



NEWSLETTER

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a voice for women's health



The Health Risks of Vaping

We've let the genie out of the bottle!



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New Evidence on the

HARMS OF VAPING



By Sue Claridge

Once viewed as an ideal tool to help smokers quit, vaping, which on current evidence is undeniably safer than smoking tobacco, is without a doubt harmful in its own right. Two recent studies have confirmed that cancer is highly likely to be one of the long-term harms from vaping.

Auckland Women's Health Council has always been strongly in favour of vaping as a tool to help tobacco smokers quit. However, in recent years mounting evidence that vapes are not harmless has given us reason to oppose the widespread availability of vapes for never-smokers, while still supporting their use as a means to reduce the number of tobacco smokers. We continue to staunchly advocate for a future smokefree Aotearoa New Zealand.

Electronic cigarettes, or vaping devices, have been widely marketed as a safer alternative to traditional tobacco smoking. Their rapid uptake, particularly among young people, has sparked intense public health debate both in Aotearoa New Zealand and overseas. While vaping eliminates combustion, which is responsible for many of the toxic by-products in cigarette smoke, vaping is a far from harmless habit. Vaping aerosols contain a complex mixture

Key Messages

- Smoking is dangerous and contributes to numerous health issues including cancer.
- If you don't smoke, don't start!
- Vaping is safer than smoking tobacco, but it's relative.
- Vaping causes significant harms to health, including probably being carcinogenic.
- If you smoke and want to give up, vaping can be helpful and is safer than smoking tobacco.
- But if you don't vape and don't smoke, don't start vaping.
- If you do vape for reasons other than to give up smoking tobacco — stop!
- The current Government has failed to take the opportunity to protect never-smokers in Aotearoa New Zealand from the harms of vaping.

of chemicals, including nicotine, flavouring agents, solvents such as propylene glycol and glycerin, and a range of potentially toxic and carcinogenic compounds formed during heating.

The harm to health from vaping has largely been ignored by legislators and regulators in Aotearoa New Zealand.

Not only has the current Government undermined efforts to create a smokefree New Zealand with the repeal of parts of the [SmokeFree Environments and Regulated Products Act 1990](#), they have failed to take the opportunity to protect New Zealanders from the harms of vaping with the 2025 amendment of that Act.

In our December 2024 *Newsletter*¹ we reviewed the harms of vaping as they were understood then, following [our submission on the Smokefree Environments and Regulated Products Amendment Bill \(No 2\)](#).

The harms of vaping are increasingly well documented^{2,3} including:⁴

- addiction;
- intentional and unintentional poisoning;
- acute nicotine toxicity, including seizures;
- burns and injuries;
- respiratory irritation, airway inflammation, and impaired immune response in the lungs;
- cardiovascular effects such as increased heart rate and blood pressure; and
- adverse impacts on adolescent brain development and function.

Cases of e-cigarette or vaping-associated lung injury (EVALI) have demonstrated that, under certain conditions, vaping can cause severe acute lung damage.⁵

However, it is the growing evidence of the long-term risk of cancer that really should be ringing massive alarm bells among policy makers, legislators and regulators.

Cancer risk from vaping is inherently more difficult to study than other harms, because cancers often take decades to develop. As a result, much of the current evidence comes from laboratory studies, animal models, chemical analyses, and epidemiological inference rather than long-term human data. Despite a lack of direct evidence that vaping will cause cancer, we need to be taking a precautionary approach. It could be catastrophic to do, as we did with tobacco smoking, and wait decades to take action to restrict use of vapes, risking

hundreds or perhaps thousands of cases of cancer 15 or more years into our future.

The Recent Australian and New Zealand Research

Two recent medical papers, written by Australian and New Zealand research groups, provide important insights into the carcinogenic risk of vaping.

The Carcinogenesis Paper

Professor Bernard Stewart of the University of New South Wales, and his colleagues from various other Australian universities and hospitals, examined the evidence from different scientific perspectives.⁶

Their study, published in the journal *Carcinogenesis*,⁷ examined the biological effects of e-cigarette vapor on cellular systems. The researchers focused on biomarkers associated with cancer risk, including DNA damage, oxidative stress, and gene expression changes.

The study found that exposure to vape aerosols led to measurable increases in DNA damage markers in human cell lines. Notably, the degree of damage varied depending on the composition of the vape liquid, with certain flavourings and higher temperatures producing more harmful by-products. The authors also reported disruptions in pathways involved in cell cycle regulation and DNA repair, both of which are critical in preventing malignant transformation.

“Biomarkers [...] indicate vaping-attributable oxidative stress, epigenetic change and inflammation in oral and respiratory tissue often specified in comparison with smoking.”⁷

Importantly, while the effects observed were generally less severe than those associated with cigarette smoke, they were significant. The study concluded that vaping is not biologically inert and may contribute to cancer development through cumulative cellular damage over time.

This research highlights a key point: reduced harm compared to smoking does not mean negligible risk. Even relatively lower levels of carcinogenic exposure can translate into meaningful health risks when exposure is chronic.

“Considering all the findings — from clinical monitoring, animal studies and mechanistic data — e-cigarettes are likely to cause lung cancer and oral cancer,” said Prof. Stewart in an UNSW article.⁶

He said “the clearest and almost definitive evidence” of the link between cancer and vaping was a study

that showed the development of lung cancer in mice exposed to e-cigarette aerosols.⁸

The researchers emphasised that, while switching from smoking to vaping may reduce cancer risk, initiating nicotine use through vaping among non-smokers, introduces avoidable exposure to carcinogens.

The New Zealand Medical Journal Paper

Concomitant with the Australian study, researchers from the University of Canterbury, led by toxicologist Professor Ian Shaw, were undertaking their own comprehensive review of the available chemical, toxicological, and epidemiological evidence of the cancer risk from vaping.

The researchers wrote that, “[s]ince it will be many years before an epidemiological study on the carcinogenic risk of vaping can be carried out [...] we combine what is known about the chemistry of vape liquid components under vaping conditions with published animal and *in vitro* studies to predict the carcinogenic risk of vaping.”⁹

Shaw *et al.* concluded that vape aerosols contain multiple known carcinogens, though typically at lower concentrations than cigarette smoke.⁹

In the discussion about the relative benefits of vaping as a means to stop smoking tobacco, they acknowledge an important point — the uptake of vaping among young never smokers as a trendy alternative to smoking.

“This means that the risk-benefit profile changed considerably because the benefit of smoking cessation was no longer part of the risk-benefit equation,” the researchers wrote.

The review highlighted uncertainties, particularly the lack of long-term epidemiological data. However, it argued that existing evidence is sufficient to raise concern, especially given the widespread use of vaping products among youth, concluding that their “risk assessment supports the use of vaping for smoking cessation because the overall cancer risk is lower than for smoking, but does not exonerate vaping in its own right because taking up the habit introduces a new vaping-associated cancer risk.”⁹

The authors stressed that public health messaging should avoid framing vaping as “safe,” instead describing it as “less harmful than smoking but still risky.”

