



National Survey on Cancer Awareness and Attitudes

October 2026



Abbreviations	
CAPI	Computer Assisted Personal Interviewing
CATI	Computer-Assisted Telephone Interviewing
COPD	Chronic Obstructive Pulmonary Disease
CSO	Central Statistics Office
COVID-19	Coronavirus Disease 2019
GP	General Practitioner
HRT	Hormone Replacement Therapy
HSE	Health Service Executive
HPV	Human Papillomavirus
NCCP	National Cancer Control Programme
UV	Ultraviolet

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About the National Cancer Control Programme

The National Cancer Control Programme (NCCP) was established in 2007. The NCCP is part of the Health Service Executive (HSE). The NCCP works with partners to prevent cancer, treat cancer, and improve survival and quality of life for people with cancer. The NCCP implements many of the recommendations of the [National Cancer Strategy](#).

This report should be cited as:

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Acknowledgements

We would like to thank all respondents who generously gave their time to participate in this study. Their experiences, perspectives and feedback form the foundation of the findings presented in this report.

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PERSONAL EXPERIENCE OF CANCER



85%

know at least one person who has been diagnosed with cancer

SPONTANEOUS AWARENESS OF CANCER RISK FACTORS

Smoking



Alcohol



UV Exposure



Overweight



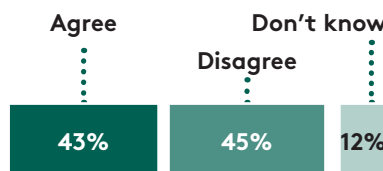
Infections



Shown are the top 5 modifiable risk factors responsible for the most cancers in Ireland (as per 2020 NCRI report on modifiable risk factors)

ATTITUDES TO CANCER RISK FACTORS

Drinking any alcohol, even small amounts, increases the risk of developing cancer



87%

agree there are things they can do to **reduce their risk** of developing cancer

74%

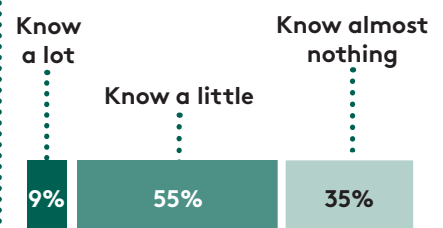
would be in favour of a total ban on **commercial sunbed use** in Ireland

AWARENESS OF RADON

54%

report having heard of radon

Self-assessed understanding of radon among those who have heard of it



EARLY DIAGNOSIS



Just

49%

spontaneously recognise persistent unexplained pain could be a sign of cancer



Just

42%

spontaneously recognise that change in bowel habit could be a sign of cancer



Just

39%

spontaneously recognise that unexplained weight loss could be a sign of cancer



95%

of people agree that going to the doctor as soon as possible after noticing a symptom of cancer could increase the chances of surviving

Introduction

This report presents the findings from the 2026 National Survey on Cancer Awareness and Attitudes, commissioned by the HSE National Cancer Control Programme (NCCP) and carried out by Ipsos B&A. The survey was conducted on a random sample of adults aged 18 and over living in Ireland. It examines public awareness, beliefs and behaviours in relation to cancer prevention and early diagnosis.

Cancer is the leading cause of death in Ireland. Around one in two people in Ireland can expect to be diagnosed with cancer during their lifetime¹, with the number of cancer cases projected to rise in the coming decades. This makes cancer prevention and early diagnosis central to reducing avoidable illness and premature mortality. It is estimated that 30-50% of all cancers are preventable², and a key and effective measure in the prevention of cancer is to reduce exposure to modifiable risk factors. These include behavioural factors (e.g. tobacco smoking and alcohol consumption), metabolic factors (e.g. overweight and obesity) and environmental factors (e.g. exposure to radon and ultraviolet (UV) radiation). For those who do develop cancer, early diagnosis is key to improving survival rates, reducing treatment severity and improving quality of life.

The NCCP has a leading role in developing and supporting cancer prevention and early detection activity in Ireland. To do this well, it needs robust and up-to-date evidence on what people know, what they believe, and how they say they would respond to potential cancer risks and symptoms. The first National Survey on Cancer Awareness and Attitudes, conducted in 2022³, provided this baseline evidence.

The 2026 survey builds on that earlier study and allows changes over time to be assessed across a range of key indicators. It repeats core measures of cancer awareness and attitudes so that trends can be tracked, while also extending the study to cover additional topics of current policy interest, including sunbed use and awareness of radon. This provides a broader picture of public understanding of cancer risk in Ireland and supports the continued development of targeted communications, prevention measures and early diagnosis initiatives.

As with the earlier wave, the survey was designed to inform public health action. The findings are intended to help the NCCP and its partners identify strengths in public awareness, gaps in understanding, and groups that may benefit from more focused interventions. They also provide updated evidence to help evaluate the impact of campaigns and wider policy measures.

¹National Cancer Registry Ireland (2020) Cancer in Ireland 1994–2018 with estimates for 2018–2020: Annual report of the National Cancer Registry. NCRI, Cork, Ireland.

²Wild, C.P., Weiderpass, E., & Stewart, B.W. (2020). World Cancer Report: Cancer Research for Cancer Prevention. Lyon: International Agency for Research on Cancer.

³HSE National Cancer Control Programme (2022). The NCCP National Survey on Cancer Awareness and Attitudes. <https://www.lenus.ie/entities/publication/ec50a8b3-1669-4d45-8af9-7c67a034b16a>

This report focuses on descriptive findings from the 2026 survey and, where relevant, compares them with results from the previous wave. In doing so, it aims to provide a clear account of current public awareness and attitudes, and to support evidence-based decision-making in cancer prevention and early detection in Ireland.

The aims of this research were to:

- 1.** Assess beliefs about cancer, including knowledge and awareness of risk and preventive factors.
- 2.** Assess attitudes and behaviours in relation to cancer risk factors.
- 3.** Assess knowledge of early signs and symptoms of cancer.
- 4.** Assess health-seeking behaviours, including barriers and enablers to seeking medical advice.
- 5.** Compare findings with the results of the 2022 National Survey on Cancer Awareness and Attitudes to monitor trends over time.
- 6.** Analyse results by HSE health region to inform regional initiatives.
- 7.** Inform the development of cancer prevention and early diagnosis initiatives.

The research survey was conducted among a representative sample of adults aged 18 and over living in Ireland. Ethical approval was provided by the Research Ethics Committee at the Royal College of Physicians of Ireland. A total sample size of 2,877 was achieved, with fieldwork conducted face to face between March and June 2026 inclusive. Where necessary, data were weighted in line with the most up-to-date Central Statistics Office (CSO) estimates of the population.

Methodology

Questionnaire Design

The aim of the survey was to inform the development of cancer prevention and early diagnosis initiatives. Considering this aim, the questionnaire was designed to gather accurate and policy-relevant information from the adult population in Ireland, while also supporting comparison with the previous wave of the study.

The questionnaire was developed by the NCCP and its research advisory group, in consultation with the research team, and drew on internationally validated measures. As in the earlier survey, questionnaire development was informed by the Cancer Awareness Measure⁴, the Awareness and Beliefs about Cancer measure⁵, and the French Cancer Barometer⁶, with demographic items adapted from established Irish survey sources.

To support trend analysis, most items from the previous survey were retained unchanged, while new questions were added in areas identified as current priorities for the NCCP. New items were added to examine sunbed use and to evaluate awareness and understanding of radon. Items to assess sunbed use were adopted from the Healthy Ireland Survey and those used to measure awareness of radon were adopted from the Canadian Radon Awareness Survey⁷.

Given the sensitive nature of the topic, care was taken to ensure that questions were worded clearly and respectfully, and that the questionnaire remained acceptable to respondents. The revised questionnaire was reviewed and tested prior to fieldwork to confirm comprehension, flow and suitability for face-to-face administration.

Sample Design

The survey was conducted among adults aged 18 and over living in Ireland. As with the previous wave, the target sample was designed to be nationally representative, while also supporting subgroup analysis.

A key change in the 2026 survey was the sampling design used to support comparison across HSE health regions. To achieve statistical robustness across health regions, a quota sampling approach was used to achieve an equal proportion of respondents from each health region. In practice, this meant that the less populous health regions were oversampled relative to their share of the national population, ensuring that each region achieved a sufficient sample size to

⁴https://www.cancerresearchuk.org/sites/default/files/cam_questionnaire_items_2008-2020.pdf

⁵Simon AE, Forbes LJL, Boniface D, et al an international measure of awareness and beliefs about cancer: development and testing of the ABCBMJ Open 2012;2:e001758. doi: 10.1136/bmjopen-2012-001758

⁶<https://www.e-cancer.fr/Comprendre-prevenir-depister/Reduire-les-risques-de-cancer/Barometre-Cancer>

⁷ https://publications.gc.ca/collections/collection_2023/sc-hc/H14-436-2023-eng.pdf

support robust regional estimates. The achieved sample was subsequently weighted to restore the true population distribution across regions (see the Data weighting section below).

Sampling was based on a stratified random approach. The national population was first stratified by HSE health region and then by community size, so that the sample included an appropriate spread of cities, towns and rural areas. Sampling points were selected geographically, and respondents were then recruited using quota controls, including age interlocked with gender and social class, to ensure broad representation across key demographic groups.

This represents an important methodological difference from the previous survey. The 2022 survey used computer-assisted telephone interviews (CATI) using a mobile telephone random digit dial approach. This was the most appropriate approach at the time due to the COVID-19 pandemic restrictions. The 2026 survey used an address-based, face-to-face sampling approach, which is better suited to regional sampling and more inclusive coverage of the adult population.

Interviewer Briefing and Training

All interviewers working on the study received project-specific briefing and training before fieldwork began. This included detailed guidance on the questionnaire, respondent selection procedures, gaining informed consent, and techniques to support high-quality data collection.

Because cancer can be a sensitive topic, interviewers were also briefed on how to approach discussions with empathy and professionalism. Interviewers completed dedicated sensitivity training so that they were equipped to manage emotional responses appropriately and maintain a respectful respondent experience throughout the interview. Many respondents may have had experience of cancer, either personally or through friends and family, and interviewers were trained in how to approach respondents with the appropriate tone and where to direct respondents if they had any concerns.

Survey Fieldwork

An important methodological difference between the 2022 survey and the 2026 one was the move from CATI to face-to-face interviewing using Computer Assisted Personal Interviewing (CAPI). The 2022 survey (n=2874) was conducted by telephone because face-to-face interviewing was not appropriate during the COVID-19 period. For the 2026 wave, face-to-face interviewing was selected as the preferred approach because it is better suited to achieving robust coverage across all HSE health regions and to supporting participation among groups that may be less likely to engage by telephone.

Fieldwork was conducted face-to-face between the 23rd of March and the 3rd of June 2026. A total of 2877 interviews were completed nationwide. The use of CAPI allowed interviews to be administered in a consistent manner in respondents' homes, while also improving questionnaire flow, routing and quality control. Participation in the survey was completely voluntary, and participants were not incentivised to complete the survey. Interviews lasted for an average of 25 minutes.

The choice of face-to-face fieldwork also reflected the sensitive nature of the topic. In-person interviewing can help establish trust and rapport more effectively, support clearer communication, and reduce the risk of misunderstanding when asking about personal health beliefs and behaviours.

However, this change in methodology needs to be considered when examining any changes in results between 2022 and 2026. Changing methodologies means that the dynamic between interviewer and respondent is altered and that respondents may engage with questions in a different way.

Data Cleaning and Validation

As interviews were conducted using CAPI, questionnaire routing and many validation checks were built into the survey script and applied during fieldwork. This reduced the likelihood of interviewer error, minimised missing data, and improved consistency in how questions were administered.

Data were checked throughout and after fieldwork to identify any inconsistencies, outliers or quality issues. Open-ended responses and “other, specify” answers were reviewed and coded as required, and the final dataset was cleaned and validated prior to analysis.

The use of CAPI also strengthened quality assurance by capturing interview metadata, including timing information, which could be used to monitor fieldwork quality. Interviewer contacts would be subject to back-checking as part of the study’s overall quality control procedures.

Data Weighting

While the sampling design aimed to achieve a broad and balanced sample of adults aged 18 and over, weighting was applied where necessary to ensure that the final dataset reflected the profile of the adult population in Ireland. As in the previous report, weighting was used to align the achieved sample with known population distributions on key demographic variables.

For the 2026 survey, weighting was based on Central Statistics Office population data derived from the CSO Population and Migration Estimates April 2025 for age and gender, The Labour Force Survey Q1 2026 for employment status, and the 2022 Census for education level and the HSE health regions. The weighting variables were age group by gender, education, work status and HSE health region. Weighting was particularly important in this wave to correct for the approximately equal sampling across the six HSE health regions, which meant the unweighted regional profile did not reflect the actual population distribution across these regions. The weighting process therefore adjusted the achieved sample back to the correct population balance, ensuring that national estimates are representative of the adult population of Ireland. The unweighted and weighted profiles of the achieved sample are shown in Table 1 below.

Table 1. Weighted and unweighted sample characteristics.

	Unweighted	Weighted
Gender	%	%
Men	45	49
Women	55	51
Age		
18-24	8	11
25-34	13	16
35-44	19	19
45-54	19	18
55-64	16	15
65-74	14	11
75+	10	9
HSE health region		
HSE Dublin and North East	17	23
HSE Dublin and Midlands	17	21
HSE Dublin and South East	17	19
HSE South West	17	14
HSE Mid West	17	8
HSE West and North West	16	15
Education		
Less than Leaving Certificate	12	27
Leaving Certificate	35	34
Post-Leaving Certificate	52	39
Working Status		
Employed	56	62
Unemployed	4	4
Student	5	6
Unable to work due to permanent sickness or disability	2	1
Looking after home or family	8	9
Retired	23	17
Other	1	1

Margins of Error

All sample surveys are subject to a margin of error, which varies with the size of the sample (or sub-sample) and the survey estimate in question. Illustrative margins of error for the achieved sample size of 2,877 and for some example smaller sub-sample sizes are shown in the table

below, calculated at the 95% confidence level. The average achieved sample size in each HSE health region was approximately 480. As a result, estimates for individual health regions carry a wider margin of error than national estimates.

Table 2. Margin of errors at different sample sizes and prevalences.

Sample size	Prevalence		
	10% or 90%	30% or 70%	50%
2,877 (full sample)	±1.1%	±1.7%	±1.8%
1500	±1.5%	±2.3%	±2.5%
1000	±1.9%	±2.8%	±3.1%
480 (average per health region)	±2.7%	±4.1%	±4.5%
200	±4.2%	±6.4%	±6.9%

The above margins of error assume simple random sampling. The design effect associated with the stratified, quota-controlled sample design and the weighting applied may slightly increase the effective margins of error of the reported results.

Analysis Approach

The approach taken to analysis involved analysing each question in the survey by a range of socio-demographic variables, including gender, age, HSE health region, educational attainment, working status, ethnicity and nationality. Significant differences (or lack thereof) are noted throughout this report. Where differences are described as significant, significance testing was conducted using a test of proportions (z-test) or Chi-squared test at the 95% confidence level ($p < 0.05$).

Where question wording was retained from the 2022 survey, results are compared with the previous wave to identify changes in awareness, attitudes and behaviours over time. When interpreting these comparisons, it should be noted that the change in data collection mode, from telephone (CATI) in 2022 to face-to-face (CAPI) in 2026, may account for some of the differences observed, as survey mode can influence how respondents answer certain questions, particularly those of a sensitive nature.

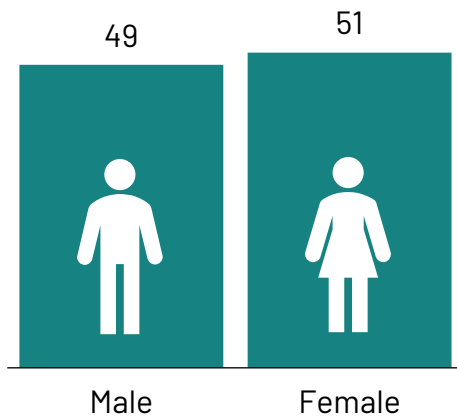
Results are additionally broken down by HSE health region throughout the report. The 2026 sample design, with approximately equal numbers of interviews achieved in each region, supports this regional analysis and provides a basis for informing region-specific cancer prevention and early diagnosis initiatives.

Note on reporting

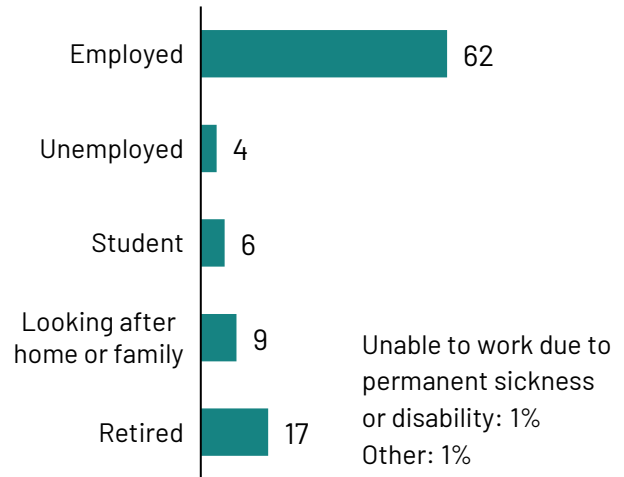
Percentages throughout this report may not sum to 100, and “net” figures may not sum to the total of their constituent elements. This is due to individual figures being rounded to whole percentages.

Profile of Survey Respondents

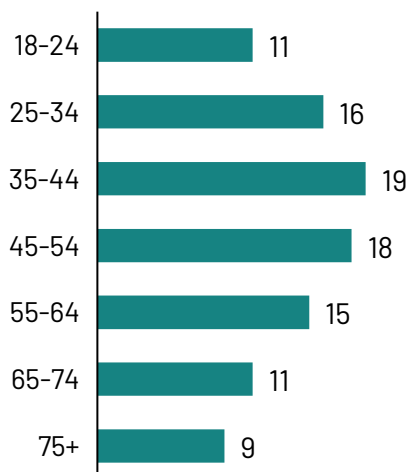
Gender (%)



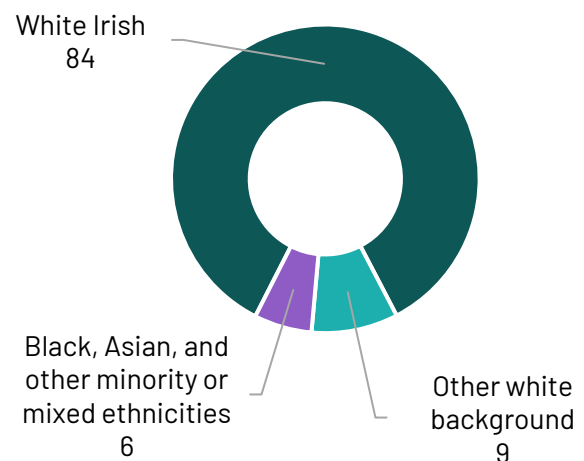
Working Status (%)



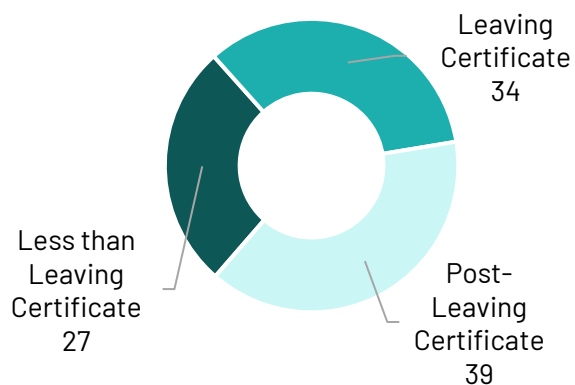
Age (%)



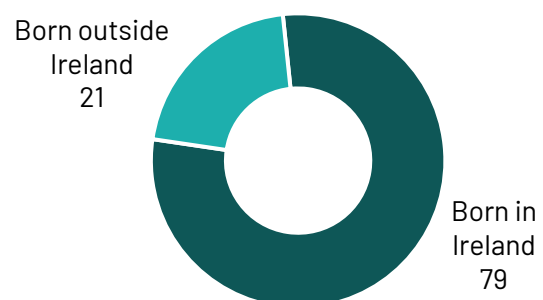
Ethnicity (%)



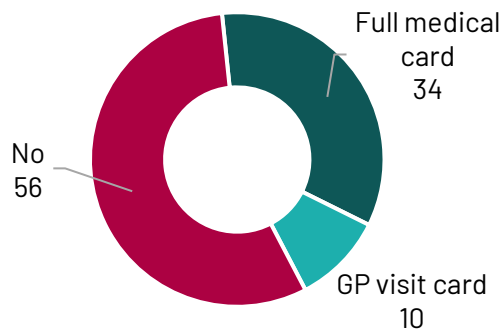
Education (%)



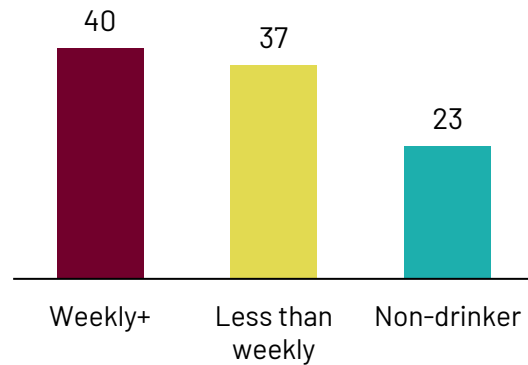
Country of Birth (%)



Full Medical / GP Visit Card (%)



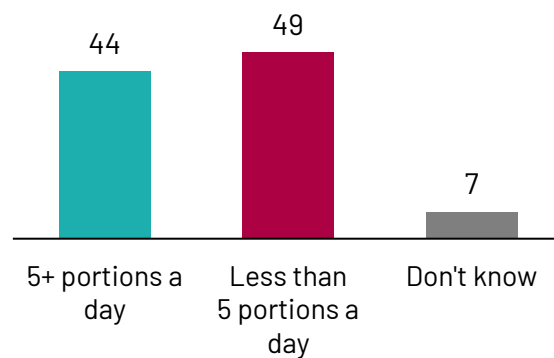
Alcohol Consumption (%)



Long Term Illness Scheme (%)



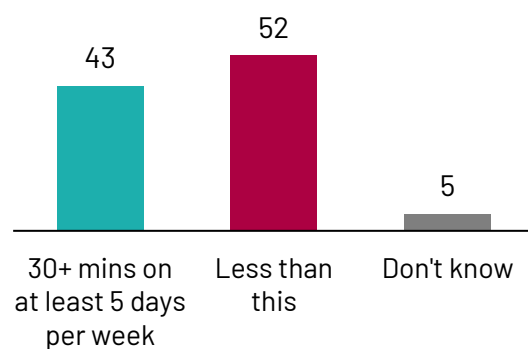
Fruit and Vegetable Intake (%)



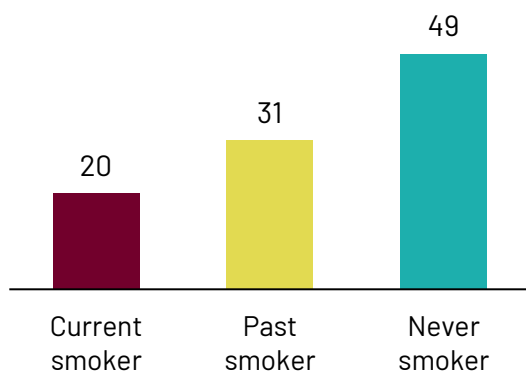
Private Health Insurance (%)



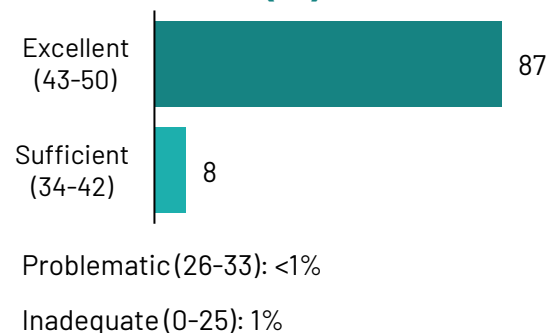
Physical Activity Level (%)



Smoking Status (%)



Healthcare Information Literacy* (%)



*Healthcare information literacy is the ability to find, understand, evaluate and use health information to make safe and informed medical decisions. It was measured using 12-items adapted from the European Health Literacy Survey Questionnaire (HLS-EU-Q47). Scores are summed and transformed into a standardised 0-50 index.

