

research systems, institutions and personnel. As a result, research activities in many low- and middle-income countries reflect more closely foreign and global health research priorities than the research needs of the countries in which research is being conducted. As externally funded research is virtually monopolised by HIV/AIDS, tuberculosis and malaria,³ little if any funding or research capacity is left to deal with other diseases, conditions or the improvement of health systems, let alone for research with a more expanded goal of social and economic development (i.e. “research for health”).

The concept of “responsible vertical programming”⁴ defines a health research programme as “responsible” if it “succeeds in building the capacity of a country’s researchers and the national research system – in the process of achieving its own research goals”. It sets out some practical steps that decision-makers in countries and in research programmes can take to increase the synergy between national research capacity and research programme implementation.

Countries have to take responsibility to put in place and resource a basic national health research system that provides mechanisms for research governance, identifies national priorities and formulates and implements a policy framework to enhance the effectiveness of the national research effort.

Vertical programmes have to realize that their research cannot be conducted in isolation from national contexts and that their contributions to the research infrastructure from which they benefit will enhance research output and quality in the future. They can do this by ensuring that – as a minimum – activities align with, rather than fragment, national research system needs and by investing in equitable partnerships that strengthen the capacities of national researchers, research institutions and research systems.

It is clear that health system strengthening needs both information and research. Stated in another way, national health information systems and national health research systems are key tools in generating the evidence needed to guide health and health sys-

tem improvement in low- and middle-income countries, just as they are in high-income countries.

“Responsible vertical programming” is about supporting long-term sustainable development as the primary objective of all development interventions in low- and middle-income countries. At the same time, we agree with Bhattacharya in acknowledging that there is still much to be learned about how best to integrate “vertical” and “horizontal” programmes. What is not in any doubt, however, is that strengthening of national research and information systems should be a key component of (large) health and health research programmes. ■

**Andrew Kennedy^a
& Carel IJsselmuiden^a**

References

1. Bhattacharya S. The local bases of global public health: complexities and opportunities. *Bull World Health Organ* 2008;86:163. PMID:18368197
2. Who owns the information? Who has the power? *Bull World Health Organ* 2008;86:170-1. PMID:18368202
3. AHA study: donor alignment and harmonisation in health research. Geneva: Council on Health Research for Development (COHRED); 2008. Available from: http://www.cohred.org/main/AHA_study.php [accessed on 8 July 2008].
4. Responsible vertical programming: how global health research can deliver essential research, achieve impact and build national systems. Geneva: Council on Health Research for Development (COHRED); 2007.

Integrating cervical cancer prevention in HIV/AIDS treatment and care programmes

Peckham and Hann’s call for integrating cervical cancer prevention as part of broader sexual and reproductive health prevention services¹ is especially relevant to sub-Saharan Africa where both cervical cancer and sexually transmitted infections, especially HIV/AIDS, are widely prevalent.

Over the past decade, successful HIV/AIDS care and treatment programmes have been instituted in over a dozen hardest-hit sub-Saharan African countries, largely through bilateral

and multilateral programmes like the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.² HIV-infected women are at heightened risk for pre-invasive and invasive neoplasia of the cervix.^{3,4} HIV/AIDS care and treatment programmes thus provide an ideal platform to integrate cervical cancer prevention activities in countries which face a dual burden of both AIDS and cervical cancer, an AIDS-defining disease. With steady donor support over the past 5 years, these programmes are slowly but steadily contributing to the development of health-care service delivery capacity in emerging nations by establishing infrastructures, training the health-care work force, and tackling complex and challenging problems in implementation and scale-up.⁵

Limited access to cervical cancer prevention services, the usual circumstance for women in low-resource environments, serves as a counterforce to the life-prolonging potential of increased access to affordable antiretroviral therapy. Cervical cancer prevention strategies that use visual inspection with acetic acid (VIA) and same-visit cryotherapy (“see-and-treat”) are cost-effective alternatives to cytology-based screening programmes. These procedures can be performed by nurses and other non-physician health-care workers and allow screening and treatment to be linked to the same clinic visit. Our experience in Zambia has shown that VIA-based prevention services that are nested within the context of antiretroviral therapy programmes allow early detection of cervical cancer in high-risk HIV-infected women in a cost-effective way.^{6,7} It also allows opportunities for the provision of broader gynaecologic and other health care for women. Eventual integration of low-cost, rapid screening tests for detecting human papillomavirus within VIA-based screening services will additionally increase programmatic efficiency. When cervical cancer prevention services are offered to HIV-infected women in a venue attended by non-HIV-infected women, a scalable intervention is established that can reach out to all women regardless of HIV status.

^a Council on Health Research for Development (COHRED), Geneva, Switzerland. Correspondence to Andrew Kennedy (e-mail: kennedy@cohred.org).

