Ministry of Health, Environment & Sustainability

National Cancer Policy

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FOREWORD

It is with great pride and a profound sense of responsibility that I present the Cayman Islands' first **National Cancer Policy**. This policy marks a critical milestone in strengthening our national response to cancer and reflects this Government's commitment to protecting and improving the health and wellbeing of our people through a coordinated, evidence-based approach to cancer prevention and early detection.

Cancer continues to place a growing burden on individuals, families, communities, and our healthcare system. Behind every diagnosis is a person, a family, and a support network whose lives are changed by the impact of this disease. This policy responds to that challenge by establishing a clear national framework for organised cancer screening, quality assurance, and continuous improvement. By prioritising population-based screening for breast, cervical, and bowel cancers, conditions for which effective screening tools exist, we are focusing our efforts where they can achieve the greatest impact in reducing preventable mortality, improving health outcomes, and enhancing quality of life for our population.

As a Government, we recognise that improving cancer outcomes requires more than treatment alone. It requires investment in prevention, the early identification of disease, strong clinical governance, reliable data, and coordinated action across the health sector. This policy provides the foundation for that work and demonstrates our commitment to building a healthcare system that is proactive, patient-centred, and responsive to the needs of our community.

This policy is intended as a foundational and evolving framework. It establishes the initial standards, governance structures, and programme priorities upon which a comprehensive national cancer programme will be built. As evidence advances, technologies develop, and local capacity expands, the policy will be regularly reviewed and updated in collaboration with the National Cancer Consultation Group, ensuring continued alignment with international best practice and the evolving needs of the Cayman Islands population.

Central to this policy is a commitment to equitable, patient-centred care. No individual should face avoidable barriers to early detection, diagnosis, or timely follow-up. Strong governance, robust data systems, quality assurance, and shared accountability across both the public and private sectors will be essential to delivering high-quality cancer screening services and improving outcomes for all residents of the Cayman Islands.

This policy reflects the collective effort of many dedicated stakeholders and demonstrates what can be achieved when Government, healthcare professionals, community partners, and citizens work together towards a common goal. It represents the beginning of a sustained, long-term approach to cancer prevention and control that will help safeguard the health of current and future generations.

I extend my sincere thanks to all who contributed to the development of this policy and to the many professionals who work every day to improve the lives of those affected by cancer. I look forward to its implementation and ongoing refinement as we continue working together to build a healthier, stronger, and more resilient Cayman Islands for all.

Hon. Katherine Ebanks-Wilks
Minister for Health, Environment & Sustainability
Cayman Islands Government

Message from the Chief Officer

The Cayman Islands' first **National Cancer Policy** provides more than a strategic direction for cancer prevention and early detection, it establishes the framework through which we can translate national priorities into measurable action and outcomes. Central to its success is a commitment to **data-driven decision-making**, ensuring that planning, resource allocation, programme monitoring, and future policy development are informed by reliable evidence and a clear understanding of the needs of our population.

Delivering on the vision outlined in this policy will require strong collaboration across the health sector and beyond. Effective cancer prevention and control depends on coordinated action between government entities, healthcare providers, regulatory bodies, community partners, and other stakeholders. By strengthening inter-agency coordination and fostering a shared commitment to accountability and continuous improvement, we can build a more integrated and responsive system that better serves the people of the Cayman Islands.

I thank the Honourable Minister for her leadership and commitment to advancing this important national priority, and I extend my appreciation to the Ministry's Policy Team, the National Cancer Consultation Group, and all those who contributed to the development of this policy. Together, we are laying the foundation for a stronger, evidence-informed health system that will support better outcomes for individuals, families, and communities for generations to come.

Tamara Ebanks
Chief Officer
Ministry of Health, Environment & Sustainability
Cayman Islands Government

1.0 EXECUTIVE SUMMARY

This National Cancer Policy establishes a framework for the implementation, monitoring, evaluation, and oversight of cancer screening programmes across the Cayman Islands. It adopts recognised cancer quality standards and clinical guidelines to promote standardised care pathways and ensure consistent, high-quality delivery of services. The policy prioritises evidence-based population screening for three cancers: bowel (colorectal); cervical, and; female breast, selected due to their prevalence and the effectiveness of available screening tools. Other cancers remain under review as evidence evolves. This policy promotes the use of data collection systems within healthcare facilities offering cancer screening, helping to enable timely call and recall of individuals at recommended intervals. Oversight by the National Cancer Consultation Group will also help to ensure programmes are evidence-based, accessible, patient-centred, and aligned with international best practices.

2.0 DEFINITIONS

2.1 AGE-STANDARDISED RATE (ASR)

An age-standardised rate (ASR) is a summary measure of the rate that would have been observed if the population had a standard age structure. Standardisation is necessary when comparing several populations that differ with respect to age, because age has a strong influence on the risk of cancer. An ASR is a weighted mean of the age-specific rates; the weighting is based on the population distribution of a standard population[1]. This policy uses the ASR to show cancer incidence, not cancer mortality.

2.2 CANCER

Cancer is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow uncontrollably, go beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.[2]

2.3 BOWEL (COLORECTAL) CANCER

Bowel cancer, also known as colorectal cancer, begins in the large bowel, which includes the colon and rectum, and is one of the most common cancers in Western countries. It occurs when cells in the lining of the bowel grow and divide uncontrollably, often developing from non-cancerous polyps that, over time, can become malignant.

2.4 CERVICAL CANCER

Cervical cancer is a slow-growing cancer that develops in the cervix, most commonly caused by persistent infection with certain high-risk types of Human Papillomavirus (HPV). It typically begins with abnormal changes in cervical cells (a condition known as dysplasia) which can progress to cancer over many years if left undetected and untreated.

[1] Ervik M, L. F., Laversanne M, Colombet M, Ferlay J, Miranda-Filho A, Bray F. (2024). *Global Cancer Observatory: Cancer Over Time*. International Agency for Research on Cancer. https://gco.iarc.who.int/overtime
[2] World Health Organization. (2026). *Cancer*. World Health Organization. Retrieved 6/2/2026 from https://www.who.int/health-topics/cancer#tab=tab_1

2.5 FEMALE BREAST CANCER

Breast cancer is a disease in which cells in the breast grow and divide uncontrollably, forming a tumour. It typically begins in the ducts (which carry milk to the nipple) or the lobules (which produce milk), but it can also arise from other breast tissues. If left untreated, these abnormal cells may invade nearby tissues and spread (metastasise) to other parts of the body through the bloodstream or lymphatic system. Symptoms may include a new lump or thickening in the breast or armpit, changes in the size, shape, or appearance of the breast, nipple discharge, inversion, or changes to the skin around the nipple. Breast cancer can occur in both men and women, while female breast cancer occurs in biological women.