General Attitudes to Cancer

Designing effective interventions to reduce cancer risk behaviours and improve early detection requires a clear understanding of public attitudes towards cancer. The survey therefore opened with a series of questions on respondents' personal experience of cancer and their general beliefs about the disease. As this survey repeats the 2022 baseline, results throughout this section are compared with those of the previous wave, allowing changes in public attitudes over the past four years to be identified.

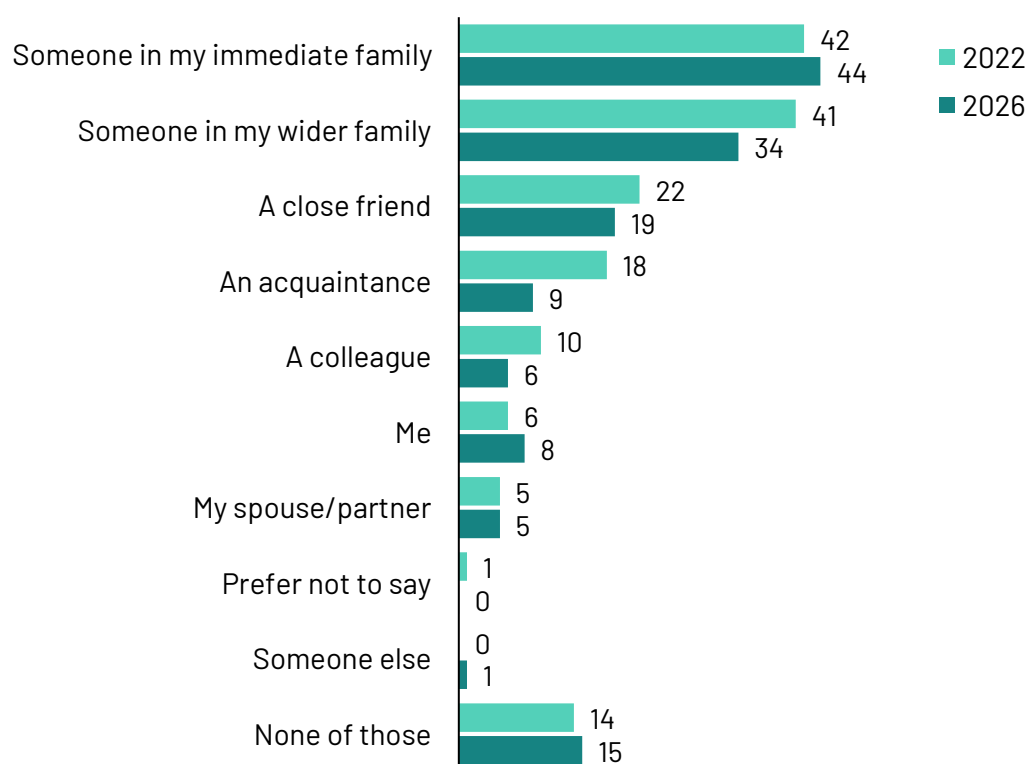
Personal Experience with Cancer

Respondents were first asked whether they, or anyone among their family or friends, had ever been diagnosed with cancer (Figure 1). Overall, 85% know at least one person who has been diagnosed with cancer, in line with the 86% recorded in 2022. The most common experience remains a diagnosis within the family: 44% report that someone in their immediate family has had cancer (2022: 42%), and 34% cite a member of their wider family (2022: 41%).

Eight per cent of respondents report that they themselves have been diagnosed with cancer (2022: 6%), of which 25% (2% of all respondents) were undergoing treatment at the time of interview (2022: 15%, or 1% of all respondents). These findings show that cancer continues to affect the lives of most people in Ireland.

Figure 1. Personal experience with cancer

% of who say they or someone in their family or friends had cancer



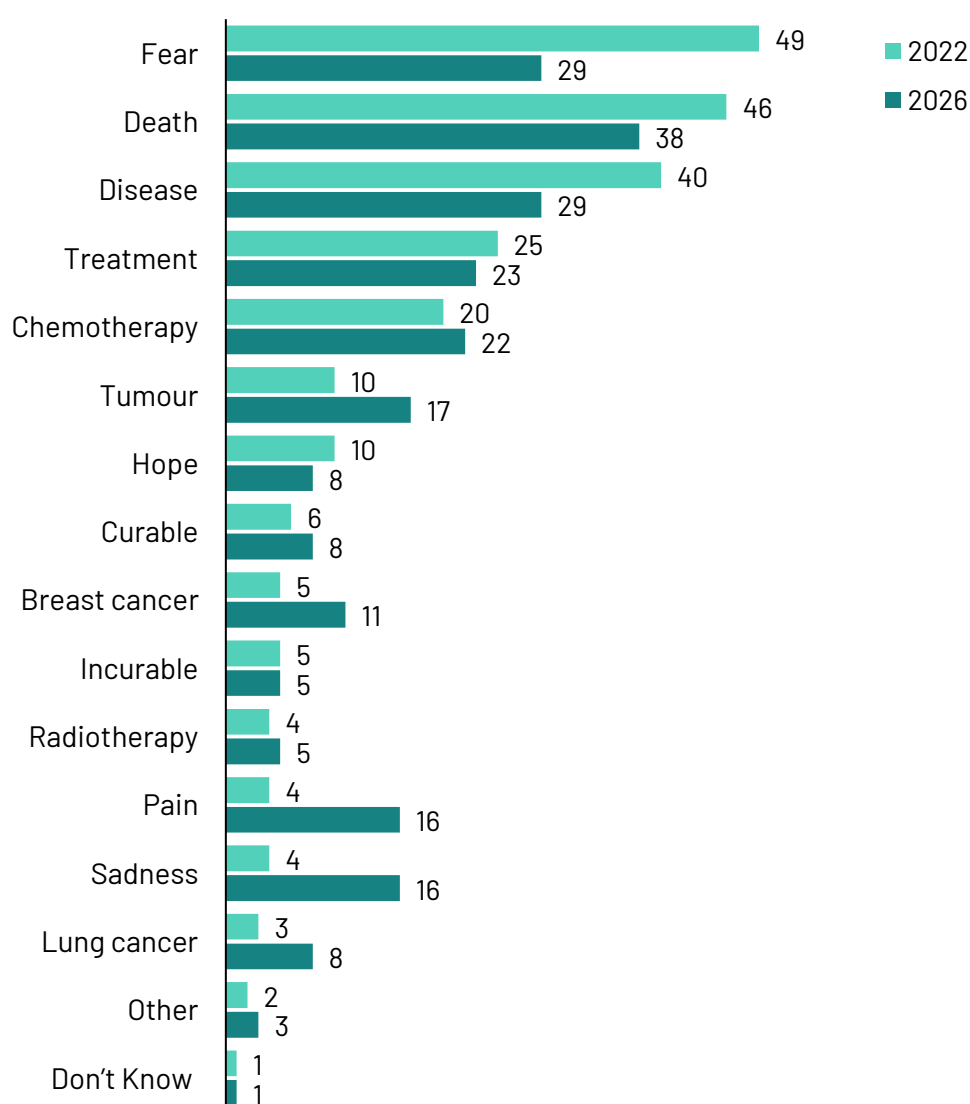
Words Associated with "Cancer"

Respondents were asked which three words first came to mind on hearing the word "cancer" (Figure 2). As in 2022, the words cited are predominantly negative. "Death" (38%; 2022: 46%), "Fear" (29%; 2022: 49%) and "Disease" (29%; 2022: 40%) remain the most common responses.

Demographic patterns are consistent with 2022: women (32%) remain more likely than men (27%) to associate cancer with "Fear" (2022: 54% and 45% respectively), while those aged under 35 (35%) are more likely than those aged 65 and older (17%) to cite "Disease".

Figure 2. Words associated with 'cancer', 2022-2026

% who think of these three words when they think of cancer



Attitudes to Cancer

While the word "cancer" still provokes a negative first response, views on cancer prognosis remain optimistic overall. Respondents continue to see cancer as a disease that is often curable and survivable, and one whose risk can be reduced.

As Figure 3 shows, 81% strongly or somewhat agree that "These days many people with cancer can expect to continue with normal activities and responsibilities", and 86% agree that "Cancer can often be cured". These findings are broadly consistent with those found in 2022 (Figure 4), except the proportion who agree that "These days many people with cancer can expect to continue with normal activities and responsibilities" has decreased slightly (2022: 87%; 2026: 81%).

A majority (76%) disagree that "A diagnosis of cancer is a death sentence". The proportion who agrees with this statement has fallen from 25% in 2022 to 21% in 2026. Eighteen per cent believe that "Nothing can be done to reduce your risk of cancer", compared with 16% in 2022. The large majority who reject this statement is encouraging, suggesting there is continued scope to reduce the prevalence of modifiable cancer risk behaviours, a topic explored in more detail later in this report.

Figure 3. Attitudes to cancer, 2026

% who agree or disagree with each statement

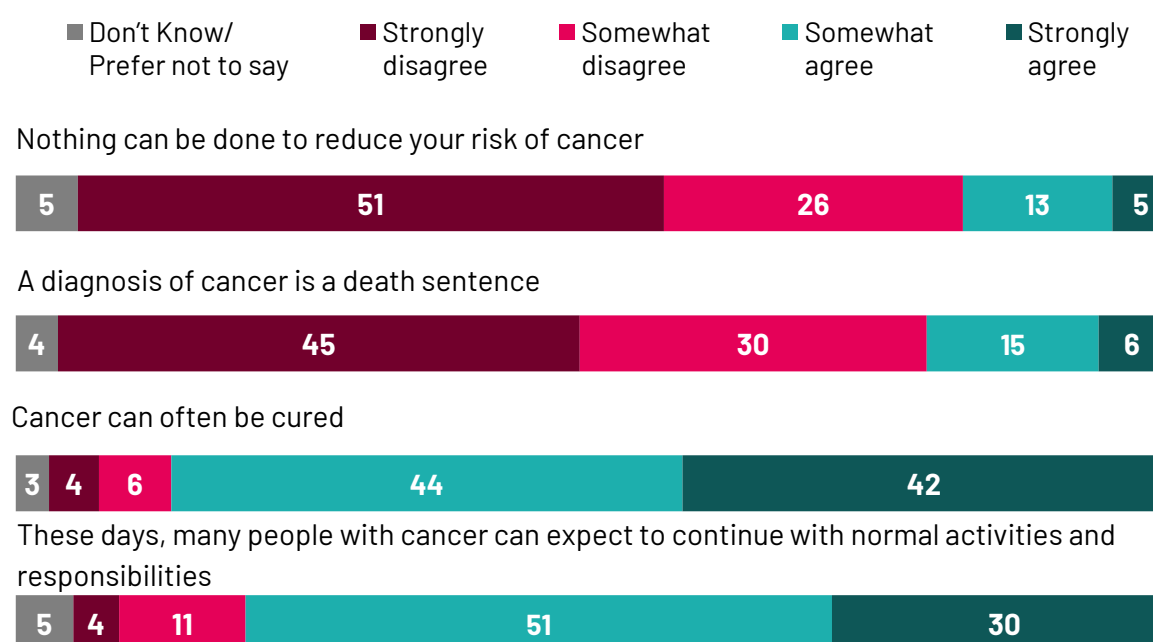
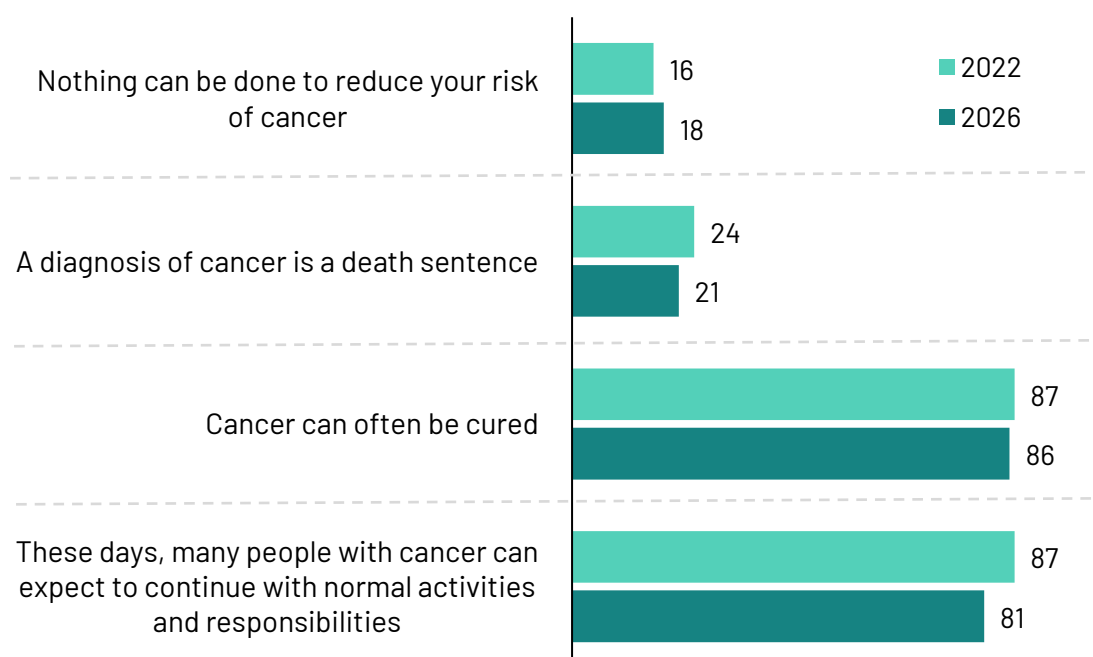


Figure 4. Attitude to Cancer, 2022-2026

% who strongly or somewhat agree with each statement



As in 2022, the clearest demographic divide in attitudes to cancer is by age, with those aged 65 and older holding the most negative perceptions of cancer (Table 3). Understanding the views of older people remains particularly important, given that more than half of cancer diagnoses and three quarters of cancer deaths occur in those aged over 65⁸.

People aged 65 and older (23%) are more likely to agree that "Nothing can be done to reduce your risk of cancer" compared with those younger than 54. Views among the over 65s remain somewhat contradictory. Twenty five per cent of this group agree that "A diagnosis of cancer is a death sentence" (2022: 32%), the highest of any age group. Yet they are also among the most likely to agree that "Cancer can often be cured" (89%; 2022: 87%) and remain the group most likely to agree that people with cancer "can expect to continue with normal activities and responsibilities" (86%; 2022: 92%).

⁸ Ageing and Public Health – an overview of key statistics in Ireland and Northern Ireland (2020)

Table 3. Attitudes to Cancer by age (% who strongly or somewhat agree).

	18-24	25-34	35-44	45-54	55-64	65+
These days, many people with cancer can expect to continue with normal activities and responsibilities	68	73	78	82	85	86
Cancer can often be cured	82	86	83	88	89	89
A diagnosis of cancer is a death sentence	19	24	17	17	22	25
Nothing can be done to reduce your risk of cancer	17	15	16	15	21	23

Other patterns observed in 2022 have also persisted. Agreement that "Nothing can be done to reduce your risk of cancer" (Less than a Leaving Certificate level: 27%; Post-Leaving Certificate: 10%) and "a diagnosis of cancer is a death sentence" (Less than a Leaving Certificate level: 29%; Post-Leaving Certificate: 14%) is higher among those who left school before completing the Leaving Certificate than those with a higher level of education. As noted in the 2022 report, lower educational attainment is strongly correlated with age, so these findings should be treated with caution.

Some notable differences in attitudes to cancer were also found across HSE Health regions (Table 4). For instance, those living in the Dublin and Midlands Health regions were the most likely to agree that "Nothing can be done to reduce your risk of cancer" (28%) and "a diagnosis of cancer is a death sentence" (32%) and were the least likely to agree that people with cancer "can expect to continue with normal activities and responsibilities" (76%).

Table 4. Attitudes to Cancer by HSE health region (% who strongly or somewhat agree)

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
These days, many people with cancer can expect to continue with normal activities and responsibilities	80	76	80	85	77	86
Cancer can often be cured	89	85	86	87	86	86
A diagnosis of cancer is a death sentence	17	32	18	18	22	15
Nothing can be done to reduce your risk of cancer	16	28	15	15	13	17

Awareness of Cancer Risk Factors

A key aim of this research is to build a clearer picture of public knowledge of cancer risk factors. Establishing which health behaviours people believe carry the greatest cancer risk and how these perceptions vary across demographic groups will help the NCCP and other organisations to plan risk reduction initiatives more effectively and to target those groups most at risk. Where comparable data are available, this year's findings are set against those of the 2022 report, allowing us to track how public understanding has shifted over the intervening period.

Beliefs about Reducing Cancer Risk

Before examining specific risk factors, it is important to establish whether people believe they can influence their cancer risk at all. To do this, respondents were asked to rate their level of agreement with the statement "There are things I can do to reduce my risk of developing cancer."

Encouragingly, 87% agree there are things they can do to reduce their risk of developing cancer, with more than half (54%) agreeing strongly (Figure 5).

Figure 5. Attitude to reducing risk of developing cancer

To what extent do you agree or disagree...



This is only marginally lower than the 90% of respondents who agreed with this statement in 2022 (Figure 6).

Figure 6. Attitude to reducing risk of developing cancer, 2022-2026

% who strongly agree or somewhat agree with each statement



Although there was high level of agreement across most demographic groups, some notable differences were found (Table 5). As with 2022, those aged 65 or older (80%) were the least likely of any age group to agree that there are things they can do to reduce their risk of developing cancer, whereas those aged 18 to 24 (92%) were the most likely to. Level of agreement also increased with education attainment, with those who had less than a Leaving Certificate level of education (77%) reporting significantly lower levels of agreement than those with a Leaving Certificate (87%) or with Post-Leaving Certificate education (93%).

Unlike in 2022, where no differences were found between genders, men (89%) were more likely than women (85%) to think that there are things they can do to reduce their risk of developing cancer (Table 5). Agreement also differed by HSE health region, with those living in the HSE West and North West regions (82%) reporting the lowest level of agreement, whereas those living in the HSE Dublin and South East region (90%) reporting the highest level of agreement.

Table 5. Percentage (%) who strongly or somewhat agree with the statement “there are things I can do to reduce my risk of developing cancer” by demographic characteristics.

Gender	%
Men	89
Women	85
Age	
18-24	92
25-34	89
35-44	87
45-54	87
55-64	89
65+	80
HSE health region	
HSE Dublin and North East	88
HSE Dublin and Midlands	88
HSE Dublin and South East	90
HSE South West	85
HSE Mid West	86
HSE West and North West	82
Education	
Less than Leaving Certificate	77
Leaving Certificate	87
Post-Leaving Certificate	93

Awareness of Cancer Risk Factors

As in 2022, awareness of cancer risk factors was measured in two stages. Respondents were first asked to spontaneously name as many things as they could think of that could increase a person's chance of developing cancer. The interviewer then read a list of 32 behaviours and

exposures and asked whether they thought each could increase a person's risk of getting cancer. These items were grouped into five categories:

1. Smoking
2. Sun exposure and other environmental factors
3. Diet, drinking and exercise
4. Health conditions, medicines and treatments
5. Other factors (e.g. mobile phone use)

While most of the factors listed have an established link with cancer, some with no proven association (e.g. mobile phone use) were included to guard against acquiescence (i.e. respondents responding "yes" to all options) and to inform potential myth-busting initiatives.

