

LEARNING BRIEF

TESTING FOR AND MANAGEMENT OF CERVICAL CANCER AMONG SEX WORKERS

Successes, challenges and lessons learned from the POUVOIR (Côte d'Ivoire) and SUCCESS II (Guinea) projects

SUCCESS

POUVOIR
pour les droits et la santé des travailleuses du sexe

Solthis
Committed expertise in health

Summary

Cervical cancer (CC) is the leading cause of cancer-related deaths among women in Guinea and Côte d'Ivoire. Female sex workers (SWs) are particularly at risk due to their high exposure to human papillomavirus (HPV), high prevalence of HIV, and multiple vulnerabilities that limit their access to care.

As part of the POUVOIR (Côte d'Ivoire, 2022–2025) and SUCCESS II (Guinea, 2024–2026) projects, Solthis has implemented tailored, innovative strategies to reach key populations, providing them with cervical cancer screening using self-sampling HPV tests and thermocoagulation treatment. These two initiatives are some the only ones in the sub-region that specifically target SWs with this approach.

This learning brief draws on experience from both projects and **documents the approaches implemented, the results achieved and the lessons learned**, with the aim of sharing these lessons with key stakeholders in the region (Ministries of Health, NGOs, CSOs, technical and financial partners).

Context and project overviews

Cervical cancer: a major challenge and effective prevention tools

Sub-Saharan Africa accounts for 21% of global CC-related deaths, with 120,000 new cases and 70,000 deaths each year. In Guinea and Côte d'Ivoire, it is the leading cause of cancer-related deaths among women. However, CC is largely preventable through HPV testing, which is recommended by the WHO as part of its "screen, triage, treat" approach to support early treatment of precancerous lesions.

Two innovations complement this approach: HPV self-testing, which has a very good acceptance rate and facilitates access for marginalised women, and thermocoagulation, which is a simple treatment option that allows same-day care in the vast majority of cases.

Sex workers: women who are particularly vulnerable

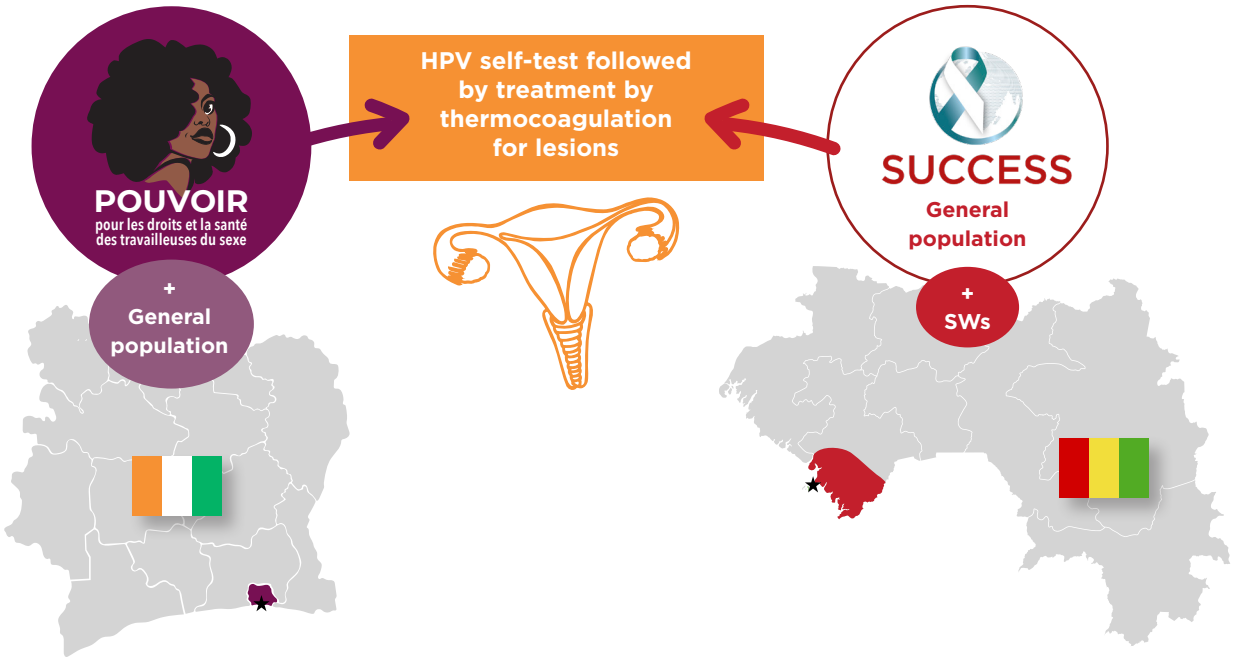
SWs have cumulative risk factors: high exposure to HPV, high prevalence of HIV, socio-economic vulnerability, stigmatisation, geographic mobility and limited time availability. The SW population are very varied in terms of age, working arrangements (bars, hotels, brothels, on the street) and nationality.

Two pioneering projects in the West Africa sub-region

Two projects taking different approaches: POUVOIR focused on sex workers and SUCCESS II focused on the general population with sex workers as a secondary target group.

The POUVOIR project (Côte d'Ivoire, 2022–2025) aimed to strengthen empowerment and access to sexual and reproductive health and rights (SRHR) for sex workers. The CC strategy was implemented in partnership with Médecins du Monde (MdM), who carried out systematic CC screening among the general population in Abobo (13,621 women, including 638 SWs and 263 women living with HIV). Solthis provided community expertise to access SW sites and implement an outreach strategy by offering HPV self-testing; MdM supported laboratory logistics and supervision of partner health centres.

