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INTEGRATION OF CERVICAL CANCER SECONDARY PREVENTION INTO SEXUAL AND REPRODUCTIVE HEALTH AND HIV SERVICES IN GUINEA

LEARNING BRIEF

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Introduction

Cervical cancer (CC) is one of the most common cancers affecting women worldwide, with nearly 90% of deaths occurring in low- and middle-income countries. In sub-Saharan Africa, women are most commonly diagnosed at an advanced stage, while secondary prevention (early detection and treatment of precancerous lesions) remains underdeveloped, despite the availability of effective prevention approaches and adapted technologies.

There are two promising innovations to improve secondary prevention in these contexts. The WHO 2021 strategy states that HPV testing – to identify women with high-risk infections – is the first level of triage, followed by visual inspection after acetic acid (VIA) to confirm if any precancerous lesions are present. This combined approach is more reliable and more standardised than VIA alone. Portable thermal ablation devices, including thermocoagulation, simplify the treatment of lesions on site, eliminating challenges associated with the gas supply required for cryotherapy. Despite the clinical effectiveness of these two approaches being well established, there are still questions around operational feasibility and sustainability for large-scale roll out in resource-limited settings.

Against this backdrop, the SUCCESS II project (Scale Up Cervical Cancer Elimination with Secondary Prevention Strategy) was implemented in Guinea by Solthis, in partnership with the National Cancer Control Programme and the National HIV Control Programme.

The project was launched in 2024 as part of a regional initiative supported by UNITAID and Expertise France. It aimed to strengthen secondary prevention of CC in the Guinean health system by introducing HPV testing – with self-testing options – and the treatment of precancerous lesions by thermal ablation, at sexual and reproductive health services and HIV care provision services.

This learning brief draws on the SUCCESS II project's experience of integrating secondary CC prevention services into sexual and reproductive health and HIV care provision services in Guinea. This brief combines accounts and experiential knowledge from those involved. It documents the service integration model implemented and analyses the drivers and barriers to sustainable integration, taking into account contextual factors that influence innovations being adopted into health systems. This brief is for decision-makers, technical and financial partners, and implementation teams involved in women's health and cancer and HIV responses.

Key messages

1. **HPV screening and treatment of precancerous lesions are achievable and well accepted at decentralised level,** in both sexual and reproductive health and HIV care provision services.

2. **Having service provider support for these innovations is not sufficient to ensure they are routinely adopted:** persistent organisational and structural challenges limit integration of CC screening into routine practice and weaken continuity of the care pathway.

3. **Integration of CC screening and treatment within HIV services is a promising model** for improving access to and the quality of care for women living with HIV. It is a model that warrants being strengthened and scaled up.

4. In addition to introducing biomedical innovations, **the sustainability of CC prevention services requires more significant transformation in healthcare provision:** a shift from an approach centred on reproductive health to a comprehensive, integrated service centred on women's needs throughout their lives.

1. Introducing the intervention

Implementation context

At the start of the project, secondary prevention of CC in Guinea was still in its infancy. Although initiatives supported by WHO and Jhpiego had been introduced in 2016, including VIA screening and cryotherapy treatment, roll out was limited (72 sites in 2026) and concentrated at the tertiary and secondary levels. Care provision remains concentrated in a limited number of hospitals and focused on tertiary cervical cancer care. Furthermore, HPV vaccinations are not yet available in the country, making secondary prevention all the more crucial.

Target population and geographic coverage

The project aimed to screen and monitor 7,000 women aged 25 to 49 from three target groups: **the general population, women living with HIV, and sex workers.** The project focused on the Conakry and Kindia regions, supporting twenty health care facilities at all levels of the health system: one national reference laboratory, three hospitals, seven community health centres and six community health centres.

Project components

The project aimed to introduce an integrated and decentralised model of secondary CC prevention in sexual and reproductive health and HIV care provision services. It involved several key activities.

