Cervical cancer is a global public health problem accounting for almost 300,000 deaths annually.¹ Eighty-three percent of new cases and 85% of related deaths occur in resource-poor countries; affecting poor, vulnerable, and disenfranchised women at the prime of life. Cervical cancer is preventable and, in most cases, curable, if identified in its early stages.² The most frequent form and leading cause of cancer mortality among Ethiopian women, cervical cancer is often at an advanced stage by the time they seek screening services. Records show that of the nearly 22 million Ethiopian women over the age of 15, approximately 7,600 are diagnosed with cervical cancer and roughly 6,000 women die of the disease each year.³ These figures are probably significantly lower than the actual number of cases, given the low level of awareness, cost, and limited access to screening services and lack of a national cancer registry.

The 534,000 women over age 15 living with HIV in Ethiopia are among the most vulnerable to cervical cancer. Human Papilloma Virus (HPV) is a sexually transmitted infection and the most common cause of cervical cancer. Women living with HIV are more readily infected with certain types of HPV, more likely to develop precancerous lesions, and more vulnerable to rapid development of these lesions than HIV-negative women. Given the efficacy of antiretroviral treatment and the growing number of HIV-positive women who are living longer, special attention must be focused on screening and treatment for this population. This effort is consistent with the President’s Emergency Plan for AIDS Relief (PEPFAR) recommendations for preventive and palliative HIV/AIDS care.

Addressing the Screening and Treatment Gap: The Single-Visit Approach

Scientific and public health advances have made cervical cancer one of the most preventable and treatable malignancies. Cytology-based screening (Pap smear test) has significantly reduced cervical cancer incidence and mortality in developed countries. Yet it has had limited success in Ethiopia and other resource-poor countries, as it requires repeated testing, laboratory analysis, and proper diagnostic, treatment, and follow-up protocols. Ethiopia has invested little in the infrastructure, training, and laboratory capacity required for successful Pap smear screening. As a major public health problem, the disease disproportionately affects the country’s most vulnerable: poor, rural, and HIV-positive women.

Cervical cancer prevention strategies in low-resource settings are most successful and cost-effective when they require few visits and offer a “screen and treat” (single-visit) approach.⁴ One such approach combines visual inspection of the cervix with acetic acid wash (VIA) and same-day cryotherapy for women with premalignant lesions. This low-tech and low-cost alternative to the conventional Pap smear test has been proven to be safe, acceptable, and feasible.⁵ A trained provider can visually inspect the cervix after it is washed with an acetic acid solution (ordinary table vinegar), which causes precancerous and cancerous tissue on the cervix to appear as white blotches. The provider can then provide same-day cryotherapy (freezing
of cells) for premalignant lesions and refer women with cancerous lesions to referral facilities for further evaluation and treatment. This simple, single-visit prevention strategy requires only low-cost and widely available equipment, can be performed by non-physicians, and does not require complex laboratory infrastructure. Women are screened, lesions are detected, and premalignant lesions are treated in one visit, ensuring higher treatment compliance for those who screen positive. The screening can be integrated into regular reproductive health and HIV/AIDS care and treatment services.

**Success with Single-Visit Screening and HIV**

A Nigerian study demonstrated VIA as a sensitive screening test for pre-cancerous cervical lesions in HIV-positive women. The single-visit approach for HIV positive women was also successfully implemented in 13 outlying primary care government-operated clinics and tertiary care hospitals in Lusaka, Zambia.

Addis Tesfa

Pathfinder has done VIA advocacy, training, and capacity building in Kenya, Bolivia, and India, with demonstrable success in all regions. Pathfinder’s five-year Addis Tesfa Project will build on this experience and anticipates screening at least 5,000 HIV-positive women and treating them when necessary. Three hundred community-based support groups will integrate cervical cancer information and support into their activities. At least 20,000 HIV-positive women and their communities will receive information on the disease and its prevention. Throughout the project, Pathfinder will support comprehensive facility services, educate the community about cervical cancer prevention, and establish lasting alliances with local partners. Together with the FMOH and SPIRES, the project will establish services in 14 health institutions (including five Cervical Cancer Prevention Centers of Excellence) in the regions of Addis Ababa, Amhara, Oromia, Tigray, and Southern Nations, Nationalities, and People’s Region (SNNPR).

Evidence shows that successful and sustainable program implementation is only possible if robust collaboration and coordination exist between national health officials as part of a broad base of stakeholders, international donors, and implementers. The implementation and documentation of this initiative will serve as a catalyst to Ethiopia’s FMOH to scale-up this intervention nationwide, ultimately increasing the general population’s access to the single-visit approach.

---


This publication was supported by Cooperative Agreement Number 1U2GPS001935 from Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.