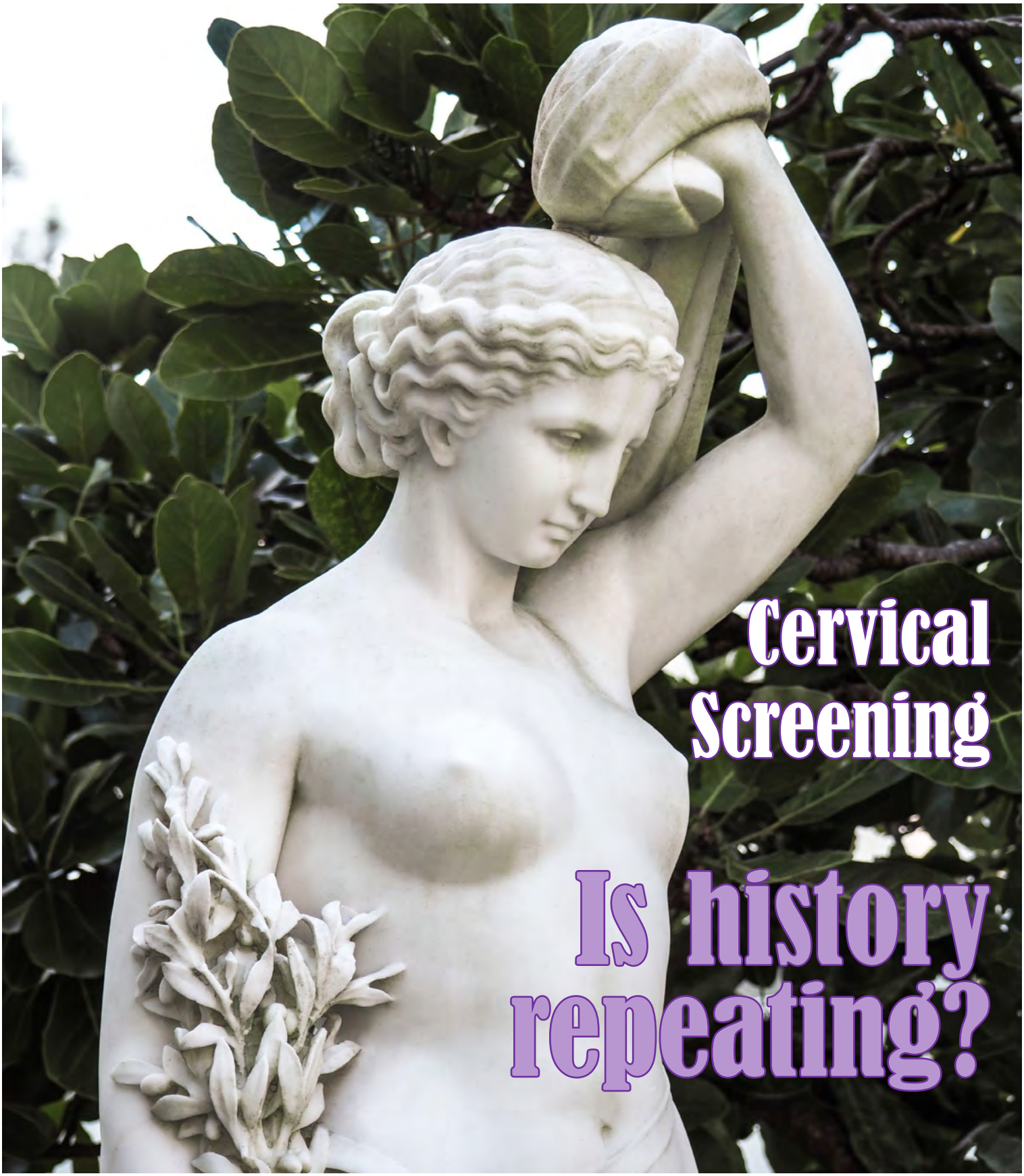
AWHC

NEWSLETTER

August-September • 2026

a voice for women's health



Cervical Screening

Is history repeating?

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Mobilising Aotearoa to Save Our Health System

By Sue Claridge

Something extraordinary is happening across Aotearoa New Zealand. Over the past year, health activism has surged — health consumers and consumer groups, the health workforce, advocacy organisations, umbrella organisations — all of them converging to amplify a single, desperate message: our public health system is collapsing, and it must be saved.

This is not exaggeration. It is diagnosis.

"The health system is in intensive care and is starting to flatline."

That was the verdict of Malcolm Mulholland, who opened a state of the health system address hosted by Kaitiaki Hauora in Porirua on the 24th of August. Kaitiaki Hauora now counts 31 organisational members — health consumer advocacy groups, health workforce organisations and unions — who have initiated and supported campaign after campaign to force a health system in crisis into the public eye, using collaboration and the power of many voices to effect change.

The scale of this movement, this health activism, goes far beyond any one umbrella organisation. Campaigns, meetings and events are multiplying faster than any calendar can hold them. But they all point the same direction: toward a world-class, people-centred, safe and equitable health system that actually meets the needs of every New Zealander.

The ordinary people of our nation are doing something extraordinary. They are mobilising to save the system that is supposed to save them.

On the 25th of July, the Forbidden Pharmacy (see page 20) opened for a single day in downtown Auckland. A collaboration between 17 patient organisations representing people affected by cancer, rare disorders and chronic conditions, it was an immersive public installation stocked with more than 200 medicines; medicines publicly funded overseas, but denied New Zealanders.

Four days later, on the 29th of July, more than 1000 people from a variety of community organisations, including health and care workers, packed into the Health and Care Pre-election Forum hosted by Te Ohu Whakawhanaunga in Tāmaki Makaurau Auckland to demand change in our health and care sector.

The movement is gathering momentum!

On the 17th of September, Aotearoa New Zealand will mark its first co-ordinated participation in World Patient Safety Day (see page 4), led by the Health Consumer Advocacy Alliance, Patient Voice Aotearoa and Kaitiaki Hauora.

And it's not only patients and advocates sounding the alarm — it's the clinicians themselves.

In 2025, doctors Art Nahill and Glenn Colquhoun drove their 'vanbulance' from Te Hāpua in the Far North to Wellington, on a Hīkoi 4 Health (see page 22). What they heard, what they witnessed on that journey, became a book, *Rethinking Health* (see page 23) that details a genuine paradigm shift, a vision of what our health system could be if we finally mustered the will for once-in-a-century change. On the 18th of September, Art and Glenn set off again, this time to carry what they learned, and their vision for a future health system, back to the communities that shared their views in 2025.

In October, intensive care specialist Dr David Galler and Patient Voice Aotearoa founder Malcolm Mulholland take to the highway in a different van, travelling from Bluff to Cape Reinga on the Health of Our Nation tour — to listen, to learn, and to talk, unflinchingly, about the future of our public health system — see page 31 for more details.

Auckland Women's Health Council will continue to lend our support to these and other organisations; using our voice to amplify the voices of the other advocates and organisations working so hard to effect desperately needed change in our health system.

This edition of the Auckland Women's Health Council Newsletter breaks with our usual format.

Continued on page 4

Editorials are not something we run as a rule. But the sheer scale of this crisis, and the extraordinary groundswell of action rising to meet it, demanded addressing in this edition. I have worked in women's health consumer advocacy since 2003 and I have never seen activism at this level. Never!

This edition is different in another way, too. Our feature article (page 6) is a long, unsparing review and analysis of a recently released report on the National Cervical Screening Programme Register – quite possibly the longest piece we have ever published. No apology for that. AWHC has its genesis in the women's health activism of the late 1980s and the Cartwright Inquiry into cervical cancer treatment at National Women's Hospital. We were key stakeholders in establishing the NCSP. We reported on the Gisborne Cervical Cancer Inquiry in 2000. We have never stopped scrutinising this programme. Given that herstory, it was important to do justice to the failures and flaws the report revealed and the potential harm to women/wāhine.

Aotearoa Casts First Light on World Patient Safety Day

Aotearoa New Zealand will bathe in the orange glow of World Patient Safety Day on the 17th of September as the Health Consumer Advocacy Alliance, Patient Voice Aotearoa and Kaitiaki Hauora take our first nationally co-ordinated, patient and whānau-led World Patient Safety Day campaign to the people, to hospitals and clinics, and to landmarks around the motu.

As one of the first countries in the world to welcome the new day, Aotearoa New Zealand will also be among the first to mark World Patient Safety Day.

There is already real momentum building. Health organisations, clinicians, patients, whānau and communities are keen to take part, with participation growing across the country. The campaign includes the global Light It Orange for Patient Safety and Health System Safety initiative, with Auckland's Sky Tower and landmarks in Wellington, Tauranga, Whangārei and Dunedin already confirmed to be illuminated in orange, with more expected to join.

A National Patient Safety Forum in Auckland, live streamed nationwide, will bring together patients, whānau, clinicians, health leaders and Members of Parliament from across the political spectrum. Patients and whānau will share their lived experiences directly with MPs, including the changes they believe are needed to reduce avoidable harm and build a safer health system. Four MPs have already confirmed their attendance, representing three major political parties.

The orange lighting of landmarks across Aotearoa will provide powerful visuals, but the real story is the people behind them; New Zealanders whose lives have been changed by preventable harm, alongside the health professionals and decision-makers working to make healthcare safer.

WORLD PATIENT SAFETY DAY 2026

THURSDAY, 17 SEP 2026

Light it Orange

For Patient Safety and Health System Safety

World Patient Safety Day is a global day of action focused on reducing avoidable harm and making healthcare safer.

For the first time, Aotearoa New Zealand is coming together for World Patient Safety Day — Landmarks will light up orange, people will gather and conversations will happen as communities across the country come together to make patient safety visible.

Show up for patient safety.
Make it visible. Make it meaningful.

LEARN MORE

www.consumeradvocacyalliance.co.nz

TAKE PART

- **Light it orange**
  Illuminate your building, workplace or community space.
- **Wear orange**
  Show your support on 17 Sep 2026
- **Start the conversation**
  Bring people together to talk about patient safety and what needs to change.
- **Join the National Patient Safety Forum**
  Hear directly from patients, whānau, health professionals, and health leaders working towards a safer health system.
  17 Sep · Auckland + livestream nationwide

Register for the Forum

If you can't make it in person, join the Patient Saftey Forum live stream online.

Kaitiaki Hauora
TOGETHER FOR PUBLIC HEALTH

The Health Consumer Advocacy Alliance
Experts by Experience

PATIENT VOICE AOTEAROA
HE REO TŪRORO O AOTEAROA

Damning Report on NCSP Register Raises Significant Concerns

By Sue Claridge

Thirty-eight years after the Cartwright Inquiry, women/wāhine are being failed by a cervical screening register that has myriad flaws and raises the spectre of serious harm to an unknown number of women eligible for screening. The failures of the new Register represent a betrayal of everything the Cartwright Inquiry Report recommended. Women's health advocates, including the Auckland Women's Health Council, are demanding urgent, transparent accountability.

Wednesday, the 5th of August, marked 38 years since Judge Silvia Cartwright released her landmark report into the treatment of cervical cancer at National Women's Hospital. That report led directly to the establishment of the National Cervical Screening Programme (NCSP), and it explicitly called for the urgent establishment of a central register to guarantee quality control.

On the 3rd of August, just two days before that anniversary, HealthNZ (HNZ) published a highly critical report on a review of the new Register implemented in 2023. The HNZ report, *Review of the National Cervical Screening Programme's Population Based Register*,[1] found myriad flaws with the new Register including: almost one million screening notifications never sent to eligible women; screening histories of existing participants not properly transitioned onto the new Register; and a concerning level of clinical risk arising from the excessive number of recommendation mismatches between screening laboratories and the Register;[2] and colposcopy clinic messages rejected by the Register.

