

Cancer Screening and Diagnosis in Correctional Settings

Introduction

The National Commission on Correctional Health Care (NCCHC) recognizes that cancer is a leading cause of death in prisons and the critical role of cancer screening in diagnosing cancer at an earlier stage, which increases the likelihood of cure and improved survival. NCCHC recommends the following:

Who should be screened

1. Cancer screening in prisons should follow the same evidence-based guidelines used in the community, with added attention to the higher risk profile of incarcerated populations (e.g., higher smoking rates, infectious disease burden, and barriers to prior care). Correctional facilities should offer cancer screening to eligible individuals, with a focus on those with longer periods of incarceration (at least several months). This recognizes that individuals whose incarceration is anticipated to be only days or weeks may benefit more from community-based screening to avoid care fragmentation.

Six cancers for which screening should be considered

2. Correctional facilities should follow U.S. Preventive Services Task Force (USPSTF) recommendations on cancer screening, which cover breast, cervical, colorectal, lung, and prostate cancers.¹
3. Additionally, recognizing the higher incidence of liver cancer among incarcerated individuals, correctional facilities should offer liver cancer screening for patients at high risk of developing liver cancer, including those with cirrhosis and certain patients with hepatitis B, as recommended by the American Association for the Study of Liver Diseases (AASLD).²

Strategies to improve the reach of screening

4. Correctional facilities should implement evidence-informed population-level cancer screening strategies, including patient- and clinician-directed interventions. Intake is a key opportunity to review prior screening history, initiate overdue screening, and prioritize those over age 50 with no documented history of cancer screening. Note: Screening for cervical cancer should begin at age 21 and screening for breast cancer should begin at age 40.
5. Correctional facilities should measure cancer screening rates and aim to achieve rates comparable to those achieved in the community. If screening rates fall below these thresholds, quality improvement initiatives should identify barriers to screening and consider implementing appropriate strategies to overcome these barriers.

Strategies to improve cancer diagnosis and linkage to cancer care

6. Correctional facilities should have systems for facilitating and tracking timely follow-up of positive screening tests, including further diagnostic workup and/or referral to oncology or other specialty care. Facilities should target a time from diagnosis to treatment initiation of 4 weeks, which is the national average.
7. Correctional facilities should promote awareness among the incarcerated population and prison health staff

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ON CORRECTIONAL HEALTH CARE

of “red flag” symptoms that should prompt cancer workup (e.g., unexplained weight loss), and the fact that incarcerated patients are diagnosed with cancer at a median age approximately 10 years younger than nonincarcerated patients.

8. Correctional facilities should ensure that people who are released to the community after a positive screening test or during cancer workup or treatment are provided with a community referral, support to link to appropriate follow-up care, and health records necessary to resume community-based care without delay.

Position Statement

Cancer in correctional facilities

Although cancer deaths are rare in jail, where the average length of incarceration is short, cancer is a leading cause of death in prison and is rising as prison populations age.^{3,4} Compared with individuals who have never been incarcerated at the time of cancer diagnosis, individuals who are diagnosed with cancer in jail or prison are much more likely to die from their cancer.^{5,6} Although this is attributable to many factors, one contributor to higher cancer mortality is later stage of diagnosis.⁷⁻⁹

Cancer screening

Six cancers – breast, cervical, colorectal, liver, lung, and prostate – have screening tests to enable early detection of cancer. These screenable cancers account for approximately 50% of all cancers diagnosed in prison.⁸ Notably, although evidence for increased risk of cancer among incarcerated compared with nonincarcerated individuals is mixed, elevated risks of developing cervical, liver, and lung cancers are well documented, likely related to high prevalence of risk factors such as HPV infection, smoking history, alcohol use, and viral hepatitis,^{5,8} and, in the case of cervical cancer, low rates of screening and treatment for premalignant lesions. Cancer screening enables early detection of cancers, which leads to earlier stage at diagnosis, increased likelihood of cure, and improved cancer survival. Some cancer screening interventions (e.g., colonoscopy, Pap smears) can also prevent the subsequent development of cancer by identifying and removing precancerous precursors. Additionally, because early-stage cancer costs less to treat than late-stage cancer, increased screening is associated with lower health care spending.^{10,11} Thus, cancer screening can lead to better patient outcomes with lower overall spending.