The list was updated in 2026 to include other forms of oral tobacco (snus) and high blood pressure, while stress and aerosol use were no longer read out as prompts. The results discussed below combine spontaneous and prompted responses unless otherwise stated.

Smoking

Factors related to smoking tobacco remain by far the most widely recognised. Virtually all respondents (95%) identify smoking tobacco products as increasing the risk of developing cancer, and 84% did so spontaneously, without any prompting. Recognition is also high for exposure to another person's smoke (77%), chewing tobacco (68%) and other forms of oral tobacco such as snus (64%).

Unlike in 2022, when no significant differences were found between smokers and non-smokers in their recognition of the cancer risks of smoking, smokers in 2026 were less likely to identify tobacco-related factors as increasing someone's chance of cancer. Ninety two per cent of smokers identify smoking tobacco products as increasing cancer risk (non-smokers: 96%), 72% identify exposure to another person's smoke (non-smokers: 79%) and 63% chewing tobacco (non-smokers: 70%).

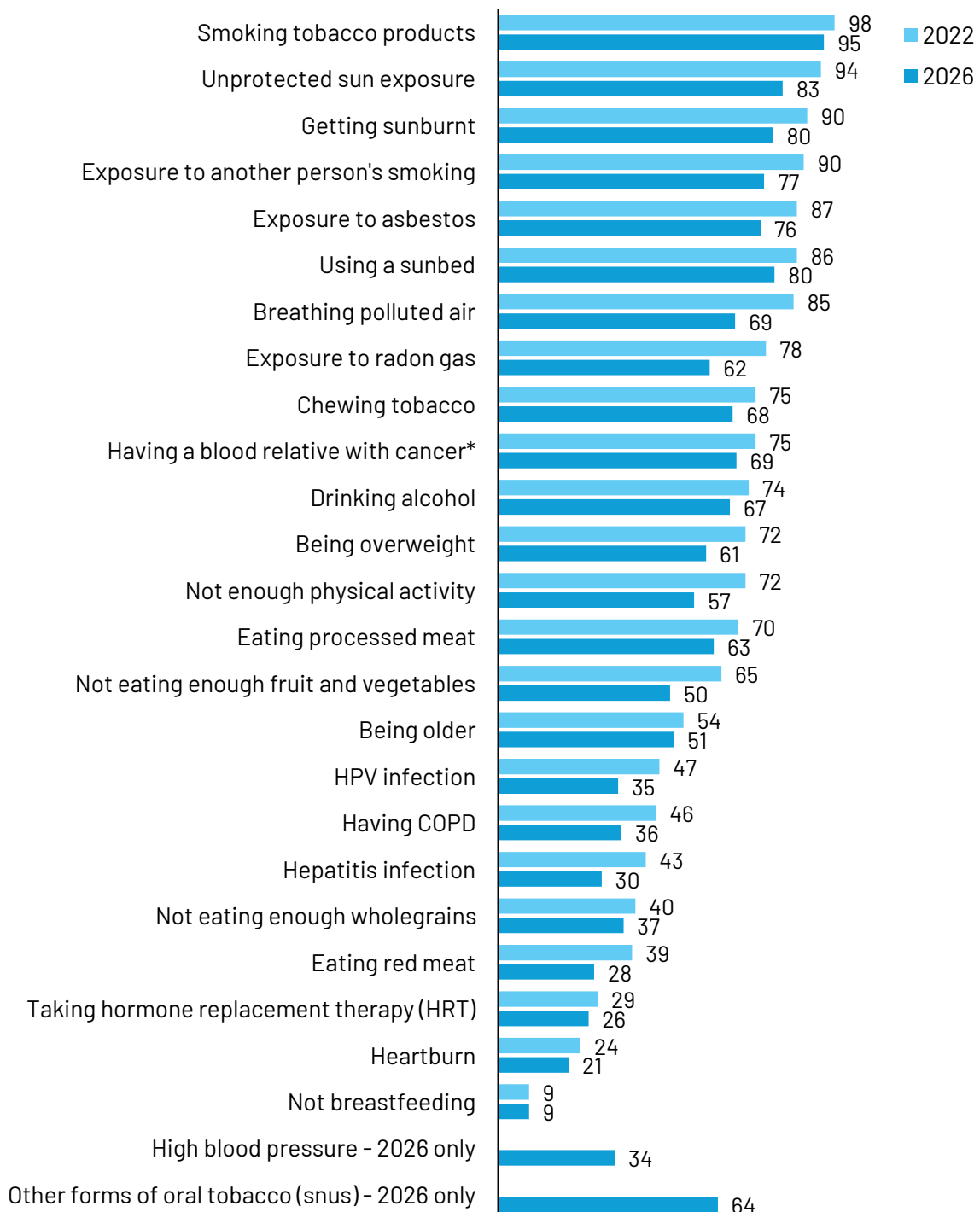
Sun exposure and other environmental factors

Factors related to ultraviolet radiation continue to rank highly. Unprotected sun exposure is identified by 83% of respondents, getting sunburnt by 80% and using a sunbed by 80%. Other environmental exposures are somewhat less well recognised. Seventy-six per cent identify exposure to asbestos, 69% breathing polluted air and 62% exposure to radon gas.

Figure 7. Awareness of cancer risk factors, 2022-2026

% who thought this could increase a person's chance of developing cancer

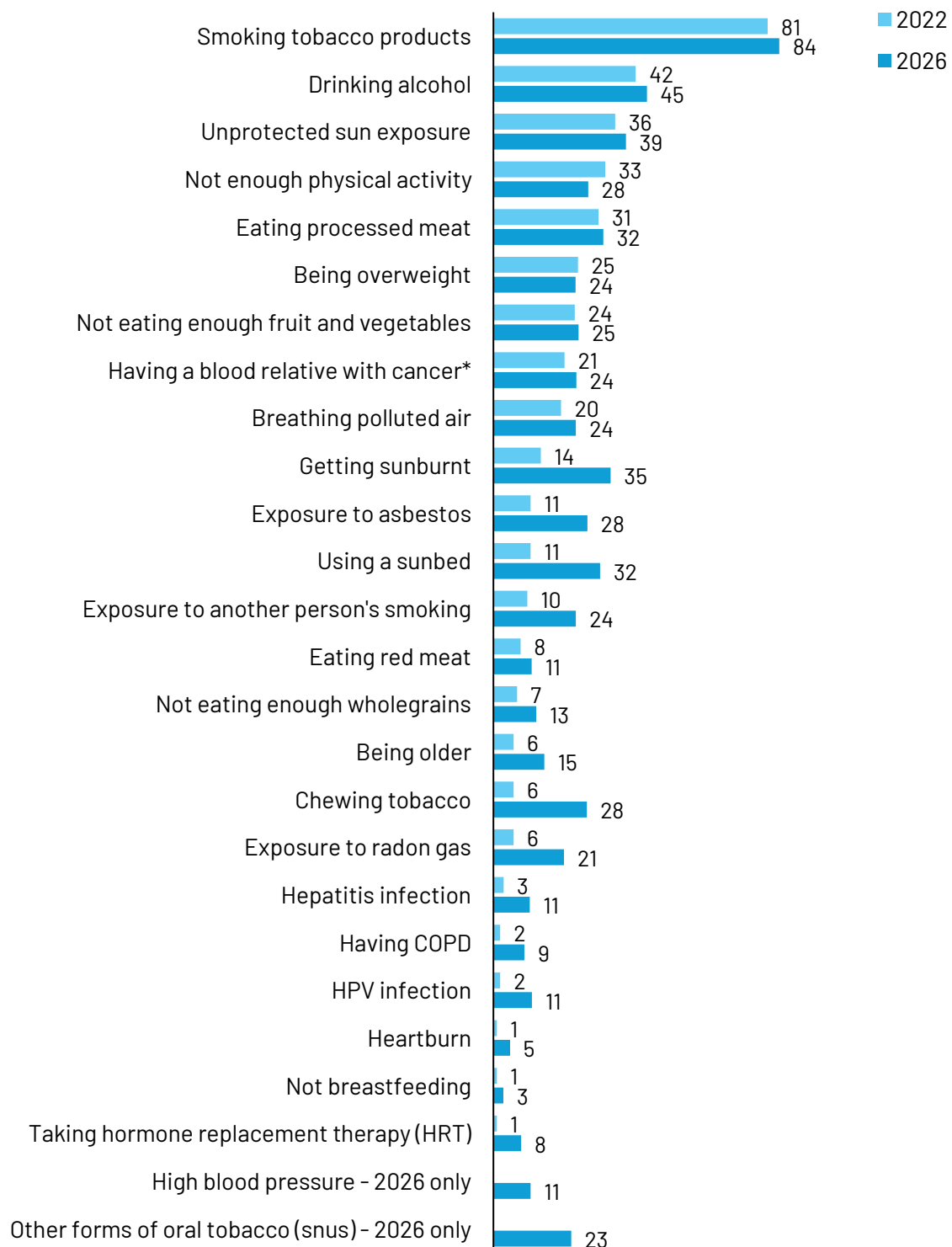
Results are a combination of spontaneous and prompted awareness



*Note: this was written as "having a close relative with cancer" in the 2022. COPD, chronic obstructive pulmonary disease.

Figure 8. Spontaneous awareness of cancer risk factors, 2022-2026

% who thought this could increase a person's chance of developing cancer



*Note: this was written as "having a close relative with cancer" in the 2022. COPD, chronic obstructive pulmonary disease.

Alcohol consumption

Around two thirds of respondents (67%) identify drinking alcohol as a cancer risk factor. As was the case in 2022, alcohol is notable as the only risk factor apart from smoking for which more people mention it spontaneously (45%) than identify it only when prompted (22%). This suggests that, where the link between alcohol and cancer is recognised at all, it is reasonably front of mind. As in 2022, drinking status was not associated with recognition of alcohol as a cancer risk factor, with 69% of those who drink weekly, 67% of those who drink less often and 67% of non-drinkers identifying it.

Diet and exercise

Recognition of dietary, weight and activity-related risk factors remains lower than many health-related factors. Around three in five identify eating processed meat (63%) and being overweight (61%) as a risk, while 58% identify low levels of physical activity and half (50%) not eating enough fruit and vegetables. Fewer identify not eating enough wholegrains (37%) or eating red meat (28%).

Those who said they eat five or more portions of fruit and vegetables a day were more likely to identify not eating enough fruit and vegetables as a risk factor (57%; less than five portions a day: 45%), and those who are physically active on five or more days a week are more likely to identify low levels of physical activity (62%; fewer than five days: 53%) and drinking alcohol (73%; fewer than five days: 62%).

Health conditions, medicines and treatments

Awareness of factors relating to health conditions, medicines and treatments is lower again. Half (51%) recognise that being older increases cancer risk, while around a third identify chronic obstructive pulmonary disease (36%), HPV infection (35%) and hepatitis infection (30%). Around a quarter identify taking hormone replacement therapy (26%) and a fifth heartburn (21%). 34% identify having high blood pressure could increase a person's chance of developing cancer.

Other factors

Awareness of other factors like being older (51%) and having a blood relative with cancer (69%) was modest, whereas only 9% thought not breastfeeding increased someone's chances of cancer.

Comparison between the 2022 and 2026 waves

A consistent pattern emerges when the 2022 and 2026 waves are compared. Spontaneous mentions have risen substantially for most risk factors, but the overall spontaneous and prompted response has decreased slightly for most factors. This combination of higher unprompted recall alongside lower overall selection could suggest that respondents are more discriminating in the factors they accept as cancer risks. However, it may also reflect differences in how the questions were administered between waves, with the face-to-face interviewing approach leading to less "yes" responses for prompted factors. Comparisons of total awareness across the two waves should therefore be treated with a degree of caution.

Demographic differences in awareness

As in 2022, differences by gender are relatively modest and are concentrated on a few notable factors (Table 6). Women are more likely than men to identify using a sunbed (84%; men: 77%), HPV infection (39%; men: 30%), taking hormone replacement therapy (31%; men: 22%) and having a blood relative with cancer (74%; men: 65%). Men are more likely to identify being overweight (64%; women: 58%), being older (55%; women: 48%) and breathing polluted air (72%; women: 67%). Notably, the gender gap observed in 2022 for alcohol has closed: 69% of men and 66% of women now identify drinking alcohol as a cancer risk factor, compared with 70% and 77% respectively in 2022.

Table 6. Awareness of selected cancer risk factors by gender, 2022–2026. Results are a combination of spontaneous and prompted awareness

	Men	Women
Using a sunbed	77	84
Having a blood relative with cancer	65	74
HPV infection	30	39
Taking hormone replacement therapy (HRT)	22	31
Not eating enough wholegrains	34	39
Being overweight	64	58
Being older	55	48
Breathing polluted air	72	67
Low levels of physical activity	59	55

Awareness of several risk factors also differed by age (Table 7). Recognition of most risk factors declined with age, with the widest gap found for HPV infection, identified by 44% of those aged 18 to 24 and only 21% of those aged 65 and older. Similar patterns were seen for other forms of oral tobacco (18–24: 71%; 65 and older: 55%), low levels of physical activity (18–24: 61%; 65 and older: 47%) and eating processed meat. The pattern is reversed for not eating enough wholegrains (65 and older: 43%; 18–24: 33%). Given that advancing age is itself the single largest risk factor for cancer, the generally lower awareness among older respondents remains an important target for communications.

Table 7. Awareness of selected cancer risk factors by age, 2022-2026. Results are a combination of spontaneous and prompted awareness

	18-24	25-34	35-44	45-54	55-64	65+
Smoking tobacco products	99	97	97	94	92	92
Other forms of oral tobacco (snus)	71	71	68	60	63	55
Exposure to asbestos	70	73	74	74	86	80
Drinking alcohol	71	67	73	68	65	61
Eating processed meat	60	71	65	67	60	54
Low levels of physical activity	61	58	63	58	57	47
Not eating enough wholegrains	33	34	32	37	39	43
HPV infection	44	43	43	35	29	21
Hepatitis infection	37	32	32	27	29	27
High blood pressure	56	40	33	27	28	30

Educational attainment was also associated with significant differences in awareness (Table 8). Those who left school before completing the Leaving Certificate reported lower awareness of almost every risk factor measured. The widest gap was found for eating processed meat (47%; post-Leaving Certificate: 74%), low levels of physical activity (44%; post-Leaving Certificate: 66%), other forms of oral tobacco (49%; post-Leaving Certificate: 74%), HPV infection (22%; post-Leaving Certificate: 45%) and being overweight (52%; post-Leaving Certificate: 68%). As noted elsewhere in this report, lower educational attainment is strongly correlated with age, so these findings should be interpreted alongside the age patterns described above.

Table 8. Awareness of selected cancer risk factors by educational attainment, 2022-2026. Results are a combination of spontaneous and prompted awareness.

	Less than Leaving Certificate	Leaving Certificate	Post-Leaving Certificate
Smoking tobacco products	89	96	98
Other forms of oral tobacco (snus)	49	64	74
Exposure to another person's smoking	67	78	84
Unprotected sun exposure	77	82	88
Exposure to radon gas	54	60	68
Drinking alcohol	63	62	75
Being overweight	52	59	68
Low levels of physical activity	44	57	66
Eating processed meat	47	62	74
Not eating enough fruit and vegetables	39	51	56
HPV infection	22	33	45

E-cigarettes

79% of respondents thought e-cigarettes and vapes increase a person's chance of developing cancer, of which 41% thought this spontaneously. This is up from 74% (8% spontaneous) in 2022. Younger adults were more likely to think e-cigarettes increase a person's chance of developing cancer, with 88% of those aged 18 to 24 thinking this, 50% of which thinking this spontaneously. This compares with 75% (34% spontaneous) of those aged 50 or older.

Belief in factors with no proven link to increase the risk of cancer

Several behaviours and exposures respondents mentioned and were prompted to assess have no proven association with cancer risk. The proportion of respondents identifying these behaviours and exposures as increasing cancer risk highlights the misperceptions that persist around cancer risk. 29% believe that using a mobile phone increases cancer risk and 22% think a blow to the breast will. Smaller proportions think drinking coffee (11%) and wearing a tight bra (10%) increases the risk of cancer.

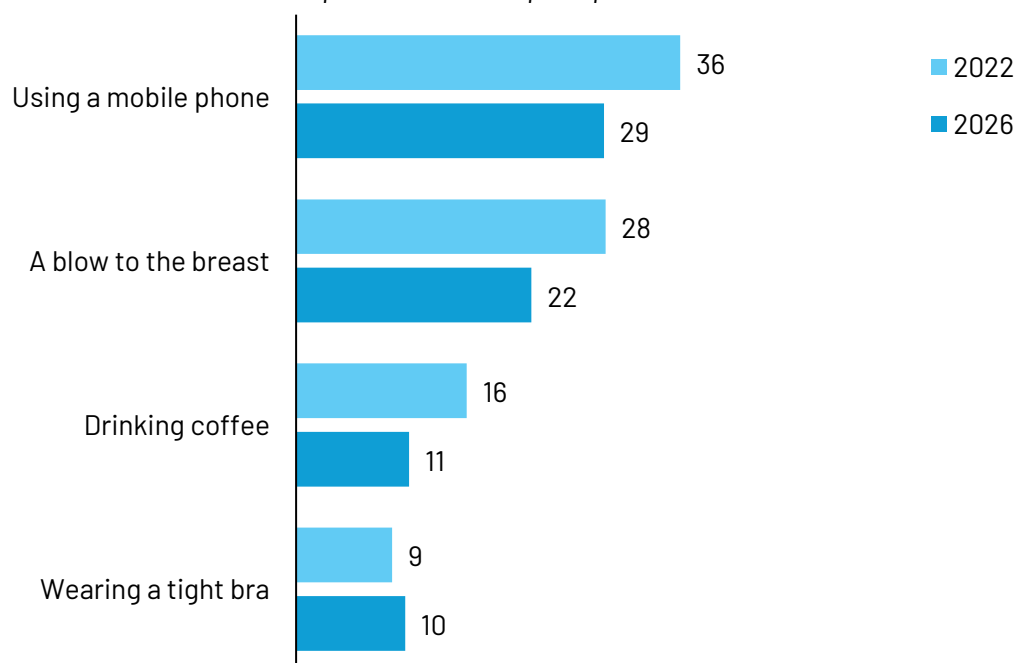
Encouragingly, most of these misperceptions have become less common since 2022. Belief that using a mobile phone increases cancer risk has fallen from 36% to 29%, that a blow to the breast does so from 28% to 22%, and that drinking coffee does so from 16% to 11%.

As in 2022, the factors relating to women's health attract higher levels of endorsement among women, although the gap has narrowed. A quarter of women (25%) incorrectly identify a blow to the breast as increasing cancer risk, compared with 18% of men, and 14% identify wearing a tight bra, compared with 7% of men. The equivalent figures for women in 2022 were 37% and 13%, respectively.

Figure 9. Belief in factors with no proven link to increase the risk of cancer, 2022-2026

% who thought this could increase a person's chance of developing cancer

Results are a combination of spontaneous and prompted awareness



Attitudes to Smoking and Cancer

The link between tobacco and cancer has been highly publicised for decades, and recognition of smoking as a cause of cancer remains near universal. To explore public understanding in more depth, respondents were presented with a series of statements about the link between smoking and cancer and asked to what extent they agreed or disagreed with each. Three statements were repeated from 2022, while two were introduced for the first time in 2026: "Quitting smoking at any time reduces your risk of developing cancer" and the incorrect statement "Smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter".

Public understanding of the multifaceted link between smoking and cancer remains strong. Eighty-five per cent agree that "Even if you don't smoke yourself, being exposed to other people's smoke can cause cancer". This is slightly lower than the 89% recorded in 2022. Eighty-six per cent agree that "A former smoker can get a cancer related to their smoking even a long time after quitting smoking" (2022: 83%), and 82% agree with the new statement that "Quitting smoking at any time reduces your risk of developing cancer".

As in 2022, a notable minority hold misperceptions about smoking. Around one in four (26%) agree with the incorrect statement that "Smoking can only cause cancer if you are a heavy smoker over a long period of time". This remains broadly unchanged from 2022 (27%). Just under three in ten (28%) agree with the new incorrect statement that smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter.

Figure 10. Attitudes towards smoking and cancer

% who agree or disagree with each statement

■ Don't know/
Prefer not to say ■ Strongly disagree ■ Somewhat disagree ■ Somewhat agree ■ Strongly agree

Smoking can only cause cancer if you are a heavy smoker over a long period of time



Quitting smoking at any time reduces your risk of developing cancer



Even if you don't smoke yourself, being exposed to other people's smoke can cause cancer



A former smoker can get a cancer related to their smoking even a long time after quitting smoking

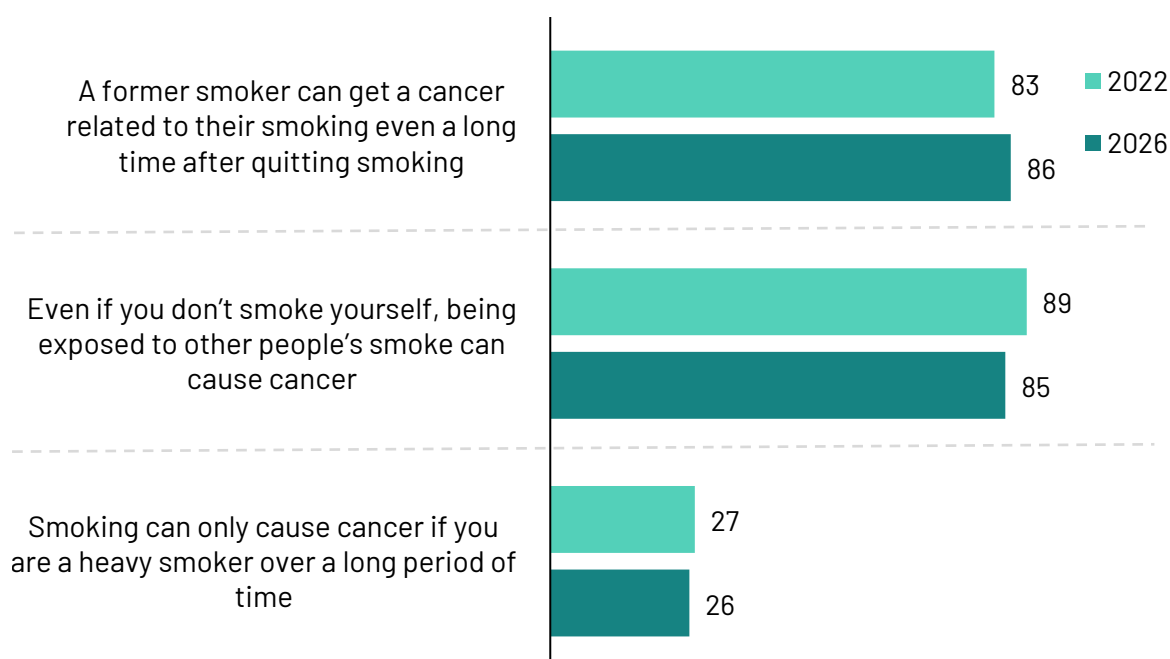


Smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter



Figure 11. Attitudes towards smoking and cancer, 2022-2026

% who strongly or somewhat agree with each statement



Some modest but significant differences were found by age (Table 9). Recognition that quitting smoking at any time reduces cancer risk is highest among those aged 18 to 24 (89%), while those aged 45 to 54 were the least likely to agree that smoking can only cause cancer if you are a heavy smoker over a long period of time (19%).