"The review raises serious questions that warrant ongoing independent monitoring and public reporting so that any adverse consequences are identified promptly and addressed transparently."[2]

Kaitiaki Nursing has said that "Many of the issues identified through this public review were already well known to those working within the system."[3]

Certainly, red flags were raised back in 2023 when both the AWHC and Federation of Women's Health Councils (FWHC) expressed concern about the changes being implemented. At that time it was proposed, in HNZ's 'Simplify to Unify' broad sweeping restructure, that the National Screening Unit (NSU) be disestablished as a stand-alone agency and absorbed by the Immunisation Prevention Directorate of the National Public Health Service (NPHS). The disestablishment of the Clinical Director NSU and Group Manager NSU roles was a foregone conclusion. The data analytics team was to be relocated to the then Service Improvement and Innovation Directorate. These changes and the loss of institutional knowledge created "exactly the kind of workforce churn that our organisations warned would be a recipe for disaster."[2]

Changes to the National Cervical Screening Programme

On implementation in 1990, the NCSP recommended three-yearly Pap smear cytology tests for people with a cervix* aged 20 to 69.

In November 2019, the starting age for routine screening was raised from 20 to 25; international evidence showed that screening people aged 20 to 24 offered negligible benefit and risked diagnostic harm.

In September 2023, the primary screening primary test changed from a standard cytology Pap smear to a Human Papillomavirus (HPV) test, which included vaginal self-testing options. This change required a new population-based NCSP Register, and was designed to facilitate invitations and recalls, and track progress through the new clinical pathways.

* While the majority of those participating in the cervical screening programme are women/wāhine, it is important for transmen and nonbinary people who have a cervix to be tested as well. In this article, when we refer to women/wāhine in the context of cervical screening, for the readability of this article, even where not specified we include transmen and nonbinary people with a cervix.

"This was a world leading change to the cervical screening programme. Why did they risk the Register going live with known issues and missing functionality? This was no accident. The failures were inevitable despite the concerns we had expressed," says Barbara Robson, Co-convenor of the FWHC.[2]

The Critical Findings of the Review of the Register

The expert review panel essentially found that the Register was set up to fail, with serious quality and safety issues surfacing soon after the launch.[1] It was rolled-out within a compressed and pressured timeline, with an original go-live date of July 2023 that was pushed out to September. Testing of the Register was rushed with inadequate clinical input and user acceptance testing.

There was poor translation of clinical guideline requirements into technical/Register rules, with no effective feedback loop between clinical and technical teams.

The Register was launched with limited functionality and several known issues, including incomplete data migration from the previous register. In fact, the Register was only "60–70% ready" when it went live, with known defects deferred to a 'fast-follow' (that is, to theoretically be fixed soon after implementation). "This included the roll-out of the Register's notification functionality… and data migration of some participant screening records with screening history scenarios deemed too complex to migrate automatically." [1]

The review panel said that because there were known 'defects', "robust failsafe processes were necessary to ensure the Register was operating safely or to detect where it was not"; the failsafe processes still needed to be developed further at the time of the review. The review was completed in June 2025, and we don't know from the report if those failsafe processes are now properly functional.

There were multiple functional failures and issues identified in almost every part of the NCSP pathway[1] (see Figure 1 on page 8, and below):

- ***Incomplete migration of participant data from the old register:*** screening histories of existing enrolees in the NCSP were not properly transitioned onto the new Register. Some participants had screening history scenarios deemed too complex to migrate automatically. Additionally, there were issues related to data migration for patients with a history of gynaecological cancer or a hysterectomy, requiring individual manual review. The Register does not hold a complete screening history for all participants.
- ***Eligible population identification:*** A significant proportion of women identified in the NHI* as being eligible did not have their data transferred to the new Register if they hadn't had any contact with the health system for three years or more. This was due to a Register 'rule' that determined them to be 'inactive'; (see **Cohorting** on page 9). Māori are under-counted in ethnicity data, blocking enhanced outreach; transgender and non-binary people with a cervix can be missed because the NHI has no field for sex at birth.
- ***Notifications:*** as of June 2025, roughly 968,000 women/wāhine (or 62% of the eligible population at the time) were not sent notifications, including a large number of women/wāhine caught up in 'cohorting' that was incorrectly implemented and exacerbated by the exclusion of 'inactive' women/wāhine. Some 160,000 notifications were 'triggered' but never sent and approximately 808,000 notifications were never even triggered.
- The Register does not yet include the ability to send notifications by text message and/or email. Texts and/or emails would have provided more options to reach participants and may have helped reach higher risk individuals, including those without a stable place of residence.†
- ***No "look-back" functionality:*** the Register cannot identify people who are unscreened/under-screened based on prior history, a function that was considered essential but never built — another massive failure in designing the Register without critical functionality. As a result, individuals have, at times, been placed on the wrong pathway or given the wrong pathway status. "This is particularly problematic for individuals who are at higher risk given their screening history as they may not be recalled

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* National Health Index

† Author's note: in recent years (perhaps the last 10-15 years) I have received NCSP postal notifications by for a woman who does not live at my address and hasn't for at least 26 years (the time I have lived there), and possibly never did. I have repeatedly "returned to sender" with the notation on the front of the envelope that the addressee does not live there. These notifications well and truly predate the new Register. If the NSU pre-2023 could not update their former register records when repeatedly advised, then what hope do we have for the new Register?

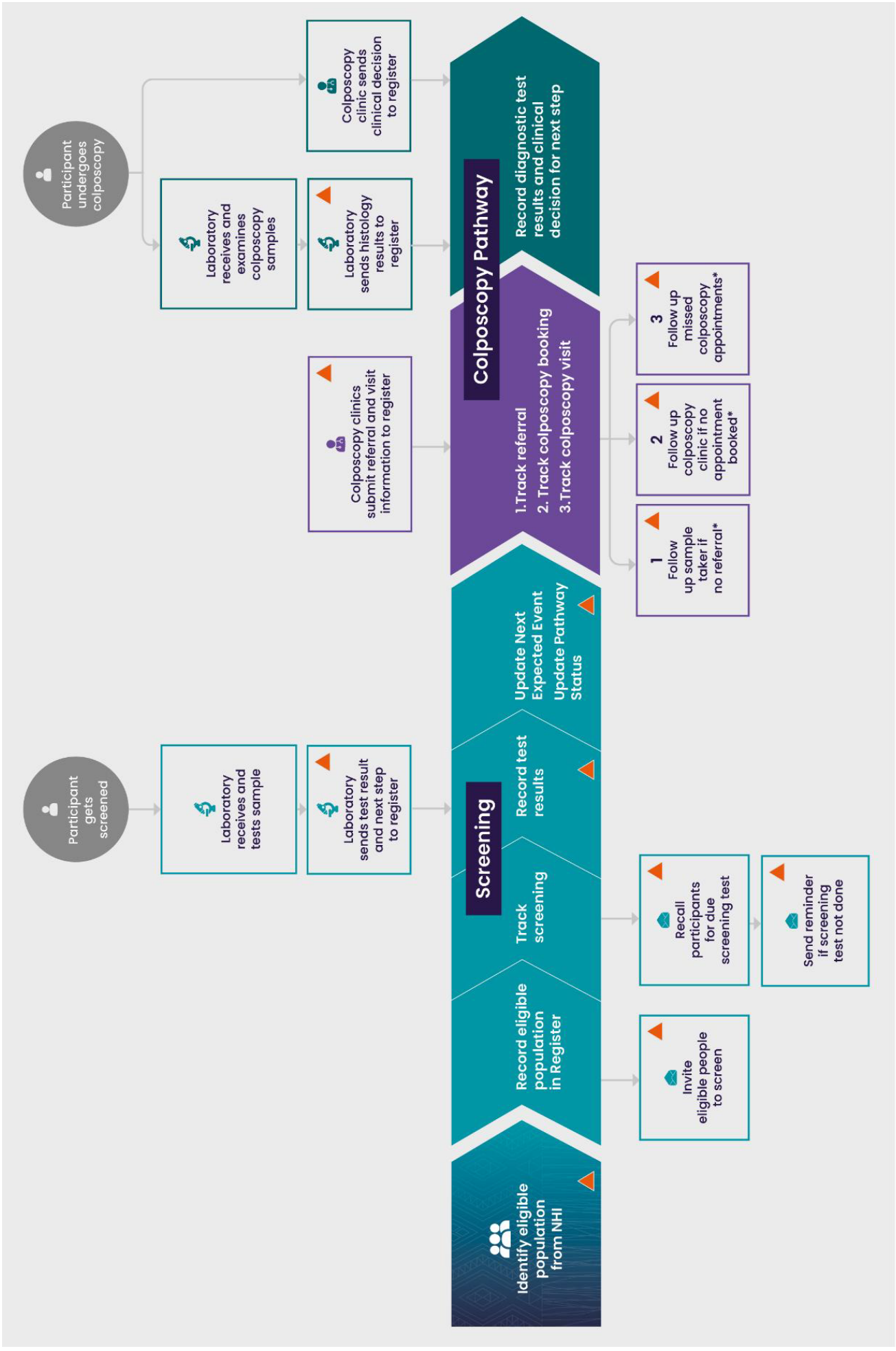


Figure 1: Overview of the Register's role in the NCSP pathway.[1]

in line with clinical guidelines, for example, individuals who have suffered from persistent HPV infection over a long period of time, with no previous examination of the cervix."[1] Delayed diagnoses, which could well arise from this deficiency in the Register, will likely negatively impact prognoses of patients with pre-cancerous changes or cancer.

- ***Recommendation mismatches:*** laboratory results frequently conflict with what the Register expects, creating large backlogs of manual review tasks and potential delays to colposcopy referral. When there is an outstanding recommendation mismatch task, notifications are not sent and tracking is turned off. This meant that as of the 31st of January 2025, there was a backlog of 4,720 women/wāhine who were the subject of outstanding recommendation mismatch tasks, potentially placing them at risk, while manual resolution of the mismatch was undertaken.

  The review found that "there is a risk that mismatch issues will get worse before they get better, if learning from past problems does not occur."

  The Register also rejects some information sent from colposcopy clinics and it was "not always clear why the information had been rejected." Resolving these rejections takes time to be investigated.

- ***Abnormal-result follow-up:*** tasks generated to flag participants not progressing through the pathway are not prioritised by clinical urgency, and volumes exceed what staff can process. Some people are discharged without a colposcopy visit without the reason being visible, and tracking for those women/wāhine ceases until their record is manually updated, leaving them in limbo and at clinical risk.

Remedial Work and Functionality Yet to be Delivered

The review panel found that "there has been no independently peer-reviewed monitoring report published, so the sector and public cannot see whether the programme is safe and effective." They also found that "governance was weak, with unclear roles and responsibilities between the NCSP and Digital Services, no unified risk/issue register, and thin incident-investigation resourcing."

According to the review report, although some remedial work has been undertaken to address the problems, the Register is ***not yet functioning as a reliable clinical safety net***. Key items of planned functionality are still to be delivered, including:

Cohorting

Cohorting was the process that was used to phase in notifications when primary HPV screening first started; there were three cohorts, with cohort one being the highest priority and cohort three the lowest priority. It was intended as a transition measure to be discontinued in March 2024, but was still in effect as of May 2025*.

What this meant was "eligibility and recall notifications [were] only sent to those in cohort one: who are those aging into the programme as well as unscreened or under-screened Māori or Pacific people who are not enrolled in primary care."[1]

Cohorts two and three were not sent notifications including "those who [were] unscreened or under-screened of any ethnicity and enrolled in primary care; and unscreened or under-screened non-Māori/non-Pacific individuals not enrolled in primary care."[1] Of these, 108,000 women/wāhine were not sent an eligible to participate notification because they were 'inactive'; a further 495,000 women/wāhine did not receive other notifications they should have because they were 'inactive'.

This failure of the Register defies belief!