► **Context analysis and field assessment:** evaluation of intervention sites and community assessment.

► **Institutional integration and regulatory framework strengthening:** support with the national strategic cancer control plan, developing standards and guidelines on secondary prevention of cervical cancer.

► **Capacity strengthening of service providers:** training curriculum, pool of national trainers, initial training courses, coaching and formative supervision on site.

► **Supply chain support:** procurement and delivery of supplies and equipment to the sites.

► **Integration into existing health services:** setting out patient pathways and routes, methods to refer patients and transport samples.

► **Demand creation and community engagement:** developing communication and awareness-raising tools, including materials on self-testing.

2. Integration process and model

Demand creation and referral to screening services

Mobilising women to access screening services was structured around three complementary levels:

► **at community level,** the project combined mass **awareness campaigns and small group sessions (film and discussion workshops, health education and self-gynaecology).** For those living furthest from services, including women living with HIV and sex workers, **self-testing** could be carried out on site or following workshops;

► **at sexual and reproductive health services,** referrals happened at several entry points, depending on how facilities were structured and the availability of trained staff: **waiting rooms, antenatal and postnatal consultations, gynaecology, family planning and prevention of mother-to-child transmission (PMTCT) services,** as well as **paediatric and general medical consultations;**

► **at HIV services,** awareness-raising and guidance were provided during **educational talks,** by **psychosocial workers,** and during **ARV follow-up consultations**.

Screening and communicating results

Screening was «opportunistic» and was either instigated by healthcare professionals, or on a voluntary basis - requests from patients who had been sensitised. At most sites, screening was generally carried out in gynaecology outpatient clinics, and less often in family planning clinics.

Women living with HIV were initially referred to maternity services for screening. **Counselling, HPV testing and follow-up of results were gradually integrated into HIV care provision services as a result of task shifting to psychosocial workers.**

Sample transportation to the laboratory and monitoring of results were centralised at maternity units for all patients regardless of their point of entry. A paper-based register and individual follow-up records were used for patient monitoring. **Regardless of the result, the women were called back by phone for an appointment to tell them their result, offer counselling and, where necessary carry out VIA. A telephone reminder system was put in place to limit loss to follow-up.**

Care provision for pre-cancerous lesions and referrals

VIA and treatment of eligible precancerous lesions were carried out in health centres by midwives or doctors. Where lesions were not eligible for thermocoagulation – due to their size or stage of progression – patients were referred to a hospital for specialist care.

Laboratory network and sample transportation

At the start of implementation, the laboratory network was based on a centralised model at the National Institute of Public Health (INSP), and two sites with their own laboratories (Donka University Hospital, Flamboyant Medical Centre). Sample transportation to laboratories used a pre-existing national system of motorcycle couriers - an existing logistical solution.

During the project, the INSP laboratory became unavailable, which necessitated the process to be reorganised: samples were redirected to the two operational laboratories, taking into account their capacity to handle them and the geographic proximity of the sites, and a third laboratory (DREAM) was added to strengthen the overall capacity of the system.



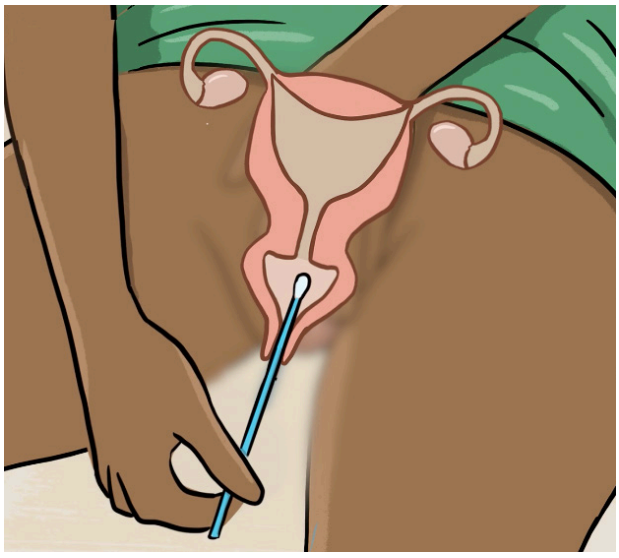
CC screening/management cascade in SUCCESS II

► **7,000 women screened,** 93% of whom used self-testing and 31% of whom were women living with HIV.

