Te Kāwanatanga o Aotearoa
New Zealand Government

Report of the Parliamentary Review Committee Regarding the **National Cervical Screening Programme** 2025

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Released 2026 **health.govt.nz**

Citation: Parliamentary Review Committee. 2026. *Report of the Parliamentary Review Committee Regarding the National Cervical Screening Programme 2025*. Wellington: Ministry of Health.

Published in September 2026 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-991324-92-4 (print)
ISBN 978-1-991324-93-1 (online)
HP 9179

This document is available at health.govt.nz



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Mihi

E ngā mana, e ngā reo, e ngā karangatanga maha o tēnei whare.

E ngā mate, haere, haere, okioki i ruia mai i Rangiātea.

E ngā kanohi ora, tēnei au e mihi ana ki a koutou.

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

To all those who hold authority in this space — the clinicians, the kaimahi, the stakeholders, the service providers, the advocates, the communities, and the wāhine who trusted us with their voices — we acknowledge you.

To those we have lost to cervical cancer, whose deaths were preventable, whose absence is the reason this report exists — go gently, rest. You are not forgotten. You are the reason we are here.

To the living — those who screen, those who care, those who fight for equity, and those still waiting for a system that sees them — we greet you. This report is for you.

Greetings to you, greetings to you, greetings to you all

He wāhine, he whenua, ka ngaro te tangata.
Without women and land, humanity would be lost.

Hutia te rito o te harakeke, kei hea te kōmako e kō?
If the heart of the flax bush is removed, where will the kōmako sing?

These two whakataukī are not simply words of greeting. They are a charge – and a reckoning.

He wāhine, he whenua, ka ngaro te tangata.

Without women, without the land, humanity ceases. Wāhine Māori are not a demographic. They are not a statistic. They are not a priority group to be managed within a programme. They are the condition on which all of us exist.

And yet, between 2018 and 2022, wāhine Māori died from cervical cancer at more than twice the rate of other New Zealanders. Not because cervical cancer cannot be prevented. It can. Not because we lacked the tools. We had them. But because a system – designed without wāhine Māori at its centre – consistently, predictably and structurally left them behind.

Hutia te rito o te harakeke, kei hea te kōmako e kō?

When you remove the heart of the flax bush – the rito, the most precious and protected shoot – the whole plant is diminished. The kōmako has nowhere to sing. The whānau has no centre. The next generation has no foundation. This is what the data

tells us has happened. This is what wāhine Māori, their whānau and the communities who care for them told us – in interviews, in surveys, in submissions – throughout this review.

The 2023 transition to human papillomavirus (HPV) self-testing was a turning point. For many wāhine Māori, being able to do their own test – on their terms, in their own time, in their own space – was transformative. It was an act of rangatiratanga. We acknowledge and celebrate that.

But a new test is not a new system. Barriers remain. Te Tiriti o Waitangi obligations remain unmet. And wāhine Māori are still waiting for a programme that places them – not as an afterthought, not as a target group – but at the heart of every decision made.

Foreword

The concept ‘he tapu te whare tangata’ guides this Parliamentary Review Committee (PRC) report. ‘He tapu te whare tangata’ emphasises the sacredness of the womb as the house of humanity, where all human life grows. This includes the importance of the cervix, which protects the womb. Cervical cancer is now preventable. He tapu te whare tangata informs our vision for cervical cancer elimination so that wāhine Māori and all people who have a cervix can lead long, happy and healthy lives. Protecting te whare tangata secures and nurtures our future generations.

Screening is an important part of cervical cancer elimination. The 2023 rollout of the National Cervical Screening Programme (NCSP) making human papillomavirus (HPV) self-testing available was a pivotal moment for cervical screening in Aotearoa New Zealand. The fact that people eligible for cervical screening could do their own test was a gamechanger. The old programme worked best for non-Māori, non-Pacific, non-Asian women who did not have a disability and whose gender was aligned with sex assignment at birth. The old programme also worked best for women who had a fixed address, were enrolled in a primary health organisation (PHO), and were able to make an appointment and travel to have their cervical screening test. It worked for women who could understand and speak the English language, were able to juggle children and other caring duties, were able to take time off work or study and, for many, were able pay for the test. It worked for women who could tolerate a genital speculum examination. It worked best of all for people who had good experiences of the health system and felt safe, respected and listened to.

The costs for those who did not benefit from the old programme were high. Cervical screening coverage for wāhine Māori and Pacific women was significantly lower, and wāhine Māori were more than 2.3 times as likely to die from cervical cancer compared with other ethnicities. This failure to uphold Te Tiriti o Waitangi actively diminished and dismissed the mana of te whare tangata.

The 2023 NCSP provided a long-awaited opportunity to address many of the barriers outlined above and contribute to redressing injustices. Importantly, it was informed by research showing how inequities are designed into systems and how they can be deliberately designed out.

This review comes two and a half years after the September 2023 NCSP began. Based on recommendations from the previous 2022 review and long-standing inequities in the NCSP, we strived to uphold equity at all steps. As we worked through the PRC process we asked: Who is at the centre of the cervical screening system? Who is benefitting and who is being left behind?

This is the first PRC to include consumer voices. We were humbled by the overwhelming response to our call for survey responses and the willingness of participants to be interviewed. We wish we could have spent more time interviewing and meeting people in-person. We hope that the voices of these participants are well represented and this report privileges community and whānau centred evidence.

We met many individuals who work within the system of cervical screening, diagnosis and treatment. We heard from many more through the survey responses. Universally, all were passionate and committed to making a positive difference. From advocates and policy makers to kaiāwhina, nurses, doctors, colposcopists, gynaecologists, oncologists and community leaders, a plethora of experiences, views, aspirations and realities informed this review.

The high level of interest and commitment from so many people to be heard in this review shows how important the NCSP is and the will for this programme to succeed. Success means nobody with a cervix dies from this preventable disease, starting with those over-represented in mortality statistics. Wāhine Māori must be a priority, and every aspect of the NCSP should align with Te Tiriti o Waitangi.

We heard that people are ready to take action – now – towards cervical cancer elimination.

We humbly thank every person who contributed to this review. We acknowledge all who have experienced or are having treatment for cervical cancer and those who care for them. We extend aroha to all whānau who have lost a loved one to cervical cancer. You were at the forefront of every step in this mahi.

Thanks also to our peer reviewers Drs Jane MacDonald and Tania Huria. Thanks to the PRC secretariat for your excellent support.

Finally, we celebrate every person who has had a cervical screen and the champions of cervical screening found in every community.

About the Parliamentary Review Committee

The 2025 PRC is made up of three members: Sarina Ponga, Dr Tania Slater and Julie Avery.

Sarina Ponga is currently employed as Chief Executive of Raukura Hauora o Tainui. She has worked across the health sector as an experienced Auditor at Health New Zealand – Te Whatu Ora/HealthShare Ltd and Māori Health Equity Gains Clinical Manager at Hauraki PHO – Waikato and was also Clinical Services Manager at Raukura Hauora o Tainui (2016–2019). She has an extensive nursing background with over a decade of working across multiple disciplines in both the secondary and primary health sectors. Her committee and governance experience with memberships across multiple advisory groups includes being Co-Chair of the National Nursing Leaders Group – General Practice of New Zealand (GPNZ), and an executive board member of both the GPNZ and the General Practitioners Leadership Forum (GPLF).

Dr Tania Slater (Ngāti Kahu, Ngāpuhi) is a Senior Research Fellow at Te Tātai Hauora o Hine – National Centre for Women's Health Research Aotearoa, Faculty of Health, Victoria University of Wellington. She is also an Honorary Research Fellow, Research Centre for Hauora and Health, Massey University. Tania was part of a large research

team implementing universal offer HPV self-testing for cervical screening in Te Taitokerau to inform the new NCSP. She has worked across academia, government, private sector and non-governmental organisation settings and served on funding and ethics committees over many decades.

Julie Avery is currently employed as Director of Nursing/Nurse Practitioner at Sexual Wellbeing Aotearoa. She was previously a Nurse Practitioner/Clinical Nurse Lead at Auckland Medical Aid Centre (2021–2023), Nurse Practitioner (colposcopist) at Women's Health Waitematā District Health Board (WDHB) (2018–2021), Clinical Nurse Specialist at Early Pregnancy Clinic WDHB (2017–2018), and Nurse Advisor at Family Planning Auckland & Northland (2007–2017). Her committee experience includes the Executive Committee Abortion Providers Group Aotearoa New Zealand (APGANZ) 2022, Executive Committee Nurse Practitioner New Zealand (NPNZ) 2021, member of Women's Health College NZ, member of Primary Care Nurse College NZ, and member of the College of Nurses NZ.

Contents

Mihi iii

Foreword v

About the Parliamentary Review Committee vi

Executive summary 1

Key findings 2

What must change now 2

Recommendations 3

Introduction 5

The 2025 parliamentary review 5

Methodology 5

The changing health sector 9

Overview of past PRCs 10

Cervical cancer 11

The NCSP 2023 change to HPV testing 19

Rationale for the change in primary screening approach 19

Preparation, training and delivery of the NCSP 20

Cervical screening pathway 21

2025 PRC findings and recommendations 23

Setting a direction for the NCSP 23

Accessibility remains a key driver behind inequities 29

Strengthening the sector to provide a safe and equitable service 49

Monitoring, evaluation and reporting 63

Progress for past PRC recommendations 69

Glossary 77

Appendix 1 – Terms of Reference of the National Cervical Screening Programme Parliamentary Review Committee 2025 80

Appendix 2 – List of interviewees 86

Appendix 3 – Consumer participant survey questions 88

Appendix 4 – Provider and practitioner survey questions **94**

Appendix 5 – National Cervical Screening Programme team staffing as at August 2025 **96**

References **97**

List of Figures

Figure 1: Rate of all cervix cancer deaths between 2018-2022, by prioritised ethnicity 12

Figure 2: Up-to-date cervical screening coverage, by ethnicity, December 2022 – December 2025 14

Figure 3: Up-to-date cervical screening coverage, by age group, December 2022 – December 2025 15

Figure 4: Quarterly HPV immunisation coverage July to September 2025, by age and sex 17

Figure 5: Quarterly HPV immunisation coverage July to September 2025, by age and ethnicity 17

List of Tables

Table 1: Participant ethnicity 6

Table 2: Participant age distribution 7

Table 3: Participant gender, sexuality, disability status 7

Table 4: Rural vs non-rural residence 7

Table 5: Awareness of HPV testing and self-testing (NCSP transition) 8

Table 6: Key for prioritisation of 2022 PRC recommendations, used in Table 7 70

Table 7: 2022 PRC recommendations progress review 71

Executive summary

The 2025 Parliamentary Review Committee (PRC) was established by the Minister of Health, Hon Simeon Brown, under section 112O of the Health Act 1956, which states that a review of the National Cervical Screening Programme (NCSP) must occur every three years. In our terms of reference (appended), we were expected to have a particular focus on those population groups who have been under-screened/unscreened and over-represented in cervical cancer incidence and mortality rates (including Māori and Pacific populations).

This report is a summary of our assessment of the current programme, which introduced human papillomavirus (HPV) primary screening, with the offer of self-testing, in 2023.

The scope of the 2025 review is appended. In summary, we had a primary focus on how the programme has progressed or delivered past PRCs' recommendations and the programme's recent change to HPV testing as the primary test for cervical screening. We had a specific focus on the following:

1. Evaluate the progress of implementing the recommendations of the past three PRC reviews.
    a) Assess if implementation of underway/completed recommendations has contributed to more equitable outcomes for cervical screening.
    b) Reconfirm recommendations that have not yet been implemented that should continue to be progressed and update any recommendation wording to align with the current context of NCSP delivery.
    c) Suggest prioritisation of these recommendations for implementation with consideration to what is required from NCSP to implement.
2. Evaluate the shift to HPV testing as the primary test for cervical screening.
    a) Evaluate if the cervical screening workforce has the necessary capacity, capability, and resource to deliver HPV testing and a pathway to treatment – specifically, capacity, capability and training of the colposcopy and cytology workforce.
    b) Evaluate if there is equitable access to, and uptake of, HPV testing, as well as quality and retention across the whole cervical screening pathway.
    c) Evaluate if there is equitable access to, and uptake of, colposcopy services.
    d) Evaluate how the delivery of HPV testing and colposcopy could be strengthened to address community feedback:
        i) Conduct interviews with consumers to gain a better understanding of end-to-end experience accessing services from the NCSP.
        ii) Incorporate feedback of Iwi-Māori Partnership Boards (IMPBs) and other relevant groups.

Our findings are shaped by four foundational principles. First, Te Tiriti o Waitangi is a binding obligation, not a policy aspiration, and the NCSP must be measured against it – failures treated accordingly as Treaty breaches. Second, the NCSP exists to eliminate cervical cancer inequities; technical robustness serves that purpose, and cannot be the primary measure of success. Third, Māori data sovereignty requires that Māori screening data be treated as taonga, governed with and by wāhine Māori through the National Kaitiaki Group, with secure systems, transparent processes, and clear consequences when obligations are breached. Fourth, equity must be binding, resourced, monitored and enforceable – with Māori and Pacific outcomes reported first and co-governance embedded across all parts of the NCSP.

Underpinning all of this is the need for adequate investment. To genuinely value wāhine Māori and all women and people with a cervix, the NCSP must be properly resourced at every level. The systemic failures documented in the Cartwright and Ministerial Inquiries must never happen again.

Key findings

- HPV self-testing is widely accepted and is increasing participation, including for wāhine Māori and other under-screened groups.
- The main equity risk has shifted to **follow-up**: access to cytology and colposcopy is not consistently timely or equitable.
- Governance and accountability are not yet Te Tiriti based; Māori authority is not consistently embedded in decision-making.
- Māori data governance requires strengthening: protected Māori screening data must be treated as taonga, with clear processes, resourcing and auditing.
- Cost and access barriers persist (including inconsistent fees), alongside workforce and capacity pressures across the pathway.
- Monitoring and public reporting remain insufficient, particularly for pathway performance and equity outcomes.
- There is an urgent need to improve the NCSP Register's capability to support the programme.

What must change now

To achieve cervical cancer elimination, the NCSP must operate as an end-to-end pathway and be accountable for equity in outcomes, not only screening uptake. This requires:

- Te Tiriti based co-governance that centres wāhine Māori, strengthens Māori data sovereignty, and invests in follow-up workforce and resourcing capacity
- a fit-for-purpose, clinically safe NCSP Register
- culturally safe care and transparent public reporting across all steps of the NCSP pathway.

Our recommendations centre on Māori leadership and accountability for outcomes across the full pathway. The NCSP must move quickly to embed Te Tiriti based co-governance with real Māori decision-making authority, including strengthened partnership with IMPBs. Māori data sovereignty must be strengthened and resourced in genuine partnership with the National Kaitiaki Group. A Māori-led cervical cancer elimination strategy must be developed and funded, with a clear action plan and binding accountability for equity outcomes.

These structural changes must be matched by practical system settings that:

- remove cost barriers through consistent, free-of-charge screening and follow-up
- expand kaupapa Māori, community-based and mobile services
- strengthen cultural safety and workforce capability
- improve monitoring and public reporting so that inequities are visible and acted upon.

These recommendations are not aspirational. They are the minimum required to honour Te Tiriti o Waitangi, protect te whare tangata, and deliver a cervical screening programme that works for all wāhine, in every community.

Recommendations

1. Strengthen governance of the NCSP by:
    a) adopting a Te Tiriti based co-governance arrangement that gives Māori a sustained voice and real decision-making authority over strategic direction and key programme decisions
    b) confirming and documenting the role of IMPBs, agreeing engagement expectations, and implementing shared performance monitoring.
2. The NCSP national team and the National Kaitiaki Group should work together to strengthen Māori data governance.
3. Strengthen specialist advisory functions through:
    a) restoring a sustainable equity advisory function
    b) restoring clinical and technical advisory expertise
    c) ensuring governance and advisory pathways include diverse communities and lived experience.
4. Ensure Māori-led development and implementation of a Cervical Cancer Elimination Strategy and Action Plan, with continued equity focus for wāhine Māori, Pacific women and under-screened/unscreened people. Pair this with investment.
5. Fund free cervical screening for all women and people with a cervix.
6. Provide sustained media, communication and information about cervical screening in the context of cervical cancer elimination for present and future screening participants.

7. Increase support and resourcing for primary care providers, including general practices and all community screening providers (Screening Support Services, hauora providers, Sexual Wellbeing Aotearoa, Smear Your Mea, midwives).
    a) Pay midwives to provide cervical screening.
    b) Expand and socialise wider kaiāwhina reach with rollout of training and support for more kaiāwhina – for example, those working in general practice.
    c) Develop a clear and consistent communication plan for updates to the clinical practice guidelines for cervical screening.
    d) Ensure training for cervical screeners is accessible through fully funded scholarships, and ensure the screening workforce is visible on a centralised register.
    e) Ensure all cervical screeners carry out NCSP HPV Primary Screening Modules, and that refresher training is carried out every three years to maintain competency.
8. Investigate validation of point-of-care testing for HPV self-tests.
9. Learn from, resource, support, collect and share data with community/mobile cervical screening and colposcopy services.
10. Strengthen the sector to recognise, engage with, and respond effectively to groups traditionally underserved by the NCSP.
11. Strengthen engagement with the Department of Corrections to ensure women in prison and on remand are able to access follow-up for HPV test results.
12. Implement cultural safety training at all levels of the NCSP, including leadership, policy, operational and clinical levels.
13. Undertake a national assessment of colposcopy and laboratory services demand and capacity.
14. Provide timely and transparent public reporting across all parts of the pathway, not just screening uptake.
15. Ensure a review of the NCSP Register is available for future PRC reviews or include a review of the register as part of the review.
    a) Require cervical screeners to maintain their own patient recall system until the NCSP Register is fully functioning and reliable.
16. Extend the PRC review cycle to five years and provide funding to action review.
17. Fill NCSP national team vacancies, addressing capacity and resourcing requirements to support the programme.

Introduction

The 2025 parliamentary review

Under the Health Act 1956 (Part 4A, section 112O), the Minister of Health must establish a committee of up to three people to review the National Cervical Screening Programme (NCSP) at least once every three years. The legislation requires the committee to focus on the continuous quality improvement of the NCSP, with a view to reducing the incidence and mortality rates of cervical cancer. The Minister of Health appointed this committee in July 2025. This is the fifth parliamentary review of the NCSP.

As set out in the terms of reference (see Appendix 1), we – the 2025 Parliamentary Review Committee (PRC) – had a particular focus on how the NCSP has progressed or delivered on past PRC recommendations, and evaluating the shift to human papillomavirus (HPV) testing as the primary test for cervical screening. We were expected to concentrate on those population groups who have been under-screened/unscreened and over-represent the burden of cervical cancer – including Māori and Pacific populations.

The population-based NCSP Register has recently undergone a separate review to assess its clinical quality and safety. The scope of this review acknowledged the NCSP Register's integral role in the success of the programme and guided us to avoid duplication of the separate review. We were not able to access the NCSP Register review until after this report was drafted, and have therefore not been able to include it in this report.

Where we identified areas of concern or opportunities for the future direction of the NCSP that were outside of the key focus areas of the review, in accordance with our terms of reference we included these observations and opportunities in this report. In addition, where similar feedback was received from multiple interviewed sources, direct quotes from some key interviews have been included to support the discussion and findings of this report.

Methodology

Findings and recommendations were informed by both qualitative and quantitative data.

Engagement with stakeholders

We connected with key stakeholders throughout the review to ensure that the correct people and groups were engaged with and to ensure information informing the final report was correct and up to date. These stakeholders include the NCSP national team and the National Kaitiaki Group (NKG), and this engagement was led via the Public Health Agency.

Interviews

Between September 2025 and February 2026, we conducted 44 interviews with a range of key stakeholder groups and consumers. These interviews captured detailed experiences with, and viewpoints on, the NCSP from both those who access NCSP services and those involved in the delivery of NCSP services.

The complete list of interviewees is set out in Appendix 2. Interviews took place either online or in-person and were guided by a semi-structured set of questions. Questions were tailored where appropriate to suit the interviewee's knowledge or expertise and ensure relevant information could be gathered. However, interviews were guided by the participants, and they had space to talk about what was important to them regarding the NCSP. All interviewees were invited to share any further thoughts not addressed in the interview via email.

Surveys

We distributed two surveys, one for cervical screening participants (Appendix 3) and one for providers and practitioners (Appendix 4). Survey responses provided greater insight into perspectives on and experiences with the NCSP.

Both surveys were accessed via the Ministry of Health's online platform, CitizenSpace. The participant survey was circulated through the NCSP national team's networks. These networks distributed the survey to their groups and patients to ensure as many participant voices as possible were heard. The provider and practitioner survey was sent out to the NCSP national team's sector engagement list of contacts to ensure the sector was well represented.

The provider and practitioner survey contained free-text fields and received 69 total responses. Of the respondents, 54 provided their role/job title and included a pool of registered nurses/practice nurses, screening support nurses, screening advisors and kaimahi, register coordinators, general practitioners (GPs), clinical directors, gynaecologists, pathologists, nurse managers and senior medical officers.

The participant survey was primarily quantitative with some free-text fields. The survey received 405 responses. To ensure the survey captured a wide range of views and experiences, we asked several demographic questions. The participants' demographics data are shown in Tables 1 to 5.

Table 1: Participant ethnicity

Ethnicity	Number	Percentage
NZ European	254	62.72%
Māori	96	23.70%
Pacific	27	6.67%
Asian	12	2.96%
Other	56	13.83%
Not provided	3	–

Table 2: Participant age distribution

Age group (years)	Percentage
20–24	0.49%
25–34	15.80%
35–44	25.93%
45–54	25.68%
55–64	23.70%
65–74	8.40%
<20 or >75	0%

Table 3: Participant gender, sexuality, disability status

Gender	Number	Percentage
Female	403	99.50%
Male	1	0.25%
Not provided	1	0.25%

Sexuality	Number	Percentage
Heterosexual/Straight	369	91.11%
Gay/Lesbian	10	2.47%
Bisexual	8	1.98%
Other	2	0.49%
Chose not to answer	12	2.96%
No answer	4	0.99%

Disability status	Number	Percentage
Yes	26	6.42%
No	374	92.35%
Chose not to answer	1	0.25%
No answer	4	0.99%

Table 4: Rural vs non-rural residence

Location	Number	Percentage
Rural/Remote	95	23.46%
Not rural	380	76.05%
No answer	1	0.25%

Table 5: Awareness of HPV testing and self-testing (NCSP transition)

Response	Number	Percentage
Yes, aware	385	95.06%
No, not aware	16	3.95%
No answer	4	0.99%

The participant responses highlighted positive and negative experiences in accessing NCSP services, barriers and issues in accessing care, thoughts on HPV self-testing, and suggestions for change.