2.6 SCREENING PROGRAMME

A screening programme is not just a single test, but a process and a pathway. It starts by identifying the people who are eligible for screening, referred to as the target population or cohort. The screening pathway includes diagnosis and treatment. Sometimes the pathway operates as a cycle, with people who have a normal screening test being invited back in an agreed timeframe (such as two years) to be screened again. The final step in the pathway is the reporting of outcomes and evaluation of the screening programme. A screening programme will only be effective if all parts of the screening pathway are provided correctly (identifying the eligible population; invitation and information on cancer screening; testing; referral of positive results and reporting of negative results; diagnosis; intervention; treatment and follow-up; and, reporting of outcomes).[3]

2.7 NATIONAL EPIDEMIOLOGIST

The National Epidemiologist is employed by the Ministry of Health, Environment & Sustainability and is trained in epidemiology, which is the branch of medical science investigates the presence, distribution and determinants of health-related states or events (including disease). Epidemiology helps us to understand how many people have a disease or disorder in different population groups, if the occurrence is changing, and what factors are causing or influencing this, in order to inform the control of health problems across the population.

3.0 INTRODUCTION

3.1 PURPOSE

This policy outlines the national framework for the implementation, monitoring, evaluation, and oversight of cancer screening programmes across the Cayman Islands. It also adopts evidence-based and internationally recognised cancer quality standards and guidelines to establish standardised care pathways to guide practitioners and ensure consistency in the delivery of care.

The policy sets evidence-based programmes for the screening of three (3) priority cancers:

- bowel (colorectal);
- cervical, and;
- female breast.

[3] Europe, W. H. O. R. O. f. (2022). *A Short Guide to Cancer Screening: Increase Effectiveness, Maximize Benefits and Minimize Harm*. W. R. O. f. Europe. https://iris.who.int/server/api/core/bitstreams/fce0432a-c1d2-47ef-bda1-5f87ab44d298/content

These cancers have been identified due to their prevalence and the availability of effective population-based screening tools. While other cancers, such as prostate, lung, ovarian, brain, pancreatic, blood, etc., fall outside the current scope for this national policy, they will remain under review. As new research emerges, these cancers may be considered for inclusion based on the strength of evidence supporting population-level screening.

Early detection through organised, systematic screening is central to reducing cancer-related mortality, improving treatment outcomes, and lowering the long-term costs of care.

Oversight of the policy will be provided by the National Cancer Consultation Group (NCCG) (*see 6.1*), comprising key stakeholders from both the public and private healthcare sectors, not for profit sector and those with lived experience. The NCCG is responsible for ensuring that all cancer screening programmes and guidance proposed to the Minister responsible for Health are:

- evidence-based;
- accessible;
- equitable, and;
- patient-centred.

It will also lead efforts in quality improvement, performance monitoring, and the adoption of international best practices.

3.2 SCOPE

This policy applies to all public and private healthcare providers involved in delivering cancer screening and care across the Cayman Islands. This includes primary care practitioners, specialists responsible for referrals and follow-up care, as well as laboratories and diagnostic service providers. It also extends to public health professionals engaged in education, outreach, and awareness campaigns.

All stakeholders should comply with the policy's standards to ensure a coordinated, evidence-based, and high-quality approach to cancer screening. This framework promotes consistency in care, supports early detection, and aims to reduce cancer-related morbidity and mortality across the population.

Healthcare facilities and practitioners should report on cancer-related data in accordance with relevant legislation. These efforts are essential for monitoring trends, informing policy decisions, and ultimately improving health outcomes and quality of life for the people of the Cayman Islands.

3.3 CANCER RISK AND INCIDENCE RATES

A person's risk of developing cancer depends on many factors, including age, genetics, and exposure to risk factors, including some potentially avoidable lifestyle factors. Smoking is the leading preventable cause of cancer[4], linked to cancers of the lung, mouth, throat, and many other

[4] Insitute, N. C. (2017). *Tobacco*. U.S. National Institues of Health. Retrieved 6/2/2026 from https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco

organs. In the Cayman Islands, 1 in 8 (12.5%) adults are current smokers.[5] Alcohol consumption is also known to increase the risk of cancer (more than 1 in 2 adults [55%] are current drinkers, defined as drinking alcohol within the past 30 days). Diet also plays a key role: intake of processed foods high in salt raises cancer risk, while fruits, vegetables, and whole grains offer protective benefits. Approximately 1 in 5 adults always or often eat processed foods high in salt, while 85% eat less than the recommended portion of 5 servings of fruit and/or vegetables per day. Physical inactivity and obesity contribute to cancer risk by increasing inflammation[6], where 1 in 5 adults (19.7%) are not meeting World Health Organisation (WHO) recommendations for exercise, and 1 in 3 adults (33%) are obese. Healthy lifestyle choices can significantly lower cancer risk.

While a national evidence-base on the incidence and lifetime risk of cancer does not exist in the Cayman Islands, this policy draws on research conducted in the United Kingdom (UK), United States of America (USA) and other Caribbean (Barbados, Bermuda, Guadeloupe, Martinique, Puerto Rico, and Trinidad and Tobago)[7] populations. UK, USA and Caribbean data provides possible estimates in the absence of local data, until the Cayman Islands establishes its own national population-based cancer registry.

3.3.1 Bowel (Colorectal) Cancer

Early detection of bowel cancer is critical, as it significantly improves the chances of successful treatment and long-term survival. Treatment options depend on the exact location and stage of the cancer and may include surgery, chemotherapy, and radiotherapy.

UK research demonstrates that the estimated lifetime risk of being diagnosed with bowel cancer is 1 in 20 (5%) for females and 1 in 17 (6%) for males.[8] Although early-onset bowel cancer (in people under 50) is rising globally, it remains relatively rare in the UK, where only 1 in 20 cases are diagnosed in individuals under 50.[9] USA research shows that approximately 3.9% of men and women will be diagnosed with colorectal cancer at some point during their lifetime.[10]

In the Caribbean, the average Age-Standardised Rate (ASR) for incidence for bowel cancer is as follows: males, colon incidence rate is 17.7 cases per 100,000 and rectal is 8.8 cases per 100,000, and females, colon incidence rate is 14.0 cases per 100,000 and rectal is 5.4 cases per 100,000. This compares to the UK and USA ASRs as seen in *Table 1*.

