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The mana of tāngata whaikaha Māori drives positive change within whānau, hapū, iwi and wider social systems.

Submission on the Second Draft of the Global Plan of Action on the Health of Indigenous Peoples (2027–2040)

WHO Western Pacific Regional Consultation, 9 June 2026

Submitted by: Te Ao Mārama Aotearoa (TAMA), New Zealand's umbrella Disabled People's Organisation for tāngata whaikaha Māori, pan-iwi and pan-impairment, recognised as a representative organisation consistent with UNCRPD General Comment No. 7

On behalf of: The National Taumata of Tāngata Whaikaha Māori, whose consensus position this submission represents

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Status: Offered in support and furtherance of the comments made by Dr Ingham as part of New Zealand's Delegation to the GPoA consultation

Standpoint: The intersection of Indigenous rights and disability rights, on behalf of tāngata whaikaha Māori (Māori with lived experience of disability)

Reference draft: Second draft GPoA, version 7 March 2026. Comments are keyed to paragraph numbers and action domains, per the reviewer guidance.

Overall viewpoint

TAMA offers its strong and overwhelming support for the draft Global Plan of Action. A dedicated global plan for the health of Indigenous Peoples is long overdue. It will be warmly received by tāngata whaikaha Māori, and by Indigenous Peoples across the Western Pacific and beyond.

We thank the World Health Organization for its sustained efforts to develop the Plan, and for supporting an inclusive consultation process that has made room for Indigenous voices, including the voices of Indigenous persons with disabilities.

The comments that follow are offered in that spirit. They are intended to strengthen a Plan that we strongly endorse, not to detract from it.

Key recommendations

In summary, we ask that the Plan:

1. add a dedicated, resourced action for Indigenous persons with disabilities, co-designed with their representative organisations and with their Free, Prior and Informed Consent;
2. anchor the Plan in both UNDRIP and the CRPD, name the intersectional gap between them, and add habilitation (CRPD Article 26) to the life course and the continuum of care;

3. require disability-disaggregated data within Indigenous populations, reported across the full range of functional difficulty and governed by Indigenous data sovereignty, and give clear direction that the Washington Group short set is for disaggregation, not a measure of prevalence, with fuller instruments such as WHO's Model Disability Survey and Indigenous-defined measures used where prevalence is needed;
4. make the Plan's core monitoring indicators disability-disaggregated and inclusive of Indigenous persons with disabilities, and have WHO include them in its engagement and accountability platforms; and
5. match ratification with enforceable, domesticated and independently monitored accountability, so that commitments are acted upon and not only agreed.

Priorities for immediate action. If the Plan can absorb only a limited number of changes, we ask WHO to prioritise the first three: a dedicated, resourced action naming Indigenous persons with disabilities; anchoring the Plan in both UNDRIP and the CRPD with habilitation added to the life course; and disability-disaggregated data governed by Indigenous data sovereignty.

What success looks like. If WHO adopts these recommendations, Indigenous persons with disabilities would be named in the Plan's actions, counted in its data, supported to lead, and able to hold health systems to account for the outcomes that follow.

About this submission

Te Ao Mārama Aotearoa (TAMA) is New Zealand's umbrella Disabled People's Organisation for tāngata whaikaha Māori: pan-iwi and pan-impairment. Consistent with UNCRPD General Comment No. 7¹ on the participation of persons with disabilities through their representative organisations, TAMA is a representative organisation of disabled people, and is therefore properly placed to speak to the rights of Indigenous persons with disabilities.

This submission represents the consensus position of the National Taumata of Tāngata Whaikaha Māori². It is offered in support and furtherance of the comments made by Professor Dr Tristram R. Ingham KSO ONZM as part of New Zealand's Delegation to the GPoA consultation.

We engage with the draft Plan from the standpoint of the intersection of two bodies of rights: the rights of Indigenous Peoples and the rights of persons with disabilities. This intersection is where the draft Plan is currently weakest, and where it has the greatest opportunity to lead.

TAMA's oral contribution to the consultation focused on Priority 4 (interlinked environmental and social determinants). This written submission is our opportunity to provide input across the full Plan: comments on the guiding principles (Section 1), and comments on each of the Plan's five priorities in turn (Section 2).