Iwi-Māori Partnership Boards

We connected with Iwi-Māori Partnership Boards (IMPBs) via survey to understand how the NCSP is experienced and observed at a local system level, particularly in relation to equity for wāhine Māori – we heard from Tairāwhiti Toitū Te Ora and Te Tiratū, as well as Te Rūnanga o Ngā Wairiki Ngāti Apa and Te Oranganui Trust. Engagement with IMPBs sought to draw on their role in representing iwi, hapū and whānau perspectives; monitoring local health system performance; and providing insight into structural barriers, facilitators, and regional variation affecting access, participation and outcomes. This included understanding how changes such as the transition to HPV primary screening are translating on the ground, how information and services are reaching communities, and whether current programme settings, data, and partnership arrangements enable effective local oversight, advocacy and Māori participation in service design and delivery. These insights supported our assessment of progress against previous recommendations and identification of opportunities to strengthen Māori partnership, equity and governance within the cervical screening system.

Data and information

The NCSP national team provided recent data and information that informed our review and findings. This included key NCSP information, screening-related data and various reports and documents, along with specific training data from the New Zealand Qualifications Authority (NZQA).

Recent data from the NCSP national team were not available to be published at the time of writing this report, so we decided to use publicly available data. This means that in some cases the data are older.

For this report we have used the following data sources.

- Cervical screening data are sourced from the NCSP Register.
- Ethnicity and domicile data are sourced from the Ministry of Health's National Health Index (NHI).
- Population data are sourced from Stats NZ 2018 Census Population Projections 2024 update. The denominator is the projected population for the end-point of the monitoring period.

- Deprivation data are sourced from Otago University's NZDep2018 Index of Deprivation.

Style and language

This PRC review differs from previous reviews in that we have deliberately chosen to include many quotes from interview and survey participants. We were guided by advice from governance groups at the outset of the review, and the scope of the review directing us to include consumer and stakeholder voices.

Vignettes providing short examples of cervical screening experiences are highlighted throughout the report. These are either taken with permission from interviewees, or are composite stories and quotes from survey responses. No real names are used.

This report is written primarily in the first person. Where appropriate, we refer to 'the 2025 PRC', but in general, engaging directly with the reader is intended to strengthen our accountability to all PRC interview, survey and submission participants.

In regard to gender-affirming language used in this report, we were led by multiple sources, including the previous PRC, the Pae Ora (Healthy Futures) Act 2022, the academic literature[1] and, most of all, what people told us as part of this review. Throughout the report we use the terms 'women' and 'wāhine. In this report, these terms also include those assigned female at birth who have a different gender identity, therefore we are including all people with a cervix. It is important to name people with a cervix as this embeds accountability to all people eligible for cervical screening. We use 'wāhine Māori' to describe Māori women.

We use the terms 'primary HPV screening' and 'HPV test'. Our deliberate use of the wording 'HPV self-test' recognises the rangatiratanga of doing your own test. We are aware that this differs to the Australian terminology of self-collection.[2]

To avoid confusion, we have used 'National Cervical Screening Programme (NCSP)' when referring to the full national cervical screening system, including policy settings, funding, governance arrangements, service delivery, providers, laboratories, colposcopy services, the NCSP Register, and participants. We have used 'NCSP national team' to refer specifically to the Health New Zealand – Te Whatu Ora head-office team responsible for coordinating, administering and supporting the programme.

Kupu o te reo Māori are used throughout this report.

A glossary can be found at the end of this report.

The changing health sector

The Pae Ora (Healthy Futures) Act 2022 introduced significant reforms intended to transform how health services, including primary and community care, are planned and delivered in Aotearoa New Zealand. These reforms focused on equity, prevention and improving Māori health outcomes. These principles are especially important for

primary care and the NCSP, where early access, ongoing care and culturally responsive services are key to better outcomes for wāhine Māori.

From 2022 to 2023, these reforms gave primary care and NCSP providers more chances to work in line with what communities wanted. Te Aka Whai Ora (the Māori Health Authority) was set up to lead Māori health strategy and commission kaupapa Māori services. Te Whatu Ora – Health New Zealand took charge of national planning and service delivery. Both were intended to work as equal partners, with support from IMPBs and local planning. For primary care and screening, this approach meant more local input, stronger Māori leadership, and better links between prevention, screening and treatment.

Localities could have played an important role for NCSP and hauora Māori providers. They were designed to enable place-based planning, allowing primary care, Māori providers, public health and communities to work together, designing services that remove barriers to screening access, follow-up and continuity of care. Locality plans were intended to inform commissioning decisions and equity monitoring, creating potential for tailored outreach, kaupapa Māori models of care, and improved screening participation among under-screened/unscreened populations.

However, from late 2023, the direction of the reforms shifted following a change in government. In 2024, Te Aka Whai Ora was disestablished through legislative amendment, and its functions were redistributed between the Ministry of Health – Manatū Hauora and Health New Zealand – Te Whatu Ora. For primary care, this marked a significant change: Māori-led commissioning and co-decision-making mechanisms were removed and kaupapa Māori service development became embedded within a centrally managed system rather than led by an independent Māori authority.

During this time, the role of IMPBs also narrowed. While IMPBs were originally intended to influence planning, commissioning and monitoring at a local level, over time their role was reduced to mainly giving advice and engaging with communities. From 2024 to 2025, the government focused more on national performance targets, workforce stability, and service delivery.

Overview of past PRCs

The PRC provides independent, statutory oversight of the NCSP, with a mandate to assess whether the programme operates safely, effectively and equitably, and to report on systemic risks and opportunities for improvement. The 2015, 2018 and 2022 PRC reviews collectively indicate that the programme faces persistent structural challenges rather than isolated operational issues. Both reviews identified ongoing inequities in access and outcomes, deficiencies in national stewardship and accountability, inconsistent quality assurance across the screening pathway, and limited system capacity to implement sustained improvements based on review findings. The 2022 review expanded upon earlier findings by explicitly framing these challenges within Te Tiriti o Waitangi obligations and principles of equity by design, emphasising the necessity for collective responsibility, mana enhancing approaches and stronger system leadership. As an astute highlight, the previous PRC also acknowledged the

progression of the NCSP and the outcomes it has achieved within the complexities of an evolving health system.[3]

Cervical cancer

Cervical cancer has been described in detail in previous PRC reviews. Globally, it remains a significant public health concern, ranking as the fourth most common cancer among women, with an estimated 660,000 new cases reported in 2022. In Aotearoa New Zealand there were 892 (163 Māori and 729 non-Māori) cervical cancer registrations between 2019 and 2023.[4]

Almost all cervical cancer cases are attributable to infection with oncogenic types of HPV, a highly prevalent sexually transmitted infection that affects the skin and mucosal surfaces of the genital, anal and oropharyngeal regions.[5]

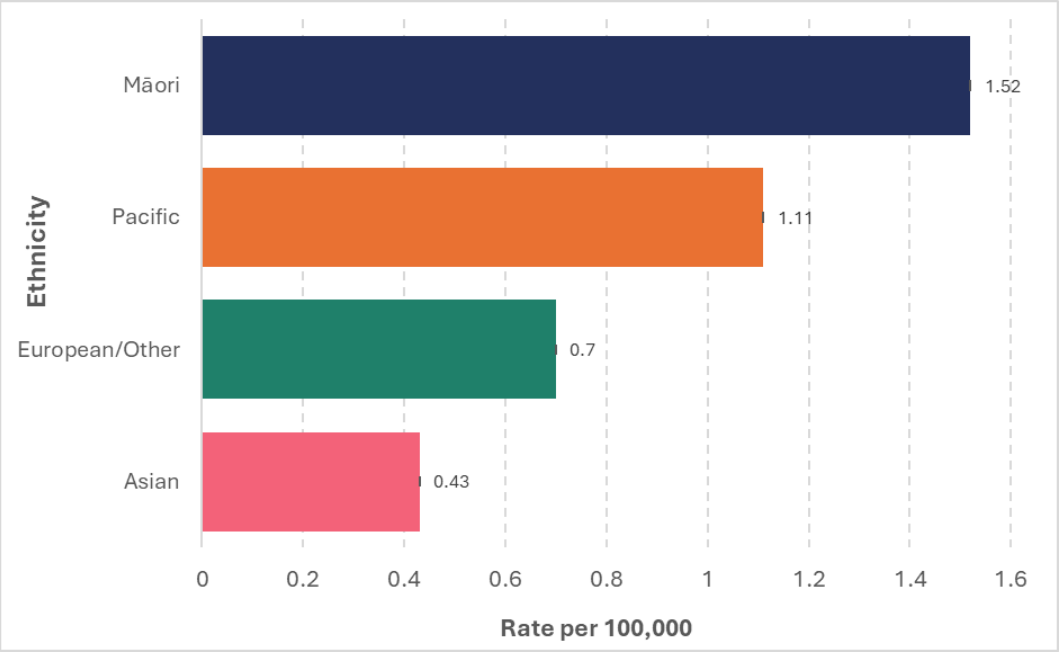
HPV infection is extremely common, with nearly all sexually active individuals acquiring the virus at some point, usually without any symptoms. In most cases, the immune system clears the virus spontaneously. However, persistent infection with specific carcinogenic HPV types can lead to the development of abnormal cervical cells, which, if undetected or left untreated, may progress to cervical cancer over time.[6]

Screening can detect pre-cancerous lesions that can be treated, preventing the development of cervical cancer. There have been two reviews of cervical cancer occurrences undertaken by Otago University for the NCSP. The consultation process for a third review commenced in 2025. These reviews examine information held by the NCSP Register and New Zealand Cancer Registry in order to determine the demographics and screening histories of New Zealand women with confirmed cervical cancer. The reviews have found that over 80% of women diagnosed with cervical cancer have not been adequately screened.[7,8]

Cervical cancer mortality

The 2018–2022 cervical cancer mortality data (Figure 1) highlights stark and persistent inequities across ethnic groups. These differences highlight continued inequities in cervical cancer outcomes, underscoring the urgent need for strengthened, equity-focused prevention and early detection efforts for Māori and Pacific women.

Figure 1: Rate of all cervix cancer deaths between 2018-2022, by prioritised ethnicity



Source: Health New Zealand cancer web tool

Cervical cancer elimination

The World Health Organization (WHO) has a global strategy to eliminate cervical cancer as a public health problem. The WHO defines elimination for cervical cancer as four cases per 100,000 women-years. The WHO sets the following targets for elimination:

- Vaccination: 90% of girls fully vaccinated with the HPV vaccine by the age of 15
- Screening: 70% of women screened using a high-performance test by the age of 35, and again by the age of 45
- Treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed.[9]

Background to cervical screening in Aotearoa New Zealand

Screening to prevent cervical cancer in Aotearoa New Zealand has the whakapapa of two government inquiries showing breaches of Te Tiriti o Waitangi and obligations to protect te whare tangata. The 1988 Cartwright Inquiry into unethical cervical cancer treatment at National Women's Hospital exposed systemic failures and barriers for women.[10] Systemic failures allowed a study led by Dr Herbert Green following up women with major cervical abnormalities without treating them and without women's knowledge or consent. Systemic barriers included an opportunistic cervical screening system that disadvantaged Māori, Pacific, low-income and older women.

The inquiry also surfaced profound breaches of Te Tiriti o Waitangi. Wāhine Māori had experienced disproportionately poor outcomes from cervical cancer, yet their voices, needs and cultural realities had been systematically ignored within a health system that

failed to honour the Crown's obligations as a Treaty partner. The principles of tino rangatiratanga – the right of Māori to exercise authority over their own health and wellbeing – and ōritetanga, or equity, had been fundamentally undermined by a system that treated wāhine Māori as passive recipients of care rather than as active partners in decisions about their own bodies.[11]

The Cartwright report led to significant reforms in the New Zealand health and disability sector, including the establishment of the Health and Disability Commissioner and the Code of Health and Disability Services Consumers' Rights, which protected 'informed consent' as a legal right (see the Health and Disability Commissioner Act 1994).

The report's recommendations called for a national cervical screening programme, the establishment of independent ethics committees, greater patient protections, and patient-centred health care with patient participation in health service decision-making. In response, the NCSP was launched in 1990.

A decade later, a further inquiry into cervical screening was required. In Tairāwhiti Gisborne, a woman received four misreported screening tests and was subsequently diagnosed with cervical cancer. The inquiry found extensive under-reporting of abnormal tests over a prolonged period by a laboratory owned by the pathologist Dr Michael Bottrill, who misread the tests. The Ministerial Inquiry made 46 recommendations for future action, including quality assurance around laboratory cervical screening services, and performance standards put in place for the NCSP Register and the New Zealand Cancer Registry.[12]

Both inquiries highlighted a lack of accountability by the health system towards wāhine Māori and all women and people with a cervix, and a lack of consequences when breaches occur. In 2026, we continue to call for explicit accountability arrangements, including expectations for remedial action, timeframes and consequences when obligations are not met.

Cervical screening coverage

In Aotearoa New Zealand the NCSP target is to reach 80% screening coverage for the eligible population, higher than the WHO's 70% screening target. Coverage is defined as the proportion of wāhine/women and people with a cervix eligible for screening who have their screening up to date. This definition aligns with other high-income countries with an organised screening programme.

For this report we have used the 'coverage up-to-date' data. This indicator replaces the '3-year coverage' calculation to make it relevant following the change to HPV primary screening from the previous cytology-based programme.

The calculation of coverage considers when the participant's most recent test was in relation to the implementation of HPV primary screening to account for the change to the screening interval. This allows coverage to continue to be monitored during the transition period. For example, a participant whose most recent test was prior to 12 September 2023 would be considered up-to-date for a period of three years following

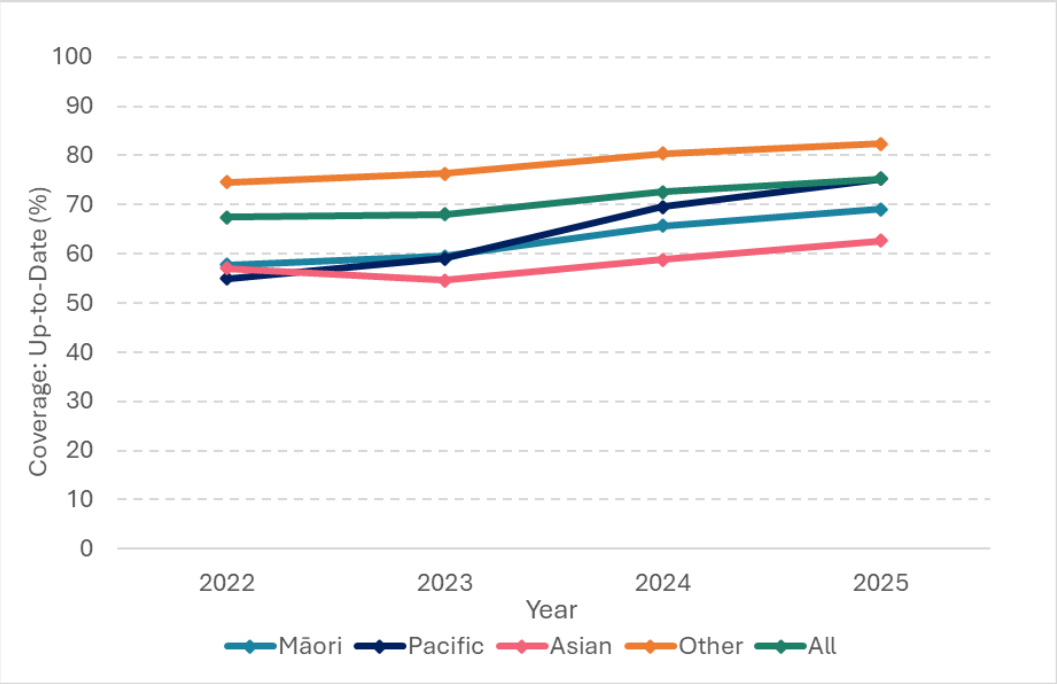
that test. A participant whose most recent test was after 12 September 2023 would be considered up-to-date for a period of five years following that test.[13]

Note that the data below look at screening coverage from before and after the introduction of HPV primary screening in September 2023. This report discusses that transition in further detail in the section titled 'NCSP 2023: The change to HPV testing'.

Coverage by ethnicity

National cervical screening overall coverage has increased from 67.4% in 2022, before HPV testing was introduced, to 75.3% in 2025. However, it remains inequitable (Figure 2). The rollout of HPV primary screening in September 2023 has increased coverage for wāhine Māori and Pacific women, but coverage has not been brought to the same level as for non-Māori, non-Pacific, non-Asian women. This group has over 80% screening coverage. Asian women remained the lowest-screened group at 62.6% in 2025, with only small increases in coverage.

Figure 2: Up-to-date cervical screening coverage, by ethnicity, December 2022 – December 2025



Source: Health New Zealand National Cervical Screening Programme Coverage Reporting Tool

Cervical screening coverage has increased across all population groups since the introduction of HPV self-testing. Pacific participants have shown the largest improvement, with coverage rising by 20.3% since December 2022, while coverage for wāhine Māori has increased by 11.3%. Although Asian participants have shown an increase, this is only by 5.6%, highlighting the need for sustained support to access screening.

These increases reflect the broader benefits of HPV self-testing, which has been accepted across communities. They highlight the effectiveness of transitioning to HPV primary screening in enhancing participation and addressing long-standing inequities within the NCSP. The increases observed align with evidence showing that HPV

self-testing is highly acceptable and has strong potential to reduce barriers to access.[14] Many participants prefer self-testing due to greater comfort, privacy and autonomy, supporting its role in improving equitable screening outcomes.[15]

Coverage by age

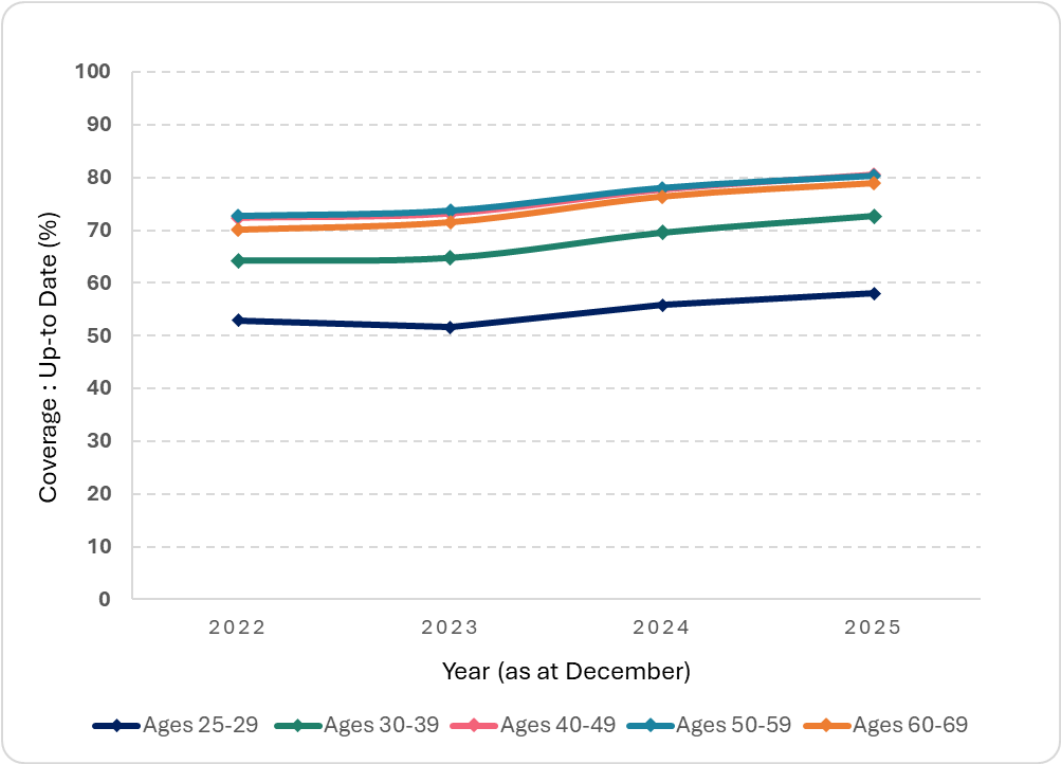
Data also show a clear increase in cervical screening coverage across age groups following the introduction of HPV self-testing at the end of 2023, with uptake consistently increasing from 2023 to 2025 (Figure 3).

Screening uptake is lowest among those aged 25–29. Uptake rises with age, peaking in the 40–49 and 50–59 years age groups, then falls slightly for those aged 60–69.

However, the 60–69 years age group has the greatest increase in participation following the introduction of the HPV self-test, with a participation increase of 8.7% over the four-year period. This was closely followed by the 30–39 years (8.5% increase), 40–49 years (8.1% increase) and 50–59 years (7.6% increase) age groups. Participation increased by just 5.1% for the 20–29 years age group.

Overall, the data indicate that HPV self-testing has improved accessibility and contributed to higher screening participation, especially among middle and older age groups; however, targeted approaches are still needed to better support younger women to enter the NCSP. A recent study of younger women's attitudes to screening suggests communications that target rangatahi at the time of school-age vaccination alongside consistent updates throughout secondary school would encourage participation in the NCSP as a vehicle to cervical cancer elimination.[16]

Figure 3: Up-to-date cervical screening coverage, by age group, December 2022 – December 2025



Source: Health New Zealand National Cervical Screening Programme Coverage Reporting Tool

HPV vaccination coverage

HPV vaccines are highly effective in preventing HPV infection, and are now proven to dramatically decrease the incidence of cervical cancer as well as protecting against other HPV- related cancers, including throat, anal, vulval, vaginal and penile cancers.[17] The proven optimal time to vaccinate is before sexual activity in young people (aged 9–13) when the immune system is most responsive.

