National Council of Women of New Zealand
Te Kaunihera Wahine o Aotearoa

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MAKING EQUALITY REALITY

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S26.14

Submission to Te Aho o Te Kahu/the Cancer Control Agency on the Draft Cervical Cancer Elimination Plan

Introduction

1. The National Council of Women of New Zealand, Te Kaunihera Wāhine o Aotearoa (NCWNZ) is an umbrella group representing around 60 affiliated organisations and 300 individual members. Collectively, our reach is over 200,000, with many of our membership organisations representing all genders. NCWNZ has 12 branches across the country.

2. NCWNZ's vision is a gender equal New Zealand and research shows we will be better off socially and economically if we are gender equal. Through research, discussion and action, NCWNZ in partnership with others, seeks to realise its vision of gender equality because it is a basic human right.

3. This submission has been prepared by the NCWNZ Safety Health and Wellbeing Action Hub and the Submissions Coordination Committee. Our submission is based on extensive consultation with our members on women's health issues over many years, including submissions on the Pae Ora (Healthy Futures) Bill, the Women's Health Strategy, and the Draft Mental Health and Wellbeing Strategy[1]. Given the very tight timeframe, we have been able to have only limited consultation with our membership on this Draft Cervical Cancer Elimination Plan (the Draft Plan)[2].

4. We appreciate the opportunity to make a submission on the Draft Plan, which provides an exciting opportunity for Aotearoa/New Zealand to eliminate this awful but preventable disease, and to protect future generations from cervical and other cancers

[1] National Council of Women of New Zealand, Submissions: Submissions - National Council of Women of New Zealand. S23.07 Submission to Manatū Hauora | Ministry of Health on the Women's Health Strategy; S21.28 Submission to the Health Committee on the Pae Ora (Healthy Futures) Bill, and S26.05 on the Draft Mental Health and Wellbeing Strategy 2026 – 2036.

[2] Te Aho o Te Kahu, Cancer Control Agency. 2026. Draft New Zealand Cervical Cancer Elimination Plan (draft Plan).

caused by the HPV virus. We find the Draft Plan comprehensive, clear and coherent, and well-presented.

5. NCWNZ's submission is structured around comments on the 4 Pillars of the Draft Plan; we have not completed the feedback forms, as many of the items require more clinical expertise than we have.

6. We have also commented on "out of scope" issues that we consider absolutely critical to the effectiveness of the Plan - e.g., ring-fenced and sustainable funding, as well as workforce development - in light of the recent report on the alarming failures of the National Cervical Screening Programme's Population Based Register, an essential element of the Plan.

Summary

7. Cervical cancer services are yet another area in which disparities exist between Māori, Pasefika, some other ethnicities, disabled and low-income groups of women. In our submission on the Women's Health Strategy[3], and consistently throughout all our submissions, we have highlighted these large and continuing disparities. We are very pleased to see this acknowledged in the Draft Plan.

8. NCWNZ has advocated strongly for disabled women as a disadvantaged group of women. There are little data and research about their experiences of health services and their health outcomes; hence it is good to see this acknowledged in the Draft Plan. The same is true for LGBTQI people.

9. However, we fear that this could be a missed opportunity to finally eliminate cervical cancer unless there is clear prioritisation of this Plan by Te Whatu Ora/Health NZ and Government commitment to annual, budgeted ring-fenced funding until the targets are met, and beyond to maintain achievements.

Recommendations

10. NCWNZ recommends that there is:

    i. a clear commitment to honouring Te Tiriti o Waitangi/The Treaty of Waitangi included in the Draft Plan;

    ii. clear acknowledgment of equity, accessibility, and Te Tiriti o Waitangi obligations embedded throughout the Plan;

    iii. a clear commitment to adequately resourcing communities and their organisations to co-design and deliver the Plan;

    iv. targets for elimination for each ethnicity and priority population, which would be a better indication of progress - especially on equity;

[3] National Council of Women of New Zealand, Submissions: Submissions - National Council of Women of New Zealand. S23.07 Submission to Manatū Hauora | Ministry of Health on the Women's Health Strategy

v. encouragement for young men and older people to receive vaccinations;

vi. routine offering of HPV testing during pregnancy included in the Plan;

vii. free Cervical screening for everyone who is eligible;

viii. free recall and follow-up processes for people overdue for repeat HPV tests, cytology tests, and colposcopy appointments; and

ix. budget for actions - including a workforce development plan and a commitment to annual, budgeted ring-fenced funding - until the targets are met, as well as beyond, in order to maintain achievements.

Te Tiriti o Waitangi

11. The NCWNZ submission on the Women's Health Strategy states:

    "The unmet health needs and outcome disparities between wāhine Māori and Pākehā women are shocking and a breach of Te Tiriti o Waitangi obligations" (p.27)[4].