Horizontal and diagonal collaborations between agencies and individuals focusing on HIV/AIDS care and cancer prevention could open new vistas for expanding availability of care for women at risk of one or both of these conditions, thereby ensuring wider programme impact. The conjoint contributions of such collaborations may be larger than the sum of their parts. ■

Mulindi H Mwanahamuntu,^a Vikrant V Sahasrabudde,^b Jeffrey SA Stringer^c & Groesbeck P Parham^c

References

1. Peckham S, Hann A. A sexual health prevention priority. *Bull World Health Organ* 2008;86:490-1. PMID:18568280 doi:10.2471/BLT.08.053876
2. PEPFAR and the fight against HIV/AIDS. *Lancet* 2007;369:1141. PMID:17416238 doi:10.1016/S0140-6736(07)60536-4
3. Franceschi S, Jaffe H. Cervical cancer screening of women living with HIV infection: a must in the era of antiretroviral therapy. *Clin Infect Dis* 2007;45:510-3. PMID:17638204 doi:10.1086/520022
4. Parham GP, Sahasrabudde VV, Mwanahamuntu MH, Shepherd BE, Hicks ML, Stringer EM, et al. Prevalence and predictors of squamous intraepithelial lesions of the cervix in HIV-infected women in Lusaka, Zambia. *Gynecol Oncol* 2006;103:1017-22. PMID:16875716 doi:10.1016/j.ygyno.2006.06.015
5. Stringer JS, Zulu I, Levy J, Stringer EM, Mwango A, Chi BH, et al. Rapid scale-up of antiretroviral therapy at primary care sites in Zambia: feasibility and early outcomes. *JAMA* 2006;296:782-93. PMID:16905784 doi:10.1001/jama.296.7.782
6. Parham GP, Mwanahamuntu MH, Pfaendler KS, Mkumba G, Sahasrabudde VV, Hicks ML, et al. Building a cervical cancer prevention program into an HIV care and treatment infrastructure. In: Marlink R, Teitelman S et al., eds. *From the ground up: a guide to building comprehensive HIV/AIDS care programs in resource-limited settings*. Washington, DC: Elizabeth Glaser Pediatric AIDS Foundation; 2008.
7. Pfaendler KS, Mwanahamuntu MH, Sahasrabudde VV, Mudenda V, Stringer JS, Parham GP. Management of cryotherapy-ineligible women in a "screen-and-treat" cervical cancer prevention program targeting HIV-infected women in Zambia: Lessons from the field. *Gynecol Oncol* 2008;e-pub 13 June.

Evaluation of the WHO Assessment Instrument for Mental Health Systems

We read with interest the recent paper by Hamid et al. on the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS),¹ an instrument that we are pleased to have developed and that fills a major gap in this field.^{2,3} We thank the authors for their interest and their mostly positive appraisal of WHO-AIMS.

We would like to note that the primary objective of the WHO-AIMS project is to enable countries to generate information on the strengths and weaknesses of their mental health system to facilitate improvement of services. Through a WHO-AIMS assessment, countries are enabled to develop information-based mental health plans with clear baseline information and targets, and to monitor progress in implementing reform policies.

Given the objective of the project, the WHO-AIMS instrument has been designed to be used by a local team for comprehensive assessment of the country's mental health system (or an assessment of a region within the country). A complete assessment using WHO-AIMS usually takes 3 to 6 months and involves an iterative process of checking and triangulating data between the local team and the ministry of health (which is the source of many critical elements of the assessment). This work is carried out with continuous and substantial technical support from WHO headquarters, regional and country offices. The final report is jointly published by the WHO country office and the ministry of health. WHO has now published WHO-AIMS assessments on 36 countries (available at: http://www.who.int/mental_health/who_aims_country_reports/en/index.html).

Though the Hamid et al. paper does not provide details of the method-

ology followed in collection of WHO-AIMS data, it appears that the authors were not able to use the recommended WHO-AIMS method.⁴ Also, the paper gives data for just a few indicators out of 155 included in the instrument. In view of these limitations, we believe that this paper provides a less than adequate basis for evaluation of this instrument.

WHO will soon publish a report on available WHO-AIMS data from a large number of countries. This report is likely to provide a more adequate basis to evaluate this instrument. ■

Shekhar Saxena,^d Antonio Lora,^d Mark van Ommeren,^d Thomas Barrett,^d Jodi Morris^d & Benedetto Saraceno^d

References

1. Hamid H, Abanilla K, Bauta B, Huang KY. Evaluating the WHO Assessment Instrument for Mental Health Systems by comparing mental health policies in four countries. *Bull World Health Organ* 2008;86:467-73. PMID:18568276 doi:10.2471/BLT.07.042788
2. Saxena S, Lora A, van Ommeren M, Barrett T, Morris J, Saraceno B. WHO's Assessment Instrument for Mental Health Systems: collecting essential information for policy and service delivery. *Psychiatr Serv* 2007;58:816-21. PMID:17535942 doi:10.1176/appi.ps.58.6.816
3. Saxena S, van Ommeren M, Lora A, Saraceno B. Monitoring of mental health systems and services - comparison of four existing indicator schemes. *Soc Psychiatry Psychiatr Epidemiol* 2006;41:488-97. PMID:16565914 doi:10.1007/s00127-006-0053-3
4. World Health Organization Assessment Instrument for Mental Health Systems, version 2.2. Geneva: WHO; 2005.

^a University Teaching Hospital, Lusaka, Zambia.

^b Institute for Global Health, Vanderbilt University, Nashville, TN, United States of America. Correspondence to Vikrant Sahasrabudde (e-mail: vikrant.sahasrabudde@vanderbilt.edu).

^c University of Alabama at Birmingham, Birmingham, AL, USA.

^d Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland. Correspondence to Shekhar Saxena (e-mail: saxenas@who.int).