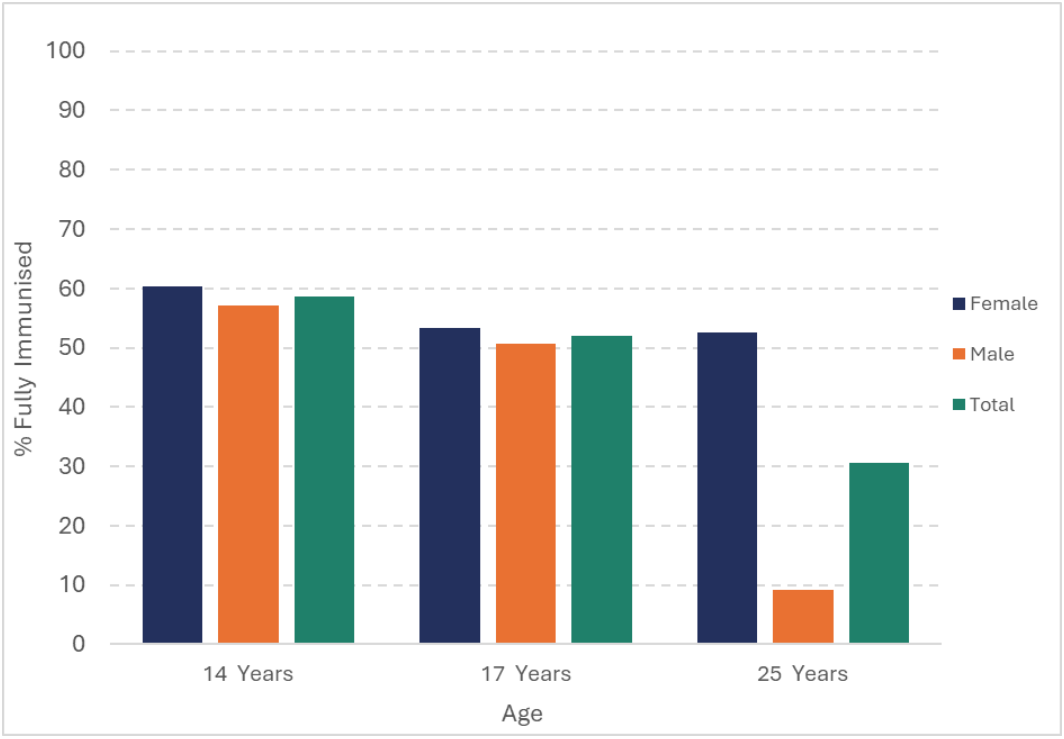
Aotearoa New Zealand's target is to achieve 75%–80% coverage for HPV immunisation in both boys and girls to ensure herd immunity and cancer prevention. The Aotearoa New Zealand HPV vaccination programme was introduced in 2008 and utilised a three-dose quadrivalent vaccine for females up to the age of 18 years. A largely school-based vaccination programme was then introduced for females aged 11–15.

The dosing schedule also changed in 2017, with children aged 14 and under only needing two doses to be considered fully vaccinated.[18] A single dose schedule has recently been introduced in many countries around the world, but in Aotearoa New Zealand two or three doses, depending on age at first dosage, are still required to be considered fully vaccinated.[19]

Compared to Australia, Aotearoa New Zealand has extremely poor HPV vaccination coverage overall, with inequitable access for tamariki Māori and children in rural areas. National vaccine coverage for 14-year-olds in the 2025 April–June quarter was 49% for Māori and 63% for European/Other.[20] In comparison, Australia's 2024 vaccine coverage was 79% for First Nations females (83% overall) and 73% for First Nations males (81% overall).[21]

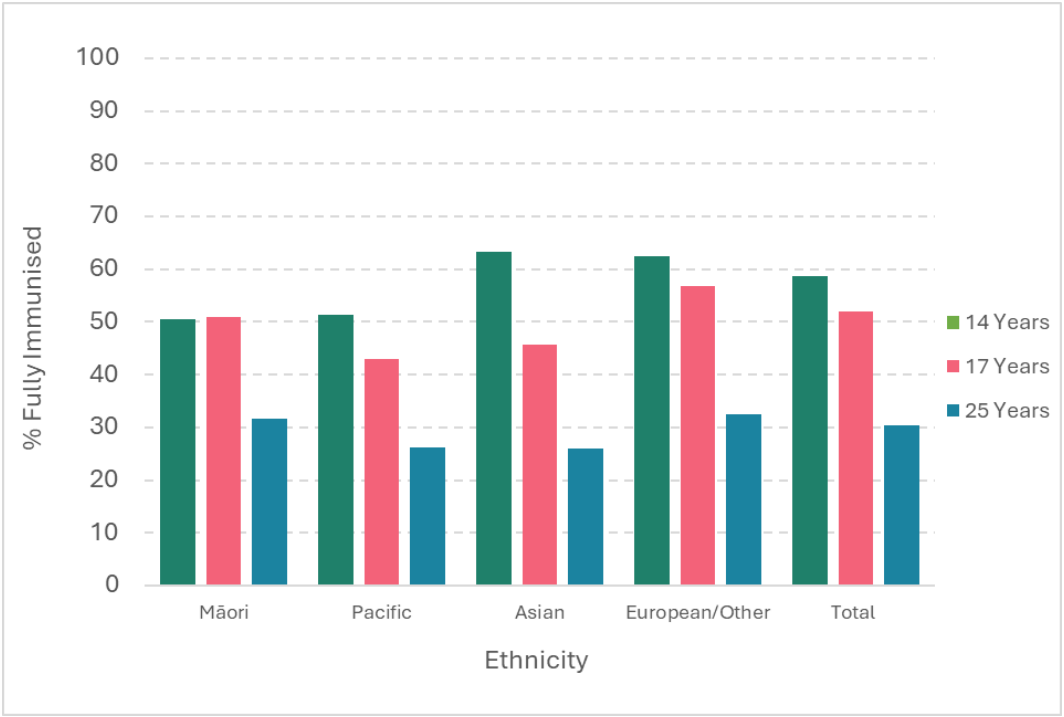
The HPV immunisation data for those eligible who received the required number of doses to be considered fully vaccinated from July 2025 to 30 September 2025 (Figures 4 4 and 5) show that all age groups, genders and ethnicities are below the 75%–80% coverage target, with Māori and Pacific groups significantly below, highlighting continued disparities in access and equity. Coverage declines further with age across every ethnicity, showing that relying on the school-based programme is not enough and that additional approaches are required to support uptake among young adults who remain unvaccinated.

Figure 4: Quarterly HPV immunisation coverage July to September 2025, by age and sex



Source: Health New Zealand HPV immunisation coverage data

Figure 5: Quarterly HPV immunisation coverage July to September 2025, by age and ethnicity



Source: Health New Zealand HPV immunisation coverage data

HPV vaccination forms one of the foundational pillars of New Zealand's commitment to the WHO global strategy to eliminate cervical cancer. The New Zealand HPV immunisation programme directly contributes to the first of these three pillars through universal access and early delivery of the vaccine. Health New Zealand – Te Whatu Ora emphasises that HPV immunisation is free for everyone aged 9 to 26, including non-residents under the age of 18 years and is delivered primarily through schools in Year 7 and 8, ensuring that most girls are offered vaccination well before age 15.

HPV vaccination also reinforces the second and third pillars of the WHO framework. Reducing the prevalence of high-risk HPV types that cause cancer acts as a prevention measure enhancing the effectiveness of the screening pathway. The Immunisation Advisory Centre highlights that Gardasil 9 protects against nine HPV types, including those responsible for approximately 90% of cervical cancers, noting that the vaccine 'is designed to protect … from HPV infection that can cause genital warts, precancerous cell changes and cancer in the throat, cervical cancer and anal, vaginal, vulval or penile cancers.'[22] A highly vaccinated population reduces the number of individuals at risk of developing high-grade lesions, thereby decreasing downstream pressures on screening and treatment services; both essential components of the 70% and 90% WHO targets.[23]

Diagnosis and treatment

We do not have publishable data to inform Aotearoa New Zealand's progress in meeting the WHO diagnosis and treatment target for elimination of cervical cancer. Interim programme monitoring will be published in 2026.

The NCSP 2023 change to HPV testing

In 2023 the NCSP introduced HPV primary screening as the first-line testing option, with the offer of self-testing, while still recognising cytology as a vital component of the screening pathway, particularly for follow-up and clinical triage purposes. This was a package of care delivered by general practice and other primary care providers, including invitation to screen, information about the HPV test, notification of results and support to follow-up.

Rationale for the change in primary screening approach

The rationale behind the introduction of HPV primary screening included the following key benefits.[24]

- **Increased sensitivity of HPV testing**

  The WHO affirms that HPV testing is significantly more sensitive than cytology, providing stronger early detection capability and reducing the likelihood of missed precancerous lesions. According to the WHO's Global Health Observatory documentation: 'HPV testing has better sensitivity, reproducibility, and negative predictive value than cytology'.[25] HPV testing detects high-risk HPV infections long before cytological abnormalities appear. The WHO concludes that this improved sensitivity makes HPV testing a more effective screening tool, capable of preventing a greater proportion of cervical cancer cases through earlier identification and timely treatment of precancerous changes.

- **Longer protection and screening interval**

  A negative HPV test provides greater and longer reassurance compared to a negative cytology result, allowing the screening interval to safely extend from three-yearly to five-yearly for most participants. Research into HPV primary screening outcomes reported that 'a negative HPV test result is associated with a very low risk of CIN3+ over six or more years', providing strong justification for lengthening the screening interval in programmes that adopt HPV primary screening.[26]

- **Supporting equity through self-testing**

  Self-taken vaginal swabs are now available, removing the need for a speculum exam for most people. This improves accessibility and supports more equitable screening outcomes, especially for Māori and Pacific women and under-screened groups, who have historically experienced greater barriers to smear-based cytology screening and lower screening participation rates. A study of Māori,

Pacific and Asian women found that 'self-sampling for human papillomavirus (HPV) has been shown to increase participation in cervical cancer screening', noting that these groups have the lowest screening rates and stand to benefit the most from accessible self-testing options.[27]

The revised NCSP anticipated improved screening access to reduce long-standing and unacceptable inequities.

- **Alignment with international best practice**

  International research shows that countries such as the Netherlands, Australia, England, Scotland and Wales have transitioned from cytology to HPV-based screening and have reported increased detection of cervical precancerous lesions in first screening rounds, confirming superior sensitivity and effectiveness of HPV testing to identify at-risk individuals earlier.[28]

Preparation, training and delivery of the NCSP

The guiding principles for the change to HPV primary screening were to:

- deliver a best-practice national cervical screening programme by international comparison
- make screening coverage more equitable across all population groups
- improve equity of outcomes (cervical cancer incidence and mortality) across all population groups
- maintain and improve the safety and quality of screening for all those enrolled
- maintain a skilled and competent workforce to deliver the national programme
- be managed to ensure a smooth transition to the new primary screening pathway
- maintain and improve the NCSP Register's capability to support the programme
- allow all participants to choose whether their sample is a self-test or is taken by a clinician.

The NCSP centres on offering people a choice between a self-test or a clinician-collected sample, followed by HPV testing, triage through cytology or colposcopy when needed, and clear follow-up processes.

Preparation for the transition involved upgrading laboratory and IT systems, redesigning clinical pathways, ensuring supply of self-test kits, and embedding equity planning to better support Māori, Pacific, rural and gender-diverse communities. The rollout was informed in real time by national research.[29]

Training was planned to be delivered across the sector, covering HPV epidemiology, new sample-collection methods, clinical pathways, cultural safety and updated administrative processes. Key training components included targeted learning modules tailored for clinicians, nurses and kaiāwhina to ensure a clear understanding of the updated screening guidelines. Clinical competence was strengthened through training

and retraining for sample takers in liquid-based cytology (LBC) collection, alongside new unit standards focused on supporting HPV self-testing.

Further discussion of the training to support the rollout of HPV primary screening is included in the section titled 'Strengthening the sector to provide a safe and equitable service'. While there were challenges faced, the NCSP was successfully rolled out and, as is evident in this review, has increased cervical screening coverage in Aotearoa New Zealand.

> It's pretty remarkable because many other countries have put lots of money and funding into transforming their own programmes for similar or worse results than New Zealand. Huge commendation for everyone involved even though funding for the NCSP's transition to HPV was less than adequate. They managed to make New Zealand's screening programme internationally recognised as being up there with the best programmes.
>
> - *Interview participant*

Cervical screening pathway

We have highlighted several parts of the pathway below. Full clinical guidelines and comprehensive flowcharts outlining all updates can be found in the *Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand*.[30]

Universal offer of HPV self-testing

In September 2023, the NCSP changed to HPV primary screening with offer of self-test.

Anyone with a cervix who has ever been sexually active should be offered an HPV primary screening test from age 25 to age 69. The revised screening pathway allows all participants to choose between a self-test or a clinician-taken sample, ensuring greater flexibility and accessibility while maintaining clinical safety and accuracy.

If the LBC option is chosen, the test is screened for HPV and only reflex tested with cytology if HPV is detected.

Follow-up after HPV detection result

The updated pathway introduced new management processes for participants based on the results of their HPV tests, refining risk assessment and follow-up to better target those who require closer monitoring. Follow-up is determined by HPV detection result.

- **'HPV not detected' result:** Participants with an 'HPV not detected' result will be recalled for their next screening test in five years (or three years for those who are immune deficient). Participants aged 65 and over (or 67 and over if immune suppressed) and no abnormal subsequent cytology or histology results can cease screening.

- **'HPV detected Other' result:** Participants who choose the self-test option and receive an 'HPV detected Other' result are advised to have a speculum examination so that a clinician can collect a cytology sample, ensuring that adequate diagnostic information is available to guide appropriate clinical follow-up, including prioritised referral to colposcopy if high-grade cytology is detected.
- **'HPV detected 16' or 'HPV detected 18' result:** Participants who test positive for HPV 16/18 are directly referred to colposcopy services, offering a more equitable and streamlined pathway for those with the highest-risk HPV types.

Those aged between 70 and 74 years who were under-screened/unscreened prior to age 70 should have an HPV test and can cease screening if HPV not detected.

Cytology

The *Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand* state that cytology continues to play an important role in managing those with HPV 'Other' detected, as it offers additional diagnostic information needed to stratify risk and determine appropriate follow-up, including colposcopy referral.

Colposcopy

Where HPV 16/18 is detected on a swab-collected sample, referral to colposcopy will follow for all participants when the result is reported.

Laboratories

Laboratory services supporting HPV primary screening and the associated colposcopy and histology pathways are delivered through a network of publicly funded and privately operated laboratories across Aotearoa. Under the NCSP, the principal providers for HPV testing and diagnostic services include Pathlab, Awanui Labs (formerly Southern Community Laboratories), and LabPlus (via APS). These laboratories are required to meet stringent criteria covering quality standards, staff qualifications, training and ongoing professional development, quality management systems, risk management procedures, record-keeping and service capacity.

Health New Zealand – Te Whatu Ora specifies several core expectations for laboratory service delivery. These include maintaining high technical quality and robust quality assurance systems to ensure reliable HPV, cytology and histopathology results; sustaining a flexible and appropriately skilled workforce capable of managing changing volumes across HPV testing, triage cytology and histology workloads; and ensuring that services are delivered in a way that upholds tikanga Māori and supports culturally safe practice. Laboratories are also expected to contribute to a seamless, end-to-end diagnostic pathway, ensuring timely receipt, testing, reporting and clinical follow-up across primary care, colposcopy and pathology services.

Effective integration between HPV laboratory services and colposcopy services is essential to ensuring a safe, timely and high-quality diagnostic pathway under the NCSP. The shift to HPV primary screening places greater reliance on laboratories to provide accurate HPV results and deliver reflex/triage cytology, which feed directly into referrals and assessment in colposcopy clinics. Ensuring that laboratory and colposcopy services function cohesively is also fundamental to supporting equity and timelines.

2025 PRC findings and recommendations

Setting a direction for the NCSP

Stronger direction

Cervical cancer is now preventable and can be eliminated. The focus of this PRC review is on the NCSP; however, screening is only one part of the process for eliminating cervical cancer. As discussed earlier, elimination requires progress in all three areas – vaccination, screening and treatment.

Provider and stakeholder interviews described the need for a strategy and stronger governance to bring the functions together.

Aotearoa New Zealand does not have an elimination strategy and action plan. A plan is currently in the early stages of development by Te Aho o te Kahu – Cancer Control Agency and Manatū Hauora - The Ministry of Health. In the absence of an agreed, funded and accountable strategy, efforts across HPV vaccination, cervical screening, diagnosis and treatment remain fragmented. This limits progress towards elimination and perpetuates inequities, particularly for wāhine Māori and other priority groups.

> We need a national cervical cancer elimination strategy. Australia has one and we don't.
>
> - *Interview participant*

We heard that the NCSP national team and the immunisation group within Health New Zealand – Te Whatu Ora could work together better. This includes for public health messaging, workforce training and information to health providers. And, as recommended in the 2022 PRC review, it also includes collaboration on the National Immunisation Register (now called the Aotearoa Immunisation Register (AIR)) to ensure access to the register for cervical screening providers to enable opportunistic vaccination.

Participants described ongoing uncertainty about NCSP processes and accountability, particularly following changes to NCSP staffing, funding settings, guidance resources, advisory arrangements and wider sector settings. They linked this uncertainty to inconsistent messaging and variable guidance, which has reduced confidence among regional and local providers and weakened programme-wide implementation.

Introduction of the HPV self-test provides an opportunity to energise efforts for a cervical cancer elimination strategy and action plan. Inviting participation in a screening programme that can eliminate cervical cancer is a powerful way of expressing rangatiratanga and gives space to whānau to be champions of cervical screening.[31] A strategy alone is not enough to eliminate cervical cancer. It requires an action plan that is funded. Interview and survey participants stressed the need for action. We have waited too long.

> It is important to keep telling people that we don't get any closer to cervical cancer elimination by screening people. We need to screen them and get them all the way through the pathway.
>
> - *Interview participant*

Stronger governance

> This goes back to a point made earlier about the need to establish stronger governance within the programme so that we can function well together.
>
> - *Interview participant*

This review found that there was no clear governance in place for the NCSP. Clear governance provides stability when people, processes or structures change.[32] It locks decisions to the NCSP's purpose and aligns strategic direction, clinical quality, equity commitments and public accountability so they reinforce each other rather than compete.

Te Tiriti based co-governance with Māori

While cervical screening rates for wāhine Māori have increased, they remain inequitable. Wāhine Māori and Pacific women have more than twice the mortality rate for cervical cancer.[33] Cervical screening uptake has increased for both wāhine Māori and Pacific women but colposcopy attendance is still lower than for non-Māori non-Pacific women, suggesting persistent inequities in access.

> Te Tiriti o Waitangi is not an aspiration – it is a binding obligation that requires the Crown to ensure that Māori health, data and lives are actively protected, centred and prioritised in every aspect of the cervical screening system.
>
> - *Interview participant*

This message was consistent across interviews. Participants were clear that Māori must be present in governance – and across every level of the NCSP – in ways that shift power, not simply visibility. Meaningful representation requires Māori authority,

capability and influence embedded in decision-making, accountability, design and delivery. Without Māori leadership and genuine power-sharing, the NCSP will continue to reproduce inequities for wāhine Māori, and Te Tiriti obligations to actively protect Māori health and data will not be met.

The NCSP should adopt a Te Tiriti based co-governance arrangement that gives Māori a sustained voice and real decision-making authority over strategic direction and key programme decisions. This is critical for developing a national cervical cancer elimination strategy, where Māori leadership must shape priorities, investment decisions, monitoring and accountability so the system delivers equitable outcomes.

Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry documents persistent inequities in health outcomes for Māori because services were often misaligned with Māori needs and realities.[34] The Waitangi Tribunal linked this to the Crown's failure to actively address these inequities and not enabling Māori tino rangatiratanga in health system decision-making.

Furthermore, *Hauora* underscores that Māori leadership is essential to achieving equity, noting that when Māori are empowered to lead, design and govern health services, the system is better positioned to deliver culturally responsive care and improve outcomes for Māori communities, consistent with the Treaty guarantee of tino rangatiratanga.

The 2022 PRC report made clear that co-governance is not simply a structural aspiration, but a practical necessity – one that depends on role clarity, robust relationships, meaningful partnership and effective advisory input.

Design principles for NCSP co-governance should be explicit and enforceable. They should include:

- clearly defined shared decision-making authority (including which decisions require joint agreement)
- Māori co-leadership at governance level (for example, co-chairing and agreed escalation pathways)
- transparent roles and accountabilities across national and regional levels (including how other Māori governance entities are engaged)
- fit-for-purpose resourcing to enable meaningful participation
- routine equity monitoring with public accountability so decisions can be tested against impacts for wāhine Māori and corrected where inequities persist.

Accountability should be formalised through agreed equity measures, time-bound deliverables and regular public reporting on progress and outcomes for wāhine Māori.[35]

Iwi-Māori Partnership Boards (IMPBs)

> While there are formal references to partnership, it is not clear how IMPBs are intended to meaningfully influence decisions within the NCSP. Engagement tends to occur after key settings have been determined, rather than through early, shared problem-definition and co-design. Without clear roles, resourcing and feedback loops, IMPBs are limited in their ability to represent whānau voice, shape locally responsive models, or provide effective governance-level oversight. As a result, partnership feels consultative rather than co-governed.
>
> *- IMPB survey participant*

Partnership arrangements between the NCSP, Health New Zealand – Te Whatu Ora, and IMPBs were widely described as unclear or under-powered. While some engagement exists, IMPBs reported limited influence over service design, prioritisation and local implementation. Similarly, current NCSP data products were viewed as insufficiently granular, timely or localised to enable effective IMPB oversight and targeted action.

IMPBs provide an established statutory mechanism for Māori to partner with Health New Zealand – Te Whatu Ora at the regional/locality level and participate in planning and decision-making across the health sector.[36] Their ability to navigate between tribal leadership, iwi, communities and the health sector gives purpose to the broad reach IMPBs can encompass. Further defining and strengthening the relationship with IMPBs will profoundly increase equitable service delivery. The NCSP should adopt a clear partnership approach with IMPBs – whether as key stakeholders and/or co-governance function.