'Inactive' Women (NHI active rule)

Data extracted from the NHI to populate the Register excluded women who had not engaged with/not been active in the health system for three years or more. Therefore, there was no visibility of these 'inactive' women in the Register. This rule referred to as the 'NHI active rule' in the review, was a decision of the Register, not the NHI.

This rule totally ignores the reality that many healthy young women don't have a need to go to a doctor. There must be thousands of sexually active young women who haven't needed to go to a doctor for years, especially in the middle of an ongoing and increasingly consequential cost of living crisis, in which healthy women would not be spending money on needless visits to their GP.

The Review team recommended this NHI active rule be amended to six years or eliminated.

* It is worth noting that issues with the Register were picked up in March 2024, and the review was commenced in November 2024; cohorting was still in place seven months later in May 2025. The review was completed in June 2025.

- ability to directly refer support to screening services;
- integration of screening histories with General Practice (GP) systems;
- ability to 'flag' historically under-screened participants in the Register;
- functionality to invite, remind and recall participants;
- ability to automatically account for complex patient scenarios (currently must be set manually);
- improved review of patient screening histories (currently impacted by resourcing).

In a nutshell, it was reckless of HNZ to implement the Register in 2023. It was foolhardy to rely on it to perform important functions when they knew that much of the designed and desired functionality of the Register was either missing or not working as intended.

Why These Failures Matter So Much

Four long-standing women's health organisations†, who all strongly advocated for the establishment of the National Cervical Screening Programme Register, are appalled that 38 years on from the Cartwright Inquiry we are having to fight to ensure that women/wāhine and other people with a cervix have access to a safe and effective screening programme that prevents the development of invasive cervical cancer.

The failures of the new NCSP Register are a betrayal of everything the Cartwright Inquiry Report recommended. In Judge Silvia Cartwright's recommendations for the implementation of a national population-based screening programme, she wrote that it should be ensured that:[4]

i **Administrative problems are kept to a minimum****.

ii **Optimum numbers of women** who are or have been sexually active are reached by the programme.

iii Cultural, privacy and financial considerations are taken into account, so that screening is acceptable and available to all women.

This current debacle is "a sickening echo of history."[2] The 2001 Gisborne Cervical Screening Inquiry, only eight years after the NCSP began, found the register at the time was in such a sub-optimal state that results were routinely under-reported, with normal or negative readings issued for what were in fact abnormal or precancerous cells. Women were, in the words of that Inquiry, "severely injured" as a result. The entire rationale for a centralised, high-quality register was to make sure this could never happen again."[2]

Yet, it has happened again!

Isis McKay, General Manager of Women's Health Action, reflects the concerns of all four women's health organisations, saying "The issues identified in the review are serious and raise important questions about the reliability of systems that consumers should be able to trust."

She "acknowledge[s] the distress these findings may cause for individuals and whānau and believe[s] it is vital that those affected receive clear information, support, and timely communication."

These sorts of failures have the potential to erode trust in ***all*** aspects of the NCSP. In some populations it can be hard enough to achieve target enrolment and screening rates. That the screening **is not free (except for the highest priority groups)** has long been a 'bone of contention', and this latest concern just adds to the overall failure of the NCSP to be in 2026 the programme that was envisaged back in 1988.

Judge Silvia Cartwright presiding at the Cartwright Inquiry.

* Women's Health Action (formerly Fertility Action) was founded in 1984 by Sandra Coney and Phillida Bunkle; Auckland Women's Health Council in 1988; the Federation of Women's Health Councils in 1990; and the Cartwright Collective in the early 1990s. All four organisations were strong advocates for the implementation of the NCSP and have long been key stakeholders in the NCSP with an abiding concern for and interest in how the NCSP is run and for the success of the programme.

** Author's emphasis.

Where are our Minister of Health and Director General of Health?

There has been near-total silence from Minister of Health Simeon Brown and other health spokespeople across the political spectrum, including previous Ministers of Health in the period from 2023 leading up to the implementation of primary HPV screening and the implementation of the Register, to when the review of the Register was triggered in 2024. These ministers would no doubt have been briefed on the issues.

Simeon Brown's only apparent public comment to date has been through a spokesperson, including that "the register began under the previous Labour-led government"; "improved screening rates were also mentioned."[5] He expressed no concern for the unknown number of eligible women who could be harmed by the failings of the Register.

Director-General of Health Audrey Sonerson has a role in ensuring there is communication between HNZ's National Public Health Service, the Ministry's Public Health Agency and the NCSP Parliamentary Review Committee about implementing recommendations from both reviews in line with wider action plans for cervical screening. She too has been silent.

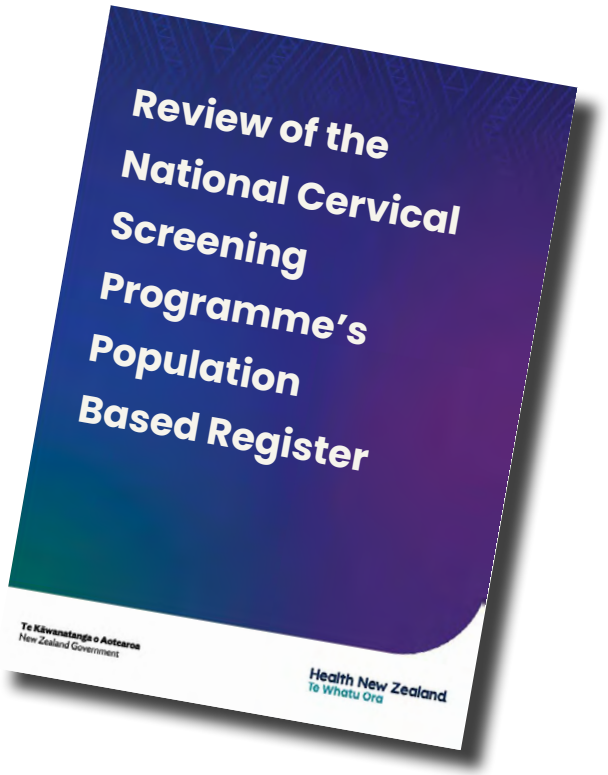
It is particularly disturbing that there has been no comment from her, but this may reflect her very limited background in health. Before being appointed by Simeon Brown as DG of Health, her previous role was Chief Executive of the Ministry of Transport. She has degrees in economics.

In April 2025, we asked how New Zealanders are supposed to have confidence in two people (Sonerson and Minster of Health Simeon Brown), "who seem to have no background in health, to know anything about what is wrong with our health system and what health consumers and the health workforce desperately need from our health system."[6]

Having said that, any worthy economist would surely see that prevention is less costly than cure, and that the total economic burden of preventable cervical cancer on individuals, families, communities and the entire nation, far outweighs funding a world-class cervical screening programme.

Te Tiriti and Equity

The ability of the NCSP to deliver an equitable programme for wāhine Māori has been a critical issue for decades. Wāhine Māori have been harder to reach, faced more barriers to access screening, and at significantly higher risk of developing and dying from cervical cancer. This has been exacerbated by wāhine Māori having lower enrolment rates with primary care, lower incomes, availability of culturally safe services, and undercounting by the NHI.*



Progress has been made. Cervical screening is now free for high priority groups, such as wāhine Māori and Pasifika; there is increased availability of culturally safe services; and HPV primary screening with the self-test option has made it easier to reach and enrol wāhine Māori. However, implementing a Register with so many critical flaws risks undermining progress made to improve equity for wāhine Māori and other underserved populations.

The NCSP Register review panel found significant failings of the Register to properly address equity and the NCSP's responsibilities under Te Tiriti.[1] It noted:

- The Tiriti o Waitangi and Equity Strategy remains in draft form and that a final version has not yet been published on the public facing website.
- There had been "limited implementation of the draft Te Tiriti o Waitangi and equity strategy" and seemingly limited consideration of equity for groups such as rural women/wāhine, those

* Significantly fewer people are recorded as Māori in official health databases than actually identify as Māori. HiNZ reported that "Recent audits of ethnicity data quality show that one in five Māori were not identified as Māori on the National Health Index (NHI) when compared to self-identified ethnicity recorded on the Census." "Despite the protocols being in existence for nearly 20 years, there is evidence that they are not being adhered to and Māori have continued to be systematically undercounted over this time period."[7]

with disabilities or with a severe mental illness, and the LGBTQI+ community.

- It was unclear that the governance envisioned in the draft strategy, described as, 'a co-governance partnership with a group made up of tangata whenua partners who can oversee and steer all NSU programmes' is in place yet.
- "The HPV self-test will maximise autonomy and the NCSP must clearly communicate that cervical screening is advised for all people with a cervix." However, this will have no effect until the Strategy is published.[1]

Further, the failure to ensure the Register could send notifications by text or email, known to be the preferred communication method for many Māori and Pasifika participants, seems incomprehensible. Apparently, this functionality is now being "trialled" and hopefully will prove to be considerably more cost effective than sending notifications by post.

In its recommendations the review panel states that:

- The NCSP should finalise and publish its Te Tiriti o Waitangi and Equity Strategy. Once finalised, NCSP leaders should consider whether the programme is currently in alignment with this strategy, and take action to address any gaps found.
- The NCSP should issue updated guidance to screening providers on how to effectively capture details of individuals' ethnicity, gender, and sex assigned at birth and have these recorded in the Register.

What Needs to Happen

Women/wāhine deserve more than a promise that "improvements are underway." They deserve a full, transparent accounting — in public, and without delay. Currently, the harm caused by this debacle is incalculable, and may not be realised for years to come.

AWHC, FWHC and the Cartwright Collective were all relieved to see that the review panel shared our concern that there had been no monitoring report. The panel recommended that NCSP should publish an independently peer reviewed monitoring report as soon as possible.[2] This would ensure a level of accountability to the sector and the public about the impact of the new HPV programme.

But where is that monitoring report? The *Action Plan* states, for the 2025/2026 year, delivery was focused on "Producing the first peer-reviewed monitoring report following the transition to HPV Primary Screening."[8] Has it been completed? When will it be published?

"The lack of a monitoring report also means that the public are unable to be assured that the NCSP is providing safe and effective cervical screening f or Aotearoa New Zealand."

In a press release[2] issued on the 14th of August, our organisations called for:

- A clinically safe and equitable cervical screening programme.
- A commitment to regular, independent, transparent reviews into the performance of the screening programme from the implementation of primary HPV screening, identifying any harm caused by the Register's failures and other wider sector issues; the findings to be made public in a timely way.
- Immediate, direct contact with every person affected by a missed or delayed notification.
- A cervical screening programme that is free for all participants, as originally promised.
- Public accountability from HNZ, the Director-General of Health and the Minister of Health.
- Guaranteed, ring-fenced clinical leadership and resourcing for the National Cervical Screening Programme, protected from further restructuring, subject to confirmation of the organisational structure of the core functions and responsibilities of the Prevention Screening Directorate, NPHS and specific screening related roles in other directorates within HNZ.
- Strengthened collaborative governance, timely and effective monitoring, consumer representation.

We understand the 2025 NCSP Parliamentary Review report has been completed, and, once it is tabled in Parliament (possibly not until after the election in November), it will be made public. Once that happens, we believe that both the Parliamentary Review report and the current Register review report, and the capacity of colposcopy clinics need to be reviewed to decide if a thorough independent audit of the NCSP is justified.

Given the serious flaws in the Register and the major changes in not only the cervical screening programme, but the structure supporting population screening within HealthNZ, such an audit would systematically review invasive cancer cases, screening histories and Register, HPV screening and colposcopy performance to identify system failures.

STOP PRESS

The Government Says that Cervical Screening Will be Free From March 2027

Yes, we are celebrating — finally cervical screening will be free for all women/wāhine and transmen and nonbinary people with a cervix from 25 to 69 years of age. Cervical screening is the only screening programme that can actually prevent cancer, and the National Cervical Screening Programme has reduced the incidence of cervical cancer by more than 50% and deaths by more than two thirds since 1990. Making it free will remove the cost barrier and reach more under-screened and unscreened people.

