Gender-Based Violence and Barriers to Cervical Cancer Prevention in Ethiopia

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TABLE OF CONTENTS

I. Executive Summary

II. Statement of Purpose

A. Client Description, Project Goals, Deliverables

III. Review of the Current Policy & Policy Issues

A. Background
B. Literature Review
C. Policy Issues

IV. Statement on the Necessity of Change

V. Methodology

VI. Key Findings

VII. Discussion

VIII. Policy Proposals

IX. Recommendations

X. Implementation

XI. Conclusion

XII. Bibliography

I. Executive Summary

Our research examines how gender-based violence (GBV) limits and restricts women's access to cervical cancer healthcare. We examined Grounds for Health's existing programs in Ethiopia; Grounds for Health is a non-profit organization that establishes cervical cancer prevention programs for women in coffee growing communities. Our methodology consisted of interviews and a focus group conducted in Addis Ababa and Hawassa, Ethiopia.

Our research highlights four key findings. 1) Different groups of women, including unmarried women, religious women, and women in rural settings, are less likely to utilize care or have access to it because of community stigma, taboos, and faith barriers. 2) Health extension workers are deeply trusted and relied upon by the community of women they serve. 3) Self-testing, implemented by Grounds for Health in 2022, has increased women's access to cervical cancer screenings. 4) Despite increases in testing due to both self-testing and awareness campaigns, persistent harmful norms create barriers to cervical cancer testing for some groups of women.

Based on these findings, as well as findings from desk research, there are 10 policy options for Grounds for Health to consider that fall under the categories of *outreach campaigns*, *increased advertising*, and *education initiatives*. *Outreach campaign* options include male engagement campaigns and increased messaging on confidential access of screening for unmarried women and GBV survivors. *Increased advertising* includes: Installing posters on walls of health posts with information on importance of cervical cancer screenings, as well as radio campaigns in local languages that advertise the importance of cervical cancer screenings and include testimonials from local women. *Education initiatives* include: Couples-based health

education focused on joint decision-making and school-based HPV and health curriculums for primary and secondary schools.

Beyond policy options for Grounds for Health, we also provide 2 policy options for the Ministry of Health to apply more broadly in Ethiopia. These options are: A mobile alert system to promote the importance of cervical cancer screenings to both men and women and the normalization of screening through story telling by sharing stories of women who benefitted from early detection.

Recognizing the logistics behind putting these policy options into practice, and the capacity needed to implement each of the above options, we recommend that Grounds for Health prioritize these four initiatives: Male engagement campaigns that target husbands and male community leaders, door-to-door outreach conducted by health extension workers both advertising and providing discrete care, radio campaigns in local languages to normalize screening and dispel myths, and the use of posters and flyers as educational materials. We recommend that Grounds for Health work to implement these four initiatives across their programming in Ethiopia. Furthermore, our implementation plan suggests that Grounds for Health initiate a pilot program in one specific region where screening rates are low. The application of the pilot program is key because it is an actionable and likely effective option for increasing screening rates rapidly. Ultimately the research laid out in this paper seeks to describe the link between GBV and women's access to cervical cancer healthcare. From our findings, we have recommended feasible action with the goal of creating sustainable change.

II. Statement of Purpose

Cervical cancer is the fourth most common cancer among women globally, yet it is almost entirely preventable with screening and treatment of cervical precancers and diagnosis of early-stage invasive cancers.[1] According to our client Grounds for Health, cervical cancer is almost 100% preventable, but if left undetected 4.5 million women, especially in lower-income countries, may die from it in the next 15 years.[2] At the same time, GBV is a prevailing issue globally, with nearly 1 in 3 women experiencing physical or sexual violence in their lifetime.[3] East and Southern Africa have some of the highest rates of GBV in the world; the World Bank reports that 42% of women in the region experience GBV in their lifetime.[4] The prevalence of GBV has been shown to restrict women's access to essential healthcare services. For example, intimate partner violence (IPV) can limit a woman's ability to travel to a healthcare facility, or in some cases, prevent her from receiving care altogether.[5]

The combination of societal gender norms, combined with the high rates of GBV in Ethiopia, are key factors that prevent women from accessing preventative healthcare. Therefore, it is crucial to study the link between GBV and access to cervical cancer screenings in order to better understand the structural and social barriers women face, identify how violence exacerbates existing inequalities and health access, and develop targeted interventions that

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[1] Mamsau Ngoma and Philippe Autier, "Cancer Prevention: Cervical Cancer," *ecancermedicalscience* 13 (2019): 952, https://doi.org/10.3332/ecancer.2019.952

[2] Grounds for Health, https://groundsforhealth.org/.

[3] United Nations, "Violence against Women Remains Devastatingly Pervasive," *UN News*, November 25, 2024, https://news.un.org/en/story/2024/11/1157046

[4] UN Women Africa. "How Gender Data Is Enabling Better ServicePreventives for Gender-Based Violence Survivors: A Tale of Five Countries in East and Southern Africa." November 2024. https://africa.unwomen.org/en/stories/feature-story/2024/11/how-gender-data-is-enabling-better-services-for-gender-based-violence-survivors-a-tale-of-five-countries-in-east-and-southern-africa

[5] Linda A. McCloskey, Christine M. Williams, Elisabeth Lichter, Meredith Gerber, Michael L. Ganz, and Robert Sege, "Abused Women Disclose Partner Interference with Health Care: An Unrecognized Form of Battering," *Journal of General Internal Medicine* 22, no. 8 (2007): 1067–72 https://pmc.ncbi.nlm.nih.gov/articles/PMC2305736/

ensure early detection and treatment. From our research on the way that GBV impacts women's access to cervical cancer screenings, we consider policy options and then provide recommendations for concrete ways that Grounds for Health can increase women's access to their services.

Our Client and Deliverables

Our client is Grounds for Health, a non-profit organization registered in Vermont that was founded in 1996. Grounds for Health is dedicated to expanding global inclusive healthcare, specifically by preventing cervical cancer in coffee communities. Grounds for Health works at the secondary prevention level, centered on cervical cancer screening. Since its beginning, Grounds for Health has screened 251,677 women and treated 21,028 women. There is no particular connection between coffee communities and cervical cancer, but many lower-income countries with disproportionately high cervical cancer rates are also top coffee growers. Coffee is grown in rural communities, where access to healthcare is more limited than in urban settings. Grounds for Health aims to establish equitable care for women working in these rural coffee-growing communities.