We recommend the NCSP national team take the following actions with IMPBs to meet statutory obligations, strengthen Te Tiriti based decision-making and accountability, and better align national strategy with regional priorities and delivery realities:

- Engage with IMPBs to establish genuine relationships, agree engagement expectations, and implement shared performance monitoring.
- Confirm and document the role of IMPBs in the NCSP, including whether they are formalised key stakeholders and/or part of a co-governance partnership.

Support and advisory expertise for the NCSP

The 2022 PRC report recommended clarifying the roles, functions, accountabilities and engagement protocols between the National Screening Unit (NSU) and all advisory and leadership groups. Although the NSU has since been disestablished, the need for clear roles, decision pathways and engagement expectations remains and should be addressed explicitly within current structures.

We identified the following four areas where strengthening governance would clarify accountability, make decision pathways explicit, and support equity-focused implementation across the programme.

1. Māori data sovereignty

The National Kaitiaki Group (NKG) has a statutory role in relation to protected Māori cervical screening data and is mandated to consider and approve applications to disclose, use or publish this information.[37] Their role is crucial to protecting Māori data sovereignty within the NCSP.

> There is a gap in governance and Māori data governance ... We can do so much more ... to give breadth of equity not just to be something on the wall ... to have power and Te Tiriti o Waitangi to have real essence. Systemic thinking and transformation happening. The legacy to be more of an umbrella instead of regulatory committee.
>
> *- Interview participant*

The NKG's role should extend beyond case-by-case approvals to actively support quality improvement and rebuild confidence in how Māori data is governed. We recommend the NCSP national team and the NKG jointly strengthen Māori data governance. This could include the following actions.

- Affirm Māori cervical screening data as taonga in NCSP documentation.
- Document clear, transparent processes for accessing, analysing and publishing Māori data that reflect the NKG's approval role.
- Invest in secure systems for managing protected information.
- Ensure sustainable resourcing for the NKG's statutory functions.
- Set out expectations for ongoing monitoring and auditing of compliance with Māori data sovereignty principles.

These changes also require the NCSP to treat the NKG as a core governance partner – respected, properly resourced, and involved early in decisions that affect Māori data and equity outcomes.

2. Sustainable equity advisory group

The Partnership Action and Equity (PAE) advisory rōpū provides independent advice to the NCSP, using a population health perspective and an evidence-based approach. Membership includes scientific and clinical expertise, Māori leadership and community voices. The PAE rōpū played a major role in the 2023 transition to HPV primary screening.

However, the PAE rōpū was paused in August 2025. At the time of interviews for this review, it did not have terms of reference in place and was not meeting. This pause has weakened the connection between strategy, tikanga and day-to-day operational realities, and has reduced confidence in programme decisions. We recommend the NCSP national team restore a sustainable equity advisory function, as this is critical for ensuring Māori leadership and equity advice are visible, influential and embedded in programme decision-making.

3. Clinical and technical advisory oversight

More than two years after the transition, participants described issues that require stronger clinical and technical oversight alongside PAE's equity lens. As the operating environment becomes more complex, the NCSP needs ready access to specialist advice on clinical outcomes, digital systems, laboratory and molecular issues, and regulatory requirements.

> The biggest need, as I see it, for programme monitoring is that we would benefit from having some kind of group we could take our very detailed clinical or technical questions to. We run into very specific questions that are far beyond our expertise, like lab or molecular issues, and it would be helpful to have a specialist group we could go to, in addition to PAE. PAE serves as an important equity lens and advisor, as well as having feet on the ground, but they can't answer technical questions.
>
> *- Interview participant*

The NCSP national team should put in place a clear pathway for timely specialist input so operational risks and complex technical questions are addressed consistently. We recommend the NCSP national team confirm the specialist clinical and technical expertise required and establish how that expertise will be accessed.

4. Diverse advisory representation

Stronger governance also depends on whose voices are included. Advisory pathways must reflect the communities most affected by screening access and outcomes – especially where current engagement is limited.[38] Broader diversity across culture, lived experience, professional background and community connection will surface issues earlier, reduce the risk of narrow decision-making and strengthen public accountability for equity.

We recommend the NCSP national team ensure governance and advisory pathways include diverse communities and lived experience. Priority groups include Asian communities, rainbow communities, disabled people, and unenrolled whānau (including people on remand). This can be achieved through one (or both) of the following options:

1. establish formal partnerships with existing community cohorts and organisations that represent these groups, with clear engagement expectations, and/or
2. create a dedicated advisory group with representation from these communities and lived experience to provide ongoing input into NCSP decisions.

Recommendations

Recommendation (2025)	Included in 2022 review	Included in 2018 review
1. Strengthen governance of the NCSP by: a. Adopting a Te Tiriti based co-governance arrangement that gives Māori a sustained voice and real decision-making authority over strategic direction and key programme decisions b. Confirming and documenting the role of IMPBs, agree engagement expectations and implement shared performance monitoring.	✓	✓
2. The NCSP national team and the NKG work together to strengthen Māori data governance.		✓
3. Strengthen specialist advisory functions through: a. restoring a sustainable equity advisory function b. restoring clinical and technical advisory expertise c. ensuring that governance and advisory pathways include diverse communities and lived experience.		
4. Ensure Māori-led development and implementation of a Cervical Cancer Elimination Strategy and Action Plan, with continued equity focus for wāhine Māori, Pacific women and under-screened/unscreened people. Pair this with investment.	✓	✓

Accessibility remains a key driver behind inequities

Access to cervical screening is one of the most significant factors influencing inequitable screening uptake and cervical cancer outcomes in Aotearoa New Zealand. Across interviews and surveys, participants consistently described how financial cost, location, service models, information gaps and system complexity have created compounding barriers to access. These barriers disproportionately affect wāhine Māori and other groups such as Pacific peoples, people with disabilities, people who live rurally and those facing socioeconomic disadvantage.

While the introduction of HPV primary screening, particularly self-testing, has been described by many as a gamechanger in terms of rangatiratanga and acceptability, acceptability alone does not ensure access. For many participants, the ability to engage with screening depended not just on willingness, but on whether screening was free, nearby, culturally safe, clearly explained by trusted providers and available in places and spaces that worked for them. When these conditions were not met, screening tended to be delayed or avoided altogether, which perpetuates inequities across the screening pathway.

Financial barriers to access

> Money should never be the barrier to being checked.
>
> - *Interview participant*

Financial cost continues to be a major barrier to cervical screening in Aotearoa. Despite long-standing recognition of the issue, cervical screening is not universally free. This results in inconsistent charging practices and ongoing barriers to participation, particularly for wāhine Māori and other priority populations.

At present, cervical screening is intended to be free for priority populations through a zero-fees initiative funded by Health New Zealand – Te Whatu Ora. Under this initiative, eligible participants should not be charged a co-payment when they access cervical screening. Follow-up testing is also intended to be free for everyone, regardless of their eligibility for free routine screening.

The initiative funds general practices via primary health organisations (PHOs), Sexual Wellbeing Aotearoa (formerly Family Planning) and Screening Support Services (SSS). Collectively, the NCSP, Regional Commissioning, and Hauora Māori Services administer 63 agreements with primary care providers, SSS and Sexual Wellbeing Aotearoa. The contracting arrangements in place are uncapped, demand-based, fee-for-service contracts, which should remove the cost barrier to serve priority populations.

Priority groups are:

- all wāhine Māori and whānau with a cervix aged 25–69
- all Pacific women and people with a cervix aged 25–69
- all women and people with a cervix aged 25–69 who hold a Community Services Card
- all women and people with a cervix under the age of 25 who are already part of the NCSP (for example, they commenced screening before the screening age was lifted from 20 years to 25 years) AND who are Māori, Pacific or hold a Community Services Card.

This equity focus is intended to address a systemic barrier for wāhine Māori and others to screening.[39] However, our interview and survey responses showed that this does not always work in practice.

Some priority group women, including wāhine Māori, told us they had been charged a fee for their HPV test. Participants also described a lack of transparency about payment, sometimes assuming their HPV test would be free and then being charged an unexpected fee, which created confusion or distress. Charges varied widely, ranging from no cost to over $100. We also heard that some had been charged a fee for follow-up cytology, which should be free for everyone regardless of their eligibility for free routine screening.

These inconsistent charging practices indicate that implementing universally free cervical screening could benefit from regulatory oversight to prevent variation in practice charges and protect equitable access. Universal free cervical screening could also eliminate confusion and uncertainty for providers and participants. For example, during the COVID-19 vaccination rollout there were no co-payments charged nationally as the amount that was funded to general practices was all-inclusive. Additionally, all public communications about the COVID-19 vaccinations explicitly stated there was no cost to patients, whānau etc. This resulted in an alignment of expectations from both service providers and the public, therefore eliminating any confusion or distress.

Mere's story

Mere is a 66-year-old wahine Māori who lives in a rural area of Te Ika-a-Māui. Her income is New Zealand Superannuation. Mere is a firm supporter of cervical screening after losing a whānau member to cervical cancer in the 1990s. A regular screener, Mere is always up-to-date. She has lived in different parts of Aotearoa and has never been charged for her cervical screen.

Mere shared her delight at the ease and rangatiratanga of the HPV self-test. However, when she got home she was surprised to see that her general practice had sent her a bill.

> Got home and my phone pinged and it said pay $40 thank you. Now that is a serious barrier for any woman to get tested. Pretty sure I have never been charged ever.
>
> ***- Mere***

People made it clear that cost remains a significant disincentive. It also sends a powerful message about value. Because cervical screening is not universally free (unlike New Zealand's breast and bowel screening programmes), it can create the perception that cervical screening is less important and optional rather than essential.

> Cost is still a major barrier for a large percentage of women to screen. Especially when GPs set the price, so costs can be over $100 depending on where you go. So the mindset is, why spend money on something that 'isn't needed, because I'm healthy' when feeding the children is top priority.
>
> *- Provider survey participant*

The cost of the HPV test is only one part of cervical screening. Women already make a financial or time contribution to cervical screening – for example, through time off work, travel and childcare – which creates further barriers to access.

> It is just another thing to do. I need to take half a day off work to get to the doctor and with work and mum duty it just keeps going to the bottom of the list. And that is for someone who wants to have it done.
>
> - *Consumer survey participant*

This review aligns with all previous NCSP PRC reviews, as we found financial cost is a major barrier to cervical screening. We re-affirm the 2015, 2018 and 2022 PRC recommendations that cervical screening should be fully funded, so that all people should receive free cervical screening.

Universal free cervical screening would align the NCSP with bowel and breast screening programmes. It would recognise, value and honour he tapu te whare tangata, wāhine Māori and all women and people with a cervix.

Service location and delivery models

Where and how cervical screening and follow-up colposcopy is delivered plays a crucial role in access. The current model of cervical screening based primarily in general practice with additional screening provision by SSS and other organisations such as Sexual Wellbeing Aotearoa to support whanaungatanga, manaakitanga and continuity of care is working for most people. However, there need to be options for those who are not enrolled in general practice, live in rural areas, face transport or mobility challenges, or have had negative experiences in mainstream health settings.

A cervical screening model with HPV self-testing centred in general practice has been shown to be accessible and acceptable for wāhine Māori[40] and the wider population.[41] Further, breast screening rates improved significantly when undertaken by general practice in a rural, Māori community.[42] However not all people are enrolled in general practice, and cost and accessibility can limit engagement. To improve equitable screening access, the NCSP pathway (training, offering the HPV self-test or LBC, giving results, diagnostic services, the NCSP Register) must be strengthened so that a wider range of primary care touchpoints can be utilised. This could include organisations such as hauora Māori providers (iwi health providers, community providers, integrated general practice and outreach services), Pacific health providers, Sexual Wellbeing Aotearoa, disability-focused providers and midwives. Broadening the delivery model in this way will enable people to access services in settings they already use and trust, reducing barriers and strengthening participation across the screening pathway.

Community delivery

We heard from interview, survey and submission participants that relationships are paramount to wāhine Māori and all women and people with a cervix in engaging with cervical screening. This aligns with the literature showing local knowledge and connections enhance screening for rural general practice.[43] The introduction of the HPV test has opened up possibilities for more community-based cervical screening where these relationships play a key role. People overwhelmingly described improved access when cervical screening and colposcopy services were available in community-based, mobile or kaupapa Māori-led settings, including marae-based clinics, at outreach events or in culturally anchored initiatives such as Smear Your Mea.

These services reduced practical barriers (travel, parking, appointment availability), but more importantly, fostered trust, safety, rangatiratanga and whanaungatanga.

> The self-test for me is a great option that allows me to take these preventative measures looking after my health while keeping my mana intact and without compromising my values and mana as a woman. Got my test done at a Pacific community event in the weekend, as I have a busy life of work, children and family, been [sic] able to access that service in the weekend while in the community with the kids was great for me.
>
> *- Consumer survey participant*

Mobile cervical screening clinics are enhanced by the HPV self-test. Two 'new' tools available to the NCSP with HPV self-testing are point-of-care testing (PoCT) and mailing out swabs for self-testing at home. We recommend investigating validation of PoCT for the HPV self-test as PoCT is becoming more readily available and will inevitably increase across Aotearoa New Zealand.[44] Digital capability to incorporate PoCT HPV results into community laboratory data and the NCSP Register must be investigated to ensure same-day LBC and colposcopy follow-up in rural areas, ensuring participant safety and maintaining a low risk profile for false negatives or false positives.

We do not support centralised national mailout of the HPV self-test for people entering the NCSP at age 25 or centralised mailout of self-testing kits at any age as the only option, as connection and relationships have been shown to be paramount in equitable cervical screening delivery.[45,46] Some survey participants shared a preference for HPV testing kits to be mailed to them. However, we could not find any New Zealand studies showing high return rates for mailed HPV self-test swabs compared to testing in general practice or completed tests collected from homes by kaiāwhina or other non-clinical staff. Community providers, survey participants and recent literature have showed us the value of providing options, that no size fits all, and mailout may work for some people.[47]

We also spoke to providers about their mahi and heard about how bringing screening to the community, rather than requiring people to fit around the health system, reduced barriers to access across the whole screening pathway.

Smear Your Mea

> This programme is so important and as a Māori māmā who doesn't put herself first, without Smear your Mea in particular I would've kept putting my test off.
>
> ***- Consumer survey participant***

Smear Your Mea is a successful kaupapa Māori cervical screening initiative that began in 2017 when kapa haka leader Talei Morrison was diagnosed with cervical cancer. Talei shared her cervical cancer journey via a blog to encourage wāhine Māori and all people to champion cervical screening. Talei passed away in 2018. She left a powerful legacy in Smear Your Mea, which began to offer cervical screening at kapa haka events, including Te Matatini, and has grown to include an annual 'Ride for Talei' and regular screening events.

> Smear Your Mea became a huge movement in the kapa haka world as it broke down the barriers to access and removed the stigma. Seven years on, it shows there is still mahi to be done.
>
> ***- Interview participant***

Te Matatini is a key platform to encourage performers and spectators to be screened – for example, setting challenges to get entire kapa haka rōpū screened by taking testing to practices and having nurse involvement in this process.

> We used our platform to spread the word around cervical cancer, around cervical screening and how important it is. To get the check-ups, but it was mainly about educating our wāhine on taking the fear out because that's initially how we ended up being in this position, was Talei was so fearful of going for a test because of a bad experience.
>
> ***- Interview participant***

Innovative, community-initiated screening such as Smear Your Mea can be better supported to affirm rangatiratanga and deliver cervical screening to wāhine Māori. We recommend more resourcing for community screening services like Smear Your Mea, alongside support to better capture their screening data. The current system is not set up to count the number of cervical screens undertaken as part of Smear Your Mea initiatives.

Te Waka Hauora Wahine – The Woman's Health Bus

Te Waka Hauora Wahine – The Woman's Health Bus offers a range of women's sexual and reproductive health care in rural and remote locations and at community events. Women and people with a cervix are able to access swab or clinician-taken HPV +/- colposcopy as indicated by their clinical status. During research studies they offer PoCT results within two hours, with same-day next diagnostic step offered.

> Being in the community and being visible means we have demystified colposcopy for a lot of people and created an experience very different from a hospital setting.
>
> ***- Interview participant***

The Woman's Health Bus partners with hauora Māori providers and places value on relationships and trust with community and whānau. HPV testing with PoCT has been shown to integrate same-day cervical screening and follow-up care into remote health care settings, increasing participation in screening programmes, especially for those in remote areas.

Marae based colposcopy clinics

Marae based clinics for cervical screening regularly take place throughout the country and have been running via general practice and SSS for many years. While it is commonplace for screening to take place in familiar community settings such as marae, there are few marae based colposcopy clinics. Marae based colposcopy access has been shown to be acceptable and accessible to wāhine Māori and Pacific women.[48]

An interviewee described the benefits of marae based colposcopy clinics in creating a welcoming, mana enhancing environment based in familiar surroundings. One clinic shared their information sheet tailored to wāhine who visit the clinic, including photos of the clinic and colposcopy staff and a mihi from each to introduce themselves. Additionally, basing colposcopy clinics in marae settings was more efficient in seeing patients than hospital-based colposcopy clinics.

> People … have to travel further to (name of hospital) for their appointment. And given the higher Māori and Pacific populations in these areas, there is structural racism there. I found in the community clinics that I'm able to see just as many, if not more people per clinic. I don't think that a more holistic community approach takes longer. If anything, it's more efficient.
>
> *- Interview participant*

Despite the success of marae based clinics in engaging and welcoming patients to colposcopy, the NCSP systems were designed for hospital-based colposcopy. Marae based clinics rely on the goodwill of individual colposcopists who are willing to organise and work outside the hospital setting.

> We want a sustainable service. The clinics rely on a lot of innovation and good will – need to be innovative to get around system barriers.
>
> *- Interview participant*

Findings from this review support actions that promote sustainability for community-based colposcopy. Despite the success of marae based clinics in engaging and welcoming patients to colposcopy, the NCSP systems were designed for hospital-based colposcopy. Marae based clinics rely on the goodwill of individual colposcopists who are willing to organise and work outside the hospital setting. We recommend the NCSP national team works with and supports colposcopists to identify and address system barriers for those wanting to offer colposcopy in community settings.

System barriers limit the sustainability and effectiveness of community models

Although community-delivered screening and colposcopy clearly improve access, this review identified several system barriers limiting their ability to be sustainable or far-reaching.

Screening Support Services (SSS)

SSS contracts are administered by BreastScreen Aotearoa (BSA) and Hauora Māori Services, with funding allocated to a mix of PHOs, regional Health New Zealand – Te Whatu Ora teams, Hauora Māori partners and community providers (including one Pacific health provider). Many of the lead SSS providers also subcontract to community health providers.

> It takes a lot of time and effort to get women into the colposcopy clinic – the support to screening staff do a great job but there's not enough of them. The system's not set up for the hours of work that it takes to get one person into clinic.
>
> *- Interview participant*

Interview participants described opportunities for improving the coverage, management and reporting of SSS. The current model was considered inequitable, with gaps in provision. There is currently no cervical screening SSS provision in Taranaki, Nelson Marlborough and West Coast, and a reduction in provision of services by Māori and Pacific health providers.

The NCSP needs SSS that can engage effectively with wāhine Māori and Pacific women, with a particular focus on people not enrolled in primary care.

> Around 2016, a lot of contracts were taken away from Māori and Pacific providers and given to mainstream providers, which had a significant impact in coverage, participation and engagement in the Auckland region.
>
> - *Interview participant*

The previous PRC had a strong focus on equitable outcomes for wāhine Māori, cervical screening for under-screened/unscreened populations, particularly people who are not enrolled in primary care. We re-affirm this and support the previous PRC's recommendation of a strengthened SSS delivery and reporting model with better information sharing from the NCSP Register. We also recommend improved support for general practice through resourcing NCSP in-person relationship engagement with providers (Recommendation 7), training for kaiāwhina in general practice (Recommendation 7b) and funding to encourage midwives in cervical screening provision (Recommendation 7a).

Enrolment in primary care

The number of people who are not enrolled in primary care is increasing.[49] Some interviewees outlined the efficiency and potential effectiveness of enacting identification of unenrolled people on the NCSP Register. With proper Māori data sovereignty processes followed, provision of this information to SSS could involve reporting by NCSP that captures all unenrolled people and their screening status. Regional and district teams could then work alongside SSS to focus on people not enrolled in primary care.

Contracting and reporting frameworks for community providers

The results-based accountability (RBA) framework for contracting SSS does not capture or value important narrative data, missing opportunities for measuring relationship development and community-generated cervical screening promotion. In using the measure of counting numbers of cervical screens, providers could 'pick the low hanging fruit' from a list of under-screened/unscreened women. When focusing on numbers in reporting, there was no incentive for whanaungatanga and manaakitanga.

> RBA contracts do not work for our communities because providers don't necessarily have to go out and engage with wāhine/whānau if they have access to data from the Register – they can operate from inside an office.
>
> - *Interview participant*

It is important that RBAs reflect the needs of communities. Placing primary value on the number of screens undertaken at an event or clinic did not always show the important trust, relationship and dissemination work that can grow from these interactions. Interview and survey participants wanted more emphasis on narrative reporting.

> Ultimately, the more events we go to, the more women get screened. Limitations are that it ends up being a numbers game and people only care about how many screenings we got. We really value our narrative or qualitative reporting because it's not just about the number of women screened, but the women we had discussions with to get them thinking about screening in future, and the conversations they may then go on to have with their friends and whānau. Exponential outreach counts, so our narrative reporting is something we put a lot of work into.
>
> *- Interview participant*

Payment for midwives

For some wāhine Māori and people with a cervix, midwifery services may be their only connection with health care. HPV primary screening can be performed at any time postpartum, as HPV testing is not affected by hormonal changes such as postpartum oestrogen deficiency or inflammatory cervical changes that can interfere with the interpretation of early postpartum cytology. As per the *Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand*, if a follow-up assessment cytology, HPV test and/or colposcopy is required postpartum, it should be performed at least six weeks after delivery. This interval is optimal to reduce the risk of cytology interpretation difficulties due to oestrogen deficiency or unsatisfactory cytology.

The flexibility of HPV screening allows midwives more opportunity to offer opportunistic screening, before care is transferred back to primary care providers, thereby increasing the likelihood of timely screening uptake. The 2022 PRC review recognised under-resourcing for general practice and we re-affirm the need to strengthen general practice and SSS so that all women and people with a cervix can receive good information, communication and care throughout the cervical screening pathway. We extend this recommendation to including funding for midwives to provide opportunistic cervical screening, as for some wāhine Māori and people with a cervix, midwifery services may be their only connection with health care services.