[5] Government, C. I. (2023). *STEPS 2023 National Health Survey Understanding the prevalence of risk factors for non-communicable diseases in the Cayman Islands* https://gov.ky/documents/35692/0/STEPS_23_Report_Digital_compressed.pdf/6e782802-ee72-8ef3-e0ec-1f136e3f42e8?t=1765505044447

[6] Lamabadusuriya, D. A., Jayasena, H., Bopitiya, A. K., De Silva, A. D., & Jayasekera, P. (2025). Obesity-driven inflammation and cancer risk: A comprehensive review. *Seminars in Cancer Biology*, *114*, 256-266. https://doi.org/https://doi.org/10.1016/j.semcancer.2025.07.007

[7] (CARPHA), C. P. H. A. (2026). *Cancer Incidence in the Caribbean Volume 1* https://caribbeancrh.carpha.org/Portals/0/Caribbean_Cancer_Incidence_Report_APPROVED.pdf?ver=NwQgYzNGwtum1X4_1mkYtA%3d%3d

[8] UK, C. R. *Risks and Causes of Bowel Cancer*. Retrieved 6/2/2026 from https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/bowel-cancer/risk-factors

[9] Gunn, T. (2024). *Bowel Cancer Rates Rising in Younger Adults Around the World* Cancer Research UK - Cancer News https://news.cancerresearchuk.org/2024/12/11/early-onset-bowel-cancer-rise-global-phenomenon/

[10] Insitute, N. C. *SEER Cancer Stat Facts: Colorectal Cancer* National Cancer Institute https://seer.cancer.gov/statfacts/html/colorect.html

Table 1. ASR per 100,000 population incidence by sex for colon and rectum cancer across USA, UK and Caribbean populations

	Caribbean (2013-2018)	USA* (2013-2017)	UK-England* (2013-2017)
Men			
Colon	17.7	18.9	21.5
Rectum	8.8	9.8	13.8
Women			
Colon	14.0	15.6	17.0
Rectum	5.4	6.1	7.2

Source: Caribbean Public Health Agency (CARPHA). Cancer Incidence in the Caribbean Volume 1. 2026

According to the Cayman Islands national STEPS survey[11], around one in three (28.6%) people aged 45-69 report ever having a faecal-immunochemical test (FIT) examination to look for hidden blood.

3.3.2 Cervical Cancer

Cervical cancer is highly preventable. Approximately 99.7% of cases are linked to HPV infection[12], making vaccination and regular screening critical public health tools. HPV vaccination, when administered before exposure to the virus, is highly effective in preventing the types of HPV that most commonly cause cervical cancer. Routine cervical screening can detect precancerous cell changes early, allowing for timely treatment before cancer develops.

Research suggests that between 1 in 142 females (UK)[13] and 1 in 167 females (US)[14] in will be diagnosed with cervical cancer in their lifetime.

Achieving high HPV vaccination coverage will significantly lower HPV transmission rates. This could eliminate nearly all cervical cancer-related deaths and reduce long-term healthcare costs, making vaccination and screening vital strategies for cancer prevention and control.

In the Caribbean, the ASR for incidence of cervical cancer is 9.6 cases per 100,000. This compares to the UK and USA ASRs as seen in *Table 2*.

Table 2. ASR per 100,000 incidence for cervical cancer across USA, UK and Caribbean populations

	Caribbean (2013-2018)	USA* (2013-2017)	UK-England* (2013-2017)
Cervix Uteri	9.6	6.0	7.7

Source: Caribbean Public Health Agency (CARPHA). Cancer Incidence in the Caribbean Volume 1. 2026

[11] Government, C. I. (2023). *STEPS 2023 National Health Survey Understanding the prevalence of risk factors for non-communicable diseases in the Cayman Islands* https://gov.ky/documents/35692/0/STEPS_23_Report_Digital_compressed.pdf/6e782802-ee72-8ef3-e0ec-1f136e3f42e8?t=1765505044447

[12] Walboomers, J. M., Jacobs, M. V., Manos, M. M., Bosch, F. X., Kummer, J. A., Shah, K. V., Snijders, P. J., Peto, J., Meijer, C. J., & Muñoz, N. (1999). Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. *J Pathol*, *189*(1), 12-19. https://doi.org/10.1002/(sici)1096-9896(199909)189:1<12::Aid-path431>3.0.Co;2-f

[13] (NICE), N. I. f. H. a. C. E. (2025). *Cervical Cancer and HPV: How common is it?* Retrieved 6/2/2026 from https://cks.nice.org.uk/topics/cervical-cancer-hpv/background-information/prevalence/

[14] Insitute, N. C. *SEER Cancer STAT Facts: Cervical Cancer*. Retrieved 6/2/2026 from https://seer.cancer.gov/statfacts/html/cervix.html

According to STEPS[15], among women aged 25 – 49 years, nearly 7 in 10 women (67.8%) have ever been screened for cervical cancer, meaning around a third in this age grouping have never been screened.

3.3.3 Female Breast

Research shows that 1 in 7 (UK)[16] and 1 in 8 (US)[17] women will be diagnosed with breast cancer in their lifetime. However, nearly 23% of cases are preventable[18], highlighting the role of lifestyle and reproductive factors. Oral contraceptives contribute to fewer than 1% of cases, while post-menopausal hormone therapy accounts for around 2%.[19] Overweight and obesity are responsible for 8% of breast cancer cases, as is alcohol consumption. Not breastfeeding also increases risk, contributing to 5% of cases.[20]

Reproductive history plays a significant role in risk. Having children later in life is associated with a higher risk, while each live birth reduces risk by 7%.[21][22] Breastfeeding provides additional protection, reducing breast cancer risk by 4.3% for every 12 months of breastfeeding. It also lowers the risk of Triple-Negative Breast Cancer by 20% and reduces risk by 22–55% in BRCA1 mutation carriers.[23] Emerging research also suggests breastfeeding may reduce the risk of childhood blood cancers[24], offering added long-term health benefits.

The 2024 NICE clinical knowledge summary paper offers a very good overview of managing family history risk for breast cancer. In summary, they suggest that 5-10% of breast cancers are likely to be linked to a hereditary genetic predisposition.[25] The genes most commonly linked to hereditary risk are those with mutations in Breast Cancer 1 and 2 genes (BRCA1 / BRCA2). Approximately 1 in 400–800 (0.2 – 0.25%) of the general population have mutations in the BRCA1 and BRCA2 genes.[26] However, the prevalence of these mutations does vary by

[15] Government, C. I. (2023). *STEPS 2023 National Health Survey Understanding the prevalence of risk factors for non-communicable diseases in the Cayman Islands* https://gov.ky/documents/35692/0/STEPS_23_Report_Digital_compressed.pdf/6e782802-ee72-8ef3-e0ec-1f136e3f42e8?t=1765505044447

[16] UK, C. R. *Breast Cancer Risk*. https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer/risk-factors

[17] Insitute, N. C. *Breast Cancer Risk in American Women*. Retrieved 6/2/2026 from https://www.cancer.gov/types/breast/risk-fact-sheet

[18] Brown, K. F., Rumgay, H., Dunlop, C., Ryan, M., Quartly, F., Cox, A., Deas, A., Elliss-Brookes, L., Gavin, A., Hounsome, L., Huws, D., Ormiston-Smith, N., Shelton, J., White, C., & Parkin, D. M. (2018). The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. *Br J Cancer*, *118*(8), 1130-1141. https://doi.org/10.1038/s41416-018-0029-6

[19] UK, C. R. *Breast Cancer Risk*. Retrieved 6/2/2026 from https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer/risk-factors

[20] Ibid.

