, earnings, unemployment rates, education rates, and in health statistics, reveal that Māori women in particular face systemic and structural inequalities. Numerous studies have demonstrated Māori and Pacific women have inequitable health outcomes and that there is an urgent need for specific approaches to the health of Māori and Pacific women. We continue to believe these should be developed by Māori and Pacific women themselves and as such have not made specific comments in this area.

We also wish to note that while we agree that Aotearoa New Zealand does have a proud history of being at the forefront of women's rights, **we believe that a failure to recognize the importance of gender differences, a lack of a human rights focus, failure to address gendered violence and poverty perpetuates forms of discrimination against women.**

In making this submission we note that the Aotearoa New Zealand Government has a number of other international obligations in relation to the status of women in New Zealand including

- The International Covenant on Civil and Political Rights

- The International Covenant on Economic, Social and Cultural Rights
- The International Convention on the Elimination of All Forms of Racial Discrimination
- The Convention on the Rights of the Child
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- The Convention on the Rights of Persons with Disabilities
- The Declaration on the Rights of Indigenous Persons

Women's Health Action applauds the positive steps taken to advance equal rights for men and women, however, we believe much more needs to be done in eliminating discrimination against women in Aotearoa New Zealand and addressing the CEDAW committee's recommendations and concluding observations.

General comments: Part One.

Article 2: Policy measures to eliminate discrimination

We support the development of the Human Rights Commission Action plan and the interactive tracking of Government response. We hope these resources and the governments' obligations under CEDAW and other international treaties will receive wider promotion so that the public and civil society is encouraged to be involved in monitoring and commenting on government progress in eliminating discrimination and promoting human rights.

Article 3: The development and advancement of women

We believe the Ministry for Women should add an additional goal of pay equity to their priority areas and work towards some way of recognizing the unpaid work women do particularly as carers.

Currently the carers' action strategy fails to address the economic hardship and interruption to employment opportunities faced by carers. We do not agree that the government has made enough progress in this area. In particular WHA considers the payment of family carers of disabled people to be an important gender issue which is due for resolution and we welcomed the decision of the Court of Appeal in the family carers case (Ministry of Health v Atkinson and others) in June 2012.

Women are the main carers of children and adults and suffer the effects of poverty disproportionately[1]. We believe limiting eligibility and limiting further claims of carers only contributes to further discrimination.

We believe the government must do more to ensure New Zealand women and girls are free from violence.

Domestic and sexual violence are gendered crimes, which damage the health of women and their families. Intersectoral strategies including changes to policing, the family court system and support services must be developed. Domestic and sexual violence can be perpetrated by, or

[1] Baker, 2002; Facts About Poverty 2009; WHO, 2008

against, anyone but overwhelmingly the sexual assault of adults is perpetrated by men against women and women and children are most frequently the victims of domestic or family violence.

The link between the experience of violence and poor health is well established. Studies indicate domestic violence of all kinds is a predictor of both psychological distress and physical illness. This view is supported by the New Zealand Medical Association (NZMA) who have stated that family violence in general is a serious health issue in Aotearoa New Zealand because of the adverse acute and long-term physical, mental and social health consequences and the significant economic cost to the nation[2]. Experience of violence has multiple and complex negative effects on health, many of which can remain even when the person has left the violent situation.

Despite widespread acknowledgement that a considerable problem exists, there is a lack of proper funding for specialist sexual violence support services including 24 hour phone and crisis services and ongoing support services, contracting and reporting arrangements are complex and there are few sustained funding arrangements. **There is also a need for services that reflect the diversity of our communities including specialist services for Māori and for minority groups along with training and support for sector workers. We also believe there is significant evidence that changes to intersecting services such as the police and justice department including changes to court processes, the training of judges and lawyers and of police are essential.**

In addition women and children are not necessarily guaranteed protection by the court. Recent New Zealand research has highlighted the difficulties women currently face with negotiating care and contact arrangements for their children through New Zealand's family law system. Women's experiences of the Family Court system suggest the systemic serving of fathers' interests over mothers' ability to care for and protect their children, are compounded when women are separating from violent relationships[3].

Data collection in this area is also unreliable. For example, there is no completely accurate data available regarding sexual violence in particular, in Aotearoa New Zealand and there are significant anomalies both in the recording and defining of sexual violence and the fact that violence and sexual violence in particular is underreported. There are also differing definitions

[2] Hassall I, Fanslow J. Family Violence in New Zealand: we can do better. NZMJ 27 January 2006, Vol 119 No 1228 URL: http://www.nzma.org.nz/journal/119-1228/1830/.
[3] Elizabeth, V., Gavey, N., Tolmie, & J. (2010). Between a rock and a hard place: resident mothers and the moral dilemmas they face during custody disputes. Feminist Legal Studies, 18, 253-274.

being applied to this data, for example the NZ Family Violence Clearinghouse May 2012 Sexual Assault and Sexual Violence Tables note that "In the sexual assault tables please note that the apprehensions table refers specifically to sexual assault, whereas the prosecutions and convictions tables are for the broader term sexual violence. Although all violent offences are thought to be under-reported to the police, sexual offences are substantially more likely to be under-reported"[4].

We have concerns that recent changes to the Family Court aimed to encourage parents to work out childcare issues outside the Court room and through Family Dispute Resolution are safe and experiences in Australia[5] with similar legislation shows they put both women and children at risk particularly when women and children are experiencing violence. At the International Women's Caucus in December 2015, Attendees were interested in whether an evaluation of the related to Family Court reforms was underway, and if so, when the results of the evaluation would be made available. We received the following reply:

"The Ministry of Justice advises that there has been no comprehensive evaluation of the family justice system reforms introduced in 2014. However, the Ministry's Research and Evaluation team has undertaken a small scale qualitative study of how two key aspects of the reforms are working, to help identify potential opportunities for improvement. These are: the new Family Dispute Resolution (FDR) service and mandatory self-representation (requiring parents to appear for themselves in the early stages of proceedings under the Care of Children Act 2004 unless an exemption applies). The researchers interviewed a range of people including parents, FDR mediators, lawyers, Family Court judges and court staff. This paper is expected to be released early this year. The Ministry of Justice is planning to undertake a comprehensive analysis of administrative data related to the family justice system reforms in mid-2017. This timing should allow a sufficient number of parties to have progressed through the system"[6].

We look forward to this report.

We believe violence is one of the most significant challenges to the health of women and girls. The prevalence of this type of violence is supported by current cultural norms, gender inequalities

[4] 7% of sexual violence incidents are reported – Ministry of Justice, 2010, *The New Zealand Crime and Safety Survey: 2009*, pg 45 *and NZ Family Violence Clearinghouse May 2012. Data summary 2.* Violence Against Women

[5] Wilcox, K. Thematic review 2. Intersection of Family Law and Family and Domestic Violence (2012) Australian Domestic & Family Violence Clearinghouse. University of New South Wales

[6] Letter received from H. Gray, Senior Policy Analyst Ministry for Women 2016.

and institutionalised misogyny and media portrayal of women and girls. It is exacerbated by various factors including economic inequality, poverty, high crime levels, alcohol and drug abuse, poor victim support[7] from both the police and the judiciary and the underfunding of support services.