The SUCCESS II project (Guinea, 2024–2026) stands out for its strong institutional foundation: its main objective was the introduction and implementation of CC screening using HPV testing within the national health system. It also provided support to the National Cervical Cancer Control Programme (PNLCC) and aimed to ensure sustainability in public facilities. The main target groups were women living with HIV and the general population (6,894 women screened, including 2,090 women living with HIV). SWs were a secondary target group (target: 100, reached: 259) who were primarily reached through the Kindia Community Centre (CCK), the only centre dedicated to key populations in the city, and to a lesser extent through Fraternité Médicale Guinée (FMG).



Why are we doing this learning exercise?

These two projects are the only known initiatives in the sub-region that specifically target sex workers using an HPV self-testing and thermocoagulation treatment approach. The aim of this learning brief is to describe the selected approaches, identify the success factors and challenges encountered, and share promising practices in the region.

Methodology: analysis of quantitative data supplemented by qualitative data collection (semi-structured interviews, community dialogues) from peer educators, social workers, health staff, partner NGOs/organisations, national cancer control programmes and Solthis teams in both countries.

Testing and care provision cascades

The table below shows the CC cascades for SWs in both projects, compared with other target populations. The data for Côte d'Ivoire cover the period May 2023 to December 2024; the data for Guinea were ongoing at the time of writing (data as of March 2026).

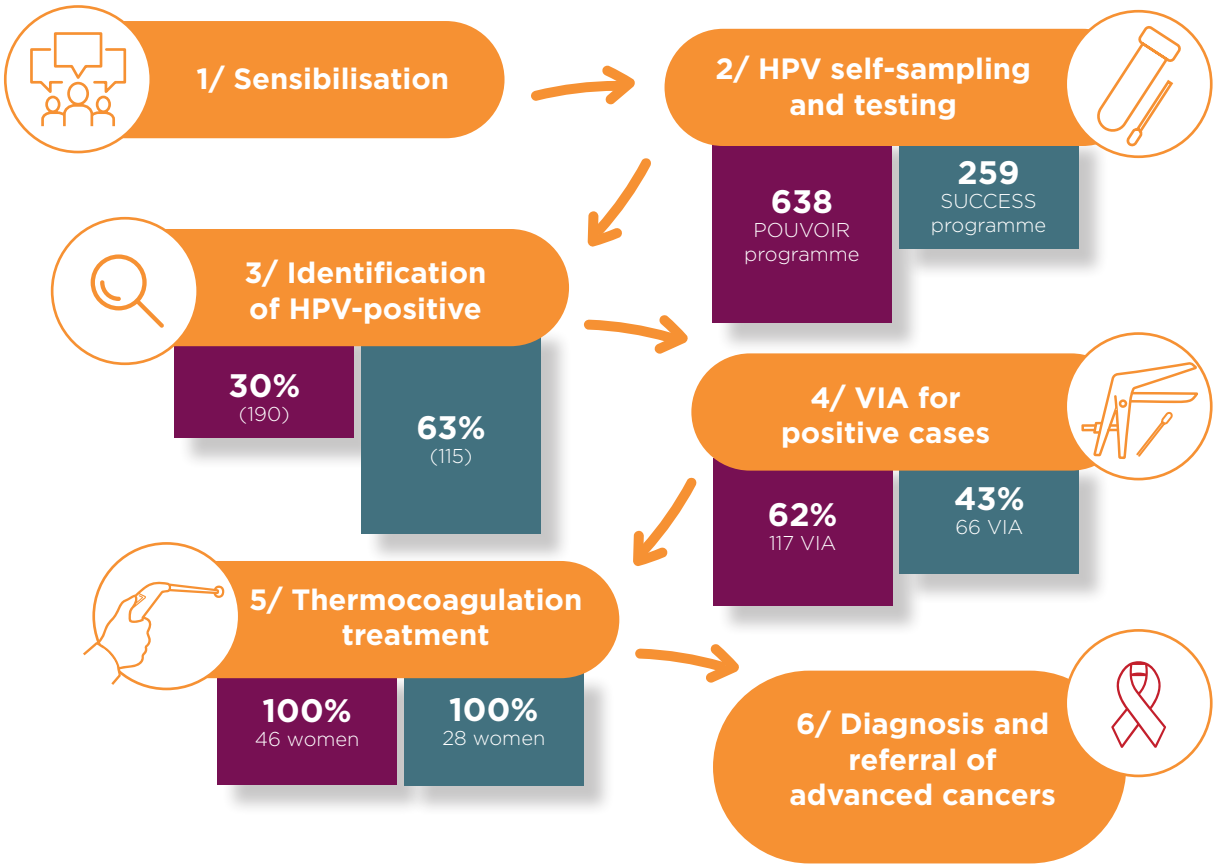
Stage of the cascade	SWs	General population	Women living with HIV	SWs	General population	Women living with HIV
	POUVOIR (Côte d'Ivoire)			SUCCESS II (Guinea)		
HPV test performed	**638** outreach intervention at SW sites	~12.720 (est. out of 13,621 total)	263	**259** CCK: 217 | FMG: 42	4.545	2.090
Results received	Results within 7 days			**184 / 259 (71%)** 8–10 months	1 to 3 months (can be up to 10 months) Weak lab system	
HPV+ rate	**30% (190)**	22%	38%	**62,5% (115/184)** of results received	42% across all populations	
VIA carried out	**62% of HPV+ (117)**	N/D		**57% of HPV+ (66)**	67%	79%
	72% across all populations					
Positive VIA (lesions)	**29% of VIAs (34)**	18%	28%	**43% des VIAs (29)** of which 1 large lesion	24%	17%
Treatment (thermocoagulation)	**100% eligible (44)**	N/A		**100% of VIA+ (28)**	84%	93%
1-year follow-up	~12% major difficulties	N/A		No change	N/A	

Understanding the cascade

SWs have significantly higher HPV positivity rates than the general population in both countries (30% in Côte d'Ivoire, 62.5% in Guinea), which justifies them being a priority target group.