[21] Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease. (2002). *Lancet*, *360*(9328), 187-195. https://doi.org/10.1016/s0140-6736(02)09454-0

[22] Ma, H., Bernstein, L., Pike, M. C., & Ursin, G. (2006). Reproductive factors and breast cancer risk according to joint estrogen and progesterone receptor status: a meta-analysis of epidemiological studies. *Breast Cancer Res*, *8*(4), R43. https://doi.org/10.1186/bcr1525

[23] Stordal, B. (2023). Breastfeeding reduces the risk of breast cancer: A call for action in high-income countries with low rates of breastfeeding. *Cancer Medicine*, *12*(4), 4616-4625. https://doi.org/https://doi.org/10.1002/cam4.5288

[24] Søegaard, S. H., Andersen, M. M., Rostgaard, K., Davidsson, O. B., Olsen, S. F., Schmiegelow, K., & Hjalgrim, H. (2024). Exclusive Breastfeeding Duration and Risk of Childhood Cancers. *JAMA Network Open*, *7*(3), e243115-e243115. https://doi.org/10.1001/jamanetworkopen.2024.3115

[25] (NICE), N. I. f. H. a. C. E. (2024). *Breast cancer - managing FH: What is known about the genetic risk factors?* https://cks.nice.org.uk/topics/breast-cancer-managing-fh/background-information/genetic-risk-factors/

[26] Petrucelli, N., Daly, M. B., & Feldman, G. L. (2010). Hereditary breast and ovarian cancer due to mutations in BRCA1 and BRCA2. *Genet Med*, *12*(5), 245-259. https://doi.org/10.1097/GIM.0b013e3181d38f2f

ethnicity and country of origin. The highest prevalence of carriage is found in people with Ashkenazi Jewish ancestry, approximately 1 in 40 (2.5%).[27]

More than 6 out of 10 women who inherit a BRCA1 or BRCA2 mutation will develop breast cancer during their lifetime. Among women who have been diagnosed with breast cancer, those who have a BRCA1 or BRCA2 mutation have an increased risk of developing cancer in the opposite (contralateral) breast in the future compared with those who do not have such a change.[28] Individuals with inherited BRCA2 changes, especially breast cancer survivors, have a higher chance of developing contralateral breast cancer by 20 years after their first breast cancer diagnosis, than the general population.[29][30]

In a cancer study (using data from 2010 – 2018) examining breast and ovarian cancer incidence in Caribbean-born women found that, among 57 women from the Cayman Islands who had a grandparent born in one of the Caribbean countries included in the study, the average age at breast cancer diagnosis was 52.5 years. Most cases were identified at earlier stages, with 42.9% at Stage 1 and 46.4% diagnosed at Stage 2, while only 10.7% were diagnosed at Stage 3 and none at Stage 4. The study also reported that approximately one in four women (26.8%) had triple-negative breast cancer. Additionally, the study noted that among women in Cayman with breast and ovarian cancers, overall 1.6% had BRCA1 mutations and 3.2% had BRCA2 mutations.[31]

In the Caribbean, the ASR for incidence of female breast cancer is 58.8 cases per 100,000. This compares to the UK and USA ASRs as seen in *Table 3*.

Table 3. ASR per 100,000 population incidence for female breast cancer across USA, UK and Caribbean populations

	Caribbean (2013-2018)	USA* (2013-2017)	UK-England* (2013-2017)
Breast	58.8	91.0	92.4

Source: Caribbean Public Health Agency (CARPHA). Cancer Incidence in the Caribbean Volume 1. 2026

In the Cayman Islands, the 2023 STEPS Survey identified one in five women (20.2%), aged 45-69 years have never had a mammogram. One in three (32.1%) women aged 45-69 years report having had one in the past year, and one in four (25.9%) report having had a mammogram 1-

[27] Ibid.
[28] Yadav, S., Boddicker, N. J., Na, J., Polley, E. C., Hu, C., Hart, S. N., Gnanaolivu, R. D., Larson, N., Holtegaard, S., Huang, H., Dunn, C. A., Teras, L. R., Patel, A. V., Lacey, J. V., Neuhausen, S. L., Martinez, E., Haiman, C., Chen, F., Ruddy, K. J., . . . Couch, F. J. (2023). Contralateral Breast Cancer Risk Among Carriers of Germline Pathogenic Variants in ATM, BRCA1, BRCA2, CHEK2, and PALB2. *Journal of Clinical Oncology*, *41*(9), 1703-1713. https://doi.org/10.1200/jco.22.01239
[29] National Comprehensive Cancer Network: NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic. Version 3.2024

[30] Giannakeas, V., Lim, D. W., & Narod, S. A. (2021). The risk of contralateral breast cancer: a SEER-based analysis. *Br J Cancer*, *125*(4), 601-610. https://doi.org/10.1038/s41416-021-01417-7
[31] George, S. H. L., Donenberg, T., Alexis, C., DeGennaro, V., Jr, Dyer, H., Yin, S., Ali, J., Butler, R., Chin, S. N., Curling, D., Lowe, D., Lunn, J., Turnquest, T., Wharfe, G., Cerbon, D., Barreto-Coelho, P., Schlumbrecht, M. P., Akbari, M. R., Narod, S. A., & Hurley, J. E. (2021). Gene Sequencing for Pathogenic Variants Among Adults With Breast and Ovarian Cancer in the Caribbean. *JAMA Network Open*, *4*(3), e210307-e210307. https://doi.org/10.1001/jamanetworkopen.2021.0307

2 years ago. Among all women, uptake of mammograms has not changed since 2012, when almost half (46.4%) had never had a mammogram, similar to 50.8% in 2023.[32]

3.4 IMPACT OF CANCER

Cancer has significant implications for both individuals and society, making it a priority for public health policy in the Cayman Islands. For patients, cancer treatment is not only physically demanding but also emotionally taxing, leading to anxiety, depression, and fear of recurrence. These challenges, compounded by the stigma surrounding certain cancers, impact mental health and overall wellbeing. Addressing both physical and psychological aspects of cancer care is critical to improving patient outcomes.

The economic burden of cancer is profound, with high medical costs and lost productivity. Many patients face financial strain due to treatment costs, while lower workforce participation and reduced productivity occur as individuals take time off or leave their jobs. These factors place a heavy burden on the economy, highlighting the need for policies that promote early detection, equitable access to care, and mental health support. Strengthening cancer care pathways and providing comprehensive services will help mitigate these broader societal impacts.

As detailed in the Cayman Islands National Insurance Company (CINICO) annual reports, neoplasms (tumours) accounted for, on average, the second mostly costly condition from 2021 – 2024 (*see Table. 4*).

Table 4: CINICO Top 10 Diagnosis from 2021 to 2024 per Million Dollars

Diagnosis	2021	2022	2023	2024	2025	Average
Circulatory/Cardiovascular system	$20.5	$31.9	$30.6	$32.0	$38.9	$30.8
Neoplasms	**$15.1**	**$19.3**	**$24.1**	**$28.5**	**$24.2**	**$22.2**
General visit	$15.2	$18.2	$18.6	$23.5	$27.5	$20.6
General visit (Drugs)	-	-	$15.8	$17.6	$19.9	$17.8
Mental disorders	$9.8	$9.3	$11.1	-	$10.4	$10.2
Nervous system	$6.2	$8.3	$8.4	$9.3	-	$8.1
Musculoskeletal system and connective tissue	$14.5	$15.0	$22.3	$22.4	$23.4	$19.6
Endocrine, nutritional and metabolic	$7.4	-	-	$8.4	$8.9	$8.2
Injury and poisoning	$6.6	$7.9	$11.6	$11.0	$10.7	$9.6
Symptoms, signs and abnormal clinical	$11.5	$11.4	$12.3	$13.1	$13.2	$12.3
Respiratory system	-	$7.3	$8.7	$8.9	$11.9	$9.2
Digestive system	$7.8	$10.5	$11.0	$12.1	$13.1	$10.9

Source: CINICO Annual Reports[33] (2021, 2022, 2023, 2024 & 2025).

