

MCMS or from other sources, would have been feasible and informative. With no such analysis, extrapolation of these findings to other settings is difficult.

Although the investigators report strong associations between neonatal mortality and place of birth (home vs hospital), such inferences are based on a cross-sectional analysis of the 2002–08 MCMS data that did not take account of important covariates. Many characteristics differentiate families that choose (or have access to) facility deliveries and those who deliver at home; such differences would be expected to exist within, and not just between, sociodemographic categories. The lack of statistical adjustment for key confounders suggests that the estimates of preventable fractions should be cautiously interpreted.

Finally and importantly, we acknowledge the concerns about quality of the data from China's MCMS, on which Feng and colleagues base their conclusions. Although the MCMS is a rich source of demographic data, it has been criticised for systematically under-reporting births and deaths and for the large variation in the distribution of surveillance sites in the past two decades.^{2,8,10} Inaccurate estimation of the number of births might have biased the analyses. For example, if home births were less likely to be reported than hospital births, home-birth mortality rates could be spuriously inflated. Additionally, increases in the completeness of birth reporting over time could result in apparent declines in neonatal mortality rates.

Provision of high-quality facility-based obstetric and neonatal care will undoubtedly improve neonatal survival, and Feng and colleagues indicate how this improvement might have developed in China during the past 15 years. Nevertheless, a more complete assessment of the effect of China's national policy to promote institutional deliveries on neonatal mortality rate is warranted. We look forward to further studies based on MCMS data, especially with creative

combinations of information from many sources¹¹ and analyses aimed at untangling the complex effects of policies and interventions on maternal and child health. Studies using China's abundant epidemiological and demographic data, and the uniqueness of its nationwide policy experiences, could offer invaluable contributions to worldwide public health knowledge.

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Science to policy: M8 Alliance invites policy makers to step in

A year ago, we introduced the M8 Alliance and called for academic medicine to take more responsibility for global health. The M8 Alliance connects leading medical universities and national academies worldwide to create a network that actively seeks dialogue with governmental representatives, policy makers, non-

governmental organisations, civil society, and health-related industry on specific global health challenges.¹

On some aims we have had progress, for example on the effects of global warming on health, a topic that is still neglected at our peril. Initiated by the M8 Alliance and through discussions at the World Health Summit



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in 2010, the Interacademy Medical Panel (IAMP)—the organisation of 65 national academies of medical science—presented a statement on the health threats of climate change. The IAMP made a number of recommendations that emphasise the health co-benefits of policies to mitigate climate change for the UN climate change talks in Cancun, Mexico, in November, 2010.² A first important step, but much more needs to be done to engage governmental representatives and other policy makers and to provide scientific evidence to focus their attention on urgent health issues with long-term consequences.

The M8 Alliance does not sufficiently involve academic institutions from low-income and middle-income countries where societal transition and demographic change alter their population's health burden.³ These countries, in particular, are looking for the development of cost-effective interventions and low-cost health infrastructure.⁴ It is therefore an important development that this year Brazil and Singapore have joined the M8 Alliance through the University of São Paulo and the National University of Singapore. Both countries represent outstanding examples of the effects of national policies that put significant emphasis on health.^{5,6} The M8 Alliance has begun to hold regional meetings in 2011; these are held in the particular year's co-hosting country (2011 Melbourne, Australia; 2012 Baltimore, USA; and 2013 Singapore) and focus on topics of relevance for the hosting region.

The M8 Alliance continues in its aim to provide the scientific sources for evidence-based policy. Four key aims are currently a focus for the group's attention and activities: mental wellbeing in large urban areas and megacities, reduction of risk factors for non-communicable diseases, the health impacts of climate change, and research and workforce capacity building in low-income and middle-income countries.

Urbanisation progresses at a rapid pace, bringing new and different challenges. Three quarters of the world's megacities of 10 million or more people, such as Mexico City, Mexico, São Paulo, Brazil, or Mumbai, India, are in middle-income countries. By 2050, 70% of the world's population will live in urban areas.⁷ Insufficient security, lack of private space, and inadequate housing conditions are among the social stressors that are associated with an increased stress vulnerability and a higher risk for mental disorders in urban dwellers.⁸

Societal transition is leading to rapid demographic changes, especially in middle-income and low-income countries, that result in higher life expectancies but also in an increase of chronic diseases without adequate prevention capacities. Epidemiological projections show an increase of 80% for diabetes in Africa between 2006 and 2025, compared with the predicted worldwide increase of 55%.⁹ Processed food, high in fats, salt, and sugar, fuels the obesity epidemic, which has become one of the major health threats in countries like Mexico and Brazil.