There is significant emphasis on the Mates and Dates programme in the CEDAW report. The evaluation, while largely positive, took place very soon after delivery of the pilot programme and looked only at the short term impacts. It also noted that "It cannot, however, be expected on the basis of a time-limited pilot to change what are complex and entrenched beliefs and behaviour systems."

Evidence shows that violence prevention requires a systems approach[8] and an all of government response and support for coordination across Ministries and sectors. The Ministerial Group on Family and Sexual Violence, National Sexual Violence Strategy and action plans should, for example, align with the new Ministry of Health Sexual and Reproductive Health Plan, and other cross-sector initiatives must be strengthened. Significant changes need to be made to intersecting services such as the police and justice department including changes to court processes, the training of judges and lawyers and of police are essential.

We believe the government must do more to ensure that disabled women, including women over 65 with disabilities are not discriminated against. We look forward to the update of the disability plan to ensure issues such as aging with a disability and violence against women with disabilities is addressed[9].

We believe that while marriage equality was a step forward much more needs to be done to develop and advance human rights standards for people of diverse sexual orientation and gender identity (SOGI) of all ages. In particular in regards to access to quality and appropriate health services.

[7]Women's Health Action. 2012. Silent Injustice. Women's Experiences of the Family Court. Cartwright Seminar.
[8] For example Herbert. R. and McKenzie.D. 2014. The Way Forward An Integrated System for Intimate Partner Violence and Child Abuse and Neglect in New Zealand
[9] Beaulaurier, R. L., Seff, L. R., & Newman, F. L. (2008). Barriers to help-seeking for older women who experience intimate partner violence: a descriptive model. [Research Support, U S Gov't, Non-P H S]. *J Women Aging, 20*(3-4), 231-248.

Treaty bodies and Special Procedures have repeatedly affirmed the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity (SOGI). Despite this Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) populations in Aotearoa NZ have very few specific health services and access to general health services continues to be a problem because of discrimination, homo/transphobia, and heterosexism.

While research is lacking in many areas recent studies have identified ongoing areas of discrimination, including violence[10]. However, currently crime statistics do not identify the sexual orientation of victims and a clear assessment of offending based on the victim's sexuality (real or perceived) is not possible.

A 2011 study confirmed higher levels of mental health distress amongst all GLBTI and an absence of specific services of health promotion activities[11]. There is also evidence of differential general life outcomes for LGB people in relation to heterosexual populations, including higher rates of physical and verbal assault, bullying and victimisation, depression and social isolation, workplace discrimination and impediments to career progression. Same sex attracted young people are more likely to be subjected to homophobia[12]. It is not surprising therefore that bullying, depression, suicide are at higher levels amongst young same sex attracted students[13]. The Youth 2000 survey found that school is an important place for young people to learn about sexuality, sexual health and sexual safety[14]. Recent New Zealand studies have reported that while most school-aged same sex attracted youth (male and female) reported feeling 'happy and supported by friends and/or family', the same young people were also three times as likely to exhibit depressive symptoms and half had deliberately self-harmed in the last year – figures more than double that reported by heterosexual youth[15]. In addition there is ample evidence in Australian

[10]Rankine, J. (2001). The great, late lesbian and bisexual women's discrimination survey. Journal of Lesbian Studies, 5 (1/2), 133-143.

[11] Te Pou. (2011). Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report

[12] Baker, J. (2002). How homophobia hurts children: Nurturing diversity at home, at school and in the community. New York: Haworth Press, Inc. Bioethics Council.

[13] Youth Suicide Prevention Information New Zealand [SPINZ]. (2004). SPINZ information series No. 5: Sexual orientation and suicidal behaviour. Retrieved on July 6, 2004, from http://www.spinz.org.nz/content.asp?id=40

[14] Adolescent Health Research Group. NZ Youth: A profile of their health and well-being. Auckland: University of Auckland; 2003. (www.youth2000.ac.nz)

[15] Lucassen MF, Merry SN, Robinson EM, Denny S, Clark T, Ameratunga S, Crengle S, Rossen FV. Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students. Aust N Z J Psychiatry. 2011 May;45(5):376-83. Epub 2011 Mar

studies and one NZ study of discrimination experienced by older SOGI particularly in residential care services.

Unfortunately the lack of comprehensive data on the gay, lesbian, bisexual, trans and intersex (GLBTI) population in New Zealand primarily because few New Zealand services request information about SOGI and inequitable funding means insufficient research has been undertaken on best practice to improve health outcomes for LGBTIQ populations. We believe more needs to be done to improve data collection and research of SOGI populations in health services and to develop practice standards to improve public health service delivery for SOGI populations.

The Youth 2000 survey found that school is an important place for young people to learn about sexuality, sexual health and sexual safety. Youth 2000 also identified higher levels of violence at school and at home[16]. Little has changed in the intervening years[17]. Bullying, depression, suicide are at higher levels amongst young same sex attracted students. Recent research, on the health and well-being of transgender high school students found that transgender students and those reporting not being sure are a numerically small but an important group. They are diverse and represented across demographic variables. Transgender youth face considerable health and well-being disparities, including being especially vulnerable to mistreatment, depressive symptoms, self-harming and unable to access the health care they needed[18]. **Transgender rights and health do not feature in the State's report and urgently needs focus and resource.**

While New Zealand has a comprehensive sexuality education curriculum, a 2007 Education Review Office review of the teaching of sexuality education in years 7 to 13 found widespread failings and inconsistencies. We believe improvements are needed to the promotion of child and adolescent mental health in schools is not consistent around the country and issues like sexual health, gendered violence and mental health and suicide are not consistently addressed.

Ministry of Education Sexuality Education resources and guidelines must affirm the need for an inclusive school environment, which supports and acknowledges diversity including sexual

[16] Adolescent Health Research Group 2013. Youth 2000 national youth health survey.
[17] Adolescent Health Research Group 2013. Youth 2012national youth health survey series.
[18]Clark TC, Lucassen MFG, Bullen P, Denny SJ, Fleming TM, Robinson EM, Rossen FV . The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12) Retrieved from http://www.jahonline.org/article/S1054-139X(13)00753-2/references

orientation and gender identity. Schools need more encouragement to question gender stereotypes, and assumptions about sexuality and acknowledge the sexual diversity of New Zealand communities and recognise the rights of those who identify as lesbian, gay, bisexual, transgender, intersex, and other sexual and gender identities.

We believe it would be useful to clarify that the Statistics New Zealand's Statistical Standard for Gender Identity will be used in the next national census in 2018.

Article 5: Sex role stereotyping and prejudice

We believe sex role stereotyping and prejudice still forms the basis for unequal treatment of women in Aotearoa New Zealand in at least two important areas.