Context and rationale

Indigenous Peoples experience disability at substantially higher rates than non-Indigenous populations, with estimates commonly in the range of 20 to 33 per cent (Inter-Agency

¹UN Committee on the Rights of Persons with Disabilities (2018), General Comment No. 7 on the participation of persons with disabilities, including children with disabilities, through their representative organizations, CRPD/C/GC/7. [ohchr.org](https://www.ohchr.org)

²The National Taumata is TAMA's national leadership council. It comprises our 55-plus representative (affiliating) rōpū and organisations across 15 Pou.

Support Group on Indigenous Peoples' Issues, 2014), a disparity that Resolution 76.16 itself acknowledges. They also carry a large and well-documented health and life-expectancy disadvantage relative to non-Indigenous populations across many countries (Anderson and others, The Lancet and Lowitja Institute Global Collaboration, 2016). At the intersection of indigeneity and disability these disadvantages compound rather than simply add, as the UN Special Rapporteur on the rights of Indigenous Peoples has set out (A/HRC/57/47, 2024). Indigenous persons with disabilities are, in effect, among the most marginalised within already marginalised populations, yet they remain largely absent from both Indigenous health policy and disability policy. Although our evidence is grounded in Aotearoa, the pattern is regional and global: Indigenous persons with disabilities across the Western Pacific and beyond face the same intersecting exclusion, and the recommendations that follow are framed to apply in any national context.

Aotearoa illustrates the pattern. A national survey of 7,230 Māori adults found that 15.1 per cent reported at least a lot of difficulty across the Washington Group domains, while 70.2 per cent reported some difficulty, cognitive difficulty being the most common at 47.6 per cent (Ingham and others, 2025). This matters because Member States routinely treat the Washington Group short set as a measure of disability prevalence, when it was designed only to disaggregate outcomes. Applying its narrowest cut-point records the majority of Māori, those reporting some difficulty, as non-disabled, understating our numbers and marginalising us in the very data meant to drive action. The true prevalence of impairment among Māori is likely substantially higher, given the impairing effects of racism, colonisation and poorly adapted health systems; fuller and Indigenous-defined measures, such as WHO's Model Disability Survey, are needed to count us accurately. The first Māori-specific estimates from the Global Burden of Disease Study (Ministry of Health, 2025) found that Māori lost 123,685 years of life to premature death in 2021, at double the age-standardised rate of non-Māori, with non-communicable diseases accounting for 78 per cent of that loss and self-harm the leading cause among Māori aged 15 to 44 years.

The disability dimension sharpens this further. New Zealand data on amenable mortality, that is, deaths that could be avoided through timely and effective health care, show that disabled people die from amenable causes at around five times the rate of non-disabled people, and disabled Māori at around ten times the rate of non-disabled non-Māori (Health Quality and Safety Commission). Because the measure is, by design, confined to avoidable deaths, the cause lies in the health system's response and not in impairment itself, consistent with the point made at Section 1.5.

These figures are almost certainly underestimates. As set out in Section 3, disabled people remain largely invisible in national data, and statistics are not disaggregated by disability and indigeneity together. The scale of this avoidable and compounding harm, and its very invisibility, is the reason this submission asks the Plan to centre Indigenous persons with disabilities explicitly, rather than treat them as a group to be noted in passing.

1. Comments on the guiding principles

These comments address the Plan's guiding principles. Several of them also apply across all five priorities.

1.1 Disability inclusivity as a guiding principle: welcome, but the obligation is too weak

We are gratified to see disability inclusivity included as a guiding principle (para 20), and we support the person-centred language used in the draft, which is consistent with the social model of disability. This is an important step that distinguishes this Plan from earlier global instruments.

However, the operative framing is too weak. Paragraph 20 opens “Applying approaches that advance health equity, gender equality and disability inclusivity **means that** health policies and programmes...”. This describes good practice rather than requiring it.

- **Recommend:** recast paragraph 20 as a binding obligation, for example that Member States and other actors shall design and implement health policies and programmes that advance health equity, gender equality and disability inclusivity.

1.2 Transformational, not incremental, change

The draft Plan rests on a logic of progressive realisation. For tāngata whaikaha Māori and Indigenous persons with disabilities, incremental change is inadequate. The scale and persistence of inequity, compounded across the lifecourse and across generations, requires transformational change.

- **Recommend:** the Plan name transformational change as its stated ambition, and frame its priorities and actions as instruments of structural transformation rather than gradual adjustment.