In an interview with *Radio New Zealand*,¹⁰ Prof Ian Shaw said it was impossible to definitively conclude that vaping caused cancer without actual data of

people who had contracted the disease, but with an important caveat:

“It takes at least 15 years for cancers to develop after exposure to cancer-causing chemicals. I don’t want us to be waiting those 15 years to get some data to say that vape smoking does or does not cause cancer.”¹⁰

Not unexpectedly, the Vaping Industry Association of New Zealand (VIANZ) argued against the evidence that vaping could cause cancer, saying the studies did not include human outcomes studies, and there was only a “theoretical” risk assessment.¹⁰

Jonnathan Devery, chairperson of VIANZ, criticised the study, saying that it conflated theoretical hazard with real-world risk¹⁰ — but then he would say that; members of VIANZ make a living from selling vape products, to more than half a million New Zealanders who vape on a daily basis.

Dual use — where people both vape and smoke, as seen in Aotearoa New Zealand vaping prevalence and trends¹¹ — may negate much of the potential benefit of vaping, maintaining high levels of exposure to carcinogens.

From a public health perspective, the implications are clear. Vaping should not be considered safe, particularly for non-smokers and young people. At the same time, it may play a role in harm reduction for smokers who switch completely from cigarettes.



Young wāhine Māori have some of the highest rates of vaping: 25.2% of 14-15 year old wāhine Māori vape daily.¹¹

Adult Vaping Stats for Aotearoa New Zealand¹¹

Adult daily vaping increased significantly from 3.5% in 2019/20 to 11.7% in 2024/25. An estimated 509,000 people were vaping daily in 2024/25.

In 2024/25 5.5% of New Zealanders over the age of 15 smoked tobacco daily, 10.3% vaped daily and 1.4% both smoked and vaped daily.

Since 2017/18, smokers have dropped from 12.1% of the adult population, while daily vapers have increased from 1.4%. The total percentage of adults vaping and/or smoking has increased by 2.4% since 2017/18 from 14.7 to 17.1%. The absolute increase in daily vaping prevalence has been substantially greater than the decrease in daily smoking.

Vaping prevalence was highest among younger age groups. In 2024/25 daily vaping prevalence was 23.0% among 18-24 year-olds, 20.5% among 25-34 year-olds and 13.6% among 15-17 year-olds. In 2024/25 138,000 15-24 year-olds vaped daily, over a quarter of all people who vaped daily.

In the 15-24 year age group, daily smoking has decreased from 11.7% to 2.3% since 2017/18, while daily vaping has increased from 1.8% to 19.2%.

There are significant ethnicity differences in prevalence: Māori have the highest prevalence of daily vaping at 27.5%, Pasifika people at 20%, European and other at 11.5%, and Asian at 5.6%. When data were adjusted for age and gender, Māori were over 2.5 times more likely to vape daily than non-Māori,

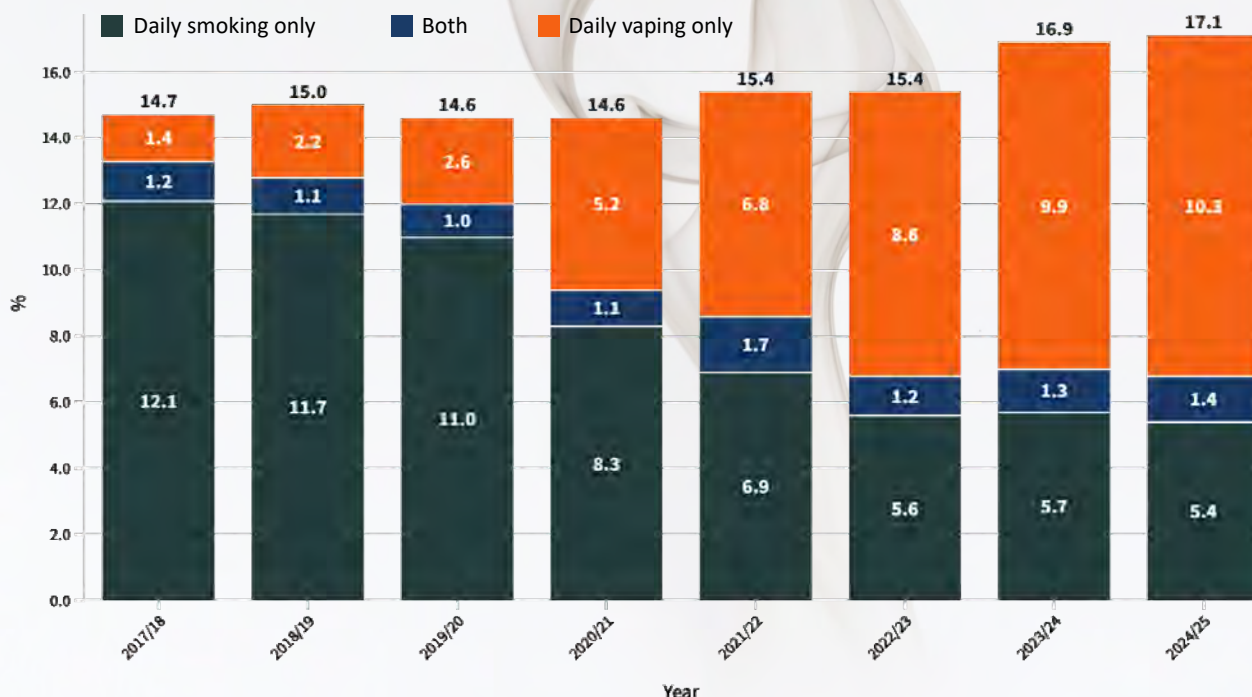
and Pasifika people were almost one and a half times more likely to vape daily than non-Pasifika people.

The prevalence of smoking or vaping, or both, daily was 38.8% among Māori and 28.1% among Pasifika people, significantly higher than among non-Māori and non-Pasifika adults. Although daily smoking prevalence has fallen among Māori, prevalence of smoking or vaping daily (or both) has increased owing to the substantial increase in daily vaping.

Vaping is highest in people living in the most deprived neighbourhoods (21.1%) compared with the least deprived (7.2%), and the increase in vaping between 2015/16 and 2024/25 is significantly higher in the most deprived quintile compared with all other quintiles.

There are “strong disparities by both area-level deprivation and ethnicity” with considerably more vape retailers concentrated in the more deprived neighbourhoods and in places that have the highest proportion of Māori, Pasifika and Asian people.¹²

The vaping prevalence survey¹¹ concluded that uptake among adolescents and people who have never smoked poses risks to physical and mental well-being. The authors also point out that full transition from smoking to vaping is required to reduce the health risk and that dual use of both tobacco and vapes may be as harmful, or even more harmful than smoking alone.



