The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Tēnā koe Prof Signal,

Thank you for the opportunity to provide feedback on the Cancer Awareness Measure (CAM) Aotearoa New Zealand Survey.

Our position

The Royal New Zealand College of General Practitioners (the College) welcomes research that improves understanding of cancer awareness, help-seeking, access to healthcare and screening participation, and the commitment to equal explanatory power for Māori, Pacific Peoples, Asian and European populations. The survey adequately covers topics relevant to general practice, including symptom awareness, help-seeking, access, and re-presentation. Alongside Aotearoa New Zealand-specific amendments, we suggest a small number of high-value supplementary items, recognising that extensive changes could affect the comparability of this validated instrument. These cover previous healthcare experiences, culturally safe communication, whānau involvement where desired, continuity of care and safety-netting, and should be tested for feasibility and cultural responsiveness. Analysis and presentation of results should also show the role of the health system and providers in cancer awareness and care, rather than attributing issues to individuals' perceptions and behaviours. The aim should be research that recognises whānau strengths and agency, identifies health-system responsibilities, and supports mana-enhancing improvements.

Adaptation to the Aotearoa New Zealand context

Health and illness are understood differently across cultures; Māori models of health, for example, recognise relational and collective dimensions of wellbeing. We would welcome clarity on Māori involvement in this research, including in adaptation of the questionnaire, testing, results interpretation, dissemination, and governance.

We offer two recommendations to improve the questionnaire's applicability within Aotearoa New Zealand:

1. Primary care and service terminology

Replace 'GP surgery/practice' with terminology that is natural and consistently understood in Aotearoa New Zealand, such as 'general practice,' and that also works for people receiving first-contact care through Māori, Pacific or other community-based providers.

Clarify the 'walk-in service' response option in F6 and H4. Consider separately identifying urgent care or after-hours clinics and avoid examples that overlap with the separate A&E option. This would clarify where people seek care when general practice access is unavailable.

2. Primary care roles

Review whether the healthcare professional options in F4 adequately reflect multidisciplinary, Māori, and Pacific primary care models. Roles such as kaiārahi, kaiāwhina, health coaches and health improvement practitioners should be included where relevant to the purpose of the question.

Questionnaire content

1. Health literacy, continuity, and safety-netting

The questionnaire comprehensively assesses what individuals know, believe, and do in relation to cancer, but the emphasis risks framing cancer awareness and engagement primarily as individual knowledge or behaviour deficits. Health literacy is a shared responsibility: providing information does not establish understanding or informed consent. Clinicians and services must communicate in accessible, culturally safe ways, create space for questions and support informed choice. Wider social conditions can also enable or constrain whānau to understand information, exercise choice, and access timely care.

We recommend the questionnaire explore whether respondents received information they could understand, could ask questions, participated meaningfully in the assessment and plan, felt listened to, had options and next steps explained in a way that supported informed choice, and knew how to seek further help if symptoms persisted or worsened.

We also recommend examining whether respondents saw their preferred or usual healthcare professional, not only whether an appointment was available. An appointment with an unfamiliar clinician may represent access, but not necessarily continuity of care. These measures could illuminate clinical safety, continuity, and diagnostic pathway barriers, and be incorporated into sections F, H, and I.

2. Trust, cultural safety, and previous experiences

We recommend adding response options to the Section D item concerning reasons for delaying or avoiding seeking care to capture previous healthcare experiences. In addition to the existing response options, consider including: "I had previously felt dismissed by a healthcare professional or service;" "I had experienced racism or discrimination in healthcare;" and "I had previously received care that felt culturally unsafe." This would help identify whether previous healthcare experiences affect trust and subsequent help-seeking, rather than attributing delay primarily to individual attitudes or behaviour.

3. Whānau involvement

We recommend using 'whānau' consistently, including in J1, as a relational concept rather than a direct substitute for 'family'. Whānau are often central to recognising symptoms, interpreting information, making decisions, and navigating services, not simply a source of encouragement or practical support. We encourage questions on whether, where desired by the person, whānau helped recognise symptoms, interpret information, support decision-making, communicate with services or navigate subsequent care.

Analysis, interpretation, and dissemination

We suggest analysis and framing of results avoid deficit framing and show where barriers arise and where responsibility for improvement sits. Findings should clearly distinguish: (i) individuals' recognition of symptoms and decisions to seek care; (ii) barriers to accessing appropriate care; and (iii) delays within the health system, including assessment, investigation, referral, and follow-up. This will avoid attributing delayed diagnosis and treatment principally to individuals.

Screening analysis should distinguish informed decisions not to participate from non-participation due to inaccessible services, inadequate information, unanswered concerns, or other barriers. Participation matters, but so does the quality of communication and the ability to make a culturally safe, informed choice.

To help evidence translate into service improvement, we encourage the research team to give Māori and other communities many opportunities to inform interpretation of, and action on, the findings. Dissemination should be accessible and culturally relevant, treating communities as participants in interpretation and action rather than only recipients of results.

The College's research and advocacy on general practice access, continuity and equity may provide useful context when interpreting findings, and we would welcome opportunities to contribute primary care expertise to interpretation and implementation.

Specific wording and response-option recommendations

- Use ‘e-cigarettes/vaping’ consistently, and ensure explanatory statements about tobacco, vaping, alcohol, weight, and diet are clinically reviewed for accuracy, balance, and applicability to Aotearoa New Zealand.
- Ensure response options and examples are matched where possible for consistency. For example, A2 identifies ‘salami’ as a processed meat whereas C3 identifies ‘chorizo’.
- Review lengthy or double-negative statements for plain language. For example, in E1, consider changing ‘I don’t think the health service (Health New Zealand) has enough staff or equipment to see all the people with cancer that need to be diagnosed’ to ‘The health service (Health New Zealand) does not have enough staff or equipment to see all the people with cancer that need to be diagnosed’.

Thank you again for the opportunity to comment.

Nāku noa, nā



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