1.3 The intersectional gap between UNDRIP and the CRPD

Indigenous persons with disabilities sit at the intersection of two rights frameworks, and fall through the gap between them. UNDRIP Articles 21 and 22 direct that particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities, but it does not operationalise this. The Convention on the Rights of Persons with Disabilities (CRPD) recognises in its preamble persons subject to multiple discrimination, including on the basis of indigenous origin, but it does not substantively address indigeneity. Neither instrument operationalises the intersection.

The draft Plan currently cites UNDRIP but does not cite the CRPD at all. This is a significant omission for a plan that names disability inclusivity as a principle.

- **Recommend:** cite the CRPD alongside UNDRIP in the Background and Guiding Principles, name the intersectional gap explicitly, and position the Plan as the instrument that bridges it.

1.4 No specific operational actions for Indigenous persons with disabilities

Disability appears in the draft as a vulnerability descriptor (para 8), an item in the heterogeneity list (para 12), a clause in the equity principle (para 20), and scattered references thereafter. There is no action domain, no specific action, and no indicator directed at Indigenous persons with disabilities as a group. This is despite Resolution 76.16 itself recognising that Indigenous Peoples disproportionately experience disability, with some research indicating rates as high as 20–33 per cent.

- **Recommend:** add explicit, resourced operational actions for Indigenous persons with disabilities, co-designed with their representative organisations under Free, Prior and Informed Consent. These should be threaded through Priority 1 (leadership), Priority 2 (coverage and accessibility), Priority 4 (determinants) and Priority 5 (data and accountability), with at least one dedicated action that names the group.

1.5 Health system failure as a generator of impairment; health as an upstream determinant

The draft frames health largely as a downstream outcome of social and environmental determinants. This is only half the picture. Health system failure, through inaccessible, discriminatory, delayed or absent services, itself generates and entrenches impairment and disability. Health is also an upstream determinant of social wellbeing, education, employment and participation.

- **Recommend:** the Plan recognise, in the Background and in Priority 2, that health system failure is a mechanism that produces impairment, and that health functions as an upstream determinant of social wellbeing and not only as a downstream result of other determinants.

1.6 The life course approach must include habilitation

The continuum of care named in paragraph 28 (promotive, preventive, curative, rehabilitative and palliative) and the life course principle (para 22) both omit **habilitation**. Habilitation, recognised in CRPD Article 26, is distinct from both prevention and rehabilitation. It supports people with congenital or early-acquired impairments to attain function and independence, and it is required to begin at the earliest possible stage. Its absence reflects a prevention-and-treatment paradigm that does not serve people who have always lived with impairment.

- **Recommend:** add habilitation explicitly to the continuum of care in paragraph 28 and to the life course approach in paragraph 22, with reference to CRPD Article 26.

1.7 Co-design and co-production must be ethical

The draft Plan relies throughout on co-design and co-production with Indigenous Peoples. We support this, but caution that co-design is not inherently safe. Where it is under-resourced, time-bound or externally led, it can become extractive and tokenistic, reproducing the power imbalances it claims to address.

- **Recommend:** qualify the Plan's references to co-design and co-production as ethical co-design: reflexive, reciprocal, power-sharing, adequately resourced, and accountable to Indigenous Peoples, including Indigenous persons with disabilities. The concept of ethical co-designing developed by tāngata whaikaha Māori in Aotearoa offers one tested model.

2. Comments on the priorities

The following comments address each of the Plan's five priorities in turn. They should be read together with our comments on the guiding principles above. Our most detailed comments concern Priority 4, the priority on which TAMA contributed orally to the consultation.

Priority 1: Indigenous leadership, workforce, and the global health architecture

- **Action domain 1.1.** Indigenous Peoples' leadership in paragraph 24 must explicitly include disabled Indigenous leaders, tāngata whaikaha Māori. Participation mechanisms should guarantee the leadership of, not merely access for, Indigenous persons with disabilities: resourced to lead, with accessible meeting practice and reasonable accommodation. The principle nothing about us without us, already invoked for research in paragraph 41, should apply across all five priorities.
- **Action domain 1.2.** The Indigenous health and care workforce should explicitly include disabled Indigenous health workers, with accessible education pathways and reasonable accommodation, recognising the trust and lived expertise they bring to their communities.
- **Legitimacy, representativeness and accountability of participation.** The draft rightly emphasises Indigenous participation, engagement and leadership, and we strongly support this direction. Meaningful participation, however, requires more than the existence of participatory mechanisms: it also requires confidence in the legitimacy and representativeness of those participating. Indigenous Peoples are not a singular constituency and may hold diverse perspectives, priorities and aspirations, so questions arise about who is empowered to speak, who is heard, and whether those participating are regarded by Indigenous communities as legitimate representatives of their interests. This goes to the heart of self-determination: participation that is not regarded as legitimate by those affected risks weakening trust, reducing engagement, and limiting the effectiveness of otherwise well-intentioned processes. Implementation of the Plan should therefore give consideration not only to Indigenous participation, but to the legitimacy, accountability and representativeness of the mechanisms through which Indigenous voices are engaged and heard, including engagement through Indigenous Peoples' own representative organisations, consistent with the principle reflected in General Comment No. 7.