Our research on women's access to sexual and reproductive healthcare aligns with Grounds for Health's mission of promoting inclusive healthcare in coffee communities. Grounds for Health is in a unique position to support our research because it has established connections with community organizers and leaders, allowing us to conduct a closer examination of gendered dynamics that prevent women from accessing services. During our collaboration with Grounds for Health's work in Ethiopia, we conducted interviews and an analysis, at the request of our client, to examine the link between GBV and access to cervical cancer prevention. This analysis

helped identify how women in local communities currently access such healthcare, the barriers they face, and the strategies to make these services more accessible. From our research, a concrete deliverable we are providing for Grounds for Health is a gender tool kit outlining how the organization can modify its future programming to be more gender-responsive and reach more women who are restricted from accessing care as a result of GBV. We hope that this toolkit will provide the team with resources and information on how to better serve women who face GBV. Our hope is that every woman who is eligible can and will be screened because the program directly addresses their needs and barriers to care.

III. Review of Current Policies and Policy Issues

Background

Gender-Based Violence: Definition and forms

GBV refers to violence or harm that is directed at an individual based on gender.[6] It can occur in both public and private spaces and may include sexual, physical, psychological, emotional, and economic forms of harm.[7] GBV also includes threats, coercion, manipulation, and restrictions on a person's autonomy or decision-making.[8] Common forms of GBV include "intimate partner violence, sexual violence, child marriage, female genital mutilation, and so-called "honor" crimes."[9] The consequences of GBV can be severe and long-lasting, affecting survivors' physical health, mental health, economic security, and overall well-being.[10]

Sexual Violence

[6] UNICEF "Gender-Based Violence Information Pack," https://www.unicef.org/serbia/en/media/16751/file
[7] United Nations High Commissioner for Refugees (UNHCR), "Gender-Based Violence," https://www.unhcr.org/what-we-do/protect-human-rights/protection/gender-based-violence
[8] UNICEF "Gender-Based Violence Information"
[9] UNHCR, "Gender-Based Violence"
[10] UNHCR, "Gender-Based Violence"

Sexual violence is a form of GBV that includes any non-consensual sexual act or behavior. This can include rape, unwanted touching or kissing, unwanted sexual advances, female genital mutilation, and other forms of sexual coercion.[11] Sexual violence does not only refer to penetrative acts, but can also include non-penetrative and non-contact forms of abuse.[12] In all cases, sexual violence involves forcing or pressuring a person to participate in sexual activity without their full and informed consent.

Physical Violence

Physical violence refers to the intentional use of physical force that causes, or has the potential to cause, injury, pain, or suffering.[13] This can include hitting, slapping, beating, shaking, pushing, biting, burning, choking, cutting, shooting, or other forms of physical harm.[14] The consequences of physical violence can range from minor injuries to severe injury, permanent disability, or death.[15] Physical violence can also contribute to broader health consequences, including unintended pregnancies, adverse pregnancy outcomes, sexually transmitted infections, and urinary tract infections.[16]

Psychological and Emotional Violence

Psychological and emotional violence includes behaviors that harm a person's sense of self, emotional well-being, or mental health.[17] This can include humiliation, degradation, name-calling, constant criticism, stalking, harassment, isolation, intimidation, and threats of physical

[11] UNICEF "Gender-Based Violence Information"
[12] UNICEF "Gender-Based Violence Information"
[13] UNICEF "Gender-Based Violence Information"
[14] UNICEF "Gender-Based Violence Information"
[15] UNICEF "Gender-Based Violence Information"
[16] National Center for Biotechnology Information, *Infectious Diseases of Poverty* (Bethesda, MD: National Library of Medicine, 2016), https://www.ncbi.nlm.nih.gov/books/NBK305160/
[17] UNICEF "Gender-Based Violence Information"

harm.[18] Rather than causing visible injury, psychological violence often operates through persistent emotional control and manipulation.[19] Its consequences can include anxiety, sleep difficulties, trouble concentrating, loss of appetite, anger, irritability, depression, self-harm, and suicidal thoughts.[20]

Economic Violence

Economic violence refers to behaviors that limit a person's access to financial resources and threatens their security.[21] GBV both contributes to and is reinforced by poverty.[22] Women experiencing violence may face barriers to maintaining employment, achieving financial independence, or accessing essential services.[23] In contexts where men are expected to be the primary financial providers, economic control can become a way to restrict women's mobility and decision-making. For example, men may withhold money needed for transportation to health facilities, preventing women from accessing cervical cancer screening or other forms of healthcare.

GBV, Autonomy, and Decision-Making

Although GBV is often associated with physical or sexual violence, it can also include restrictions on autonomy and decision-making. Limiting a woman's ability to make choices about her own body, healthcare, mobility, or finances is a form of control that can reinforce broader patterns of gender inequality. In the context of this research, restrictions on women's

[18] UNICEF "Gender-Based Violence Information"
[19] UNICEF "Gender-Based Violence Information"
[20] NCBI, *Infectious Diseases of Poverty*.
[21] Parmita Das, "Economic Abuse," *Berkeley Economic Review*, April 2, 2019, https://econreview.studentorg.berkeley.edu/economic-abuse
[22] NGO Committee on the Status of Women, New York, "Feminization of Poverty," https://ngocsw.org/feminization-of-poverty
[23] NGO Committee on the Status of Women, New York, "Feminization of Poverty,"

decision-making are especially important because they may affect whether women are able to seek cervical cancer screening or treatment.

Cervical Cancer: Defining Cervical Cancer, Prevention, and Treatment for Pre-Cancer

Cervical Cancer is the 4th most common cancer amongst women worldwide.[24] It is most commonly caused by the human papillomavirus (HPV), a common sexually transmitted infection, that can lead to cervical neoplasia, a precancerous condition that can be found in 99.7% of cervical cancer cases.[25] Cervical Neoplasia is primarily caused by chronic infection with high-risk strains of HPV.[26] Risks that may cause HPV infection common in African countries are early marriage, intercourse (under age 15), a high number of sexual partners, polygamy, a partner that has intercourse with other partners, unprotected sexual intercourse, and a history of sexually transmitted infections.[27]

Despite its prevalence, cervical cancer is almost 100% preventable.[28] Primary prevention for cervical cancer is the HPV vaccine which is administered to girls as early as 9 years old and given in 2 to 3 doses depending on how early the first dose was administered.[29] Secondary prevention of cervical cancer includes different types of cervical cancer screening. Cervical cancer cytology, or the study and analysis of cells for diagnostic purposes, is one of the most

[24] World Health Organization, "Cervical Cancer," December 2, 2025, https://www.who.int/news-room/fact-sheets/detail/cervical-cancer.
[25] Mamsau Ngoma and Philippe Autier, "Cancer Prevention: Cervical Cancer," *ecancermedicalscience* 13 (2019): 952, https://doi.org/10.3332/ecancer.2019.952
[26] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.
[27] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.
[28] World Health Organization, "Cervical Cancer,"
[29] Centers for Disease Control and Prevention, "HPV Vaccine Recommendations for Health Care Providers," July 9, 2024, https://www.cdc.gov/hpv/hcp/vaccination-considerations/index.html

effective methods of cancer screening in industrialized countries.[30] This cytology led to a significant decline in the incidence and death of invasive cancer by the early identification and treatment of preinvasive lesions. Cervical cancer screening programs aim to identify cervical cancer precancerous cell changes in order to provide appropriate follow-up treatment.