As of publication of this statement, USPSTF guidelines recommend screening for breast, cervical, colorectal, and lung cancer for all individuals within specified age ranges (in the case of lung cancer, with a specified smoking history, as well).¹ Additionally, USPSTF guidelines encourage patients and clinicians to discuss on an individual basis whether prostate cancer screening is appropriate.

Incarcerated individuals have 3 to 7 times higher rates of liver cancer than the general population.^{8,12} USPSTF guidelines do not have recommendations about liver cancer screening, as such screening is appropriate only for those with diagnoses that increase their risk of liver cancer. However, AASLD has published guidelines recommending screening for patients with cirrhosis and certain patients with prolonged hepatitis B infection.² Accordingly, these individuals should be screened for liver cancer, aligned with AASLD screening criteria.

Screening guidelines are updated frequently, so health care professionals working in correctional facilities need to ensure that their facility screening practices align with current guidelines.

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Although cancer screening should be offered to all eligible individuals, it may not be feasible or desirable for individuals who are anticipated to be incarcerated for a short period of time (days or weeks) to avoid care fragmentation upon release to the community. Cancer screening in prisons should be guideline driven, risk stratified, and equity focused, with emphasis on catch-up care and continuity. Thus, NCCHC recommends that cancer screening be offered to all eligible individuals whose length of incarceration is anticipated to be at least several months. This would allow for appropriate diagnostic follow-up for those who screen positive as well as linkage to treatment.

Unfortunately, cancer screening rates in U.S. correctional facilities may be low. Public data on cancer screening in jails and prisons is scant, and a literature review found few studies, and these had significant data limitations.¹³ This review suggests that cervical cancer screening rates in correctional facilities may be comparable to the general population, but that screening rates for other cancers is likely low. Notably, the review found no studies evaluating lung or liver cancer screening rates in correctional facilities, and a subsequent study found that correctional facilities were less likely to offer screening for lung and liver cancer than for other cancers, despite higher incidence of these cancers among incarcerated individuals.¹⁴ In 2025, a federal report on colorectal cancer screening in federal prisons showed that less than half of prison residents were up to date on colorectal cancer screening.¹⁵ In contrast, cancer screening rates in California prisons are on par with or better than national screening rates in the general population, demonstrating that high screening rates are possible under certain conditions, including intentional policies to increase screening.^{16,17}

Barriers to cancer screening and strategies to overcome them

There are numerous barriers to cancer screening in correctional facilities that likely vary across contexts. Common barriers include the logistics of conducting off-site screening tests (e.g., CT scans for lung cancer screening, colonoscopies), the lack of public health infrastructure to identify which individuals are eligible for and have received screening as well as appropriate interval for the next screening, clinician shortages that require prioritization of acute care over preventive care, lack of clinician familiarity with frequently changing screening guidelines, and inadequate patient privacy for screening procedures or specimen collection (e.g., for stool-based colorectal cancer screening).^{14,15,18}

Many evidence-informed strategies to improve cancer screening have been used in community settings. Some of these strategies may be applicable or could be tailored to correctional settings. Successful strategies include patient-directed interventions such as navigation (trained personnel assist individuals with the screening process), education (e.g., videos, flyers, printed materials), reminders (via mail, email, or text), and direct provision of screening supplies (e.g., fecal immunohistochemical test kits for colorectal cancer screening).¹⁹⁻²³ Successful clinician-facing interventions include education, reminders, and feedback on screening completion and gaps (“audit and feedback”). Interventions that combine multiple components are more effective than single-component interventions, as are interventions tailored to specific cultural contexts.