The first is in the way violence against women, including sexual violence, is portrayed by the media and dealt with by the courts and the police. The idea that women deserve or provoke violence or assault or that they lie about it is pervasive in New Zealand society and instances of it are readily available in print radio and on the internet.

We believe the Ministry for Women and government in general must lead attitudinal change in the police, the judiciary and in the education system to challenge these extremely damaging beliefs. More research needs to be done about the effects of stereotyping and discrimination particularly in relation to violence.

The second is the lack of value attached to what is seen as 'women's work' in particular the unpaid role of mothers and carers and the work of women in female dominated occupations including work such as cleaning and nursing. While an aim of increasing the numbers of women in trades and other areas is laudable it is time we placed a higher value on the female dominated occupations.

We believe the Ministry for Women must do more to counter sex role stereotyping and prejudice and support equitable pay rates across occupations and placing value on women's work as carers.

Part 2: Participation and equality in political and public life, representation and nationality.

We would like to see Para 84: which asserts women have 'on average better health than men' **include more detail about the higher levels of disability women face and the effects of poverty and disadvantage on the health outcomes of New Zealand women[19].**

Part 3: Education, equal access, opportunities and conditions in relation to employment, health, social assistance and rural women.

In our society gender determines social position, living conditions and opportunities. The roles and expectations traditionally assigned to women in our society involve caring for children and other roles which are assigned lower status and give women less power and self -determination than men.

According to the NZ Human Rights Commission 2010 draft document 'Human Rights and Women', women carry a disproportionate burden of poverty in New Zealand. Today, women's average hourly earnings are lower than men's and women are over-represented among the low paid workers. We agree a key factor contributing to the gender pay gap is occupational segregation: women are clustered in a relatively narrow range of traditionally female-intensive, poorly paid occupations. Very few women work as tradespeople. In addition, women are still responsible for the majority of unpaid work – raising children, household chores, and supporting elderly and unwell relatives. This is because men are more likely than women to have the capacity to work full time and to work longer hours.

Research has demonstrated that mother led families have much higher poverty rates than coupled or lone-father families. Lone-mothers tend to have lower education and job skills than partnered mothers or fathers, and many lone-mothers cannot find jobs with adequate wages to support their families, especially if they pay for childcare services. The child poverty rate for children in single parent households is 52 percent. The vast majority of these households are headed by a woman, who is also living in poverty and subject to ongoing stigmatisation[20].

We believe all parents should be given choices and flexibility to make decisions about what works best for their family, this includes supporting a parent (if they wish) to stay at home to care for

[19] Women's Health Action.2014. The case for a Women's health strategy. Available at: http://www.womens-health.org.nz/wp-content/uploads/2014/08/Womens_Health_Strategy_A4_web.pdf
[20] Baker, 2002; Facts About Poverty 2009; WHO, 2008 and New Zealand Income Survey, June 2011 quarter.

their child for at least the first year of life. Socioeconomic disparities are increasing and there are around 622,000 people in poverty in this country or one in seven households, including around 230,000 children[21]. Recent legislative changes have had a disproportionately negative impact on vulnerable women and children in a vicious cycle of poverty, marginalisation and social exclusion and have failed to take into account the fact that the health of lone mothers receiving social welfare is already compromised by poverty and social marginalisation and has further undermined and stigmatised sole parents and their children. The government has failed to address structural barriers including lack of availability of affordable childcare, lack of availability of sufficiently flexible part-time family friendly work, and lack of opportunities to up-skill can undermine their ability to engage in paid-work.

When gender and poverty collide there can be an additive effect on health. For example, the vulnerability of lone mothers on welfare in New Zealand to poor health has been well demonstrated. Research with lone mothers receiving the DPB in New Zealand found that an accumulation of factors associated with their social and economic status contributes to the incidence of poor physical and mental health[22]. Evidence clearly shows that child poverty, while having a number of factors, which may worsen it or improve it, is mostly a result of parental low income and income inequity. Women are the main carers of children, and they suffer the effects of poverty to a disproportionate extent. Despite the gender pay gap in New Zealand, on comparing weekly earnings, women have been targeted with cuts in benefits to sole parents and opposition to paid parental leave.

At the International Women's Caucus in December 2015, the following query regarding content of the draft CEDAW report were raised in regards to para 36B *"Ensure that the ongoing welfare reforms do not discriminate against disadvantaged groups of women and that an independent evaluation of their gendered impact is made."* In particular, attendees were interested in the gender impact evaluation. The draft CEDAW report contains the following response to that recommendation:

"… The Government is committed to ensuring that gender analysis takes place at all stages of policy development. The legislation relating to the welfare reforms was reviewed to ensure it

---

[21] http://nzccss.org.nz/work/poverty/facts-about-poverty/

[22] Baker, M. 2002 'Poor health, Lone-mothers, and Welfare reform: competing visions of employability', *Women's Health and Urban Life* 1 (2) December: 4-25.

was consistent with the New Zealand Bill of Rights Act 1990, which prohibits unjustified discrimination against women. The welfare reforms involve a comprehensive monitoring and evaluation plan, involving both monthly monitoring of the effects of the changes on all clients and a four year plan to evaluate how well the welfare reforms have been implemented relative to policy intent. The four year plan includes assessment of the impact of the welfare reforms on the outcomes for various client groups, such as sole parents. An evaluation of the effects of the welfare reforms from clients' perspectives will be published later in 2015. Should a theme emerge from these evaluations, of disadvantage to a particular group, it will be reported and the findings will form an integral part of the design of future interventions for beneficiaries[23]."

The evaluation has been completed[24] . However, on reviewing it we do not agree that this document measures the effect of welfare reforms on women or makes any effort to identify any discriminatory effects. It does not constitute a gendered analysis of the welfare reforms. We are also concerned that the research was not undertaken independently.

We believe the state party needs to do more to make more progress toward gender equity in rates of pay, paid parental leave, flexible working arrangements and equal access to trade training and promotion opportunities and valuing the work of parenting, including that done by sole parents.

Caring for children and/or for sick family members constitutes some of the most important 'work' to be done in any society.

An Australian based research project 'Making Work Pay' found that for many women parenting alone, returning to work or increasing hours of paid work not only reduced their income support payments but increased other costs including child care, transport and petrol in traveling to and from work, and costs related to increased use of convenience foods[25]. The sole parents in the study reasonably felt that the financial rewards from working ought to meet these additional costs and provide for tangible extra benefits for the family. In general, the research shows us a system in which punitive benefit cuts; sanctions; greater administrative surveillance interact to

[23] Letter received from H. Gray, Senior Policy Analyst Ministry for Women 2016.

[24] Available at: http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/evaluation/report-into-welfare-reform-client-perspectives/

[25] Bodsworth, E 2010, *Making Work Pay: And Making Income Support Work*, Brotherhood of St Laurence, Melbourne http://www.bsl.org.au/pdfs/Bodsworth_Making_work_pay_2010.pdf

create perverse outcomes, making paid work not only unattractive but simply not an option for many income support recipients. Returning to paid employment has also been identified as significant barrier to breastfeeding for many women. Research shows this is particularly the case for low income families.