► Of the HPV samples analysed, nearly 40% were positive:

► **63% of women who tested positive underwent a VIA test;**

► **92% of women with a positive VIA received treatment by thermoablation** and 100% of women with a large lesion received Loop Electrosurgical Excision Procedure (LEEP) after referral to a specialist centre.



3. Lessons learned

Decentralisation of secondary prevention of CC is feasible and well accepted at primary and community levels

The experience of the project confirms that secondary prevention of cervical cancer can be rolled out beyond hospital settings, to local health centres and community spaces.

At provider level, **the majority of healthcare professionals surveyed emphasised that HPV testing – particularly the self-testing method – made it considerably easier to integrate screening into their services.** Compared with VIA, this approach was seen as being easier to implement, faster and less burdensome for patients. It also has the advantage that is can be offered in different types of consultations within maternity services, by several categories of professionals, which increases the opportunities for screening and makes it possible to adapt provision to women's preferences.

Programme managers saw the potential of expanding screening to the community level and organising mass campaigns. This was seen as a significant added value to reach women furthest away from services.

In addition, **the availability of a higher number of human resources trained in VIA and portable thermal ablation equipment made it possible to offer integrated care within the same department using a «one-stop shop» model.** This configuration **reduces reliance on referrals to** other facilities, **simplifies the pathway for women,** and **shortens the time between screening and treatment of precancerous lesions,** thereby limiting the risk of women being lost to follow-up between these two critical stages.

> ***Thanks to self-testing and the ability to treat lesions on site, we no longer have to refer patients to another hospital. Everything is done within the same department, and it's more comfortable for women.***
> Gynaecologist, Maternity Department, Flamboyant Medical Centre.

Gradual integration of screening into HIV care provision services improves accessibility and quality of the care pathway for women living with HIV



In the initial pathway, referring women living with HIV to maternity services for screening created several potential obstacles: being **exposed to stigma in non-specialist services, confidentiality issues** related to HIV status, and **risks around continuity of follow-up.**

Gradual integration of screening into HIV services, made possible by training psychosocial workers and task shifting – covering awareness-raising,

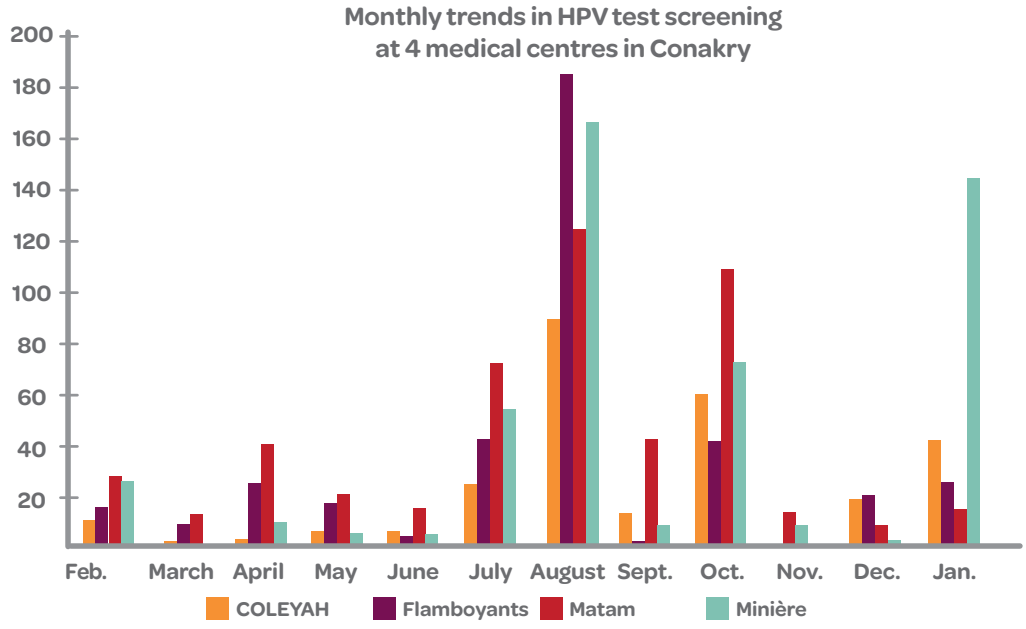
help with self-testing and communicating results – has significantly overcome these barriers.