The most common form of screening is a Pap smear, which has reduced cervical cancer incidences and mortality, preventing between 50% and 70% of expected cases.[31] Some countries have adopted liquid-based cytology to improve the detection of cervical intraepithelial neoplasia (CIN), which are abnormal cell changes that can develop into cervical cancer.[32] However, this method is not always reliable and can be difficult to implement on a large scale because results can vary depending on the provider interpreting the test. Lower-cost alternatives, such as visual inspection with acetic acid (VIA) and visual inspection with Lugol's iodine (VILI), have shown positive results in low- and middle-income countries.[33] These methods are often used through a "see and treat" approach, where women are screened and treated in the same visit, reducing the need for multiple appointments while increasing access to screening.[34] It is important to note that all of the above methods include a speculum exam.

In 2021, the World Health Organization created new guidelines, recommending HPV DNA testing as the preferred method for cervical cancer prevention globally. HPV DNA testing is the most effective screening test in terms of identifying women with cervical precancers, and

[30] Nirali Patel et al., "A Comparison of Conventional Pap Smear and Liquid-Based Cytology for Cervical Cancer Screening," *Gynecology and Minimally Invasive Therapy* 12, no. 2 (2023): 77–82, https://doi.org/10.4103/gmit.gmit_118_22
[31] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.
[32] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.
[33] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.
[34] Ngoma, Mamsau, and Philippe Autier. "Cancer Prevention: Cervical Cancer," 952.

can be done via self-collection by a swab of the vaginal walls done by the woman herself.[35] This form of screening has further expanded women's access to screenings, and has the potential to continue to do so; HPV test kits are more clinically accurate and more portable, allowing women to perform them themselves and allowing for them to be conducted outside of traditional exam settings. A key benefit of HPV DNA testing is the reduction of the need for a speculum exam, which is something that women greatly appreciate.[36]

GBV as a Public Health Issue

We return to GBV to make a critical point: GBV fundamentally shapes women's access to healthcare. GBV is not only a human rights issue, but also a major public health concern. Its effects can be both immediate and long-term. Short-term consequences may include physical injury, trauma, unwanted pregnancy, sexually transmitted infections, and barriers to healthcare.[37] Long-term consequences may include chronic pain, reproductive health complications, depression, anxiety, and other psychological effects.[38] Because GBV can shape women's ability to access care, make health decisions, and seek prevention services, it is directly connected to broader health outcomes, including cervical cancer prevention and treatment.

Literature Review

Cervical Cancer in Ethiopia

[35] World Health Organization (WHO), "New Recommendations for Screening and Treatment to Prevent Cervical Cancer," July 6, 2021, https://www.who.int/news/item/06-07-2021-new-recommendations-for-screening-and-treatment-to-prevent-cervical-cancer
[36] World Health Organization (WHO), "New Recommendations for Screening and Treatment"
[37] Giulia Lausi et al., "Decision-Making and Abuse, What Relationship in Victims of Violence?" *International Journal of Environmental Research and Public Health* 20, no. 10 (2023): 5879 https://pmc.ncbi.nlm.nih.gov/articles/PMC10218381/
[38] Giulia Lausi et al., "Decision-Making and Abuse"

Despite being one of the most preventable forms of cancer, cervical cancer remains a major public health challenge in Ethiopia. Cervical cancer is the second deadliest form of cancer for women in the country, with approximately 33.7 million women aged 15 and older at risk of developing the disease.[39] In 2020 alone, there were an estimated 7,445 cervical cancer cases and 5,338 deaths.[40] The numbers may be even higher than this, as general data and recent data specifically, is somewhat lacking. At the same time, screening rates remain critically low, with some estimates suggesting that in certain parts of the country less than 5% of women have ever been screened for cervical cancer.[41]

In recent years, the Ethiopian government and international partners have expanded cervical cancer prevention efforts through large-scale screening and vaccination campaigns. In 2025, the World Health Organization and the Ethiopian Ministry of Health launched a month-long cervical cancer screening campaign across six regions, including Addis Ababa, Oromia, Sidama, and Amhara.[42] The campaign surpassed its original target by screening over 275,000 women and treating thousands of precancerous lesions using a same-day "see-and-treat" approach. More than one million people were also reached through awareness campaigns involving health extension workers, women's groups, and religious leaders.[43] Similarly, the nationwide HPV vaccination campaign launched in 2024, supported by UNICEF, World Health

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[39] Laia Bruni, Greta Albero, Beatriz Serrano, Maria Mena, Juan José Collado, David Gómez, Judit Muñoz, F. Xavier Bosch, and Silvia de Sanjosé, *Human Papillomavirus and Related Diseases in Ethiopia: Summary Report 10 March 2023* (ICO/IARC Information Centre on HPV and Cancer, 2023), accessed September 28, 2025, https://hpvcentre.net/statistics/reports/ETH_FS.pdf

[40] Bruni et al., *Human Papillomavirus and Related Diseases in Ethiopia.*

[41] Tewodros Yosef et al., "Determinants of Cervical Cancer Screening Uptake among Reproductive-Age Women in Southwest Ethiopia: A Case-Control Study," *Frontiers in Oncology* 14 (October 22, 2024): article 1424810 https://www.frontiersin.org/journals/oncology/articles/10.3389/fonc.2024.1424810/full

[42] World Health Organization, "A National Milestone in Women's Health – As Ethiopia Concludes Month-Long Cervical Cancer Campaign with Record-Breaking Results," January 15, 2026, https://www.afro.who.int/countries/ethiopia/news/national-milestone-womens-health-ethiopia-concludes-month-long-cervical-cancer-campaign-record

[43] World Health Organization, "A National Milestone in Women's Health," January 15, 2026.

Organization, and Gavi, the Vaccine Alliance, successfully expanded vaccine access and doubled the number of vaccinated girls to approximately 13 million.[44] While these campaigns demonstrate growing national commitment to cervical cancer prevention, harmful social and gender norms continue to create barriers to healthcare access.