But we have questions:

Why has it taken so long?

Is this blatant vote buying?

It was always supposed to be free. How many women have died because successive Governments have ignored the very real barriers to equitable health care and disease prevention, and failed for 36 years to make cervical screening free in line with breast and bowel screening?

Or is this damage control after the realease of the damning report on the NCSP Register almost two years after an independent review into failings of the Register commenced?

Betsy Marshall of the Cartwright Collective, and the Cancer Society representative in both the Cartwright and Gisborne Inquiries, points out that "If HealthNZ is promoting cervical screening to well women, it has an ethical obligation to ensure that these women are likely to benefit and will not be subjected to unnecessary harm due to the programme's potential failures. An audit might be the only way to address this obligation."

In their submission to the to the NCSP Parliamentary Review Committee in 2025, Barbara Robson and Barbara Holland, co-convenors of the FWHC, wrote regarding continuous prospective audit of all cervical cancer diagnoses*:

"The 2022 progress report on this 2018 recommendation indicated a business case had been completed for a prospective audit of all invasive cervical cancers and funding for one year had been approved. A project team was then developing policies and procedures for undertaking this audit. So, where has this got to? Is there a continuous prospective audit of all cervical cancer diagnoses or has it stalled?"

Why has it taken more than a year for the women/wāhine of Aotearoa New Zealand to find out about the problems with the Register, courtesy of an investigative journalist who seemingly triggered the public release (or at least hastened the release) of the review report and the associated action plan that HNZ had been working on for nearly a year?

"Consumers deserve a health system that is transparent, accountable, and committed to continuous improvement. We remain committed to working collaboratively with the sector to ensure lessons are learned and that the National Cervical Screening Programme continues to deliver safe, equitable, and trusted care for all," says Isis McKay, General Manager of Women's Health Action.

The National Cervical Screening Programme can trace its origins to the benchmark and transformative Cartwright Inquiry and resultant report that led to significant reforms in women's health and patient safety. The NCSP has been enormously successful in reducing the incidence of and mortality from cervical cancer. It is our only screening programme that has the ability to prevent cancer.

The incidence of cervical cancer in Aotearoa New Zealand dropped by more than 50 per cent between 1990 and 2018 (from 13.9/100,000 women to 6.7/100,000 women) and deaths have dropped by more than two-thirds (from 5.5/100,000 to 1.7/100,000, approximately of 69%).[9] There is now optimistic talk of eliminating cervical cancer in Aotearoa New Zealand.[10]

However, we risk the continued success of the NCSP with rushed, ill-conceived changes, and under-resourcing and underfunding of both the systems that underpin the programme and the staff that run it. Sadly, given the sidelining of women's health in this country (see page 14), we should not be surprised by these outcomes.

Author's Acknowledgement: I would like to acknowledge the significant contribution made to this article by Barbara Robson, co-convenor of the Federation of Women's Health Councils – phone and email conversations about the Review Report and Action Plan, reviews of various drafts of this article and suggestion edits, and sharing her wisdom and knowledge of the NCSP and the NHI.

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* A prospective audit of cervical cancer diagnoses would collect and analyse data on new cases of cervical cancer as they happen, to ensure that they were not the result of incorrect testing (i.e. a false negative in either Pap smears or HPV tests), failures of the Register, or delays or misdiagnosis in colposcopy, etc.

Sidelining Women's Health

By Sue Claridge

It is pretty clear that women's health simply doesn't matter to the Government, health policy and decision makers, and those who hold the health system purse strings. The issues described in our feature article on the failures of the National Cervical Screening Programme are just the "tip of the iceberg" and epitomise the lack of attention paid to women's health; the lack of priority placed on women's health.

One only needs to consider the years it took for the health authorities to take seriously the enormous harm caused to thousands of New Zealand women/wāhine by surgical mesh. It took over a decade of persistent activism by mesh injured women/wāhine — many of whom were catastrophically injured — and a restorative justice process, before any meaningful progress was made towards acknowledging what had happened. In fact, it took five years for relevant stakeholders to sit around a table to even begin discussing the issue.

Following the restorative justice process in 2019, the New Zealand Female Pelvic Mesh Service was established to provide specialist care and support for those who have been injured and suffering harm from pelvic mesh used for stress urinary incontinence (SUI) and pelvic organ prolapse (POP). The ongoing demand for this service is substantial, and it will be needed for many years to come.[1] Significant and sustained investment will be required, not only to keep the service operating, but to ensure it remains a properly resourced, high-quality specialist service capable of meeting the needs of women who have been harmed.[1]

Yet a significant gap remains.

Women experiencing complications from ventral mesh rectopexy*, a mesh procedure used to treat rectal/bowel prolapse, are unable to access the national Mesh Service unless they have also had pelvic mesh inserted for POP or SUI. Although the injury is in the same anatomical area — the pelvis — women whose only pelvic mesh is from a rectopexy procedure are excluded from the Mesh Service. Instead, they are referred to colorectal services, without access to the same specialist mesh pathway and wraparound support.

This is despite the fact that rectopexy is a surgical treatment for "posterior compartment pelvic organ prolapse", and is considered by ACC as a pelvic organ prolapse repair.[2]

After everything it took to establish a national specialist service for people harmed by pelvic mesh, it is unacceptable that people harmed by ventral mesh rectopexy are still excluded from that service and left to navigate a separate pathway. Promises have been made that women harmed by rectopexy mesh will be included at some point in the national Mesh Service.[1] Whether those promises will actually translate into equitable access to specialist, multidisciplinary, wraparound care and support remains to be seen.

* Ventral mesh rectopexy is a surgical procedure used to treat rectal prolapse and related conditions, in which surgical mesh is attached to the front (ventral) side of the rectum and secured to the sacrum (lower spine) to hold it in place.

And there's more…

There are the hundreds of women/wāhine harmed by the Essure permanent contraceptive device[3] who are still waiting for health agencies to formally recall and follow-up those who had the device implanted, having been gaslit and ghosted by the very health professionals who persuaded them to have the procedure.

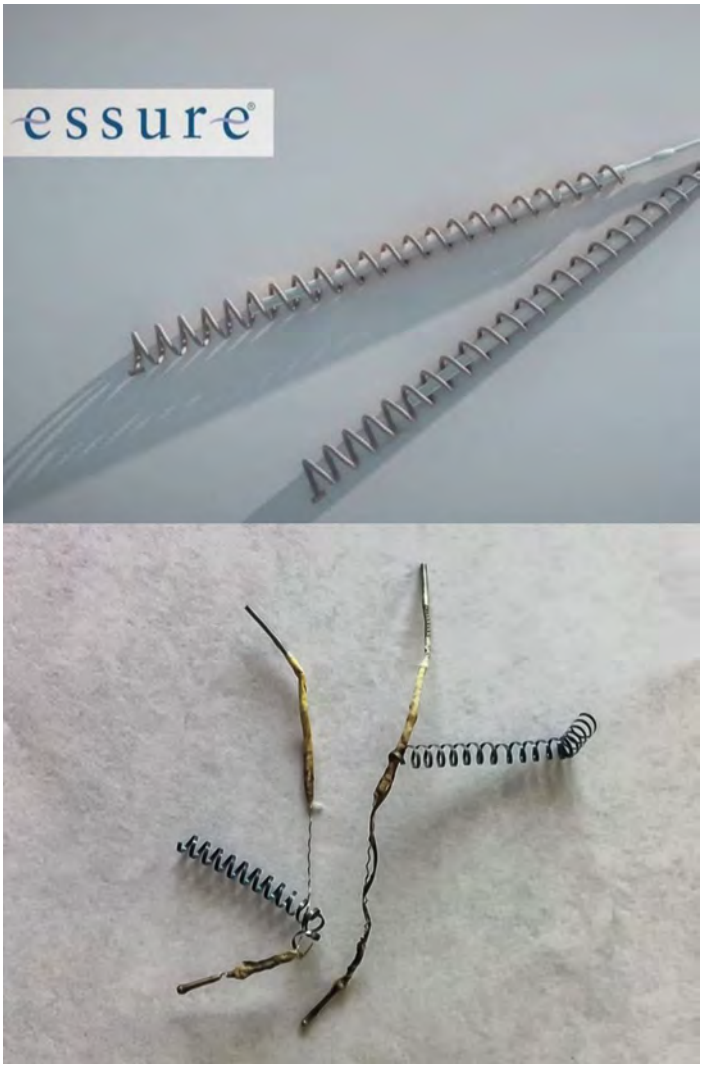
Catrina McGregor, who suffers from ongoing harm caused by Essure, launched a Parliamentary petition in 2024, seeking an investigation into Essure, a comprehensive recall of all women who had them implanted and full ACC coverage for any Essure-related care they may require. As a result of the petition, a team within the HealthNZ was set up to consider next steps in assisting women harmed by Essure, and they engaged with Essure injured women/wāhine and the Auckland Women's Health Council.

Despite high hopes that HealthNZ was taking this issue seriously and was actually going to do something for the women/wāhine whose health has been destroyed by Essure, everything has gone quiet. When I emailed the leaders of the HealthNZ Essure team recently to get an update on progress, no-one bothered to reply!

Surgical mesh and Essure are just two of the serious 'harm to women in the health system' issues on which AWHC has published articles in recent years. I don't have room here to go into detail about the women who suffered horrific harm from endometrial ablation procedures[4], and the women who have suffered significant adverse events associated with breast implants in breast reconstructions after breast cancer, including developing new cancers from the implants,[5] among other issues.

For a moment we should return to the NCSP Register and the review report, to get a sense of the attitude to women's health that it is not unusual to encounter in our health system.

Cervical cancer is preventable. The NCSP has proven this over the years, successfully reducing both the incidence of and mortality from cervical cancer. This benefits not only the individual women who don't develop invasive cervical cancer as a direct result of the screening programme, but whānau, communities and our nation as a whole, not the least of which is because of the economic benefit of avoiding costly cancer treatment in our public health system, and enabling women to live healthy lives.



Essure before implantation (top) and after removal (bottom), when the device has migrated, distorted, fractured and embedded itself in fallopian or uterine tissue causing extreme pain and systemic health issues.

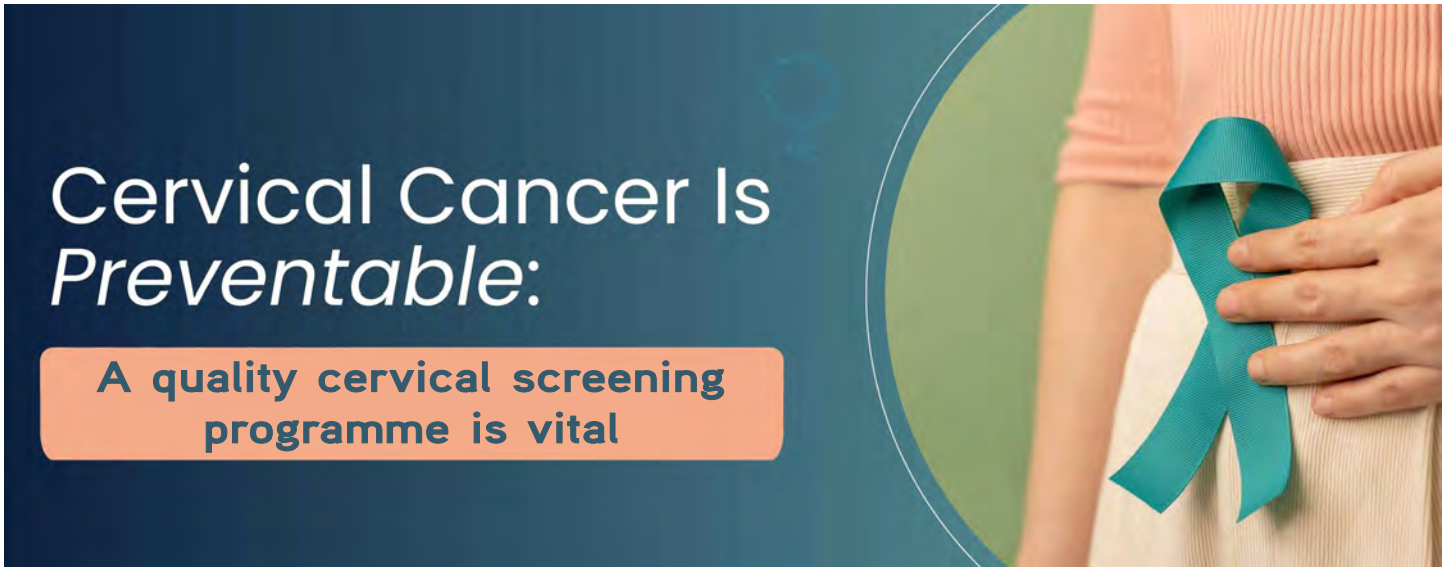
So, how is that a programme that was meant to protect women/wāhine has an IT system that has failed so abysmally?