Nonetheless, correctional facilities are unique care environments that require a pragmatic approach to improve cancer screening. Although data supporting interventions to improve cancer screening specifically in correctional facilities is much more limited than data for interventions in the community setting, the correctional health community has described several strategies to overcome barriers:²⁴

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- a. Bringing screening tests into correctional facilities whenever possible, such as by using mobile mammography vans
- b. In recognition that many incarcerated individuals have suffered sexual trauma, using recently approved self-administered HPV testing to reduce need for clinician-administered invasive pelvic exams^{25,26}
- c. For screening that must be conducted off-site, planning screening drives that coordinate bulk screening to reduce staffing and transportation barriers (e.g., lung cancer screening caravans²⁷)
- d. Creating screening templates within electronic health records, especially to track smoking history to enable identification of patients eligible for lung cancer screening or to track other factors that affect eligibility for or modality of screening (e.g., family history, comorbidities that dictate the need for colonoscopy rather than stool-based colorectal cancer screening)
- e. Educating clinicians on updates to screening guidelines
- f. Educating patients on cancer screening recommendations so they can advocate for themselves
- g. Creating enforceable metrics that hold prisons and/or correctional health vendors accountable for cancer screening

Moreover, as is commonly done in the community through measures such as the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures,²⁸ progress on cancer screening completion rates should be measured using population dashboards, with target screening rate thresholds matched to screening rates achieved in the community.²⁹ If screening rates fall below the thresholds, quality improvement initiatives should identify barriers to screening and consider implementing appropriate strategies to overcome them. Departments of corrections and correctional health vendors alike may use contractual negotiations to agree on target screening rate thresholds, incentives for meeting such thresholds, and resources necessary to achieve these targets, ensuring alignment of care delivery and resource availability. Ideally, screening rates would be published regularly on publicly accessible websites (such as one used in California¹⁷) to ensure transparency and accountability.

Cancer diagnosis and linkage to care

Cancer screening is just the first step in the care continuum. For patients with positive screening tests, timely diagnostic confirmation, new cancer diagnosis workup, oncology evaluation, and treatment initiation improves cancer outcomes.^{30,31}

After a positive screening test, most individuals require confirmatory testing. Correctional health staff should be educated on appropriate follow-up after positive screening tests, as these are often managed in primary care (e.g., a colonoscopy after a positive stool-based test). Population health efforts (e.g., dashboards, clinician performance indicators) can be used to track individuals with positive tests undergoing further workup to ensure timely follow-up.

After a diagnosis of cancer is made or when it is strongly suspected, incorporating multidisciplinary care teams is important. Referral to oncology or other appropriate specialists should be expedited. To the extent to which specialists are willing to engage prior to formal consultation, early oncology involvement may enable correctional facilities to obtain necessary new cancer workup (e.g., appropriate imaging) prior to an in-person consultation, facilitating time to treatment. In the nonincarcerated population, the median time from diagnosis to treatment initiation is 26 days, and delays as short as an additional 4 weeks to treatment initiation are

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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

associated with worse stage at diagnosis and survival.^{30,31} To facilitate treatment within 4 weeks of diagnosis, correctional facilities should attempt to have initial oncology or other appropriate specialist consultation within 2 weeks of a diagnosis.

Throughout screening and diagnostic processes, it is important to communicate the goals, processes, risks, and benefits of screening and further workup to patients, particularly as many incarcerated people have limited health literacy or access to health information. When tests are positive, the ordering clinician should explain the results and next steps rather than defer to a downstream clinician to disclose a possible cancer diagnosis. Clear communication improves patient comprehension and may increase adherence to diagnosis and treatment plans.

Patients may be released from correctional facilities in the midst of cancer screening, workup, treatment, or posttreatment surveillance. Correctional facilities should provide these patients with referrals to community-based care, support to link to appropriate follow-up care (e.g., Medicaid enrollment, assistance making appointments timed after release), and health records necessary to resume community-based care without delay.