Priority 2: Health service coverage and financial protection

- **Action domain 2.1.** The accessibility standard in paragraph 28 (availability, accessibility, acceptability, quality) should name disability accessibility explicitly, covering physical, communication and attitudinal barriers, with reasonable accommodation as a requirement rather than an aspiration.
- **Action domain 2.2.** Financial protection should account for disability-related costs, such as assistive devices, support and transport, which are a major driver of catastrophic out-of-pocket spending for disabled Indigenous people and are frequently excluded from coverage.
- **Action domain 2.3.** Health emergency preparedness and response should be disability-inclusive by design, consistent with our Priority 4 comment below.
- **Choice of Indigenous-led services.** Coverage should secure a genuine, well-supported choice of Indigenous-led services, not only mainstream provision. This principle of options requires that Indigenous-led and mainstream pathways are both adequately resourced, so that disabled Indigenous people are not disadvantaged by choosing their own (linking to Priority 3).

- **Communication accessibility.** Linguistic accessibility should extend to Indigenous sign languages and to interpreters fluent in both Indigenous spoken and signed languages, alongside accessible formats. In Aotearoa the near absence of interpreters trilingual in te reo Māori, New Zealand Sign Language and English illustrates a gap likely mirrored elsewhere. This connects to the Decade of Indigenous Languages already cited in the Plan.
- **Children, youth and mental health.** Māori are a demographically young population, so the child and youth dimension of this work is proportionally large. Disabled Indigenous children and youth need early identification, habilitation and inclusive education, and culturally safe mental health support. The Plan should reflect the Convention on the Rights of the Child alongside the CRPD and UNDRIP for this group, consistent with the Joint Statement of the Committees on the Rights of the Child and of Persons with Disabilities. In Aotearoa, self-harm is the leading cause of years of life lost for Māori aged 15 to 44, and conditions that disproportionately affect Indigenous children, such as foetal alcohol spectrum disorder, are poorly served where they do not by themselves qualify for disability support.

Priority 3: Intercultural approaches and traditional medicines

Mātauranga Whaikaha Māori. Tāngata whaikaha Māori hold our own ways of knowing, being and experiencing the world. This mātauranga shapes how we understand health, wellbeing, impairment and disability, and it is distinct from both biomedical knowledge and the knowledge of non-disabled Indigenous Peoples. The Plan's strengths-based, holistic and intercultural approaches should recognise Mātauranga Whaikaha Māori as a knowledge system in its own right, and provide for it to inform health services, traditional healing, and research (see Priority 5).

- **Action domain 3.1.** Intercultural and integrated service models, including rongoā and other Indigenous healing practices, should be accessible to and inclusive of disabled Indigenous people across the continuum of care, so that access to traditional and biomedical systems is not itself disabling.
- **Action domain 3.3.** Workforce capacity-building should pair cultural safety with disability responsiveness, co-designed with disabled Indigenous people, so that intercultural practice does not overlook disabled members of the community.
- **Build on models that work.** The Plan should point to existing Indigenous-led and self-determined models as exemplars, for instance Whānau Ora commissioning and the Enabling Good Lives approach in Aotearoa, which show how holistic, self-determined design improves outcomes when adequately resourced.

Priority 4: Interlinked environmental and social determinants

This is the priority on which TAMA contributed orally to the consultation. Three points arise.

Accessibility of the environment and of environmental protection. Access to a healthy environment, and to environmental protection and emergency safeguards, is disproportionately constrained for some subpopulations, including disabled people. Climate adaptation, disaster preparedness and emergency response (paras 33 and 35) carry elevated risk for Indigenous persons with disabilities, who are more likely to be left behind in evacuation, relief and recovery.

