

LETTER

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

Published online first on June 4, 2024. DOI: 10.20529/IJME.2024.035

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.

Conflict of interest and funding: The author has no conflict of interest or specific funding to declare.

Muhammad Haroon Stanikzai (haroonstanikzai1@gmail.com), Department of Public Health, Faculty of Medicine, Kandahar University, District # 10, 3801, Kandahar, AFGHANISTAN.

References

1. Tharwani ZH, Kumar P, Shaeen SK, Islam Z, Essar MY, Ahmad S. Maternal mortality in Afghanistan: Challenges, efforts, and recommendations. *Clin Epidemiology Glob Health*. 2022;15:101038. <http://dx.doi.org/10.1016/j.cegh.2022.101038>
2. Goshomi U. The importance of antenatal care. *Afr J Midwifery Women's Health*. 2022;16(4):1–1. <http://dx.doi.org/10.12968/ajmw.2022.0033>
3. Stanikzai MH, Wafa MH, Wasiq AW, Sayam H. Magnitude and Determinants of Antenatal Care Utilization in Kandahar City, Afghanistan. *Obstet Gynecol Int*. 2021 Jul 2;2021:1–7. <http://dx.doi.org/10.1155/2021/5201682>
4. Samiah S, Stanikzai M, Wasiq A, Sayam H. Factors associated with late antenatal care initiation among pregnant women attending a comprehensive healthcare facility in Kandahar Province, Afghanistan. *Indian J Public Health*. 2021;65(3):298. http://dx.doi.org/10.4103/ijph.ijph_62_21
5. Stanikzai MH, Tawfiq E, Jafari M, Wasiq AW, Seddiq MK, Currie S, et al. Contents of antenatal care services in Afghanistan: findings from the national health survey 2018. *BMC Public Health*. 2023 ;23(1). <http://dx.doi.org/10.1186/s12889-023-17411-y>
6. Sharma J, O'Connor M, Rima Jolivet R. Group antenatal care models in low- and middle-income countries: a systematic evidence synthesis. *Reprod Health*. 2018;15(1):. <http://dx.doi.org/10.1186/s12978-018-0476-9>
7. Sadiku F, Bucinca H, Talrich F, Molliqaj V, Selmani E, McCourt C, et al. Maternal satisfaction with group care: a systematic review. *AJOG Glob Rep*. 2024;4(1):100301. <http://dx.doi.org/10.1016/j.xagr.2023.100301>
8. Jans S, Westra X, Crone M, Elske van den Akker-van Marle M, Rijnders M. Long-term cost savings with Centering-based group antenatal care. *Midwifery*. 2023;126:103829. <http://dx.doi.org/10.1016/j.midw.2023.103829>