Integration into HIV services provides several cumulative benefits:

- women living with HIV are a relatively easy to access patient group as they receive regular monitoring at HIV services, which increases the opportunities to offer screening, to reconnect with those who have been lost to follow-up, and to ensure continuity between the different stages of the care pathway;
- support activities carried out by psychosocial workers – educational talks, home visits, support during ARV follow-up consultations – strengthen this dynamic by creating regular points of contact with patients;
- HIV service teams have proven experience in individualised follow-up, psychosocial support and counselling – skills that can be directly adapted to deliver results and support women who test positive;
- finally, carrying out screening within HIV services allows women to remain in a familiar environment, where their HIV status is known and respected, therefore limiting the risk of unintentional disclosure and the fear of stigmatisation associated with this.

Despite the innovations introduced being well received, routine adoption remains limited

The activity data show a discrepancy between care providers' reported adherence to screening and its effective integration into routine practices. At the start of the project, partner sites set monthly testing targets based on the availability of supplies and laboratory testing capacity, set at an average of around 50 tests per month per site. These targets, which were modest given the active caseloads of sexual health and HIV services, have not been consistently met outside of mass campaign periods. Monthly trend data on the number of women screened during 2025 (see figure below) shows that the campaigns held in July–August and October 2025 account for around 70% of the total screening volume.



This indicates that screening services are still dependent on one-off initiatives rather than being effectively integrated into routine healthcare practices. **Women living with HIV, who are a priority population group for the project, currently represent only 31% of those tested, compared with an initial target of 65%, reflecting the fact that testing is still not sufficiently integrated into PMTCT and care provision services.**

This finding suggests that the conditions required for a continuous and sustained service – availability of trained staff, structured patient flows, institutional prioritisation – are not yet fully in place. It also indicates that making an innovation routine generally takes longer than the lifetime of a project and is part of a gradual process that requires long-term support.

Barriers and obstacles to integrating secondary CC prevention services

Organisational constraints that that impact frontline providers

An increase in workload and the lack of dedicated space are the most frequently cited obstacles. Providers describe a situation where they are having to have a patient consultation within another consultation, making it difficult to fully integrate activities. Completing monitoring tools, communicating the results and following up with patients are seen as time-consuming and tedious. In several health centres, the situation is exacerbated by the fact that some providers are not paid, which impacts their motivation to take on new tasks.

▶ Delays in providing HPV test results hindering screening provision

The time between taking a sample and communicating the result – and sometimes lack of results due to the process not working properly at the start of the project – has been a barrier to testing provision. Some healthcare professionals are reluctant to initiate screening when it is not guaranteed they will receive a result within a reasonable timeframe. They fear causing anxiety for the patient, creating additional appointments that are difficult to attend, or creating follow-up situations they have no control over.