- **Recommend:** build explicit accessibility and disability-inclusion requirements into the environmental and emergency actions under Priority 4 and action domain 2.3.

Action domain 4.1: resilience, and legal protection of the environment under Indigenous leadership. We welcome the focus on Indigenous-led ecosystem stewardship (paras 33 to 35). We recommend going further on two fronts.

- **Resilience.** Name individual and community resilience as a health-protective outcome of Indigenous environmental leadership, not only as a byproduct of ecosystem management.
- **Legal protection.** Move beyond stewardship to the legal protection of the environment under Indigenous leadership. The legal personhood of Te Awa Tupua, the Whanganui River, under the Te Awa Tupua (Whanganui River Claims Settlement) Act 2017, is an exemplar of Indigenous-led legal protection that safeguards the environmental determinants of health. The Plan should recognise such models.

Historical and continuing harms of health and disability systems. The social determinants in action domain 4.3 should expressly recognise that health and disability systems have themselves harmed Indigenous persons with disabilities, through institutionalisation, segregation from whānau and community, seclusion, and coercive care, often underpinned by eugenic and assimilationist policy. Documented for tāngata whaikaha Māori in Aotearoa, these harms have lasting intergenerational effects and persist in some settings. This complements the Plan's reference to coercive sterilisation at paragraph 39.

- **Recommend:** action domain 4.3 recognise the historical and continuing harms of health and disability systems to Indigenous persons with disabilities, and provide for redress and for safeguards against coercive practices.

Action domain 4.4: a missed opportunity on intersectional subpopulations. Action domain 4.4 rightly centres the health of Indigenous women and girls. As drafted, however, it is a missed opportunity to prioritise disabled people and other intersectional subpopulations, including takatāpui and LGBTQI+ Indigenous people. These groups experience multiplicative, not merely additive, disadvantage in access to the social determinants of health. Intersectionality should be understood as the compounding of distinct forms of disadvantage with named root causes, colonialism, racism and ableism, and not as a single additional population category, which would obscure those causes.

- **Recommend:** extend action domain 4.4, or add a companion action, to explicitly name disabled Indigenous people and takatāpui and LGBTQI+ Indigenous people, and to apply an intersectional analysis of compounding disadvantage.

Priority 5: Research, data sovereignty, and accountability

- **Action domain 5.1.** Indigenous-led and co-produced research should include disabled Indigenous researchers and disability-focused research priorities, under the principles of Free, Prior and Informed Consent and nothing about us without us.
- **Action domain 5.2.** Indigenous data sovereignty, as advanced by Te Mana Raraunga, must extend to disabled Indigenous peoples. The data sovereignty of tāngata whaikaha Māori must itself be addressed: disabled Indigenous peoples, through our representative organisations, should exercise ownership, control, access and possession of data about us. This is the data sovereignty expression of the

leadership point under Priority 1, and it is not satisfied by holding disability data under generic Indigenous control alone.

- **Action domain 5.3.** Paragraphs 43 and 44 require disaggregation by sex, age and socio-spatial characteristics, but not by disability. Data that is invisible cannot be acted upon. Disaggregation by disability within Indigenous populations is essential, using internationally comparable tools such as the Washington Group Short Set on Functioning, governed by Indigenous data sovereignty safeguards as set out in action domain 5.2. Disaggregation should also reflect Indigenous conceptualisations of disability, not only biomedical categories, and report across the full range of difficulty rather than only the narrowest cut-point, which undercounts Indigenous disability. The Plan should give clear direction distinguishing the short set, which is for disaggregation, from the measurement of prevalence, which is better served by fuller instruments such as WHO's Model Disability Survey alongside Indigenous-defined measures.
- **Action domain 5.4.** Joint accountability platforms should include tāngata whaikaha Māori and disabled Indigenous representation as of right, not by invitation. Accountability information should be published in accessible formats, including Indigenous languages, sign languages, Easy Read and Braille.
- **Core indicators and WHO platforms.** The core set of indicator domains foreshadowed in the Plan should be disability-disaggregated and include indicators on Indigenous persons with disabilities. WHO should also include Indigenous persons with disabilities, through their representative organisations, in its civil society engagement and in the Plan's monitoring and accountability arrangements.
- **Enforcement and domestication.** Ratification is not enforcement. In dualist legal systems, which are common among States Parties, international instruments are directly enforceable only to the extent that they are incorporated into domestic law. Neither the CRPD nor UNDRIP has been domesticated in Aotearoa, so the rights they affirm remain largely unenforceable for tāngata whaikaha Māori. The Plan should call on Member States to give domestic legal effect to these instruments and to provide enforceable accountability, not ratification alone (see Section 3).