To promote equity and end discrimination workplaces should be family friendly and everyone should be entitled to a living wage. **In particular, we believe a change is required in the government discourse and information around poverty and beneficiaries is needed.**

Article 12 Health:

We do not agree that this section of the draft gives a clear picture of the health of New Zealand women, nor does it address the areas of discrimination women still face in regards to health.

The World Health Organization's definition of health includes *"complete physical, mental and social wellbeing and not merely the absence of disease and infirmity. Women's Health involves their emotional, social and physical wellbeing and is determined by the social, political and economic context of their lives, as well as biology"*. Aotearoa New Zealand has high levels of violence against women and children, there is a significant income gap between men and women, and women are often held responsible for the health of their families. Women are also subjected to societal pressures about appearance and body size, and the effects of sexism, all of which impacts on their wellbeing.

While New Zealand women in all groups live longer than New Zealand men, there are sex and gender differences in significant areas of health. Biological differences, including anatomy, physiology, metabolic processes and genetics, may result in differing biological responses for women and men to illnesses and disease. In addition, gendered norms shape many aspects of women's lives including career, body image, education and physical activity, which also affect health. Women may also have different attitudes to health and view health as more intimately connected to their lives and be, or be seen as, responsible for the health of others including children and adults disabled by age or chronic illness.

The past 50 years have seen significant change in women's social roles. Women today balance the stresses of multiple roles, including family and childcare responsibilities, paid employment, and

community and voluntary activities. As is evident in this draft, despite many gains, women in New Zealand continue to experience persistent inequities, including higher rates of poverty, a gender pay gap, high rates of intimate partner and sexual violence, lower representation in decision-making and disparate access to paid parental leave and early childhood education. Young women and girls are bombarded by media messages telling them that their value lies in their youth, beauty and sexuality. This has negative consequences on their self-esteem and self-image and their right to define their own identity[26]. Multiple disadvantages compound and restrict many women's access to health, undermining their basic human rights.

Women have also been excluded from much of the health care research that guides policy development and what is known in medical research is often characterised by a gender blindness or failure to consider the effects of health interventions on women. It is notable that the draft refers to the mortality from coronary disease but not the factors that contribute to its poor diagnosis in women[27]. A focus on gender provides an important window for studying all aspects of health and can form the basis for health policies, which target the specific or unique needs of women.

We believe more needs to be done to ensure gender equity[28] in health and health equity between women and between women and men including equitable access, evidence based information about health interventions, medicines and devices that is gender specific.

Breast Screening

We applaud the gains made in coverage of Mäori and Pacific women participating in the programme and the recent move to update the breast screen resources and information.

HIV screening and antenatal HIV screening

We agree with NZ Family Planning that consistent, accurate data about the prevalence and rates of HIV infection and other sexually transmitted infections (STIs) is required to inform prevention efforts and policy decisions alongside management, tracing and treatment. Currently the annual

---

[26] Eaves End Violence Against Women Coalition Equality Now OBJECT November 2012

'Just the Women'*An evaluation of eleven British national newspapers' portrayal of women over a two week period in September 2012, including recommendations on press regulation reform in order to reduce harm to, and discrimination against, women

STI Surveillance report relies on inconsistent data from three different sources to estimate prevalence and to identify which populations and regions have the highest disease burden. Collecting comparable data on sexual and reproductive health issues was a recommendation of the Value for Money report.

The Ministry of Health funds a universally offered and free antenatal HIV screening programme intended to reduce the transmission of HIV from mother to baby during the perinatal period. While it is a requirement that practitioners seek informed consent before referring pregnant clients for an HIV test, in practice, HIV screening has been added to the routinely undertaken suite of antenatal blood tests and many women are not aware that they are being referred specifically for HIV screening. Women's Health Action supports the work being undertaken by the Ministry of Health in partnership with the National Screening Unit to develop a suite of information resources for practitioners and clients of antenatal services to ensure informed consent for all antenatal screening including HIV screening is obtained. However we would support an on-going audit of pregnant women's knowledge and understanding of antenatal screening including HIV screening and whether their informed consent was gained for screening.

Development of a sexual and reproductive health plan.

We support the current development of a national plan for sexual and reproductive health as a means to provide the direction, coordination and resourcing needed to address health inequity and further reduce teen birth and pregnancy rates. We also note sexual and family violence prevention and positive sexual and reproductive health are intimately linked. These connections should be highlighted in the report. The development of the sexual and reproductive health plan support health equity for all New Zealanders including SOGI and those with other non-binary sexual and gender identities. We believe this plan must be developed in consultation with a cross section of New Zealand women and healthcare organisations and incorporate diverse populations and age groups.

We also support initiatives to reduce teen pregnancy including improving access to health services for young people, particularly Māori and Pasifika (44). It is important that health care organisations have the capacity and flexibility to explore, implement and evaluate innovative ways to meet the needs of young people. A national plan for sexual and reproductive health

should ensure that teen pregnancy initiatives across sectors and Ministries are effectively aligned. It is also important to acknowledge and address the connection between sexual and reproductive health and educational outcomes. A birth may disrupt a teenage girl's education, even temporarily.

We support the inclusion of increasing access to reproductive health services as a priority in the New Zealand Aid Programme Strategic Plan 2015-2019 (52). We appreciate current efforts "to achieve better gender outcomes in our health and education programmes in the Pacific" but suggest that the report needs to provide more detail about this work.

Reproductive and sexual health rights

Treaty bodies and Special Procedures have repeatedly elaborated the concept of sexual and reproductive health as requiring the freedom to decide if and when to reproduce, or not to reproduce; the right to information and informed consent and to have access to safe, effective, affordable and acceptable methods of family planning of choice and appropriate health-care services; and the removal of punitive measures[29].

The majority of New Zealanders enjoy a high standard of sexual and reproductive health. However, current actions by the State Party and Judiciary are undermining rights to sexual and reproductive health, particularly for those who are already marginalised as a result of ethnicity and socio-economic status. We are concerned by evidence of attempts to influence the contraceptive choices of women receiving welfare assistance through the offer of subsidised health care for women who elect to have a long-acting reversible contraceptive.

In addition reforms of the Domestic Purposes Benefit (DPB) have introduced sanctions on women's welfare entitlements if they have a subsequent child while receiving welfare assistance. This results in an economically coercive environment for women's reproductive decision-making when they are receiving welfare assistance. We consider that this is discriminatory as it treats one section of the population based on gender and work status, and uses a financial disincentive to manipulate choices regarding child bearing and contraception. We believe it is in direct conflict with the concept of 'freely chosen'.

[29] Punitive measures related to sexual and reproductive health impede access to health-care particularly where there is a fear of criminal prosecution or punitive measures.