12. The Draft Plan says it is taking a population needs-based approach and acknowledges Māori as a high-needs population regarding cervical cancer. In the Supplementary Document (SD), there is a statement about Te Tiriti/the Treaty:

    "The health sector is committed to honouring the special relationship between Māori and the Crown under the Treaty of Waitangi... the Hauora Māori Advisory Committee has identified cervical screening and HPV vaccination as measures for improving Māori health outcomes. Recommendations from the Hauora Māori Advisory Committee monitoring reports on these areas have been used to inform the plan" (p.9)[5].

13. However, Te Tiriti/the Treaty is not mentioned in the Draft Plan itself, which is what most people will access; this is extremely disappointing. We recommend that such a statement is included.

Inclusion/meeting diverse needs

14. NCWNZ is similarly concerned that specific actions to support disabled, Pasefika, ethnic, and LGBTQI communities are spelt out in the Supplementary Document but are not adequately reflected in the Draft Elimination Plan itself. In our view, these actions should be explicitly incorporated into the Plan.

15. We welcome the emphasis on working with and through "grassroots" and trusted community organisations; however, to have integrity and to be effective, communities, their advocates, and service delivery providers must be central to the design, development, implementation, and evaluation of all implementation activities.

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[4] National Council of Women of New Zealand, Submissions: Submissions - National Council of Women of New Zealand. S23.07 Submission to Manatū Hauora | Ministry of Health on the Women's Health Strategy

[5] Te Aho o Te Kahu, Cancer Control Agency. 2026. Draft Supplementary Document to the New Zealand Cervical Cancer Elimination Plan (supplementary document).

Targets

16. Although NCWNZ recognises that setting realistic but ambitious targets requires clinical expertise, some of the targets seem to us unambitious, as they are already close to achievement. For example, 80% of eligible are up to date with screening, when we are already at about 77%.

17. Additionally, given existing disparities, we recommend providing specific elimination targets for each ethnicity and priority population; this would provide a better indication of progress, particularly in terms of equity.

18. NCWNZ notes that elimination is not eradication; targets must therefore be continually monitored and reported, and funding sustained.

Pillars

Pillar 1: Improve HPV vaccination rates

19. Prevention is always better than cure, and the effectiveness of the HPV vaccine means this area should be the priority in the Plan. NCWNZ strongly supports all the proposed measures, but particularly #7 to identify and particularly focus on Māori, Pacific peoples, people living in areas of high deprivation, disabled people and those having their first cervical screening at age 25 if they aren't already vaccinated. We recommend that young men and older women be identified as priority groups for vaccinations.

20. We also particularly support #5 and #8, and the emphasis on working through providers that already have established connections with people with unmet need, with tailored information, resources and tools to increase HPV vaccination uptake - such as Iwi-Māori Partnership boards.

21. NCWNZ supports the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) guideline to explore routine offering of HPV testing during pregnancy, for example, at the time of booking an antenatal visit.[6]

22. However, we believe that the Plan should be clearer concerning the provision of adequate and sustainable resourcing in order to support equitable participation and implementation.

Pillar 2: Improve HPV screening coverage and follow-up of positive screening results

23. Given the recent report on the alarming failures of the National Cervical Screening Programme's Population Based Register, it is very disheartening to see that the increase in screening due to the introduction of primary/self HPV testing is being undermined by widespread, systemic failures in the NCSP, particularly in terms of notification. We find it difficult to accept Te Whatu Ora/Health NZ's statement that there is *no indication that*

[6] National Cervical Screening Programme. (2023). *Section 11: Screening and colposcopy during pregnancy*. https://pmaanz.org.nz/assets/Uploads/FINAL_CPG-Section-11-Screening-and-colposcopy-during-pregnancy.pdf

anyone has experienced harm as a result of pathway status or follow-up failures.[7] At best, many women will have experienced anxiety and stress from delays in notification.

24. NCWNZ supports the proposed actions on screening; however, it is not clear which of these are part of the 48 recommendations from the Review report, which are already underway, and which will be new actions.

25. We strongly recommend that cervical screening should be free for everyone who is eligible in order to remove another very real barrier to access. There is no reason that bowel and breast cancer screening should be free but not cervical. (#11)

26. We note that #15 recommends strengthening recall and follow-up processes for people overdue for repeat HPV tests, cytology tests and colposcopy appointments. If this service was free for everyone, it could improve rates of recall. Currently, some people have to pay to see the GP twice; i.e., if they have had one appointment for a self-swab (which then comes back positive) and then need a second appointment to have a traditional cervical sample or smear conducted by their GP.