3. Application, enforcement, and the accountability gap

A plan is only as strong as its application and enforcement. In many countries the obstacle is not a lack of knowledge but a lack of action. Aotearoa illustrates a pattern likely common elsewhere: official inquiries repeatedly document systemic failure affecting Indigenous persons with disabilities, yet action does not follow, and is at times withdrawn. This section builds on the determinant identified under Priority 4 and the enforcement point under Priority 5.

The enforcement gap. As noted under Priority 5, ratification is not enforcement. In dualist systems neither the CRPD nor UNDRIP is directly enforceable unless incorporated into domestic law, and neither has been domesticated in Aotearoa. The rights they affirm therefore remain, in large part, declaratory for Indigenous persons with disabilities.

Knowledge without action. Successive independent inquiries have established the failures, yet implementation lags:

- The Abuse in Care Royal Commission of Inquiry (Whanaketia, 2024), the largest public inquiry in New Zealand history, found Deaf and disabled people and tāngata whaikaha Māori at the centre of an over-use of segregated, institutional care, and that colonisation, racism and ableism meant more Māori entered care and were treated more harshly.
- The Health and Disability Commissioner and the Health Quality and Safety Commission, in reports on residential disability support, on complaints from disabled people, and in A Window on Disability (2025 to 2026), continue to document restraint, unsafe care, bias, and the failure to treat disabled people and whānau as experts in their own lives.
- The Royal Commission of Inquiry into COVID-19 Lessons Learned (2024, 2026) found disabled people faced inaccessible information, support shortfalls and discrimination, and called for their involvement in pandemic planning.
- The Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry (Wai 2575) found Crown breaches of te Tiriti o Waitangi in health, with disability a named dimension of the inequity.
- Treaty-body findings are being set aside. The CRPD Committee's 2022 Concluding Observations on New Zealand recommended frameworks reflecting the Treaty, the CRPD and UNDRIP that recognise the self-determination of Māori persons with disabilities (Concluding Observation 6(b)). The Government has since listed that recommendation among those with no action currently proposed, reversing a position previously agreed by Cabinet.

The result is that, to this day, disabled people remain largely invisible to the health system. National statistics are not disaggregated by disability and indigeneity together, existing tools do not capture Indigenous conceptualisations of disability, and the shift from a periodic census to rolling surveys risks worsening this. What is not counted is not acted upon.

- **Recommend:** the Plan require Member States to act on what their own inquiries and treaty-body reviews already establish, to give domestic legal effect to the CRPD and UNDRIP, and to put in place enforceable, independently monitored accountability for the health of Indigenous persons with disabilities. Commitments that are documented but not implemented, or agreed and then withdrawn, are not accountability.

Proposed drafting

To assist the drafters, and to respect the 5,000 word limit, we offer ready-to-use wording for our three highest-priority changes. Each is paired with a suggested offsetting reduction so that net length is controlled.

1. A dedicated action for Indigenous persons with disabilities (Priority 1). Proposed insertion: “Member States and other actors shall, together with Indigenous persons with disabilities and their representative organisations and with their Free, Prior and Informed Consent, develop and resource specific measures to realise their right to health, addressing the intersection of indigeneity and disability across all Priorities.”

Suggested offsetting cut. Replace the separate descriptions of disability at paragraphs 8, 12 and 20 with a single defined term, used consistently thereafter.

2. Habilitation and the CRPD (paragraph 28 and the Guiding principles). Proposed insertion: amend the continuum of care to read “promotive, preventive, curative, habilitative, rehabilitative and palliative”, and add to the Guiding principles a reference to the Convention on the Rights of Persons with Disabilities, in particular Article 26, alongside UNDRIP.

Suggested offsetting cut. The telemedicine sentences in paragraph 29 can be condensed to one.

3. Disaggregation and indicators (action domain 5.3 and the core indicators).

Proposed insertion: “Member States shall disaggregate health data by disability within Indigenous populations, reporting across the full range of functional difficulty rather than a single cut-point and governed by Indigenous data sovereignty; the short set shall be used for disaggregation, not as a measure of prevalence, for which fuller instruments such as WHO’s Model Disability Survey and Indigenous-defined measures shall be used; and WHO’s core indicator set shall include indicators on Indigenous persons with disabilities.”

