that ought to circumvent these problems, all too often they fail in practice.

The conflict between private interests in science, protected by patents and cloaked in secrecy, and open access research remains one of the most contentious issues in modern science and one that affects us all. This latest scientific development is simply another arena in which this conflict will play out.

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A moment of truth for global health

A cross cutting approach is needed to meet the challenges of the global financial crisis

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The past decade has been a "golden window" for global health.[1] New disease specific health initiatives and major new funding programmes have contributed to impressive gains.[2 3] In 2008, for example, 10 000 fewer children were dying each day than in 1990.[3] But there are disturbing signs that the window may be closing.

Donor agencies have warned African countries that financial help for HIV treatment programmes cannot be assured.[1] The Global Fund to Fight AIDS, tuberculosis, and malaria and the Global Alliance for Vaccines and Immunisation (GAVI Alliance) face serious funding shortfalls. The Spanish government just announced that it will cut foreign aid by €600m (£506m; $734m) as part of its austerity measures, and other donor governments seem likely to follow suit.[4] Without sustained funding to strengthen the fragile health infrastructure of developing countries, the millennium development goals are unlikely to be reached.

How will the global health community respond? One risk is that the various sub-communities, or silos, such as those working on HIV, malaria, vaccines, or health systems, will advocate and compete for their own stake in the shrinking pot of donor money.

A more rational response would be for the community to come together and agree on a "cross cutting" agenda for global health. Such an agenda should focus on how to get the overall global health architecture right, and how to ensure maximum return for every dollar invested.

This agenda should tackle four key areas. A better understanding of these interconnected areas could help to lay a foundation to make decisions in global health that are based more on empirical analysis and less on disease based advocacy or political whim.

The first point is to ensure a robust sustained way to finance the global health system. Most interest currently centres on innovative financing mechanisms, the "new architecture for development."[5] The high level Taskforce on Innovative International Financing for Health Systems laid out a menu of different mechanisms.[6] Some are up and running, such as the "mandatory solidarity levy" on airline tickets that generates about €180m a year in France, most of which goes to UNITAID to support the scaling up of treatments for HIV, tuberculosis, and malaria. Others, such as a proposed tax on currency market transactions, are at an earlier stage.

One problem with these new mechanisms is that they tend to fund specific silos and so could perpetuate the fragmentation in global health. Another is that they risk letting donors off the hook for their unfulfilled commitments—the group of eight countries (G8), for example, has failed to live up to its 2005 Gleneagles commitments.[7] From a cross cutting viewpoint, it would be valuable to stand back and consider the implications of these new financing mechanisms, which are adding yet more complexity to an already messy global health landscape. Could they be launched in a more strategic and coordinated way? Could they be harmonised and reorganised to raise money explicitly to support horizontal integrated delivery of health through stronger health systems?

A second point is to make sure that money raised is spent rationally and efficiently, with a strong focus on supporting the needs of countries and better alignment between aid flows and national priorities, as laid out in the Paris Declaration on Aid Effectiveness.[8] Here there are lessons to be learnt from the new and innovative global health initiatives. The global fund and the GAVI Alliance adopted demand driven approaches to development assistance, in which money is invested in programmes proposed by developing countries themselves rather than by donors. Could demand driven financing be a model for basing global health decisions on the needs expressed by countries themselves rather than on the latest "fashionable" topic?

A third point is to encourage donors to use strategic methods for deciding how much money to allocate directly to countries and how much to invest in multilateral funds, such as the global fund. At present these decisions seem to be ad hoc. Why, for example, did the government of the United States reduce its proposed allocation to the global fund in its budget for financial year 2011 compared with 2010? These

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"We need to ensure that what is termed as a demanding issue really is a demanding issue. Africa is still poor at using evidence to inform practice. Malaria drugs are still being shipped to health facilities where malaria is not endemic, leading to expiry of much needed drugs. Budgets are made on percentage increments instead of emerging trends. Evidence based resource allocation is almost unheard of in my country."

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kinds of decisions should be made less haphazardly and be based more on an overarching framework that considers the strengths and weaknesses of bilateral versus multilateral assistance for global health.

The final point is to develop better methods to track funding flows, estimate funding gaps, and evaluate whether funds have been spent in ways that improve health. The data on global health funding flows have been called "messy and inadequately tracked,"[9] although the Institute for Health Metrics and Evaluation has developed better tracking methods.[2] The science of estimating funding gaps faces major hurdles, as shown by the wide range of estimates for how much money will be needed to reach the health millennium development goals.[10] As for evaluating global health initiatives, we agree with the *Lancet* that the lack of serious commitment to such evaluation is "damaging the entire global health movement."[11]

We realise that a cross cutting agenda would require an extraordinary degree of joint working among multiple global health actors. But there are promising signs of more "joined up" thinking: eight of the largest global health agencies recently made a joint commitment towards "analysis, synthesis, validation, and use of health data"[12]; the global fund, GAVI Alliance, and World Bank are entering a partnership to create a joint platform for strengthening health systems; and the Obama administration's Global Health Initiative takes a more integrated, government-wide approach than that taken by previous US administrations.

Cross cutting policy matters tend to be neglected for several reasons. There is no vigorous advocacy or lobby group for these matters. A cross cutting agenda can feel threatening to some advocates for specific health topics. From a political perspective, the agenda will hardly win votes—it will not cause ripples of excitement to run through parliaments or electorates. But if we remain stuck in our silos during this time of economic uncertainty we will miss our opportunity to fashion an overarching global health system that can effectively deliver health for all.

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Female genital mutilation

Paediatricians should resist its medicalisation

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Female genital mutilation is defined by the World Health Organization as any procedure that involves partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons.[1] Worldwide, 100-140 million girls and women are estimated to live with the consequences of such practices.

Although a graded classification of types exists,[2] female genital mutilation is recognised internationally as a violation of human rights with no health benefits. Immediate risks include haemorrhage, infection, and death. Long term consequences include menstrual problems, infertility, psychosexual and psychological difficulties, and adverse obstetric outcomes including caesarean section, perineal trauma, haemorrhage, and perinatal death.[3] So why did the American Academy of Paediatrics (AAP) amend an earlier policy to suggest that United States law could be changed to allow doctors to "nick" female genitalia, as a cultural compromise?[4] Women's rights organisations, the World Health Organization, and the UK Royal Colleges of Obstetrics and Gynaecology and Paediatrics and Child Health all expressed dismay.[5 6] The AAP released a statement on 27 May to say that they have withdrawn the policy,[7] but at the time of going to press it remains available unchanged on their website.[4]

Migration has led to an increase in women with genital mutilation in developed countries. In 2001, 66 000 were estimated to live in England and Wales, with over 20 000 young girls at risk. An estimated 1.43% of all childbirths in 2004 occurred in women with genital mutilation (6.3% in inner London).[8] The 1985 Prohibition of Female Circumcision Act made it an offence to carry out, aid, abet, or procure any form of female genital mutilation in the United Kingdom. The 2003 Female Mutilation Act closed the loophole that allowed fami-