A divide was also found by education attainment level, with those with less than a Leaving Certificate being more likely to agree that only heavy, long-term smoking causes cancer (32%; post-Leaving Certificate: 20%), and being less likely to agree that second-hand smoke can cause cancer (78%; post-Leaving Certificate: 90%) or that quitting at any time reduces risk (74%; post-Leaving Certificate: 86%).

Table 9. Attitudes towards smoking and cancer by age (% who strongly or somewhat agree).

	18-24	25-34	35-44	45-54	55-64	65+
Smoking can only cause cancer if you are a heavy smoker over a long period of time	30	27	26	19	25	28
Quitting smoking at any time reduces your risk of developing cancer	89	83	81	80	81	80
Even if you don't smoke yourself, being exposed to other people's smoke can cause cancer	83	91	88	81	82	84
A former smoker can get a cancer related to their smoking even a long time after quitting smoking	93	89	88	84	84	83
Smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter	33	30	23	26	30	28

Some differences were also observed across HSE health regions (Table 9). Agreement that second-hand smoke can cause cancer was lowest in the HSE Dublin and Midlands region (78%) and highest in the Mid West (91%), while agreement that quitting at any time reduces risk is lowest in the Dublin and Midlands and Mid West regions (both 77%). Agreement with the incorrect filter statement ranged from 21% in Dublin and North East to 34% in the South West.

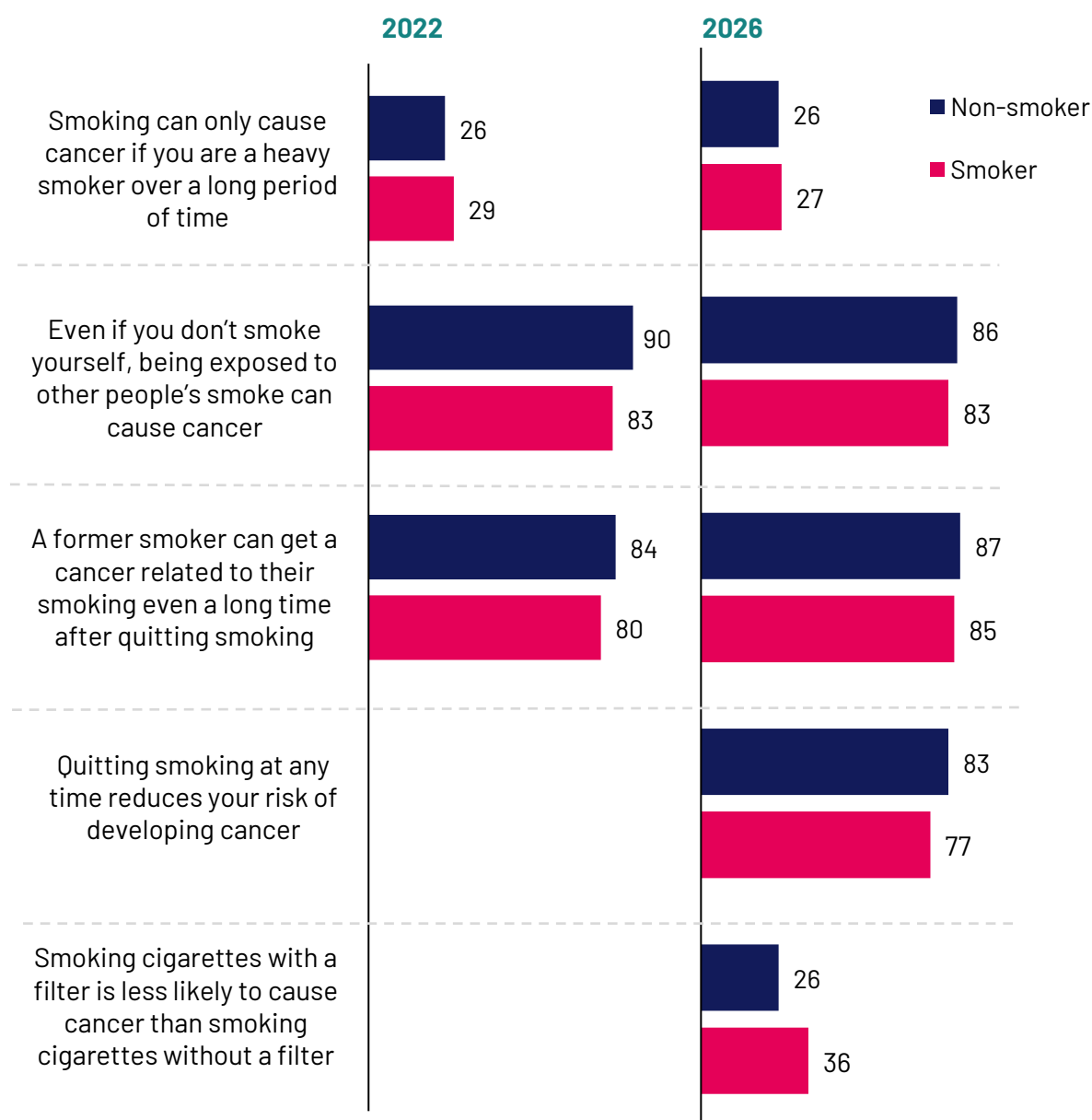
Table 10. Attitudes towards smoking and cancer by HSE Health region (% who strongly or somewhat agree).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Smoking can only cause cancer if you are a heavy smoker over a long period of time	28	31	24	25	21	22
Quitting smoking at any time reduces your risk of developing cancer	82	77	85	85	77	84
Even if you don't smoke yourself, being exposed to other people's smoke can cause cancer	88	78	89	82	91	85
A former smoker can get a cancer related to their smoking even a long time after quitting smoking	86	84	89	85	89	85
Smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter	21	29	31	34	24	30

As in 2022, smokers were somewhat less likely than non-smokers to perceive the link between smoking and cancer, although the differences remain small. Eighty-three per cent of smokers agree that second-hand smoke can cause cancer compared with 86% of non-smokers. This is a narrower gap than in 2022 (Smokers: 83%; non-smokers: 90%). Smokers were also less likely to agree that quitting smoking at any time reduces cancer risk (77%; non-smokers: 83%). The clearest difference relates to the new filter statement, where 35% of smokers incorrectly agreed that filtered cigarettes are less likely to cause cancer, compared with 26% of non-smokers.

Figure 12. Attitudes towards smoking and cancer by smoking status

% who strongly agree or somewhat agree with each statement



Attitudes to Alcohol and Cancer

There is strong scientific consensus on the link between alcohol consumption and cancer, with a direct causal link established between alcohol intake and at least seven types of cancer. Improving public knowledge of this link remains a public health priority, with the planned introduction of providing cancer warning labels on alcohol products as part of the Public Health (Alcohol) Act in 2028. As in 2022, respondents were presented with four statements about alcohol and health and asked to what extent they agreed or disagreed with each.

Beliefs about the link between alcohol and cancer continue to vary considerably across the population. Forty-three per cent agree that “Drinking any alcohol, even small amounts, increases the risk of developing cancer”, while a similar proportion (45%) disagree. In 2022, 50% agreed with the closely related statement that drinking alcohol, even moderately, increases the risk of developing cancer (37% disagreed). While the change in wording means this comparison should be treated with some caution, these findings confirm that substantial uncertainty about the alcohol–cancer link persists.

There are, however, some signs of modest improvement on the remaining statements. Forty per cent agree with the incorrect statement that “Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time”, down from 45% in 2022, with 50% of people now correctly disagreeing with this statement. Agreement that “Drinking a little alcohol is better for your health than not drinking any alcohol” has fallen from 39% in 2022 to 34%, and agreement that “Drinking alcohol is only bad for your health if you drink enough to get drunk” has fallen from 29% to 27%.

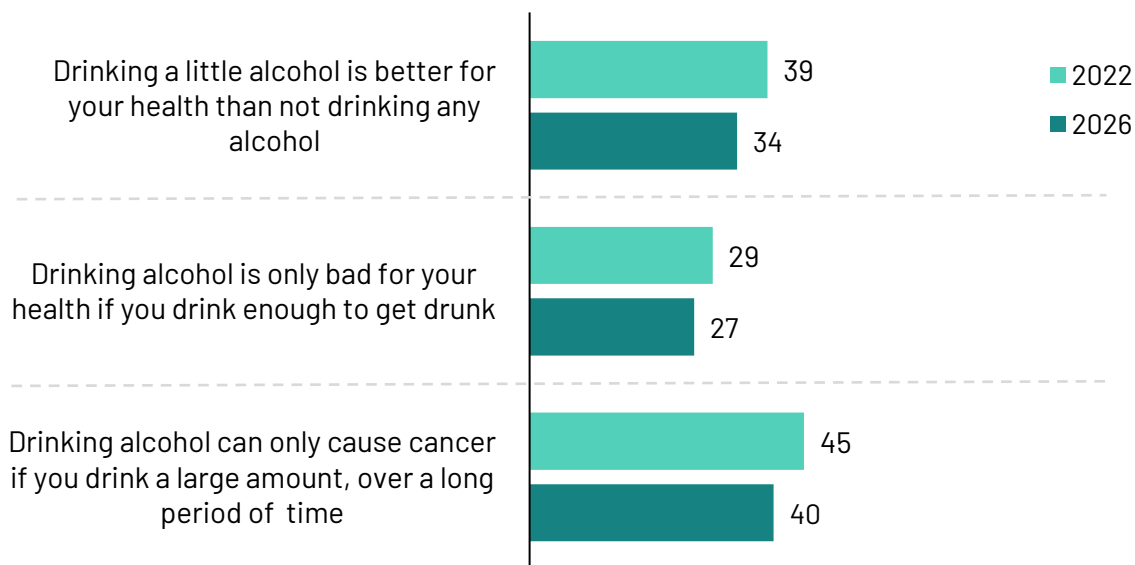
Figure 13. Attitudes towards alcohol and cancer

% who agree or disagree with each statement



Figure 14. Attitudes towards alcohol and cancer, 2022-2026

% who strongly agree or somewhat agree with each statement



As in 2022, the clearest demographic differences are by age and education (Table 11). A majority of those aged under 35 agree that drinking any alcohol, even small amounts, increases cancer risk (18-24: 55%; 25-34: 57%), compared with just 30% of those aged 65 and older. Older respondents are also markedly more likely to endorse the persistent myth that “drinking a little alcohol is better for your health than not drinking any alcohol”: 47% of those aged 65 and older agree that drinking a little alcohol is better for your health than not drinking any, compared with 23% of 18-24-year-olds. The educational divide observed in 2022 also persists: 53% of those with post-Leaving Certificate education agree that even small amounts of alcohol increase cancer risk, compared with 29% of those with less than a Leaving Certificate, while the latter group are more likely to agree that a little alcohol is better for health (43%; post-Leaving Certificate: 25%).

Table 11. Attitudes towards alcohol and cancer by age (% who strongly or somewhat agree)

	18-24	25-34	35-44	45-54	55-64	65+
Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time	45	39	37	35	37	46
Drinking alcohol is only bad for your health if you drink enough to get drunk	21	23	24	24	33	37
Drinking a little alcohol is better for your health than not drinking any alcohol	23	29	27	33	40	47
Drinking any alcohol, even small amounts, increases the risk of developing cancer	55	57	48	39	33	30

Some notable differences were also found across HSE health regions (Table 12). Agreement with the incorrect statement that only heavy, long-term drinking causes cancer is highest in the West and North West (44%) and Dublin and North East (43%) regions and lowest in the Mid West (32%) and South West (33%). Those living in the West and North West were also the most likely to agree that a little alcohol is better for health than none (43%; Dublin and North East: 28%), and the least likely to agree that any alcohol, even in small amounts, increases cancer risk (38%; Dublin and South East: 47%).

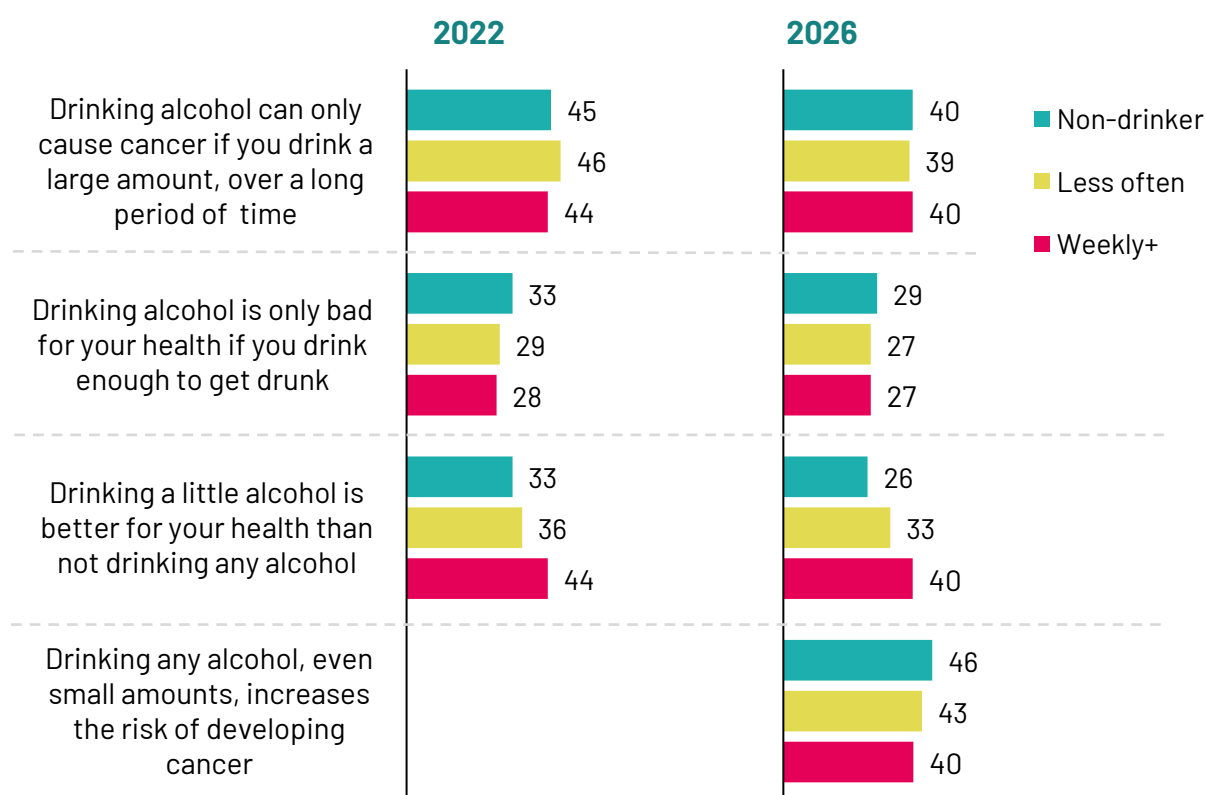
Table 12. Attitudes towards alcohol and cancer by HSE Health region (% who strongly or somewhat agree).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time	43	37	42	33	32	44
Drinking alcohol is only bad for your health if you drink enough to get drunk	29	30	26	25	23	29
Drinking a little alcohol is better for your health than not drinking any alcohol	28	33	35	38	28	43
Drinking any alcohol, even small amounts, increases the risk of developing cancer	44	40	47	42	44	38

Consistent with 2022, drinking status remains a weak indicator of attitudes towards the health effects of alcohol, with differences that are small and run in conflicting directions across the four statements. The clearest gap concerns the perceived benefits of light drinking, where 40% of those who drink alcohol weekly agreed that a little alcohol is better for your health than not drinking any, compared with 33% of those who drink less often and 26% of non-drinkers. On the remaining statements, differences between drinkers and non-drinkers are minimal, underlining that uncertainty about the health effects of alcohol exists among drinkers and non-drinkers alike.

Figure 15. Attitudes towards alcohol and cancer by frequency of alcohol consumption, 2022-2026

% who strongly agree or somewhat agree with each statement



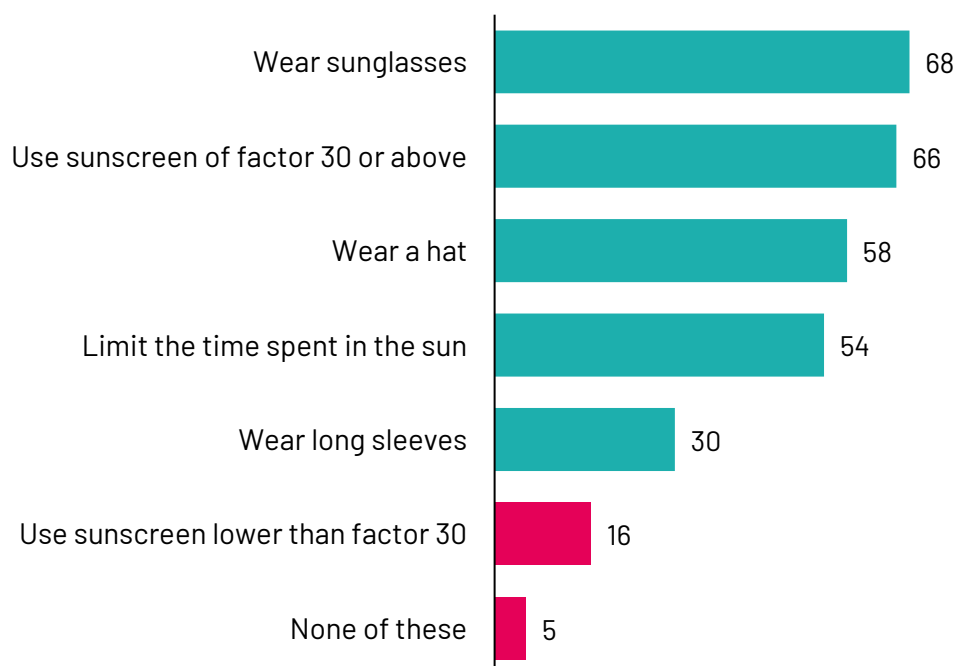
Sun Protection

Factors related to exposure to ultraviolet radiation remain among the most highly recognised cancer risk factors. As in 2022, the survey therefore included a question measuring the extent to which respondents take action to reduce this risk, asking which, if any, sun protection methods they use frequently during the summer in Ireland. The response categories were refined in 2026, splitting out wearing long sleeves, a hat and sunglasses into separate response options instead of a single category as in 2022. In addition, a new category of sunscreen lower than factor 30 was added to estimate the proportion of people who use sunscreen less than the recommended 30 or above factor level. These response option changes mean direct comparisons with 2022 should be made with caution.

The overwhelming majority (95%) report using at least one form of sun protection frequently during the Irish summer. Wearing sunglasses is the most commonly reported method (68%), followed by using sunscreen of at least factor 30 (66%), wearing a hat (58%), limiting time spent in the sun (54%) and wearing long sleeves (30%). A further 16% report using sunscreen of lower than factor 30. Reported use of the measures that are comparable across the two waves has declined slightly.

Figure 16. Sun protection methods

% who report frequently using this method of sun protection during the summer in Ireland



Some notable demographic differences were found for sun protection behaviour. Gender differences were largest for sunscreen use, with 74% of women reporting using sunscreen of at least factor 30 compared with 58% of men. Women were also more likely to limit their time in the sun (60%; men: 47%). Men (7%) were more likely than women (2%) to report using none of the methods listed.

Those aged 65 and older were less likely than younger respondents to use sunscreen of at least factor 30 (58%, falling to 50% among those aged 75 and older). But those aged 65 or older are also more likely to report limiting their time in the sun (64%), wearing a hat (67%) or wearing long sleeves (40%) (Table 13).

Table 13. Sun protection method usage by age (%).

	18-24	25-34	35-44	45-54	55-64	65+
Limit the time spent in the sun	43	48	54	55	53	64
Wear long sleeves	19	21	33	30	29	40
Wear a hat	44	54	58	59	61	67
Wear sunglasses	68	72	73	70	61	62
Use sunscreen of factor 30 or above	63	70	71	71	64	58
Use sunscreen lower than factor 30	18	12	16	18	21	13
None of these	5	4	4	6	5	4
Don't know	0	1	0	0	0	1

Across HSE health regions (Table 14), use of sunscreen of at least factor 30 was highest in the Dublin and South East region (74%) and lowest in the West and North West (59%), while those in Dublin and South East region were also the least likely to report using none of the methods listed (2%).