Recently, child welfare and protection legislation and polices are being extended to include the pre-natal period resulting in punitive measures in relation to women's conduct during pregnancy. For example the Ministry of Health's Child Protection Alert System within Health has defined 'child' as including the fetus and is resulting in the initiation of child protection proceedings during the prenatal period. A pregnant woman has recently been incarcerated in the interests of protecting her fetus from harm posed by her alcohol use. In addition there has been a sustained focus over the last year on the effects of maternal obesity on child health suggesting that larger sized mothers are actively harming their own children.

While declining teen birth and pregnancy rates are cited as an example of progress since the last report, they are still high by international standards and higher among Māori and Pasifika. There are inequitable sexual and reproductive health outcomes in New Zealand, which require urgent attention. Other areas of concern include New Zealand's rates of teen pregnancy and sexually transmitted infections, especially amongst youth, which remain high by OECD standards. However there is a lack of strategic and coordinated action by the state party to improve sexual and reproductive health and counter discrimination faced by teen mothers.

A Ministry for Women paper[30] explored the relationship between young motherhood and engagement in education, employment and training. The paper reports that nearly half of all young mothers (age 15-24) are in education, employment and training, signifying the other half are not. The paper finds that young single mothers in particular, have difficulty securing work. It is important that all women have the ability to choose if and when to become a mother.

Sexual and reproductive health service infrastructure: legislation, policy, service provision, funding and programmes, are largely underpinned by dominant binary conceptions of gender, sex and sexual orientation. This results in a lower quality of care for people of diverse sexual orientation and gender identity and for intersex persons and is a barrier to access for these populations.

Women experiencing violence by an intimate partner may have few choices around their sexual and reproductive health, including preventing unplanned pregnancy. A research projected featured in New Zealand Doctor[31] looked at Bay of Plenty DHB electronic patient records

[30] Molloy, S. and Potter, D (2014) *NEET by choice? Investigating the links between motherhood and NEET status*. Ministry for Women.
[31] Claydon, L. (2015) *Family violence affects women's sexual and reproductive health.* 16 December 2015.

retrospectively and found that among women disclosing family violence, "almost 25% had an unplanned pregnancy".

The government could to do more to improve sexual and reproductive health by ensuring the availability and accessibility of a full range of contraceptive methods and abortion services, free of discrimination arising from coercive policies and suspending sanctions on women who have subsequent children while in receipt of welfare and other legislation/policies intended to influence reproductive decision making.

Abortion[32]

We disagree with the government response (39) to the recommendation to review abortion laws. **Abortion law in New Zealand is outdated and inconsistent with a human rights based approach to women's health, as advocated by New Zealand in the international community. We believe New Zealand's commitment "to maintaining a legal and policy framework that provides universal protection against all forms of discrimination" is not reflected in current abortion laws, which are discriminatory to women.**

The central abortion law exists within the Crimes Act 1961. Abortion is a crime unless two certifying consultants agree that one of the grounds for legal abortion is met. The current legal framework unnecessarily limits a woman's access to health care. No other health matter necessitates this level of legally required certification; it is only women who are required to go through such a complex legal process to obtain a health service, which is well established, as safe and effective. In order to access an abortion almost all women (over 97%) are forced to claim that the birth of a child would seriously harm her mental health; this is not an accurate reflection of the status of mental health of New Zealand women. The Act is demeaning and discriminatory to women in requiring a medical procedure to be considered under the Crimes Act.

Criminalisation also creates a system, which wastes public funds on unnecessary consultation, and causes delays accessing abortion services. The Abortion Supervisory Committee reported that "fees payable to certifying consultants for consultations with women considering termination of pregnancy totaled $4,030,165 in the year ended 30 June 2015."In countries around the world,

[32] This section and parts of the reproductive health sections of our submission are also informed by work done by NZ Family Planning

women have the right to decide whether or not to have an abortion autonomously. The requirement for two consultants to certify that a woman's pregnancy meets the grounds for accessing an abortion is not based on medical best practice.

We also disagree with the government response to recommendation 40. While unsafe abortion is not currently a health care problem in New Zealand, but we do believe that there is inequitable access to abortion services, which vary by DHB region and provider. Where DHBs choose not to contract with providers in their geographic region, or where providers are not available, they contract with nearby DHBs. This means that women in some regions may be required to travel hundreds of kilometers to access abortion services[33]. There are also regional variations in when abortion is provided and discrepancies in services provide to areas with high Māori populations.

Another on-going challenge facing abortion services, overall New Zealand currently lags behind other OECD countries in regards to the timeliness of first trimester abortions. Pregnancy terminations are a safe procedure however those conducted during the first trimester, particularly before the 10th week have a reduced risk of complications. Despite this, according to the latest Abortion Supervisory Committee report nearly half of all abortions in 2013 were performed after the end of the 9th week of pregnancy and in some regions such as Northland and Auckland the number was much higher representing unnecessary barriers and access issues.

The committee also reported on the harassment of women and staff entering hospital facilities by anti-abortion individuals and groups and the committee reported, 'Women attend medical service providers for a variety of reasons and should be able to enter clinics without feeling they are the subject of coercion or humiliation'.

About 13,000 women have an abortion each year, making it a common procedure for women. No other health matter necessitates this level of legally required certification; it is only women who are required to go through such a complex legal process to obtain a health service, which is well established, as safe and effective. In order to access an abortion almost all women (over 97%) are

[33] Based on information retrieved online by Family Planning, eleven (55%) DHBs do not contract the full range of abortion services for women within their region. Eight (40%) do not provide any abortion services within their DHB region. One DHB contracts with Family Planning to provide medical abortions only; there are no surgical abortion services in the region. Two DHBs contract for surgical abortions, but do not offer medical abortions. A number of providers offer surgical abortions under general anaesthesia, which is unnecessary for most first trimester abortions, and represents a waste of resources and an unnecessary risk to women.

forced to claim that the birth of a child would seriously harm her mental health; this is not an accurate reflection of the status of mental health of New Zealand women and is demeaning and discriminatory.

In addition, while abortion rates are declining, Māori and Pasifika are over represented in abortion statistics. Thirteen percent more Māori women who are pregnant have abortions than European women who are pregnant, likely reflecting higher rates of unplanned pregnancy and inequities that exist in society, including access to health care.

We believe New Zealand's abortion law does not support women's autonomy in decision-making about whether or when to have children. New Zealand's commitment "to maintaining a legal and policy framework that provides universal protection against all forms of discrimination" is not reflected in this legislation, which is discriminatory to women.

We believe the legal framework should be changed to reflect abortion as essential reproductive health care, and a human right for women and girls, not a crime. The draft report should state that abortion law exists within the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977, and the law has not been reviewed or modified to reflect current medical best practice, social contexts, gender equity and human rights.