HealthNZ has attempted to reassure us that all is well and there was no harm done:

"After 13,000 case reviews so far there is not yet any indication that anyone has experienced harm as a result of follow-up issues," said Alana Ewe-Snow, National Director, Prevention Screening for HealthNZ's National Public Health Service.[6]

But how do we know? Cervical cancer can take years to develop, and women may not know that they are at risk, may not realise that no recall notification is not necessarily good news.

One woman didn't find out for two years that her HPV test done in July 2024, was not able to be processed.[7] Ms Ewe-Snow told *Stuff* that some "tests cannot be processed due to technical reasons, and in these cases the healthcare provider (usually a



GP clinic) is notified by the laboratory and told to recall the patient." But surely a failed test should also be flagged in the Register and the woman notified that way.[7]

It gets worse!

On the 24th of August, investigative journalist Nicholas Jones (who broke the story on the NCSP Register failings[6]) reported on a 30-year-old Māori woman who was eventually diagnosed with stage 3 cervical cancer, after an unconscionable level of delay in follow-up after a positive HPV test result.[8]

"Rose"* tested positive for HPV 16/18† in the cervical screening programme, and should have — according to the guidelines — been referred to colposcopy** within 30 working days. It took six and a half months before she had a colposcopy appointment by which time she had developed severe symptoms of cervical cancer, including daily vaginal bleeding, which on one occasion led her to collapse. When she was eventually diagnosed with cervical cancer — 218 days after her original referral[8] — there were delays in commencement of her treatment, forcing her to book a private oncology appointment, and with a treatment plan was referred back to the public system. She finally began treatment two months after diagnosis, despite the fact that "the Government's 'faster cancer treatment' standard is within 31 days."[8]

Experts and consumer advocates warned that the shift to primary HPV screening would place pressure on limited colposcopy services.[8, 9] The NCSP Register review report also found that "colposcopy waiting times currently far exceed recommended timeframes, due to high demand and low capacity."[10]

Rose was not just a victim over an under-resourced and overwhelmed colposcopy service, but of the appalling failures of the new Register. The "Register's intended functionality to identify where follow-up has not occurred and initiate action to address this by creating tasks, is a critical safety process,"[14] say the review panel in the report. A critical safety process that absolutely failed Rose, and quite probably led to the advanced stage of her now invasive cervical cancer. How many other "Roses" are there around the motu?

During the NCSP Register review, the review panel undertook interviews with "a range of staff involved in the development of the Register and the delivery of cervical screening".[10] When discussing the notifications — 968,000 of them — that were never sent out, comments were made to the effect "it would cost several hundred thousand dollars to send 'catch-up' batches of notifications to all of these individuals," that some of these notifications had not been budgeted for and there was no funding available.

"It was also said that, as only about 20% of recipients were likely to act, this would not be an efficient use of funding."[10]

Let's unpack that.

Regarding the apparent lack of funding to send out catch-up batches, how can those notifications

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* Not her real name.

† HPV primary screening tests for high-risk types of HPV that are known to cause cervical cell changes. HPV Types 16 and 18 carry the highest risk and cause the majority of cervical cancers. Another pooled group of 12 additional high-risk HPV types are also tested for. If a woman/wāhine tests positive for HPV16 or 18 she is referred directly to colposcopy. If the result is for HPV "other" a cervical liquid-based cytology (LBC) sample will be taken.

** colposcopy is a medical procedure used to closely examine the cervix for abnormal cells using a specialised magnifying instrument called a colposcope. It helps detect early cell changes or precancerous conditions before they can develop into cancer.

not have been budgeted for? The 968,000 notifications were supposed to go out and didn't because of flaws in the Register. But surely there was funding for that, because why else would you have a Register that triggered notifications but no funding to send them?

Fortunately, irrespective of what NCSP staff said at the time, the review panel in their recommendations said, "Catch-up batches of unsent notifications must be sent as soon as possible."[10] Since the release of the report, Jane Grant, the manager of the NCSP, has said that "Budget was not the reason that those catch-up batches were not sent. There's been ongoing work from that time to strengthen the notification processes and to send out batches of notifications. It absolutely was not related to funding."[11]

There seems to be a pretty big disconnect between NCSP staff and management.

However, the more horrifying comment was that, as just 20% of women/wāhine receiving notifications were likely to act on them, it wasn't a cost-efficient exercise. Never mind that that 20% represented not just a few women, but more than 193,000!

This is an unbelievably cavalier attitude of staff towards a screening programme that over the years has saved thousands of lives*. How dare NCSP staff decide that potentially saving ten lives and preventing many even more cancers is not worth the cost of sending catch-up notifications?

(Based on rates of incidence and mortality from cervical cancer prior to the introduction of the NCSP, there could be as many as 27 cervical cancers and 10 deaths among those 193,000 women if they failed to have screening.)

It doesn't matter how many women/wāhine act on a catch-up notification, it is HealthNZ's responsibility to correct their mistake. Not to mention the considerably greater cost of treating the cervical cancers that should have been prevented had HNZ been doing their job, nor the personal and community burden of preventable cancer.

This really epitomises the lack of concern for women's health in Aotearoa New Zealand. The issues with the NCSP, the Register and delays in treatment, are symptomatic of the state of women's health in this country. As Andrea Vance said in her 9th of August article in *The Post*, "None of this happened in a vacuum. It is the end result of a culture where healthcare for women is an afterthought."[12]

As well as the NCSP Register debacle, far too many women are on long waiting lists for specialist appointments, especially gynae-oncology, and there is a significant shortage of women's health specialists. For example, the only gynae-oncologist in the Wellington region left in November 2024, and with no plan to fill that vacancy, women/wāhine from the Wellington region now have to travel to Christchurch for surgical treatment.[13]

The ways in which women's health in Aotearoa New Zealand is underfunded, unrecognised and treated as irrelevant or invisible gets longer every week.

The lack of recognition and invisibility of women's health issues is not helped by what Dr Fiona Imlach, of the Department of Public Health at University of Otago, says is "New Zealand's failure to properly capture health data on conditions that primarily affect women."[14] This "is contributing to a 'health gap' — and the consequences are being felt not only by women, but by the wider economy."[14]

A 2024 World Economic Forum Insight Report on the women's health gap found that "For all the efforts to improve gender equity over the past century, the gap between men's health and women's health remains wide, whether it's in research, data, care or investment."[15]

The Report says that despite women living longer than men, "women spend 25% more of their lives in debilitating health."[15] This is consistent with New Zealand data that shows that while women had a life expectancy of 83.2 years, their health

* Official Ministry of Health and government reviews estimate that the screening programme prevents roughly 750 cervical cancers and saves around 100 lives each year.

expectancy was only 65.2 years, meaning that on average they spend 18 years in poor health![16]

Medical research has persistently defaulted to the male body, resulting in "fewer available and less effective treatments for women."[15]

"Women are more likely to face barriers to care, and experience diagnostic delays and/or sub-optimal treatment" — 34% of the health gap is attributed to this care delivery gap.[15]

Additionally, "health burdens for women are systematically underestimated, with datasets that exclude or undervalue important conditions."

- Living well and ageing well.

The women/wāhine of Aotearoa New Zealand can tell you that as of August 2026, the Ministry of Health and HealthNZ have failed to make any real progress on any of these priorities. There may have been some tinkering around the edges, but overall, within our public health system, women/wāhine are worse off than they were three years ago.

Prioritising women's health benefits everyone — our women/wāhine, our whānau/families, our communities and even our GDP[24].

"A common theme we heard in our engagement was that gender bias is affecting women's health and wellbeing and their experiences in the health system. Women, the health sector, and organisations that support women, told us that women are often not heard or understood when they access health care, and there is a lack of knowledge and understanding and support in many areas of women's health."

— Women's Health Strategy[20]

Dr Imlach says that in Aotearoa New Zealand there is a lack of primary care data around conditions that only affect or disproportionately affect women, including endometriosis and other menstrual disorders, menopause, migraine and mood disorders.[14, 17]

In 2021, AWHC (among other women's health advocates) argued strongly for a women's health strategy to be included in the Pae Ora (Healthy Futures) Bill.[18] When Pae Ora (Healthy Futures) was enacted in 2022, it mandated a women's health strategy, as one of seven nationwide strategies to improve population health outcomes and reduce equity disparities. Not only did AWHC make a submission on the women's health strategy[19], but we were considered a key stakeholder and had meetings with the Ministry of Health women's health strategy team during the development of the strategy.

There are four priorities set out in the Women's Health Strategy:[20]

- A health system that works for women (overarching priority).
- Improving health care for issues specific to women.
- Better outcomes for mothers, whānau, and future generations.

When is HealthNZ, the Ministry of Health, and whichever parties are in government at any given time, going to give us what was promised — a health system that works for women!

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Help Us Continue Our Work

We need your help to continue our important work for the women/wāhine of Aotearoa New Zealand.

Auckland Women's Health Council relies on community funding grants and donations to keep our organisation functioning and to pay for operating expenses.

Subscription to our *Newsletter* and membership of the Council are free. People can subscribe to the *Newsletter* without becoming a member and receive the *Newsletter* directly into their email inbox. We continue to make it freely available on our website from the date of publication. We strongly believe in the importance and value of the information that we provide, the analysis and gendered perspectives on health, and we want all women/wāhine to have access to this without the burden of cost.

We have made donating to the Auckland Women's Health Council easier for those able to support us financially. We don't ask for a specific amount, but because we are a registered charity, any donations of $5 or over are eligible for a New Zealand charitable giving tax credit.

There are two ways that you can donate directly to the AWHC: through internet bank transfer or via Givealittle using your credit card. Information on making a donation through either of these methods is provided on our website. Thank you in advance to all those who can support us through a donation.

Auckland Women's Health Council

THE FORBIDDEN PHARMACY

By Sue Claridge

What a Locked-Door Installation Reveals About New Zealand's Medicines Gap

"Imagine being told the medicine you need exists — and it works. It's funded and prescribed every day in countries like Australia and the UK. But because you're in New Zealand, you can't afford it.

This is not hypothetical. It's the reality for thousands of New Zealanders right now."[1]

— Rare Disorders New Zealand

On a drizzly Saturday at the end of July, more than 1,500 people[2] walked through the doors of a "pop-up pharmacy" in Shed 10 on Auckland's waterfront. Its shelves were fully stocked, its packaging familiar — but every one of the 200+ medicines behind the glass were locked away, unreachable.

That was the point.

The Forbidden Pharmacy, a public installation created by a coalition of 17 patient organisations, was designed to shine a light on an issue that stays far too well hidden in health policy debate: the gap between the medicines New Zealanders need and the medicines Pharmac actually funds.