Table 14. Sun protection method usage by HSE Health region (%).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Limit the time spent in the sun	48	53	61	56	53	53
Wear long sleeves	29	28	28	32	31	33
Wear a hat	60	46	64	65	62	56
Wear sunglasses	68	60	74	68	67	69
Use sunscreen of factor 30 or above	67	65	74	62	70	59
Use sunscreen lower than factor 30	16	10	16	19	17	18
None of these	6	6	2	4	6	5
Don't Know	0	0	1	0	0	1
Refused	0	0	0	0	0	0

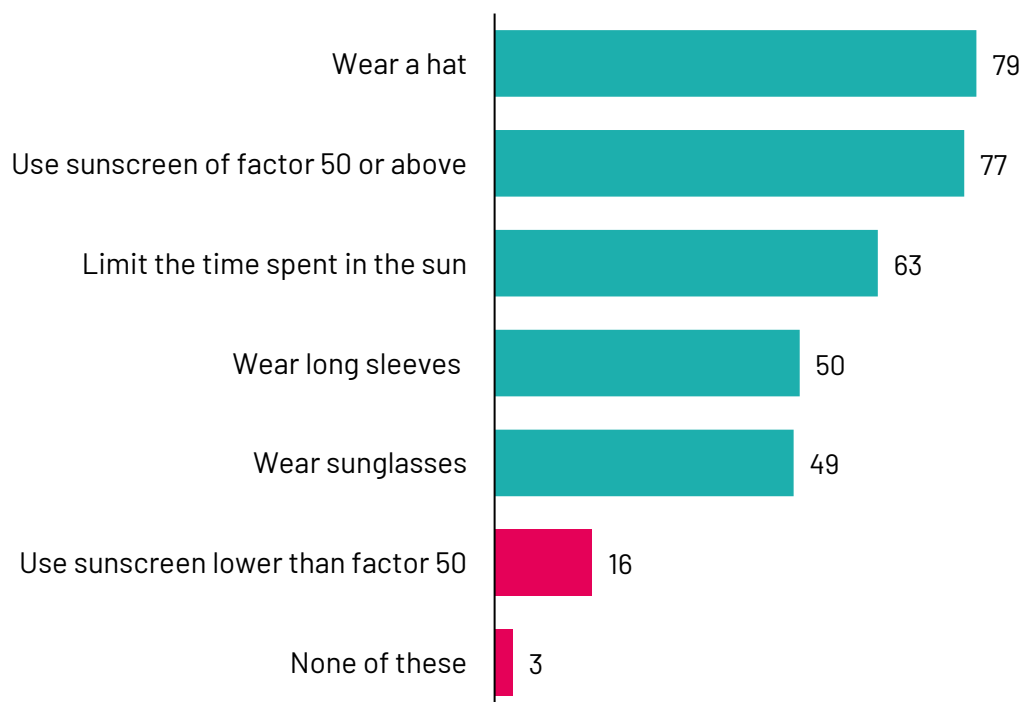
Child's Sun Protection

Just over a quarter of respondents (28%) are the parent or guardian of a child aged under 12. As in 2022, this group was asked which sun protection methods they use frequently during the summer in Ireland to protect their child, with the same refined response categories as above, except the sunscreen factor level is set at 50 or above instead of 30 to reflect the differing recommendations for adults and children.

Almost all parents and guardians (97%) report using at least one form of sun protection for their child. Wearing a hat is the most commonly reported method (79%), followed by using sunscreen of at least factor 50 (77%), limiting the child's time in the sun (63%), wearing long sleeves (50%) and wearing sunglasses (49%). Sixteen per cent of parents or guardians say their child uses sunscreen lower than factor 50.

Figure 17. Sun protection methods used by children

% who report their child frequently uses this method of sun protection during the summer



Reported use of sunscreen of at least factor 50 for children is highest in the Mid West (88%) and Dublin and South East (85%) regions and lowest in the South West (74%) and Dublin and North East (70%) regions (Table 15).

Table 15. Sun protection methods used for children by HSE health region (%)

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Limit the time spent in the sun	67	62	62	58	67	60
Wear long sleeves	51	57	44	51	47	48
Wear a hat	79	70	91	81	73	81
Wear sunglasses	53	46	59	45	48	39
Use sunscreen of factor 50 or above	70	75	85	74	88	79
Use sunscreen lower than factor 50	16	13	20	23	11	17
None of these	4	4	1	1	1	3

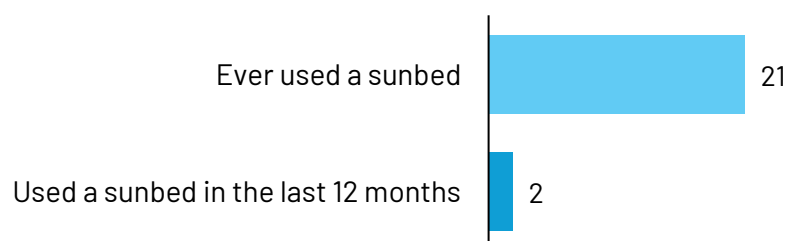
Sunbed Use

Sunbed use is an established cause of skin cancer, including melanoma, with ultraviolet-emitting tanning devices classified by the International Agency for Research on Cancer as carcinogenic to humans. The 2026 survey therefore included some additional questions on sunbed use.

Overall, one in five respondents (21%) report having ever used a sunbed. Among those who have ever used a sunbed, 11% report having done so in the past 12 months, equivalent to around 2% of all adults.

Figure 18. Sunbed use

% who have ever used a sunbed



Women (30%) are almost three times as likely as men (11%) to have ever used a sunbed, with 4% of women and 1% of men having used one in the past 12 months (Table 16). The proportion who have ever used a sunbed was highest among those aged 55 to 64 (30%), whereas use within the last 12 months was highest among those aged 25-34 year (5%).

Table 16. Sunbed use by gender and age (%).

	Men	Women	18-24	25-34	35-44	45-54	55-64	65+
Ever used a sunbed	11	30	12	20	22	28	30	12
Used a sunbed in the last 12 months	1	4	4	5	3	1	1	<1

Ever use of sunbeds was highest in the HSE Dublin and North East region (27%) and lowest in the West and North West (17%)(Table 17). Use in the past 12 months was highest in the Mid West region (5%).

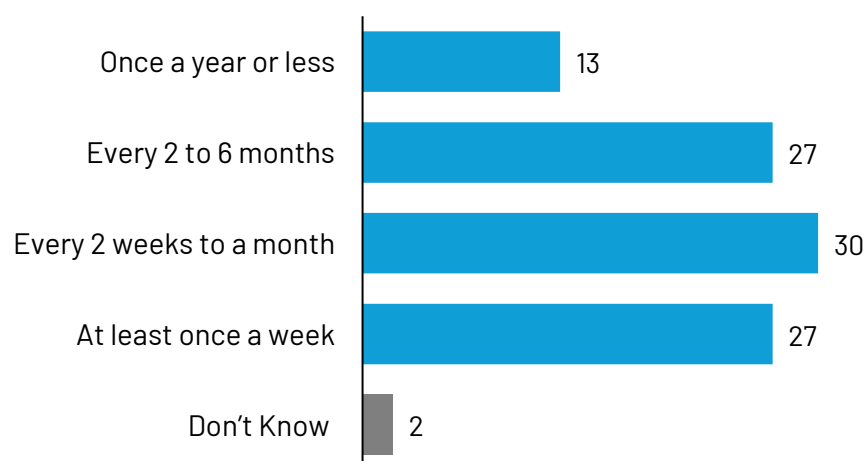
Table 17. Sunbed use by HSE health region (%).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Ever used a sunbed	27	19	19	21	21	17
Used in last 12 months	2	3	1	2	5	1

Among those who used a sunbed in the past 12 months, 57% report using one at least monthly (Figure 19). It is important to note that the small base size (n=63) for this question means the finding should be treated as indicative only.

Figure 19. Usage frequency among sunbed users

% usage frequency of those that have use a sunbed in the last 12 months (n=63)



Support for a Ban on Sunbeds

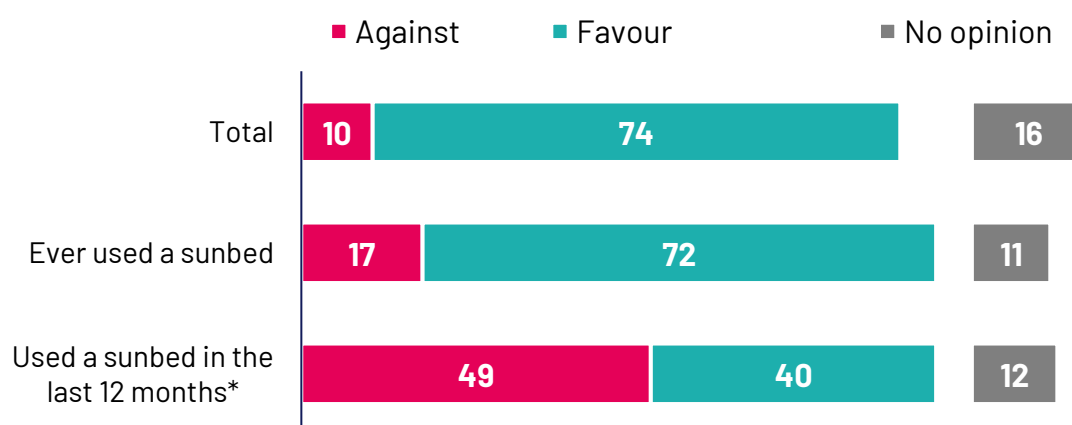
Given the established link between sunbed use and skin cancer and considering ongoing policy discussions regarding further restrictions on commercial sunbed use, a new question was included in the 2026 survey to assess public support for a potential ban on commercial sunbeds in Ireland. To ensure respondents had some context on existing legislation and current policy considerations, they were first read the following statement:

"In 2014, the Irish Government made it illegal for people under the age of 18 to use sunbeds. The Government is now considering the introduction of a total ban on commercial sunbed use in Ireland."

Respondents were then asked whether they would be in favour or against a total ban on commercial sunbed use. Three quarters (74%) of respondents said they would be in favour of a total ban on commercial sunbeds, with 10% against and 16% expressing no opinion. Notably, even among those who have ever used a sunbed, 72% say they are in favour of a total ban. However, support is far lower among those who have used a sunbed in the past 12 months (40%

Figure 20. Support for a ban on sunbeds

% who would be in favour or against a total ban on commercial sunbed use in Ireland



*Small base size (n=63)

Support is higher among women (77%; men: 71%), those aged 65 and older (79%) and those who were born in Ireland (78%; not born in Ireland: 61%). Support was lower among those aged 18-34 (18-24: 64%; 25-34: 67%) and smokers (68%).

Support varied slightly by HSE health regions, ranging from 68% in the Mid West to 78% in the Dublin and North East and Dublin and South East regions (Table 18).

Table 18. Attitudes to a total ban on commercial sunbed use by HSE health region (%).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Favour	78	71	78	69	68	74
Against	8	12	8	12	14	11
No opinion	13	17	14	19	18	15

Usage of injections, nasal sprays or tablets to help get a tan

Respondents were also asked, for the first time, whether they have ever used injections, nasal sprays or tablets to help get a tan. Reported use of these products was very low, with just 1% of respondents saying they have ever done so, with no meaningful variation by gender, age, education or region. Use was more common among those who have used a sunbed in the past 12 months (12%), although this is based on a small number of respondents.

Awareness of Radon

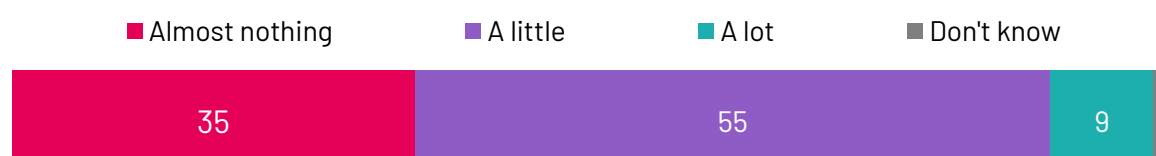
Radon is a naturally occurring radioactive gas and is the second largest cause of lung cancer in Ireland after smoking. A series of new questions on radon was introduced in 2026 to establish baseline levels of public awareness of radon. Just over half of respondents (54%) report having heard of radon before the day of the interview. Perceived understanding of radon among those who have heard of it was limited. Only 9% of this group say they know a lot about radon, while 55% say they know a little and 35% say they know almost nothing.

Figure 21. Awareness and understanding of radon

% who have heard of radon and their level of understanding



% of those aware of radon who say they know a lot, a little or almost nothing about it (n=1714)



Awareness of radon is higher among men (62%) compared to women (46%). Awareness also increased with age, with 31% of those aged 18-24 years having heard of radon, compared with 63% of those aged 45 and older. Awareness is also higher among those born in Ireland (58%; not born in Ireland: 39%) and those with post-Leaving Certificate education (59%; less than Leaving Certificate: 50%) (Table 19). Men who have heard of radon are more likely than women to say they know at least a little about it (a lot or a little: 70%; women: 57%).

Table 19. Percentage (%) who have heard of radon by demographic characteristics.

Gender	%
Men	62
Women	46
Age	
18-24	31
25-34	41
35-44	52
45-54	64
55-64	64
65+	63
Education	
Less than Leaving Certificate	50
Leaving Certificate	51
Post-Leaving Certificate	59
Country of birth	
Ireland	58
Not Ireland	39

Awareness of radon varies considerably across HSE health regions (Table 20). It was highest in the HSE South West region (66%) and West and North West (65%), regions that contain many of the areas of the country with the highest radon levels, and lowest in the Dublin and Midlands region (36%).

Table 20. Awareness of radon and perceived understanding by HSE health region (%).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Heard of radon	54	36	55	66	54	65
<i>Perceived understanding of radon among those that have heard of it</i>						
A lot	8	6	11	9	4	14
A little	57	64	58	49	47	51
Almost nothing	35	27	31	41	47	34
Don't know	<1	3	<1	1	2	<1

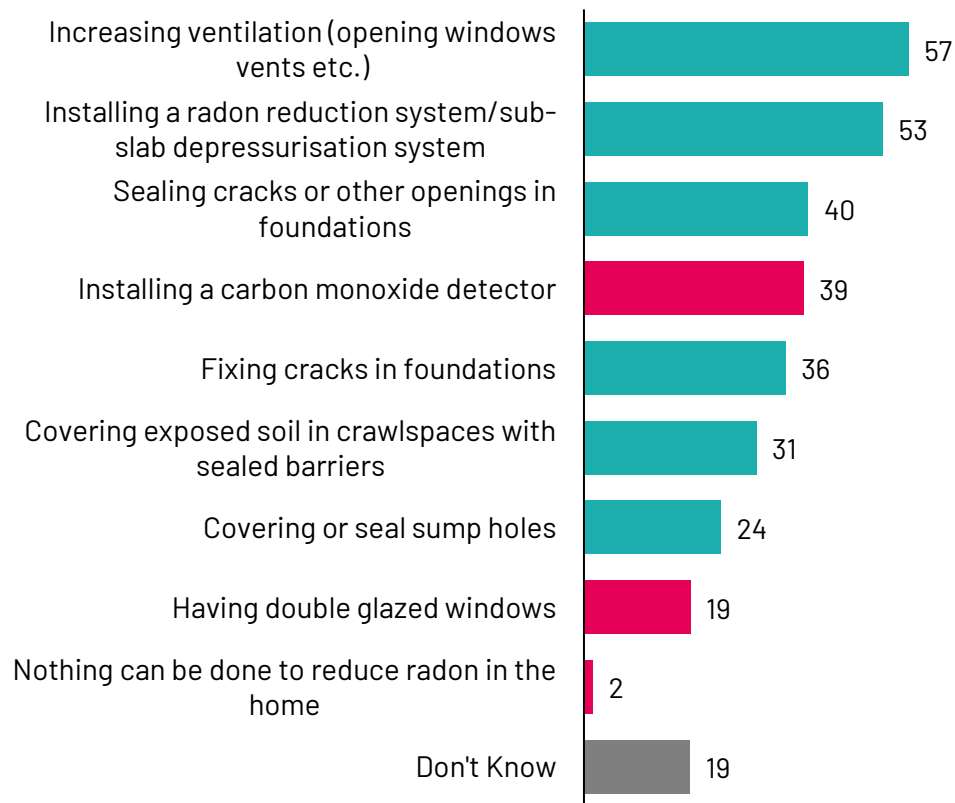
Awareness of Measures to Reduce Radon

Those who had heard of radon were then asked which, if any, of a list of measures they think can help reduce radon in a home. Increasing ventilation was the most commonly identified measure (57%), followed by installing a radon reduction system or sub-slab depressurisation system (53%), sealing cracks or other openings in foundations (40%), fixing cracks in foundations (36%), covering exposed soil in crawlspaces with sealed barriers (31%) and covering or sealing sump holes (24%).

Two common misperceptions were also evident. Thirty-nine per cent believe that installing a carbon monoxide detector can help reduce radon in the home, and 19% believe that having double glazed windows can do so, neither of which are effective measures to reduce radon in the home. A further 19% said they don't know, while 2% believe that nothing can be done to reduce radon in the home.

Figure 22. Awareness of ways to reduce radon in the home

% who believe each action can reduce radon in a home



Knowledge of effective measures to reduce radon in the home are highest in the West and North West and Dublin and South East HSE Health regions (Table 21).

Table 21. Perceived measures to reduce radon in the home by HSE health region (%; base: those who have heard of radon).

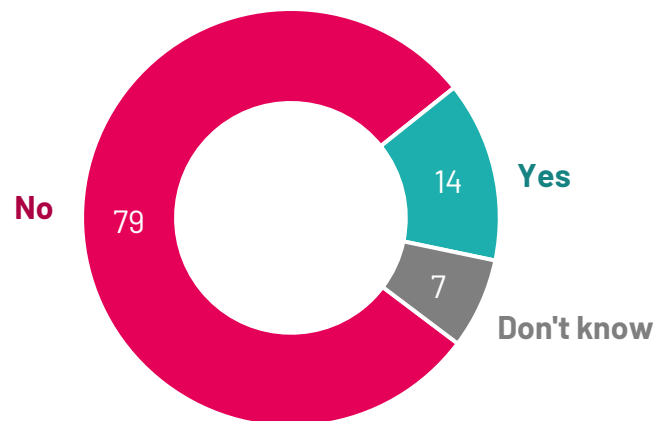
	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Increasing ventilation (opening windows vents etc.)	58	57	63	47	49	65
Sealing cracks or other openings in foundations	37	37	45	31	37	50
Installing a radon reduction system/sub-slab depressurisation system	46	51	65	37	47	69
Covering exposed soil in crawlspaces with sealed barriers	26	27	39	23	27	39
Installing a carbon monoxide detector	30	34	44	44	36	44
Having double glazed windows	17	14	22	17	18	23
Covering or seal sump holes	22	21	30	17	21	33
Fixing cracks in foundations	40	24	41	21	41	46
Nothing can be done to reduce radon in the home	1	1	2	2	1	2
Don't Know	21	26	15	20	25	11

Tested Home for Radon

Those who had heard of radon were also asked whether they or someone else in their household had tested their current home for radon. Fourteen per cent report that their home has been tested, with 79% saying their home had not been tested and the remaining 7% stating that they don't know if it had or not.

Figure 23. Tested home for radon

% who have tested their current home for radon



Home testing for radon is more common among those with post-Leaving Certificate education (18%; less than Leaving Certificate: 11%) and among those who say they know a lot about radon (41%).

Reported testing is highest in the South West and West and North West HSE Health regions (both 19%) and lowest in the Dublin and North East region (7%) (Table 22).

Table 22. Percentage (%) whose household has tested their current home for radon by HSE health region (base: those who have heard of radon).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Yes	7	11	16	19	12	19
No	90	80	78	74	78	72
Don't know	3	9	6	7	10	9

Awareness of Cancer Signs and Symptoms

A key goal of this study is to monitor public awareness of cancer warning signs and symptoms, and to monitor how people would respond should they notice a potential sign or symptom of cancer. This information will inform interventions to improve the early diagnosis of cancer in Ireland. As this survey repeats the 2022 baseline, results throughout this section are compared with those of the previous wave, allowing changes in awareness and health-seeking behaviour over the past four years to be identified.

The survey included a number of questions aimed at gauging awareness of cancer warning signs and symptoms, how respondents would react if they were to notice a potential sign or symptom of cancer, as well as attitudes towards, and barriers to, attending a GP.

Awareness of Cancer Warning Signs and Symptoms

Respondents were first asked to name as many cancer warning signs and symptoms as they could think of, before being presented with a list of cancer signs and symptoms and asked whether they thought each could indicate cancer. The results reported here combine spontaneous and prompted responses to give total awareness of each sign or symptom (Figure 24).

As in 2022, most cancer warning signs achieve high levels of recognition once respondents are prompted, with most of the signs and symptoms listed identified by at least three-quarters of respondents. The most widely recognised warning signs remain unexplained lumps or bumps (97%; 2022: 98%), coughing up blood (94%; 2022: 97%), unexplained bleeding (92%; 2022: 96%) and a change in the appearance of a mole (91%; 2022: 97%).

Comparison between the 2022 and 2026 waves

A similar pattern to that observed for the awareness of cancer risk factors is evident when awareness of cancer warning signs and symptoms is compared across survey waves. Spontaneous awareness has increased for many symptoms, suggesting that knowledge of cancer warning signs is becoming more top-of-mind among the public.

The largest increases in spontaneous awareness are observed for symptoms such as losing your appetite (34%, up from 14% in 2022), persistent unexplained pain (49%, up from 39%), a change in bowel habit (42%, up from 30%), unexplained weight loss (39%, up from 24%), unexplained bruising (25%, up from 7%) and difficulty swallowing (27%, up from 10%). Awareness of a number of less recognised symptoms has also increased notably from a low base, including unexplained night sweats (15%, up from 3%), feeling full very quickly (16%, up from 3%), heartburn or indigestion (13%, up from 4%) and unexplained ulcers inside the mouth (18%, up from 4%).