Pillar 3: Improve treatment of cervical pre-cancer and cancer

27. In health-related submissions, NCWNZ has repeatedly drawn attention to workforce issues, such as training, recruitment, and retention. It is clear that workforce capacity is the main reason for delay in treatment of cervical cancer. "*This may reflect the fact that surgery is the most common initial treatment for cervical cancer and is subject to additional capacity constraints, including operating theatre availability, access to general anaesthesia and other surgical workforce capacity"* **(**SD, p.30)[8]**.** As a result, permanent and well-established gynaecological oncology specialty services are only available at Auckland City Hospital and Christchurch hospital. Given the usual ethnic and socioeconomic disparities, we find these regional disparities are simply unacceptable.

28. We are encouraged by statements and recommendations in the Draft Plan about continuing efforts to further improve timely treatment for high-grade pre-cancerous lesions. For example, focus on gynaecological oncology services, supported by updated service data to inform resourcing and planning, and support for workforce expansion and sustainability. However, this is meaningless without clear monetary considerations for actions, and workforce development plans with funding attached.

Pillar 4: Enablers

29. NCWNZ is heartened to see acknowledgment of the lack of data on key populations, and the subsequent need for improved understanding of the relationship between sexuality and gender minority status and cervical cancer risk to ensure that screening services are

[7] Health NZ. August 2026. Review of the National Cervical Screening Programme's population-based register https://www.healthnz.govt.nz/publications/review-of-the-national-cervical-screening-programmes-population-based-register

[8] Te Aho o Te Kahu, Cancer Control Agency. 2026. Draft Supplementary Document to the New Zealand Cervical Cancer Elimination Plan (supplementary document).

inclusive, accessible and responsive to the needs of people from LGBTQI+ communities (SD22)[9].However, collection of data and research must be led by and delivered through those communities and their organisations with adequate funding and support to do this.

Conclusion

30. NCWNZ welcomes this Draft Plan for the elimination of cervical cancer as a realistic goal within the foreseeable future. We also welcome the acknowledgement of the huge existing disparities between Māori, other ethnicities, disabled people, LGBTQI people, and low-income people across all related services. The focus on working with and through communities and their organisations is also welcome.

31. NCWNZ, however, considers the lack of commitment to ring-fenced and sustained funding to be a fundamental flaw. An exciting opportunity risks being lost if left to the uncertainties of political annual budget cycles and competing priorities.

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NCWNZ Board

Raewyn Stone
NCWNZ Safety Health and Wellbeing Action Hub

[9] Ibid.

Appendix: Statistics on Perinatal outcomes in Aotearoa/New Zealand

a. Every year, about 650 babies and 10 mothers die in pregnancy or shortly afterwards. These rates have not changed for nearly 30 years.

b. About 700-900 of our whānau lose a child every year through stillbirth, foetal abnormality, or Sudden Unexpected Death in Infancy (SUDI), with more than 13,000 additional whānau affected by miscarriage before 20 weeks gestation.

c. There are significantly higher perinatal-related mortality rates per 1000 births for babies with mothers of Pacific (12.40) or Indian (13.66) ethnicity, compared with babies of Pākehā mothers (10.36).

d. There are at least 67 permanently damaged children born with neonatal encephalopathy every year. From 2016-2020 these rates have not improved.

e. More Māori pēpē are premature - 8.1%, compared to an overall rate of 7.4% - and wāhine Māori are more likely to have a preterm death; where the baby survives, they are more likely to have illness or disease that lasts a lifetime.

f. Around 15% of all women are affected by perinatal distress severe enough to be considered clinically significant, and up to half of all mothers may be affected to some extent.

g. From 2006–2020, there were 76 direct maternal deaths and 57 indirect maternal deaths.

h. Suicide is the largest single cause of maternal death in Aotearoa New Zealand.

i. Wāhine Māori are 2.91 times more likely to die by suicide as a direct result of maternal mortality than Pākehā women.

j. Babies from quintile 5 (i.e., the most deprived) areas have higher perinatal mortality rates for almost all causes compared with babies living in quintile 1 (i.e., the least deprived) areas. This gap is widening.

k. Women under 20 have the highest rate of neonatal death, [at] a rate of 5.46 deaths per 1000 live births, compared with an average rate of 2.72 deaths per 1000 live births for all maternal age groups.

l. There are declining but remaining relatively high rates of teenage pregnancy, with Māori rates significantly higher. In 2022 the rate for the entire population aged 15-19 was 11.07 but 26.50 for Māori.

m. Disabled women are the least satisfied with maternity services because of lack of access to services, as well as judgmental and negative attitudes from health providers for choosing to have a baby.