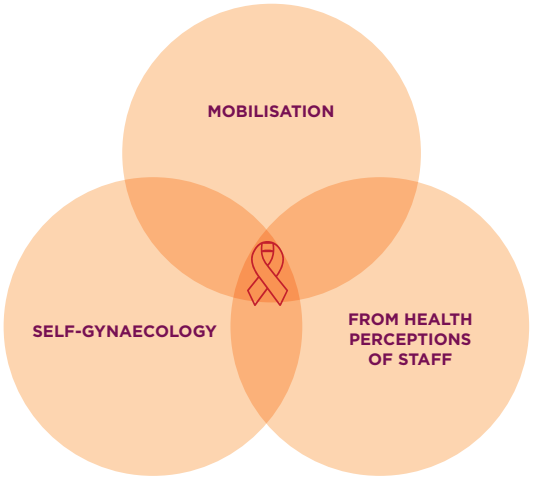
Carrying out VIA (Visual Inspection with Acetic Acid) is generally a critical component of the CC cascade. In both countries, the HPV+ -> VIA linkage rate for SWs is lower than the project average (62% in Côte d'Ivoire, 57% in Guinea, compared to 72% overall). This reflects sex work-related barriers that are common – mobility, lack of time, low prioritisation of their own health. Added to this in Guinea are the long delays to receive your laboratory results and a lack of awareness of VIA. Follow-up at 1 year remains a major challenge.





An integrated system of community and medical interventions

Both projects combine several types of complementary interventions to support SWs throughout the cascade and to strengthen both the demand for and supply of healthcare services. Three main elements made up this approach:



Outreach awareness-raising approach

Understanding SW environments is crucial to be able to access them

Accessing female sex workers involves throughly understanding their environment and their social structure. In Côte d'Ivoire, MdM approached Solthis due to our ability to access SW sites through our peer educators (PEs). In Guinea, the partnership with the CCK made it possible to work with an existing community network supporting key populations. The relationship of trust established between SWs and the centre's doctor was also a determining factor for testing uptake.

> *Overall, the role PEs in prevention, screening and support was really significant. Without PE support it wouldn't be possible to access the system. It is important to understand that SWs are part of a well-organised system. Brothels and residences – if you're not part of the system, you're not going to get very far.*
>
> *MdM, Côte d'Ivoire*

POUVOIR (Côte d'Ivoire): repetition and trusting relationships as key factors

In Côte d'Ivoire, the POUVOIR project carried out intensive sensitisation using an outreach approach through small group discussions that covered many different SRHR topics. **Repeating messages was identified as a key factor for understanding the screening cascade:** 1 to 3 years later, the SWs were still able to remember complex information (difference between HPV+/cancer, VIA confirmatory test, existence of treatment, abstinence required).

Conditions on the ground: awareness-raising in bars and informal restaurants is difficult (low light levels, noise, distractions) and requires visits to happen late in the day. Hotels and brothels provide a more suitable setting. English-speaking SWs were difficult to reach because of the lack of English-speaking PEs and tools in English.

It is crucial to involve managers and owners: they were invited to regular workshops in Côte d'Ivoire and once they were made aware they facilitated access to their sites and encouraged SWs to take part.

> ***She told me about it several times... 3 or 4 times, I think (...) The fact that she talked about it all the time gave me the courage to come and do it.***
> *SW, Côte d'Ivoire*

> ***You have to go to those bars at the right time (...) from around 11:30pm or midnight you'll find them (...) If you go back to the do the self-testing the next day they might be asleep. You raised their awareness, you worked yourself to death...but then maybe they have gone off with someone.***
> *PE Côte d'Ivoire*

SUCCESS II (Guinea): multiple integrated entry points

In Guinea, CC awareness-raising used several entry points that complemented pre-existing activities, rather taking an outreach approach to specifically targeting sex work sites.

Entry point	Description and advantages	Barriers identified
Self-gynaecology workshop	SWs invited specifically: high uptake of HPV testing (7-8/10 accept)	Low number of SWs reached: recruitment bias, availability/compensation
Outreach awareness-raising through PEs PIG/Equal Santé + referral to CCK (75% of SWs)	PEs from other projects mobilise SWs on sites, PEs can be shared, cost savings, integrated SHRH approach	Not counted as a SUCCESS project activity: loss in quality and loss of cohesiveness of information
On-site talks (CCK) by PEs or a doctor	Preparing for screening during the visit	Limited time, high level workload, limited retention of information
Consultation due to another reason at CCK or FMG	Offer CC screening integrated into another consultation (HIV, STI, FP, etc.)	Variable results: SWs are not prepared for the comprehensive cascade, not very effective (3% of CC screenings at CCK)
One-off ticket-based campaigns	The «ticket» approach -> reaches more peripheral SWs and their loved ones Campaign in August: 142 women screened	Profiles different to the priority SW target group
Referrals from family and friends	Informal referral by family and friends (reaches more peripheral SWs)	Reliant on PE motivation, movement of SWs, profiles different to the priority SW target group