However, overall awareness based on the combined spontaneous and prompted measure has declined slightly for many symptoms. As with awareness of cancer risk factors, the

combination of higher spontaneous recall alongside slightly lower overall awareness may suggest that respondents are becoming more selective in the symptoms they associate with cancer. However, it may also reflect the change in survey methodology between waves, from telephone interviewing in 2022 to face-to-face interviewing in 2026, which may have reduced agreement with prompted items. Comparisons of total awareness between the two waves should therefore be interpreted with some caution.

Figure 24. Awareness of cancer warning signs and symptoms, 2022-2026

% who thought this is a warning sign or symptom of cancer

Results are a combination of spontaneous and prompted responses

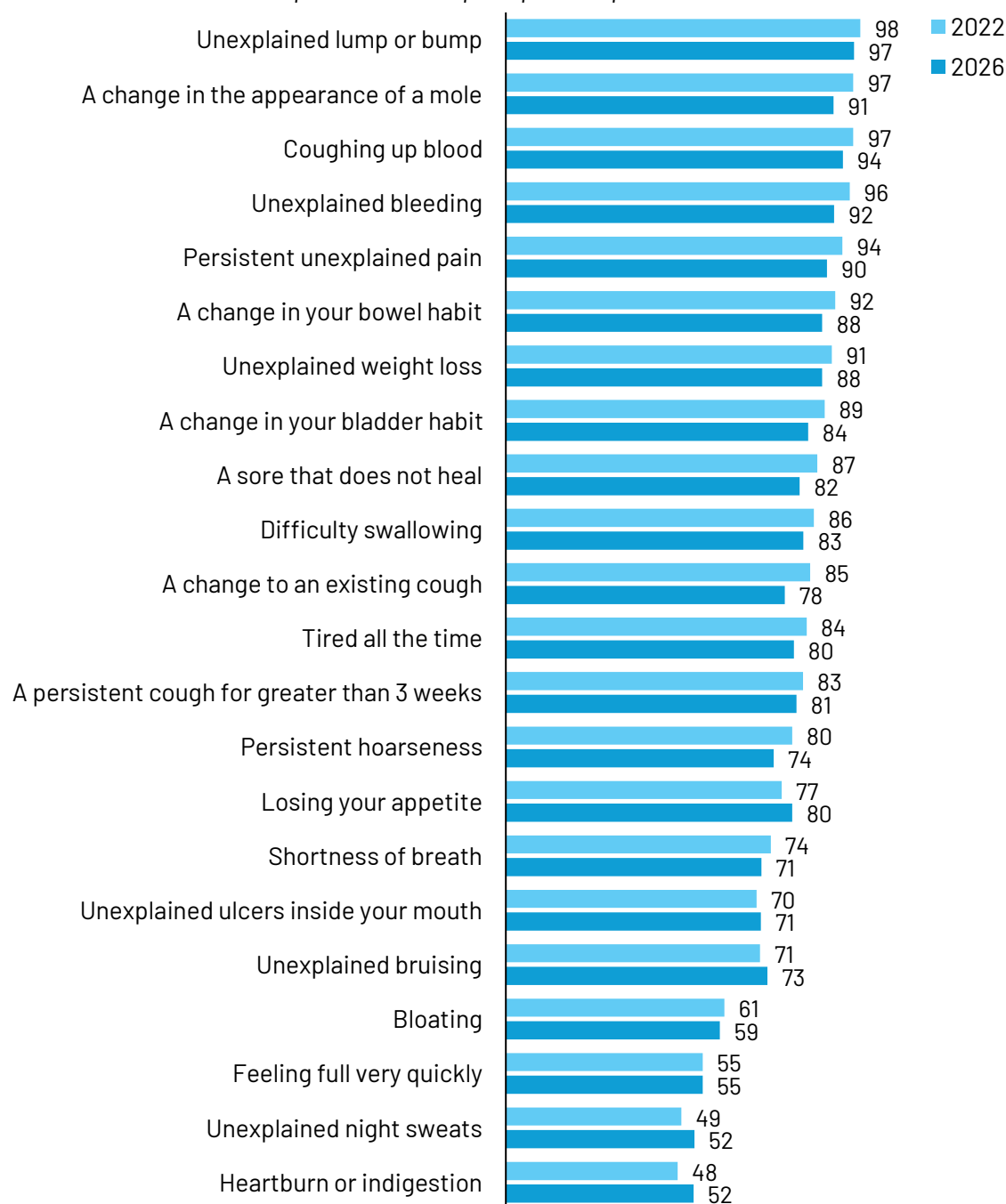
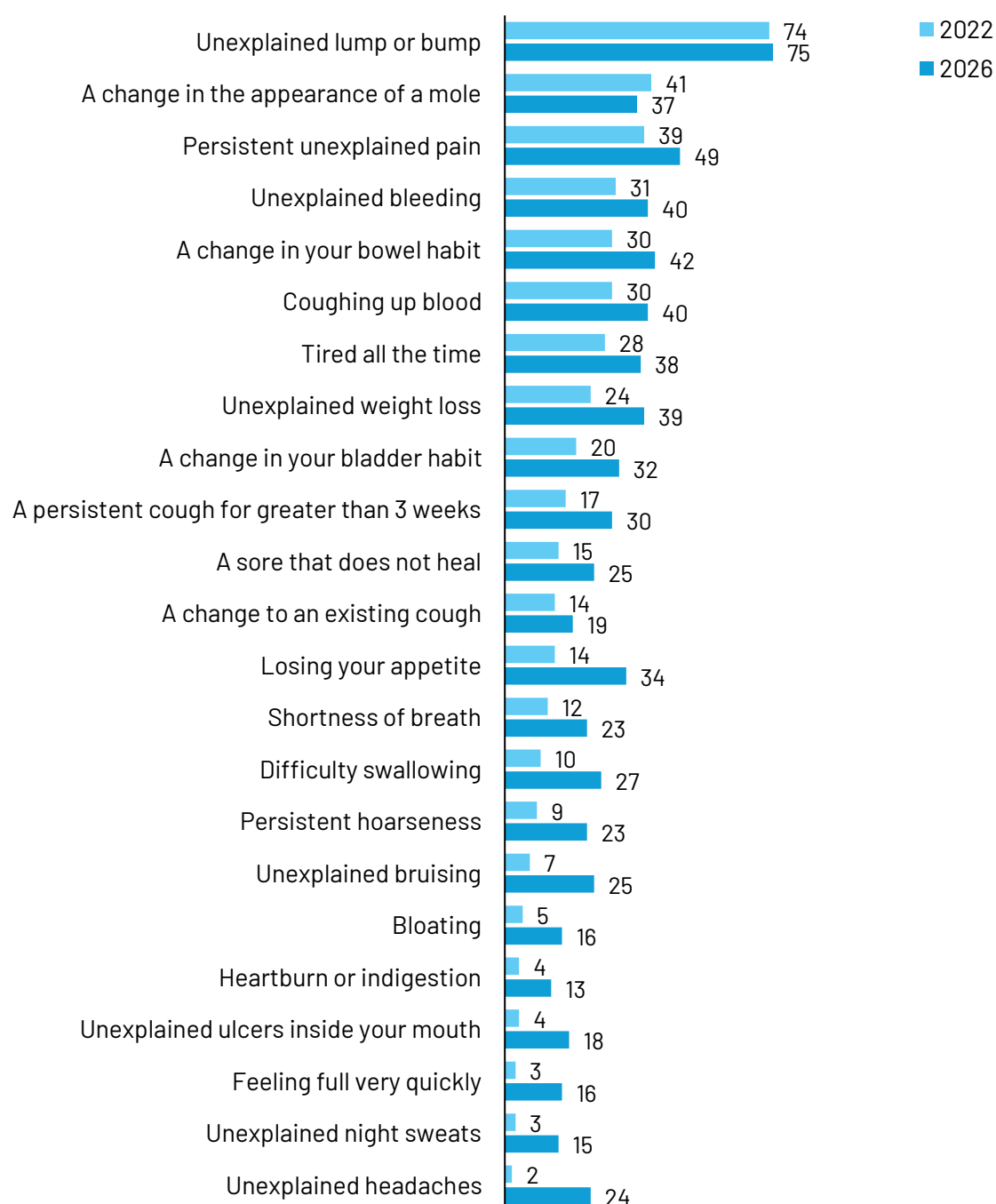


Figure 25. Spontaneous awareness of cancer warning signs and symptoms, 2022-2026

% who spontaneously thought this is a warning sign or symptom of cancer



As in 2022, the main demographic differences in the ability to identify cancer warning signs and symptoms is gender, with women more likely than men to correctly identify many signs and symptoms (Table 23). The most notable gender gaps are for unexplained bruising (women: 77%; men: 68%), feeling full very quickly (women: 60%; men: 50%), bloating (women: 63%; men: 55%), heartburn or indigestion (women: 55%; men: 49%), difficulty swallowing (women: 86%; men: 80%) and persistent hoarseness (women: 77%; men: 71%).

Comparison by age shows that those in the oldest age group (aged 75 and older) remain less likely to correctly identify several signs or symptoms of cancer, including unexplained mouth ulcers (65%), shortness of breath (67%), heartburn or indigestion (46%) and unexplained night sweats (49%). It is notable, however, that two of the gaps observed in 2022 have narrowed considerably. Awareness of being tired all the time (83%) and unexplained bruising (73%) among those aged 75 and older is now in line with the population average (2022: 77% and 64%, respectively). As advancing age is the leading risk factor for cancer, it remains important to address the lower levels of awareness among older people where they persist.

Table 23. Awareness of various cancer warning signs and symptoms by gender and age (% identifying each as a possible sign of cancer, spontaneous and prompted combined).

	Total	Male	Female	Under 50	50-64	65-74	75+
Unexplained lump or bump	97	97	97	97	98	96	97
Coughing up blood	94	93	95	93	97	95	93
Unexplained bleeding	92	91	92	90	94	91	94
A change in the appearance of a mole	91	89	94	89	95	92	93
Persistent unexplained pain	90	88	91	90	91	87	89
A change in your bowel habit	88	86	90	87	91	89	85
Unexplained weight loss	88	86	90	86	90	89	92
A change in your bladder habit	84	84	84	83	85	88	86
Difficulty swallowing	83	80	86	79	88	88	83
A sore that does not heal	82	79	84	79	84	88	84
A persistent cough for greater than 3 weeks	81	81	81	78	85	83	85
Tired all the time	80	78	83	80	80	80	83
Losing your appetite	80	78	82	78	83	80	80
A change to an existing cough	78	76	80	74	83	81	82
Persistent hoarseness	74	71	77	71	79	79	79
Unexplained bruising	73	68	77	73	72	73	73
Shortness of breath	71	69	72	70	74	71	67
Unexplained ulcers inside your mouth	71	70	71	72	70	67	65
Bloating	59	55	63	57	64	65	55
Feeling full very quickly	55	50	60	53	57	58	61
Unexplained night sweats	52	50	54	53	52	51	49
Heartburn or indigestion	52	49	55	50	54	58	46

Some notable differences in symptom awareness were also found across HSE health regions (Table 24). Those living in the Dublin and Midlands health region record the lowest levels of awareness for the most of the signs and symptoms measured, with particularly large gaps for unexplained bruising (60%) shortness of breath (65%), unexplained bleeding (84%) and unexplained weight loss (80%). Awareness tends to be highest in the Dublin and South East and West and North West health regions. This regional pattern mirrors that observed for general attitudes to cancer earlier in this report and suggests that awareness-raising initiatives may usefully be targeted at the Dublin and Midlands health region.

Table 24. Awareness of selected cancer warning signs by HSE health region (% identifying each as a possible sign of cancer, spontaneous and prompted combined).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Coughing up blood	95	89	95	94	95	97
Unexplained bleeding	94	84	93	91	93	95
A change in the appearance of a mole	92	86	94	93	90	95
Unexplained weight loss	88	80	92	89	89	94
Unexplained bruising	75	60	79	73	71	78
Shortness of breath	68	65	81	70	70	72
Bloating	55	50	68	62	60	65

First Action Taken if Noticed a Physical Sign Suggestive of Cancer

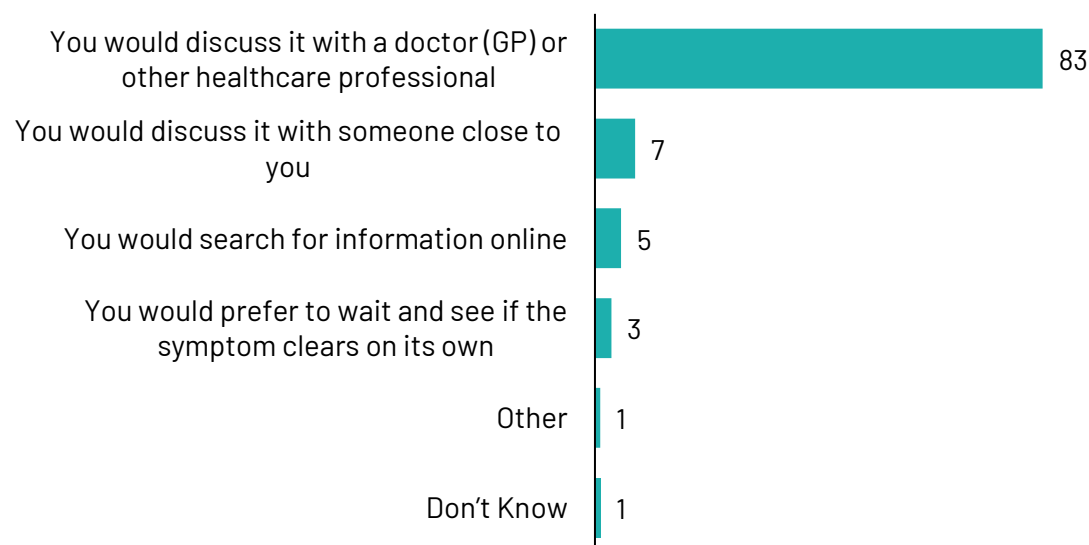
Respondents were next asked what they would do first if they were to notice a physical sign suggestive of cancer. Given the importance of early detection to cancer survival rates, it is highly important to encourage people to attend their GP without delay should they notice a potential sign or symptom of cancer.

Most (83%) report that they would discuss it with a doctor or other healthcare professional first if they noticed a physical sign suggestive of cancer. This is an increase on the 72% who said they would discuss it with a doctor first in 2022. It should be noted that the wording of the response options was broadened in 2026 to include other healthcare professionals, such as a public health nurse or pharmacist, which may account for some of this increase.

Nonetheless, the proportions selecting each of the alternatives have fallen correspondingly. Seven per cent now say they would discuss it with someone close to them first (2022: 14%), 5% would search for information online first (2022: 8%), and 3% would prefer to wait and see if the symptom clears on its own (2022: 5%). While actual behaviour may differ from behaviour reported in a survey, it is encouraging that an even greater proportion of respondents than in 2022 report that they would prioritise speaking to a healthcare professional.

Figure 26. First action taken if they noticed a sign of cancer

% who would do this action if they notices a physical sign suggestive of cancer



As in 2022, significant differences were observed by age (Table 26). Those aged 65 and older remain the most likely to say they would discuss a potential symptom with a doctor or other healthcare professional first (89%), while those aged 18 to 24 are the least likely to do so (75%), with those aged 18 to 24 being more likely to say they would discuss it with someone close to them (11%) or search for information online (10%). One departure from the pattern observed in 2022 is among those aged 55-64. In 2022, those aged 55 to 64 were among the most likely to prioritise discussing a symptom with a doctor (83%), but only 77% said they would do this in 2026, with 13% saying they would first discuss it with someone close to them.

Table 26. First action taken if they noticed a sign of cancer by age.

	18-24	25-34	35-44	45-54	55-64	65+
You would discuss it with a doctor (GP) or other healthcare professional	75	82	85	85	77	89
You would discuss it with someone close to you	11	7	6	5	13	5
You would search for information online	10	6	4	5	4	2
You would prefer to wait and see if the symptom clears on its own	3	3	2	3	4	3
Don't Know	<1	1	1	1	2	<1

Some variation is also observed across HSE health regions (Table 27). Those living in the West and North West health region were the most likely to report that they would speak to a doctor

or other healthcare professional first (88%), while those in the Dublin and Midlands (79%) and Dublin and South West (80%) health regions were the least likely to do so.

Table 27. First action taken if they noticed a sign of cancer by HSE health region (%).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
You would discuss it with a doctor (GP) or other healthcare professional	81	79	86	80	85	88
You would discuss it with someone close to you	9	9	7	6	6	6
You would search for information online	6	5	4	5	5	2
You would prefer to wait and see if the symptom clears on its own	3	3	2	5	3	3
Other	<1	1	1	<1	1	1
Don't Know	1	2	1	2	<1	<1

Other factors associated with a higher likelihood of prioritising a visit to a doctor were consistent with those identified in 2022, although the differences are smaller than in 2022. Non-drinkers (88%) remain more likely than those who drink alcohol weekly (81%) to say they would speak to a doctor or other healthcare professional first, as are those who eat five or more portions of fruit and vegetables a day (85%; fewer than five: 82%). This may again indicate that the likelihood to visit a GP if they noticed a sign of cancer is associated with healthier lifestyle behaviours in general.

Attitudes to Cancer Treatment and Survival

Several attitude statements were also included on the topic of cancer treatment and survival (Figure 27 and Figure 28). As in 2022, virtually all respondents (95%) agreed that “Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving”.

Perceptions of cancer treatment remain considerably more negative. Most respondents (58%) agreed with the statement “Most cancer treatment is worse than the cancer itself”, marginally higher than the 55% who agreed in 2022. Of greater concern, the proportion who agree that “I would NOT want to know if I have cancer” has risen from 13% in 2022 to 19% in 2026. Given the importance of early diagnosis to cancer outcomes, understanding and addressing this apparent increase in avoidance should be a priority for future communications.

Figure 27. Attitudes to cancer treatment

% who agree or disagree with each statement

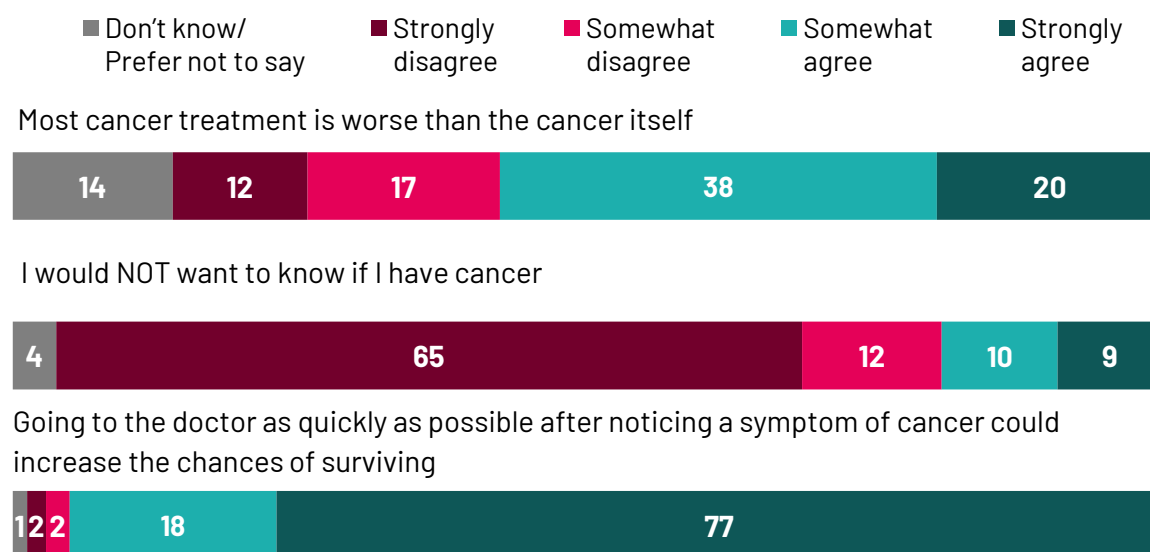
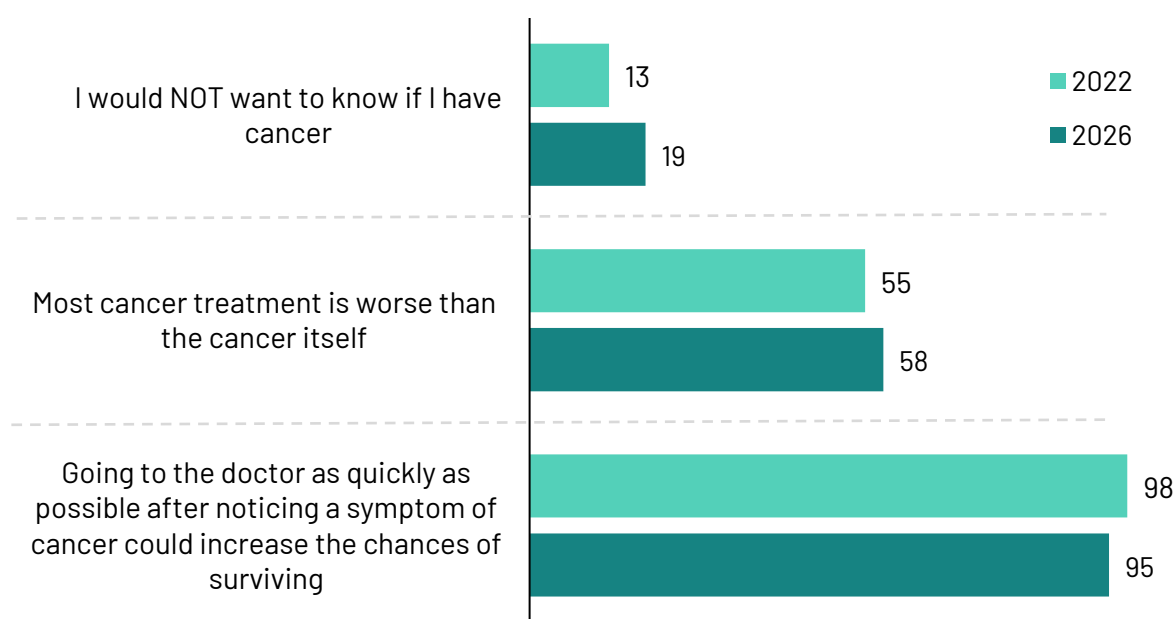


Figure 28. Attitudes to cancer treatment, 2022-2026

% who strongly or somewhat agree with each statement



The age patterns observed in 2022 largely persist (Table 28). Agreement that most cancer treatment is worse than the cancer itself again rises with age, from around half of those aged 18-24 (51%) to almost two-thirds of those aged 65 and older (64%). Those aged 65 and older (25%) were also the most likely to agree that they would not want to know if they had cancer.