Daily vaping or daily smoking (or both) among adults over the age of 15 in Aotearoa New Zealand.¹¹

Letting the Genie Out of The Bottle

History has shown that once you “let the genie out of the bottle” it is difficult to get him back in. Notwithstanding the aggressive lobbying of the tobacco industry, if we had known 100 years or more ago, about the widespread and devastating harm that smoking tobacco would have on human health, we may have had more stringent anti-smoking laws far sooner. As it is, we are still dealing with the almost impossible task of reducing smoking of tobacco products to zero in this country, decades after it became patently obvious that the habit causes significant harm to smokers and those around them. Of course, politics and the commercial and lobbying power of the tobacco industry has constantly undermined efforts to make Aotearoa New Zealand smoke free.

We have no doubt that vaping has an important part to play in assisting smokers to quit tobacco products, and we have no opposition to the use of vapes for this purpose.

What has become absolutely undeniable is that, while vaping is safer than smoking tobacco, it *is not* harmless! In fact, an increasing body of research evidence has shown that it carries significant risk to health, albeit less than that of smoking tobacco.



Putting the Vape Genie Back Where it Belongs

Vaping should not and should never have been made commercially available in such a way that never-smokers, predominantly younger people, would take it up as a “lifestyle habit”. We now have a whole new generation of people who have taken up a harmful habit in the misguided belief that it was safe.

We have argued, as have other individuals and organisations concerned about the uptake of vaping among never-smokers, that vapes should not be available except as a tool to help tobacco smokers quit.

There should be no retail availability of vaping products at all, and they should only be accessible

to tobacco smokers trying to quit. Retailers of vaping products are necessarily driven by a profit model that is predicated on increasing sales, and therefore, increasing both the number of customers and the number of vape products each customer purchases. This is in direct opposition to the concept of reducing tobacco smoking rates and providing the practical tools and support to existing smokers to quit smoking.

We believe that the only valid option for the supply of vape products is through pharmacies to tobacco smokers legitimately trying to quit. Retailing of vape products must be prohibited and vape products must only be available through controlled outlets (in the way that methadone is for opioid addicts) that are not driven by the profit model for the sales of such products.

Unfortunately, our current Government has pandered to the tobacco industry, whose sole purpose is the manufacture and sale of harmful tobacco products for profit, and who have turned to manufacturing and selling vape products to make up for lost revenue from declining sales of smoked tobacco products.

We can only hope that the two recent studies showing the risk of cancer from vaping is sufficient for this Government or the next, to overturn the current

legislation that allows the commercial sales of vapes for recreational vaping. The Government needs to show some backbone and put the health of New Zealanders first.

It is long past time we put the genie back in the bottle.

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STOP PRESS

PCOS Has Been Renamed PMOS!

Wednesday 13 May 2026

Polyendocrine Metabolic Ovarian Syndrome (PMOS) is the new name for the condition previously known as Polycystic Ovary Syndrome (PCOS), which impacts 1 in 8, or more than 170 million women worldwide.

The [Royal Australia New Zealand College of Obstetricians and Gynaecologists](#) issued a statement about the name change saying:

“The term polycystic ovarian syndrome was coined in 1935, reflecting the originally limited understanding of the condition as solely affecting the ovaries. Subsequent research has highlighted the wide-ranging features of the condition — endocrine, reproductive, cardiometabolic, hormonal, psychological, and more. [...] early assumptions have persisted through the misleading name, causing many patients to begin their healthcare journey alarmed or confused, believing they must require surgical intervention for multiple large ovarian cysts. In fact, recent studies have shown that people with PMOS do not have a higher rate of abnormal ovarian cysts than those without the condition. This misunderstanding can dominate early consultations and delay more constructive conversations about symptoms, treatment, and long-term management.”

Auckland Women's Health Council is pleased that the change from PCOS to PMOS has been adopted. Polyendocrine Metabolic Ovarian Syndrome is a

far more holistic description of the condition. The name change should improve health professionals' understanding of the condition. This is particularly important for GPs, as they are usually the first health practitioner that women seek help from. Years of research showed that the term PCOS was confusing and in many cases harmful to women, and potentially hampered diagnosis.

The name change should reduce diagnostic delays because it better describes/encompasses the wide range of symptoms that women with PMOS experience, rather than just focusing on the ovaries. Because there will be a better understanding of the condition, that will hopefully lead to faster diagnosis and better care, in large part because the new name acknowledges the variety of symptoms women experience.

Over time and as the new name is adopted and better understood, women/wāhine with PMOS will likely have better experiences when they seek healthcare, improved and more holistic treatments addressing all the symptoms they experience, and better quality of life.

We are really pleased for the women/wāhine of Aotearoa New Zealand that the name has changed and hope that their lived experience of PMOS, and its impact on their lives, is more widely acknowledged and validated, and they receive better care as a result.

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Auckland Women's Health Council Annual Report

This article has been taken from the 2025 Annual Report presented at the Auckland Women's Health Council Annual General Meeting on the 26th of March 2026. The entire report can be [viewed on our website](#).

Reflecting on 2025

The year has been marked by stress, constraint and, at times, a sense of despair within Aotearoa New Zealand's health system. Structural reform, funding constraints, workforce shortages, and increasing pressure on services, combined to create an environment in which access to timely, affordable and equitable care became increasingly uncertain. The gap between what is promised and the lived experienced has grown more visible.

Within this shifting landscape, the Auckland Women's Health Council continued its work as an independent voice for women's health, grounded in evidence, shaped by advocacy, and guided by a commitment to equity – particularly where inequities persist and deepen.

Public reporting throughout the year has pointed to a system under sustained pressure. Cost-cutting measures have been accompanied by hiring freezes, workforce reductions, and ongoing staff shortages. The effects are tangible: longer waits for specialist care, delays in diagnosis and treatment, and a workforce under increasing strain. These are not isolated issues but part of a broader pattern that speaks of a system struggling to meet demand.

For women, these pressures have not been felt equally. Longstanding inequities remain deeply embedded, particularly for Māori and Pasifika communities. Barriers to access persist, outcomes are poorer, and experiences of institutional racism continue to shape interactions with health services.

These realities are not new, but in a constrained environment, and as acknowledgement and honouring of Te Tiriti o Waitangi is increasingly removed from legislation and regulation, they risk becoming more entrenched rather than addressed.

The Council has consistently drawn attention to these disparities, emphasising that equity must remain central to any meaningful reform.

In 2025, the Council's work, communications and collaborations provided a clear and consistent lens



on these issues. In its submission on proposed amendments to the Pae Ora (Healthy Futures) Act, the Council raised concerns about the direction of legislative change and its implications for equity, transparency, and public accountability. At the heart of this response was a simple but critical position: that a strong, publicly accountable health system must remain grounded in Te Tiriti and actively work to address inequities in health outcomes. This work also reflected the Council's role in ensuring that women's perspectives, including those of wāhine Māori and wāhine Pasifika, are not marginalised.