Important point:

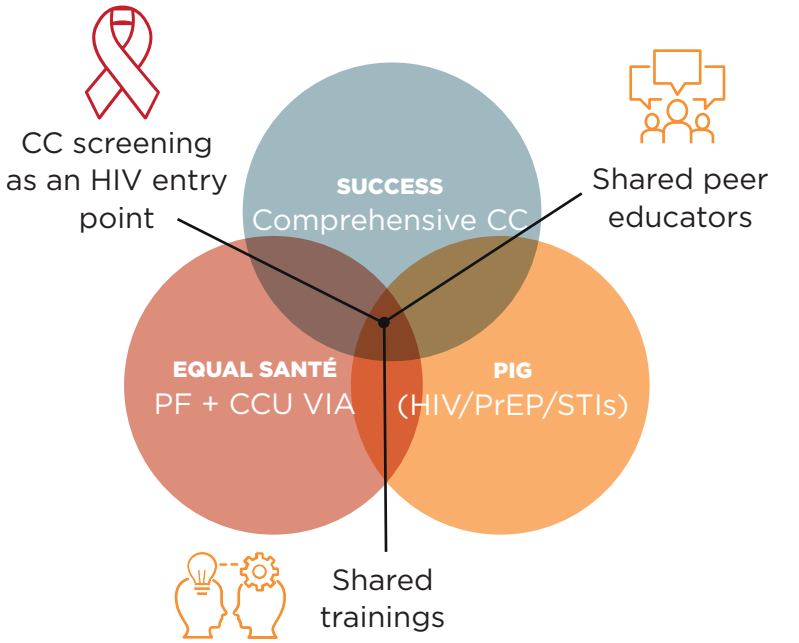
In both countries, the approaches outlined did not make it possible to reach SWs operating online, who are increasing in number. Developing tailored approaches, such as training PEs on digital network.s or WhatsApp methods, would make it possible to reach target groups who are generally more isolated.

CCK (Guinea): synergy between three SRHR projects

CCK was implementing three complementary projects in parallel – Plan International Guinea (PIG) (HIV, PrEP, STIs), Equal Santé (family planning + cervical cancer screening using VIA) and SUCCESS II (comprehensive cervical cancer screening) – providing sex workers with an integrated SRHR package with benefits across projects:

- SUCCESS II benefited from Equal Santé and PIG's outreach interventions, which raised awareness among SWs of CC despite them not being recorded in the SUCCESS II project;
- Equal Santé has integrated HPV **self-testing and thermocoagulation treatment through** SUCCESS II (expanding their service package);
- PIG uses CC as a "entry point" to encourage SWs who are reluctant to take an HIV test to attend CCK;
- the 3 projects shared trainings/ debriefing sessions, supervisions and field visits.

> ***Whether SWs are from the Equal Santé, Global Fund or SUCCESS project, when a team goes out, the comprehensive awareness package is delivered on the ground: HIV, STIs, cervical cancer and planning.***
> *CCK Coordinator, Guinea*



Important point:

Sharing PEs between projects can lead to a drop in quality of the information being shared, due to less in-depth training on CC for PEs who were initially focused on other projects. A shared minimum training course on the CC cascade is recommended for all roving PEs combined with a training toolkit translated into relevant languages to support their work.

Self-gynaecology workshops

86
SWS PARTICIPATED
+ 16 PES (CÔTE D'IVOIRE)

21
SWS PARTICIPATED
+ 16 PES (GUINEA)



75-80%
SWS WHO TRIED OUT
SELF-EXAMINATION

Self-gynaecology workshops are single-sex sessions (around 10 participants), repeated over time, following a horizontal and supportive approach. They take place in three stages: talking circle (sharing experiences), knowledge transfer, and self-examination of the cervix. The aim is for women to take ownership of their bodies and of knowledge, rather than simply sharing information.

Comparing the Côte d'Ivoire and Guinea formats

Entry point	Description and advantages	Barriers identified
Number of sessions per cohort	4 sessions	3 sessions
CC focus	Secondary (various SRHR topics)	Primary (2 out of 3 days focused on CC)
Other topics	Anatomy (and self-examination), contraception, GBV, health and menstrual dignity	Anatomy, medical self-defence and self-examination
Facilitators	Solthis and Covie facilitators	PE from CCK (following tailored training)
Medical professionals	Espace Confiance and Solthis midwives	Women from the PNLCC - national ownership

Good level of adherence and more effective SRHR integration

In both countries, a good level of adherence to the methodology was observed. It is worth noting that despite the format in Guinea focusing on CC, spontaneous feedback received from SWs mainly related to self-examination and the methodology itself. This suggests that integrating CC into a comprehensive SRHR approach (like in Côte d'Ivoire) could be a more effective way to spark interest among participants.

In Côte d'Ivoire, the workshops also complemented the initial training for PEs (short and intensive 3 day training), which enabled them to deepen their knowledge and experience it for themselves. Supervisions were seen as a key factor in the quality of awareness-raising.

> ***Self-gynaecology is better. Because we take the time to get to know ourselves. We have more detailed information.***
> *PE in Côte d'Ivoire*

Self-examination: a key moment of self-awareness

The self-examination of the cervix approach was highly appreciated: it enables knowledge and ownership of one's body, enhances understanding of CC by visualising the cervix, and prepares women for VIA by familiarising them with the plastic speculum (which is more gentle than a metal one). In Guinea, the practice of self-examination has also opened up discussions about body acceptance in a context where female genital mutilation (FGM) is highly prevalent. The PEs also mentioned that self-examination gave them "greater confidence to deal with healthcare staff".