Breastfeeding

In reference to Health and Health Services (Article 24), Preventative Healthcare and Health Promotion - Women's Health Action strongly supports the recommendations made by Children's Commissioner's Expert Advisory Group on Solutions to Child Poverty, which states that government should develop and evaluate a national child nutrition strategy. This strategy should include actions for improving breastfeeding rates. Breastfeeding is well recognised for its short-term and long term benefits for infants and toddlers. New Zealand has high breastfeeding initiation rates, but breastfeeding rates in the first six weeks of infants' lives decline steeply. **Accessible, appropriate support for breastfeeding in whānau, communities and society is essential for improving breastfeeding rates.**

In reference to Health and Health Services (Article 24), Maternity- Women's Health Action strongly supports Aotearoa New Zealand's publicly funded Lead Maternity Carer (LMC) model.

There is a high level of satisfaction expressed by the majority of New Zealand women with the LMC model and for the partnership and continuity of care that this model supports. Women's Health Action applauds the New Zealand College of Midwives, the Midwifery Council of New Zealand and Health Workforce New Zealand for their proactive work in supporting an enhanced mentoring programme for newly qualified midwives.

Primary birthing is associated with lower rates of medical interventions during labour and birth and higher levels of satisfaction, without increasing risk to themselves or their babies. However, the number of births in secondary or tertiary hospitals in Aotearoa New Zealand has progressively increased. To decrease rates of medical interventions for women experiencing normal pregnancies more needs to be done to develop birthing units with policies and practices to support normal labour and birth. **Women's Health Action would like to see support from the New Zealand Government for a national campaign aimed at increasing the number of births at home and in primary birthing units for lower risk women.**

Perinatal and maternal mortality.

New Zealand's maternal mortality rate, the death of a mother while pregnant or up to six weeks after birth, is significantly higher than many other OECD countries with comparable health systems including Canada, United Kingdom and Australia [34].Suicide has consistently been the leading cause of maternal deaths in New Zealand since data collection began in 2006 (PMMRC, 2015). There were 13 maternal deaths from suicide during 2006 to 2010, almost a quarter of the total record (PMMRC, 2012). The Perinatal Maternal Mortality Committee (PMMRC) has made a number of recommendations to improve maternal mental health services in New Zealand. Following the Ministry of Health report 'Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand' (2012), the government, in 2013, allocated an extra $18.2 million into maternal mental health services in the North Island, largely channeled to those needing acute care with a new Mother and Babies unit at Starship Hospital, as well as some expansion to respite care facilities in the region and more in-home care for mothers. This brings the total number of in-patient acute care units for the country to two, with the other based in Christchurch. Other recommendations from the PMMRC that still require action have been the need for better coordination between existing services in the primary and specialist

[34] OECD Statistics, 2016, retrieved from http://stats.oecd.org/index.aspx?queryid=30116

sectors, improved processes for the sharing of information between providers, and the referral of pregnant women and new mothers with a history of mental illness for psychiatric assessment and management even if they are currently well. Consistency in access to maternal mental health services in various regions, and the quality and appropriateness of services for Māori and Pacific women also remain a concern.

Women's Health Action is concerned by the high rates of maternal mortality as a result of suicide. We believe more needs to be done to address maternal and infant mental health and is particularly concerned about the frequent separation of women and their infants when accessing mental health services. **Access to Mother-baby units or self-care units is essential to assist with bonding and also the health, development and well-being of the infant.**

Oxytocin which is a highly active hormone during breastfeeding has a mentalisation-enhancing function which presents a powerful opportunity for the mother to optimize her understanding of, and focus on, the mental state of her infant this is critical for a secure infant attachment. **We recommend the establishment of Mother-baby units or self-care units and increased education about infant mental health for all agencies and individuals involved with maternal and infant health.**

Employment and Breast feeding

As reported in the New Zealand governments seventh periodic report and in the CEDAW committees 2012 concluding observations, the introduction of The Employment Relations (Breaks, Infant Feeding, and Other Matters) Amendment Act 2008 (the Act) in 2009, is a positive contribution towards Articles 11 and 12 (employment and health). However employer's knowledge of their responsibilities under the Act remains unacceptably low, recent studies have shown that over half of employers are unsure (17%) or unaware (38%) of the Act[35], additionally research carried out by Women's Health Action, found that 20% of breastfeeding employees had none of the required supports provided to them by their employers[36]. Women's Health Action encourages the New Zealand Government to urgently address the current gaps in knowledge and application of this Act.

[35] Employers & Manufacturers Association. (2015). Employers Survey 2015: Advocacy & Industry Relations. Auckland: EMA. Retrieved from https://www.ema.co.nz/resources/EMA%20Reports%20and%20Documents/Advocacy/Employers-Survey-2015.pdf
[36] Women's Health Action. (2015). Breastfeeding at work - Employers survey. Auckland: Point Research. Retrieved from http://www.womens-health.org.nz/wp-content/uploads/2015/08/20150819-WHA-Breastfeeding-at-Work-Employers-Survey.pdf

As stated in the draft report breastfeeding initiation rates are reasonably high (80%). Approximately 96 % of pregnant women intend to breastfeed for at least 6 months[37] . However by the time their baby is six months of age, 74% of women are either fully (34%) or partially (40%) formula feeding, and only 18% of women (dropping down to 10% for Māori women) are exclusively breastfeeding to six months as per World Health Organization recommendations[38]. We support the government's current efforts to address our low rates of exclusive breastfeeding, In addition we recommend the government consider its obligations under the WHO/Unicef Global Strategy for Infant and Young Child Feeding (World Health Organization, 2003) in particular we encourage the following:

- **Inclusion of 'increased initiation and duration of breastfeeding' as a National Health Target.**
- **Review and redevelopment of a National Strategic Plan of Action for Breastfeeding.**
- **Establishment of a National Infant and Young Child Feeding Committee.**
- **Evaluation of how District Health Boards are currently funding lactation support within each of the regions maternity facilities and community breastfeeding support services (including staffing levels).**

In relation to the World Health Organization (WHO) International Code of Marketing of Breast-milk Substitutes[39]. We believe that the current voluntary and self-regulatory (INC Code) is not working effectively. We recommend that the government act in accordance with the recommendations made by the Committee on the Rights of the Child that "The New Zealand Government implement fully the International Code of Marketing of Breastmilk Substitutes"[40].

Part 5: Equality before the law and the elimination of discrimination against women in all matters relating to marriage and family relations

Additional comments and areas of concern:

[37] Morton, S. M., Atatoa Carr, P. E., Bandara, D. K., Grant, C. C., Ivory, V. C., Kingi, T. R., Waldie, K. E. (2010). Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Report 1 - Before we are born. Auckland, New Zealand: Growing up in New Zealand.

[38] Royal New Zealand Plunket. (2012-2013, 2014-2105). Report prepared for Women's Health Action Trust. Retrieved October 27, 2015

[39] World Health Organization. (2003). Global Strategy for Infant and Young Child Feeding. Geneva: World Health Organization

[40] Committee on the Rights of the Child. (2011). Consideration of reports submitted by States parties under article 44 of the Convention - Concluding observations: New Zealand. Committee on the Rights of the Child.