Our engagement online, especially social media, enabled more immediate and responsive communication, to respond quickly to emerging issues – workforce shortages, service changes, or gaps in care – while also sharing research, lived experiences, and informed commentary. These

spaces have become a way to both reflect and connect, linking individual experiences to wider systemic concerns.

The picture that emerges from 2025 is of a health system at a crossroads. We can only hope our policy makers and decision makers will set us on the right path towards a patient-centred health system that will ultimately work towards health and well-being for all New Zealanders.

In this context, independent, evidence-based advocacy matters. It creates space for scrutiny and lived experience, and for uncomfortable truths to be named. We continue our work with clarity and purpose. By documenting pressures, challenging inequities, and advocating for structural change, together with other individuals and organisations, we have helped ensure that women's health remains on the agenda.

This 2025 annual report reflects that work. As we approach our 38th anniversary the task is clear: to contribute to making our health system equitable, accessible, responsive, culturally safe, affordable and accountable to all women in Aotearoa New Zealand.

Our Work

Our core work remains communication with New Zealanders on issues central to women's health through:

- our *Newsletter*;
- submissions on consultations;
- the website; and
- social media.

Collaborations and connections with other organisations within the health sector are increasingly important as we all strive to improve the public health system for all New Zealanders. We are all pulling in the same direction, fighting for the same things: safe, accessible, effective, evidence-based, equitable health care that enables New Zealanders to live their best, healthiest lives, albeit our main focus is on the women/wāhine of Tāmaki Makaurau.

During 2025, a significant piece of work was ensuring that the

Council was compliant with new requirements under changes to the Charities Act 2005 and the new Incorporated Societies Act 2022. This work was spearheaded by a Legislation and Governance sub-Committee, and we are pleased to report that as of the 27th of March we have completed all the necessary work and re-registered as an Incorporated Society. Although we still have some work to do reviewing our governance, policies and procedures, the bulk of this important work to secure the future of the Council as a charitable entity, has come to an end. As a Committee, we look forward to returning our focus to main goal of providing an independent feminist voice focused on women's/ family health and health services in Tāmaki Makaurau.

Unfortunately, since 2020, the Council has received considerably less funding than in the previous five years; in 2025 it was approximately half the funding we received prior to Covid. We understand the economic and social factors that have contributed to a greater number of worthy organisations competing for limited funds, and we are immensely grateful to our main funders – COGS and Lottery Community Auckland Committee – and our individual donors. However, the decreased funding has impacted on how much we can achieve for the women/wāhine of Tāmaki Makaurau | Auckland. The health landscape in Aotearoa New Zealand remains difficult and our health system and workforce is under strain. This environment makes it even more critical for independent, patient-centred, consumer advocacy to stay strong, vocal, and visible, to ensure all women/wāhine have accessible, equitable, affordable, available, accountable and culturally appropriate health care services.

In an effort to maintain the same output, Executive Committee members have had to take on more voluntary work, contributing in the vicinity of 700 voluntary hours to the Council during 2025, in addition to the paid work of our Communications Manager.

We will be looking at other potential sources of funding in the coming year in an effort to increase funding levels to ensure that we can continue to



provide the advocacy, evidence-based independent information and support to women that we have been known for, for almost 38 years.

Looking Forward

More than a quarter of the way through the 21st century, it is hard not to wonder where the women's health activism of the late 20th century has gone. This activism led to the Cartwright Inquiry into unethical research on women at National Women's Hospital, that in turn led to the establishment of the National Cervical Screening Programme and the Health and Disability Commissioner, and the implementation of the Code of Health and Disability Services Consumers' Rights.

A number of factors (including the cost-of-living crisis, long-term underfunding of the health workforce, and international health workforce shortages) have coalesced to impose the greatest stresses on our health system for decades. Our health system is in crisis and our health workforce is under significant stress; never has the ability of people to take responsibility for their own health and well-being been so important. The Aucklanders who face the greatest barriers to both accessing health services and positive health outcomes — including women, particularly wāhine Māori and Pāsifika, those from migrant and refugee communities, and those living with disabilities — need help and support to navigate the health system, to access evidence-based information on health-care services, and to understand their rights as patients and health consumers.

We know from our discussions and work with our allies and collaborators, that there is no lack of concern for what is happening in our health system. There is no lack of passionate, dedicated New Zealanders working incredibly hard in underpaid or voluntary positions to effect change and create a functional health system that places health consumers at the centre. In this we include very many members of the health workforce, doctors and nurses who are so overworked and burnt out

that they feel they have no option but to take strike action, to ensure that their very real concerns about the well-being and safety of New Zealanders in our health system are heeded by those with the power to make better, fairer, more equitable decisions.

The global stresses that we all face as we write this annual report — the state of the world, the standing and place of our nation in that global environment — can all too easily lead to a sense of powerlessness. It can all too easily lead us to acquiesce to the sometimes overwhelming need to hunker down and ensure the safety and security of our own families, rather than put energy into fighting for a better system for all.

The Auckland Women's Health Council was founded almost 38 years ago, in the aftermath of devastating revelations about the harm to women in one of our hospitals. While there have been changes and improvements since then, in recent years there has been a sense of going backwards in healthcare; that we are falling behind other developed nations. We cannot overstate the importance of standing up and using our voices for the women/wāhine of Aotearoa New Zealand; the importance of having influence and exercising it wherever and whenever we can. We understand that we can't change the world overnight, or even just our small corner of the world. But we must take power and energy from every time we make a difference in any woman's life. We must join together with others who are also working for better outcomes, to achieve affordable, accessible, safe and best-practice health care.

Continued advocacy for the right to provide informed consent to health and disability services, for better health outcomes for women, for greater engagement in health care issues, and greater participation of women in setting policy, sees slow, incremental changes. While there is still work to be done for the women/wāhine of Aotearoa New Zealand and their health and well-being, we plan to be there and be part of that work.

This is how we will make a difference — not by waiting for, but by insisting on change.

We remain a voice for women's health.

Possible Relief from Endometriosis Pain

By Sue Claridge

Recent research has offered hope to the one in ten women that suffer endometriosis in Aotearoa New Zealand. A University of Otago study, published in April this year, has found that the use of medicinal cannabis has benefits for some New Zealanders suffering the severe pain of endometriosis. Participants in the research experienced reduced levels of pain and improvements in quality of life, including improved sleep and reduced anxiety about their health, during the three-month study in which some were prescribed CBD* oil and other were prescribed CBD oil and cannabis flower.