[32] Government, C. I. (2023). *STEPS 2023 National Health Survey Understanding the prevalence of risk factors for non-communicable diseases in the Cayman Islands* https://gov.ky/documents/35692/0/STEPS_23_Report_Digital_compressed.pdf/6e782802-ee72-8ef3-e0ec-1f136e3f42e8?t=1765505044447

[33] (CINICO), C. I. N. I. C. (2021, 2022, 2023, 2024). *Annual Reports*. https://www.cinico.ky/annual-reports/

4.0 DIRECTIVES

This policy is structured around three core objectives, each aimed at enhancing cancer screening and care across the Cayman Islands.

The first objective is to establish national screening protocols, promoting a consistent, evidence-based approach to early detection. The second objective is to implement quality standards that guide the delivery of safe, effective, and high-quality cancer care. The third objective is to adopt national guidelines to help define standardised clinical care pathways, ensuring patients receive timely and coordinated care from initial screening through diagnosis and treatment.

The policy's primary aim is to increase early detection rates for female breast, cervical, and bowel (colorectal) cancers through a standardised national approach, enabling earlier intervention when treatment is most effective. This is vital for improving survival outcomes and reducing cancer-related mortality.

4.1 SCREENING PROGRAMMES

These programmes are designed for population-level cancer screening, based on the assumption that individuals are generally healthy and asymptomatic. In cases where cancer or pre-cancer is suspected, practitioners must refer to the guidelines outlined in the relevant section (*see page 17*), which provide clinical guidance for investigation, referral, and follow-up care.

Opportunistic screening (offering preventive care during unrelated medical visits) enhances the comprehensiveness of health services. It ensures that every patient interaction becomes a valuable opportunity to improve overall wellbeing. While conducting cancer screening, practitioners are encouraged to perform additional preventive checks, such as measuring blood pressure, reviewing vaccination status according to the current national immunisation schedule, and offering any vaccines the patient is eligible to receive.

If patients attend with children, practitioners should also take the opportunity to check the vaccination status of accompanying children and administer any age-appropriate vaccines, provided eligibility and consent requirements are met.

In the case that the patient has symptoms or expressed that they felt should be tested, where the clinician determines it clinically necessary, screening should not be delayed until the next routine screening interval. If the patient is eligible and it is appropriate to do so, screening should be offered immediately.

These programmes do not support the use of self-examination, routine practitioner-led physical examination, or thermography as valid cancer screening methodologies. Such approaches are not supported by current evidence for population-level screening and should not be used in place of validated screening tests.

The guidelines promote an evidence-based, patient-centred approach to preventive care and early cancer detection.

Table 5: Summary of National Cancer Screening Schedule

<table>
<tr><th rowspan="2">Cancer type</th><th colspan="5">Age (years)</th></tr>
<tr><th>24.5 – 29</th><th>30 – 39</th><th>40 – 49</th><th>50 – 64</th><th>65 – 74</th></tr>
<tr><td>Bowel (Colorectal)</td><td colspan="2"></td><td colspan="3">Faecal immunochemical test (FIT) every two years or Colonoscopy every 10 years (45 – 74 years)</td></tr>
<tr><td>Cervical</td><td colspan="4">HPV testing with cytology triage every 5 years (until 64 years)
(Catch-up immunisation at first screening if required)</td><td></td></tr>
<tr><td>Female breast</td><td></td><td>Family history assessment (at 30 & 39)</td><td colspan="3">Mammography every two years for females 40 – 74 years (check-up for BRCA1/ BRCA2 if not done/not on record at age 30)</td></tr>
</table>

4.1.1 Bowel (Colorectal) Cancer

Target Population: Adults aged 45 to 74 years
Screening Method: Faecal immunochemical test (FIT) and Colonoscopy
Frequency: FIT every two years or Colonoscopy every 10 years
Key Actions:

- Provide at-home FIT kits with return-by-mail systems where possible, and offer via primary care.
- Ensure rapid access to colonoscopy (following appointment with specialist nurse to discuss findings) for positive FIT results (provided two weeks after sample is examined).
- Ensure access to colonoscopy without a positive FIT results, where GPs determine clinically necessary based on persistent symptoms.
- Investigate abnormal results using MRI only in rectal cancer and CT abdomen and chest following colonoscopy.
- Facilities should maintain colorectal cancer screening register to enable call and recall.

4.1.2 Cervical Cancer

Target Population: Women aged 24.5 years to age 64 years[34] (offer catch-up vaccination at first appointment if required, ask about breast cancer family history at aged 30 if not on record)
Screening Method: HPV testing and cytology triage (where indicated)
Frequency: Every 5 years
Key Actions:

- Utilise high-risk HPV DNA testing[35] and where indicated, liquid-based cytology[36]
- Offer via screening via primary care
- Provide self-sampling kits where appropriate/possible where women would prefer this method, or where access is more difficult, to increase participation.
- Women aged 65 years and older are invited if a recent cervical cytology sample is abnormal, or they have not had a cervical screening test since 50 years of age and they request one[37]
- Facilities should maintain a cervical cancer screening register to enable call and recall.

4.1.3 Female Breast Cancer

Target Population: Women aged 40 to 74 years
Screening Method: Mammography
Frequency: Every two years from 40 – 74. Exceptions to this include the need for additional screening were advised by radiology due to breast density (the advice of a radiologist specialising in breast pathology should be sought and followed as to the need for any additional modality of screening this may include MRI or ultrasound, but not thermography).

When women reach the age of 30 years, a family history assessment should be undertaken. A family history assessment should be taken again at 39 years. If women do not attend the appointments at 30 years and 39 years, family history must be taken at mammography appointment at 40 years.

Given that carriage of BRCA1 or BRCA2 mutations give not only a very high lifetime risk of developing breast cancer but are also very strongly implicated in ovarian and pancreatic cancers, identifying BRCA1 or BRCA2 gene carriage is critically important.