Table 28. Attitudes to cancer treatment by age (% who strongly or somewhat agree).

	18-24	25-34	35-44	45-54	55-64	65+
Most cancer treatment is worse than the cancer itself	51	53	56	57	63	64
I would NOT want to know if I have cancer	17	18	17	17	21	25
Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving	97	94	95	96	96	95

Women (65%) remain considerably more likely than men (50%) to agree that most cancer treatment is worse than the cancer itself (Table 29). Agreement is also higher among those who left school before completing the Leaving Certificate (66%; post-Leaving Certificate: 51%) and among smokers (65%; non-smoker: 56%).

Smokers (23%; non-smoker: 19%) and those who left school before completing the Leaving Certificate (24%; post-Leaving Certificate: 14%) are more likely to agree that they would not want to know if they had cancer. This is a particular concern given that smoking is a leading risk factors for cancer, meaning avoidance may be higher among those at greatest risk.

Those who have themselves been diagnosed with cancer are the most likely to agree that most cancer treatment is worse than the cancer itself (65%; no experience of cancer: 53%). However, they are less likely to say they would not want to know if they had cancer (13%; no experience: 23%) and the most likely to agree that going to the doctor quickly could increase the chances of surviving (97%).

Table 29. Attitudes to cancer treatment by key demographic groups (% who strongly or somewhat agree).

Men	Women	Less than Leaving Cert.	Leaving Cert.	Post-Leaving Cert.	Smoker	Non-smoker	Diagnosed with cancer themselves	Knows others diagnosed	No experience of cancer
Most cancer treatment is worse than the cancer itself									
50	65	66	59	51	65	56	65	59	53
I would NOT want to know if I have cancer									
20	18	24	21	14	23	19	13	19	23
Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving									
95	96	94	94	97	94	95	97	95	93

Some notable differences are again observed across HSE health regions (Table 30). Agreement that “Most cancer treatment is worse than the cancer itself” is highest in the West and North West (66%) and Dublin and Midlands (64%) health regions, and lowest in the Dublin and North East and Dublin and South East health regions (both 52%). Those living in the Dublin and Midlands health region are also the most likely to agree that they would not want to know if they had cancer (24%), roughly one in four, compared with 15% in both the Mid West and South West health regions.

Table 30. Attitudes to cancer treatment by HSE Health region (% who strongly or somewhat agree).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
Most cancer treatment is worse than the cancer itself	52	64	52	58	57	66
I would NOT want to know if I have cancer	18	24	22	15	15	19
Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving	95	93	95	97	95	96

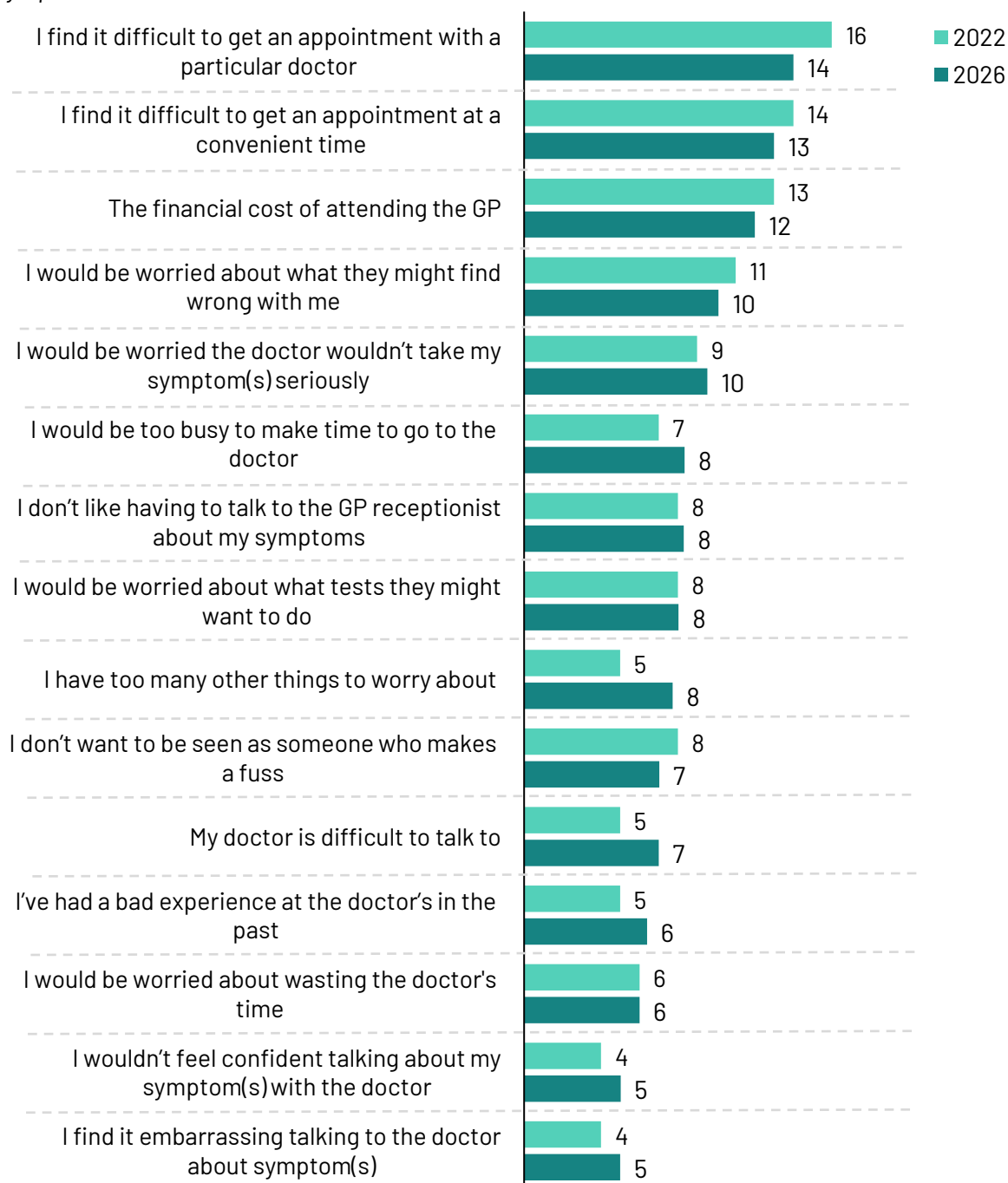
Barriers to Visiting a Doctor

The final part of this section examines if respondents would perceive any barriers to visiting a GP if they were to notice a sign or symptom of cancer. Overall, as in 2022, reported barriers to attending a GP in relation to cancer symptoms are low, with most potential barriers being mentioned by fewer than one in ten respondents. Moreover, the overall ranking of barriers is largely unchanged from 2022.

As in 2022, difficulties getting an appointment represent the most commonly mentioned barriers, with 14% saying difficulties getting an appointment with a particular doctor would stop them (2022: 16%), and 13% referencing difficulties getting an appointment at a convenient time (2022: 14%). This is followed by the financial cost of attending the GP, mentioned by 12% (2022: 13%).

Figure 29. Potential barriers to visiting a doctor, 2022-2026

% who think this would stop them from visiting a doctor if they noticed a warning sign or symptom of cancer



Barriers to attending a GP remain considerably higher for younger people (Table 31). The financial cost of attending the GP would stop more than one in four of those aged 18-24 (27%; 65+: 4%), while 20% of 18 to 24 year olds report difficulties getting an appointment with a particular doctor as a barrier (20%; 65+: 6%). Twenty-two per cent of those aged 18-24 say that being worried the doctor would not take their symptoms seriously would stop them attending, compared with just 4% of those aged 65 and older.

The significant age gradient observed in 2022 persists across almost all barriers mentioned, with those aged under 35 the most likely to say they would be prevented from attending a doctor, and those aged 65 and over the least likely. The main exceptions are worries about what tests might be done (65+: 9%) and a lack of confidence talking about symptoms with the doctor (65+: 7%), which show no decline with age.

In contrast to 2022, where no significant gender differences were found, women were somewhat more likely than men to cite being worried the doctor would not take their symptoms seriously (women: 12%; men: 7%) and disliking having to talk to the GP receptionist about their symptoms (10% and 7% respectively).

Table 31. Barriers to visiting a doctor by age (% saying each would stop them).

	18-24	25-34	35-44	45-54	55-64	65+
I find it difficult to get an appointment with a particular doctor	20	19	14	10	18	6
I find it difficult to get an appointment at a convenient time	18	19	12	11	15	5
The financial cost of attending the GP	27	16	9	8	12	4
I would be worried about what they might find wrong with me	20	10	7	10	11	9
I would be worried the doctor wouldn't take my symptom(s) seriously	22	15	7	7	9	4
I would be worried about what tests they might want to do	14	11	4	6	8	9
I don't want to be seen as someone who makes a fuss	8	11	5	7	7	5
I don't like having to talk to the GP receptionist about my symptoms	8	11	8	6	11	7
I would be too busy to make time to go to the doctor	14	11	8	9	8	4
I would be worried about wasting the doctor's time	7	10	5	4	6	4
I have too many other things to worry about	12	9	9	8	9	3
My doctor is difficult to talk to	10	10	5	4	10	5
I've had a bad experience at the doctor's in the past	12	11	5	5	6	4
I find it embarrassing talking to the doctor about symptom(s)	5	8	5	3	6	5
I wouldn't feel confident talking about my symptom(s) with the doctor	6	7	3	4	4	7

Reported barriers also vary across HSE health regions (Table 32). The financial cost of attending the GP shows the widest regional variation, cited by 17% of those in the Dublin and Midlands health region and 15% in Dublin and North East, but by just 3% in the West and North West and 7% in the Dublin and South East. Difficulties getting an appointment, whether at a convenient time or with a particular doctor, are also most commonly cited in the Dublin and North East (16% and 15% respectively) and Dublin and Midlands (15% and 16%) health regions. Overall, those living in the Dublin and South East and West and North West health regions report the fewest barriers to attending a GP.

Table 32. Barriers to visiting a doctor by HSE health region (% saying each would stop them).

	Dublin and North East	Dublin and Midlands	Dublin and South East	South West	Mid West	West and North West
I find it difficult to get an appointment at a convenient time	16	15	10	9	12	11
I find it difficult to get an appointment with a particular doctor	15	16	10	11	14	13
The financial cost of attending the GP	15	17	7	12	13	3
I don't like having to talk to the GP receptionist about my symptoms	11	8	7	9	9	6
I would be worried about what they might find wrong with me	10	13	5	13	10	10
I have too many other things to worry about	10	10	5	8	9	5
I would be too busy to make time to go to the doctor	9	10	6	9	8	8
I would be worried the doctor wouldn't take my symptom(s) seriously	9	13	10	9	8	8
I would be worried about what tests they might want to do	9	9	5	11	9	7
I don't want to be seen as someone who makes a fuss	7	10	6	8	9	3
I would be worried about wasting the doctor's time	6	6	5	8	7	4
I find it embarrassing talking to the doctor about symptom(s)	6	6	6	7	4	2
I've had a bad experience at the doctor's in the past	6	6	7	8	9	3
My doctor is difficult to talk to	6	6	8	9	11	4
I wouldn't feel confident talking about my symptom(s) with the doctor	4	6	4	6	7	5

Conclusion

The findings from the 2026 National Survey on Cancer Awareness and Attitudes present a generally positive picture of public awareness of and attitudes towards cancer in Ireland. But it also highlights several areas where further action is needed.

Most adults recognise that cancer risk can be reduced, they are able to identify many of the most common cancer risk factors and warning signs, and they understand the importance of seeking medical advice promptly when symptoms arise. Attitudes towards cancer survival also remain largely optimistic, with most people rejecting the view that a cancer diagnosis is a death sentence and recognising that many cancers can be treated successfully.

At the same time, the survey identifies continuing gaps in public understanding. Awareness of some established cancer risk factors, particularly alcohol consumption, radon, being overweight, lack of physical activity and certain infections like HPV and hepatitis, remains lower than awareness of risks such as smoking and sun exposure. Knowledge of less specific cancer symptoms, including heartburn or indigestion, unexplained night sweats, bloating and feeling full quickly, also remains relatively limited. These findings suggest that public awareness campaigns should continue to focus on both well-known messages and on those risks and symptoms that are less widely recognised.

The results further highlight the importance of targeted approaches. Older adults, those with lower levels of educational attainment, and residents of some HSE health regions were more likely to hold fatalistic beliefs about cancer and demonstrated lower levels of awareness in several areas. Younger adults, meanwhile, reported higher levels of practical and attitudinal barriers to consulting a doctor if they were to notice a sign or symptom of cancer. These differences underline the need for communications and structural interventions that are tailored to the needs and experiences of specific population groups.

The survey also points to emerging opportunities for cancer prevention. Awareness of radon is modest, with most who are aware feeling they know very little about it. Moreover, only a minority say they have tested their home for radon. There is substantial public support for further policy action in areas such as commercial sunbed use. Encouragingly, most respondents report positive intentions to seek professional advice if they notice a possible cancer symptom, and reported barriers to doing so remain relatively low.

Overall, the findings suggest that awareness of cancer prevention and early diagnosis remains strong in Ireland. Nonetheless, the decline observed across some indicators since 2022, on top of some persistent misconceptions, demonstrates the need for continued investment in public education and engagement. The evidence from this survey provides an important foundation for the NCCP and its partners to refine prevention, awareness and early diagnosis initiatives, ensuring that future efforts are targeted where they can have the greatest impact on reducing the burden of cancer in Ireland.



Appendices

Appendix A – Questionnaire

2026 National Survey on Cancer Awareness and Attitudes Questionnaire – FINAL

CONSENT

Good morning/afternoon/evening. My name is from Ipsos B&A, we are conducting research to learn about the Irish population's awareness and understanding of cancer. You have been randomly selected to take part in the survey, along with over 2,500 other people in Ireland.

Unfortunately, as cancer is a common disease, some people participating in the survey have been affected by cancer. I do not want to cause any upset and would like to reassure you that you have been invited to participate at random and the reason for the survey is to improve cancer outcomes in Ireland.

The survey will take approximately 20 minutes to complete.

I have a participant information sheet with some further information that you can read before proceeding.

Before we continue, I need to inform you that many of the questions relate to health and to reassure you that all of your answers are completely confidential and your rights under the Data Protection Act will be fully observed, including not answering and choosing to end the interview. Your participation is voluntary. Your responses will be anonymous, therefore once the interview is completed it will not be possible to withdraw from study. The HSE National Cancer Control Programme may anonymously use your responses in reports or publications related to this.

For quality control and training purposes this interview may be monitored or recorded.

Q.S4 Are you okay to proceed on this basis?

Yes	1 PROCEED
No	2 TERMINATE INTERVIEW

PRE SURVEY DEMOGRAPHICS

Q.A Firstly, have you, anyone in your family or any of your friends had cancer?
PROBE TO PRECODES. MULTICODE.

Me	1
My spouse/partner	2
Someone in my immediate family (e.g. parents, child, brother, sister, siblings)	3
Someone in my wider family (e.g. grandparent, grandchild, cousin, aunt, uncle, niece, nephew)	4
A close friend	5
Someone else (please specify).	8
None of those	9
Prefer not to say	10

IF ANSWER '1' AT Q.A, ASK:

Q.B Are you currently undergoing treatment for cancer?

Yes	1
-----------	---

No..... 2

MODULE 1: BELIEFS ABOUT CANCER

I am now going to ask you some questions in relation to your beliefs about cancer. Please note this is not a test and we are simply trying to understand your current awareness of this disease.

- Q.1** When I say the word cancer to you, what three words come to mind?
If subject does not know how to answer, follow up with "In your opinion, what springs to mind when I say the word "cancer" to you?"

INTERVIEWER – RECORD WORDS PRECISELY. IF WORD IS NOT ON THE LIST, THEN USE OTHER SPECIFY CATEGORY

Disease	1
Tumour	2
Breast cancer	3
Lung cancer	4
Death	5
Incurable	6
Curable	7
Treatment	8
Chemotherapy	9
Radiotherapy	10
Fear	11
Hope	12
Pain	13
Sadness	14
Other (specify:)	15
Don't Know (DNRO)	16
Refused (DNRO)	17

- Q.2** I am now going to read out some opinions that you might hear about cancer. To what extent do you agree or disagree with each one?

ROTATE ORDER. READ OUT

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know	Prefer not to say
These days, many people with cancer can expect to continue with normal activities and responsibilities	1	2	3	4	5	6
Most cancer treatment is worse than the cancer itself	1	2	3	4	5	6
I would NOT want to know if I have cancer	1	2	3	4	5	6
Cancer can often be cured	1	2	3	4	5	6
Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving	1	2	3	4	5	6
A diagnosis of cancer is a death sentence	1	2	3	4	5	6
Nothing can be done to reduce your risk of cancer	1	2	3	4	5	6

MODULE 2: CANCER RISK REDUCTION

I am going to ask you some questions in relation to cancer risk factors. Please note this is not a test and we are simply trying to understand your current awareness of this disease.

Q.3 To what extent do you agree or disagree with the following statement ... ?

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know	Prefer not to say
There are things I can do to reduce my chances of developing cancer.	1	2	3	4	5	6

Q.4 What things do you think could increase a person's chance of developing cancer?
Please list as many things you can think.

PROBE TO PRECODES. MULTICODE

SMOKING

Smoking tobacco products (cigarettes, cigars, pipes, roll your own, shisha)	1
E-cigarettes/vapes	2
Chewing tobacco.....	3
Other forms of oral tobacco (snus)	4
Exposure to another person's smoking (second hand smoke).....	5

EXPOSURE TO THE SUN/OTHER ENVIRONMENTAL FACTORS

Living near pylons/ wind turbines.....	6
Unprotected sun exposure	5
Getting sunburnt.....	6
Using a sunbed	7
Exposure to radon.....	8
Exposure to asbestos.....	9
Breathing polluted air	10

DIET, DRINKING & EXERCISE

Not eating enough fruit and vegetables	11
Eating red meat.....	12
Eating processed meat, for example bacon, ham, sausages	13
Not eating enough wholegrains (brown rice, wholegrain bread).....	14
Drinking alcohol.....	15
Drinking coffee	16
Not enough physical activity	17
Being overweight.....	18

HEALTH CONDITIONS/MEDICINES/TREATMENTS

Taking hormone replacement therapy (HRT)	19
High blood pressure	
Having chronic obstructive pulmonary disease - COPD.....	21
HPV infection	22
Hepatitis infection.....	23
Heartburn	24

OTHER FACTORS

Using a mobile phone	25
Being older	26
Stress	27
Having a blood relative (sibling, parent, grandparent, aunt) with cancer.....	28
Not breastfeeding.....	29
Wearing a tight bra.....	30
A blow to the breast	31
Aerosol use	32

Other (specify: _____)	33
None of these.....	34

Don't Know (DNRO).....	35
Refused (DNRO).....	36

For each of the following can you tell me which, if any, of these you think increase a person's chance of developing cancer. You may have already mentioned some of these.

ROTATE ORDER OF Q.5A-E. DO NOT SHOW ANSWERS GIVEN AT Q.4.

Firstly,...
And next....

Q.5a ...some things related to smoking.
ROTATE ORDER. READ OUT

Smoking tobacco products (cigarettes, cigars, pipes, roll your own, shisha)	1
E-cigarettes/vapes	2
Chewing tobacco.....	3
Other forms of oral tobacco (snus)	4
Exposure to another person's smoking (second hand smoke).....	4

Q.5b ...some things related to exposure to the sun and other environmental factors
ROTATE ORDER. READ OUT

Unprotected sun exposure	1
Getting sunburnt.....	2
Using a sunbed	3
Exposure to radon.....	4
Exposure to asbestos.....	5
Breathing polluted air	6

Q.5c ...some things related to diet, drinking and exercise
ROTATE ORDER. READ OUT

Not eating enough fruit and vegetables	1
Eating red meat.....	2
Eating processed meat, for example bacon, ham, sausages	3
Not eating enough wholegrains (brown rice, wholegrain bread)	4
Drinking alcohol.....	5
Drinking coffee	6
Not enough physical activity	7
Being overweight.....	8

Q.5d ...some things related to health conditions, medicines and treatments
ROTATE ORDER. READ OUT

Taking hormone replacement therapy (HRT)	1
High blood pressure	2
Having chronic obstructive pulmonary disease - COPD	3
HPV infection	4
Hepatitis infection.....	5
Heartburn	6

Q.5e ...some things related to various factors
ROTATE ORDER. READ OUT

Using a mobile phone	1
Being older	2
Having a close relative with cancer.....	4

Not breastfeeding.....	5
Wearing a tight bra.....	6
A blow to the breast	7

Q.6 I am now going to read out some opinions that you might hear about tobacco. To what extent do you agree or disagree with each one?

ROTATE ORDER. READ OUT

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know	Prefer not to say
Smoking can only cause cancer if you are a heavy smoker over a long period of time	1	2	3	4	5	6
Quitting smoking at any time reduces your risk of developing cancer	1	2	3	4	5	6
Even if you don't smoke yourself, being exposed to other people's smoke can cause cancer	1	2	3	4	5	6
A former smoker can get a cancer related to their smoking even a long time after quitting smoking	1	2	3	4	5	6
Smoking cigarettes with a filter is less likely to cause cancer than smoking cigarettes without a filter	1	2	3	4	5	6

Q.7 I am now going to read out some opinions that you might hear about alcohol. To what extent do you agree or disagree with each one?