For women, the installation lands close to home. Several of its most visible patient advocates were women living with cancer, and the installation itself is a stark illustration of the funding pressures shaping breast, gynaecological, bowel and blood cancer care in Aotearoa New Zealand.[3]

A queue, not a maybe

Our medicines are funded through Pharmac; the health agency assesses new treatments and decides which are subsidised. Many drugs clear Pharmac's clinical assessment and are ranked as worth funding, only to sit on what is known as the Options for Investment list — treatments Pharmac has approved in principle but cannot afford within its capped budget. As campaign materials from the Migraine

Foundation explain, the list "is not a 'maybe.' It's a queue," with medicines waiting years for a budget large enough to reach them.[2]

The scale of that queue, according to figures the campaign draws from a recent PhRMA global access report, is stark: of 477 modern medicines launched worldwide over the past decade, only 24 have been funded in Aotearoa New Zealand — meaning roughly 95 percent of new medicines available elsewhere do not reach our shelves.[4, 5]

We currently spend about 0.4 percent of GDP per capita on publicly funded medicines, compared with an OECD average of 1.4 percent, placing our access to modern treatments among the weakest of comparable nations, alongside Poland, Turkey and Mexico on some measures.[4] Currently 600,000 New Zealanders are waiting for medicines Pharmac has recommended but does not fund.[6]

The cost behind the statistics

Behind those figures are patients making decisions no one should have to make. Judith Ansell, 70, is living with metastatic HER2-low breast cancer that has spread to her bones.[3, 4] After selling her home and moving in with her daughter to free up funds for treatment, she has already spent almost $100,000 on private cancer care and now faces a further bill of roughly $64,000 for six months of trastuzumab deruxtecan (Enhertu),[4] a drug funded in Australia, South Africa, Scotland and Lithuania, but not in New Zealand.

"The financial and emotional toll is becoming unsustainable as my treatment options narrow," Ansell has said, calling on political parties to "unlock access to the medicines New Zealanders need."[4]

Campaign spokesperson Tim Edmonds bluntly describes the choices patients face: "This is having to make decisions no New Zealander should ever have to make, remortgaging homes, setting up Givealittle pages, moving to another country," he said.[7]

Other stories featured in the installation include Jess, who lives with chronic migraine and lacks access to any of the four anti-CGRP medications sitting on Pharmac's priority funding list, and Jemma who has stage four bowel cancer and has spent hundreds of thousands of dollars for an unfunded drug and life-prolonging surgeries in Australia.[3, 7]

Politicians walk through, questions remain

The installation's opening drew MPs from National, Labour, ACT and New Zealand First,[1] along with Health Minister Simeon Brown, who toured the display and acknowledged there was "still more work to do" to improve medicines access.[6] Notably, the Green Party, Te Pāti Māori and The Opportunity Party did not attend, despite being invited.[2]

The campaign is careful to frame its 'ask' not as lobbying for specific drugs or interfering with Pharmac's clinical independence, but as a call for government to properly fund the agency so that medicines it has already deemed worth funding can actually reach patients.

Extending the message

In August, the campaign's backers released a 90-second film built entirely around patient interviews rather than voiceover. Director Reagen Butler spent two intense days filming one-on-one conversations with participants, later built into the installation's own screens.

It was the patients' statements and voices that were most important. "All of them are in really tricky situations they have very little ability to do anything about," Butler said of the participants, "but they had such a resolution and a power to them."[8]

With the general election looming, the coalition — spanning cancer, rare disorders, migraine, epilepsy and cardiac charities — is now collecting public signatures on an open letter to party leaders, urging a sustained, multi-year lift in medicines investment. For clinicians and patients navigating Aotearoa New Zealand's funding system, the installation's message is unambiguous: the medicines exist, the assessments are done, and what is missing is the money to unlock the door.

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Vanbulance Tour + book launch & documentary screening

Hīkoi 4 Health is an independent, grassroots initiative to advocate for a high-quality, equitable, and sustainable health system by amplifying community voices from across New Zealand.

In 2025, doctors Art Nahill and Glenn Colquhoun drove from Te Hāpua to Wellington in an old Ford Transit van painted up as a whimsical ambulance to protest the state of the New Zealand health system. They held a series of public meetings along the way to capture people's experiences and hear their ideas for reform.

Art and Glenn are getting back behind the wheel of their signature 'vanbulance' to launch their new book, *Rethinking Health: Lessons from the Hīkoi 4 Health* (see Book Review on page 23), alongside an upcoming documentary release. Starting on the 18th of September, the team will travel the length and breadth of the North Island again, to deliver their findings directly to the communities that shared their stories during the original 2025 hīkoi.

The hīkoi kicks off with a special documentary screening followed by a Q & A with Art and Glenn in Auckland on September 18th at The Factory Theatre in Onehunga, before heading through Northland, the Bay of Plenty, Gisborne, Hawke's Bay, Taranaki, and Manawatū, concluding with a presentation of their book to members of Parliament in Wellington.

According to Art, "though the kaupapa is coming to an end, we hope that some of the ideas in the documentary and book will create a sense of hope that that we're not chained to the old ways of doing things and that we can reimagine the kind of high-quality, equitable, and sustainable health system we all deserve."

Members of the public, local health advocates, and media are invited to attend the regional events to connect with the team and secure copies of the book. The most up-to-date information and any itinerary changes will be posted on healthreformnz.org

The official Hīkoi 4 Health tour itinerary is as follows:

Sept 18: Auckland – Documentary screening and Q&A at The Factory Theatre, Onehunga (7pm)

Sept 19: Kaitaia – Peekaboo Cafe (4:00 pm)

Sept 20: Kerikeri – The Old Packhouse Cafe (12:30 pm)

Te Tii – Te Hiruhārama Hou marae (5:30 pm)

Sept 21: Whangārei – Hihiaua Cultural Centre (12:00 pm)

Sept 22: Hamilton – Te Kōhao Health Clinic (3:00 pm)

Sept 23: Whakatāne – Knox Presbyterian Church (6:00 pm)

Sept 24: Ōpōtiki – Ōpōtiki District Library (12:00 pm)

Gisborne – Manawaru Cafe (6:00 pm)

Sept 25: Hastings – Hastings Library (1:00 pm)

Sept 27: Whanganui – Lockett Gallery (11:00 am)

New Plymouth – Te Whare Hononga, Taranaki Cathedral (6:00 pm)

Sept 28: Palmerston North – Palmerston North Library (2:00 pm)

Levin – Horowhenua Youth Health Service (6:00 pm)

Sept 30: Wellington – Parliament Grounds (12:00 pm)

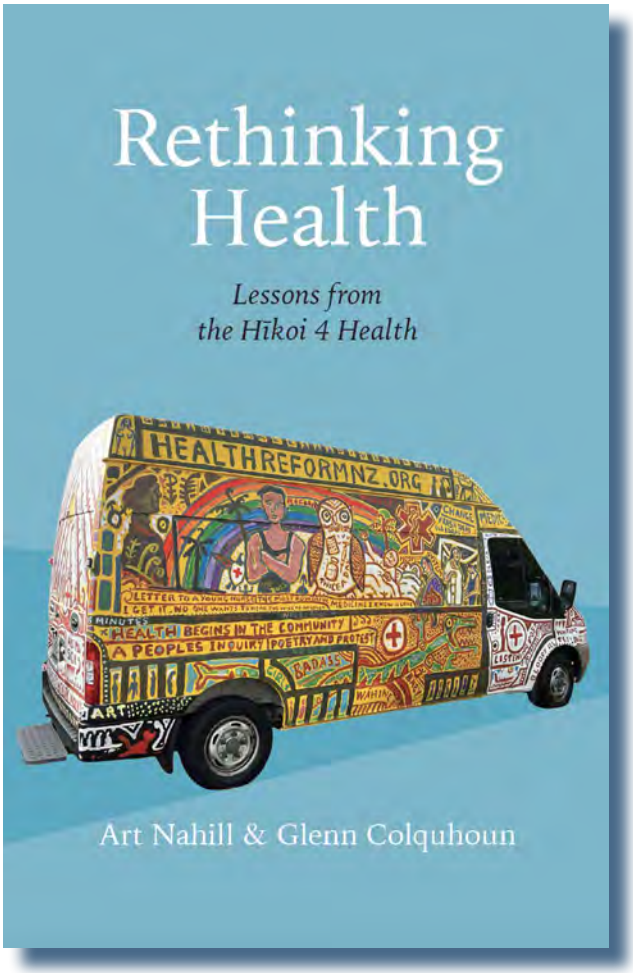
Documentary screening, Q & A at Lighthouse Theatre on Cuba, Te Aro (6:00 pm)

Rethinking Health

Lessons from the Hīkoi 4 Health

By Art Nahill and Glenn Colquhoun

Review by Sue Claridge



Often when I feel a book is worth reviewing, I find something on virtually every page that I want to quote in my review. Impossible, of course, but this is how *Rethinking Health* by Art Nahill and Glenn Colquhoun reads.

What I'm really saying is "There's so much great stuff in here, so much that really resonates, just read it for yourself." But that would make for a really brief piece, and would be rather pointless as reviews go.

The back cover blurb tells us that Art and Glenn are doctors — Art worked for 20 years as a physician at Middlemore and Auckland Hospitals. Glenn is a GP working in adolescent health in Horowhenua.

Both are poets.

Published poets!

Which is really not what I was expecting, but also very cool, because doctors do have lives outside our health system. To be honest, doctors probably really need fulfilling, rewarding lives outside our health system. Which leads me to the Hīkoi 4 Health.

In 2025, they bought an old transit van, had it painted like an ambulance and drove it from Te Hāpua, in Northland, to Wellington. The imagery on the cover shows a van that looks less like an ambulance than a hippie campervan off on a fun and adventurous road trip.

Art and Glenn's excellent hikoi

However, what is inside the book, is not some hippie travel journal full of fun, frivolity and adventure, but the story of the Hīkoi 4 Health. It's the story of two doctors, so disillusioned by the state of the public health system in which they work, that they both put down their poetry books and their stethoscopes to find out from health consumers and innovative health workers what a fit-for-purpose health system would look like in Aotearoa New Zealand in the 21st century.

Rethinking Health is a fairly short book, running to only 135 pages of actual text; a relatively easy day's read, if one was to read it cover to cover in one sitting.

Rethinking Health is going to naturally attract readers with

Hīkoi 4 Health videographers Emily and Oriwa, with Glenn and Art with the vanbulance.

real concern for our "critically ill" health system; especially those who work within it, and members of health consumer and workforce organisations who have been advocating for change for years if not decades. For such readers, *Rethinking Health* is 'preaching to the converted'. While some of the ideas for reform that are laid out in the book may be 'outside the box', the overall concerns, observations and issues that need truly innovative approaches to solve, will largely be familiar territory.

What we really need is for every member of parliament and aspiring MP to read it… not just those who hold health portfolios or spokesperson roles, but every single Member of Parliament. We need all the policy makers and decision makers in the Ministry of Health and HealthNZ, and all the leaders in all our hospitals and other health services to read it. The boards and managers in all our health agencies as well.

To really read it, as if their futures depended on understanding what this book is actually saying.

They acknowledge that our allopathic, conventional western medical approach to health and healing is not the only approach that is valid, and they acknowledge the role of holistic and 'alternative' approaches that are increasingly important to many New Zealanders.

In their vision for building a health system that is fit for purpose in twenty-first-century Aotearoa New Zealand, Art and Glenn present some radical ideas, a concept of a health system that structurally, practically and functionally looks very, very different from what we have now. It is certainly a far more holistic and people centred vision than anything I've seen before.

I don't doubt that there will be a lot of "shock-horror" reactions. Exclamations that, well, you can't build a health system that looks like that!

