Given the challenges of implementing high-quality cervical cancer prevention services, especially in developing countries, there is considerable interest in exploring the accuracy and acceptability of visual approaches to detect precursor cervical disease and/or cancer. There are several types of visual screening. Early studies used visual inspection, which involved simply looking at the cervix with the unaided eye for any signs of early cancer. Also known as “downstaging,” this approach was not accurate in identifying precursor lesions or cancer. Visual inspection with acetic acid (VIA) has been shown to be a more promising screening approach for identifying women with high-grade precancerous lesions.

VIA involves swabbing the cervix with a 3 to 5 percent acetic acid (vinegar) solution prior to visual examination. Differences in precancerous cell structure and opacity make abnormal cells temporarily appear white when exposed to this solution. The health care provider performing the test determines whether the test result is positive or negative for possible precancerous lesions or cancer.

### VIA: An Overview

Many aspects of VIA make it an appealing approach for use in low-resource settings. In most cases, costs associated with launching and sustaining VIA screening are lower than those associated with other methods; VIA is a relatively simple, easy-to-learn approach that is only somewhat reliant upon infrastructure for its adequate performance, assuming that sufficiently trained providers are available. The approach does not require laboratory involvement and non-physicians can perform the procedure, provided that they receive adequate and ongoing training. As a result, VIA generally has the potential for greater population coverage than other available screening approaches. The results of the procedure are available immediately, making it possible to provide further management, including an offer of immediate treatment of some suspected precancerous lesions during the same visit.

### Table 1. Recent VIA Screening Study Findings

<table>
<thead>
<tr>
<th>First Author (Year)</th>
<th>Country</th>
<th>Number of Women</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Level of Provider</th>
<th>Grade of Disease Detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belinson et al. (2001)²</td>
<td>China</td>
<td>1,997</td>
<td>71%</td>
<td>74%</td>
<td>Gynecologic oncologist</td>
<td>CIN II† and more severe</td>
</tr>
<tr>
<td>University of Zimbabwe/JHPIEGO (1999)³</td>
<td>Zimbabwe</td>
<td>2,203</td>
<td>77%</td>
<td>64%</td>
<td>Nurse-midwife</td>
<td>HSIL‡ and more severe</td>
</tr>
<tr>
<td>Denny et al. (2000)⁴</td>
<td>S. Africa</td>
<td>2,944</td>
<td>67%</td>
<td>83%</td>
<td>Nurse</td>
<td>HSIL and more severe</td>
</tr>
<tr>
<td>Sankaranarayanan et al. (1999)⁵</td>
<td>India</td>
<td>1,351</td>
<td>96%</td>
<td>68%</td>
<td>Nurse</td>
<td>Moderate/severe dysplasia and more severe</td>
</tr>
<tr>
<td>Sankaranarayanan et al. (1998)⁶</td>
<td>India</td>
<td>3,000</td>
<td>90%</td>
<td>92%</td>
<td>Cytotechnician</td>
<td>Moderate/severe dysplasia and more severe</td>
</tr>
<tr>
<td>Londhe et al. (1997)⁷</td>
<td>India</td>
<td>372</td>
<td>72%</td>
<td>54%</td>
<td>Not specified</td>
<td>HSIL and more severe</td>
</tr>
<tr>
<td>Megevand et al. (1996)⁸</td>
<td>S. Africa</td>
<td>2,426</td>
<td>65%</td>
<td>98%</td>
<td>Nurse</td>
<td>HSIL and more severe</td>
</tr>
<tr>
<td>Cecchini (1993)⁹</td>
<td>Italy</td>
<td>2,105</td>
<td>88%</td>
<td>83%</td>
<td>Midwives</td>
<td>CIN II and more severe</td>
</tr>
<tr>
<td>Slawson et al. (1992)¹⁰</td>
<td>USA</td>
<td>2,827</td>
<td>29%</td>
<td>97%</td>
<td>Clinicians</td>
<td>CIN II and more severe</td>
</tr>
</tbody>
</table>