Cancer diagnosis outside of screening tests

Half of cancers diagnosed among incarcerated individuals do not have screening tests, and even patients who undergo cancer screening can develop cancer between screening intervals. Notably, individuals diagnosed with cancer during incarceration have a median age in the mid-50s, approximately 10 years younger than the median individual diagnosed in the general population.^{8,32} Thus, correctional health staff should be vigilant for signs or symptoms of cancer even in younger patients and should further work up patient self-report of such signs or symptoms, when clinically appropriate. Although there is no comprehensive list, the American Cancer Society provides a list of symptoms that could represent cancer, such as unexplained weight loss, new palpable masses, and hematochezia.³³ The presence of these symptoms may also reflect noncancerous conditions; if clinicians have a concern for cancer, they should initiate a diagnostic workup and, if a diagnosis is confirmed, ensure timely linkage to appropriate specialty care.

July 31, 2026 – Adopted by the National Commission on Correctional Health Care Governance Board

References

1. United States Preventive Services Task Force. (n.d.). *Recommendation topics*. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics>
2. Singal, A. G., Llovet, J. M., Yarchoan, M., Mehta, N., Heimbach, J. K., Dawson, L. A., Jou, J. H., Kulik, L. M., Agopian, V. G., Marrero, J. A., Mendiratta-Lala, M., Brown, D. B., Rilling, W. S., Goyal, L., Wei, A. C., & Taddei, T. H. (2023). AASLD Practice Guidance on prevention, diagnosis, and treatment of hepatocellular carcinoma. *Hepatology*, 78(6), 1922–1965. <https://www.doi.org/10.1097/hep.0000000000000466>
3. Carson, E. A., & Cowhig, M. P. (2020). *Mortality in state and federal prisons, 2001–2016 – Statistical tables*. <https://www.bjs.gov/content/pub/pdf/msfp0116st.pdf>

