age on child mortality as it operates through parental education. Sensitivity analyses (appendix 1 to the Article[1] pp 4–5) showed that incorporating additional study-level covariates using Demographic and Health Survey (DHS) microdata did not have a large effect on our final estimates.

One way to estimate the effect size of parental education having controlled for mother's age is to take the coefficients reported in table 3 of the Article[1] and add the interaction for mother's age to education. Rough estimates indicate that accounting for maternal age would attenuate the per-year effect of parental education on the mortality of children younger than 5 years for both mothers and fathers (reduced by 1·0% for mothers and 0·7% for fathers). However, mediation analyses were not tenable with the data as published, and so an analysis of the effect of maternal age, as it operates independently of parental education, was beyond the scope of this study.

We acknowledged the potential for geographical heterogeneity in the association between parental education and child mortality.[1] We found no evidence for systematic variation between high-income and low-income countries, as approximated by restricting our study to DHS and non-DHS data (appendix 1 to the Article[1] p 25). Our analyses found evidence for variation between studies, which we interpret as variation between countries. In fact, we found that adding study-level variation to our estimates gave a range of possible relative risks across countries between 39·0% and 23·0%, with our average global estimate being 31·0% (figure 6 in the Article[1]). This variation is likely to be driven by country differences in health-care provision, education quality, and other social determinants of health. Explaining these factors should be encouraged in future research and might contribute to identifying opportunities for interventions to promote maternal and child health.[2]

We declare no competing interests.

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Fetal dysanatrophy—a new discipline?

In response to the report on the Orwellian abuse of fetal imagery in current US legislative abjuration of termination of pregnancy services,[1] and due to the increasing concern that we have lost our scientific focus in the understanding and management of fetal growth disorders, I propose a new discipline within that of fetomaternal medicine.

Failure to reach optimal growth in otherwise structurally typical fetuses is a substantial contributor to perinatal mortality and morbidity, and yet little advance in diagnosis and management has occurred in the past decade.[2] In contrast, fetal dysmorphology, the branch of medicine concerned with the antenatal management of human teratology is a well established discipline and, as an evolved discipline, has driven the major developments at a population level in the diagnosis and management of genetic and structural fetal malformations.

An establishment of a complimentary discipline for fetal growth disorders in otherwise structurally and genetically healthy fetuses should be considered. Instead of relying on descriptive terminology, such as fetal growth restriction or small for gestational age, which relate to outcome, a specific new discipline of fetal dysanatrophy should be considered—the study of unsuccessful nurturing (fetal, fetomaternal, maternal, or external causation) in otherwise healthy fetuses. The establishment of fetal dysanatrophy groups around the world would help refocus our efforts to better understand and better diagnose and manage antenatal fetal growth disorders. The fetal dysanatrophy discipline could also, by consensus, help develop the ethical imperatives that govern the dissemination and use of fetal imagery.

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COVID-19 Excess Mortality Collaborators. Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21. Lancet *2022;* **399:** *1513–36*—In this Article, Tanzania and Uganda should have been listed under eastern sub-Saharan Africa in the table. The totals for eastern sub-Saharan Africa correctly included Tanzania and Uganda in the original version and have not been changed. The uncertainty intervals for *The Economist* estimate of excess deaths in the Research in Context panel and Discussion section have been updated to 18·0 million (95% uncertainty interval 12·9–21·0). These corrections have been made to the online version as of April 14, 2022, and the printed version is correct.

COVID-19 Forecasting Team. Variation in the COVID-19 infection–fatality ratio by age, time, and geography during the pre-vaccine era: a systematic analysis. Lancet *2022;* **399:** *1469–88*—In this Article, Tanzania and Uganda should have been listed under eastern sub-Saharan Africa in table 2. The totals for eastern sub-Saharan Africa correctly inclxnzania and Uganda in the original version and have not been changed. These corrections have been made to the online version as of April 14, 2022, and the printed version is correct.