▶ Still only partial institutional ownership

CC prevention continues to be seen as an add-on activity, rather than an integral component of sexual and reproductive health or HIV care provision packages. This mindset can be explained by the fact that integration of monitoring tools and systems remains incomplete. Cervical cancer screening has not yet been integrated into monitoring records for women living with HIV or into routine monitoring indicators for SRH and HIV services. This lack of formal inclusion in tools and guidelines makes provision dependent on the individual motivation of trained providers rather than on a service standard integrated into the day-to-day operation of facilities.

> ***HPV screening takes time. Filling in the forms and the records takes up a lot of time, and we don't have enough space to carry out the activity properly. We need to be organised between ourselves. Only the midwives trained by the project carry out the screening but we have to do these tasks.***
> Midwife, Maternity Department, Matam Medical Centre



Catalysts and drivers of service integration

► Ongoing support to aid practice

Implementation of on-site supervision and coaching has helped to build the confidence and skills of service providers, particularly in carrying out VIA and thermocoagulation treatment, which are sometimes new practices that require sustained technical support to be carried out properly and maintained over time. Support from gynaecologists working in maternity units has also played a key role in this process, fostering a mentoring dynamic within these units.

► Local organisational adaptations as drivers of integration

In response to constraints linked to space and staff availability, several sites have put pragmatic solutions in place: scheduling slots and days dedicated to testing based on room availability and days for collecting samples, and organising work in pairs to share tasks: counselling, completing forms, administrative monitoring of samples. These adjustments helped to streamline the pathway and better integrate testing activities into service structures.

► Community-based approaches that show potential to create demand and keep women in the care pathway

The demand creation approaches implemented by the project – film screenings followed by discussions, self-gynaecology and health education workshops, and awareness-raising in small groups – have demonstrated their ability to increase uptake of screening by women, whether through referral from the community to health facilities or by providing screening directly at community sites.

These local discussion spaces have also made it possible to identify and address unmet sexual and reproductive health needs – contraception, menstrual health, STI prevention – particularly among women living with HIV and sex workers. By offering a space for more in-depth support than a conventional consultation, they promote higher quality information provision and foster a relationship of trust with healthcare professionals. These are two conditions conducive to empowering women and keeping them engaged in their healthcare journey.