> ***I attended one gynaecology consultation during my first pregnancy, but since then I've been afraid because they inserted their fingers, and it hurt. So I haven't been back since then.***
> *SW, Guinea*

Important point:

Self-examination can be seen as "self-diagnosis": for example, in Guinea, one of the SWs interviewed said she was able to identify lesions with the naked eye. It is crucial to clearly distinguish between self-examination and self-diagnosis, and to systematically emphasise the need for VIA to identify precancerous lesions.

Rapid skills transfer (Guinea)

In Guinea, the CCK PEs were quickly trained to lead frontline workshops to boost the self-confidence and the facilitation skills of SWs, supervised by Solthis. This increased autonomy has fostered a climate of trust, especially as PEs worked in local languages (Soussou, Pulaar, Malinké). The participation of women from PNLCC has fostered national ownership of this innovative methodology. In Côte d'Ivoire, skills transfer from the Solthis team to Covie facilitators was more gradual.

Important point:

Medical topics require technical support and the involvement of healthcare professionals to ensure the reliability of messages conveyed. The role of PEs is crucial for building trust, but must be combined with support on the medical component. **For more technical content, additional tools such as film discussions, which were piloted in Guinea, or short videos shown in waiting rooms or via WhatsApp can enhance understanding of CC and ensure that information is passed on.**

Ensuring workshops are used in a strategic way

Self-gynaecology workshops are innovative, but they reach only a small number of women at a time and require significant resources. In a context of limited funding, it is recommended that workshops are strategically targeted based on two complementary approaches: (1) To form in-depth training for PEs, strengthening their capacity to raise awareness; (2) To target SW «champions» who are then responsible for raising awareness among their peers on the ground.

Communicating about CC: finding the right balance

55%

OF SWS HAD HEARD OF CC AT THE START OF THE PROJECT (CÔTE D'IVOIRE, 2022)

87%

OF SWS HAD HEARD OF CC BY THE END OF THE PROJECT (CÔTE D'IVOIRE, 2025)

Source: KAP survey, POUVOIR research (CIV)



97%

OF SWS HAD HEARD OF SELF-TESTING (END OF CÔTE D'IVOIRE PROJECT IN 2025 – MUNICIPALITY OF ABOBO)

Addressing knowledge gaps

Although CC is less well known than breast cancer, it is something SWs and PEs are interested in, with several stating that they know women who have died from the disease. The fact that it resonates on a personal level is an effective entry point for raising awareness

> *My aunt-in-law had this problem. So I know what it's about, and so does a friend of mine.*
> *SW, Côte d'Ivoire*

Positive communications vs anxiety-inducing communications

Solthis' approach is to promote positive and non-stigmatising communications. In Guinea, a partnership with the TheInkLink organisation supported the development of an image library and short videos to raise awareness and provide information to ensure messages do not make people anxious. Despite this, stakeholders on the ground in both countries often use arguments based on fear to "shock people into compliance".

What information should be communicated and when?

Two communication approaches and two different results

	POUVOIR — Côte d'Ivoire	SUCCESS II — Guinea
Communication approach	Comprehensive throughout the cascade	Minimised: focus on the HPV test
Reference to VIA	Yes, systematically	Rarely mentioned by PEs
Reference to abstinence	Yes, beforehand	Low level: to avoid discouraging people
Impact observed	Being HPV+ played down, good retention	Being HPV+ a concern, VIA not well known
HPV+ rate among SWs	30% (vs 22% among general pop.)	62% (vs 42% on average across all populations)

In Côte d'Ivoire, the PEs rolled out a comprehensive approach to communication throughout the entire cascade. This was possible due to the repeated and ongoing nature of awareness-raising activities. In Guinea, a more gradual approach was taken (focus was on HPV, VIA was left to the doctor, abstinence was rarely discussed) so as not to overwhelm SWs with anxiety-provoking information. This has had an unintended effect: being HPV+ has often been equated with cancer by SWs, due to a lack of explanation about the VIA confirmation stage.

In both countries, SWs have a significantly higher HPV+ rate than the general population. It is therefore all the more important to communicate, from the outset of awareness-raising, that being HPV+ does not mean you have cancer, and that VIA is necessary as a confirmatory step.

> *During the talks, we say to them: "If you have a positive result, you have to take the treatment, otherwise you could die."*
> *PE, Guinea*

Adapting the language and materials

Where there are challenges with literacy, it is helpful to refer to the cervix using accessible language, such as «the bit that holds your baby during pregnancy» or «the bit that feels like the tip of your nose». In Guinea, the materials were adapted to the main local languages (Soussou, Malinké, Pulaar).

A persuasive argument for SWs: "This could stop you from being able to work". The HPV virus can, in the long term, prevent SWs from working. SWs understand and take notice of this argument around protecting their source of income.

Recommendations: communications



1. Develop comprehensive repeat communications throughout the cascade, starting with awareness-raising, including VIA and post-treatment abstinence, to make being HPV+ less scary and prepare SWs at each stage.