In Ethiopia, low rates of screening are related to several intersecting factors, including limited availability of screening services and gender and cultural norms that dissuade or prevent women from seeking services. A study analyzing gender disparities and barriers to accessing essential health services, including sexual and reproductive healthcare, found that many women –especially unmarried, young, or religious women – were stigmatized and shamed for seeking healthcare.[45] A research report from 2025 indicates that only 15% of married women in Addis Ababa, Ethiopia, receive spousal support for seeking cervical cancer screening services.[46]

GBV in Ethiopia

To understand the extent to which cultural and gender norms impede access to cervical cancer care in Ethiopia specifically, it is essential to examine the broader prevalence of GBV and harmful social norms within the country. GBV remains highly prevalent in Ethiopia, with the 2016 Ethiopia Demographic and Health Survey (DHS) reporting that 35% of ever-married women between the ages of 15–49 have experienced physical, emotional, or sexual violence

[44] World Health Organization Regional Office for Africa. "The Human Papillomavirus (HPV) Single-Dose Schedule Elevated the Total Number of Vaccinated Girls in Ethiopia to over 13 Million." *WHO Africa*, January 17, 2025. https://www.afro.who.int/countries/ethiopia/news/human-papillomavirus-hpv-single-dose-schedule-elevated-total-number-vaccinated-girls-ethiopia-over

[45] Agumasie Semahegn et al., "Gender Disparities and Barriers to Access and Use of Essential Health Services in Ethiopia: Designing Primary Health Care through Gender Lens," *PLOS Global Public Health* 5, no. 6 (June 20, 2025): e0004813, https://pmc.ncbi.nlm.nih.gov/articles/PMC12180718/

[46] Ebrahim Mohammed, Girma Taye, Mathewos Aseffa, Adamu Addissie, and Ahmedin Jemal, "Cervical Cancer Screening Uptake and Sociocultural Barriers among Women in Addis Ababa, Ethiopia: Population-Based Study," *Cancer Epidemiology, Biomarkers & Prevention* 34, no. 5 (May 2025): 691–97. https://pubmed.ncbi.nlm.nih.gov/40036054/

from a husband or intimate partner.[47] Additionally, 68% of women agreed that wife-beating can be justified under certain circumstances, reflecting the normalization of violence against women within some social and cultural contexts.[48] In the broader East and Southern Africa region, approximately 42% of women experience some form of GBV, further demonstrating the widespread nature of the issue.[49] These forms of violence and inequality directly shape women's healthcare access, autonomy, and ability to seek preventative services such as cervical cancer screening.

In addition to high rates of GBV, harmful traditional practices and restrictive gender norms continue to affect women and girls across Ethiopia. Data shows that in rural areas approximately 68% of women aged 15–49 have undergone FGM,, despite national and international efforts to reduce the practice.[50] Although child marriage and FGM are not the central focus of this research, they remain important examples of the broader patriarchal systems and gender norms that limit women's bodily autonomy and decision-making power. These practices are tied to wider societal expectations that prioritize male authority and reinforce women's subordinate status within the household and community. Research conducted in rural Ethiopia found that women are often expected to manage domestic responsibilities while men maintain control over financial resources and major household decisions.[51]

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[47] Gender-Based Violence Area of Responsibility, "Ethiopia," *Global GBV Country Dashboard*, https://gbvaor.net/global-gbv/country/158https://gbvaor.net/global-gbv/country/158

[48] GBV AoR, "Ethiopia."

[49] UN Women Africa. "How Gender Data Is Enabling Better ServicePreventives for Gender-Based Violence Survivors: A Tale of Five Countries in East and Southern Africa." November 2024. https://africa.unwomen.org/en/stories/feature-story/2024/11/how-gender-data-is-enabling-better-services-for-gender-based-violence-survivors-a-tale-of-five-countries-in-east-and-southern-africa

[50] FGM/C Research Initiative, "FGM in Ethiopia," Orchid Project, https://www.fgmcri.org/country/ethiopia/

[51] Dereje Geleta, et. al., "Gender Norms and Family Planning Decision-Making Among Married Men and Women, Rural Ethiopia: A Qualitative Study," *Science Journal of Public Health* 3, no. 2 (March 7, 2015): 242-250. https://www.researchgate.net/publication/276105233

It is also necessary to highlight the way shortcomings in the legal system allow harmful norms and practices to persist despite formal protections. Ethiopia has outlawed harmful traditional practices such as FGM and child marriage, and in 2017 the Ministry of Health formally banned the medicalization of FGM in both public and private health facilities, but despite this, enforcement remains inconsistent.[52] In 2024, the Ethiopian Islamic Affairs Supreme Council issued a decree endorsing FGM as an Islamic practice and encouraging its medicalization, illustrating the tension between federal legal protections and influential religious and customary institutions.[53] Scholars have linked these enforcement challenges to Ethiopia's system of legal pluralism, in which customary and religious legal systems continue to operate alongside federal law.[54] Although the Ethiopian constitution establishes fundamental rights protections and recognizes the supremacy of constitutional law, local customary and religious courts often continue practices that conflict with federal protections that have limited accountability.[55] This creates an environment in which harmful gender norms and practices can persist despite legal reforms.

These broader gender norms and systems of inequality have direct implications for women's healthcare access, including cervical cancer prevention and treatment. Existing literature demonstrates that women in Ethiopia, particularly those living in rural areas, often face

[52] World Health Organization, "Ethiopia Bans Medicalization of Female Genital Mutilation (FGM)," January 31, 2017, https://www.afro.who.int/news/ethiopia-bans-medicalization-female-genital-mutilation-fgm

[53] United Nations Children's Fund (UNICEF), *UNICEF Ethiopia Annual Report 2024* (Addis Ababa: UNICEF Ethiopia, 2025), https://www.unicef.org/media/172886/file/Ethiopia.pdf.pdf

[54] David Cohen et al., "Gender Norms in a Context of Legal Pluralism: Impacts on the Health of Women and Girls in Ethiopia," *Global Public Health* 19, no. 1 (2024): 2326016, https://doi.org/10.1080/17441692.2024.232601

[55] David Cohen et al., "Gender Norms in a Context of Legal Pluralism"

barriers to accessing healthcare due to restrictive social norms, limited financial autonomy, stigma surrounding reproductive healthcare, and unequal household power dynamics.[56]

In Ethiopia, traditional social and cultural norms are very prevalent. A study in rural areas of Ethiopia found that according to gender norms in society, men's views and opinions are valued over women's, and men are viewed as the sole decision-makers.[57] Cultural norms further exacerbate gender norms as many proverbs and sayings reinforce gender roles. Furthermore, religion plays an important role in this as many people see traditional gender norms as if "it was given by God and universally accepted on the world."[58] Ultimately, this results in women having almost no decision-making powers in society. These norms are particularly important in understanding barriers to cervical cancer screening and prevention, as women's ability to seek care is often shaped not only by healthcare availability, but also by the broader gendered power structures that influence everyday life.

Policy Issue

The combination of high rates of GBV in Ethiopia and high rates of cervical cancer mortality call for an examination of how GBV limits women's access to cervical cancer healthcare. As outlined above, data suggests that various forms of GBV restrict women's access to healthcare services, while it is also known that cervical cancer screenings are effective ways of identifying precancers. With these two realities in the balance, this paper details our examination of how forms of GBV decrease women's access to cervical cancer screenings in rural Ethiopia.