*Verification bias occurs when the reference test is not performed on all study subjects, including women with negative screening results.
†Cervical intraepithelial neoplasia (see PATH’s Fact Sheet, Pap Smears, for more information on terminology).
‡High-grade squamous intraepithelial lesions (see PATH’s Fact Sheet, Pap Smears, for more information on terminology).
It is important to note, however, that VIA is less effective among post-menopausal women because of the tendency for the squamocolumnar junction (the point at which columnar cells meet ectocervical squamous cells of the cervix) to recede into the cervical os, making observation of lesions difficult. Adequate Pap smears also tend to be more difficult to obtain and are less reliably interpreted in post-menopausal women.

**VIA Can Be Reasonably Accurate**

Several studies examining the accuracy of VIA have found the technique to be reasonably accurate, but differences in study protocols, populations studied, and outcomes make it difficult to generalize across studies. In addition, verification bias was a problem in many studies because a reference test was not performed on all study subjects, including women with negative screening test results. This bias tends to inflate sensitivity estimates of the test being assessed, and has been a common problem in many assessments of screening techniques including cytology and human papilloma virus (HPV) testing. Nevertheless, some broad conclusions regarding VIA’s usefulness in low-resource settings can be made based on results of both published and unpublished work (see Table 1). In general, the sensitivity of VIA in detecting high-grade dysplasia in low-resource settings is at least equal to that of cytology, while VIA’s specificity is somewhat lower.

The limited specificity of VIA is a concern to some due to the potential for unnecessarily treating women with false-positive results. Treating these women may overburden the health care system and increase costs both to the health system and the women, as well as potentially causing women unnecessary discomfort or health risks. Additional research is needed to clarify the health and cost implications of false-positive VIA screening, including treating women with no precancerous lesions.

**References**


**Variations on VIA**

In an effort to increase VIA’s specificity, variations to the approach are being explored. VIA with magnification (VIAM) uses a device such as the AviScope™—a low-power (4x) hand-held visual inspection device with a built-in light source—to examine the cervix after application of acetic acid. Preliminary findings from an ongoing study in Calcutta, India, indicate that VIAM has a sensitivity of 69 percent and a specificity of 82 percent. Another variation on VIA is visual inspection using Lugol’s iodine (VILI) instead of acetic acid. VILI involves applying an iodine-based solution as a means of temporarily staining normal cervical cells brown, leaving the abnormal cells with a yellow or unstained appearance. It is not yet known whether VIAM or VILI offer significant advantages over VIA.

**Use of VIA as a screening test method involves performing VIA and then, based on a positive result, referring the woman for further testing. In some cases, VIA is used alone, without further testing, to determine whether or not a woman should receive immediate treatment.**

**Training Is Essential to Success**

Adequate and ongoing training is essential for enabling health care providers to evaluate the features of a lesion to make an accurate assessment. Lesions vary in size, thickness, opacity, and border definition (larger, thicker, more opaque lesions with clear borders adjacent to the squamocolumnar junction suggest more severe disease). Similar to cytology, the subjective nature of the test makes development of universal diagnostic standards important. The feasibility of using VIA for wide-scale screening is untested and, to a large extent, will be determined by the effectiveness of training and monitoring efforts.

**Policy Recommendations**

- Ensure that health care providers, including non-physicians, receive adequate training and regular supervision to maximize their skills in performing VIA and classifying findings.
- Monitor the performance of VIA and develop quality-improvement procedures to ensure that providers perform VIA competently.
- In addition to quality improvement, explore ways to maximize the accuracy of VIA and identify key factors contributing to its viability as a screening approach.
- Implement follow-up protocols linking screening, diagnosis (if used), treatment, and monitoring of treated women.
- Support research to explore use of VIA as part of a two-stage screening process with VILI, VIAM (see above), Pap, or HPV testing.