“Endometriosis is a chronic, inflammatory disease where tissue similar to the uterine endometrium grows outside the uterus, leading to cyclical or consistent pain, inflammation, and, commonly, infertility.”¹ Women in Aotearoa New Zealand face a one in 10 chance of developing the disease, which is characterised by severe and at times disabling pain, among other symptoms.¹

Reporting on a prospective cohort study, researchers from Aotearoa New Zealand and Australian wrote that women report low satisfaction with current medical treatment and management of endometriosis. These approaches include hormonal medications, laparoscopic surgery, and analgesics (frequently opioids), which lead to a high rate of side-effects and discontinuation of treatment.²

More effective and non-addictive treatments are a research priority for endometriosis,² and research has shown that the endocannabinoid system (ECS)

has a significant potential role in treating endometriosis,^{3, 4} particularly for managing pain and inhibiting the growth of lesions. Previous studies have indicated that dysregulation of the ECS is involved in the development, progression, and pain mechanisms of the disease.³ A 2024, study found CBD to be a “promising therapeutic agent for endometriosis because it has analgesic, anti-

The Endocannabinoid System

The endocannabinoid system (ECS) is a complex cell-signalling system found throughout the human body, which helps regulate many physiological processes, including mood, pain, appetite, sleep, memory, immune response, and stress.⁶ It was only formally identified in the 1980s and 1990s during research into cannabis and its active compounds,² and it is now recognised as an important biological system involved in maintaining homeostasis — the body’s internal balance. The ECS consists of three main components: endocannabinoids, cannabinoid receptors, and enzymes.²

De Blasio *et al.* write that endocannabinoids — endogenous or naturally occurring cannabinoid molecules produced by the human body — exert important actions in female reproductive organs, including the ovary, oviduct and uterus.⁷ Results from a study undertaken by US researchers “suggests that the endocannabinoid system is involved in both endometriosis and its associated pain.”³

Research indicates that women with endometriosis suffer dysregulation of the ECS that “may contribute to symptom development, lesion proliferation, and disease progression.”²

* Cannabidiol oil, which does not induce the “high” or intoxicating effects associated with cannabis products that contain THC or tetrahydrocannabinol.



inflammatory, immunomodulatory, anti-angiogenic, antiproliferative, and neuroprotective effects.”⁵

Given the extensive role of the ECS in the female reproductive tissue, Dr Claire Henry and her colleagues believe that “cannabis may slow endometriosis progression [...] potentially reducing the need for future surgical interventions, assisted reproductive treatments, and other medical therapies.” They refer to a 2019 survey of 213 New Zealand women with endometriosis who were self-medicating with cannabis, in which respondents reported a variety of symptoms were “much better” as a result:⁸

- pain reduction 81%,
- sleep improvement 79%,
- nausea or vomiting reduction 61%,
- 81.4% reduced use of other medications,
- 59% completely stopped using a medication, most commonly analgesics (66%); opioids (40%) were the most common class of analgesics stopped.⁸

It was with this background, and in the context of the availability of legalised medicinal cannabis in Aotearoa New Zealand, that Dr Henry and her colleagues undertook their research. They make note of the fact that there is concern among GPs regarding efficacy and safety of medicinal cannabis. They state that there is a need for more substantial evidence before “medicinal cannabis is a widely accepted and legitimised treatment in the [New Zealand] medical community.”²

Their small prospective cohort study aimed to determine if “a larger randomised controlled trial would be warranted.”²

Study Results Paint a Hopeful Picture

The findings of the study paint a hopeful and nuanced picture of the benefits of medicinal cannabis for managing endometriosis symptoms.

Predominantly, participants reported meaningful reductions in pelvic pain, with average “overall” pain scores dropping from 5.46 to 3.77 over the course of the study. “Worst pain” scores also declined significantly, falling from 7.62 to 5.38.

The Study

Twenty-eight women over the age of 18 with diagnosed endometriosis, and who were deemed clinically suitable were recruited for the study.² The participants were allowed to continue their usual medical management of endometriosis throughout the study period. They all completed endometriosis health profile questionnaires, and pain score surveys prior to starting medicinal cannabis, and pain score surveys were completed weekly through the study period. Seventeen also completed a post study interview.

- 15 participants were prescribed CBD oil alone;
- 13 participants were prescribed CBD oil and flower (containing low THC);
- age of participants ranged from 18 to 46 years with a mean of 30 years.
- participants identified as New Zealand European, Māori, European or other (including Canadian, Indian and Latin American).

The participants self-engaged with a speciality medical cannabis clinic for assessment and the prescription of medicinal cannabis for the period of the study. Six participants reported minor adverse effects; one of nausea; three of headaches that self-resolved, one of fatigue and one of drowsiness.

Alongside pain relief came dramatic improvements in quality of life. The researchers used the Endometriosis Health Profile-30 (EHP-30), a recognised measure of how endometriosis affects daily living, and found average scores improved from 68.77 at baseline to 37.40 after three months. In practical terms, participants were sleeping better, coping better emotionally, and regaining parts of life that chronic pain had taken away.

What made this study especially powerful for me, and I suspect also for those with endometriosis, was its mixed methods, both qualitative and quantitative data – the science and personal stories.

Rather than relying purely on statistical results, the researchers also interviewed participants about their experiences. Some described medicinal cannabis as “life changing.” Others said it helped them “manage pain” more effectively, while a small number reported little or no benefit.

The range of responses is important because it highlights the reality of endometriosis treatment: even within allopathic or mainstream medicine there is no one-size-fits-all solution.

One of the most compelling themes to emerge from the study was the sheer frustration many participants had experienced with conventional treatments. Many had spent years cycling through an extensive list of hormonal medications, opioids, surgeries, and anti-inflammatory drugs with mixed results and often severe side effects. Participants described feeling “zombified” on tramadol, suffering dramatic weight gain from hormonal treatments, and feeling dismissed by healthcare providers. Several explained that managing endometriosis had become an exhausting process of “trial and error.”

Against that backdrop, medicinal cannabis represented something different – not necessarily a miracle cure, but another tool in their pain management toolkit. Participants using CBD oil frequently reported improvements not only in pain, but also in sleep and anxiety. For many, those secondary benefits were just as transformative as physical pain reduction. One participant described significant improvements in their sleep; another shared that they had secured a job interview after being unable to work for three years due to illness; and another was trying for a baby. Others reported improved emotional wellbeing, describing reduced anxiety and greater resilience in coping with chronic symptoms.

Some participants were able to reduce their use of opioid medications during the study, while others reduced anxiety medications.

Cannabis flower containing THC in addition to CBD oil appeared especially useful during severe pain flare-ups. Several participants described flower as more effective than opioids because it reduced pain while still allowing them to function. One participant explained that unlike tramadol, cannabis allowed them to cook, clean, and continue daily activities rather than becoming immobilised by medication side effects.

However, the research also revealed significant challenges. Cost emerged as the single biggest barrier to accessing medicinal cannabis:

“Every participant identified cost as the main barrier to medicinal cannabis and described it as ‘unattainable’.”

Because medicinal cannabis is generally not subsidised, many patients face substantial out-of-pocket costs. Some participants worried that others with severe symptoms simply could not afford to try treatment at all.