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[34] England, N. (2025). *Guidance*
Cervical screening pathway requirements. Government of the United Kingdom. https://www.gov.uk/government/publications/cervical-screening-pathway-requirements-specification/cervical-screening-pathway-requirements-specification
[35] Organization, W. H. (2021). *WHO recommends DNA testing as a first-choice screening method for cervical cancer prevention*. https://www.who.int/europe/news/item/11-09-2021-who-recommends-dna-testing-as-a-first-choice-screening-method-for-cervical-cancer-prevention#:~:text=cervical%20cancer%20prevention-,WHO%20recommends%20DNA%20testing%20as%20a%20first%2Dchoice,method%20for%20cervical%20cancer%20prevention&text=DNA%2Dbased%20testing%20for%20human,noncommunicable%20diseases%2C%20WHO/Europe.
[36] (NICE), N. I. f. C. E. (2003). *Final Appraisal Determination*
Guidance on the use of liquid-based cytology for cervical screening
Review of existing guidance number 5. https://www.nice.org.uk/guidance/ta69/documents/final-appraisal-determination-guidance-on-the-use-of-liquidbased-cytology-for-cervical-screening-review-of-existing-guidance-number-52
[37] (NICE), N. I. f. H. a. C. E. (2026). *Cervical Screening* https://cks.nice.org.uk/topics/cervical-screening/

BRCA gene mutation does not give rise to any phenotypic features, but family history can be very suggestive. Individuals should be referred for investigation, even without a personal history of breast cancer, if they have **any** of the following:

- An immediate family member (mother, daughter, sister) who was diagnosed with breast cancer aged less than 40
- An immediate family member (father, son, brother) who was diagnosed with breast cancer at any age
- An immediate family member (mother, father, daughter, son, sister, or brother) with bilateral breast cancer where the first primary was diagnosed aged less than 50
- Two extended family members (grandparents, grandchildren, aunt, uncle, niece, nephew, half-sister, or half-brother), or one immediate family member and one extended family member was diagnosed with breast cancer at any age
- One immediate family member and one extended family member was diagnosed with breast cancer at any age AND one immediate family member or one extended family member was diagnosed with ovarian cancer at any age
- Three immediate or extended family members diagnosed with breast cancer at any age.

Refinement of risk can then be made using one of a number of risk assessment models that have been evaluated[38] and found to have good predictive values to indicate the need for formal genetic screening.

Key Actions:

- Offer routine mammograms
- Ensure follow-up diagnostics (e.g., ultrasound, biopsy) are accessible within 2 weeks of abnormal results.
- Women older than the maximum age for screening are currently excluded from the routine screening programme; however, they can continue to receive breast screening by self-referral.[39]
- Facilities should maintain a breast cancer screening register to enable call and recall.

[38] Evans, D. G. R., & Howell, A. (2007). Breast cancer risk-assessment models. *Breast Cancer Research*, *9*(5), 213. https://doi.org/10.1186/bcr1750
[39] Excellence, N. I. f. H. a. C. (2022). *Breast Screening* https://cks.nice.org.uk/topics/breast-screening/

4.2 QUALITY STANDARDS

Quality standards define key areas for improvement in healthcare by identifying variations in current practices. Each standard includes clear statements to guide quality enhancement and offers methods for measuring progress. A practical tool[40] is also provided to help healthcare facilities assess their current services against selected quality statements. This tool includes a template for evaluating existing practices, creating a structured action plan, and monitoring ongoing improvements. By using these standards and tools, healthcare providers can systematically identify gaps, implement changes, and track their impact, ultimately ensuring higher-quality care and better patient outcomes across the healthcare system. The Cayman Islands adopts the following evidence-based cancer quality standards:

4.2.1 Suspected Cancer [QS124][41]

This quality standard covers the investigation and recognition of suspected cancer, and referral to specialist cancer services for adults, young people and children. It describes high-quality care in priority areas for improvement.

4.2.2 Breast Cancer [QS12][42]

This quality standard covers the care of people with breast cancer after they have been referred to a specialist team. It includes the management of early (ductal carcinoma in situ and invasive), locally advanced and advanced breast cancer; recurrent breast cancer; and familial breast cancer. It describes high-quality care in priority areas for improvement.

4.2.3 Colorectal cancer [QS20][43]

This quality standard covers the management of colorectal (bowel) cancer in adults. It includes managing local disease and secondary tumours (metastatic disease). It describes high-quality care in priority areas for improvement.

[40] https://a.storyblok.com/f/243782/x/3cf6bcfa69/qs-service-improvement-template.xlsm

[41] Excellence, N. I. f. H. a. C. (2015, 15 April 2026). *Suspected cancer: recognition and referral*. https://www.nice.org.uk/guidance/ng12
[42] Excellence, N. I. f. H. a. C. (2011, 2016). *Breast Cancer* https://www.nice.org.uk/guidance/qs12
[43] Excellence, N. I. f. H. a. C. (2012, 2022). *Colorectal cancer* https://www.nice.org.uk/guidance/qs20

4.3 GUIDELINES

Evidence-based cancer guidelines are vital to ensure timely, consistent, and high-quality care across the cancer pathway. Guidance on suspected cancer: recognition and referral helps clinicians identify warning signs early and refer patients urgently, improving diagnostic speed and survival outcomes. For early and locally advanced breast cancer, evidence-based recommendations support accurate diagnosis, appropriate imaging, and effective treatment choices, reducing variation in care. Similarly, colorectal cancer guidelines promote optimal investigation, staging, and management based on best available evidence. Together, these guidelines improve patient outcomes, support clinical decision-making, reduce inequalities, and ensure healthcare resources are used effectively and safely. The Cayman Islands adopts the following evidence-based cancer guidelines:

4.3.1 Suspected cancer: recognition and referral [NG12][44]

This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

4.3.2 Early and locally advanced breast cancer: diagnosis and management [NG101][45]

This guideline covers diagnosing and managing early and locally advanced breast cancer. It aims to help healthcare professionals offer the right treatments to people, taking into account the person's individual preferences.

4.3.3 Colorectal cancer [NG151][46]

This guideline covers managing colorectal (bowel) cancer in people aged 18 and over. It aims to improve quality of life and survival for adults with colorectal cancer through management of local disease and secondary tumours (metastatic disease).

5.0 IMPLEMENTATION

Screening services will be provided through public and private clinics, as well as at-home testing kits where possible.

All health professionals involved in screening should read and understand this policy.

Healthcare facilities should ensure that patients are reminded of upcoming screening appointments and that appointments are offered for the next screening interval.

[44] Excellence, N. I. f. H. a. C. (2015, 15 April 2026). *Suspected cancer: recognition and referral*. https://www.nice.org.uk/guidance/ng12
[45] (NICE), N. I. f. H. a. C. E. (2018, April 14 2025). *Early and locally advanced breast cancer: diagnosis and management*. https://www.nice.org.uk/guidance/NG101
[46] (NICE), N. I. f. H. a. C. E. (2020, December 15 2021). *Colorectal cancer*. https://www.nice.org.uk/guidance/ng151

5.1 COMMUNICATION AND PUBLIC AWARENESS

A national public education campaign will be developed to inform the public about the benefits and limitations of screening, promote informed consent and individual autonomy in decision-making, and use media platforms and workplaces to encourage participation.

6.0 MONITORING

6.1 NATIONAL CANCER CONSULTATION GROUP

The National Cancer Consultation Group (NCCG) shall be responsible for the providing advice on cancer screening programmes, and advise the Minister on any updates required to the quality standards and guidance referenced in this policy.