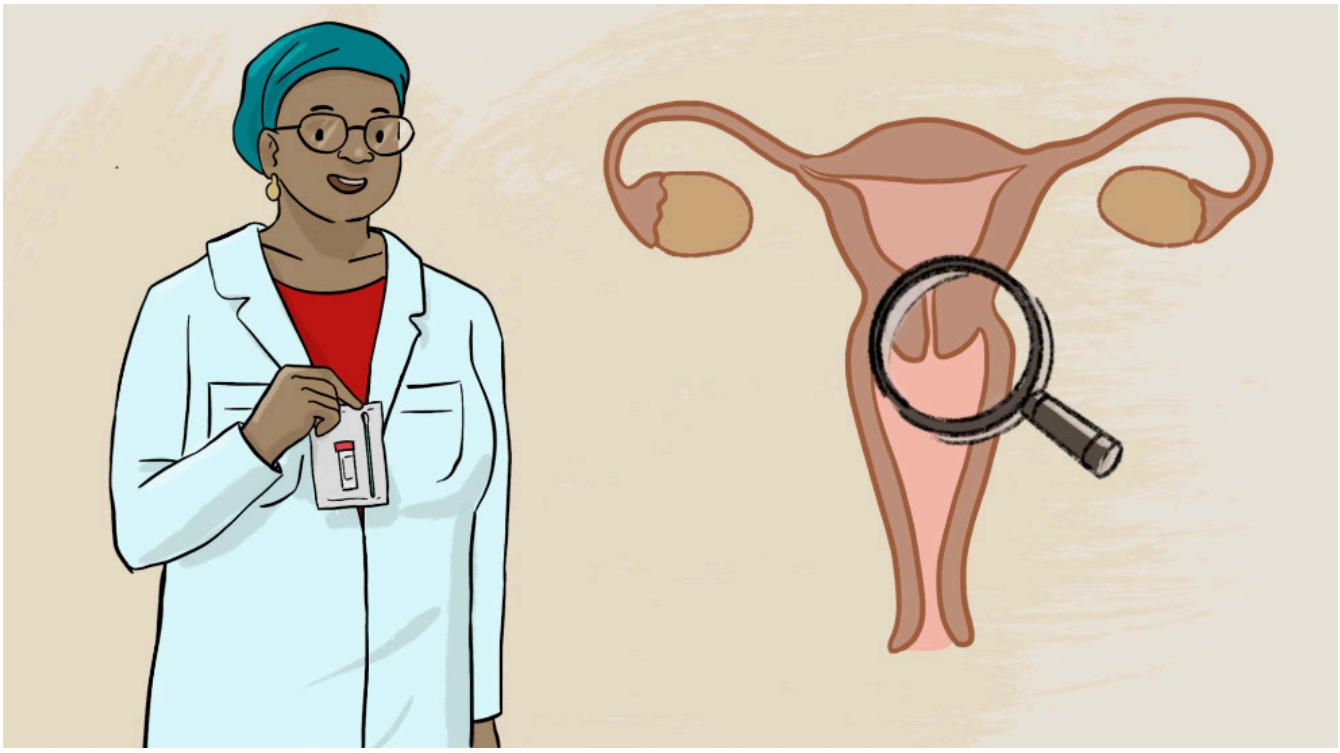
4. Discussion point

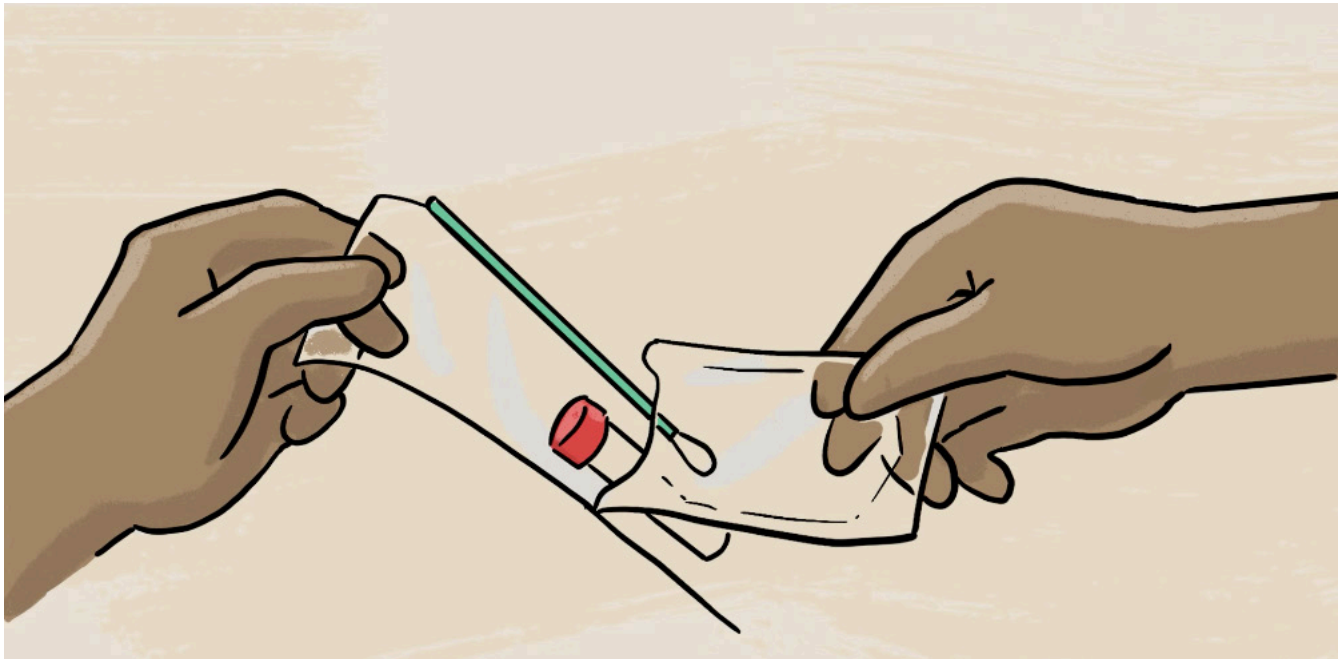
The SUCCESS II project's experience in Guinea shows that introducing HPV testing and treating precancerous lesions by thermoablation – in both sexual and reproductive health and HIV care services – is technically feasible and well accepted. It opens up meaningful potential for improving availability, accessibility and equity of CC secondary prevention.