2. Adapt tools and language to the languages spoken and the level of health literacy.

3. Train PEs on basic psychosocial skills so that they can manage emotional reactions when giving an HPV+ result.

4. Expand the range of additional tools (film screenings followed by discussions, short videos) **for SWs specifically for more complex medical information.**

5. Using argument around protecting health as both a "working tool" and as a catalyst for raising awareness.

HPV screening: two models to reach SWs

HPV self-testing: a key and well accepted innovation

Satisfaction levels with the HPV self-sampling test were very high in both countries. This approach was seen as being small ("cotton bud"), self-administered and minimally intrusive, in contrast to the metal speculum (seen as painful, cold, intrusive and unhygienic). No invalid samples were reported in either project (the few samples that were rejected samples were linked to incorrect labelling), confirming not only that it was carried out correctly, but also that having sexual relations in the 24 hours before sampling was not a criterion for ineligibility.

> ***Well, I did it the way she explained it and it wasn't hard.***
> *SW, Guinea*

In Guinea, CCK also offers an assisted self-testing option (with a midwife present) for SWs who prefer to have some support. Combined with the self-examinations carried out during the self-gynaecology workshops, the first self-test prepares women to do VIA.

Screening age: a key issue for SWs

	POUVOIR — Côte d'Ivoire	SUCCESS II — Guinée
Age for screening	30+	25+
Justification	National Cancer Control Programme (PNLCa) recommendations + HPV clearance phenomenon + limited supplies (MdM)	Alignment with women living with HIV, high HPV+ rate among young SWs
Breakdown of SWs tested	88% 30+, 12% aged 25–29	11% <25, 66% aged 25–29, 23% aged 30+

In Côte d'Ivoire, the median age of SWs was 26 (KAP study, POUVOIR project). Although the eligible age was initially 25, the threshold of 30 was later adopted, which created difficulties for teams on the ground: PEs had to turn away SWs under 30 who wanted to be screened and had to explain the phenomenon of HPV clearance. This created an uncomfortable situation, but it did not prevent the targets from being met.

> ***At sites for younger people, people under 30 wanted to do it but they were told (...) up until you're 30, there are antibodies that can destroy it and itwill go away by itself.***
> *PE, Côte d'Ivoire*

POUVOIR (Côte d'Ivoire): outreach testing approach at SW sites

Côte d'Ivoire model: one monthly session per SW site, with CC awareness-raising at the beginning of each week, followed by collection day on Thursdays, when the PEs came to the site with cool boxes. The samples were sent to the laboratory (GeneXpert); the results were delivered the following week **in person** at the sites by PEs.

> ***The fact that we go to women on the ground (...) If we made them go somewhere, because they don't like to move around (...) it would have put a stop to our work.***
> *PE, Côte d'Ivoire*

Things to be aware of:

- Time between awareness-raising and sampling: the 1–3 day gap between awareness-raising and sampling was problematic, as SWs who attended awareness-raising sessions were not always the same ones that came on the sampling day. Some PEs have asked to combine the two on the same day, which seems like a preferable approach.
- Sustainability of the approach: outreach interventions require an intensive approach - mobilising a network of PEs, repeated awareness-raising sessions, support from a CHW coach (MdM), recruiting a laboratory technician to ensure quick turnaround times, etc. - this creates specific tailored activities and raises sustainability issues. It is therefore essential to establish, where possible, a balance between the effectiveness of tailored measures and integrating these approaches into organisational routines to ensure they are sustainable.

SUCCESS II (Guinea): static and integrated approach

At CCK, HPV tests are offered at the centre in Kindia, which is dedicated to key populations and SWs are not worried about being recognised or stigmatised there. This integrated model is less expensive than an outreach approach, but there are barriers related to travel and a lack of prioritisation of asymptomatic conditions.

At FMG (Fraternité Médicale Guinée, Conakry), HPV tests are offered in an opportunistic way, during consultations people are attending for other reasons. This less systematic approach explains the low number of SWs detected at this site (42 in total).

At the Manquepas enhanced health centre (Kindia), SWs referred by PEs (PIG and Equal Santé) and those attending the HIV clinic can access CC screening at the PMTCT/CC clinic in the same centre and «blend in» with the general population. This process would be more efficient if it were formalised and systematised within enhanced health centres. The number of SWs detected as part of the SUCCESS II project is therefore definitely underestimated.

Important point:

Major challenge in Guinea: delays in delivering results. May and July 2025 had not received their results by March 2026 (8–10 months later), due to logistical challenges with the laboratory system (relocation of the National Institute of Public Health, breakdown of the Genexpert machine at Donka enhanced health centre). Approximately 71% of SWs tested at CCK had received their results. These delays have led to anxiety, disinterest and a loss of confidence among SWs.

> ***That really concerns me! (...)***
> ***If it takes time,***
> ***it means something is wrong.***
> *SW, Guinea*

Recommendations: Testing

1. Prioritise outreach interventions at SW sites where feasible: robust PE network, functional laboratory logistics and rapid delivery of results.

2. Ensure that the laboratory network is operational or there are alternative plans in place before starting testing activities, as the turnaround time for results is a major disruptive factor**.**

3. Combine sensitisation and sampling on the same day where possible to reduce loss to follow-up between the two stages.

4. For approaches in static settings, ensure referral pathways to appropriate health centres (CCK, FMG, enhanced health centres) are formalised and systematised.



Workshops on health care staff perceptions

Discussion workshops on perceptions, attitudes and practices were rolled out in both projects, targeting staff in healthcare facilities involved in providing care and support to SWs. In Guinea, a dedicated facilitation guide was developed based on the Ivorian guide (max. 18 participants: midwives, nurses, PNLCC, PNLSH).