Despite medicinal cannabis being legal, many participants still felt nervous, embarrassed, or judged when seeking treatment. Several described feeling intimidated during their first consultation, worrying they would be viewed as “drug seekers” or “stoners.” However, many participants became comfortable with the cannabis clinic doctors, and found their experience different and, compared with their interactions with other healthcare providers, easier than they thought it would be. Some participants said previous health professionals had dismissed cannabis entirely or refused to discuss it.

Importantly, the researchers were careful not to overstate the findings. This was a relatively small observational study rather than a randomised clinical trial. Participants self-selected into the study, and placebo effects or positive expectations may have influenced outcomes. Not everyone benefited equally, and some participants experienced little change.

Even so, the study represents a major step forward for endometriosis research in Aotearoa New Zealand. It provides real-world insight into how medicinal cannabis may benefit those with endometriosis, and the barriers they face.

The researchers conclude that larger, controlled clinical trials are urgently needed to better understand how medicinal cannabis works for endometriosis pain, which patients may benefit

most, and how treatments can be safely and effectively integrated into long-term care.

Finally, this is an important and very accessible paper for those who suffer from endometriosis to read. It is freely available in the journal [BMC Complementary Medicine and Therapies](#), or on [PubMed Central](#). It is a medical paper, but it is easy to read and the inclusion of quotes from participants provides insight not only into participants experience of medicinal cannabis, but their wider experience of living with endometriosis.

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Medicinal Cannabis in New Zealand

Medicinal cannabis in Aotearoa New Zealand has undergone significant legal and regulatory change over the past decade, the result of which is that medicinal cannabis is far more accessible for health consumers for a range of health conditions. However, many people may experience cost barriers.

Before 2018, access to medicinal cannabis products generally required approval from the Minister of Health, making treatment difficult, expensive, and uncommon. This changed in 2018⁹ when medicinal cannabis products for certain patients were legalised and a pathway for domestic cultivation and manufacturing was established. In April 2020, the Medicinal Cannabis Scheme came into effect,¹⁰ establishing quality standards for cannabis products manufactured or prescribed in New Zealand signalling a major shift from prohibition toward a medically supervised system designed to improve patient access while maintaining pharmaceutical oversight.

Medicinal cannabis is legal in Aotearoa New Zealand when prescribed by a registered medical practitioner.¹¹ There is no official list of qualifying illnesses, meaning physicians can decide whether cannabis-based treatment is clinically appropriate

for an individual patient.¹¹ Products available include cannabis oils, capsules, oral liquids, and dried cannabis flower intended for vaporisation, however smoking cannabis remains illegal, even for medicinal purposes.¹² Access has improved considerably since the scheme began, although affordability remains a challenge because medicinal cannabis products are not subsidised by Pharmac,¹³ and patients may pay hundreds of dollars per month depending on dosage and product type.

There are a number of specialist clinics dedicated to medicinal cannabis, and telehealth consultations have increased access for patients. Nevertheless, barriers remain, including inconsistent doctor willingness to prescribe cannabis products, limited clinical evidence for some conditions, and ongoing stigma associated with cannabis use.



Celebrating Our Wāhine Toa: Ruby Smith



1 tekarere

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Still from Ruby Smith's appearance on [Te Karere](#)

Not all our wāhine toa receive awards and accolades. Not all are “the best” or “the first” or publish medical papers, or dedicate decades of their working lives to improving the health of women in Aotearoa New Zealand.

Sometimes the bravery, strength and contribution of our wāhine toa come about in the darkest days, the times when turning inwards and away from the limelight would be the more obvious and easier path to take. Sometimes the contribution of our wāhine toa is found in what seem to be small gestures, until you learn the whole story and you understand the strength and bravery those gestures took to make.

Ruby Smith was only 32, when she was diagnosed with stage 3 mucinous ovarian cancer just six weeks after the birth of her third child. Devastatingly for her, her whānau and for her community, Ruby died on Waitangi Day this year, less than three years after her diagnosis.

During that time Ruby had two surgeries, chemotherapy and the immunotherapy drug bevacizumab, or Avastin, for which she had to pay \$30,000 as Avastin is not funded in Aotearoa New Zealand for mucinous ovarian cancer. She also travelled to Japan for a cell-based immune therapy, with support from fundraisers in her community, and a Givealittle page.

All through this, Ruby and her husband maintained a busy life with their three children. But instead of just

focussing on her health and her family, and making as much of her time with them as possible*, Ruby set about making a difference for other women/wāhine.

Despite how hard it was for her dealing with the daily pain and surgically induced menopause, Ruby shared her story in many different places. She was determined to raise awareness of a disease that many know little about and that is often diagnosed when it has already spread and metastasised.

Her story in her own words is on the [Ovarian Cancer Foundation New Zealand \(OCFNZ\) website](#), where she also gives heart felt advice to women, saying:

“To anyone experiencing symptoms of ovarian cancer or for anyone worried about their health: please, trust your gut. If something feels wrong, keep asking questions until you get the right answers. I wish I had pushed harder or gotten a second opinion sooner — maybe then my story would be a bit different.”

Ruby’s journey and her advocacy featured in the *Northern Advocate*, *Stuff* and the *New Zealand Herald* several times, as well as on social media.

In 2024, she ran the Kerikeri half marathon to raise funds for OCFNZ so it could continue to support people like her and to raise awareness of the disease.

* mucinous ovarian cancer has a five-year survival rate of just 25%.

Then, in May 2025, on World Ovarian Cancer Day, Ruby donated a song she wrote and performed — [Dig Deeper](#) — to OCFNZ. She describes it as a gift of strength, sisterhood and support, saying:

“When I was diagnosed with cancer, music became my medicine. Dig Deeper was born in the hardest moments, not just for me — but for every woman fighting, every family supporting, and every quiet hero holding it together. This song is my gift to the Ovarian Cancer Foundation, and to everyone who needs a reminder that even in our darkest moments, we still have light to give.”

It’s for the fighters.

It’s for the friends who never left.

It’s for the ones who dig deeper—when it would be easier to give up.

Watch it. Share it. Feel it. Together, we raise awareness. Together, we honour the journey.