The lessons learned from the project also show that the technical feasibility of an innovation does not guarantee its sustainable integration: organisational and structural challenges are key factors for the model to be sustainable on a large scale. Sample management, the turnaround time for results, and maintaining the care pathway are weak points, which highlight the need for investment into the organisational environment as well as in technical tools.

This project also comes at a time of rapid emergence of new technologies – rapid tests, visual assessment assisted by artificial intelligence – which are likely to transform secondary prevention models for CC in the medium term. These innovations could, in particular, alleviate some of the constraints identified by this project, by reducing dependence on laboratory processes and the turnaround times for results, which currently complicate management of the patient pathway. However, their added value will depend on the ability of healthcare systems to create the conditions for them to be adopted. This requires a rebalancing of resource allocation at the primary care level, which remains heavily focused on maternal and child health to the detriment of more comprehensive services centred on women's health throughout their lives.

There are certain limitations to this piece of work. Patient viewpoints could not be documented, which limits the assessment of their experience and the barriers to accessing care they experience. Feedback from healthcare professionals on the second part of the cascade – delivery of results, VIA, thermocoagulation – was not comprehensive due to difficulties related to the sample analysis pathway. Finally, several areas that the project contributed to were not covered by this learning exercise – strengthening the institutional framework, producing tools, support around procurement, the laboratory system and the health information system (HIS) – which are nevertheless key drivers for an enabling and sustainable environment for the integration of CC prevention services in Guinea.





5. Looking ahead

► **1. Consolidate the integration of HPV screening into HIV services:** formalise this model in national protocols, integrate cervical cancer screening into monitoring activities for women living with HIV, expand training of psychosocial workers to all care sites, quantify and make available the necessary resources, and define indicators to monitor coverage of women living with HIV within the national programme.

► **2. Support to create the required organisational conditions for the approach to become routine:** support sites with structuring work and task shifting – dedicated time slots and spaces, formalised allocation of tasks, integration of screening into routine supervision - to embed screening into the day-to-day practices of services.

► **3. Ensure continuity of the patient pathway:** define minimum standards for pathway continuity – maximum turnaround time for results, systematic counter-referrals, post-treatment follow-up – based on the analytical capacity of laboratories, a reliable system for transporting samples and communicating results, and digital tools for patient monitoring, and integrate these into site supervision tools.

► **4. Expand the range of sexual and reproductive health services:** advocate for a review of the programmatic and budget frameworks and training curricula for frontline health professionals to integrate cervical cancer prevention into a comprehensive package of sexual and reproductive health and rights services, ensuring that care related to cervical cancer prevention is free of charge, and implementing continuous quality improvement processes focused on user experiences. This will ensure SRHR services are acceptable, accessible and appropriate at every stage.

► **5. Strengthen the community-based approach and empower women:** invest in the capacities of community health workers, develop information tools to promote women's empowerment in relation to their health, and integrate cervical cancer screening into existing community mobilisation strategies – sexual and reproductive health activities, vaccination and, ultimately, HPV vaccination campaigns.



Illustrations: Laure Garancher / The Ink Link.
Ellena Juillard, MatLet Layout KAOCOM

Learn more about the project

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