Suggested offsetting cut. Paragraph 43’s general description of weak information systems can be shortened, as the operative obligation sits in paragraph 44.

Ongoing engagement

Beyond this submission, TAMA welcomes continued engagement through the Plan’s revision, costing and implementation, and offers the perspective of tāngata whaikaha Māori to WHO’s monitoring and accountability phases as the Plan moves toward the Executive Board and World Health Assembly.

Summary of recommendations

Reference	Section or action domain	Recommendation
Para 20	Guiding principle: disability inclusivity	Convert the descriptive framing into a binding obligation. Replace the wording that approaches mean policies should act, with an active duty on Member States and other actors.
General	Ambition of the Plan	Name transformational change as the goal. Progressive, incremental realisation is inadequate to the scale of inequity facing Indigenous persons with disabilities.
Background / principles	UNDRIP and CRPD intersection	Cite the CRPD alongside UNDRIP and name the intersectional gap. Neither instrument operationalises the rights of Indigenous persons with disabilities.
New action	Operational actions for the group	Add explicit, resourced actions for Indigenous persons with disabilities, co-designed with their representative organisations, threaded through Priorities 1, 2, 4 and 5.
Para 5, 19	Health system as determinant	Recognise that health system failure generates and entrenches impairment, and that health is an upstream determinant of social wellbeing, not only a downstream outcome.
Para 22, 28	Life course / continuum of care	Add habilitation (CRPD Article 26), distinct from prevention and rehabilitation, to the life course approach and the continuum of care.
Section 1.7	Ethical co-design	Qualify co-design and co-production as ethical co-design: reflexive, reciprocal, power-sharing, resourced and accountable, not extractive or tokenistic.
Action domain 1.1	Indigenous leadership	Indigenous leadership must explicitly include disabled Indigenous leaders. Apply the principle nothing about us without us across all priorities, not only research.
Priority 2	Choice of Indigenous-led services	Secure a genuine, resourced choice of Indigenous-led services (the principle of options), so disabled Indigenous people are not disadvantaged by choosing their own.
Priority 2	Communication accessibility	Extend linguistic accessibility to Indigenous sign languages and interpreters fluent in Indigenous spoken and signed languages, plus accessible formats.
Priority 2	Children, youth and mental health	Early identification, habilitation, inclusive education and culturally safe mental health support for disabled Indigenous children and youth; reflect UNCROC alongside the CRPD and UNDRIP; recognise Māori as a young population; address gaps such as FASD.
Priority 3	Mātauranga Whaikaha Māori	Recognise Mātauranga Whaikaha Māori, the distinct ways disabled Māori know, are and experience the world that shape health, as a knowledge system

Reference	Section or action domain	Recommendation
		informing services, healing and research.
Priority 3	Build on models that work	Point to Indigenous-led, self-determined models (for example Whānau Ora and Enabling Good Lives) as exemplars of holistic design that improves outcomes when resourced.
Action domain 4.1	Environmental protection	Go beyond stewardship to Indigenous-led legal protection of the environment (for example Te Awa Tupua), and name individual and community resilience as a health outcome.
Action domain 4.3	System-generated harm	Recognise the historical and continuing harms of health and disability systems to Indigenous persons with disabilities (institutionalisation, seclusion, coercive care), and provide redress and safeguards.
Action domain 4.4	Intersectional subpopulations	Extend beyond women and girls to disabled, takatāpui and LGBTQI+ Indigenous people; treat intersectionality as compounding disadvantage with named root causes (colonialism, racism, ableism), not a single population category.
Action domain 5.2	Tāngata whaikaha data sovereignty	Indigenous data sovereignty must extend to disabled Indigenous peoples; tāngata whaikaha Māori should exercise ownership, control, access and possession of data about us, through our representative organisations.
Action domain 5.3	Disaggregation	Require disaggregation by disability within Indigenous populations using the Washington Group Short Set, reported across the full range of difficulty not only the narrowest cut-point, with Indigenous data sovereignty safeguards (action domain 5.2).
Action domain 5.4	Core indicators and WHO platforms	Make the Plan's core indicators disability-disaggregated and inclusive of Indigenous persons with disabilities, and include them in WHO engagement, monitoring and accountability.
Section 3	Enforcement and domestication	Ratification is not enforcement. Call on Member States to give domestic legal effect to the CRPD and UNDRIP; in dualist systems neither is enforceable unless incorporated.
Section 3	Accountability gap	Require Member States to act on what their own inquiries and treaty-body reviews already establish, with enforceable, independently monitored accountability. Documented but unimplemented commitments are not accountability.