1. Older women's Health

Aotearoa New Zealand has an increasingly diverse population of women over 55. By 2051 older New Zealanders will make up 26 out of every 100 people, and the majority of those older New Zealanders will be women. As this population increases so will its diversity when compared with past generations. There are considerable cultural differences and attitudinal differences between these women, some of which are a reflection of a lifetime experience of health and other inequalities and the increasing disparities in New Zealand. There are also considerable differences between the health of men and women. **The diversity of older women coupled with the lack of gender based research in many areas of health means information about the health of older women in Aotearoa New Zealand is limited.**

In Aotearoa New Zealand overall female life expectancy at birth is 81.1 years, nearly five years more than male life expectancy and Māori female life expectancy is nearly nine years less than for non-Māori females. While cancers and ischemic heart disease are the leading causes of female mortality, older women have higher rates of arthritis, osteoporosis, asthma and chronic obstructive respiratory disease than men[41]. While life expectancy has continued to increase for all New Zealanders the increase in health expectancy has not kept pace and girls can expect to live 14 percent of their lives in poor health or with long-term disabilities[42]. **Older women in Aotearoa New Zealand have higher rates of arthritis, osteoporosis, asthma and chronic obstructive respiratory disease than men and are more often subject to elder abuse both by carers and family members**.

Mental health is also an issue for older women who are more likely to outlive male partners, face social isolation and anxiety about lack of financial security and safety. In addition there is evidence that distress caused by these issues may be medicalised rather than addressed at a social or economic level. Abuse and neglect of the elderly is a frequent occurrence both at home and in aged care services and is a significant health issue that must be given specific attention. Each year, New Zealand's Age Concern's Elder Abuse and Neglect Prevention (EANP) services receive over 1000 referrals about people who may be facing elder abuse or neglect. Two thirds of abused older people are women. EANP notes that older people who are dependent on others are

---

[41] British Columbia Women's Hospital and British Columbia Centre of Excellence for Women's Health. 2004.Advancing the health of women and girls.

[42] Ministry of Health NZ. 2013. Health and Independence Report. Wellington.

particularly vulnerable to abuse and that for many their health was significantly affected by the abuse they experienced. Abuse of elderly people by care services is not uncommon but abuse by family members is most common. Age Concern New Zealand (ACNZ) data shows that referrals have been increasing steadily for some time, and that services are not always able to respond to this demand.

In Aotearoa New Zealand there are significant disparities in the health of different groups of women. Differences can be found in the health of Māori and Pasifika women and other groups such refugees, and lesbian, bisexual and transgendered women reflecting the effects of a range of intersecting factors including racism, homophobia and the transgenerational effects of colonisation as well as structural barriers and socio economic differences.

Older women who are poor or disabled or belong to minorities often experience multi-sectored discrimination. Similarly, older women in prison, older sex workers and older disabled women can face neglect and abuse or financial insecurity. Many older women face neglect as they are considered no longer economically or reproductively useful, and are seen as a burden on their families. Prohibitive costs, lack of transport or the absence of geriatric medicine, primary health or mental health services often prevent older women from enjoying their human right of access to health care[43].

Our research suggests that recognition of the diversity of this population, attention to intersecting causes of health disparities, addressing ageism and a gender specific approach need to be included in order to achieve these goals. Incorporating age and gender based perspectives into all policy and research allowing sex and gender and age differences to be taken into account in the provision of all health care including addressing problems like wrong or over prescribing of medications[44] , treating mental health problems such as depression, and dealing with health problems related to violence and abuse. Government statistical data and the data of organisations such as ACC and HDC must be disaggregated by sex and age to provide gender specific

---

[43] For references see: Women's health Action. 2015. Older Womens Health Issues paper available at: Available at: http://www.womens-health.org.nz/wp-content/uploads/2015/03/Creating-Health-Strategies-for-Older-Women.pdf

[44] For example PHARMAC stats cited in *Dangerous Caring: the new pandemic*. • *Hospitalisation due* to medicine adverse events in older adults... *D Mangin*, *K Sweeney, I Heath BMJ 2007*;*335*;*285-7* & Sergi G, Rui MD, Sarti S, et al. Polypharmacy in the elderly. Drugs Aging 2011; 28 (7): 509-518. & Iyer S, Naganathan V, McLachlan AJ, et al. Medication withdrawal trials in people aged 65 years and older – a systematic review. Drugs Aging 2008; 25 (12): 1021-1031 & Garfinkel D, Mangin D. Feasibility study of a systematic approach for discontinuation of multiple medications in older adults. Arch Intern Med. 2010;170 (18):1648-1654.

information about health. Priority setting in health care services should be based on evidence that is free from systematic gender-and age biases.

We believe government must ensure the health sector and other intersecting sectors address both age and gender discrimination.

There are significant gender interaction effects that mean that women are penalized by their participation in family life, employment and where they live. There are few New Zealand studies about the impact of poverty on women over 65 but there is evidence in the international literature that there are gender differences in levels of poverty amongst older people. Because Women are living longer and because of their traditional lack of financial retirement planning, they are prime candidates for poverty. Many older women who a lack of financial security such as superannuation or savings, or not owning their own home, may also experience financial insecurity which in turn means they may try to live very frugally - cutting costs on heating, quality food, activities that promote social connectedness, or health care. These women might not experience poverty per se but are 'living poor'. In addition, the health care reforms of the last decade have also had a negative effect on poorer people, including the closing of acute-care beds, and early release from hospital without a corresponding increase in support in the community which has left ageing women with an increased and unrecognized burden of caring for partners and other family members who are ill or frail[45].

There are no strategies in place to support changes in work practice that enable older women to remain in both the formal and informal labour markets and support voluntary and gradual retirement and the work of unpaid carers. Simply transferring formal care to the unremunerated care provided by ageing women without providing compensation for lost wages and community support services is discriminatory.

We believe the government must develop health strategies which take a human rights approach to health care and address issues such as income support and access to appropriate housing and transport and put in place specific monitoring strategies to protect the frail elderly from abuse, financial exploitation or violence.

[45] McInnes, E. 2007 'When unpaid care work doesn't count: the commodification of family life in the new welfare to work order', Conference paper, University of South Australia.

2. Body image and gender discrimination

Women's Health Action believes that the current focus on weight as a health issue intersects with media and social messages that emphasise slenderness as a beauty ideal that contribute to poor body image amongst young people, particularly young women, and negatively impact on women's views about, and enjoyment of, their bodies at all ages. In addition weight loss at any age is difficult to achieve and sustain and attempts at weight-loss through dieting and excessive exercise can be harmful to health, for example, by leading to harmful eating practices and weight cycling. This approach also discriminates in other ways, for example, some variation in body size and weight is part of normal human diversity and in some instances has been associated with socio-economic deprivation, resulting in the targeting of certain population groups as being 'overweight".

However, evidence points to health outcomes are improved by increased physical activity and improved nutrition regardless of weight loss/weight status and we believe more attention needs to be given to the social determinants of both weight and health including: food security, food labeling, and limitations on advertising of low quality foods; and accessible and affordable indoor and outdoor recreational areas.