Information and communication barriers: knowing is part of accessing

> Still not a great deal of advertising. There are a large number of wāhine that are still unaware of self-screening or the option to get it done in their own whare/marae etc.
>
> *- Provider survey participant*

Access is not only physical or financial, it is also about knowledge and awareness. Interview and survey participants repeatedly described gaps in understanding about the new HPV test, how to self-test, what results mean, and why follow-up may be required. These knowledge gaps affected people across the screening pathway, from their first invitation to screen through to follow-up and referral.

To support the rollout of HPV primary testing, the NCSP ran two tailored cervical screening media campaigns for Māori and Pacific communities from September 2023 to September 2024. These campaigns focused on raising awareness about the new HPV self-test with culturally responsive and tailored online content, paid media advertising, and educational resources, including a booklet designed for wāhine Māori, *He Wahine he Taonga/Te Whare o te Tangata*. Translations of resources into eight Pacific languages was completed, and videos tailored for Pacific communities explaining the new self-test and different options for cervical screening were developed. A post-campaign review found it had favourable results, concluding a successful campaign reaching a large proportion of the target audience, delivering key messages and evoking a strong and emotional response.[50]

In addition, the NCSP national team told us that throughout 2023–2025, 38,093 campaign resources were distributed to providers to increase awareness of the new HPV self-test and importance of cervical screening. These resources included promotional banners and flags, Māori and Pacific T-shirts, branded pens, Pacific fans and fridge magnets. Educational and promotional resources that were co-designed with Māori and Pacific consumer groups and rainbow community representatives are also available free of charge in multiple languages and accessible formats.[51] Further, 814,198 educational and promotional resources (including pamphlets, brochures and guides) were requested by and distributed to providers and consumers throughout the country. The NCSP national team is unable to quantify the actual number distributed specifically to consumers, nor the number of digital downloads of resources for patient support to colposcopy appointments or posters printed for hospital walls.

While national media campaigns reached many Māori and Pacific participants and were broadly well-received, interview and survey data suggest more needs to be done. There were mixed responses about the level of understanding women had about cervical screening before, during and after their cervical screen.

Sophie's story

Sophie is a Pākehā woman in her mid-50s. She lives alone in a coastal suburb. Sophie's neurodiversity sometimes makes it hard for her to hear instructions. Sophie was notified by a nurse at her general practice that her cervical screen was due and the new HPV self-test was available. At her appointment, Sophie was not given a diagram on how to do the test and 'switched off' when the nurse explained the test to her. Subsequently, Sophie inserted the swab too far and almost broke it.

> She talked for a long time but I didn't take any of it in. They gave me the test and asked if I understood what to do and I said yes, but really I wasn't listening. I just wanted to get on with it. I have a habit of vaguing out when given instructions, especially if I have rushed to get there and I am tired but especially when people are not super direct. 'Don't push it too far up your vag' I would understand.
>
> I went to the loo and just kind of did my own thing really. I remembered in the old test they used to go right up to the cervix so I pushed the swab in as far as I could and kind of did my own cervical sweep. When I gave it back to the nurse I said sorry, it's bent. She said how far up did you put it?
>
> ***- Sophie***

For many, the self-test was a gamechanger, with autonomy and privacy highly valued. Participants noted increased uptake of screening for wāhine Māori and Pacific women, people with disabilities, non-binary people with a cervix, trans-men, and women in prison. However, awareness of the self-testing options and community-based screening was inconsistent. Additionally, during their appointment, some people received little or no guidance when offered the self-test, which led to anxiety, doubt about whether the test had been done correctly, or in some cases, incorrect sampling.

> The expectation was that I would understand how to use the self-test as it was similar to using a tampon. As I have never used a tampon this was rather daunting so I lacked confidence that I was doing it correctly.
>
> *- Consumer survey participant*

Other survey participants described confusion and distress when receiving results without adequate explanation. Some did not know what their results meant, why they were being referred for colposcopy, or why it is safe to wait five years for recall when HPV is not detected.

> The LBC came back atypical and no-one has explained what that means or why it's another year before re-testing.
>
> *- Consumer survey participant*

Recent research has shown the anxiety and fear that can result from knowledge gaps for cervical screening participants and highlights the importance of clarity around potential outcomes at the time of screening and again when sharing results.[52] Further, honouring mana wāhine and reducing cervical screening inequities requires providers to safely connect, inform and support wāhine Māori in screening.[53]

We also heard that, without good information, people seek answers from inappropriate sources. Some turn to social media or other informal sources, which can increase the risk of misinformation or even fear if the information is not presented in a clear, culturally safe way.

> What's out there is not answering the questions that people are asking me. I think there's a huge amount of variability in people's understanding. On one hand, you've got incredibly informed people. On the other hand, particularly the people we're seeing who are under and unscreened, there may not be that health literacy there. Some people are going to TikTok, which is showing content that is not culturally safe.
>
> *- Interview participant*

There is international evidence to show invitations to screen from a centralised register are less effective for cervical screening uptake than invitations from general practice.[54]

The NCSP needs to improve the provision of sustained, culturally grounded media, communication and information so that all people who are due for cervical screening understand why the HPV test is offered, how to self-test, and what to expect from results, referrals and follow-up across the screening pathway.

The HPV self-test is acceptable and accessible to under-screened/unscreened wāhine Māori.[55] Research undertaken to inform the rollout of the 2023 NCSP has emphasised the rangatiratanga of self-testing, and the relief most people experience at not having to undergo a genital speculum examination.[56] However, the benefits of the HPV test can only be fully realised if people know about the test and feel supported through the pathway with good information.

The NCSP can learn from the communication mistakes of other cervical screening programmes. Public Health Wales issued a public apology in 2022 for poor communication after a petition gained over 350,000 signatures to re-instate a three-year recall for screening. Communities did not have good enough information to feel a five-year recall was safe. Sharing the evidence with communities and whānau is critical. Recent local research recommends all information and communications about cervical screening are delivered within the wider context of cervical cancer elimination so that women feel part of a collective system to eliminate a cancer that is now preventable.

This empowerment encourages women to be the greatest champions of cervical screening, sharing positive stories with kaupapa and whakapapa whānau.[57]

The gaps in participant understanding across the screening pathway reflect inconsistency and variability in provider communication and at the public-facing media and communications level. It also reflects gaps in training for those offering the cervical screen, which is highlighted in Recommendation 7e.

Improving training for cervical screeners

Interview data show the great deal of work undertaken throughout the NCSP and the dedication and commitment each person brings to making a positive difference. However, the success of the NCSP cannot not rely on individuals in an under-resourced and under-staffed workforce. A safe and equitable cervical screening programme requires resourcing and a strong structure. Time and time again we heard from interview and survey participants of an under-staffed and under-resourced NCSP workforce. Some participants described burnout.

Inconsistency in cervical screening training

Interviewees stressed the importance of accessible training so that cervical screeners could be trained across the regions.

> We have put a lot of effort into engaging rural communities and making courses flexible, so half of it can be done at home. Nurses put in the time for the love of it, they don't get paid any extra as a nurse to be a screen taker.
>
> - *Interview participant*

Training grants for registered HPV screen-takers are targeted to improve equity by prioritising nurses working in Māori and Pacific health services, outreach programmes and clinics serving under-screened populations. This approach helps reduce financial barriers for clinicians serving communities with the greatest need.

However, while the grants subsidise up to $700 of the approximately $1,200 training cost, several factors continue to limit overall accessibility, including a remaining financial gap that employers or clinicians must personally cover, prioritisation criteria that mean some nurses may not receive a grant, and capped funding and limited training places, restricting availability.

As a result, the grant system supports but does not guarantee equitable access to HPV screen-taker training, particularly for nurses in under-resourced practices or those not meeting equity priority criteria.

> In our region, they access liquid-based cytology training through Sexual Wellbeing Aotearoa. Te Whatu Ora Health New Zealand used to provide grants for this, but not this year, which we suspect would lead to a bit of a reduction in training numbers. We have offered our own training grants, though limited in number. We're also starting to hear from the sector that some currently certified LBC takers are struggling to keep their competencies.
>
> *- Interview participant*

Following training, cervical screeners must complete a number of supervised LBCs, which requires enough patients and a qualified screener to supervise. This was sometimes a challenge in rural regions.

> There is not a sustainable workforce to support this and we need to have an ongoing plan – especially in the rural regions like Te Tai Tokerau.
>
> *- Interview participant*

Kaiāwhina who work for SSS or regional coordination teams are able to offer the HPV self-test to women if they report to a registered nurse who can undertake LBC and monitor the appropriateness of follow-up. Kaiāwhina have their own training modules to complete to be ready for this mahi. Some interview participants felt that the kaiāwhina role in offering HPV self-testing was underutilised, with those working in general practice still not eligible to complete the training.

> HPV screen-taker training was a great advancement for our non-clinical workforce to be able provide that service in the community. There is huge potential to expand this further to Māori and Pacific community providers, we need to enable and support them to do this mahi. Currently there is no extra reward or financial recognition for the kaimahi that take on this added responsibility. There should be more wrap around support – NCSP needs to strategise better and put more energy, aroha and manaaki into promoting the modules and supporting kaimahi to do the training.
>
> *- Interview participant*

We also heard that currently, nurses who are trained in HPV sample-taking are not able to order laboratory tests under their own name, but this trained workforce has the capability and capacity to order and review laboratory test results and pathways.

> This restriction limits workforce efficiency and autonomy, and it does not reflect the skill or accountability of these nurses. Removing this barrier would maximise the nursing workforce, improve timeliness, and reduce unnecessary administrative complexity. Any perceived risks or quality concerns should be addressed through appropriate governance and quality systems – not by maintaining a barrier that undermines accountability and limits service access.
>
> *- Submission participant*

A gap in the representation of doctors attending training was identified throughout interviews and survey responses. There were concerns raised by some participants that while nurse and kaiāwhina training was stringent and covered every aspect of cervical screening, there was no requirement for doctors to have this training, which was considered a risk. It was noted that some doctors did complete the training.

> We've noticed there is a bit of a challenge in keeping GPs up to date with cervical screening information. The nurses are fabulous and always come to our education sessions, but we almost never get any GPs. When we get negative feedback from women about their cervical screening experience, more often than not, it's been a GP that delivered it.
>
> *- Interview participant*

Inconsistent cervical screening refresher requirements

People qualified to take LBC samples are known as "responsible clinicians" and take clinical responsibility for swab samples taken by participants. They are referred to as 'cervical sample takers' and are required to complete cervical screening training through either training as part of a medical degree or midwifery training programme or an NZQA-accredited course for cervical sample takers. However, if they have not been practising for more than two years the NCSP recommends (rather than requires) the clinician:

- have a clinical supervisor for the first few samples (for example, three to five samples)
- review NCSP guidelines, policies and standards
- attend a cervical screening update session
- seek advice from an experienced cervical sample taker or supervisor about any changes in the intervening period and check the NSU website for this information.[58]

We recommend that regardless of qualification, everyone offering cervical screening should complete the NCSP HPV Primary Screening Modules (NZQA unit standard), including doctors, nurse practitioners, nurses, and newer positions such as physician associates. This would ensure consistency in cervical screening practice across the workforce.

We also recommend that every cervical screener should be required to have refresher training every three years to ensure they remain competent and up to speed.

Centralised visibility of the workforce

Cervical screening is NZQA unit standard approved. There are three accredited cervical sample taker training providers:

- Sexual Wellbeing Aotearoa
- Well Women and Family Trust
- Eastern Institute of Technology.

NZQA holds information about the number of people who have completed the unit standard for cervical screening. The NCSP does not hold information on the number of people who have completed the unit standard or on the number of people who are trained to undertake LBC. This separation of responsibilities means neither the NCSP nor NZQA are engaged in tracking who has completed training and when, resulting in no reminder system to ensure people refresh training.

NCSP Policies and Standards – Section 3: Cervical Screening Services plays a vital role in outlining how cervical screening services should be delivered, but it does not establish mechanisms for formal staff tracking or systematic competence assessment. Instead, it relies on employer-based processes and professional regulation to support competency assurance. The implications of not having a clear workforce oversight include having inconsistent workforce capability. Without central oversight, regional disparities in the experience or availability of sample takers may go unnoticed. This is of particular importance to ensure the availability of clinicians who have completed the unit standard for cervical screening. There may be quality assurance risks as reliance on local processes creates variability in assessment quality and reduces the NCSP's ability to audit service delivery at a system level. Lack of visibility of the workforce may affect the ability to respond to service disruptions. Without workforce visibility, the NCSP cannot accurately assess staffing shortfalls.

Given that Section 3 of the NCSP Policies and Standards focuses heavily on service delivery, we recommend the NCSP national team should update Section 3 to explicitly include:

- minimum competency standards to include completion of NCSP HPV Primary Screening Modules for all cervical screening sample takers
- requirements for providers to report training records to a central system
- defined processes for managing staff who do not meet competence thresholds
- expectations for ongoing professional development linked to national priorities
- minimum competency standards for all cervical screening workplace trainers
- minimum activities to maintain competency
- wording updated to require minimum training after two years of not practising.

By embedding these elements into the policy itself, workforce governance becomes an integral part of service quality rather than a supplementary consideration.

A centralised workforce register would serve as a national system that records the number of accredited cervical screening sample takers; their geographical distribution, competency status and training history; and workplace trainer availability. By consolidating this information, the NCSP would gain real-time visibility of its screening workforce, enabling more effective workforce planning, targeted training, and national audit functions, while ensuring consistent service quality across regions.

Training for the rollout of HPV primary testing

Training was delivered across the sector, including through targeted learning modules tailored for clinicians, nurses and kaiāwhina to ensure a clear understanding of the updated screening guidelines.

Implementation of the updated cervical screening system experienced several delays, with the Ministry of Health's original 2018–2021 timeline repeatedly pushed back due to the need to ensure appropriate laboratory infrastructure and IT systems, rather than adapting outdated systems. These delays meant that training materials, clinical pathways and provider resources for nurses, GPs, midwives and other health professionals were only finalised and released close to the 2023 launch.

A dedicated NCSP laboratory training programme was implemented in early 2023 to ensure laboratory staff were prepared for the transition to HPV primary screening. This programme began in March 2023 and included structured upskilling and a formal competency assessment, which all participating laboratory personnel were required to complete prior to the introduction of the new screening programme on 12 September 2023.

Prior to rollout, knowledge gaps were evident, with some health professionals reporting they did not feel they had a comprehensive understanding of the change to HPV screening, underscoring the need for thorough and timely education.

> Six weeks out from go-live we were scrambling to give clinics advice about the right discharge to input into GynaePlus and there's still a lack of education about how to use the system – we've heard of some instances where women have been accidentally unenrolled from the programme. This again highlights the lack of communication to the sector and how the programme didn't involve the people that actually do the work in the conversations early on.
>
> *- Interview participant*

Recall systems for cervical screeners

Concerns were also raised about whether all trained screeners kept their own recall system as a safety net to the NCSP Register. There is no current confirmation that the NCSP Register's centralised notification system has fully completed its transition; therefore, cervical screening providers should continue operating their own invite and recall processes to ensure participants receive timely screening reminders and follow-up communications. This remains essential until the NCSP can demonstrate that the centralised system is fully operational, reliable and capable of managing all notification functions safely and consistently at a national level.

Updates to clinical guidelines

The *Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand* were developed for practitioners providing health services across the cervical screening pathway. The guidelines aim to provide a standardised national approach to help providers achieve best practice outcomes.[59]

The shift to cervical screening with HPV testing created the need for a new triage system with different referral pathways to the previous LBC-based NCSP, which required updated guidelines.

Interview, survey and submission participants reported a number of issues with the process for updating the clinical guidelines.

Some noted a lack of consultation in the sector for the new guidelines, and a rush for feedback as the NCSP neared the September 2023 'go live' date.

> The other thing was that there was conflicting advice in the guidelines. Some aspects of the guidelines were not patient focused and there wasn't enough focus on patient choice or an equity perspective. Evidence to support some of the guidelines was lacking.
>
> *- Interview participant*

Others were concerned that there appeared to be confusion in the sector, as participants told us they did not know if the guidelines had been updated yet, and were not confident they would be told when the guidelines were updated. This confusion resulted from inconsistent messaging and points to a need for a cohesive, national approach to socialising guideline changes across the regions.

> I also find that the programme implements policies without communicating them to the sector. Often you'll just find out about it by accident. A good example of this is when they updated the clinical guidelines – we didn't hear about it until they were already updated. There were two versions of the guidelines floating around when we went live. Rather than piecemeal, it would be better to review them once and transparently roll it out.
>
> *- Interview participant*

Recommendations

Recommendation (2025)	Included in 2022 review	Included in 2018 review
5. Fund free cervical screening for all women and people with a cervix.	✓	✓
6. Provide sustained media, communication and information about cervical screening in the context of cervical cancer elimination, for present and future screening participants.	✓	
7. Increase support and resourcing for primary care providers, including general practices and all community screening providers (Screening Support Services, hauora providers, Sexual Wellbeing Aotearoa, Smear Your Mea, midwives). a. Pay midwives to provide cervical screening b. Expand and socialise wider kaiāwhina reach with rollout of training and support for more kaiāwhina - for example, those working in general practice. c. Develop a clear and consistent communication plan for updates to the clinical practice guidelines for cervical screening. d. Ensure training for cervical screeners is accessible through fully funded scholarships and ensure screening workforce are visible on a centralised register. e. Ensure all cervical screeners carry out NCSP HPV Primary Screening Modules, and that refresher training is carried out every three years to maintain competency.	✓	
8. Investigate validation of point of care testing for HPV self-tests.		
9. Learn from, resource, support, collect and share data with community/mobile cervical screening and colposcopy services.		

Strengthening the sector to provide a safe and equitable service

Strengthening the sector to work better with Māori, Pacific and diverse communities

> [Name of nurse colposcopist] was super, warm and organised, from booking, to test results to information. The people make the difference. Good people who give time to connect with you and make you feel like a person when vulnerable testing takes place.
>
> - *Consumer survey participant*

We heard a lot that the way in which health providers connected and communicated with screening participants made a difference to the experience of those participants. Aotearoa New Zealand has a wide range of very diverse communities, and it is important for the cervical screening sector to be able to engage with and support people from all of those communities in safe and mana enhancing ways. This must be led at a national level.

Gaps in patient communication competence

> It's great to have the self-swab and means we get more screens, but have those women had informed consent? Have they had a holistic health consult and has the entire process been explained thoroughly? That's where I think I get worries that we'll be missing things.
>
> - *Interview participant*

As discussed earlier, participant understanding of cervical screening varied greatly across the screening pathway. While some of this is due to inconsistency and variability in provider communication and at the public-facing media and communications level, it also reflects gaps in communication by the sector.

The people who invite women to undertake cervical screening, explain why they are offering the HPV test and explain what will happen before, during and after the test are a critical part of the NCSP. Their training is paramount in ensuring women and people with a cervix are warmly engaged, informed, have space to ask questions and have them answered. Ongoing contact, follow-up and an accurate recall system is also part of this role and a vital part of training.

Most interviewees and survey participants reported that the current training modules were comprehensive. However, it appeared not all competencies for those who completed the modules were adequate, and participants shared examples of women not understanding the basics of HPV, the self-test and the cervical screening pathway.

To ensure all cervical screeners – both clinicians and trained health workers – confidently and accurately explain the NCSP, training modules should be reviewed to confirm that providers and curricula adequately cover programme information and communication expectations. We also consider there are improvements that could be made to ensure those working in the sector are able to communicate with the diverse communities that we have in Aotearoa New Zealand.

Māori and Pacific communities

As mentioned earlier in this report, cervical screening, diagnostic, treatment and mortality outcomes are currently inequitable for wāhine Māori and Pacific peoples. This report and the 2022 PRC report emphasise systemic failures by the NCSP to uphold Te Tiriti o Waitangi, and we have recommended strengthening co-governance and active partnership by Māori.

Cultural safety was developed in and for Aotearoa. It has been embedded as a critical component of nursing and midwifery training in Aotearoa New Zealand for three decades, and more recently offered to registrars and specialist medical practitioners.[60]

> It is about changing the perspective toward cervical screening internally and using this to run your programme and meet the aspirations of whānau. It is about building trust, building access and doing what whānau need.
>
> - *Provider survey participant*

Culture includes Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief, and disability. Culturally safe care focuses on the delivery of quality care through changes in thinking about power relationships and patients' rights.[61,62] In understanding power imbalances and racism, both within health services and among the individuals who work in them, cultural safety shifts responsibility onto those institutions and health workers to address performance of services in meeting the health realities of Māori, including ensuring access to care.[63]

Interview and survey data suggest that at an interpersonal level, wāhine Māori continue to experience culturally unsafe care in the context of cervical screening. Some interview and survey participants shared stories of empowerment and aroha, but others shared experiences of their mana being trampled.

> We are hearing that they are just a number and treated poorly. They are not just going for a screen, they have to think about time and travel too. There are wāhine who are missing from the statistics and data, therefore not seen. It matters who is delivering their care, and they want an authentic person who actually cares about them and their experience as opposed to someone who receives money for their service. They want to be treated with dignity and respect.
>
> - *Interview participant*

The approach of Hauora Māori and Pacific providers was often seen as a positive approach as they were enveloping the whole whānau in awhi, by providing transport and kai or making a fun event of screening. We have included some examples below.

Anahera's story

Anahera is a wahine Māori who lives in a large city. Anahera attended Te Matatini with a big whānau group. She heard through socials that Smear Your Mea would be at Te Matatini offering cervical screening. Between kapa haka performances, she noted MCs announcing over the loudspeaker that you could learn about cervical screening and have your screen at the Smear Your Mea tent. Anahera and her cousin went to check it out. She discovered that she was due for a cervical screen, and she could have an HPV self-test. Anahera was with her whānau; she was surrounded by positive support in a mana enhancing environment. She chose to do the HPV self-test and encouraged her whānau to have one too.

> I had a great experience. It was done by a wahine Māori in a mobile screening van at Te Matatini. I felt safe, well looked after. I felt heard and I felt connected because it was a Māori space.
>
> ***- Anahera***

Sina's story

Sina is a Pacific woman from a provincial town in Aotearoa. She has recently become eligible for cervical screening and attended a Pacific Sisters wellness event where a holistic approach was taken, with information about different cancer screening programmes and overall wellness.

