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Challenges in integrating cervical cancer screening in HIV care clinics in West Africa: a pilot study in Abidjan, Côte d'Ivoire

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Background

The ongoing scale-up of antiretroviral therapy (ART) in low-resource settings continues to improve the prognosis of HIV-infected individuals, necessitating a focus on long-term case management especially in women. Facing the particularly high burden of cervical cancer in sub-Saharan Africa, preventive measures are therefore becoming an integral component of a comprehensive approach to the management of patients. We describe here some of the operational aspects of a cervical cancer screening procedure based on visual inspection among HIV-positive women attending ART clinics in Abidjan.

Methods

A cross-sectional study is being conducted in two HIV clinics of Abidjan, since August 2009. A mobile team composed of three trained midwives and a senior gynecologist is in charge of proposing cervical screening based on visual inspection to all HIV-infected women attending participating clinics. Midwives are in charge to perform visual inspection of the cervix with acetic acid (IVA) and lugol's iodine (IVL). Exclusion criteria are following: no previous cervical cancer or total hysterectomy, aged <25 or >59 years, pregnancy over 20 weeks. They refer positively screened women (IVA+ or IVL+), to a gynecologist in charge of the colposcopy examination (and biopsy if needed). Women with confirmed lesions are proposed an adapted treatment according to local available resources.

Results

Of the first 1,653 HIV-positive women, who attended the cervical screening consultations, 49 were not eligible and 103 were not assessable because of a prevalent cervical infection. The median age of the 1,501 screened women was 37 (IQR 32-43) years, and 1171 (78%) were on ART. 133 (9%) women were positively screened for cervical pre malignancy and referred for medical examination. 69 (4.6%, 95% CI 3.5-5.6) were confirmed by colposocopy and had histological investigation. Results of the 69 biopsy performed were as follows; 48 cervical intraepithelial neoplasia (CIN) of grade 1, 8 CIN grade 2 or 3, 2 invasive carcinoma and 10 nonmalignant findings. 22 patients were treated with cryotherapy, 16 were referred for surgical excision, and 31 were proposed a gynecological followup.

Conclusion

Several barriers were identified as limiting the ability of visual inspection used as a cervical screening method such as a high rate of cervical infection or a high rate of false-positive cervical lesions. Health care systems in West African countries cannot afford the financial and structural burdens of a conventional cervical screening program. Strategies adapted to HIV-infected women and relying on visual inspection appear feasible despite stated limitations and should be further evaluated.

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