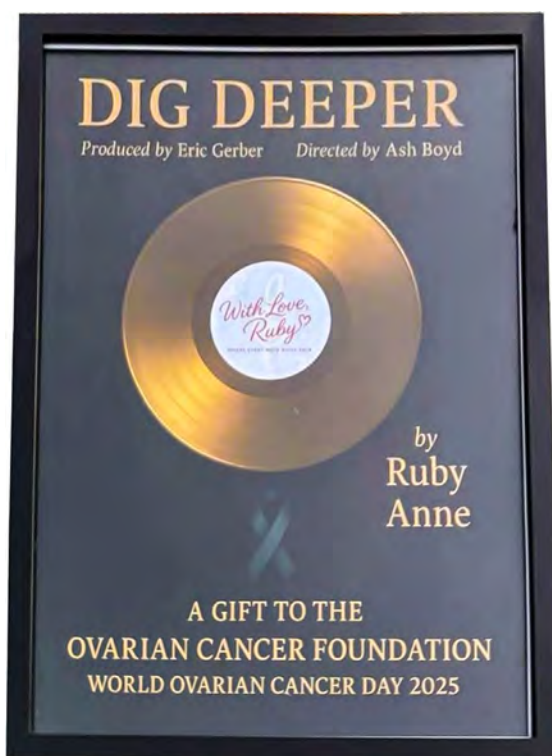
With love, Ruby

In June 2025, [Ruby spoke on Te Karere](#), sharing her experience of being diagnosed, advocating for better health care and for GPs to take women/wāhine more seriously when they present with symptoms, reflecting on her own experience of being told she had a cyst not ovarian cancer because she was too young.

On each occasion in the public eye, Ruby calmly advocated for better funding, better healthcare, greater awareness, and better and more accessible treatment. She also urged women/wāhine to advocate for themselves, to demand answers, to not allow themselves to be fobbed off by doctors.

Her final gift to OCFNZ was to be the face of their [State of Ovarian Cancer Report Aotearoa New Zealand | He kōrero mo te ahuatanga o te mate pukupuku kākano-ā-kopu ki Aotearoa](#), launched at Parliament on the 11th of February only five days after her death.

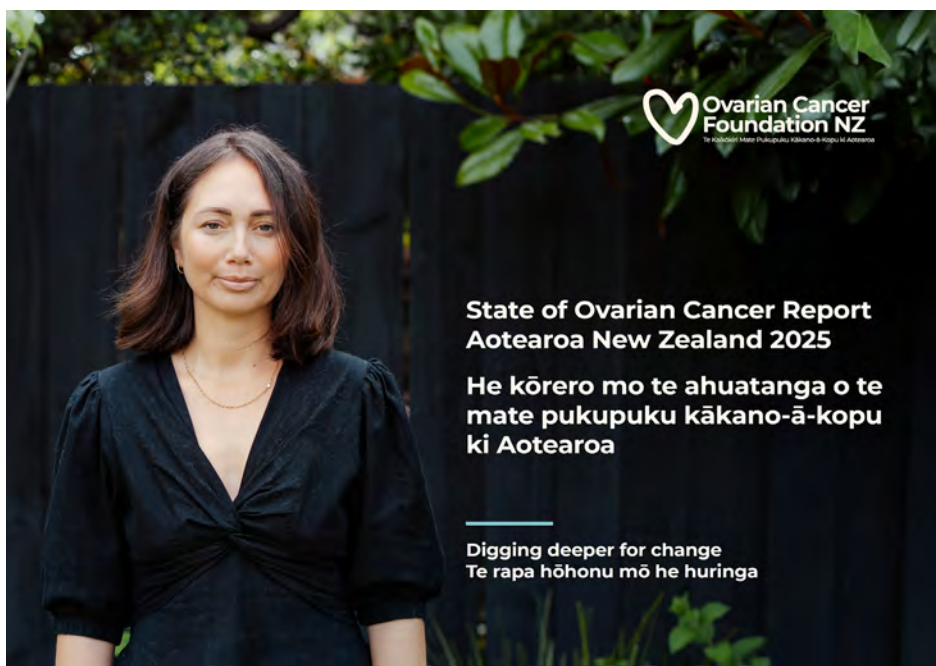
“Ruby was an extraordinary young woman with a deep love for her family, music, and



adventures. Even through the hardest moments of her cancer journey, Ruby chose love, courage, and hope. She made a conscious decision to turn pain into her superpower, to keep looking outward and caring about others, even when life was at its heaviest.”

“Ruby used her voice to advocate for women facing ovarian cancer. Her message was simple but powerful, trust your instincts, ask questions, and fight for answers. She believed in standing up for yourself and for others, and she carried that belief into everything she did.”

— Ovarian Cancer Foundation New Zealand



Health News

Kaitiaki Hauora

A new national group, [Kaitiaki Hauora - Together for Public Health](#), was launched in January in the face of a public health system in dire straits and the growing push from the current Government to privatise health.*

Kaitiaki Hauora[†] brings together patients, health workers, iwi and Māori health representatives, unions, advocacy organisations, and community groups, with backing from a growing number of organisations across the health sector. Auckland Women's Health Council joined Kaitiaki Hauora in March, because its goals and philosophies closely mirror our own. We have added our voice to the many expressing concerns about the state of our public health system, the direction it is taking, and it's increasing inability to provide timely, adequate and best practice healthcare for all New Zealanders.

Kaitiaki Hauora was formed because so many individuals and organisations around the motu share a deep concern about the growing pressure on the public health system and the impact this is having on patients, whānau, communities, and the health workforce.

At its core, Kaitiaki Hauora has three big goals:

- Adequate and sustained funding to meet the real health needs of our population.
- Protecting and strengthening publicly provided healthcare, rather than outsourcing it to private interests.
- Honouring Te Tiriti o Waitangi by embedding equity, partnership, and Māori leadership in how health services are designed, funded, and delivered.

Kaitiaki Hauora and its participants share a belief that publicly funded healthcare should be accessible to everyone, regardless of income or where they live, and that decisions about health and healthcare must be fair, evidence-based, and shaped by the people most affected.

* for more information on privatisation of healthcare see Kaitiaki Hauora's [Privatisation 101](#) on their website.

† follow Kaitiaki Hauora on [Facebook](#), [Instagram](#), or [LinkedIn](#)

The group is grounded in a commitment to Te Tiriti o Waitangi, health equity, transparency, respect for health workers, and working collaboratively across organisations and communities.

Dr David Galler, spokesperson for Kaitiaki Hauora, says the group has been formed to strengthen collective voices in support of public healthcare:

"We've come together because public healthcare matters to everyone. By working together across different parts of the health sector and community, we want to contribute to a stronger, fairer public health system for all – rich or poor, urban or rural."

Louisa Wall, Māori co-spokesperson for Kaitiaki Hauora, and Chair of the Tuwharetoa Iwi Māori Partnership Board, says Māori leadership and partnership are essential to the future of public health.

"For Māori, a strong public health system must be grounded in Te Tiriti o Waitangi and shaped by the voices of whānau, iwi and hapū. We've joined Kaitiaki Hauora because we believe publicly funded healthcare should be equitable, accessible, and designed in partnership with the communities it serves."



Protecting Public Health for all.

Kaitiaki Hauora is a nationwide coalition working to protect and strengthen Aotearoa's public health system by uniting communities, health workers, iwi Māori Partnership Boards, unions, and advocacy groups as guardians of public health.

We campaign for a well-resourced, Te Tiriti-honouring publicly provided health system that delivers equitable, culturally safe care for all.

