an important misunderstanding of our evidence—we show that the intervention is cost-effective, not that it saves money. This claim of cost-effectiveness relates to World Health Organization recommendations to compare cost-effectiveness ratios with local gross domestic product per capita.[3] Health systems-strengthening initiatives were conducted in both intervention and control arms of the trial, and so their costs had no bearing on our cost-effectiveness calculation.

We are surprised that Dr Klar did not find sufficient detail about the intervention, recruitment of facilitators, or allocation of groups described in our trial article and cited literature. To clarify, the facilitator-led women's groups progressed through a cycle of participatory learning and action meetings whereby the women themselves identified the key threats to their health and that of their children; identified their own strategies to overcome these threats, such as clean delivery kits, emergency funds, transport schemes, and local health promotion, including home visits; and implemented and evaluated these strategies. Control clusters were never exposed to the women's group intervention. Scale-up of the intervention within the same intervention clusters is detailed in the trial protocol[4] and in the article by Nahar et al,[5] which describes facilitator recruitment and retention. A particular strength of our evaluation is that we showed coverage really matters. In trials where more than 30% of newly pregnant women attend the groups, there are large and significant impacts on maternal and newborn deaths.[2] Our evaluation also enabled us to demonstrate the cost benefits of implementing the intervention at scale from the outset. In terms of further replication and scale-up, we are pleased to report scale-up initiatives in South Asia, using our action cycle for mother and child health, and draw readers' attention to the open-access Good Practice Guide (http://www.ucl.ac.uk/igh/library/good-practice-guide), with instructions on how others may replicate the intervention.

Our cluster randomized clinical trial design provides confidence that women's groups reduced mortality and improved home delivery care and feeding practices. It was not specifically designed to elucidate the underlying, contextual, and process factors, although we gathered much data to understand underlying mechanisms and essential factors for success. We have published hypotheses on these.[2,6] For now, we have good indications that population coverage and targeting pregnant women are important aspects of delivery, and home care practices, particularly hygienic behaviors, are probably crucial mechanisms. Multiple cluster randomized clinical trials with high rates of follow-up and robust statistical analyses[2] mean the intervention can now be scaled successfully where there are persistently high rates of maternal and neonatal mortality.

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Circumcision Is a Religious/Cultural Procedure, Not a Medical Procedure

To the Editor Morris and Tobian[1] note that parents are granted wide latitude in authorizing surgical procedures for their children. But that latitude is not unlimited and is fiduciary in nature. Fundamentally, male circumcision is a religious and cultural cosmetic procedure, not a valid medical procedure.

Almost 70 years ago, writing in a much less child-protective era than the present, in *Prince v Massachusetts*, the US Supreme Court held that "neither rights of religion nor rights of parenthood are beyond limitation.... Parents may be free to become martyrs themselves. *But it does not follow they are free, in identical circumstances, to make martyrs of their children* [emphasis added]...."[2]

Morris and Tobian refer to the asserted "rarity" of "adverse outcomes" from circumcision. Yet as the American Academy of Pediatrics tells us, "The true incidence of complications after newborn circumcision is unknown."[3] Moreover, unlike other medical procedures such as immunizations, which prevent serious childhood diseases, male circumcision provides no benefit to the vast majority of boys or men (and robs them of the most sensitive portion of the penis). Hence the serious injuries that do sometimes result from this needless procedure, up to and including death (estimated to be in the 3 digits annually in the United States), are truly unjustifiable tragedies.

Morris repeatedly cites his own polemics in an attempt to back up his plea that circumcision is safer in the newborn. Yet there is no evidence that the procedure is safer or better tolerated in infancy, and evidence exists to the contrary.[4]

Morris and Tobian's contentions about "medical" benefits—claimed since the late 1800s—have been repeatedly shown to be weak, most recently in a powerful 2013 statement by 38 distinguished physicians from throughout Europe and Canada.[5] Urinary tract infections strike girls much more frequently than boys, and in all such cases are treated with oral antibiotics, not surgery. But if genital surgeries on girls did reduce such infections, would Morris and Tobian favor rolling them out universally? Could they even advocate research into the question without falling afoul of medical ethics? The clear and obvious answer is no.

Circumcision breaks the cardinal ethical rule for physicians, "First, do no harm."

With the scarce medical resources we have available today, it is time to call a halt to this procedure, which even the American Academy of Pediatrics cannot claim has benefits sufficient to justify its universal practice.

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In Reply Svoboda's statements have been discredited previously.[1] Since benefits of infant male circumcision (MC) vastly exceed risks,[2] its persistence in diverse cultures worldwide likely reflects ritualization of a healthy practice,[3] rather than it simply being "cosmetic."

Meta-analyses and large randomized trials establishing protection against lifetime urinary tract infections, human immunodeficiency virus, human papillomavirus, herpes simplex virus 2, *Mycoplasma genitalium*, genital ulcer disease, penile cancer, and other conditions have led the American Academy of Pediatrics (AAP), the American College of Obstetrics and Gynecology, and the World Health Organization/UNAIDS to adopt affirmative policy statements and promote the procedure.

Contrary to Svoboda's claim, 1 in 2 uncircumcised males will have medical condition(s) caused by their foreskin, some being life threatening.[2]

Svoboda's claim that MC "robs [males] of the most sensitive portion of the penis" is not supported by medical evidence.[4]

The AAP reported complication rate is 0.2% to 0.3% for infant MC. Virtually all are minor and easily and immediately treatable. Deaths are extremely rare. Svoboda's deaths "in the 3 digits" claim is based on a fallacious assumption that the sex difference in infant mortality in the United States is almost entirely a result of MC. A similar sex difference occurs in countries with low infant MC rates.[1]

The multiauthored opinion piece by European physicians attacking the AAP 2012 policy statement was repudiated by the AAP as reflecting cultural bias in Europe.[5]

Svoboda's hypothetic arguments about urinary tract infections in girls are specious. In early infancy, their incidence in uncircumcised boys is much higher than in girls.[2] In adulthood, MC protects women from human papillomavirus that causes cervical cancer, trichomoniasis, and bacterial vaginosis.[2]

The so-called "First, do no harm" "cardinal ethical rule" is not part of contemporary medical teaching. Rather than the "Hippocratic Oath," the Hippocratic text *Epidemics* is a more likely source. This points out that the physician must have 2 objectives with regard to disease, namely to do good or to do no harm. Since risks are uncommon and minor, whereas benefits are considerable,[2] to circumcise is to do good and to do no harm.[2]

Our article referred to the AAP policy pointing out the wide latitude allowed by the law in parental decision making. We also argued that infant MC can be logically interpreted as supported by Articles 14(2) and 24(3) of the United Nations Convention on the Rights of the Child 44/25 20 November 1989. Failure to circumcise puts the child at significant medical risk, thus contravening this Convention. We presume that by "fiduciary" Svoboda might be referring to the legal or ethical relationship between parents and their child rather than money management.

Given the considerable benefits and low risk,[2] responsible, properly informed parents will likely choose MC for their infant son, just as they would choose to have him vaccinated.

Svoboda's citation of *Prince v Massachusetts* is not relevant to infant MC.

We refer the reader to an extensive evaluation of the law and ethics of childhood MC published recently by experts in law, bioethics, pediatrics, and public health.[6] Logically, Attorneys for the Rights of the Child should support infant MC.

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