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NATIONAL COMMISSION
ON CORRECTIONAL HEALTH CARE

4. Carson, E. A. (2021). *Mortality in local jails, 2000–2018 – Statistical tables*. <https://bjs.ojp.gov/library/publications/mortality-local-jails-2000-2018-statistical-tables>
5. Manz, C. R., Odayar, V. S., & Schrag, D. (2021). Disparities in cancer prevalence, incidence, and mortality for incarcerated and formerly incarcerated patients: A scoping review. *Cancer Medicine*, (10)20, 7277–7288. <https://www.doi.org/10.1002/cam4.4251>
6. Oladeru, O. T., Aminawung, J. A., Lin, H.-J., Gonsalves, L., Puglisi, L., Mun, S., Gallagher, C., Soulos, P., Gross, C. P., & Wang, E. A. (2022). Incarceration status and cancer mortality: A population-based study. *PLoS One*, 17(9), e0274703. <https://www.doi.org/10.1371/journal.pone.0274703>
7. Richman, I. B., Soulos, P. R., Lin, H.-j., Aminawung, J. A., Oladeru, O. T., Puglisi, L. B., Wang, E. A., & Gross, C. P. (2023). Incarceration and screen-detectable cancer diagnosis among adults in Connecticut. *Journal of the National Cancer Institute*, 116(3), 485–489. <https://www.doi.org/10.1093/jnci/djad242>
8. Manz, C. R., Voligny, E., Baggett, C. D., & Schrag, D. (in press). Incarceration-related disparities in cancer incidence and survival in California and Massachusetts state prisons.
9. Sunthakar, K. I., Griffith, K. N., Talutis, S. D., Rosen, A. K., McAneny, D. B., Kulke, M. H., Tseng, J. F., & Sachs, T. E. (2020). Cancer stage at presentation for incarcerated patients at a single urban tertiary care center. *PLoS One*, 15(9), e0237439. <https://www.doi.org/10.1371/journal.pone.0237439>
10. Kakushadze, Z., Raghubanshi, R., & Yu, W. (2017). Estimating cost savings from early cancer diagnosis. *Data*, 2(3), 30. <https://doi.org/10.3390/data2030030>
11. Philipson, T. J., Durie, T., Cong, Z., & Fendrick, A. M. (2023). The aggregate value of cancer screenings in the United States: Full potential value and value considering adherence. *BMC Health Services Research*, 23, 829. <https://www.doi.org/10.1186/s12913-023-09738-4>
12. Baillargeon, J., Snyder, N., Soloway, R. D., Paar, D., Baillargeon, G., Spaulding, A. C., Pollock, B. H., Arcari, C. M., Williams, B. A., & Raimer, B. G. (2009). Hepatocellular carcinoma prevalence and mortality in a male state prison population. *Public Health Reports*, 124(1), 120–126. <https://www.doi.org/10.1177/003335490912400115>
13. Manz, C. R., Odayar, V. S., & Schrag, D. (2023). Cancer screening rates and outcomes for justice-involved individuals: A scoping review. *Journal of Correctional Health Care*, 29(3), 220–231. <https://www.doi.org/10.1089/jchc.21.11.0128>
14. Manz, C. R., Nava-Coulter, B., Voligny, E., Gundersen, D. A., & Wright, A. A. (2026). Cancer screening, diagnosis, and treatment for vulnerable patients incarcerated in US prisons. *JCO Oncology Practice*, 22, 813–820. <https://www.doi.org/10.1200/op-25-00361>
15. Department of Justice, Office of the Inspector General. (2025). *Evaluation of the Federal Bureau of Prisons' colorectal cancer screening practices for inmates and its clinical follow-up on screenings*. <https://oig.justice.gov/sites/default/files/reports/25-057.pdf>
16. Manz, C. R., Voligny, E., Dahlstrom, M., Dunlap, J., Johnson, A., Rathore, V. D., Selby, M., Sun, R. K. P., & Bick, J. (in press). Rates, predictors and outcomes of cancer screening in California prisons.
17. California Correctional Health Care Services. *Health care services dashboard*. Retrieved July 9, 2025, from