> It was the first time I heard of HPV by a nurse from [name of Hauora Māori provider]. It was my first time doing a test and the ladies were so friendly and supportive. The event was held at a Church Hall so it was a safe space for us to talk about these matters. My mum and daughter both did the test also.
>
> There were over 150 women in attendance so it was a great evening of information sharing and education. We learnt also about bowel screening … I feel informed and comfortable also to ask any questions.
>
> ***- Sina***

Even in pressured clinic settings, we heard stories of connection, whakawhanaungatanga, laughter and listening. In this way, cervical screening is less transactional and more of a positive interaction.

> Whānau need to have positive experiences and engagement with the health sector to build a trusting reciprocal relationship to encourage future engagement.
>
> - *Consumer survey participant*

When whānau did not feel welcomed, listened to or looked after, they were less likely to return and even less likely to encourage others to participate in cervical screening. Every person who seeks health care must be respected and honoured before they set foot in the door.

> The last few GP practices I've had the nurses were old, cold and spent a lot of time telling me off for being overweight, not getting my smear on time, and were just generally judgemental.
>
> - *Consumer survey participant*

We also note that Recommendation 6 of the previous PRC review for anti-racism training has not been implemented.

Asian communities

Asian women have a lower cervical cancer mortality rate compared with wāhine Māori and Pacific women.[64] High mobility and access to treatment in other countries mean accurate reporting of cervical cancer rates and mortality rates for the Asian population are difficult. We did not have cervical cancer incidence data to report in this review; however, an interview participant noted that there is a significant and relatively rising incidence rate for cervical cancer in immigrant populations, with action needed to improve cervical screening access and coverage for new migrants.

Cervical screening coverage for the Asian ethnicity group is poor, with 62.6% coverage in 2025.

> I do have particular concern about our low screening rates in Asian women. I don't think we understand that and I don't think we've looked into it. They don't have higher cancer rates, but I worry that that's just the lag and I think we need to look into it now. Once they have the test, they seem to make it to colposcopy. It's just getting them to screening in the first place which is the challenge.
>
> - *Interview participant*

The Asian ethnicity definition encompasses many different population groups with diverse ethnicities, migration histories, languages and spiritual beliefs. The term 'Culturally and Linguistically Diverse (CALD)' expresses the unique health, social and service access barriers faced by people from diverse ethnic, cultural and linguistic backgrounds.

> Those who live in the Asia continent is very broad and many separate population groups which means their needs are different and their understanding and interpretation of things is different. The focus on this group is complicated.
>
> - *Interview participant*

There is little academic literature about cervical screening access for Asian women. A paper focused on Chinese women found age, immigration status and knowledge of health systems in the new country of residence were associated with barriers to screening.[65]

Asian people in Aotearoa New Zealand can face language barriers that affect their access to cervical screening. An interview participant highlighted language as a major barrier to understanding cervical screening, and interfacing with the health system for people who do not speak English.

> This is mental and emotional, forced to have their mum give a translation like a young child or may not be ready to have parents in emergency care. This shouldn't be done.
>
> - *Interview participant*

Translation services are poor, and translation by a family member is commonly used in the absence of translators. The Asian Network Incorporated provides education for Asian communities about the health and disability system in Aotearoa New Zealand, including the NCSP.

Another barrier that Asian people eligible for screening face is the cultural differences in understanding the concept of population-based screening and cultural approaches to sexual and reproductive health.

> Some women have never experienced public health in their countries and have no idea what cervical screening means … They often don't have any public health services, such as immunisation etc. They don't know what cervical screening is. So how can we get them to get screened? We cannot assume they know and understand what cervical screening is and what it does, so we need to communicate this differently.
>
> - *Interview participant*

> There is a strong stigma in Asian culture with sexual health, in particular for the cervical and breast screening programmes. This makes it complex and difficult for Asian women to access public health services.
>
> - *Interview participant*

Rainbow communities

As outlined in the 2022 PRC review and literature from the Counting Ourselves community-led survey about the health and wellbeing of trans and non-binary people in Aotearoa New Zealand, rainbow communities (groups of people with diverse gender identities, sexual orientation and sex characteristics) have described barriers to accessing cervical screening.[66] These include health promotion privileging cis-gender, heterosexual women and negative experiences of health care that is not gender-affirming.

There is potential for the HPV self-test to address some barriers to screening for trans and non-binary people; however, comfort and safety of the HPV self-test relies on a safe health care provider to offer the test and explain results and next steps.[67] Additionally, mis-gendering by health care providers and inaccurate gender data collection will make any gains difficult to measure. It is important that culturally safe care is not left to individual providers to uphold; rather, it is enacted through NCSP governance, leadership, policy and practice.

A literature review of cervical screening in transgender men called for transgender-specific guidelines and trained health care providers to work with the needs of this population.[68] While Aotearoa New Zealand does not have specific guidelines for gender-affirming cervical screening, sections of the *Guidelines for Gender Affirming Healthcare in Aotearoa New Zealand* address particular needs such as primary health care services, ensuring recalls are set up so that transgender people are offered appropriate screening at appropriate intervals.

> This may not occur by default due to the patient's sex or gender being recorded differently on their NHI or patient file from their sex assigned at birth. Many health IT systems are not linked, which means that laboratory forms, Work and Income New Zealand (WINZ) certificates, referrals and other correspondence may not reflect a person's correct gender or name. It may be helpful to explain this to your patient or client so that they understand why a form may not reflect accurate details.
>
> - *Guidelines for Gender Affirming Healthcare in Aotearoa New Zealand*[69]

People who have disabilities

The 2022 PRC cited marginalisation for people with disabilities. The sexual and reproductive health needs of people with disabilities are often overlooked by families, communities and health care providers, amplified when ability to communicate concerns or preferences about screening and health care is impeded.[70]

The HPV self-test has the potential to help people with physical or learning disabilities to access cervical screening. A survey completed by women with disabilities in Aotearoa New Zealand before the 2023 NCSP identified specific barriers to screening, including accessibility, service environment and lack of information. While some access barriers such as removing the requirement to climb onto an examination table for a genital speculum examination are ameliorated by an HPV test, other barriers such as inclusive recall methods, good information and support, and transport to the clinic are not.[71] However, HPV testing, whether self or clinician administered, and being part of cervical cancer elimination helps to open up new and inclusive conversations about screening.

While limited in numbers, this PRC review included the voices of people with disabilities. Twenty-six consumer survey respondents identified as having a disability, and they were from multiple ethnicities, sexualities and ages. Most lived in rural areas. Sixteen had done an HPV test for their cervical screen and most were self-administered. One survey participant had not been offered the option of doing the HPV self-test themselves and it was instead undertaken by their nurse or doctor. Five participants had cervical screening explained to them within the context of cervical cancer elimination. Four participants did not know what to expect for getting their test result. Two required follow-up tests: one cytology and one colposcopy. Of these, one did not understand their result. People who have a disability reported information as the main element of screening that would have improved their experience, followed by practical support, manaakitanga, kindness and hospitality.

> Time, is the greatest gift you can give a patient, followed by engagement in the process.
>
> *- Provider survey participant*

People with mental health issues, behavioural issues and experiences of trauma

The 2022 PRC also identified people who live with behavioural health conditions, mental health issues and experiences of trauma as underserved groups within the NCSP.

The HPV self-test has removed the need for a genital speculum examination for most people eligible for cervical screening, and this has encouraged cervical screening uptake. However, the availability of a self-test does not remove the continued barriers faced by victims of sexual violence, people living with intimate partner violence, and people who live with behavioural health conditions, mental health issues and experiences of trauma. Robust, trusting relationships with health care providers are critical in identifying, informing and supporting these under-serviced communities. Trauma-informed care training at all parts of the cervical screening pathway was also noted by this interviewee:

> Over the last 10 years, I do not believe we have been adequately training our medical students to provide trauma-informed care when it comes to doing speculum examinations. If this experience is negative for a patient, they may never engage with the programme again.
>
> - *Interview participant*

People in prison

There have been significant increases in cervical screening coverage for people in prison since the introduction of the HPV self-test. Wāhine Māori are over-represented in the prison system, to the extent of being one of the most incarcerated Indigenous groups worldwide.[72]

Prior to the introduction of the 2023 NCSP, cervical screening coverage for people in prison was approximately 55%. Since the 2023 rollout of the HPV self-test, approximately 88% of women and people with a cervix have been screened. The rangatiratanga of self-testing is driving cervical screening uptake for people in prison.

> It's a highly vulnerable group of women and the acceptability of this test is what comes through from the women when they are offered the test. And there's always a conversation around some education that obviously happens. When people realise that they are not being offered a smear, but they're being offered the opportunity to … take agency of their own care and do this themselves … that has definitely been the driver of the success.
>
> - *Interview participant*

While the HPV testing part of the cervical screening pathway is working well for the prison population, follow-up LBC or colposcopy is less straightforward. Approximately 50% of women are on remand, which means there is a high likelihood that when HPV results are available, the woman has been released. We heard that there are challenges with people being unenrolled from their GP provider when transferred into the care of the Department of Corrections, which means they no longer have a GP provider when they are released. This also may cause difficulties with accessing results from a test that has already happened.

> When released, a person may no longer have a primary care provider and must actively re-enrol with a GP, which can create significant inequity.
>
> - *Interview participant*

We recommend stronger sector engagement with the Department of Corrections to ensure women in prison and on remand are able to access follow-up for HPV test results.

Including the Department of Corrections in national and regional cervical screening hui is important so they can be part of national and regional discussions. For example, the Department of Corrections opportunistically connected with marae based colposcopy clinics, a gamechanger in one area for women who were otherwise required to attend hospital-based clinics.

> …for our people kind of walking through in handcuffs through a busy emergency department into an outpatient clinic … it's not nice for anybody.
>
> *- Interview participant*

We have focused on the example of women in prison, but the same engagement and inclusion principles should be used for other entities such as Women's Refuge and homeless women's shelters.

Opportunities for improvement

As you can see, we heard similar stories for a lot of different populations when it comes to accessing cervical screening. There are opportunities for strengthening the ability of the sector to engage effectively with communities who do not benefit equitably from cervical screening.

We consider the following improvements would strengthen the sector to recognise and support these different communities to achieve the best outcomes for them.

- **Better data and information about different populations:** While the HPV self-test has the ability to reduce some of the barriers for many of these communities, we don't necessarily have data to show whether it has an impact. Collecting accurate, self-identified demographic data about diverse communities, such as disaggregated data for Asian communities and self-identified gender data, is required in order to support and properly include them in the NCSP.
- **Inclusive health promotion and resources for participants:** Equitable access for different populations may mean culturally appropriate, translated resources. These should be developed in partnership with the communities they are serving.
- **Training for health care providers and culturally safe approaches to care**: Cultural safety training should be required for every person who is part of NCSP, including non-clinicians such as those in policy and leadership roles, to ensure it informs all parts of the programme. Cultural safety training across NCSP policy and operational levels would provide evidence and tools to be 'equipped and competent to work with those from diverse communities to ensure services are accessible and inclusive' (Recommendation 28, 2022 PRC report).

> And every single person in that programme at every single level has to go on a journey of cultural safety. So, like, so that we don't leave LGBTQA+ people behind because we don't understand or we don't leave disabled people behind because we don't really understand how they all fit in.
>
> *- Interview participant*

We re-affirm the 2022 PRC's recommendation of whanaungatanga and community partnerships with the NCSP to strengthen the ability for sector engagement with under-serviced groups. The cost of not recognising and taking accountability for cervical screening access and coverage for these groups is illustrated in the following quote in the context of rainbow communities.

> If a commitment to LGBTQIA equity isn't built into the policy and administrative processes that sit over the NCSP, then it is not going to be sustainably embedded in the practice and delivery of the programme. And if it isn't, then a whole community of people who we already know are underserved generally in primary health care, but most especially in services where those services have traditionally been designed and delivered based on the assumption of someone's gender, that we're going to compound.
>
> *- Interview participant*

Resourcing colposcopy and laboratory services

Colposcopy resourcing

> Colposcopy is overwhelmed with referrals since change of screening; the anticipated change was never resourced and therefore we were set up to fail the women we are providing care to.
>
> *- Provider survey participant*

The successful uptake of cervical screening with the option of HPV self-testing has created increased demand for colposcopy. The transition to HPV primary screening in New Zealand was modelled on UK and Australian data. A study in Australia highlighted much larger increases in colposcopy referrals than anticipated, resulting in long wait times.[73] It reported that colposcopy services experienced difficulty in seeing patients within recommended timeframes with the potential for inequity for women accessing appropriate follow-up in a timely way, and reported psychosocial impacts on women experiencing delays.

Interview and survey participants described a heavy and unpredictable colposcopy workload, with additional workforce and resourcing urgently required. Preliminary data suggest that there are significant delays in accessing colposcopy services, and

participants highlighted significant delays in cancer diagnoses due to demand outweighing resources.

> Waiting times have been fluctuating. The testing and repeat testing comes in cycles, so waitlists go from well-managed to not well-managed. The three-month and six-month waiting lists will often get delayed when we get peaks and troughs. People will suffer more because they are waiting longer. This is not financially sustainable for us.
>
> *- Interview participant*

> We have had multiple instances where carcinoma has been found and the patient was not seen within guidelines.
>
> *- Provider survey participant*

Due to heavy colposcopy demand, there were reports of clinicians working outside the clinical guidelines – for example, requesting an LBC from women with an HPV 16/18 result while they waited for a colposcopy appointment. Creating an additional step could be a barrier to wāhine Māori, rural women, and all women and people with a cervix in navigating the screening and diagnostic pathway.

> I'm really torn here about what the right thing to do is. If you tell people to go and have a cytology while they're waiting, that's going to be a barrier to some people and there will be inequities. On the other hand, we should be providing people with all the information to make the choice themselves about whether they want cytology done.
>
> *- Interview participant*

Across interviews and provider surveys, participants raised concerns that wāhine Māori are not accessing colposcopy at the same rate as non-Māori, non-Pacific women. We intended to present colposcopy rates and waitlists by ethnicity and region in this report, but these data were not available to be published. This limits our ability to explore whether wāhine Māori and Pacific women have equitable access to colposcopy.

> On the colposcopy dashboard for the last month, it shows that Māori colposcopy rates are significantly worse than other ethnicities, including Pacific.
>
> *- Interview participant*

Colposcopy clinics take place within wider gynaecology departments, which this interview participant described as pressured, negatively affecting colposcopy availability.

> And as for prioritisation within the hospital system, first we have to cover the birthing suite, and then we have to cover gynae operating and antenatal clinics. Colposcopy then goes to the bottom of the list. There are huge pressures on the obstetrics and gynaecology workforce.
>
> - *Interview participant*

Colposcopy services are funded by the Planning, Funding, and Outcomes (PFO) directorate of Health New Zealand – Te Whatu Ora, and the NCSP does not hold information about how and whether funding tagged to colposcopy is channelled to colposcopy. Interview data showed funding to colposcopy clinics across the regions appeared inconsistent and availability of extra funding was not transparent to colposcopy clinics. One colposcopist had heard of a funding boost going to other hospitals but they had not received it. Another hospital had been operating without a colposcopy contract for years.

Interview and survey participants described a need for more nurse colposcopists, but it was important that after training there was a clear career pathway. Nurse colposcopists were considered favourable for a number of reasons. They were able to commit to colposcopy clinics rather than being called away to other gynaecological emergencies and events in a hospital setting, they were more cost-effective than paying for a medical colposcopist, and their nursing training emphasised interpersonal skills and cultural safety, which are critical for putting people at ease for an invasive procedure.

Some interviewees observed a lack of willingness around cross-specialty training, which may be inhibiting nurse colposcopy training and career pathways. A suggestion for boosting the colposcopy workforce was mobilising locums who regularly do colposcopies. This workforce could potentially help to clear current backlogs.

> Using locums that do very few colposcopies, don't know the guidelines and only work in private clinics has many risks. You need a pool of people that do colposcopy regularly to pull from. A strategic national approach to the workforce is needed and it could be that locums may be more cost effective if the colposcopist workforce issue is a short-term one.
>
> - *Interview participant*

In the long term, planning for more nurse colposcopists and community-based clinic approaches is needed to meet future demand across the screening pathway.

Laboratory workforce

Like colposcopy clinics, laboratories were also challenged by increased demand when HPV tests were introduced in 2023. There are three laboratory providers in the country, which an interview participant described as a risk to the NCSP.

> There is a risk to the programme, because if one or more laboratory providers falls over, then there's a big problem.
>
> *- Interview participant*

Interview participants described a lack of uniformity across cytology and testing platforms as a weakness, with not enough skilled workforce for molecular testing. Interview participants predicted an unstable short-term cytoscreener and cytopathologist workforce, due to aging out and a lack of new people training in these roles.

> But the new workforce don't exist. When you're looking to train, you wouldn't necessarily look to train as a cytoscreener based on the changes of the programme. Another thing is AI tool. If you're starting your career now, why would you go into this field and other laboratory fields if there is the potential that AI may take over your job.
>
> *- Interview participant*

Interview participants agreed that while there were occasional delays, laboratory turnaround times were for the most part clinically safe. One participant thought histology should be carefully watched.

> We've managed to meet turnaround times from day one. We foresaw the risks and designed our systems with those in mind. The biggest struggle for us has been maintaining cytology volumes. Six weeks prior to launch we had nearly twice as much cytology coming through the door as we had staff to handle. Cytology is one small part of what we do, and meeting turnaround times within histology has been extremely challenging.
>
> *- Interview participant*

A recent international review of the global pathology workforce provides a comprehensive overview of structural and systemic pressures affecting pathology services, including declining staffing levels, an aging workforce and increasing diagnostic demand and complexity.[74] The review highlights that the pressures are accompanied by unfavourable workforce projections and emerging evidence of impacts on service quality and system resilience. The authors emphasise the need for coordinated system-level planning and expanded training pipelines to ensure sustainable diagnostic services. These findings highlight the relevance of proactive workforce planning for Aotearoa New Zealand, particularly in cytology and pathology roles.

A comprehensive review of colposcopy and laboratory workforce

We have limited data and information on the workforce. The information that we do have suggests that improvements can be made to future proof the workforce and support both participants and staff to have better outcomes.

As such, we recommend that a more comprehensive review should be carried out of:

- colposcopy service demand, capacity and capability
- laboratory workforce and service provision.

The comprehensive review could:

- analyse referral volumes, demand trends, case complexity, and the impact of HPV primary screening introduced in 2023 on local service demand
- assess workforce capacity, capability, skill mix, productivity, utilisation and future sustainability risks across colposcopists and laboratory and molecular testing workforces, including training pathways and succession planning
- review clinic operations, including scheduling, patient flow, bottlenecks, delays and drivers of wait-time pressures
- evaluate alternative models of care and extended-scope roles, including expanded use of nurse colposcopists and community-based services, and alignment with a nationally consistent service delivery approach
- clarify the nurse colposcopist role, including national training pathways, supervision arrangements, professional support, and quality and safety requirements
- develop national auditing and quality assurance processes, including agreed performance indicators, benchmarking and regular review cycles
- examine Māori and Pacific access, barriers and equity gaps within colposcopy services, and identify actions to improve timely and equitable access
- clarify operational and strategic roles between the NCSP and hospital and specialist services, particularly in relation to service performance and wait-time reduction
- review funding arrangements to assess adequacy, allocation and alignment with demand, equity priorities and future service requirements.

A strong focus on equity must be embedded throughout the assessment. This includes examining how Māori and Pacific people access colposcopy services, identifying any barriers that contribute to delayed care, and ensuring that service improvements actively support equitable access, experience and outcomes.

Findings from this assessment should guide decisions regarding funding requirements, workforce strategies and service redesign. The findings of such a review should inform the development of the strategy and action plan recommended in the first part of this report.

Recommendations

Recommendation (2025)	Included in 2022 review	Included in 2018 review
10. Strengthen the sector to recognise, engage and respond effectively with groups traditionally underserved by the NCSP.	✓	✓
11. Strengthen engagement with the Department of Corrections to ensure women in prison and on remand are able to access follow-up for HPV test results.		
12. Implement cultural safety training at all levels of the NCSP, including leadership, policy, operational and clinical levels.	✓	
13. Undertake a national assessment of colposcopy and laboratory services demand and capacity.	✓	

Monitoring, evaluation and reporting

Overwhelmingly, interview, provider survey and submission participants described a lack of availability of monitoring information from the NCSP. Transparent reporting would help all stakeholders – including community, clinicians, research and policy teams – to be informed about cervical screening progress and highlight gaps in safety of the clinical pathway.

> We are one programme, so communication should be across the programme. Previous parliamentary reviews have aways recommended sharing colposcopy data back to the sector, but this has never been the case. And when they do present the data, it's not always presented in a way that is useful. For example, the names of districts or regions have been removed from the graph. The sector can deliver so much more if they actually have information.
>
> - *Interview participant*

Access to timely data

Transparent and timely reporting to Māori as tangata whenua is a basic requirement in honouring Te Tiriti o Waitangi obligations. At present, Māori do not have access to evidence showing whether their needs are being prioritised and equitable outcomes are being achieved beyond screening coverage. Interviewees told us that Māori have inequitable access to colposcopy, with a lower percentage of wāhine Māori who have HPV 16/18 detected accessing colposcopy than non-Māori, non-Pacific women. Without reporting, there is no evidence to make effective changes to service design, referral pathways, communication, support services and culturally safe colposcopy and

treatment services. Without reporting, there is no evidence for action to advance equitable outcomes for Māori.

As described in other sections of this report, while HPV vaccination and cervical screening data by ethnicity are publicly available, data for colposcopy access by ethnicity are not. For a cervical cancer elimination strategy and action plan to uphold Te Tiriti o Waitangi and ensure equitable vaccination, screening, diagnosis and treatment for wāhine Māori, these data must be brought into the light. The NKG is a resource to ensure these data are shared in ways that protect data and uphold Māori data sovereignty principles.[75]

Regular monitoring of the NCSP

The NCSP would benefit from strengthened national analytical capability and consistent and transparent reporting to support evidence-informed decision-making at both national and local levels.

Survey participants told us they wanted better visibility across the whole NCSP.