References

1. World Health Assembly (2023). Resolution WHA76.16, The Health of Indigenous Peoples. apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R16-en.pdf
2. United Nations (2007). United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), in particular Articles 3, 21, 22, 23 and 24. un.org/development/desa/indigenouspeoples
3. United Nations (2006). Convention on the Rights of Persons with Disabilities (CRPD), in particular Article 26 (Habilitation and rehabilitation) and preambular paragraph (p). un.org/development/desa/disabilities
4. Te Awa Tupua (Whanganui River Claims Settlement) Act 2017 (New Zealand). legislation.govt.nz/act/public/2017/0007
5. Washington Group on Disability Statistics. Short Set on Functioning (WG-SS). washingtongroup-disability.com
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Glossary

This glossary is provided for an international health audience. It explains the te reo Māori terms and the disability and rights terms used in this submission.

Te reo Māori terms

Term	Meaning
Aotearoa	New Zealand.
Māori	The Indigenous people of Aotearoa New Zealand.
Tāngata whaikaha Māori	Māori with lived experience of disability. Whaikaha connotes strength and capability; it is a strengths-based term for disabled people.
Mātauranga Whaikaha Māori	The distinct knowledge, and ways of knowing, being and experiencing the world, held by disabled Māori. Mātauranga means a knowledge system.
Whānau	Extended family, the basic collective unit of Māori society.
Iwi	A tribe or nation. Pan-iwi means across all iwi.
Te Tiriti o Waitangi	The Treaty of Waitangi (1840), the founding agreement between Māori and the Crown.
Taumata	A leadership council or assembly. The National Taumata is TAMA's national leadership council.
Rōpū	A group or organisation.
Pou	A pillar or post; in TAMA, a leadership role or structure. TAMA spans 15 Pou.
Rongoā	Traditional Māori healing and medicine.
Takatāpui	A Māori term encompassing diverse genders and sexualities, broadly Māori who are LGBTQI+.
Te Awa Tupua	The Whanganui River, recognised in New Zealand law as a legal person with its own rights.

Other terms and abbreviations

Term	Meaning
CRPD	United Nations Convention on the Rights of Persons with Disabilities (2006), a binding human rights treaty.
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples (2007).
UNCROC (CRC)	United Nations Convention on the Rights of the Child (1989), relevant to disabled Indigenous children alongside the CRPD and UNDRIP.
General Comment No. 7	CRPD Committee guidance (2018) on the participation of persons with disabilities through their representative organisations.
DPO (or OPD)	Disabled People's Organisation; an organisation led and governed by disabled people.
Habilitation	Support to help people with congenital or early-acquired impairment attain function and independence; distinct from rehabilitation, which restores lost function (CRPD Article 26).
Social model of disability	The understanding that people are disabled by societal and environmental barriers, not by impairment alone.
Reasonable accommodation	Necessary and appropriate adjustments enabling persons with disabilities to enjoy their rights on an equal basis (CRPD Article 2).
Amenable mortality	Deaths that could be avoided through timely and effective health care.
Washington Group Short Set	A standard set of questions on functional difficulty, designed to disaggregate outcomes by disability rather than to measure disability prevalence.
Model Disability Survey	A WHO survey instrument, based on the ICF, that measures disability as a continuum and is suited to prevalence and lived experience, unlike the Washington Group short set, which is for disaggregation.
Indigenous data sovereignty	The right of Indigenous peoples to govern the collection, ownership, access and use of data about them.
Intersectionality	The compounding of disadvantage where several forms of discrimination meet, for example indigeneity and disability.
Dualism and domestication	In a dualist legal system an international treaty binds the State internationally, but is enforceable in domestic courts only once incorporated, or domesticated, into national law.
Free, Prior and Informed Consent	The right of Indigenous peoples to give or withhold consent to measures affecting them.
Nothing about us without us	The principle that decisions affecting a group must be made with that group.
Ethical co-design	Co-design that is reflexive, reciprocal, power-sharing, adequately resourced and accountable, rather than extractive or tokenistic.

Term	Meaning
YLL	Years of life lost to premature death.
GBD	The Global Burden of Disease study.