IV. Statement on the Necessity of Change

[56] Dereje Geleta, et. al., "Gender Norms and Family Planning Decision-Making"
[57] Dereje Geleta, et. al., "Gender Norms and Family Planning Decision-Making"
[58] Dereje Geleta, et. al., "Gender Norms and Family Planning Decision-Making"

In their strategic path to cervical cancer elimination, the WHO has outlined that 90% of girls need to be fully vaccinated for HPV by the age of 15, 70% of women need to be screened for cervical cancer by the age of 35, and 90% of women with precancer must be treated while 90% of women with invasive cancer must have their cancer managed.[59] Grounds for Health is directly contributing to meeting these global targets, but as a country, Ethiopia is still exceptionally far from WHO targets, as in some areas of the country less than 5% of eligible women are screened.[60]

In 2022, Grounds for Health switched from conducting speculum exams to self-administered cervical cancer screenings. In the episode of Sourced: The Coffee Podcast, Kyle Engelman, the executive director for Grounds for Health, discusses the organization's previous use of VIA which required a speculum exam and how women responded favorably to the organization's switch to self-administered testing.[61] This switch led to a positive increase in screenings as taboos around the speculum exams stopped women from getting screened. While this switch addressed one of the bigger taboos around cervical cancer screening, it did not fully address the social and cultural norms that prevent some women from accessing screenings. Social and cultural norms are deeply embedded within a society. In combination with traditional gender roles, these norms work to preserve traditional gender hierarchies that prevent women from having full autonomy over their decision-making capabilities. Without addressing these norms within society, there will continue to be a significant number of women who are unable to access cervical cancer healthcare.

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[59] World Health Organization, "Cervical Cancer Elimination Initiative," accessed April 15, 2026, WHO page
[60] Yosef et al., "Determinants of Cervical Cancer Screening Uptake."
[61] *The Coffee Podcast*, "Cervical Cancer, Women in Coffee, and Grounds for Health," season 2, episode 6, July 27, 2023, audio podcast, Apple Podcasts, https://podcasts.apple.com/us/podcast/sourced-the-coffee-podcast/id1482002568?i=1000622551945.

V. Methodology

Our research design combined qualitative methods, desk research, and fieldwork conducted in Ethiopia. Prior to fieldwork, we conducted desk research, including a literature review of cervical cancer prevention practices and GBV in Ethiopia. Fieldwork consisted of interviews with Kyle Engelman, the director of Grounds for Health, 3 additional Grounds for Health staff members, 2 urban healthcare professionals, and 8 community health extension workers, as well as one focus group with 7 healthcare providers. Health extension workers were selected because they serve as trusted members of their communities and play a critical role in door-to-door awareness raising, cervical cancer education, and screening at local health posts. In order to become a healthcare extension worker, women apply after high school to enter college where they train as health extension workers. Out of many who apply, only those with the top educational background are selected to receive healthcare training. Those selected complete a year of training in college, then return to serve in a healthcare role in their communities. Healthcare providers – nurses by training – work in clinics and receive at least three years of training. Healthcare providers are responsible for follow-up care, treatment referrals, and supporting women after diagnosis.

For ethical reasons, we did not interview women seeking services to avoid the risk of retraumatization. During interviews and the focus group, Mesfin Wana, the HPV Program Specialist at Grounds for Health, provided translation from Amharic and the Sidama language. Interview questions began with participants' professional backgrounds and roles, then progressed to discussions of social norms, and ultimately to direct questions regarding GBV.

Because many interviews were conducted in rural areas of the Sidama region, we also interviewed healthcare professionals in Addis Ababa to capture a broader perspective on differences between rural and urban healthcare systems, as well as how social norms vary across contexts. In addition to interviews and the focus group, our qualitative approach was complemented by field observations, which helped us better understand: (1) clinic structure and organization, (2) interactions among staff and between staff and patients, and (3) potential barriers to care emerging from social and cultural norms.

After returning from Ethiopia, we transcribed and coded the interviews and focus group. Twenty-two codes were derived from the interviews and put into the following categories: *community trust, community mobilization, persisting societal norms, gender norms, and service constraints.* These categories allowed us to identify the themes of: *trust in health workers as an entry point to care, community outreach as a pathway to care, changing norms and increasing rates of screening, persistent stigma shaping perceptions of reproductive health, gendered control over women's healthcare decision-making, resource constraints limiting the reach of services, and normalization of GBV within care-seeking context.* Similarly, the focus group was analyzed using 22 codes which were then put into these categories: *community beliefs and misconceptions, stigma surrounding reproductive healthcare, gender norms and household power dynamics, religion and community influence, community outreach and education, structural barriers, and gender-based violence.* These categories formed the themes of *persistent stigma shaping women's reproductive healthcare experiences, gender norms limiting women's healthcare autonomy, misinformation and low awareness surrounding cervical cancer prevention, religious and community influence shaping healthcare attitudes, community outreach increasing trust and screening uptake, structural inequalities limiting access to care, self-*

screening reducing cultural barriers to cervical cancer screening. The coding of the interviews and focus group formed 12 finding statements. Furthermore, our primary hypothesis is that although Grounds for Health has the capacity to provide cervical cancer screening services to women at risk, utilization remains limited due to socioeconomic barriers and the impact of GBV. The following represents our key findings from both our fieldwork and desk research.

VI. Key Findings

1. Women require permission from their husbands to go to healthcare clinics: Approximately 75% of health extension workers reported that women must ask their husbands for permission to visit clinics and receive healthcare services. In one instance, a health extension worker noted that when a woman tested positive, they contacted her husband directly to inform him of her diagnosis and encourage him to have her seek further treatment. This example emerged in only one interview; however, during our discussion with Kyle Engelman, she expressed significant concern that such a practice occurred..

2. Women are sometimes unable to access care because of household constraints and financial barriers: Several health extension workers identified childcare responsibilities, domestic labor, and financial limitations as key barriers preventing women from accessing healthcare. Time spent on domestic labor further limits women's access to services, as they are often not given a choice between attending to household responsibilities and accessing healthcare. When women are expected to carry the primary burden of domestic work while lacking control over financial resources, they remain dependent on male decision-making and schedules. Additionally, transportation costs were frequently cited as a barrier, with some

respondents explaining that men may prevent women from seeking care because available funds are prioritized for other household needs. These findings highlight a disconnect between the availability of services provided by Grounds for Health and women's ability to physically access them, with decision-making power and resource allocation shaped by gendered dynamics.

3. Unmarried women are unlikely to access care because of community stigma: Across interviews with health extension workers, healthcare providers, and Grounds for Health staff, we found that unmarried women often do not access cervical cancer prevention services due to stigma surrounding premarital sexual activity. Several respondents noted that in rural communities, unmarried women may avoid services altogether or seek care discreetly due to fear of community judgment and social repercussions. There was some disagreement among providers, with those in urban settings suggesting that unmarried women face fewer barriers, while providers in rural areas consistently emphasized stigma as a significant deterrent. In certain cases, health extension workers reported providing services through discreet home visits, particularly for unmarried women seeking family planning or those giving birth in secret. Although data is lacking on the proportion of unmarried women in each community, even a small number of women affected by these barriers represents a gap in service delivery.