The group will include oncologists, pathologists, nurses, as well as representatives from the Ministry responsible for Health, such as the Chief Medical Officer (CMO), Chief Nursing Officer (CNO) and the National Epidemiologist.

It will comprise representatives from public and private hospitals and not-for-profit representatives.

The responsibilities of the NCCG include advising the Minister on updates required to national screening standards, quality standards and national guidelines.

The group is tasked with consulting on the policy and monitoring the policy's effectiveness. The membership of the NCCG will be comprised of:

1. Chief Medical Officer, Ministry responsible for Health
2. Chief Nursing Officer, Ministry responsible for Health
3. National Epidemiologist, Ministry responsible for Health
4. Senior Policy Advisor, Ministry responsible for Health (Secretary)
5. Consultant Pathologist
6. Consultant Radiologist
7. Breast Cancer Surgeon
8. Gynaecological Cancer Surgeon
9. Colorectal Cancer Surgeon
10. Director of Nursing
11. Laboratory Manager
12. Not-for-profit Representative/s
13. Lived-experience Representative

6.2 QUALITY ASSURANCE

6.2.1 Data Collection

Healthcare facilities should enable their own call and recall systems to ensure patient adherence to the screening pathways, and report on a regular basis to the National Epidemiologist, the following key performance indicators:

6.2.2 Key Performance Indicators (KPIs)

Each cancer screening programme should report on (including sex and age grouping [24.5 – 29 years, 30 – 39 years, 40 – 49 years, 50 – 64 years, 65 – 74 years]):

- Number of individuals eligible, invited, screened and participation rate (%)
- Time from screening to diagnosis
- Positive predictive value of the test
- Follow-up adherence rate
- Cancer detection rate per 1,000 screened

Reports should be made to the National Epidemiologist (rachel.corbett@gov.ky) every six-months, for the periods 1st January – 30th June and 1st July – 31st December.

Reports should be made no later than one month after the end of the reporting period.

7.0 EVALUATION AND CHANGE

There will be bi-annual programme reviews by the Ministry, with recommendations for improvement. External audits will also occur every two years to ensure transparency and accountability.

This policy will be reviewed and evaluated every two years by the NCCG, or sooner if new evidence or technology emerges.

The process of reviewing and adopting new screening Laboratory methodologies will be achieved through the Laboratory quality mechanisms established within the Cayman Islands Microbiology Lab (CIMBL); in consultation with the Chief Medical Officer (CMO).

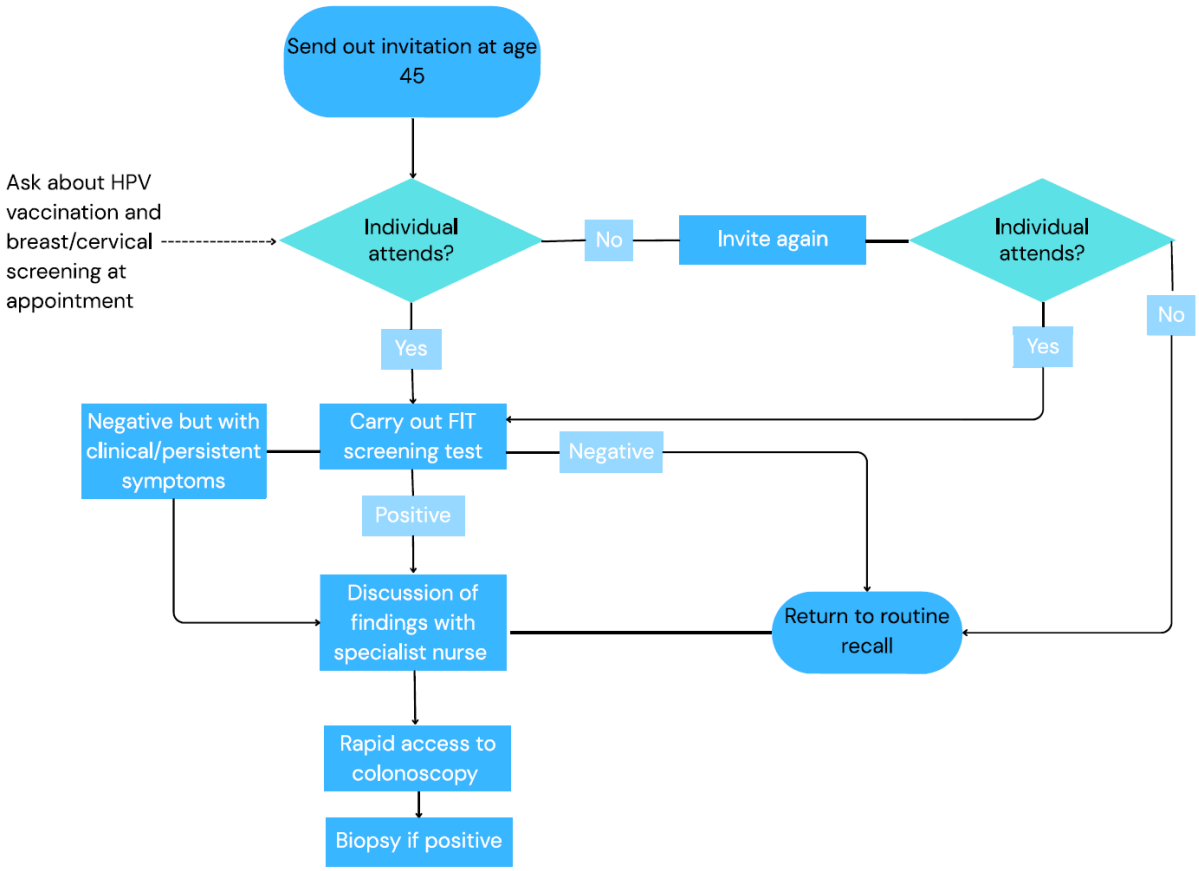
All requests for review of the policy outside of the review cycle can be made directly to the Ministry.