Finally, Pregnancy Warnings on Anti-Seizure Meds



After ten years of campaigning, Denise Astill, Jacki Morris, and the FACS NZ* community are celebrating having successfully persuaded the Ministry of Health to add a pregnancy cautionary advisory label (CAL) to 8 anti-seizure medicines prescribed in Aotearoa New Zealand.

As of the 1st of April, eight anti-seizure medicines are subject to a cautionary advisory label, warning of the risks associated with taking them during pregnancy. This is the first time a pharmacist-added pregnancy CAL has been added to any medicine in New Zealand.

The eight anti-seizure medicines, which are prescribed for seizures, mental health conditions, migraines, neuropathy and pain, are:

- carbamazepine
- phenytoin
- ethosuximide
- primidone
- oxcarbazepine
- sodium valproate
- phenobarbitone
- topiramate

Babies exposed to anti-seizure medications *in utero* can suffer Foetal Anti-Convulsant Syndrome (FACS), a life changing and often devastating condition that causes a combination of physical malformations, dysmorphic (facial) features, neurodevelopmental and/or cognitive difficulties. Although the harm caused by anti-seizure medications during pregnancy has been known about since the 1960s and 70s, many families in Aotearoa New Zealand were not told of the potential danger to their future children.

Denise Astill, founder of FACS NZ and mother of twin daughters with FACS, received assurances

from two specialists that she should keep taking her medication during her pregnancy. She has campaigned relentlessly for years for the addition of warnings to the packaging of anti-seizure medication, a move that will likely prevent at least some of the harm to babies born in the future.

In January 2025, for her work on behalf of the very many families affected by FACS, Denise was honoured in the New Years' Honours and made an [Officer of the New Zealand Order of Merit](#).

Denise and Jacki Morris (Chairperson of FACS NZ and mother of a FACS child) have acknowledged and thanked the Minister of Health, Simeon Brown MP, for ensuring that the Ministry of Health implemented this very important initiative.



Jacki Morris and Denise Astill of FACS NZ

* [Foetal Anti-Convulsant Syndrome New Zealand](#)

Midwives Have Won the Battle for Fair Pay but Not the War



[A landmark judgement issued by the High Court](#) on the 26th of March should have brought to a close a ten-year battle by midwives to receive fair and reasonable payment for their work. However, the Ministry of Health said immediately after the decision in favour of community midwives was released, that it would appeal.

The College of Midwives on behalf of more than 1500 community-based, self-employed midwives — or Lead Maternity Carer (LMC) midwives — brought a class action against the Crown. The suit claimed the Crown breached its obligations to ensure self-employed midwives receive fair and reasonable remuneration and working conditions by failing to honour contractual commitments dating back to 2015, which were recorded in two signed settlement agreements with the College.

The High Court found in favour of the LMC midwives and awarded costs against the Crown. The Court found that:

- The Crown breached its contractual promise to the College that the Crown would ensure self-employed midwives receive fair and reasonable remuneration, and ordered that loss of income to each Representative Plaintiff in the proceeding be back-dated to 1 July 2020 and to continue in subsequent years.
- Going back as far as 2007 and continuing to the present, the Crown's method for paying LMC midwives unlawfully discriminated against LMC midwives on the basis of their sex in breach of section 19 of the New Zealand Bill of Rights Act.
- In addition to damages for breach of contract, the Crown must pay to each of the Representative Plaintiffs the sum of \$1,000 for Bill of Rights damages for the "inherent loss of dignity by

virtue of the unlawful discrimination, with such an award serving to "vindicate the public interest".

Justice Cheryl Gwyn said in her decision that "The history leading up to this proceeding [...] indicates a rather cavalier approach by the Crown — entering into agreements to avoid legal liability and then choosing not to, or failing to, meet its obligations under those agreements."

College of Midwives CEO, Alison Eddy, said that the High Court decision was welcome confirmation that community-based midwives have not been valued and have been discriminated against by successive governments. She went on to say:

"More than 55,000 women and their babies receive essential pregnancy, birth and postnatal care every year from community-based midwives. Society benefits if these midwives are appropriately paid; their working conditions and contracts are fair and non-discriminatory; and they have the support systems in place to allow them to do what is a 24/7 job."

AWHC is outraged on behalf of midwives and women that the Ministry of Health is appealing the High Court decision. Not only does an appeal perpetuate costly legal action — money that would be far better spent improving the health and well-being of New Zealanders — but it is a blunt statement that they grossly undervalue the vital work done by community midwives.

Community midwives provide incredibly important and essential care and support to mums and babies at a vulnerable time of their lives. The refusal of the Crown/Ministry of Health to ensure that self-employed midwives receive fair and reasonable pay for the work they do, speaks volumes about how the health of women in Aotearoa New Zealand is viewed.



A Medically Unscientific and Harmful Practice

A Bill to make virginity testing a crime has been drawn from the Ballot

Labour Party MP, Priyanca Radhakrishnan, had her [Crimes \(Virginity Testing Practices\) Amendment Bill](#) drawn from the ballot on the 30th of April. The Bill would make the harmful practice of virginity testing and hymenoplasty — or ‘virginity repair’ — a crime.

The General policy statement heading the Bill states:

“Virginity testing refers to the inspection of female genitalia for the purpose of ascertaining history of vaginal intercourse. It is an unscientific, unreliable, and medically unnecessary practice that violates human rights and is associated with adverse outcomes for physical, psychological, and social wellbeing. Women and girls are often coerced or forced into this honour-based abuse against their will. This Bill seeks to protect vulnerable women and girls by amending the Crimes Act 1961 and introducing new offences that criminalise virginity testing and the related practice of hymenoplasty.”

In her social media post, Ms Radhakrishnan thanked the women who were brave enough to talk about their experience of virginity testing, describing the practice as a traumatic violation of rights. MP Vanushi Walters undertook the initial work on the Bill and drafted it in her name under the previous Labour Government. Ms Radhakrishnan ‘inherited’ it from Ms Walters and carried on the work.

“Virginity testing and hymenoplasty are invasive, harmful practices that violate a woman’s human rights and must be formally recognised as a crime,” Priyanca Radhakrishnan said in a press release.

“There is no cultural basis for this practice. It’s a patriarchal act of violence forced upon women that has harmful effects on their physical and emotional wellbeing. The World Health Organisa-

tion and UN Women are part of a global call to ban these practices. The UK banned it in 2022.”

“This Bill fills a gap in our current laws, that allow for such practices to happen — and they do happen here in New Zealand,” she said.

A report by the Helen Clark Foundation, [Addressing Sexual Violence in New Zealand](#), called for it to be eradicated, recommending that, in addition to the criminal offences currently envisaged in the Bill, a civil component should be considered as well, in addition to the criminal offences currently envisaged.

The report also recommends that the “Ministry of Education should ensure that the Relationships and Sexuality Education curriculum equips teachers to correct misconceptions relating to ‘virginity’ and hymens, and deliver accurate information about the biology of reproductive systems.”



Labour MP, Priyanca Radhakrishnan