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ON CORRECTIONAL HEALTH CARE

<https://cchcs.ca.gov/dashboard>

18. Manz, C. R., Nava-Coulter, B., Voligny, E., Gundersen, D., A. & Wright, A. A. (2025). Barriers and facilitators to delivering cancer care in US prisons. *JAMA Network Open*, 8(10), e2537646. <https://www.doi.org/10.1001/jamanetworkopen.2025.37646>
19. Dougherty, M. K., Brenner, A. T., Crockett, S. D., Gupta, S., Wheeler, S. B., Coker-Schwimmer, M., Cubillos, L., Malo, T., & Reuland, D. S. (2018). Evaluation of interventions intended to increase colorectal cancer screening rates in the United States: A systematic review and meta-analysis. *JAMA Internal Medicine*, 178(12), 1645–1658. <https://www.doi.org/10.1001/jamainternmed.2018.4637>
20. Ferrari, A., Jael Herrera, D., Van De Veerdonk, W., D’haenens, W., Ruiz Alejos, A., Yimer, N. B., Orwa, S., Van Bos, L., Talboom, S., Ding, L., Goossens, M., & Van Hal, G. (2025). Advancing mammographic screening among underserved groups: A systematic review and meta-analysis of intervention strategies to increase breast cancer screening uptake. *Public Health Reviews*, 46, 1607873. <https://www.doi.org/10.3389/phrs.2025.1607873>
21. Nelson, H. D., Cantor, A. G., Pappas, M., Blackie, K., Yu, Y., & Fu, R. (2025). Patient navigation services for breast and cervical cancer screening and follow-up: A meta-analysis. *JAMA Internal Medicine*, 185(8), 976–985. <https://www.doi.org/10.1001/jamainternmed.2025.1590>
22. Yang, Y., Zhao, W., Chan, D. N. S., Zhou, S., Choi, K. C., & So, W. K. W. (2025). Interventions targeted to improve lung cancer screening uptake among high-risk individuals: A systematic review and meta-analysis. *Asia-Pacific Journal of Oncology Nursing*, 12, 100746. <https://doi.org/10.1016/j.apjon.2025.100746>
23. Brouwers, M. C., De Vito, C., Bahirathan, L., Carol, A., Carroll, J. C., Cotterchio, M., Dobbins, M., Lent, B., Levitt, C., Lewis, N., McGregor, S. E., Paszat, L., Rand, C., & Wathen, N. (2011). What implementation interventions increase cancer screening rates? A systematic review. *Implementation Science*, 6, 111. <https://www.doi.org/10.1186/1748-5908-6-111>
24. Manz, C. R., Nava-Coulter, B., Voligny, E., Gundersen, D. A., & Wright, A. A. (2025). Correctional health and oncologist perspectives on strategies to improve cancer care in US prisons: A qualitative study. *JAMA Network Open*, 8(10), e2537640. <https://www.doi.org/10.1001/jamanetworkopen.2025.37640>
25. Vahabi, M., Hynes, J., Wong, J. P.-H., Kithulegoda, N., Moosapoor, M., Akbarian, A., & Lofters, A. (2024). Breaking barriers: Empowering cervical cancer screening with HPV self-sampling for sex workers and formerly incarcerated women in Toronto. *Current Oncology*, 31(12), 7994–8009. <https://www.doi.org/10.3390/curroncol31120590>
26. National Cancer Institute. (2024). *FDA approves HPV tests that allow for self-collection in a health care setting*. <https://prevention.cancer.gov/news-and-events/news/fda-approves-hpv-tests-allow-self-collection-health-care-setting>
27. Healey, T., Dayanim, G., Streltsov, N., Kane, K., Manz, C., Williams, S., Baird, G. L., & Berk, J. (2025). Lung cancer screening in the incarcerated population through a community imaging partnership. *Journal of Correctional Health Care*, 31(1), 62–69. <https://www.doi.org/10.1089/jchc.24.06.0046>
28. National Committee for Quality Assurance. (n.d.). *HEDIS*. <https://www.ncqa.org/blog/category/hedis/>
29. Sears, D., & Williams, B. (2024). *Assessing medical systems for the CA prison health care receivership: Quality*

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assessment and oversight. <https://cchcs.ca.gov/wp-content/uploads/sites/60/CA-Prison-Healthcare-Quality-Assessment-and-Oversight.pdf>

30. Dafflisio, G. J., Wang, M., Wang, X., Spratt, D. E., Zuhour, R., Khorana, A. A., Bilimoria, K. Y., & Zaorsky, N. G. (2025). Time to treatment initiation for the 30 most prevalent cancer types: Trends and predictors of change. *JCO Oncology Practice*, 22(1), 141–150. <https://www.doi.org/10.1200/op.23.00614>
31. Hanna, T. P., King, W. D., Thibodeau, S., Jalink, M., Paulin, G. A., Harvey-Jones, E., O'Sullivan, D. E., Booth, C. M., Sullivan, R., & Aggarwal, A. (2020). Mortality due to cancer treatment delay: Systematic review and meta-analysis. *BMJ*, 371, m4087. <https://www.doi.org/10.1136/bmj.m4087>
32. Aminawung, J. A., Soulos, P. R., Oladeru, O. T., Lin, H.-J., Gonsalves, L., Puglisi, L. B., Hassan, S., Richman, I. B., Wang, E. A., & Gross, C. Pd. (2023). Cancer incidence among incarcerated and formerly incarcerated individuals: A statewide retrospective cohort study. *Cancer Medicine*, 12(14), 15447–15454. <https://www.doi.org/10.1002/cam4.6162>
33. American Cancer Society. (n.d.). *Signs and symptoms of cancer*. <https://www.cancer.org/cancer/diagnosis-staging/signs-and-symptoms-of-cancer.html>