The current focus on weight as a health issue contributes to weight bias, stigma and discrimination which disproportionately effects women and is detrimental to health and wellbeing, particularly for women of size. Impacts on health and wellbeing include: undermining the quality of care provided to women of size acting as a deterrent for women of size to seek preventative health care such as screening discouraging women of size from participation in health promoting activities such as physical activity and other recreational pursuits encouraging women of size to pursue harmful eating practices such as dieting, reducing the self-esteem and body image of all women, but particularly women of size[46].

[46] Carryer, J. (2001). Embodied largeness: a significant women's health issue. Nurs Inq, 8(2), 90-97 and Campos, P. (2004) The Obesity Myth: Why America's Obsession with Weight is Hazardous to Your Health. Gotham Books: New York **and** Carryer, J. & Penny, S., (2011). Obesity and health--new perspectives from bioscience research suggest directions for clinical practice. N Z Med J, 124(1329), 73-82.

Women's Health Action believes more should be done to shift the emphasis in public health policy from individual lifestyle choices to the social determinants of health; and supporting health equity through the integration of health considerations into a broad range of policy areas such as employment, education and social policy. In addition negative and blaming media discourses about health, including those using social media, need to be challenged by health services and researchers in the same way as those which contribute to domestic and sexual violence, image and their right to define their own identity.

3. Eliminating discrimination and promoting gender equity

We believe the state party could do more to progress gender[47] equity in Aotearoa New Zealand by incorporating gender analysis[48] into all research, policy and service development across government including the work of agencies such as Health and Disability Commission, ACC, and the Health Quality and Safety Commission (HQSC). Gender analysis aims to achieve equity, rather than equality[49].

Relevant, reliable and up-to-date data is essential for gender analysis, which can reveal underlying causes or trends that are not apparent from a cursory or superficial examination. For example, coronary heart disease is the most common cause of death in New Zealand women. Yet this fact is often overshadowed by statistics, which reveal a higher incidence of coronary heart disease in men. Overseas studies have shown that, despite having more severe symptoms, fewer women had significant investigations and treatment[50]. Gender analysis would assist in ensuring maximum participation by women and increase benefits to society from women's skills. These benefits can include increased tax revenue, reduced demand for welfare assistance, and improved health status for women and children, which lowers demand on the health system and ensures better targeting of policies and programmes.

[47] The term 'gender' refers to the social construction of female and male identity. It can be defined as 'more than biological differences between men and women. It includes the ways in which those differences, whether real or perceived, have been valued, used and relied upon to classify women and men and to assign roles and expectations to them. The significance of this is that the lives and experiences of women and men, including their experience of the legal system, occur within complex sets of differing social and cultural expectations'.

[48] Gender analysis examines the differences in women's and men's lives, including those that lead to social and economic inequity for women, and applies this understanding to policy development and service delivery. It is concerned with the underlying causes of these inequities and aims to achieve positive change for women.

[49] *Gender equity* takes into consideration the differences in women's and men's lives and recognises that different approaches may be needed to produce outcomes that are equitable. *Gender equality* is based on the premise that women and men should be treated in the same way. This fails to recognise that equal treatment will not produce equitable results, because women and men have different life experiences.

[50] For example:Australian Government department of Health and Aging. 2008. Developing a Women's Health Policy for Australia-Setting the scene.

CEDAW's 2012 review of New Zealand's progress in implementing the convention expressed concern that the New Zealand government has not taken sufficient steps to ensure that gender considerations are mainstreamed into all national plans and government institutions. We believe action is still required including gender analysis as part of all government departments and agencies to ensure equitable service development.

Some other recent examples encountered by Women's Health Action where a gendered analysis was not available include assessments and audits of all health services such as the Atlas of Healthcare Variations and the cases heard by the HDC. We also believe that agencies such as the office of the Health and Disability Commissioner (HDC) should obtain and provide gendered information of complaints of injury or mistreatment and the effectiveness of products such as contraceptive and surgical implants as some particular injuries occur more commonly in women than men, particularly in the area of reproductive health.

CEDAW Article 12 notes that State parties shall take all the appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those relating to family planning. Despite this, New Zealand women experience some health inequalities simply because they are women. In particular those related to reproductive and sexual health rights.

We believe the state party needs to do more to ensure the availability and accessibility of a full range of contraceptive methods and abortion services is essential to gender equity. In addition there must be freedom from discrimination arising from coercive policies and sanctions on women who have subsequent children while in receipt of welfare and other legislation/policies intended to influence reproductive decision making.

Women also experience certain health challenges more commonly than men. For example:

• Women and girls have a higher prevalence of anxiety disorder, intentional self-harm and major depression (20.3 percent vs 11.4 percent) and eating disorders than males. In 2010, there were 2,825 hospitalisations for intentional self-harm - with 990 of those male, and 1,835 female.

• Women are more likely to experience illnesses such as migraine and osteoarthritis and experience other issues such as domestic violence that impact on their health.

• Women represent 54.3 percent of all adults with a disability. Disabled women face extra challenges - being more vulnerable to abuse, poverty and poorer health.

• Mental and primary health services, for example, must "pay special attention to women who have experienced elder abuse or other forms of violence"[51].

• Women live longer than men, hence, 4 percent of New Zealanders with a disability live in rest homes and more than two-thirds of these are women. The quality of residential care and prevalence of elder abuse significantly impact on women[52]

Many groups of women also suffer multiple forms of discrimination and inequitable health and health care underpinned by factors such as the effects of colonisation, sexism, socio economic inequalities, ageism, ableism and heterosexism. Promoting gender equity requires a whole-of-government approach, which addresses social and economic inequalities, including poverty, unequal pay rates, institutional racism, and ageism and addresses negative gendered norms. **We believe there is a case to be made for the development of a women's health strategy in Aotearoa New Zealand that is intersectoral and has a focus on promoting human rights and addressing the social determinants of health[53]**

Conclusion

We believe Aotearoa New Zealand does well on a range of human rights and gender equity issues. However, this draft report does not fully reflect the entrenched inequalities between women and men in Aotearoa New Zealand including inequitable health outcomes and other gender disparities. The failure to address the underlying socio economic factors impacting on health outcomes, the diversity of our population and ensure gendered data and analysis underpin health care decisions all contribute to the health inequalities faced by women. Failure to address antiquated abortion laws and to address the gendered nature of domestic and sexual violence and two key areas where discrimination is obvious.

We hope the final report will note these areas where further action is still required in order to eliminate the remaining areas of discrimination against women in Aotearoa New Zealand.

[51] Beaulaurier, R. L., Seff, L. R., & Newman, F. L. (2008). Barriers to help-seeking for older women who experience intimate partner violence: a descriptive model. [Research Support, U S Gov't, Non-P H S]. *J Women Aging, 20*(3-4), 231-248.
[52]Women's health action. 2014. Developing a Women's Health Strategy and Issues paper: Creating health strategies for older women.
[53] Women's health action. 2014. Developing a Women's Health Strategy and Issues paper: Creating health strategies for older women.