ROTATE ORDER. READ OUT

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know	Prefer not to say
Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time.....	1	2	3	4	5	6
Drinking alcohol is only bad for your health if you drink enough to get drunk	1	2	3	4	5	6
Drinking a little alcohol is better for your health than not drinking any alcohol	1	2	3	4	5	6
Drinking any alcohol, even small amounts, increases the risk of developing cancer	1	2	3	4	5	6

MODULE 3: AWARENESS OF CANCER

Next, we would like to ask a few questions about your awareness of cancer. Please note this is not a test and we are simply trying to understand your current awareness of this disease.

Q.9a There are many warning signs and symptoms of cancer. Please tell me as many warning signs and symptoms of cancer as you can think of.

PROBE TO PRECODES. MULTICODE.

Unexplained lump or bump	1
Persistent unexplained pain	2
Unexplained bleeding (blood in poo, pee, bleeding after sex, bleeding after the menopause, bleeding between periods) ...	3
Unexplained bruising	4
A persistent cough for greater than 3 weeks	5
Persistent hoarseness	6
Losing your appetite	7
Feeling full very quickly	8
A change in your bowel habit	9
A change in your bladder habit	10
Difficulty swallowing	11
A change in the appearance of a mole	12
A sore that does not heal	13
Unexplained weight loss	14
Bloating	15
Coughing up blood	16
Shortness of breath	17
Tired all the time	18
A change to an existing cough	19
Unexplained night sweats	20
Unexplained ulcers inside your mouth	21
Heartburn or indigestion	22
Other (specify: _____)	23
Don't Know (DNRO)	24
Refused (DNRO)	25

Q.9b Which of the following, if any, do you think could be warning signs or symptoms of cancer?
ONLY SHOW THOSE NOT SELECTED AT Q.9A
ROTATE. READ OUT.

	Yes, I think this could be a sign of cancer	No, I don't think this could be a sign of cancer	Don't know/ not sure
Unexplained lump or bump	1	2	3
Persistent unexplained pain	1	2	3
Unexplained bleeding (blood in poo, pee, bleeding after sex, bleeding after the menopause, bleeding between periods)	1	2	3
Unexplained bruising	1	2	3
A persistent cough for greater than 3 weeks	1	2	3
Persistent hoarseness	1	2	3
Losing your appetite	1	2	3
Feeling full very quickly	1	2	3
A change in your bowel habit (going more often, feeling you cannot empty your bowels)	1	2	3
A change in your bladder habit (going more often, getting up to go to the bathroom at night, difficulty emptying bladder)	1	2	3
Difficulty swallowing	1	2	3
A change in the appearance of a mole	1	2	3
A sore that does not heal	1	2	3
Unexplained weight loss	1	2	3
Bloating	1	2	3
Coughing up blood	1	2	3
Shortness of breath	1	2	3
Tired all the time	1	2	3
A change to an existing cough	1	2	3
Unexplained night sweats	1	2	3
Unexplained ulcers inside your mouth	1	2	3
Heartburn or indigestion	1	2	3

IF NOT CURRENTLY UNDERGOING TREATMENT OR NEVER TREATED FOR CANCER

Q.10 If you were to notice a physical sign suggestive of cancer, what would you do?
PROBE TO PRECODES. MULTICODE.

- You would discuss it with a doctor (GP) or other healthcare professional e.g. public health nurse, pharmacist..... 1
- You would discuss it with someone close to you 2
- You would search for information online..... 3
- You would prefer to wait and see if the symptom clears on its own 4
- Other (specify _____) 5
- Don't Know 6
- Refused..... 7

ASK ALL

Q.11 For each of the following, can you tell me whether it would stop you or would not stop you from visiting a doctor if you noticed a warning sign or symptom of cancer?
ROTATE. READ OUT.

	Would stop me	Would not stop me	Don't know
I find it embarrassing talking to the doctor about symptom(s)	1	2	3
I would be worried about wasting the doctor's time	1	2	3
My doctor is difficult to talk to	1	2	3
I find it difficult to get an appointment with a particular doctor	1	2	3
I find it difficult to get an appointment at a convenient time	1	2	3
I would be too busy to make time to go to the doctor	1	2	3
I have too many other things to worry about	1	2	3
I would be worried about what they might find wrong with me	1	2	3
I wouldn't feel confident talking about my symptom(s) with the doctor	1	2	3
I've had a bad experience at the doctor's in the past	1	2	3
I would be worried the doctor wouldn't take my symptom(s) seriously	1	2	3
I would be worried about what tests they might want to do	1	2	3
I don't want to be seen as someone who makes a fuss.....	1	2	3
I don't like having to talk to the GP receptionist about my symptoms	1	2	3
The financial cost of attending the GP	1	2	3

Q.12 Is there anything else that might put you off going to the doctor?

No..... 1
 Yes 2

WRITE IN

MODULE 4: LIFESTYLE

Thank you for your answers so far. We would now like to ask a few questions about your day to day life.

Q.8a Which, if any, of these sun protection methods do you use frequently during the summer in Ireland?

ROTATE ANSWERS. READ OUT. MULTI CODE

Limit the time spent in the sun 1
 Wear long sleeves 2
 Wear a hat..... 3
 Wear sunglasses..... 4
 Use sunscreen of factor 30 or above 5
 Use sunscreen lower than factor 30 6
 None of these (DNRO) 7
 Don't Know (DNRO) 8
 Refused (DNRO) 9

Q.8b Do you have any children aged under 12 for whom you are a parent or guardian?

Yes 1
 No..... 2
 Don't Know (DNRO) 3
 Refused (DNRO) 4

ASK IF YES AT Q.8B

Q.8c Which, if any, of these sun protection methods do you use frequently during the summer in Ireland to protect your child?

ROTATE ANSWERS. READ OUT. MULTI CODE

Limit the time spent in the sun 1
 Wear long sleeves..... 2
 Wear a hat..... 3
 Wear sunglasses..... 4
 Use sunscreen of factor 50 or above 5
 Use sunscreen lower than factor 50 6
 None of these (DNRO) 7
 Don't Know (DNRO) 8
 Refused (DNRO) 9

ASK ALL
SINGLE CODE

Q.201 Thinking now of sunbeds, have you ever used a sunbed?

Yes	1
No	2
Don't Know	3
Refused	4

ASK ALL
SINGLE CODE

Q.201a Have you used a sunbed in the last 12 months?

Yes	1
No	2
Don't Know	3
Refused	4

ASK IF YES AT Q.9a
SINGLE CODE

Q.201b. How often do you use a sunbed?

At least once a week	1
Every 2 weeks to a month	2
Every 2 to 6 months	3
Once a year or less	4
Don't know	5

ASK ALL
SINGLE CODE

Q.202. Have you ever used injections, nasal sprays or tablets to help get a tan?

Yes	1
No	2
Don't Know	3
Refused	4

In 2014, the Irish Government made it illegal for people under the age of 18 to use sunbeds. The Government is now considering the introduction of a total ban on commercial sunbed use in Ireland.

ASK ALL
SINGLE CODE

Q.203. Would you be in favour or against a total ban on commercial sunbed use in Ireland?

Interviewer information: By commercial sunbeds I mean sunbeds that are available for use in a business setting, such as a tanning salon, beauty salon, leisure centre, gym, or hotel.

Favour	1
Against	2
No opinion	3

**ASK ALL
SINGLE CODE**

Q.13 Do you smoke tobacco products?

Yes, daily.....	1
Yes, occasionally	2
No.....	3
GO TO Q.14.....	

**ASK ALL
SINGLE CODE**

Q.14 Did you ever smoke tobacco products (in the past)?

Yes, daily.....	1
Yes, occasionally	2
No.....	3

**ASK ALL
SINGLE CODE**

Q.15 In the past 6 months, how often if at all have you consumed alcohol?

Daily	1
5-6 times a week	2
4 times a week	3
3 times a week	4
Twice a week	5
Once a week	6
2-3 times a month	7
Once a month.....	8
Less than once a month.....	9
I did not drink in the last 6 months but I drank longer ago	10
I have never consumed alcohol	11
Don't know (DNRO)	12
Refused (DNRO).....	13

ASK ALL

Q.16 Each day, how many portions of fruit do you eat, on average? A portion is an apple, a pear, orange or similar sized fruit. **RECORD NUMBER OF PORTIONS DAILY**

Don't Know (DNRO).....	99
Refused (DNRO).....	98

ASK ALL

Q.17 Each day, how many portions of vegetables do you eat, on average? A portion is one medium tomato or carrot, 3 heaped tablespoons of peas or mixed vegetables. **RECORD NUMBER OF PORTIONS DAILY**

Don't Know (DNRO).....	99
Refused (DNRO).....	98
.....	

ASK ALL

Q.18 In the past week, on how many days have you done a total of 30 minutes or more of physical activity which was enough to raise your breathing rate?

Don't Know (DNRO).....99
Refused (DNRO).....98

MODULE 3: RADON

I would now like to ask you a few questions about radon.

ASK ALL

Q.204 Have you heard of radon before today?

SINGLE CODE

Yes 1
No..... 2
Don't Know (DNRO) 3
Refused (DNRO) 4

ASK IF YES Q.8

Q.204a Would you say you know a lot, a little or almost nothing about radon?

SINGLE CODE

A lot 1
A little 2
Almost nothing 3
Don't Know (DNRO) 4
Refused (DNRO) 5

ASK IF YES Q.8

Q.204b Which, if any, of the following do you think can help reduce radon in a home?

ROTATE ORDER. SHOWCARD

MULTICODE

Increasing ventilation (opening windows, vents etc.)..... 1
Sealing cracks or other openings in foundations 2
Installing a radon reduction system/sub-slab depressurisation system..... 3
Covering exposed soil in crawlspaces with sealed barriers 4
Installing a carbon monoxide detector 5
Having double glazed windows..... 6
Covering or seal sump holes 7
Fixing cracks in foundations..... 8
Nothing can be done to reduce radon in the home..... 9
Don't Know (DNRO) 10
Refused (DNRO) 11

ASK IF YES Q.8

Q.204c Have you or someone else in your household tested your current home for radon?

SINGLE CODE

Yes 1
No..... 2
Don't Know (DNRO) 3
Refused (DNRO) 4

POST SURVEY DEMOGRAPHICS

I would now like to ask you a few questions for classification purposes.

Q.19 What is your gender?

- | | |
|------------------------------|---|
| Male | 1 |
| Female | 2 |
| Other (specify: _____) | 3 |
| Prefer not to say | 4 |

Q.20 And, may I ask what is your actual age?

WRITE IN

Refused (DNRO)..... 98

ASK ALL REFUSED Q.20

Q.21 To ensure we interview a wide cross section of the public, could I first ask what age group you fall into?

- | | |
|---------------------|----|
| 18-19 | 1 |
| 20-21 | 2 |
| 22-24 | 3 |
| 25-29 | 4 |
| 30-34 | 5 |
| 35-39 | 6 |
| 40-44 | 7 |
| 45-49 | 8 |
| 50-54 | 9 |
| 55-59 | 10 |
| 60-64 | 11 |
| 65-69 | 12 |
| 70-74 | 13 |
| 75+ | 14 |
| Refused (DNRO)..... | 98 |

Q.23 How would you define your current situation with regard to work?

- | | |
|--|----|
| Working for payment or profit..... | 1 |
| Looking for first regular job | 2 |
| Unemployed | 3 |
| A student or pupil | 4 |
| Retired from employment..... | 5 |
| Unable to work due to permanent sickness or disability | 6 |
| Looking after home or family..... | 7 |
| Other (specify: _____) | 8 |
| Don't know | 99 |
| Refused..... | 98 |

Q.24 What is the highest level of education/training (full-time or part-time) which you have completed to date?

INTERVIEWER: PROBE TO PRECODES

No formal education or training.....	1
Primary education (FETAC Level 1 or 2 Cert. or equivalent). NFQ levels 1 or 2	2
Lower secondary education (Junior/Inter/Group Cert, Fetac Level 3 Cert, FÁS Introductory Skills, NCVA Foundation Cert. or equivalent. NFQ level 3	3
Upper secondary education (Leaving Cert. (including Applied and Vocational programmes) or equivalent. NFQ levels 4 or 5.....	4
Technical or Vocational , FETAC Level 4/5 Cert., NCVA Level 1/2, FÁS National Craft Cert., Teagasc Farming Cert., CERT Professional Cookery Cert. or equivalent. NFQ levels 4 or 5.....	5
Advanced Certificate / Completed Apprenticeship, FETAC Advance Cert., NCVA Level 3, FÁS National Craft Cert., Teagasc Farming Cert., CERT Professional Cookery Cert. or equivalent. NFQ level 5	6
Higher Certificate , NCEA/HETAC National Cert. or equivalent. NFQ level 6	7
Ordinary Bachelor Degree or National Diploma. NFQ Level 7	8
Honours Bachelor Degree /Professional qualification or both. NFQ Level 8	9
Postgraduate diploma, Masters Degree or equivalent. NFQ Level 9	10
Doctorate (Ph.D) or higher. NFQ level 10.....	11
Prefer not to say (DNRO)	12

Q.25 To which one of the following ethnic groups do you consider you belong?

INTERVIEWER: FIRST READ OUT WHITE, BLACK OR BLACK IRISH, ASIAN OR ASIAN IRISH OR ANOTHER BACKGROUND. THEN PROBE ACCORDINGLY.

White	Irish	1
	Irish Traveller	2
	Roma	3
	Any other White background (specify).....	4
Black or Black Irish	African	5
	Any other black background (specify).....	6
Asian or Asian Irish	Chinese	7
	Indian	8
	Pakistani	9
	Bangladeshi	10
	Any other Asian background (specify).....	11
Other including mixed background	Arabic	12
	Mixed/Other (specify).....	13

Q.26 In what country were you born?

Ireland	1
UK (including Northern Ireland)	2
Poland	3
Lithuania.....	4
Latvia.....	5
Nigeria.....	6
Romania.....	7
India	8
Philippines.....	9
Germany	10
USA.....	11
China.....	12
Slovakia.....	13
France	14
Brazil	15
Hungary.....	16
Italy.....	17
.....	
Pakistan	18
Spain	19
Czech Republic	20
South Africa.....	21
Other (specify)	22
Refused (DNRO).....	99

ASK ALL NOT BORN IN IRELAND

Q.27 For how many years have you lived in Ireland?

WRITE IN

Don't know (DNRO)	98
Refused (DNRO).....	99

SINGLE CODE

Q.28a Do you have a full medical card?

Yes	1
No.....	2

ASK IF CODE 2 AT Q.54a

Q.28b Do you have a GP visit card?

Yes	1
No.....	2

Q.28c Are you accessing the Long-Term Illness Scheme?

Yes	1
No.....	2

DUMMY VARIABLE

IF CODE 2 AT 28A AND 28B, FORCE INTO “NO MEDICAL CARD”

SINGLE CODE

Q.55 Do you have private health insurance?

Yes 1
No 2

ASK ALL

Q.205 Finally, on a scale of very easy to very difficult, how easy or difficult would you say it is...

SINGLE CODE READOUT

	Very difficult	Difficult	Easy	Very Easy	Don't know/ Refused
...to find information about symptoms of illnesses that concern you?	1	2	3	4	5
...to find information on treatments of illnesses that concern you?	1	2	3	4	5
...to find information about what to do in a medical emergency?	1	2	3	4	5
...to find out where to get professional help when you are ill? <i>[If necessary provide clarification: such as doctor, nurse, pharmacist, psychologist]</i>	1	2	3	4	5
...to understand what a doctor says to you?	1	2	3	4	5
...to understand the instruction leaflets that come with your medicine? <i>[Instruction: information or instructions given in the leaflets]</i>	1	2	3	4	5
...to understand information about what to do in a medical emergency?	1	2	3	4	5
...to understand your doctor's or pharmacist's instruction on how to take a prescribed medicine?	1	2	3	4	5
...to judge how information from your doctor applies to you?	1	2	3	4	5
...to judge the advantages and disadvantages of different treatment options?	1	2	3	4	5
...to judge if you may need to get a second opinion from another doctor?	1	2	3	4	5
...to judge if the information about illness in the mass media is reliable? <i>[Instructions: e.g. Newspapers, TV or Internet]</i>	1	2	3	4	5

Appendix B – Advisory Group Membership

National Survey on Cancer Awareness and Attitudes Advisory Group membership 2025/2026

Name	Organisation
Breeda Neville (Chair)	Consultant in Public Health Medicine, HSE National Cancer Control Programme
Maria McEnery	Cancer Prevention Officer, HSE National Cancer Control Programme
Una Kennedy	GP Advisor, HSE National Cancer Control Programme
Grace O’Sullivan	Programme Manager, HSE National Cancer Control Programme
Caroline Murray	Senior Health Promotion & Improvement Officer – Cancer Prevention, HSE West
Bernie O’Loughin	Programme Co-ordinator – Cancer Survivorship, HSE National Cancer Control Programme
Claire Collins	Director of Research & Innovation and Director of People & Culture Irish College of General Practitioners
Joe McDevitt	Epidemiologist, National Cancer Registry of Ireland
Nicola O’Connell	Research Officer, Sexual Health Programme, HSE Health & Wellbeing,
Helen McAvoy	Director of Policy, All Island Institute of Public Health
Lynn Swinburne	Senior Health Promotion Officer, National Screening Service
Kathleen Bennett	Head of the Data Science Centre RCSI / Associate Professor of Biostatistics
Claire Neill	Consultant in Public Health Medicine, HSE National Health Improvement Programme
Noreen Murtagh	Patient/ Public Representative
Karl Corcoran	Patient/ Public Representative

Note: The Irish Cancer Prevention Network, consisting of the National Cancer Control Programme, the Irish Cancer Society, The Marie Keating Foundation, Breakthrough Cancer Research, the HSE National Screening Service and The Irish Skin Foundation were consulted during the development of the research.

Appendix C – Advisory Group Terms of Reference

National Survey on Cancer Awareness and Attitudes 2025/2026

Advisory Group Terms of Reference

Purpose

The National Cancer Control Programme (NCCP) is establishing an inter-disciplinary group to advise on the development and implementation on a second National Survey on Cancer Awareness and Attitudes. The project is being co-ordinated by the NCCP Cancer Prevention Function.

Background

The first national population cancer awareness survey in Ireland was undertaken in 2022 by the HSE National Cancer Control Programme: “The NCCP National Survey on Cancer Awareness and Attitudes”. The findings addressed the cancer awareness knowledge gap, provided baseline data to inform development of cancer prevention and early diagnosis initiatives, and provided better understanding of policy priorities.

In depth analysis on findings was undertaken in relation to alcohol and obesity and results are being used to implement public health initiatives.

Cancer awareness research amongst the Traveller Community in Ireland was undertaken in 2024 and a final report is due to be published.

This project aims to repeat the National Cancer Awareness Survey with the general population. In Ireland 1 in 2 will have a cancer diagnosis. The total number of cancers will continue to rise due to an increase in the numbers of older people in the age range when the cancer typically occurs. This brings considerable challenges to health services in meeting the demand for care as well as the impact on the individuals affected. Treatment services alone cannot address the burden of cancer care. Prevention must be a key focus as it offers the most long-term, cost-effective approach for the control of cancer. For cancers that cannot be prevented, early diagnosis is key to improve survival and treatment outcomes. Repeating the research can be used to monitor trends in cancer awareness and attitudes in relation to prevention and early diagnosis. These findings can further inform initiatives and public policy and monitor the impact. In addition, data collected can potential contribute to the HSE health services reform with regional specific data being made available.

The aim of this project is to undertake and publish results of a National Survey on Cancer Awareness and Attitudes amongst adults (aged 18+) living in Ireland to

- Assess public knowledge/awareness of risk and preventive factors for cancer, including non-modifiable and modifiable factors.
- Assess attitudes and behaviours in relation to cancer risk factors.
- Assess knowledge of early signs/symptoms of cancer.

- Assess health seeking behaviour, including barriers and enablers to seeking medical advice.
- Inform development of cancer prevention and early detection initiatives.

The survey will be designed with input by the NCCP Survey Advisory Group, using the 2022 National Survey on Cancer Awareness and Attitudes. Methodology for data collection is to be decided through the procurement of an experienced marketing and research consultancy firm through the Office of Government Procurement with input from the advisory group. Ethics approval will be sought from the Royal College of Physicians Ireland (RCPI).

Data collection is planned for Q1 2026 and final report to be published Q3 2026.

Repeating the research can be used to monitor trends in cancer awareness and attitudes in relation to prevention and early diagnosis. These findings can further inform initiatives and public policy and monitor the impact. In addition, data collected can potential contribute to the HSE health services reform with regional specific data being made available.

Membership Expectations and Frequency of Meetings

Members of the advisory group are expected to actively offer feedback/advice on

1. Survey content design
2. Consultation with stakeholders
3. Data analysis
4. Production of final report
5. Submission of articles to relevant academic journals
6. Dissemination of findings

Meetings will be held virtually via MS Teams, with communication between meetings via email to support work progression.

Meeting schedule will be agreed at the advisory group first meeting. If unable to attend, apologies would be appreciated at least 48 hours in advance of the meeting. Do consider nominating an alternative to attend if appropriate.

Administration

Administrative support will be provided by the NCCP. Brief notes and action points will be circulated after each meeting.

Governance

The advisory group will be chaired by an NCCP Consultant in Public Health Medicine. The group will provide advice and guidance to the NCCP Cancer Prevention and Early Detection Function who are undertaking the actions to deliver the project. Each action and output to deliver the project will be signed off by the NCCP Consultant in Public Health Medicine, with guidance from the advisory group.

The NCCP Cancer Prevention Function is led by the NCCP Consultant in Public Health Medicine, who reports to the NCCP Director and NCCP Executive for final sign off on project deliverables.