> [We] are aware of summary outcome reports in the occasional NCSP Update that provide respective cumulative percentages of self-test, HPV 16/18 detected, HPV Other detected, unscreened or under-screened tested and overall coverage (with more detailed analysis of coverage by district, ethnicity available on Te Whatu Ora website). This is interesting but is short on performance of and/or compliance with other aspects of the pathway – e.g. follow-up of HPV Other, cytology findings, colposcopy waiting times, including from an equity perspective.
>
> *- Provider survey participant*

The NCSP national team informed us that Health New Zealand – Te Whatu Ora is intending to complete a programme monitoring report covering the time period 12 September 2023 to 31 December 2024. Concerns were raised in interviews about the delays in producing the first monitoring report since the 2023 rollout.

> We are developing our first programme monitoring report in-house – this is the first time we've done it ourselves. It used to be commissioned to Cancer Control New South Wales, but we're doing it this time because there is some urgency to review the shift to HPV testing.
>
> *- Interview participant*

This first report will not be independently commissioned; however, the NCSP national team is planning extensive independent review.

Monitoring reports should provide data by ethnicity, with Pacific and Asian ethnicity data disaggregated. The NKG articulated clearly how reporting Māori and Pacific

outcomes first signals true accountability and shows who is benefitting and who is being left behind.

National reporting of data should be underpinned by kaitiaki values and equity-focused principles and include regular equity impact reporting on Māori and Pacific access, wait times, outcomes and follow-up. Future monitoring and evaluation should be Māori-led and Pacific-led where appropriate, using kaupapa Māori and Pacific methodologies as the default, not optional alternatives.

Improved monitoring and reporting would:

- support nationally consistent monitoring of service delivery
- inform continuous improvement of the NCSP and future policy development
- inform future PRCs' assessment of the NCSP
- provide accurate data in line with the WHO Cervical Cancer Elimination Initiative.

Review of the population-based NCSP Register

The NCSP Register supports the programme by storing information, tracking participants through the screening pathway and sending reminders to participants. We note that the NCSP national team is carrying out a review of the NCSP Register separately from this review of the screening programme, and as such we have not delved into this area. That review will look into the NCSP Register's functioning, including any safety and quality issues, and future proofing.

We were not given access to the draft NCSP Register review until after this report was completed and therefore we were unable to take the review into account for this report. This gap is a significant limitation as the NCSP Register is an integral part of the NCSP. However, we are able to report some of what we heard in interview and survey responses regarding the NCSP Register and review.

- Some participants described the NCSP Register as a minimum viable product that was underfunded, clinically unsafe and not performing the function it was intended to do.
- Others described a register that cannot easily identify under-screened/unscreened women.
- There was considerable administrative burden for colposcopy staff in entering data into the NCSP Register.
- SSS could not always access screening histories on the NCSP Register, and other participants told us screening histories were sometimes inaccurate.
- Multiple participants reported the inability of the NCSP Register to contact people by email or text, which is the preferred mode of contact for Māori and Pacific communities, and people who do not have a fixed address.

We recommend the NCSP work with cervical screening providers to ensure patient safety based on the feedback above. To achieve this, as outlined in Recommendation 15a, we recommend cervical screeners maintain their own patient recall system until the NCSP Register is fully functioning and reliable.

The NCSP Register holds the taonga of Māori data. Interview participants raised concerns about Māori data sovereignty, ownership and security of the data.

> The Register is limited, the training isn't great, and the worst part about it is who owns the Register and the Māori data. How can women's data be protected when it is owned by those who created it? Māori data sovereignty must be upheld. Māori women don't sign up for this.
>
> - *Interview participant*

> The data in the NCSP Register is a big concern. We fought to have a register that could allow kaimahi to access real time data, and it hasn't delivered on this.
>
> - *Interview participant*

Review of the NCSP

PRCs have a clear scope and hear from a wide range of stakeholders. We develop recommendations based on these interviews, surveys and submissions alongside data from the NCSP. However, many previous PRC recommendations have not been implemented, and some stakeholders thought a main reason was the review cycle being too short, and that the recommendations do not come with funding for implementation.

The current three-year PRC cycle is not long enough for the NCSP to implement recommendations, and we recommend that the cycle be lengthened to five years.

> Have mentioned in previous reviews that a lot of work goes into these PRC reviews and three years isn't a long enough cycle to progress and embed recommendations before its time for the next one. There needs to be enough time to influence colleagues and the sector, to grow their understanding of what partnership and action looks like, and how we look at and talk about inequities.
>
> - *Interview participant*

We noted that the NCSP national team within Health New Zealand – Te Whatu Ora was significantly under-resourced. Team staffing as at 26 August 2025 is shown in Appendix 5, with multiple roles unfilled. While it was clear throughout the interview process that there are passionate individuals who have a personal commitment to the NCSP succeeding, the NCSP national team are inadequately resourced to run the NCSP, inhibiting their ability to provide an optimum programme and respond to PRC recommendations.

> PRC produces incredible, strategic recommendations, but we don't have the teeth to do the mahi. We need to make sure the resources are there to implement PRC recommendations and ensure that we have the right expertise to inform the approach. Any recommendation that is implemented must be done so in way that is embedded and sustainable, so it won't disappear after three years.
>
> - *Interview participant*

Individual NCSP national team staff are spread across the country and meet in-person once a year. This was seen by some interviewees as inhibiting a cohesive programme.

> Remote working can sometimes be a barrier to good communication and sometimes the programme might struggle with siloed ways of working – it can be difficult to know what's going on in other areas. If this could be improved somehow, knowledge and information sharing would be easier.
>
> - *Interview participant*

Building and nurturing strong relationships with providers is a key part of the NCSP national team's work. However, a freeze on travel has meant these relationships must now be built over video calls, phone calls and emails. One interviewee described paying for inter-regional travel out of her own pocket to ensure in-person engagement.

> The teams are under-resourced to do what they need to do.
>
> - *Interview participant*

Filling vacancies would help the NCSP at national level to appropriately support the programme and make more progress in implementing recommendations from PRCs to ensure continuous improvement of the programme.

Recommendations

Recommendation (2025)	Included in 2022 review	Included in 2018 review
14. Provide timely and transparent public reporting across all parts of the pathway, not just screening uptake.	✓	
15. Ensure a review of the NCSP Register is available for future PRC reviews or include a review of the register as part of the review a. Require cervical screeners to maintain their own patient recall system until the NCSP Register is fully functioning and reliable.		
16. Extend the PRC review cycle to five years and provide funding to action review.		
17. Fill NCSP national team vacancies, addressing capacity and resourcing requirements to support the programme.		

Progress for past PRC recommendations

The NCSP has made progress in responding to the 2022 PRC recommendations, within the context of significant system reform and constrained fiscal and workforce settings. Since September 2023, the NCSP has been focused on safely embedding HPV primary screening and the new NCSP Register – changes that represent one of the most significant transformations in the programme's history.

Despite this progress, significant challenges remain in fully delivering the PRC recommendations. The most critical outstanding issue is the absence of funding for universal free cervical screening. While zero-fees screening for needs-based priority groups has been extended and is having a positive impact, the 2022 PRC's recommendation for free screening for all eligible people remains unmet. This creates inconsistency with other national screening programmes and limits the NCSP's ability to fully remove cost as a barrier to access.

As discussed earlier, capacity constraints have also slowed progress across several recommendation areas. Reduced staffing levels, competing system priorities and tight fiscal settings have required the NCSP to phase implementation and extend timeframes for more complex reforms. As a result, a number of recommendations – particularly those requiring significant co-design, such as a fully integrated community-based screening model, cultural safety, anti-racism initiatives, disability and rainbow community research, and enhanced colposcopy quality assurance – are planned or not yet started.

The NCSP has delivered limited but meaningful progress against the 2022 PRC recommendations, particularly where actions align with the implementation of HPV primary screening and immediate equity gains. However, achieving the full intent of the 2022 PRC report will require sustained investment, workforce growth and policy decisions, most notably on universal free screening, and a shift from stabilising recent reforms to longer-term system transformation.

The 31 recommendations from the 2022 PRC review are set out in Table 7 below and should be read alongside our current recommendations. Across the 31 recommendations, 27 recommendations are open and are prioritised according to the coding in Table 6.

Table 6: Key for prioritisation of 2022 PRC recommendations, used in Table 7

Priority	Meaning	Recommendation numbers	Coding
Priority 1	Re-affirmed by the 2025 PRC. The original intent remains fully relevant, and requiring urgent attention.	Recommendations 3, 8, 14, 18 and 24	**Amber**
Priority 2	Incorporated into the 2025 PRC's recommendations. Their substance has been carried forward, strengthened or expanded within this review's findings.	Recommendations 1, 4, 5, 9, 10, 11, 12,15, 16, 17, 20, 21, 26, 27, 28, 30 and 31	**Blue**
Priority 3	Remain open with no or minimal progress reported and are not re-affirmed or included in current recommendations. These represent areas of unfinished business requiring dedicated attention.	Recommendations 7, 13, 22, 23 and 25	**Purple**
Closed	Reflecting meaningful but limited progress within a period of significant health system reform and fiscal constraint.	Recommendations 2, 6, 19 and 29	**Green**

Table 7: 2022 PRC recommendations progress review

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
Te Tiriti o Waitangi	**1**	Te Tiriti o Waitangi needs to be central to cervical screening policy, governance and practice. There is currently patchy and inconsistent engagement with Te Tiriti o Waitangi across the programme.	The requirement to complete Te Tiriti o Waitangi training has been incorporated into the final draft of the updated NCSP Service Standards. The responsibility to uphold the Articles of Te Tiriti o Waitangi has been embedded in the drafts of both the updated Clinical Practice Guidelines and Service Standards, including requirements for training and service provision.	**Open** 2025 PRC has included in recommendations
	2	Proactive appointment of senior Māori staff in alignment with the NSU's strategic priorities.	Māori staff have been appointed to permanent positions in the NCSP, including Group Manager National Cancer Screening Programmes and Director of Screening, Prevention roles. Note – this is an ongoing action for the NCSP to continue to progress.	**Closed**
Accessibility	**3**	The cost of screening has been consistently identified as a major barrier. Cost barriers perpetuate cervical cancer inequities that breach Te Tiriti o Waitangi responsibilities. The 2022 PRC reaffirms the 2018 PRC recommendation that all people should receive free cervical screening, and recommends appropriate funding processes are pursued to achieve a fully funded programme by 2024.	The NCSP continues to fund and deliver zero-fees cervical screening for needs-based priority groups (under-screened/unscreened, requiring follow-up, higher risk groups – Māori, Pacific – and those with a Community Services Card). Funding has not yet been secured for all populations to receive free cervical screening in New Zealand.	**Open** 2025 PRC reaffirms this recommendation
	4	Investment in an integrated, accessible model of community-based cervical screening is recommended. The new model should be the first line of screening for all eligible people, designed to meet the needs and preferences of Māori, Pacific and Asian communities who have historically been unscreened or under-screened.	This recommendation requires significant scoping, discovery and co-design. Changing the current service delivery model sits outside the ability to action within the three-year PRC process. Planned as part of the NCSP Operating Model/Service Delivery Model initiative, subject to resourcing.	**Open** 2025 PRC has included in recommendations

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
	5	Improved accessibility to colposcopy services is required, particularly for Māori and Pacific people. Delivery should be co-designed to meet the needs and preferences of those who historically experience delays in accessing colposcopy assessment and treatment.	Complete – SSS providers support wāhine Māori and all women and people with a cervix to their colposcopy appointments. Underway – Some colposcopy services are piloting community-based clinics, including at marae. The NCSP is finalising routine programme reports, including timeliness of visit and treatments.	**Open** 2025 PRC has included in recommendations
	6	Thoroughly explore opportunities for a change in the test of cure pathway to enable laboratories to perform HPV testing similar to the reflex HPV triage process.	Complete – implemented as part of the rollout of HPV primary screening on 12 September 2023.	**Closed**
	7	Racism is embedded across the screening pathway and is a modifiable determinant of health inequities. We recommend the NSU co-design an anti-racism plan for the sector to coordinate, consolidate and strengthen existing efforts.	Work has not yet been progressed for this recommendation.	**Open**
Elimination of cervical cancer	**8**	Development of a national strategy for cervical cancer elimination, accounting for Te Tiriti o Waitangi and the Aotearoa context, prioritising Māori and Pacific people who carry the burden of cervical cancer incidence and mortality.	Underway – The Public Health Agency within the Ministry of Health is considering options for an Elimination Strategy. Health New Zealand – Te Whatu Ora is supporting this work and will be responsible for implementing the strategy.	**Open** 2025 PRC reaffirms this recommendation
Integration	**9**	To achieve an integrated, accessible model of community-based cervical screening it is recommended that current NCSP coordination, register coordination, support to services and free screening service specifications are combined into one integrated NCSP service specification for commissioning the existing network of Māori and Pacific providers.	Significant scoping and co-design required. Planned as part of the NCSP Operating Model/Service Delivery Model initiative to complete the implementation of HPV Primary Screening, subject to resourcing.	**Open** 2025 PRC has included in recommendations
	10	Investing in research to understand the barriers to accessing the cervical screening pathway for people with physical or intellectual disability, members of rainbow communities, those with trauma histories and/or experiencing mental distress, and those who are incarcerated.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC has included in recommendations

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
	11	To improve integration between primary care and colposcopy services there needs to be strong relationships developed between the new integrated model of community-based cervical screening and colposcopy services.	All activities surrounding building an integrated model of community-based cervical screening (Recommendation 4) will include a focus on maximising integration and collaboration between providers across the screening pathway. Planned as part of the NCSP Operating Model/Service Delivery Model initiative, subject to resourcing.	**Open** 2025 PRC has included in recommendations 
	12	To enable effective integration of HPV vaccination, the NCSP should collaborate with the National Immunisation Register (NIR) services to ensure providers along the cervical screening and treatment pathway can access information on the NIR to enable opportunistic HPV vaccination.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC has included in recommendations 
Effectiveness of monitoring and evaluation	**13**	Introduction of a kaupapa Māori evaluation culture to drive improvements in Māori health outcomes. The NSU should provide advice to the sector on best practice examples for utilising equity monitoring data for improved performance.	Planned – The NCSP is exploring detailed guidance for the sector on accessing, sharing and using NCSP Register data. Planned as part of the NCSP Monitoring and Evaluation initiative, subject to resourcing.	**Open** 
	14	Consideration needs to be given to disaggregating Pacific data to monitor and evaluate cervical screening coverage for Pacific people, done in collaboration with a Pacific data sovereignty group.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC reaffirms this recommendation 
	15	The Independent Monitoring Report should bring together a synthesis of equity data. The NSU should explore opportunities for measuring access for people with disability, mental health service users, incarcerated people and rainbow communities.	Planned – A procurement process for future Independent Monitoring Reports (IMRs) will be undertaken, including a synthesis of equity data. The NCSP is committed to working with the National Kaitiaki Group on how best to present equity data. Planned as part of the NCSP Monitoring and Evaluation initiative, subject to resourcing.	**Open** 2025 PRC has included in recommendations 

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
	16	With the re-structured health sector, Iwi-Māori Partnership Boards will be a key audience of NCSP monitoring reports. The provision of reports in a form accessible and useful for Māori monitoring groups and health providers is recommended.	Underway – The Intelligence Directorate (National Public Health Service) and Hauora Māori Services within Health New Zealand – Te Whatu Ora have developed a cervical screening coverage dashboard to share coverage data with Iwi-Māori Partnership Boards.	**Open** 2025 PRC has included in recommendations 
	17	To strengthen monitoring the PRC recommends the formation of an independent, Māori led, Māori designed monitoring framework and resourced rōpū.	Underway – See actions and activities related to Recommendation 15 and future IMR reporting.	**Open** 2025 PRC has included in recommendations 
Co-governance and clinical governance	**18**	Effective co-governance requires clear communication, robust relationships, trust and role clarity. The PRC supports the establishment of co-governance and encourages the next parliamentary review to examine its effectiveness using Critical Tiriti Analysis.	N/A – to be assessed in next PRC.	**Open** 2025 PRC reaffirms this recommendation 
	19	Whanaungatanga is critical to building trust. Where regional networking is not occurring, we recommend the NSU reinstate these networks. National networking opportunities should be facilitated by the NSU on a regular basis.	A national hui for Screening Support Services was held in 2023. The NCSP facilitates monthly hui with all stakeholders, including regional teams, register teams, Screening Support Services, laboratories and colposcopy services.	**Closed** 
	20	The NCSP needs strong relationships between the NSU and all advisory and leadership groups such as the National Kaitiaki Group and the Māori Equity and Monitoring Group. Clarity of roles and functions based on terms of reference would likely go some way to improving relationships.	Complete – A National Kaitiaki Group (NKG) secretariat was recruited in July 2025, independent of the NCSP. Underway – The NCSP is in the process of updating the Terms of Reference of the NCSP Partnership, Action and Equity Rōpū. A review of the NKG Terms of Reference is also underway.	**Open** 2025 PRC has included in recommendations 

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
Clinical quality assurance in colposcopy services	**21**	Clinical quality assurance reporting needs to be prioritised with urgency within Te Whatu Ora colposcopy services. Individual colposcopist performance should be measured against key clinical indicators annually and benchmarked data provided to colposcopists.	Planned as part of the NCSP Colposcopy initiative to complete the implementation of HPV Primary Screening, subject to resourcing.	**Open** 2025 PRC has included in recommendations 
	22	There needs to be communication with Te Whatu Ora lead colposcopists and service managers that they have a responsibility to annually review individual colposcopists' practice.	Planned as part of the NCSP Colposcopy and Clinical Practice Guidelines and Standards initiatives, subject to resourcing.	**Open** 
	23	Priority is given to utilising e-colposcopy data as a mechanism of feedback to Te Whatu Ora colposcopy services. This should also be extended to private providers.	Planned as part of the NCSP Colposcopy initiative, subject to resourcing.	**Open** 
Workforce capacity and capability	**24**	The PRC recommends investment in mandatory stair-cased Te Tiriti, equity, cultural safety and anti-racism workforce development across the programme, including the NSU, to strengthen baseline competencies.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC reaffirms this recommendation 
	25	Recommend investment in workforce development in the area of kaupapa Māori evaluation.	Work has not yet been progressed for this recommendation.	**Open** 
	26	Workforce capacity in general practice is severely compromised. Equitable cervical screening coverage will rely on a new model as described in Recommendations 4 and 9. NCSP policy and guidelines will need to be reviewed to provide advice to general practice on effective engagement with the new model.	All activities surrounding building an integrated model of community-based cervical screening (Recommendations 4 and 9) will be supported by guidance and support to general practice. Planned as part of the NCSP Operating Model/Service Delivery Model initiative, subject to resourcing.	**Open** 2025 PRC has included in recommendations 

Category	#	2022 PRC recommendations	NCSP progress view (July 2025)	2025 PRC progress view
	27	The current training of sample takers requires review, and consideration should be given to delivering the training outside of the current NZQA framework. Local training and credentialing of sample takers could provide a more accessible option.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC has included in recommendations 
	28	Consideration needs to be given to strengthening the ability of the sector to engage effectively with traditionally underserved groups such as Asian, disabled and rainbow communities, and those with a history of trauma and/or mental illnesses.	Work has not yet been progressed for this recommendation.	**Open** 2025 PRC has included in recommendations 
	29	The NCSP should with some urgency engage with Te Whatu Ora colposcopy services to discuss the revised modelling data regarding colposcopy referral volumes, to assist in workforce planning.	Complete – Updated modelling was provided to colposcopy services ahead of go-live of HPV Primary Screening. Services with the greatest waitlists were provided with additional funding to help clear waitlists.	**Closed** 
	30	Urgently identify strategies to manage the increased workload and work with Te Whatu Ora colposcopy services to support these strategies.	Underway – Part of the NCSP Colposcopy initiative to complete the implementation of HPV Primary Screening.	**Open** 2025 PRC has included in recommendations 
	31	To manage workforce capacity in the new programme, monthly monitoring of referral data to colposcopy services along with key indicators should be implemented.	Underway – NCSP is developing monthly operational reporting to monitor referral data and the impact on waiting times for first specialist assessment and treatment.	**Open** 2025 PRC has included in recommendations 

Glossary

Aotearoa Immunisation Register (AIR)	A national register that securely records immunisations in Aotearoa New Zealand, including human papillomavirus (HPV) vaccinations.
Awhi	To support, nurture or embrace.
Cervical screeners	Health professionals trained to offer cervical screening and collect or process screening samples.
Colposcopy	A follow-up examination where the cervix is closely examined using a magnifying device, usually after an abnormal screening result.
Cytology	Includes smear-based cytology and liquid-based cytology (LBC). The examination of cervical cells under a microscope to detect abnormal changes.
Cytopathologist	A medical specialist who diagnoses disease by examining cells and tissues under a microscope.
Cytoscreener	A trained laboratory professional who examines cervical screening samples under a microscope to identify abnormal cell changes that may indicate risk of cervical cancer.
Genital speculum examination	An examination where a speculum is used to gently open the vagina so a clinician can see the cervix.
Hauora	Health and wellbeing
Histology/ histopathology	The examination of tissue samples under a microscope to diagnose disease.
HPV primary screening	Also called primary HPV screening. The cervical screening approach where testing for HPV is the first screening test.
HPV self-testing	A method where a person collects their own vaginal sample for HPV testing, rather than having it taken by a clinician.
HPV testing	A test that detects HPV, a very common virus that can cause cervical cancer.

Human Papillomavirus (HPV)	A common group of viruses that are spread through skin-to-skin contact. Most HPV infections are harmless and cause no health problems, however, if a high-risk infection persists, it can lead to cancers.
Iwi, hapū and whānau	Māori social structures: iwi (tribes), hapū (sub-tribes), and whānau (extended family).
Kai	Food.
Kaiāwhina	A support worker (non-regulated) who helps individuals and whānau navigate health and screening services by providing guidance, advocacy and practical support.
Kaimahi	Employee or staff member.
Kapa haka	An immersive, emotional combination of synchronised song, rhythmic dance, and chanting used to tell stories, preserve history, and express cultural identity.
Kaitiaki	A guardian or steward responsible for protecting people, knowledge or taonga (treasures).
Kaupapa	A guiding purpose, plan or set of principles.
Kaupapa Māori	An approach grounded in Māori values, knowledge and ways of doing things.
Kupu o te reo Māori	Māori words.
Mahi	Work.
Māmā	Mother.
Mana	Dignity, authority, respect and spiritual strength.
Manaakitanga	The practice of showing care, hospitality and kindness that uplifts the mana of others.
Mana wāhine	Māori women.
Marae	A communal, sacred central gathering space for Māori to celebrate culture and hold ceremonies.
Mihi	A formal or semi-formal speech of greeting, acknowledgement, or introduction.