But in totality, the ideas make sense. We can't keep operating our health system the way we have for the last three decades and expect better outcomes. It is literally the definition of stupidity and failure. What we need is true 21st century thinking and innovation to guide us towards an equitable, people-centred health and wellness system, that places prevention of ill-health as the one of the most important concepts and takes the power away from commercial interests so that all New Zealanders may live healthy lives.

"Māori world views reflect values that are crucial to good primary healthcare. These values include the idea that the wellbeing of human beings depends on the balance of their physical, mental, social and spiritual health. Māori also instinctively understand the roles of aroha and manaakitanga in medicine."

I read this book, in part, thinking about what to write in this review, expecting to take a pretty standard approach to how I would write it. By the end I had decided that summarising what the book is about is not the most important thing.

What you need to know is that Art and Glenn really listened to the people they met. Personal stories are scattered throughout the first half. They appear to have put aside the biases and beliefs about medicine that are held by most doctors I've met. Their sections on what ails our health system and how our people experience it are astute. Their observations are grounded in an understanding of the inequities of our health system and what it means for New Zealanders from many communities — Māori; Pasifika; rural; isolated; disabled; LGBTQI; impoverished; those with complex, rare, and undiagnosed conditions — to live with unmet health needs.

Art and Glenn focus on the necessity of putting prevention first; to ensure that primary care is able to prevent many people ending up in secondary care. They understand and highlight the social and commercial determinants of ill-health. They understand that health is more than just not being sick. They reference the Māori approach to health and wellbeing; that hauora is in itself a taonga.

Rethinking Health presents options for precisely that sort of health system.

Importantly, *Rethinking Health* addresses some of the biggest stumbling blocks to achieving a health system that works and meets the needs of our people.

- Our "health system should be independent from party politics", and have a legal framework that "gives it a measure of independence from Government." A health system that is not driven by political ideologies and subject to the election cycle. There must be "greater control and transparency around the ways lobbyists affect political decision-making" especially as it pertains to commercial determinants of health.
- There must be a "balance between public and private healthcare options," "better workforce management strategies", and funding reform.

- The "health system needs to be inclusive of at-risk populations"; "a prevention-focused, person-centred, community-based health system that is appropriately funded and staffed to provide the many wrap-around services often required by these groups of patients."

Some, perhaps many, people will find a few of the issues raised, and solutions offered, in *Rethinking Health*, confronting, perhaps a bit strange, outside of their comfort zone. It is thought provoking and will challenge many views about what is wrong with our health system and how it should be fixed. Many will think that scrapping what we have, starting again and building a new health system from the ground up is a step too far. But tinkering around the edges, and ill-conceived and ill-timed reforms over the last few decades has left our health system in ICU with scant optimism that it is going to recover.

If you read no other treatise on Aotearoa New Zealand's public health system this year (or next) read *Rethinking Health*. Drs Art Nahill and Glenn Colquhoun's vision for our future may not be the perfect one (is a perfect solution even possible?).

But we could do a lot worse.

The worst we could do is to carry on down the road we are already on.

Rethinking Health: Lessons from the Hīkoi 4 Health will be in selected bookshops, but will be able to be ordered from any bookshop. It will also be available from the website healthreformnz.org. It will be $30 at bookshops and online.

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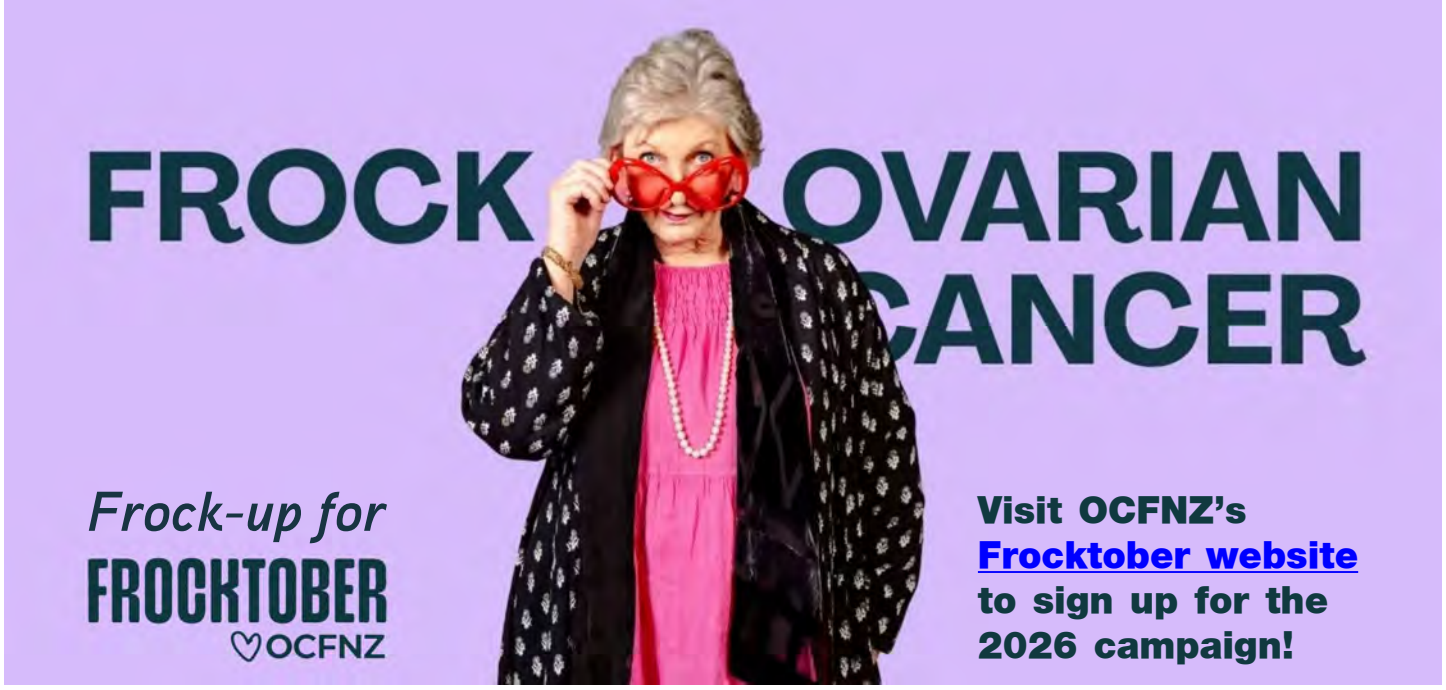
Don't forget to let us know what health topics you are most interested in.

For back issues of our Newsletter, check out our website.



New Zealanders are being asked by the Ovarian Cancer Foundation* to frock-up for Frockotober and for ovarian cancer.

Every October, Frocktober invites kiwis to dress up, stand up, and speak out for ovarian cancer research. Getting involved is simple: get dressed up — however that looks for you — and use it to start conversations, turn heads, and raise funds. No sewing skills, fashion degree or big wardrobe required; just enthusiasm, creativity and a willingness to stand out.

Turning heads in Frocktober offers a chance to spark crucial conversations about ovarian cancer. OCFNZ says its an opportunity for people to talk about the challenges of early detection, treatment and prevention and raise awareness of the often vague symptoms.

OCFNZ is also calling upon Frockers to raise crucial funds for them, thus supporting research aimed at improving detection methods, developing more effective treatments and seeking preventative measures for ovarian cancer.

Frocktober was started by 10 friends from Geelong in Australia in 2007. Their aim was to shine a spotlight on ovarian cancer, one of the least survivable and least-known cancers affecting women. In 2016, the founders entrusted the campaign to the Australian Ovarian Cancer Research Foundation, and in 2025 OCFNZ proudly became the licensed New Zealand partner for Frocktober.

In October 2025, OCFNZ held its first Frocktober campaign with over 200 participants and raised over $145,000. Together with the "Long Lunch", hosted in Auckland on the 3rd of October 2025, OCFNZ raised a total of $235,000. At the end of the year they announced the recipients of their 2025 ovarian cancer grants (find out more in AWHC's February 2026 Newsletter).

Whether you choose to wear a fabulous frock, a bold suit, a colourful shirt, or simply something that sparks conversation, every outfit has the power to make a difference. By frocking up, you're helping raise awareness of ovarian cancer while supporting research that brings us closer to earlier detection, better treatments, and ultimately, better survival rates.

As this edition of the *Newsletter* goes to press, OCFNZ's Frocktober campaign has already raised $6,483 on the way to this year's goal of $152,000!

You can keep an eye on their progress here! Or follow them on Facebook or Instagram.

* The Ovarian Cancer Foundation New Zealand (OCFNZ)

Research & News Briefs

New Endometriosis Guidelines

Welcome Step, But Not Without Gaps

In potentially exciting news for sufferers of endometriosis, changes to diagnostic guidelines announced by Minister of Health Simeon Brown and Minister for Women Nicola Grigg on the 18th of August, could see an end to the years long wait most women have to live through before their suffering is recognised.[1]

For years, women/wāhine with endometriosis have faced one of the longest diagnostic waits in women's health; a median of ten years says Endometriosis NZ Chief Executive Tanya Cooke.[2] The recent announcement that Aotearoa New Zealand will adapt the Australian Living Evidence Guideline on Endometriosis, developed by RANZCOG* for use here — expected to be finalised and rolled out in mid-2027[3] — has been met with mixed reactions from clinicians and advocates.

Laparoscopic surgery has been the "gold standard" for confirming endometriosis, forcing patients onto lengthy specialist and surgical waitlists before treatment can even begin.[3, 4] The new guidelines will let GPs make a clinical diagnosis based on symptoms, family history and physical examination, supported by imaging such as transvaginal ultrasound, rather than requiring surgical confirmation first.[1, 5] Once a clinical diagnosis is made, GPs will be able to prescribe treatment immediately, including low-impact hormonal medication, which is effective for up to 60 percent of women.

Tanya Cooke called the change "a big win," noting it should mean people "receive a diagnosis much earlier and can commence treatment".[2] Beyond faster, less invasive diagnosis, the Minister of Health argues the shift will ease pressure on the wider health system: by allowing more diagnosis and treatment to happen in primary care, fewer women will need hospital referrals purely to confirm what their symptoms already indicate, freeing specialists to focus on those needing surgery.[1] Nicola Grigg, Minister for Women, added that HealthNZ is also exploring additional pain management support, including pain education and allied health services.[1]

It seems that not everyone is convinced the guidelines alone will fix the problem. *New Zealand Doctor* reported that a women's health GP described the plan as having "holes in it you could drive a bus through",[6] reflecting concern that clinical guidance is only as good as the training, referral pathways and diagnostic capacity behind it. Sexual Wellbeing Aotearoa echoed this, warning that "unless funding follows for the treatment, training and testing, the benefits of the guidelines will be limited to those who can afford to pay."[7]

This concern is compounded by the fact that guidelines are non-binding recommendations, not mandated standards, a criticism doctors have levelled at New Zealand's endometriosis guidance for years, after the previous 2020 Ministry of Health guidelines were widely described as outdated.[4] Research by Endometriosis New Zealand and the University of Canterbury has found that low public and clinical awareness remains a major driver of diagnostic delay regardless of the guidelines used, with patients unaware of the condition facing a median 11-year wait, compared with nine years for those who had heard of it.[8] This suggests guideline changes need to be paired with broader awareness campaigns to have full effect.

Notably, the announcement did not come with a dedicated new funding package for endometriosis treatment, testing or GP training. Nicola Grigg acknowledged that "guidelines alone will not fix" the awareness and recognition problem, saying HealthNZ is "developing training and resources" to help GPs apply the new approach.[1] However, advocacy groups such as Endometriosis New Zealand and Sexual Wellbeing Aotearoa have both stressed that without dedicated funding for imaging, primary-care training and treatment subsidies, the guidelines risk widening inequities, since better care could depend on a patient's ability to pay privately.[2, 7]

* Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Auckland Women's Health Council is pleased that the diagnostic delays that affect women/wāhine with endometriosis have been addressed at a Ministerial level. However, the new Guidelines are only the starting point; their real-world impact will depend on whether the government backs them with funding, training and enforceable standards.