4. Health extension workers are deeply trusted and relied upon by the community: Health extension workers emphasized that they maintain close, trust-based relationships with the women they serve and are often aware of key personal aspects of their lives. One health extension worker noted that they are accessible by phone at all hours of the day and night to the women they serve. These relationships suggest that women generally feel comfortable sharing personal

and sensitive information with healthcare workers, including details related to sexual health and violence. This is true despite limiting factors like stigma and community norms. To address these factors, health extension workers frequently conduct door-to-door outreach and community education campaigns, targeting both women and men to raise awareness about the importance of screening. Grounds for Health previously employed one community coordinator who worked to mobilize women and increase screening rates, but now health extension workers share the responsibility of community mobilizing. Many health extension workers also described making home visits to support women who are unable to travel to clinics. These efforts play an important role in reducing barriers by providing information, engaging families, and addressing stigma associated with cervical cancer prevention.

5. In some cases, inaccurate perceptions of healthcare and taboos around the idea of cervical cancer decreased women's access to healthcare services: Health extension workers and providers both reported that inaccurate perceptions of HPV vaccination and cervical cancer discourage women from seeking healthcare services. For example, beliefs that HPV vaccines may reduce fertility were cited as a deterrent. Additionally, the nature of cervical cancer as a condition affecting reproductive organs contributes to cultural taboos against screenings, particularly surrounding speculum exams and showing one's genitals. Healthcare providers and a health extension worker also noted that some women believe screening is unnecessary if they do not feel ill, reflecting limited awareness of preventive care practices.

6. In rare cases, religion and input from religious leaders decreased women's access to cervical cancer screening services: Healthcare extension workers and providers mentioned that,

in rare cases, people may choose to pray rather than seek care due to religious beliefs. This comes from the mentality that God would not allow them to be sick or that prayer is a cure for all. Mesfin Wana, Grounds for Health's HPV Program Specialist, shared with us a story about how religion impedes women's access to care in rare cases, telling us that one woman tested positive for cervical cancer and was referred to a larger health facility to be treated for it. However, due to her religious beliefs, she went to a religious leader who prayed for her and she did not go to the appointment. Unfortunately, this woman passed away as a result of not being treated. While this was not a common finding, it represents that religion, in some cases, can prevent women from accessing essential care. However, several health extension workers and healthcare providers, as well as higher-level Grounds for Health staff, expressed that most religious leaders are supportive of Grounds for Health's services and will preach about the importance of cervical cancer prevention.

7. Home visits and home-to-home campaigns as methods of increasing care: In both interviews and the focus group, healthcare workers told us about providing services for women in their homes when distance to the clinic, stigma, or other reasons made women unable to visit the clinic in person. They also told us about going to women's homes in secret to provide family planning care to unmarried women. In accordance with finding three on trust, some of the health extension workers told us they are aware when in-home care is needed, and they provide it. While the health extension workers were hesitant to comment on or resisted the idea that stigma or cultural norms decrease women's ability to gain access to services, they did say that unofficial home visits had increased women's access to services.

8. The transition to self-testing kits allowed for increased screening rates and screening for women who were previously unable to access care: Based on interviews, the focus group, and desk research we learned that showing genitals for a speculum exam was an obstacle to screenings. Additionally, the expectation that exams would be painful was also an obstacle to increasing screening rates. Health extension workers and providers said that the increase in self-testing kits had decreased both of these obstacles.

9. GBV is a known term amongst healthcare extension workers and they have received training on GBV: All health extension workers reported receiving training on GBV during their education and demonstrated familiarity with the concept. Prior to the interviews, it was unclear whether GBV would be a commonly recognized term or if equivalent terminology existed in local languages. However, with translation support from Mesfin Wana, it became evident that workers understood and engaged with the concept of GBV.

10. Healthcare providers did not receive any training or courses on GBV: While health extension workers reported receiving GBV training, healthcare providers working in clinics indicated that they had not received similar training. This discrepancy was particularly interesting because healthcare providers receive more education than healthcare extension workers.

11. "No Barrier" Narratives Mask Structural Constraints: When asked about barriers that women face in accessing screening services, 75% of health extension workers reported that there were "no obstacles." Additionally, some health extension workers acknowledged that there

existed significant barriers in previous years, but they claimed these barriers are no longer a concern. However, when we asked follow-up questions, the healthcare workers later described limitations related to household roles, spousal dynamics, and gender norms. This suggests that barriers are normalized in the community and not always recognized as restricting access. One health extension worker who expressed the "no barrier" narrative revealed that even in the cases of extreme violence such as rape, some women come to the health posts and some do not. These discrepancies and lack of access reveal that many constraints on women's access are so normalized that they are not consistently recognized as barriers, obscuring the full extent of how gender norms and structural factors limit care-seeking.

12. Grounds for Health's follow up rate for services is extremely high at 92%: Though the screening rate in Ethiopia is still low, of the women who test positive for precancer, 92% return for treatment. This demonstrates the effectiveness of Grounds for Health's programming; the follow up rate for Grounds for Health's services is even higher than the WHO's call for 90% return for treatment in their goal of eradicating cervical cancer.[62]

VII. Discussion

From our interviews and focus group with healthcare workers and Grounds for Health staff, we found that stigma and cultural norms are major factors that prevent some women from accessing cervical cancer screenings. Additionally, many women in rural areas are impacted by GBV, as they must ask their husbands for permission to go to healthcare clinics; this restriction on women's bodily autonomy limits their ability to seek care and reflects broader harmful gender

[62] WHO, "Cervical Cancer Elimination Initiative," https://www.who.int/initiatives/cervical-cancer-elimination-initiative.

norms that shape healthcare decision-making. Beyond spousal permission, women's access is further constrained by gendered expectations around domestic labor, childcare, and limited control over financial resources, which reduce their ability to prioritize their own health.

We found that although stigma and varying forms of GBV prevent women from accessing services, health extension workers are highly trusted within their communities and often work to help women navigate these barriers through home visits, discreet service provision, and community outreach. These strategies are particularly important for unmarried women, who face heightened stigma due to the taboo around premarital sex, especially in rural areas.

Ultimately, while self-testing has improved access to screenings by reducing barriers related to fear of pain and taboos surrounding speculum exams, it does not address the underlying social norms that shape women's healthcare-seeking behavior. As a result, many women, particularly unmarried women and those requiring spousal permission, remain excluded from essential services. Findings from both the interviews and focus group further suggest that many barriers are normalized and therefore not always recognized as constraints, even by healthcare workers themselves. While respondents sometimes reported "no barriers," they later described limitations on women's access related to household roles, financial dependence, stigma, and misinformation about services. This disconnect highlights that improving access to cervical cancer care requires not only expanding service delivery, but also addressing the underlying gender norms, power dynamics, and structural inequalities that continue to restrict women's autonomy and access to care.

