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Group Antenatal Care (G-ANC): A way forward to improve Afghanistan's utilisation of maternity care

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In Afghanistan, maternal mortality and infant mortality — two key indicators of population health — are among the highest in the developing world, partly because of nearly a half-century of conflict and persistent socioeconomic instability [1]. The latest data in 2017 show that Afghanistan's maternal mortality ratio (638 per 100,000 live births) and infant mortality rate (36 per 1,000 live births) are much higher than other countries with comparable economic development [1]. Poor health infrastructure, political upheaval, reductions in donor funding and corresponding disruptions in health services, insecurity, climate change, and escalating humanitarian crises further intensify these issues [1].

Antenatal care (ANC), a core intervention of the safe motherhood initiatives, anticipates improved maternal and neonatal outcomes [2]. For instance, it is estimated that utilisation of high-quality ANC services could reduce 20% of pregnancy-linked maternal deaths [2]. A public health challenge faced by most low-and middle-income countries (LMICs), including Afghanistan, is poor utilisation of ANC services associated with inadequate resources, poverty, and cultural and traditional practices [3,4].

In Afghanistan, only 22% of pregnant women receive the

previously recommended 4 or more ANC visits, with the updated World Health Organization (WHO) recommendation of eight visits not yet implemented [3]. Moreover, 55.8% of pregnant women initiate ANC at the recommended time (during the 1st trimester), and only 1.3% of those with ANC utilisation receive all the required ANC services [4,5]. As this challenge is expected to continue, policymakers need to explore solutions that improve antenatal care utilisation.

The research in LMICs has highlighted the crucial role the group-ANC (G-ANC) model can have in helping expectant mothers with the provision of essential health services, including screening, nutritional guidance, health promotion, and early detection of complications [6]. This model of care organises similar cohorts of 8-12 pregnant women to increase discussion among participants and to ensure community-building (peer support) during the antenatal care period, and may be an effective strategy for improving the quality of maternal care and outcomes in LMICs [6,7]. A recent systematic review by Sharma et al identified that the G-ANC model has a positive impact on quality and attendance at ANC and the uptake of health facility delivery [6]. Additionally, higher client satisfaction rates and substantial long-term cost reductions were observed in G-ANC compared with standard care, as reported in other systematic reviews [7,8].

The G-ANC model of care can be considered an essential step towards improving the quality of ANC services in Afghanistan. However, the capacity of health systems to support the G-ANC model of care is not a given. The resilience of Afghanistan's healthcare system, already grappling with the rigors of conflict, combating the Covid-19 pandemic and environmental calamities, has been further compromised by natural disasters that have highlighted its vulnerabilities [1,3]. Healthcare workers may be unaware of what activities for the G-ANC model exist [5]. The health system might fail to provide the necessary resources or even discourage the training of healthcare workers for effective implementation of the G-ANC model [5]. Furthermore, low literacy rates among Afghan women, poor health infrastructure, communication barriers stemming from linguistic differences, recent restrictions imposed on women's movements, and ingrained sociocultural norms and values might be seen as threats to the G-ANC model adaptation in Afghanistan.

To appropriately tackle these barriers, we present a set of policy recommendations that should enable the healthcare system to more readily understand, support, and promote the G-ANC model of delivery in the country.

1. Before policymakers begin implementing the G-ANC model across a large number of health centres, pilot studies are needed to examine the feasibility and effectiveness of the model under the Afghan healthcare system.

2. Align the G-ANC model of delivery with national health policies and guidelines for better integration into the healthcare system.
3. Ensure the G-ANC model respects professional values, sociocultural norms, and gender dynamics to enhance its acceptability in Afghan society.

G-ANC appears to be one of the approaches to address the poor utilisation of maternal health services in Afghanistan. While robust evaluations are needed to understand the feasibility and effectiveness of group antenatal care, it is also critical to address broader factors influencing maternal health, ensuring equitable access to quality care for all, particularly the most vulnerable. We need to create an environment where every Afghan mother and newborn has the opportunity to survive and thrive.

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Fixing errors in the PubMed entry of the abstract of an article

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We chanced upon a number of errors in a PubMed entry (PMID: 24727622) of the abstract of an article published in your journal a decade ago. This prompted us to think how

PubMed entries are rectified and whether it may be important to publish an erratum in a forthcoming issue of the journal when the original source on the journal's website has no error.

The abstract as published on PubMed [1] mentioned that the study was conducted at “6 medical colleges, 7 non-teaching government hospital, and 2 corporate hospitals”. That makes it 15 sites though the total is mentioned as nine. In the PubMed entry, the study period is between August 2072 and March 2073 which is glaringly impossible (Figure 1, available online only).

This is what prompted us to check the journal's website and we found the study period was actually between August 2012 and March 2013. The entry on the journal's website [2], also says the study was conducted at 9 sites — 6 medical colleges, 1 non-teaching government hospital and 2 corporate hospitals.

Even though the entry has been on PubMed for 10 years now, the errors have not been reported or corrected. We checked how a reader could report an error or a mistake in PubMed and get it corrected.

PubMed is a repository of citations of biomedical and life science literature. The National Library of Medicine (NLM), like any other human-run institute, is prone to human or mechanical errors.

Instead of reporting errors in PubMed citations to NLM which controls PubMed, readers who spot any errors are now directed to report them directly to the publishers [3]. The team that submits the XML citation data to PubMed will then be able to fix the errors.

With the PubMed Data Management (PMDM) system released in 2016, correction of citation data is now the responsibility of PubMed data providers and not the NLM Data Review team [4].

Publishers can use their Secure File Transfer Protocol (SFTP) accounts to upload corrected files securely and in a confidential manner. Electronic submission of corrections directly by the publishers now allows the corrected version to be available to the public within 24 hours of uploading the correctly formatted XML file.

NLM's Errata policy has not changed in the recent past. Journals are expected to publish errata to correct errors appearing in the original article. In line with the International Association of Scientific, Technical & Medical Publishers (STM) guidelines, an original article is never changed [5]. Published articles remain extant, exact, and unaltered to the maximum extent possible. The publisher needs to alert readers to a correction in the publishing record without changing the publishing history.

Since these are not errors in the original article but errors in the PubMed entry for this article, we wonder if publication of an erratum is required.