Like other consumer advocates and health professionals, we want to see the Government and HealthNZ 'put their money where their mouths are'. Without funding for improved awareness, understanding of the condition, and greater empathy among among GPs for the very real pain and debilitation that women/wāhine with endometriosis suffer, these changes are just a lot of talk.

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Rewriting the Rules on Period Pain

For most Year 13 students, the biggest challenge of the school year is juggling NCEA exams, university applications and a part-time job. For Milena Carroll, Olivia Floyd and Lauren Hunt, it's also been build-ing a business from scratch, one that's tackling a problem millions of people quietly live with every month.

"We created Embrace because we know firsthand how much period pain can affect everyday life."[1]

Milena Carroll, Olivia Floyd and Lauren Hunt, co-founders of Embrace.

The three friends from Glendowie College are the founders of Embrace, a student-led start-up that has created discreet, long-lasting heat patches designed to ease period pain and keep people at school, at work, on the sports field and everywhere else life takes them. Each patch delivers targeted warmth for up to ten hours, making it easier to manage period pain through a full day of school, work or everyday life.[2]

The venture began, as so many great ideas do, inside a classroom. Embrace has its origins in the Young Enterprise Scheme (YES), a nationwide programme that gives secondary school students the chance to design, build and run a real business over the course of a year. It wasn't the trio's first attempt at entrepreneurship; last year the group made a fairly ordinary hair oil business, but they wanted this year's project to actually make a difference and stand out from the crowd.

"The idea for the business came after I was hospitalised during a rowing training camp because of period pain. I came back to school after recovering, and we had a friend group conversation with lots of people and realised how much of an issue it was."[2]

— Lauren Hunt

That determination shaped everything about Embrace, from its purpose to its product. Milena, Olivia and Lauren say they wanted to build more than just another period-care product. They describe Embrace as a movement to reduce the stigma surrounding period pain and give young women greater support so they don't have to put their lives on hold when period pain strikes.

Designing a heat patch that actually works for the body it's meant to help took real research. The team workshopped a range of shapes before settling on a triangular design that mirrors the curvature of the uterus and the female body, allowing the heat to sit exactly where it's needed most. That decision wasn't guesswork. The students surveyed a wide cross-section of potential customers, from their own schoolmates to girls' schools, sports clubs and university students, to understand what people actually wanted from a pain-relief product: something effective, comfortable and easy to use.

The result is a product created by young people, for young people, but with an appeal that stretches well beyond the school gates. Each five-pack of Embrace Heat Patches is designed to slip discreetly under clothing, delivering soothing warmth through busy days at school, packed shifts at work, sports training or exams, all without anyone knowing it's there.

What makes the Embrace story so heartening isn't just the product itself, but what it represents. Three teenagers looked at a problem that affects roughly half the population and decided they were exactly the right people to solve it, not despite their age, but because of the fresh eyes and lived experience they brought to it. Rather than treating period pain as something to simply endure, they treated it as a real problem worth a real and practical solution.

Embrace is a genuinely uplifting glimpse of the next generation of Kiwi entrepreneurs: young women unafraid to talk openly about a topic that's too often whispered about, and determined to build something that makes life a little easier for the people who need it.

Embrace's heat patches are now available to order online, shipping around the motu, with the three founders continuing to grow the business well beyond their Year 13 classroom.

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New Hope for Advanced Pancreatic Cancer

On the 26th of August the US Food and Drug Administration (FDA) approved daraxonrasib, sold under the brand name Rasonque, a new targeted therapy for metastatic pancreatic cancer, a milestone many oncologists have waited decades to see. The approval was granted roughly six and a half months ahead of the FDAs review deadline, as the drug showed 'unprecedented' results for a disease that has few treatment options.[1]

While in Aotearoa New Zealand incidence is higher among men than women (and 80% higher among Māori than non-Māori)[2], the prospect of a drug that shows such promise in the treatment of pancreatic cancer, and improved survival times, is particularly poignant for the Auckland Women's Health Council. Two of our beloved Committee members — Lynda Williams and Jo Fitzpatrick — died from pancreatic cancer just seven months apart in 2017 and 2018.

Pancreatic cancer is usually diagnosed at an advanced stage (metastatic) because the disease grows silently, with early symptoms that are common to many less serious conditions, it hides deep inside the abdomen, and there is no simple routine screening test. In Aotearoa New Zealand, the overall median survival time for pancreatic cancer is approximately three to four months, and the 5-year

survival rate is about 12%.[3] Approximately 630 New Zealanders are diagnosed with pancreatic cancer each year.[3]

Daraxonrasib is a once-daily oral pill that belongs to a new class of drugs known as RAS(ON) inhibitors, designed to block RAS proteins, a family of molecules long considered "undruggable" because of their smooth, hard-to-target structure.[4] Daraxonrasib blocks the activity of multiple RAS mutation types at once, including the KRAS mutations found in more than 90% of pancreatic adenocarcinomas, the most common and aggressive form of pancreatic cancer.[2, 4,] Because RAS mutations drive uncontrolled tumour growth, switching off this pathway can slow or shrink tumours that have resisted standard chemotherapy.

Patients don't need confirmed RAS-mutant disease to qualify, since the vast majority of pancreatic cancers are thought to be RAS-driven even when a mutation isn't detected on testing.[5]

In the phase 3, RASolute 302 trial, an international, randomised study of 500 previously treated pancreatic cancer patients, led by Dr Brian Wolpin of Dana-Farber Cancer Institute, patients receiving daraxonrasib had a median overall survival of 13.2 months, compared with 6.7 months for those on standard chemotherapy, and a 60% reduction in the risk of death.[4, 6] Progression-free survival also improved, from 3.6 months on chemotherapy to 7.2 months on daraxonrasib, and tumour response rates nearly tripled.[4] Additionally, patients had improved quality of life compared with chemotherapy.[7]

Gastrointestinal oncologist Dr Nicholas Hornstein described daraxonrasib as "the first ever effective systemic therapy for pancreas cancer that is not a chemotherapy," predicting it will quickly become standard second-line care.[7]

However, daraxonrasib is not yet available in New Zealand and has not received Medsafe approval. The Gut Cancer Foundation NZ, which represents patients affected by gastrointestinal cancers in this country, welcomed the trial results while noting the drug's absence locally, and said it would continue "advocating on behalf of our community to ensure approval for use in New Zealand is sought as quickly as possible".[2]

If this drug turns out to be as good as it promises to be from the trials, we can only hope that it will bypass the "Forbidden Pharmacy" (see page 20).

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Kaitiaki Hauora are in Campaign Mode

Kaitiaki Hauora
TOGETHER FOR PUBLIC HEALTH

Kaitiaki Hauora (see our May 2026 Newsletter) are hard out campaigning for a better health system. As well as supporting wider campaigns, such as Pay Equity, and co-hosting the Patient Safety Forum (see Page 4), they have an active poster campaign for better health care, and are preparing for a nationwide roadshow.

Poster Campaign for Better Health Care

More than 1,500 healthcare workers have told Kaitiaki Hauora what it is really like working in Aotearoa New Zealand's public health system. They think New Zealanders should hear what they have to say.

Health workers know what good care looks like. Kaitiaki Hauora's nationwide poster campaign shares anonymous reflections from the people at the heart of our public health system, helping New Zealanders understand why proper funding means more time to care and better care for everyone.

For months, Kaitiaki Hauora has been bringing people together to protect Aotearoa New Zealand's public health system, and AWHC is proud to stand alongside all the other advocacy and health workforce organisations that are members. Through public events, research, advocacy and national campaigns, they are turning concern into action and ensuring communities have a voice in the decisions that shape healthcare. The poster campaign is part of this push for change.

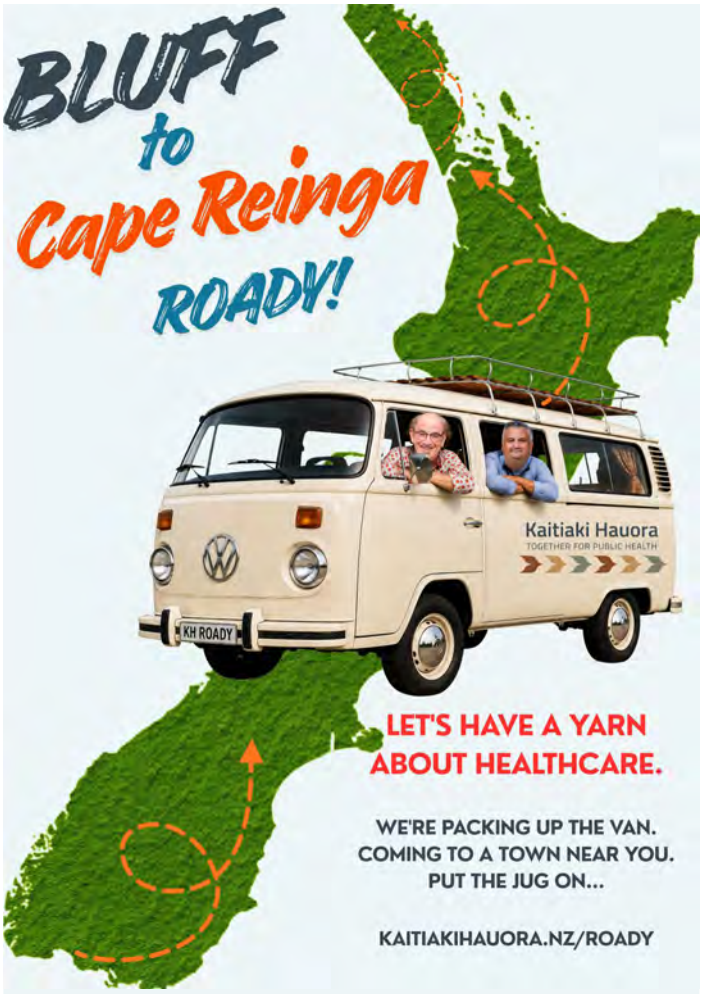
The poster campaign uses the actual words of healthcare workers from a survey about what is happening inside the public health system.

And they did not sugarcoat it. They said there aren't enough staff. That patients are waiting too long. That buildings and equipment are old and failing. That people are exhausted and burnt out.

They said they are worried they won't be able to give patients the care they need, or that something will go seriously wrong because people are being asked to do too much with too little.

The quotes on the posters come directly from healthcare workers we rely on every day. The same healthcare workers looking after you and your whānau when you need them.

Keep a look out for the posters in your community. If you'd like to be part of this campaign, you can download and print out the posters to put up at your office or workplace, a local café or library; anywhere that other New Zealanders will see them.



This October, Kaitiaki Hauora is heading from Bluff to Cape Reinga, stopping along the way to talk about the future of public healthcare in Aotearoa New Zealand.

They want to hear what's happening in your community, share what they're seeing across the health system, and have an honest conversation about what needs to change.

The public meetings are free and everyone is welcome. Find a Roady stop near you on the Kaitiaki Hauora website.

Dates, venues and local speakers are being confirmed as we go to press, and more stops will be added as details are locked in.

Why is Kaitiaki Hauora doing this? Our public health system belongs to all of us. Over the past year, Kaitiaki Hauora has heard from patients, whānau, healthcare workers and communities across the country about what's happening in our health system. Now they are coming to you.

They'll talk about what's happening, what it means for patients and communities, and what we need from our political leaders as we head towards the election.

"Roles are not being filled to save money. There's more days with one nurse on, when the work needs two."

– Paediatric Nurse

It doesn't have to be this way

High-quality public healthcare that is safe and accessible for everyone is possible.

#VoteForHealth

Kaitiaki Hauora
TOGETHER FOR PUBLIC HEALTH

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