VIII. Policy Options

To address these concerns, policy options are centered on increasing education and outreach campaigns to men and women in Ethiopia. These campaigns should target not only women, but also men, religious leaders, and the broader community norms that shape women's access to care. The specific recommendations are as follows.

Outreach Campaigns

A. Male Engagement Campaigns: Target husbands and male community leaders with messaging on the importance of cervical cancer screening. Frame the screening as protecting family health and economic stability. This aligns with insight from Dr. Hezkiel Petros, the Addis based gynecologist, who told us that because men are "breadwinners" it is key to convince them of the need for women's screening and treatment.

Strengths: Targets key decision-makers who often influence women's ability to seek care, particularly in settings shaped by entrenched gender norms and dynamics related to GBV. By framing cervical cancer screening as beneficial to family well-being and economic stability, the campaign can resonate with existing values rather than directly confronting them.

Limitations: Focusing on men as gatekeepers risks reinforcing the very power imbalances the intervention seeks to address, potentially legitimizing male control over women's health decisions. It may also marginalize women's autonomy by implying that their access to screening requires male approval. In some cases, men may feel singled out or blamed, leading to resistance or backlash.

B. Religious & Community Leader Partnerships: Partner with religious leaders and elders to deliver messages supporting screening and HPV vaccination by integrating messaging into

sermons, community gatherings, and religious events. This form of outreach and partnership is currently being conducted by Grounds for Health, but it is necessary to continue to expand this partnership and outreach.

Strengths: By targeting religious and community leaders for outreach, Grounds for Health can continue to help dispel religious myths and potentially prevent women from relying too heavily on religious faith for care, instead of cervical cancer prevention care. Additionally, if religious leaders support care, women may feel more emboldened to access it, as they see it as in line with their faith rather than at odds with it. Furthermore, if religious leaders preach about the importance of cervical cancer prevention, it could raise awareness amongst women and men and promote community engagement in helping women get the care they need.

Limitations: If religious leaders feel alienated by targeted outreach, they may amplify messaging on anti-cervical cancer prevention care. They may also feel that targeted outreach is at odds with their religious teachings and is encroaching on their religious authority.

C. Health Extension Worker Door-to-Door Outreach: Expand structured home visits to include cervical cancer education and the distribution of self-testing kits. Prioritize women who cannot travel due to GBV or stigma.

Strengths: Healthcare extension workers are deeply trusted by the community and women in the community thus likely respect their insight on healthcare matters. Additionally, door-to-door outreach allows women who are unable to visit health posts to be reached, through self-testing kits and education on the need for screening.

Limitations: Each health extension worker provides care for roughly 5,000 women, and some of them told us they are also available to provide support for women outside office hours and could

be reached over the phone. Because of the number of women they serve and the hours they work, adding any tasks to healthcare extension workers duties is not ideal.

D. Messaging about Confidential Access: Promote discreet options (self-testing, home visits) to reach unmarried women and GBV survivors. Emphasize privacy and safety in messaging.
Strengths: Helps give access to those who otherwise would not seek it out in a formal setting.
Limitations: Promotion may lead to a new form of stigma. More members of the community will be aware of "discreet services" which can result in gossip and speculation around who is taking advantage of these services, further pushing people away from clinics.

E. Advertise and offer cervical cancer screening to women at health posts all the time, not just during campaign screening events: Routine screenings allow more women to access care. When women come into health posts for other services, health extension workers should offer the screening service to them, regardless of the reason the woman visits the clinic.
Strengths: More routine screenings make access to prevention services more accessible for those who face time restraints due to household chores, taking care of children, and other domestic responsibilities.
Limitations: Lack of funding makes routine screenings difficult to achieve.

<u>Advertising Campaigns</u>

F. Radio Campaigns in Local Languages: The use of widely accessible radio to normalize screening can dispel myths such as infertility fears. Additionally, testimonials from local women and healthcare workers can help reduce fear.

Strengths: Currently, myths are dispelled through word of mouth. Radio campaigns can increase awareness-raising and myth-busting by reaching a larger audience in ways that are more accessible to them.

Limitations: Mesfin Wana, the HPV Program Specialist in Ethiopia, mentioned to us that Grounds for Health has considered trying to implement radio campaigns, but that the price of radio ads is a barrier.

G. Information Flyers for Outreach and Education: Grounds for Health should provide fliers for health posts which contain a brief overview of information on cervical cancer screening and its importance. The fliers can also highlight when the next campaign day is. Health extension workers can give a few of these fliers to women who receive screening and the women can share them with friends and neighbors. Furthermore, a Grounds for Health team member confirmed that fliers like this are currently available in Amharic but not in the Sidama language.

Strengths: These fliers could increase knowledge about the need for cervical cancer screenings. The fliers potentially educate women who are unable to access care on the importance of cervical cancer screenings; women who receive care at health posts would receive fliers they can distribute to their neighbors.

Limitations: These fliers were supplied by Grounds for Health in previous years but are no longer being distributed; this suggests they may not have been effective.

H. Display information posters on walls of clinic: These posters could be tacked to the wall at health posts and health clinics and would define the threat of cervical cancer and advertise screening dates.

Strengths: Grounds for Health already has posters that provide this information so this would be easy to implement. If the posters need to be updated, this policy option is very affordable and easy to implement and would likely not receive any pushback or organizational constraints.
Limitations: This policy option risks becoming obsolete, if health extension workers do not promote it when women arrive at the clinic. If women are not able to read the posters in the clinics this option is ineffective.

Education Campaigns

I. Couples-Based Health Education: Create programs where men and women learn together about HPV, cervical cancer, and screening. Focus on joint decision-making and reducing permission barriers.
Strengths: This policy option targets the underlying GBV that results in women having to ask their husbands for permission and would help allow more women to access screening services. It would also increase women's autonomy and decision-making in their health and within their marriage, potentially changing dynamics outside of accessing cervical cancer prevention.
Limitations: Presuming this is a free service, allowing more people to access it would place a greater burden on Grounds for Health staff to provide counseling alongside their other responsibilities. It may also require more funding.

J. School-Based HPV & Health Curriculum: Integrate cervical cancer education into secondary school programs. Include HPV vaccination awareness for both girls and boys to reduce stigma.

Strengths: Education targeting secondary school programs has the potential to transform cultural norms as it provides education before stereotypes or stigma are fully learned by individuals.
Limitations: This may be costly and require training school teachers before implementation is possible.