These workshops aim to promote patient-centred care, to change stigmatising attitudes towards key populations, and to strengthen respectful care practices - particularly around consent, bodily autonomy and preventing gynaecological violence. Gender representation considerations are central to this.

> ***I had an image of these ladies in my mind. But when we had the first training session, to be honest, it helped to answer some questions. It helped me to understand certain realities.***
> *Midwife, Côte d'Ivoire*

> ***I realised that I'm not here to judge anyone. I'm here to care for people. (...) I can give a women advice, but it's not my place to judge her.***
> *Midwife, Côte d'Ivoire*

The comments opposite and below are taken from a qualitative post-workshop survey and have been captured verbatim. They illustrate the impact on actual clinical practice.

> ***Beyond what I already knew, what I learned today has made me even more aware of the need to pay closer attention to my approach methodologies when dealing with sex workers (...) Previously I used to completely undress the women to do the gynaecological examination.***
> *Midwife, Côte d'Ivoire*

Important point:

Stigmatising attitudes were observed among reception staff at a health centre in Côte d'Ivoire. These workshops should include all staff who come into contact with key populations (reception staff, community health workers), not just healthcare staff.

From VIA to treatment: challenges of the cascade

Confirmatory VIAs: the critical link

There are many barriers to implementing VIA, which are common to both countries: lack of time, limited financial resources, failure to prioritise health, mobility of SWs, lack of awareness of VIA (especially in Guinea). Added to these barriers is that fact that asymptomatic conditions do not generate care-seeking behaviours in these contexts.

In Côte d'Ivoire, the role of PEs in referrals was a key factor for accessing care: PEs physically accompany SWs to partner health centres, negotiate priority access, cover transport costs and provide psychosocial support. This individual follow-up resulted in an HPV+ -> VIA linkage rate of 62%, which is satisfactory compared to results observed in other West African settings.

Furthermore, **the reduction in the time taken to deliver results** has significantly improved the linkage rate between results being communicated and carrying out VIA, which rose from 50% to 75% between 2023 and 2024, thanks to a dedicated laboratory technician being assigned.

> ***C'était bien, j'ai vu ça... avec elle, le premier rendez-vous, elle m'a accompagnée, elle allait s'asseoir même jusqu'à ce que la sage-femme arrive.***
> *TS HPV+, Côte d'Ivoire*

> ***Elles étaient prioritaires parce que ce sont des dames qui travaillent sur leur temps. Donc quand elles viennent on s'excuse auprès des autres femmes (...) si elles traînent trop, on sait qu'elles vont aller faire le rapport à d'autres, elles ne vont plus venir.***
> *Sage-femme, Côte d'Ivoire*

In Guinea, the procurement of a thermocoagulator at CCK (November 2025) represented a major change: SWs testing HPV+ no longer have to travel to a public health centre (enhanced health centre or regional hospital) or wait for a consultation with the partner provider at CCK, and for VIA+ provision - treatment can be carried out on the same day at CCK, with a familiar team and environment.

Avenues to explore: research is underway on tools to support AI-assisted VIA (analysis of cervical images) and advanced thermoablation (AI-assisted or imaging with automation of parameters such as application time and temperature). In the long term, these innovations could facilitate VIA outreach approaches, which are currently rare due to technical platform constraints.

Post-treatment abstinence - a crucial issue

Post-treatment abstinence is one of the key challenges for SW responses: it prevents SWs from working and has a direct impact on their economic survival and housing.

Official recommendations and planned adaptations: thermocoagulation requires a period of abstinence while the cervix heals. National recommendations (1 month in Côte d'Ivoire, 1.5 months in Guinea) have been adapted by the projects to take into account the reality of SWs, in line with national programmes:

	National guidelines	Project adaptation	Observed practice
Côte d'Ivoire	1 month of abstinence	2 weeks strict abstinence + 2 weeks condom use (validated by PNLCa)	Often <1 week; cervix discharge observed
Guinea	1.5 month of abstinence	2 weeks strict abstinence + 2 weeks condom use (approved by PNLCC)	Limited data available

Risk reduction strategy: given the challenge of abstaining completely, we adapted it to 2 weeks of strict abstinence followed by 2 weeks of condom use. This is a compromise endorsed by national programmes, recognising the economic reality for sex workers while minimising the risk of complications. Raising awareness among established partners and managers on the importance of respecting this period is also crucial.

Groups with uneven reach: occasional sex workers with other sources of income (retail, beauty) report fewer difficulties, as do those who receive support from friends and family. SWs with no other income and those who have to make compulsory payments to managers are the most vulnerable, particularly Nigerian SWs in Côte d'Ivoire. Cases of marital rape have also been reported, which have a direct impact on recovery.

> ***I lasted a week. One week. After that, I started again (...) If I had the money I would have kept it up. But unfortunately... that is not the case.***
> *SW, Côte d'Ivoire*

> ***Financially, since that's not the only thing I live off, I was able to get by(...) I do some small-scale business, to get something (...) But I would say that after the test and when I finished my treatment, I was happy with my business.***
> *Occasional SW, Côte d'Ivoire*

Important point: cases of women being informed about mandatory abstinence only after treatment were identified in both countries, and were very poorly received. It is essential to inform SWs as early as possible – ideally from the awareness-raising stage – and to repeat the information at the point of VIA. Cases of post-treatment complications related to non-compliance with abstinence are difficult to quantify, but should be documented in future projects.