In September, the UN General Assembly gathered to discuss actions on non-communicable diseases. The political declaration agreed at the meeting is an appreciated first step,¹⁰ but there is still a long way to go. Science must inform policy, especially under conditions of financial constraints when investments need to be directed towards the most cost-effective and evidence-based action plans and preventive measures.

Governments must integrate health into their political agendas, as their population's health is their most important economic asset. Politicians need to align with academia to identify the scientific evidence and arguments to determine the best strategies to choose from. It is an important and encouraging development that governmental authorities now show an increasing engagement in the World Health Summit, using this conference as a leading forum for exchange with the different stakeholder groups involved in the complex field of global and national health. Governmental authorities from more than 30 countries from all global regions are involved in this year's World Health Summit; the German Federal Government contributes with four Ministries (Education and Research, Health, Foreign Affairs, and Economic Cooperation and Development) to the conference. Interdepartmental linkages are key to assess and tackle complex health issues such as ageing populations, obesity, and cancer.

The World Health Summit 2011 in Berlin, Germany, is a unique occasion for policy makers to discuss urgent health issues with experts from all sectors with clear linkages to health, like science, the economy, and foreign policy. The door is open, and it is now up to policy makers to step in. An increasing involvement of governments of the M8 countries and beyond in the World Health Summit and the M8 process will be an important marker for success in the initiative's future.

For World Health Summit see <http://www.worldhealthsummit.org>

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Time for zero deaths from tuberculosis

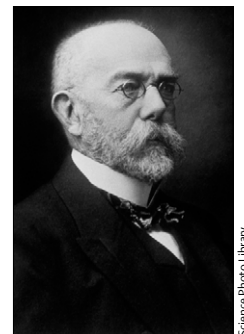
When Robert Koch presented his discovery of the tuberculosis bacillus in March, 1882, he hoped it would lead to the eradication of “this terrible plague of mankind”.¹ More than a century later, tuberculosis remains a leading killer of adults: of about 9.4 million people newly infected with tuberculosis each year, 3.5 million are undiagnosed and continue to transmit the disease and more than 1.7 million die. Tuberculosis is the main killer of people with HIV infection; drug-resistant strains continue to spread; and paediatric tuberculosis remains an area of neglect.^{2,3} In the past decade, the number of new cases of tuberculosis worldwide has barely declined, and the number of deaths remains catastrophic: more than 4500 per day for this largely treatable disease. As a *Lancet* editorial pointed out, “A status quo in tuberculosis control is unacceptable.”⁴

This status quo is not inevitable. A logical place to look for fresh leadership and vision is the Stop TB Partnership. Created in 2001 as a network of international organisations, countries, technical agencies, and donors, the Partnership was tasked with ensuring that every patient with tuberculosis has access to effective diagnosis and treatment. In its first decade, however, the Stop TB Partnership—housed at WHO headquarters in Geneva—seems to have operated essentially as a subsidiary of WHO’s Tuberculosis Department with the majority of funds going to WHO’s Tuberculosis Department, rather than external partners.^{5,6} But this situation may yet change. The newly appointed Executive Secretary of the Partnership, Lucica Ditiu, has initiated steps to address potential financial and administrative conflicts

of interest in the Stop TB Partnership’s relation with WHO. More importantly, Ditiu has called for a bold new vision in the struggle against tuberculosis. She and her team have started a campaign to prevent a million deaths among patients co-infected with HIV and tuberculosis.⁷ She should be congratulated for these steps and supported in her efforts by her Board, the WHO Director-General, governments of countries with a high-burden of tuberculosis, and the tuberculosis community. Transforming the Partnership into an effective, independent, and transparent body capable of acting as a locus for innovative thinking is a crucial step in recasting the global struggle against tuberculosis.

Changing the tenor of advocacy around tuberculosis is another important step. Without the networks of grassroots health activists and civil society institutions that define the HIV/AIDS movement, the global tuberculosis community has been unable to successfully scale-up patient-centred approaches to care, or hold governments and key international bodies (including funders) to account with regard to their commitments to tackle this disease. The health-activist community must take urgent steps to remedy this. Investment in tuberculosis-specific efforts of existing HIV/AIDS and civil society organisations—building on such efforts in Brazil, Kenya, India, South Africa, Uganda, and Zambia—or groups working on related social issues would be a start.

Much would be achieved if leaders of global health initiatives—the Global Fund to Fight AIDS, Tuberculosis and Malaria, the US President’s Emergency Plan For AIDS Relief, the US Global Health Initiative, and



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