7.1 REVIEW DATE

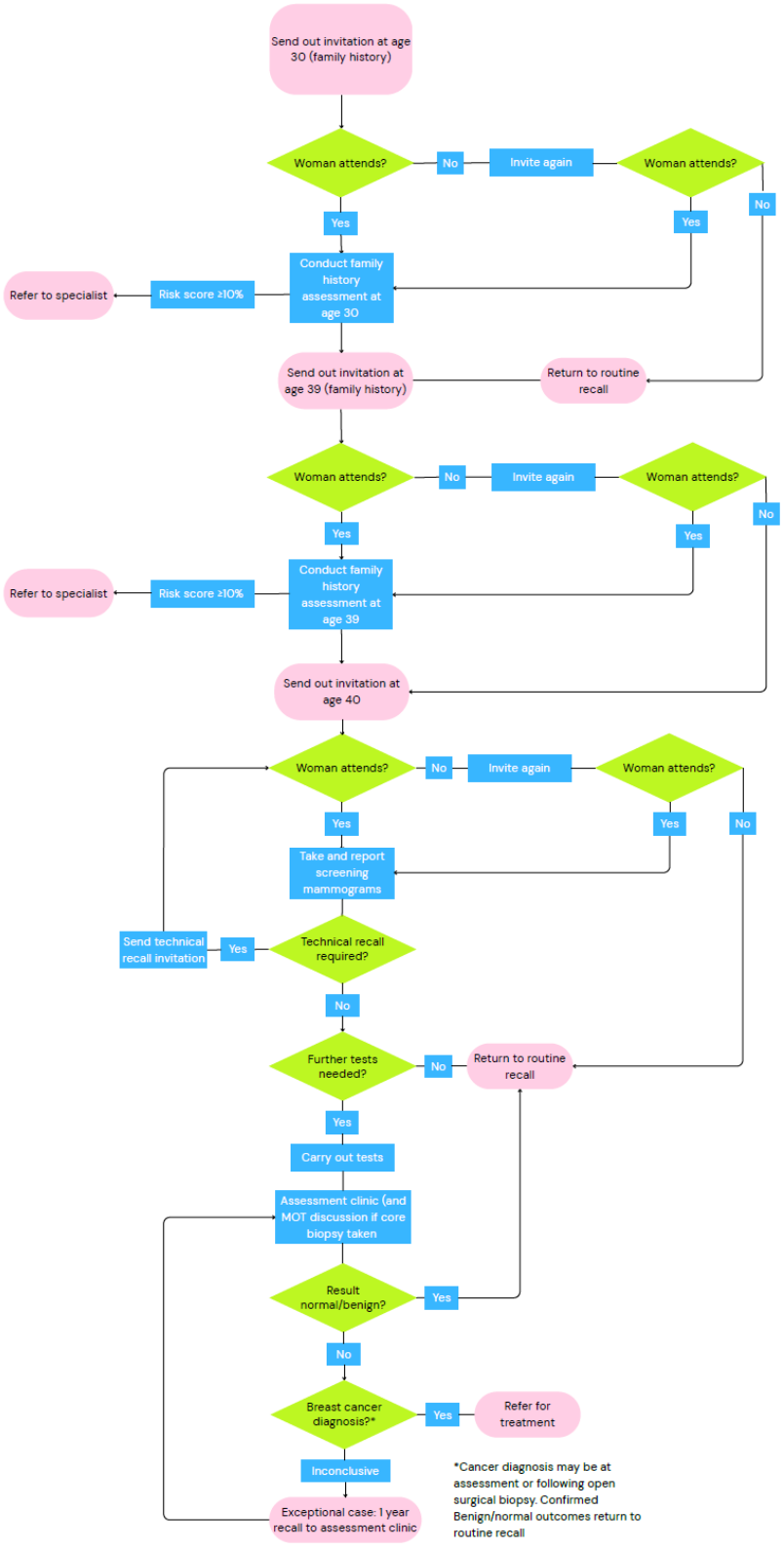
The next review date for this policy is on or before 1 July 2028.

8.0 APPENDICIES

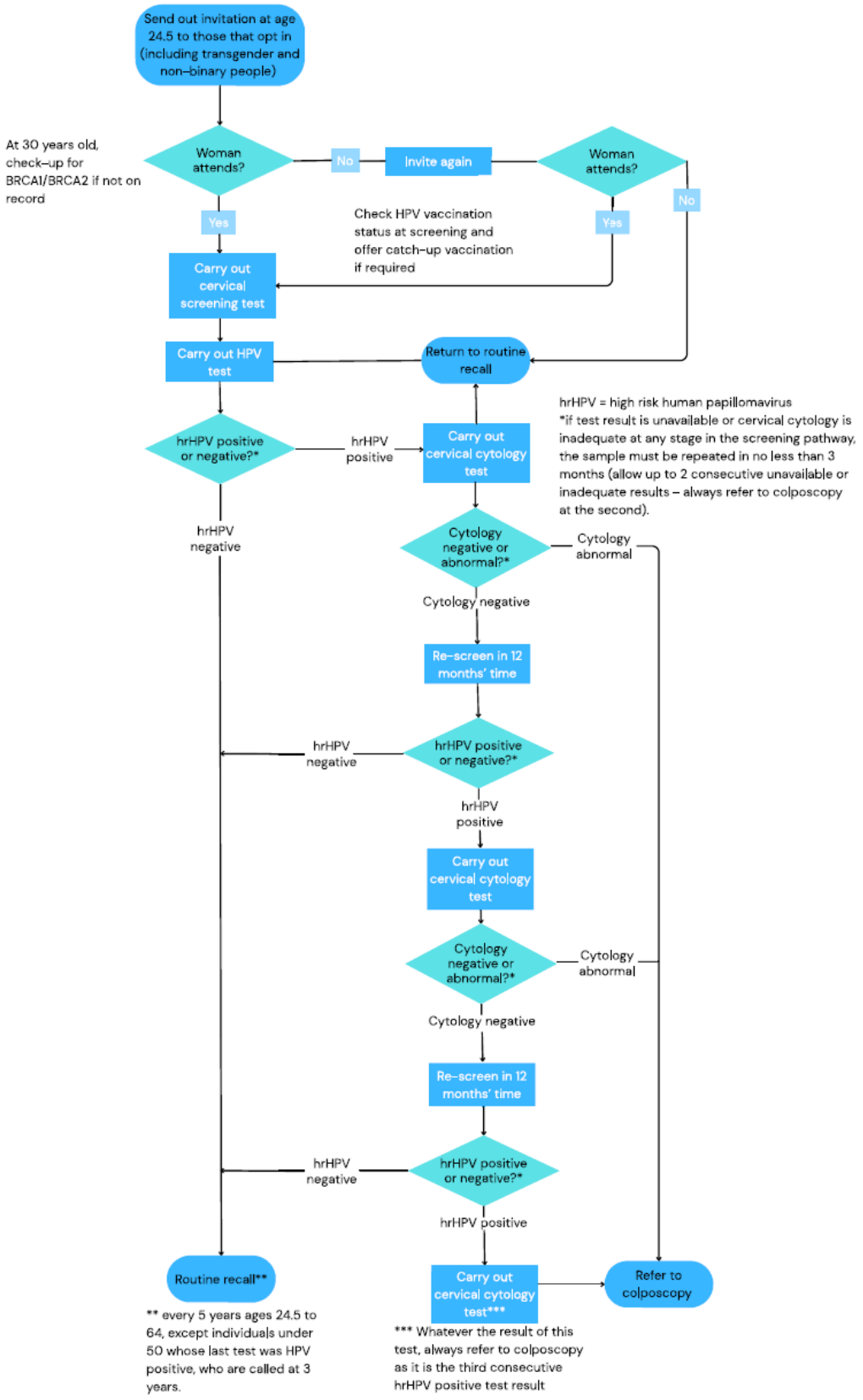
8.1 APPENDIX A: FLOWCHART FOR FIT TESTING TO SCREEN FOR BOWEL CANCER



8.2 APPENDIX B: FLOWCHART FOR FEMALE BREAST CANCER SCREENING



8.3 APPENDIX C: FLOWCHART FOR CERVICAL CANCER SCREENING



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