National Cervical Screening Programme (NCSP)	The full national cervical screening system, including policy settings, funding, governance arrangements, service delivery, providers, laboratories, colposcopy services, the NCSP Register, and participants.
NCSP national team	The Health New Zealand – Te Whatu Ora head-office team responsible for coordinating, administering and supporting the programme.
Ōritetanga	Equality, equal opportunity, and equity.
Rangatahi	Young people.
Rangatiratanga	Leadership, authority and the ability to make decisions for oneself or one's people.
Rōpū	A group, collective, team, or organisation.
Smear-based cytology	A traditional cervical screening method where cells are collected from the cervix during a speculum exam and examined for abnormalities.
Tangata whenua	Māori, the Indigenous people of Aotearoa New Zealand.
Taonga	Treasure, gift, or highly prized possession, and could extend beyond physical wealth, for example traditional knowledge and spiritual beliefs.
Te Tiriti o Waitangi	The Treaty of Waitangi.
Tino rangatiratanga	The highest expression of self-determination; Māori authority over their lives, wellbeing and futures.
Under-screened/ unscreened women	People who are eligible for cervical screening but have not been screened regularly or have never been screened.
Wāhine Māori	Māori women.
Whakapapa	Genealogy and the connections between people, ancestors and future generations.
Whakawhanaungatanga	The process of building relationships, trust and connection.
Whanaungatanga	Relationships and kinship connections that strengthen collective wellbeing.
Whānau	Extended family networks that provide care, identity and support.
Whare	House.

Appendix 1 – Terms of Reference of the National Cervical Screening Programme Parliamentary Review Committee 2025

1. Introduction

1.1 These Terms of Reference establish the National Cervical Screening Programme Parliamentary Review Committee 2025 (the Committee) and set out the:

- role and functions of the Committee
- composition of the Committee
- term and work plan requirements
- reporting requirements
- terms and conditions of appointment
- duties and responsibilities of Committee members.

1.2 The National Cervical Screening Programme (NCSP) is dedicated to reducing the incidence and mortality of cervical cancer in Aotearoa New Zealand, with a particular focus on those population groups who have been under-screened, unscreened, and over represent the burden of cervical cancer.

2. Functions of the Committee

2.1 The National Cervical Screening Programme (NCSP) Parliamentary Review Committee is a ministerial review committee established under section 112O of the Health Act 1956 (the Act). Under section 112O(1) of the Act, the Committee must review:

- the operation of the NCSP; and
- evaluation activities of the kind described in section 112T1 that have been carried out or are proposed to be carried out.

2.2 Under section 112O(2), the focus of the Committee must be the continuous quality improvement of components of the NCSP, with a view to reducing the incidence and mortality rates of cervical cancer.

2.3 The Committee is expected to have a particular focus on those population groups who have been under-screened, unscreened, and overrepresent the burden of cervical cancer (including, Māori and Pacific populations).

[1] As described in section 112T of the Act, evaluate means to monitor and assess the service delivery and outcomes of the NCSP so as to promote the fulfilment of its objectives by determining whether there are any systemic issues to address within the programme or quality improvements that may be made to it.

3. Scope of the Committee's review

3.1 While carrying out the review as required by the Act, the Committee will have a primary focus on how the programme has progressed or delivered past Parliamentary Review Committees' recommendations and the programme's recent change to human papillomavirus (HPV) testing as the primary test for cervical screening. The Committee will have a specific focus on the following:

a. Evaluate the progress of implementing the recommendations of the past three Parliamentary Review Committee reviews.

- Assess if implementation of underway/completed recommendations has contributed to more equitable outcomes for cervical screening.
- Reconfirm recommendations that have not yet been implemented that should continue to be progressed and update any recommendation wording to align with the current context of NCSP delivery.
- Suggest prioritisation of these recommendations for implementation with consideration to what is required from NCSP to implement.

b. Evaluate the shift to HPV testing as the primary test for cervical screening.

- Evaluate if the cervical screening workforce has the necessary capacity, capability, and resource to deliver HPV testing and a pathway to treatment – specifically capacity, capability and training of the colposcopy and cytology workforce.
- Evaluate if there is equitable access to, and uptake of, HPV testing, as well as quality and retention across the whole cervical screening pathway.
- Evaluate if there is equitable access to, and uptake of, colposcopy services.
- Evaluate how the delivery of HPV testing and colposcopy could be strengthened to address community feedback:
  - conduct interviews with consumers to gain a better understanding of end-to-end experience accessing services from the NCSP.
  - incorporate feedback of Iwi Māori Partnership Boards (IMPBs) and other relevant groups.

4. Scope considerations for the Committee's review

4.1 There is a separate review of the NCSP Register currently underway. The Committee will take the work of the registry review panel into account and ensure the Committee's review is complementary and not duplicative.

5. Composition of the Committee

5.1 The Committee is composed of up to three members and is appointed by and accountable to the Minister of Health (the Minister).

5.2 Under section 112O(3) of the Act, no person appointed to an NCSP review committee may be:

- a Member of Parliament
- an officer or employee of the Ministry of Health (the Ministry)
- a person who is, or has been, designated under section 112U of the Act as a screening programme evaluator
- a person who would have a material conflict of interest if appointed.

5.3 Appointed members will serve one review cycle. Once the review findings and recommendations report has been submitted to the Minister, the Committee will be disestablished.

5.4 Members who have taken part in previous reviews can be reappointed to the Committee.

5.5 The skills and experience required of the Committee to undertake a review of the NCSP include:

- knowledge, expertise and experience in cervical screening at a senior managerial or clinical level
- research and clinical experience within primary health care
- knowledge of or experience in the colposcopy and HPV cytology workforce
- experience with primary and community health care services.

5.6 In making themselves available for appointment, members should ensure that:

- there is no conflict of interest which would preclude their appointment; and
- they are available to serve for the full term of their appointment.

6. Work Plan Development

6.1 Under section 112P of the Act, the Committee must prepare a review plan before commencing the review. This plan must focus on the scope listed above in section 3 and consider the need for timeliness in the completion of the review.

6.2 Once drafted, the review plan must be consulted with interested parties and provided to the Minister for comment, and fully consider any comments made by the Minister before finalising the plan.

7. Reporting Requirements

7.1 As required under section 112R of the Act, the Committee must set out in a report:

- the details of the review
- the conclusions it has reached
- the recommendations (if any) it makes as a result of the review.

This report must be submitted to the Minister as soon as reasonably practicable after it is completed.

8. Establishment, Review Process and End Date

8.1 Members of the Committee will be appointed by the Minister. The Committee will conduct a review and deliver a report based on the findings of the review, including any recommendations.

8.2 In accordance with section 112R of the Act, the Minister must present the report to the House of Representatives no later than 10 sitting days after the date on which the Minister receives the report from the Committee, and, following that presentation, must make the report publicly available.

9. Support for the Committee

9.1 The Public Health Agency will provide secretariat support to the Committee. This support will include working with the NCSP manager to provide the Committee with relevant documentation relating to the NCSP programme for the review.

9.2 In accordance with section 112Q of the Act, for the purposes of carrying out its review, the Committee may request any information held by the NCSP that is directly relevant to the subject matter of its review.

9.3 Throughout the review, NCSP advisory groups will provide their expertise and will be available to collaborate and co-design throughout the review process.

9.4 The Secretariat supporting the Committee will maintain an interests register, listing members' interests relevant to the Committee's business. Declaration and discussion of conflicts of interest will be a standing item on each meeting's agenda, and actions arising out of this item will be recorded in the minutes.

10. Duties and Responsibilities of a Member

10.1 This section sets out the expectations regarding the duties and responsibilities of a person appointed as a member of the Committee. This is intended to aid members by providing them with a common set of principles for appropriate conduct and behaviour, and serves to protect the Committee and its members from being exposed to legal challenges.

10.2 Members have a commitment to work for the public of Aotearoa New Zealand. Members are accountable to the Minister.

10.3 Committee members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole and are not representatives of professional organisations or communities. This issue is particularly important when Committee members may, at times, be required to be party to decisions which conflict with the views of other organisations with which they are involved.

10.4 There is an expectation that members will attend all meetings and devote sufficient time to become familiar with the affairs of the Committee and the wider environment within which it operates.

11. Conflicts of Interest

11.1 Members should perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to

conflicts of interest. Proper observation of these principles will enable public confidence in the work of the Committee to be maintained.

11.2 When members believe they have a conflict of interest on a subject which will prevent them from reaching an impartial decision or undertaking an activity consistent with the Committee's functions, then they must declare a conflict of interest and absent themselves from the discussion and/or activity. This must be done at the earliest possible opportunity, in the regular agenda item around conflicts of interest, and at the point the relevant item of business comes up in the meeting.

12. Liability

12.1 Members are not liable for any act or omission done or omitted in their capacity as a member, if they acted in good faith, and with reasonable care, in pursuance of the functions of the Committee.

13. Confidentiality

13.1 Meetings, including agenda material and minutes, are confidential. Members must ensure that the confidentiality of Committee business is maintained.

13.2 Members are free to, and are expected to, express their own views within the context of meetings, or the general business of the Committee. Members must publicly support a course of action decided by the Committee, or if unable to do that, must not publicly comment on decisions.

13.3 At no time shall members divulge details of Committee matters or decisions to people who are not members, or Ministry employees. Disclosure of Committee business to anyone outside the Ministry must be the decision of the Ministry.

13.4 Committee members must ensure that documents are kept securely to ensure that confidentiality is maintained. Release of correspondence or papers can only be made with the approval of the Ministry. At the end of a member's term, all Committee information must be returned to the Ministry.

13.5 All agendas, minutes, emails, correspondence, meeting notes, documents and other written communication are subject to release under the Official Information Act 1982 unless otherwise excluded for release under the provisions of that Act.

14. Remuneration and expenses

14.1 Members of the Committee are paid fees for attendance at meetings, in accordance with the Cabinet Office Circular CO (22) 2: *Revised Fees Framework for members appointed to bodies in which the Crown has an interest* (or its successor circular) and the assessment of the Committee as a Group 4, Level 3 body.

14.2 The fee for Committee members will be $435 per day (before tax) and the fee for the Committee Chair will be $633 per day (before tax). Members will also be paid actual and reasonable meeting preparation time at the daily fee and pro rata.

14.3 Members who are employees of the wider public sector are not entitled to be paid fees for Committee business if this is conducted during regular paid work time (ie, members cannot be paid twice by the Crown for the same hours).

14.4 Members are entitled to be reimbursed for actual and reasonable travelling and other expenses incurred in carrying out their duties. The expectation is that the standards of travel, accommodation, meals and other expenses are modest and appropriate to reflect public sector norms.

Appendix 2 – List of interviewees

Organisation	
Health New Zealand – Te Whatu Ora, National Public Health Service	• Manager, NCSP • Senior Advisor, NCSP • Senior Relationship Manager, NCSP • Director, Prevention Screening • Clinical Director, Screening • Group Manager, National Cancer Screening Programmes • Public Health Medicine Specialist, Prevention
Health New Zealand – Te Whatu Ora locations	• Hawke's Bay – Regional Coordinator • Capital, Coast and Hutt Valley – Lead Colposcopist; Lead Colposcopy Nurse; Obstetrician and Gynaecologist • Northland – Obstetrician/Gynaecologist • Waitematā – Women's Health Nurse Practitioner; Colposcopy Service Manager • Waikato – Operations Manager, Screening & Health Services; Operations Manager, Women's Health; Clinical Director, Women's Health; Register Coordinator; Speciality Clinical Nurse
Aotearoa Cervical Cancer Elimination Rōpū	• Te Tātai Hauora o Hine National Centre for Women's Health Research • Cancer Society of New Zealand • Hei Āhuru Mōwai Māori Cancer Leadership Group • Royal Australia New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
ScreenSouth	Screening Coordinator
Consumer representatives	Three interviews
Individuals from the Partnership, Action and Equity Rōpū	Four representatives
Department of Corrections – Ara Poutama Aotearoa	Two representatives
Te Ahu o Te Kahu – Cancer Control Agency	Chief Advisor
National Kaitiaki Group	Four representatives
LabPLUS	• Pathologist and Director • Lead Scientist Histopathology
Pathlab	• Lead Molecular Scientist • Clinical Lead Molecular Virology • Business and Contracts Manager
Hauraki Primary Health Organisation	Cervical & Breast Screening Support Coordinator
The Woman's Health Bus	Gynaecologist and Co-Director

Organisation	
Te Hiku Hauora – Community Health – Kaitāia	General Manager, Community Programmes & Outreach – Whakapiri Ora
Mana Wāhine	Manager
Smear Your Mea	Two representatives
Māori Women's Welfare League	National Operations, Wellington
Pacific Health Service Hutt Valley	• Primary Healthcare Nurse • Population Health Community Engagement Lead
Victoria University of Wellington	Senior Lecturer in Health Service Delivery in the School of Health
University of Otago	Associate Professor, Department of Obstetrics and Gynaecology, Christchurch; Co-Director, Ngāi Tahu Māori Health Research Unit and Professor of Māori Health
The Asian Network Incorporated	Manager, Community Engagement & Health Promotion
Well Women & Family Trust	Associate Director of Nursing

Appendix 3 – Consumer participant survey questions

About you

1. Which age group do you belong to?

- ☐ 13–19 years
- ☐ 20–24 years
- ☐ 25–34 years
- ☐ 35–44 years
- ☐ 45–54 years
- ☐ 55–64 years
- ☐ 65–74 years
- ☐ 75+ years
- ☐ Choose not to answer

2. What is your ethnicity?

- ☐ New Zealand European
- ☐ Māori
- ☐ Samoa
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (please specify)
- ☐ Choose not to answer

3. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Another gender (please specify)
- ☐ Choose not to answer

4. Which of the following options best describes how you think of yourself?

- ☐ Heterosexual or straight
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Other
- ☐ Don't know
- ☐ Choose not to answer

5. Do you have a disability?

- ☐ Yes
- ☐ No
- ☐ Choose not to answer

6. Do you live in a rural or remote area?

- ☐ Yes
- ☐ No
- ☐ Choose not to answer

About your experience

1. Have you heard about the change to HPV testing and self-testing in the cervical screening programme?

- ☐ Yes
- ☐ No

If yes, how did you first hear about it? (Tick all that apply.)

- ☐ Social media
- ☐ Posters/flyers
- ☐ General practice
- ☐ Radio/TV/Streaming ads
- ☐ Word of mouth
- ☐ Other (please specify)

2. When did you last have your cervical screen?

3. How did you find out when your cervical screen was due?

- ☐ General practice
- ☐ Other (please specify)

4. Was your cervical screen:

- ☐ HPV self-test
- ☐ HPV test done by your nurse or doctor
- ☐ A smear (cervical cytology by speculum exam)
- ☐ Don't know/can't remember

5. If your screen was an HPV test done by your nurse or doctor, did they offer the test for you to do yourself?

- ☐ Yes
- ☐ No

6. Did you have to pay to have your cervical screening test?

- ☐ Yes
- ☐ No

About your experience with the HPV test

1. Who explained the new HPV test to you?

Tick all that apply

- ☐ Practice nurse
- ☐ GP
- ☐ Kaiāwhina
- ☐ Other (please specify)

2. Did they tell you about:

Tick all that apply

- ☐ Cervical cancer elimination
- ☐ Human papillomavirus (HPV)
- ☐ Doing the test yourself
- ☐ Other (please specify)

3. If you did a self-test, were you given a diagram showing how far to insert the swab into your vagina?

- ☐ Yes
- ☐ No

4. Did you know what to expect for getting your test result?

- ☐ Yes
- ☐ No

5. How long did it take to get your result?

- ☐ A few days
- ☐ A week
- ☐ 2–3 weeks
- ☐ A month
- ☐ More than a month

6. How did you receive your test result?:

- ☐ Phone call from nurse/GP
- ☐ In-person nurse/GP
- ☐ Text
- ☐ Other (please specify)

7. What was your result?:

- ☐ HPV not detected
- ☐ Invalid test
- ☐ HPV Other
- ☐ HPV 16/18
- ☐ Don’t know/can’t remember

8. Did you understand what the result meant?

- ☐ Yes
- ☐ No

9. Could you ask questions?

☐ Yes ☐ No

10. Did you feel like your questions were answered?

☐ Yes ☐ I didn't have any questions

☐ No

If your result was HPV not detected

1. When will you have your next cervical screen?

Specify month and year:

If your result was invalid test

1. Did you do:

☐ Another HPV self-test ☐ Other

☐ Clinician-taken HPV test

If your result was HPV Other

1. What information were you given?

☐ Verbal ☐ Other (please specify)

☐ Leaflet/information sheet

☐ Link to online information

2. Did you understand your result?

☐ Yes ☐ No

3. Did you attend follow-up LBC (smear)?

☐ Yes ☐ No

4. Do you understand what and when your next follow-up will be?

☐ Yes ☐ No

5. Have you been referred for or had a colposcopy?

☐ I have had a colposcopy ☐ I was not referred for colposcopy

☐ I have been referred for colposcopy, but haven't had my appointment yet

If your result was HPV 16/18

1. Have you been referred for or had a colposcopy?

- ☐ I have had a colposcopy
- ☐ I was not referred for colposcopy
- ☐ I have been referred for colposcopy, but haven't had my appointment yet

If you attended colposcopy at the hospital

1. What information were you given about colposcopy?

- ☐ Verbal
- ☐ No information, just the appointment details
- ☐ Leaflet/information sheet
- ☐ Other (please specify)
- ☐ Link to online information

2. How long was the wait to see the colposcopist?

- ☐ Less than a month
- ☐ 4–6 months
- ☐ 1–2 months
- ☐ More than 6 months
- ☐ 3–4 months

3. Who came with you to your colposcopy appointment?

- ☐ Whānau
- ☐ No-one came with me
- ☐ Support to screening service
- ☐ Other (please specify)
- ☐ Someone from my general practice

4. How did you travel to the hospital?

- ☐ Whānau drove me
- ☐ Support to screen
- ☐ Public transport
- ☐ Other (please specify)
- ☐ Taxi

5. When you arrived at the hospital:

	Yes	No
Did you feel welcome?	☐	☐
Was your name pronounced correctly?	☐	☐
Were your support people included / given a space?	☐	☐
Did people introduce themselves and ask about you?	☐	☐
Was the colposcopy procedure explained to you?	☐	☐
Could you ask questions?	☐	☐
Were your questions answered?	☐	☐

Final questions

1. What would have made your cervical screening experience better?

- ☐ Information
- ☐ Whakawhanaungatanga – connection
- ☐ Manaakitanga – being looked after, kindness, hospitality
- ☐ Practical support such as transport (including parking) child care, time off work
- ☐ Other (please specify)

2. Is there anything else you would like to tell us about the cervical screening programme in Aotearoa?

Appendix 4 – Provider and practitioner survey questions

1. **What is your role/job title?**

2. **What are the most important matters for the Parliamentary Review Committee to understand about cervical screening in Aotearoa New Zealand?**

3. **What is working well in the National Cervical Screening Programme?**

4. **What is not working well and how could this be strengthened?**

5. **How well is the National Cervical Screening Programme supporting equitable access and uptake of HPV testing for priority populations (particularly Māori and Pacific)?**

   ☐ Very well
   ☐ Well
   ☐ Adequately
   ☐ Poorly
   ☐ Very poorly
   ☐ Unsure

   Explain your answer:

6. **How well is the National Cervical Screening Programme supporting equitable access and uptake of colposcopy for priority populations (particularly Māori and Pacific)?**

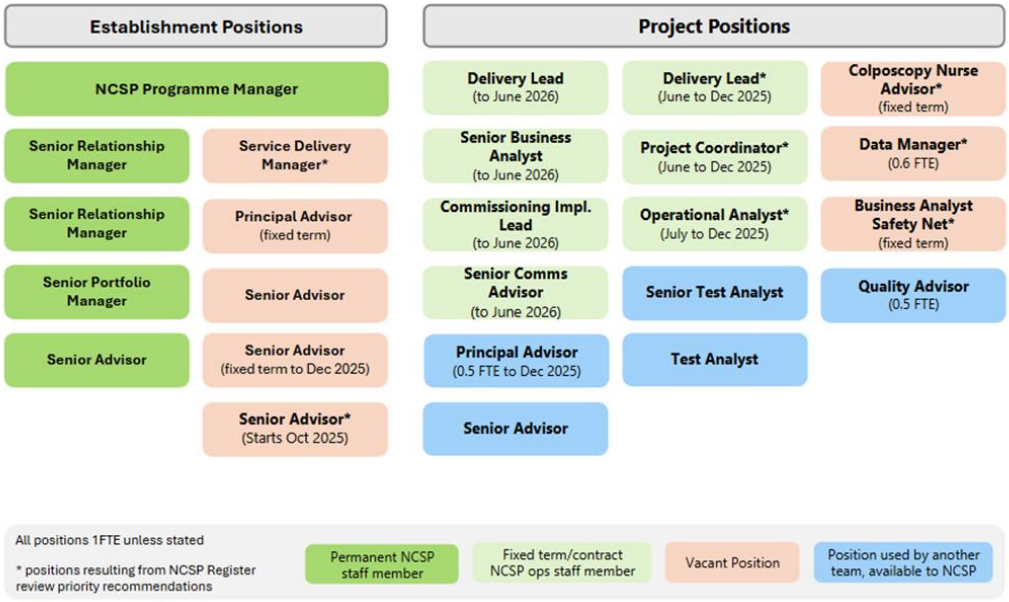
☐	Very well	☐	Poorly
☐	Well	☐	Very poorly
☐	Adequately	☐	Unsure

Explain your answer:

7. **What are your observations and/or experiences of cervical screening workforce capacity, capability and resourcing (ie, staffing levels, workload, training pathways, recruitment or retention)?**

8. **Do you have feedback or thoughts on the Clinical Practice Guidelines for Cervical Screening in Aotearoa New Zealand?**

Appendix 5 – National Cervical Screening Programme team staffing as at August 2025



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