In this month's *Bulletin*

How to use religion-based public health interventions? (p. 894, pp. 923–927)

The link between religion and tobacco control was made back in 1602 when a fatwa was issued in Morocco prohibiting the use of tobacco, writes Fatimah El Awa. In this month's editorial (p. 894) El Awa argues that public health should exploit the fact the tobacco industry sees religion as a threat for tobacco control purposes. Samer Jabbour et al. continue this theme in their paper (pp. 923–927). Enlisting religious authorities in public health campaigns to control tobacco is an age-old practice. They discuss factors WHO and other agencies should consider when using this and other religion-based public health interventions.

Global estimate for clinical pneumonia in under-fives (pp. 895–903)

Clinical pneumonia in children aged under 5 is the leading cause of child mortality worldwide. In their paper, Igor Rudan et al. set out to measure global incidence of the disease in young children. They analysed 28 community-based longitudinal studies that met their predefined quality criteria on the incidence of clinical pneumonia. They compiled a table giving global estimates of incidence of clinical pneumonia worldwide, but found it difficult to summarize their findings because of differences in design and settings of the studies. They conclude that clinical pneumonia in developing countries not only causes high levels of child mortality but also contributes significantly to the overall burden of disease in those countries.

Does public health benefit from sector-wide approach? (p. 893)

Since the mid-1990s, a new approach to health sector development has taken hold in some developing countries known as: the sector-wide approach. In their editorial, Guy Hutton et al. write that the beneficial effects of this approach can be felt in four areas of public health: country leadership and ownership, institutional and management capacity, flow of resources, and monitoring and evaluation. They argue that it is often difficult to establish whether conditions are favourable for taking such an approach in a given country. The authors conclude that it could take 5–10 years before the impact of taking a sector-wide approach to public health can be measured.

How to achieve Millennium Development Goals? (pp. 947–952)

Sachs argues in his round table base paper that scaling up health services in poor countries is vital for achieving health for all and the Millennium Development Goals (MDGs). Sachs proposes four ways to do this. Guy Carrin, one of the four discussants, agrees but argues that more investment in all sectors of the economy is also required to achieve the goals. William D. Savedoff commends Sach's "most original" argument: that investment in health is better than other uses of public funds. Jennifer Prah Ruger argues that achieving the health-related MDGs requires more political accountability in developing countries. David Sanders argues that macroeconomic reform is also needed to achieve the goals.

Governments must act to make patient safety a reality (p. 892)

About 10% of patients in industrialized countries suffer from adverse effects of treatment, such as from errors, outdated equipment or bad drug or vaccine reactions. In their editorial, Sir Liam Donaldson and Pauline Philip argue that the real number of patients who suffer harm inadvertently is probably even greater. They note that the World Alliance for Patient Safety was set up in October this year to look at the root causes and find remedies. They argue that the onus is on governments to find policies and regulations that can improve patient safety and to build up a knowledge base to help them in their task.

Do fixed-dose combination pills improve adherence? (pp. 935–939)

Fixed-dose combination pills or medicines in blister packs have become central to treating communicable diseases, such as tuberculosis and HIV/AIDS. Jennie Connor et al. argue in their paper that more needs to be known about whether patients are adhering enough to fixed-dose medicines in developing countries and whether taking medicines in this form helps to fight disease. The authors conducted a systematic review of 15 randomized controlled trials found in databases, reported between 1980 and 2002. They analysed the findings on adherence to fixed-dose combination drugs compared with adherence to non-fixed-dose combination drugs. They found very little reliable evidence identifying strategies that were most effective in terms of improving adherence.

Obesity now disease of poor in developing countries (pp. 940–946)

Studies published before 1989 suggest that obesity was disease of the socioeconomic elite in developing countries, but Monteiro et al. write in their review of studies conducted since then that the trend has changed. The authors analysed papers and reports found in databases on socioeconomic status and obesity in developing countries published between 1989 and mid-2004. They found that obesity in developing countries was no longer a disease of the elite, that the burden of obesity-related disease has shifted to poor, lower status groups and they found that women are more prone to obesity than men in lower-middle-income countries.

Spending more on health and knowledge to improve health (pp. 957–958)

In this month's news, Clare Nullis reports that developing countries have embraced the findings of the WHO Commission on Macroeconomics and Health and some have started working with WHO to implement them. In an interview with the Bulletin, WHO Assistant Director-General Dr Timothy Evans talks about how WHO is trying to apply its knowledge and expertise in the field. ■