One-year follow-up: a key challenge to overcome

The one-year follow-up of women who have received treatment is very low (12% in Côte d'Ivoire) due to women forgetting, losing their record book, disengaging, the long timeframe (1 year compared to 3–6 months for HIV), lack of active reminders. This challenge is not specific to SWs, but is exacerbated by their levels of mobility. Three-year follow-up of HPV-negative women represents an even greater operational challenge.

Recommendations: VIA, treatment, abstinence and follow-up

1. Systematically communicate about VIA from the awareness stage onwards to reduce the stigma associated with being HPV+ and prepare SWs for the full cascade.

2. Inform SWs about the post-treatment abstinence period as early as possible (ideally from the awareness phase), repeat it during VIA and document cases of complications.

3. Promote a risk reduction approach (2 weeks of strict abstinence + 2 weeks of condom use) as validated by national programmes, rather than total abstinence, which is not realistic.

4. Also raise awareness among established partners and managers of the importance of respecting the post-treatment period.

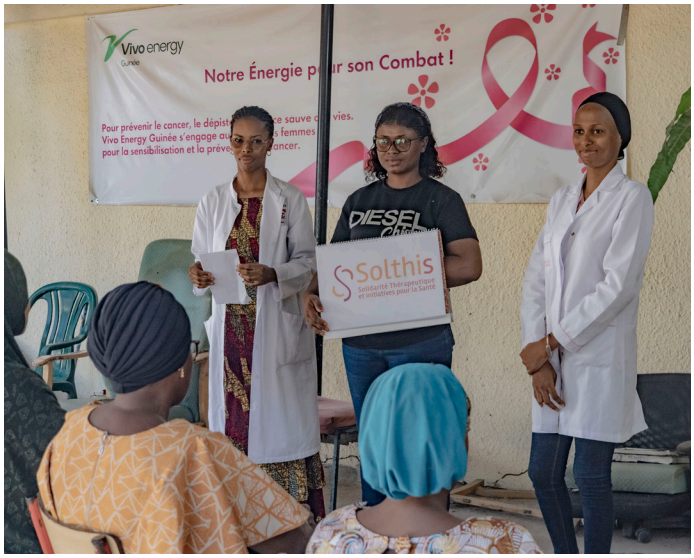
5. Explore targeted economic support measures for SWs with no other sources of income.

6. Implement active reminder systems (PEs, SF, digitalisation of data) and integrate CC monitoring into routine service packages.

From effectiveness to sustainability: cross-learning from two CC screening approaches

Experience from the POUVOIR and SUCCESS II projects confirm that no single approach is universally applicable. The outreach approach (Côte d'Ivoire) is yielding impressive results in the cascade, but requires more human, logistical and financial resources. Integration into a dedicated community centre (Guinea) provides greater optimisation of resources and improved prospects for continuity of care, but poses more challenges in terms of access to SWs and informed support at each stage of the cascade. In both cases, the issue of sustainability remains unresolved and is a critical challenge. In a context of dwindling funding for health, rather than pitting these two models against each other, they should be aligned according to local opportunities, prioritising the most efficient approaches, and a transition strategy should be incorporated from the outset of any intervention: integration into national CC plans and community stakeholders being embedded into institutions.





Key messages

Experience from the POUVOIR and SUCCESS II projects provide the following lessons for any intervention on cervical cancer screening and management targeting female sex workers in West Africa.

1. Working with peer educators and community networks

Access to key populations, uptake of testing and follow-up in the cascade require trained, committed peer educators who maintain a lasting relationship of trust with key populations. Without this network, no other approach can work effectively.

2. Integrating CC into a comprehensive SRHR approach

Self-gynaecology workshops and multi-topic awareness-raising sessions help people to understand CC as a component of women's overall health, reducing resistance and increasing interest. Integration into existing service packages (HIV, STIs, contraception) also generates savings in resources.

3. Taking services to SWs through outreach interventions

An on-site screening approach is more effective than a referral to a health centre. The conditions for success are: a strong PE network, functional laboratory logistics and rapid delivery of results. Without these conditions, a static approach using a dedicated centre (CCK model) can be an effective alternative.

4. Comprehensive and repeated communications

Providing comprehensive information about the entire cascade (HPV+, VIA, abstinence) from the outset of awareness-raising demystifies each step and prepares SWs. Repetition is key to retaining complex messages. Using suitable tools (image boxes, film screenings followed by discussions, short videos) is a major additional success factor.

5. Factor in economic challenges created by abstinence

Post-treatment abstinence is a specific obstacle for SWs: it must be addressed in advance through adapting national recommendations (risk reduction approach) and economic support measures for SWs who have no other resources.

6. Optimise timeframes and locations of care provision to strengthen the cascade

Reducing the time taken to deliver results (Côte d'Ivoire example) and consolidating care in a single location where possible (Guinea example), are key catalysts to reduce loss to follow-up and improve effe tiveness of the cascade.

7. Improving attitudes of healthcare staff

Workshops on perceptions, attitudes and practices are crucial to train care providers on the specific needs of SWs and ensure non-discriminatory care. These workshops must target all staff (reception staff, care providers) and be accompanied by institutional support to embed changes in practice.

8. Pooling resources and integrating into existing systems

Integrating CC into existing service packages and pooling PEs across projects saves resources, expands coverage and supports a comprehensive SRHR package. Pooling PEs requires high-quality standard training for all PEs.

Cette mutualisation exige une formation de qualité commune à toutes les EP.



Learn more about
the SUCCESS project

Learn more about
the POUVOIR project

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