K. GBV-Sensitive Health Education: Train health extension workers and providers to incorporate GBV awareness into education sessions. Include information on women's rights to access healthcare independently.
Strengths: Educates more people on GBV and its forms such as lack of decision-making as a form of GBV.
Limitations: Funding and time constraints may restrict ability to educate healthcare workers. Additionally, healthcare workers are educated through government programs which creates jurisdiction issues.

Policy Option for The Ministry of Health

K. MS / Mobile Alert System: Send reminders and awareness messages to both men and women. Include information like: where to go, what to bring, and when services are available.
Strengths: This would help ensure accountability and reinforce the importance of accessing the care. It would also potentially make it easier for women to go secretly, if they are not relying on phone calls to the house phone.
Limitations: This assumes access to smartphones, making it a potentially less accessible policy option. It also assumes that the Ministry of Health would spearhead this recommendation, which

potentially decreases the likelihood of it being carried out in a timely manner. Additionally, some people may perceive this as a government intervention in their personal care.

L. Normalize Screening Through Storytelling: Share stories of women who benefited from early detection. Reduce fear and stigma through relatable narratives.

Strengths: Personal narratives and storytelling on the effectiveness of cervical cancer screening makes the need for screening apparent to both men and women in the community.

Limitations: Storytelling campaigns at the national level could be costly. There is some stigma about seeking healthcare and receiving a diagnosis of sickness which prevents women from seeking care.

IX. Recommendations

Based on the policy options analyzed above, this paper recommends that Grounds for Health prioritize four interconnected approaches to address GBV and harmful social norms that limit women's access to cervical cancer prevention and care in Ethiopia. We selected these recommendations because they directly respond to barriers identified during interviews and the focus group, and they build on strategies that Grounds for Health has already begun implementing in local communities.

Male Engagement Campaigns

Grounds for Health should expand outreach efforts that engage husbands, male community leaders, and other influential men in discussions about cervical cancer prevention and screening. The interviews and focus group conducted during our research showed that many

women's healthcare decisions are influenced or controlled by male family members. Several participants said that women often must receive permission from their husbands before seeking care. Because unequal power dynamics directly restrict women's access to healthcare, engaging men is necessary to reduce barriers to screening and treatment.

Male engagement campaigns can help build immediate community support for cervical cancer prevention efforts while assisting the long-term goal of transforming harmful gender norms around healthcare access and autonomy. Explaining how screening can be beneficial to family wellbeing and economic stability may also increase acceptance among men who are often viewed as household decision-makers.

Health Extension Worker Door-to-Door Outreach and Discreet Care

Expanding structured door-to-door outreach conducted by health extension workers to include cervical cancer education, awareness-raising, and direct access to self-testing kits can greatly expand access to care. The interviews and focus group highlighted that some women are unable or unwilling to travel to health facilities due to stigma and other restrictions, so at-home services are critical. Health extension workers are uniquely positioned to help address these barriers because they are deeply trusted within their communities and possess the skills needed for education. Expanding discreet, community-based care could help reach women who may otherwise be excluded from screening services.

Radio Campaigns in Local Languages

The next recommendation suggests expansion of radio-based awareness campaigns in local languages to address misinformation surrounding cervical cancer prevention and screening.

Throughout interviews and the focus group, healthcare workers and providers said that myths, misinformation, and lack of awareness are major barriers preventing women from seeking care. Participants specifically discussed misconceptions related to infertility, fear of screening procedures, and limited understanding of cervical cancer prevention.

Radio campaigns could help normalize conversations surrounding cervical cancer and expand awareness efforts beyond word-of-mouth communication, particularly in rural communities where radio remains a common form of communication. To increase trust in screening and prevention services, campaigns could include testimonials from local women and healthcare workers. While funding limitations could present a barrier, expanding accessible public health messaging could complement existing community outreach efforts and help reduce stigma surrounding cervical cancer care.

Print and Visual Awareness Materials (Fliers and Posters)

Finally, we recommend that Grounds for Health reintroduce and expand the use of print and visual awareness materials, including informational fliers and laminated clinic posters, to increase the awareness of cervical cancer screening services. Fliers can be distributed by health extension workers to women receiving care, allowing for optional sharing within communities. Posters can be displayed in health posts, providing information on need for care and details on when the next screening campaign will take place. Materials should include clear information on the importance of screening, service availability, and campaign dates, and they should be adapted into Amharic and the Sidama language. The posters should also have visual elements to account for varying literacy levels. This approach is low-cost and easy to implement, and it uses materials that Grounds for Health previously developed. Display of posters and dissemination of

fliers reinforces messaging inside of clinics and across communities, and this could increase awareness and normalize screening.

X. Implementation

Due to the close collaboration between Grounds for Health staff, health providers, and health extension workers, the above recommendations for Grounds for Health on outreach, advocacy, and education campaigns are attainable. Door-to-door outreach and discrete care facilitated by health extension workers should first be studied through a pilot program in one community. This would involve a quantitative study to determine exactly how many women are unable to access care due to barriers, then door-to-door outreach to understand whether this secretive, at-home care has helped to remove some of those barriers. The pilot program would require a small percentage of self-testing kits to be reserved as door-to-door kits. Additionally,we recommend the program be conducted in a community where screening rates are already low to avoid taking away self-testing kits from communities where screening rates are high and where women are already accessing services. We recommend implementing this pilot program over a 12-month period and monitoring and reviewing it monthly to evaluate its effectiveness.

For male outreach campaigns, we recommend conducting them in three communities and hiring two people in each community to serve as outreach coordinators. This policy would be most successful by meeting men in their typical spaces. For example, instead of asking men to come to clinics or settings where they may feel uncomfortable, the coordinators could conduct outreach campaigns in an informal manner in comfortable spaces such as restaurants, bars, or churches. This policy will also require additional funding; we recommend a fundraising campaign that specifically contacts international donors who typically support international

development and healthcare. We also recommend partnering with the Ethiopian Ministry of Health to implement this recommendation. An additional fundraising recommendation is increasing partnerships with local coffee companies in the U.S.

The radio campaigns may require more funds than Grounds for Health currently has available. We recommend starting a fundraising campaign dedicated to funding the radio campaigns and launching them for 3 months. To monitor their effectiveness, we recommend conducting a survey of the women who do come in for care within the 3 month period and asking them where they heard about the care and how to access it. This will determine if the radio campaigns have had an influence.

XI. Conclusion

In conclusion, our research demonstrates that while cervical cancer is highly preventable, deeply rooted gender norms and GBV continue to restrict many women's access to screening services in Ethiopia. Innovations such as self-testing along with high levels of trust between health extension workers and communities have significantly improved access. However, these realities do not overcome structural and social barriers on their own. Addressing these challenges requires targeted, community-based interventions that engage men, leverage trusted local networks, and normalize screening through culturally appropriate messaging. By implementing recommended strategies, Grounds for Health has the opportunity to continue to expand its impact, reduce inequities in access, and continue to contribute to the goal of eradicating cervical cancer.

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