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# MEDICAL SCIENCE (MS)

## EDITING SAMPLE

**Prepared by:**

**RESEARCHEDIT4U SOLUTIONS PVT. LTD.**
**WHERE RESEARCH FIND WINGS**

# Medical Sciences Research Paper — Technical Copyediting Sample (Client Anonymised)

*Service: Subject-aware copyediting (Medical Sciences)* | *Style: American English* | *Mode: Track Changes + Comments*

**Prepared by: RE4U Solutions**

*Confidential — for demonstration only*

| Field | Details |
| --- | --- |
| Subject | Socioeconomic inequality in Maternal and Child Health (MCH) service use in Nepal (2011 vs 2016), examining disparities in ANC visits, skilled birth attendance, and postnatal checkups, using NDHS data and decomposition methods. |
| Type of article | Medical sciences / public health / health equity research manuscript (quantitative inequality measurement using concentration indices/curves plus Oaxaca–Blinder decomposition). |
| Sections shown in sample | Abstract (Background–Methods–Results–Conclusion), Background, Conclusions. |
| Primary goal of editing | Improve technical clarity and readability in a statistics-heavy health-equity manuscript (clean reporting of outcomes/indices, consistent terminology, and reviewer-friendly flow) while preserving meaning; American English with visible markup. |
| Editing level demonstrated | Subject-aware copyediting (Medical Sciences) with Track Changes + Comments (clarity/consistency without changing scientific conclusions). |
| Deliverables | Track-changes edited file + Comments (editorial rationale visible to the client/reviewer). |

**C) "Overall issues found" + "Solution provided" (Cover page summary — Medical Sciences)**

**Major issues (high impact)**

1. **Acronym clarity + first-use definitions:** Key terms (MCH, ANC, SBA, NDHS, MNH) appear early and repeatedly, but need consistent first-use expansion and reuse across Abstract/Background/Conclusions.

2. **Statistics-heavy readability**: Several sentences compress many numbers, comparisons, and determinants into one run, making the story harder to follow at first scan (especially in Results and the long Conclusions paragraph).

3. **Outcome definition consistency:** The three outcome measures are clear, but the phrasing/time windows need tighter parallel wording (e.g., "within two months of delivery/birth") to prevent ambiguity for reviewers.

4. **Evidence-aligned interpretation (tone control):** Some policy-forward statements read broader than the immediate evidence base and would benefit from more cautious, journal-style phrasing while keeping the message intact.

5. **Style consistency (American English):** The sample states American English, but a few UK spellings (e.g., "analyse") appear and should be standardised.

**Minor issues (low–medium impact)**

- **Grammar/wording smoothness:** A few phrases sound non-idiomatic or overly informal for a medical journal context (tightening improves professionalism).

- **Number formatting consistency:** Standardising formats such as "per 1,000 live births," spacing in citations, and long numeric sequences improves readability and reduces reviewer friction.

- **Punctuation and flow:** Long sentences in the conclusion benefit from cleaner segmentation and signposting so key recommendations land clearly.

**Solution provided (what RE4U copyeditors did)**

- **Delivered meaning-preserving, subject-aware medical copyediting to improve** clarity and reviewer readability without changing the study's findings.

- **Standardised acronyms/terminology** (first-use expansion, consistent reuse) and improved the parallel structure of outcome definitions.

- **Polished quantitative reporting** (numbers, comparators, and metric statements) and tightened sentence structure in Results/Conclusions for a cleaner narrative.

- **Applied American English consistency and provided edits in** Track Changes + Comments so the author can see what changed and why at a glance.

*Current verdict:* *The manuscript addresses a high-impact public health question socioeconomic inequality in maternal and child health service use in Nepal and the study design and intent are clear from the outset. At present, however, the narrative becomes number-dense in places: multiple outcomes, indices, and determinants are packed into long sentences, and some acronyms and outcome definitions could be introduced more consistently across sections. The conclusions would benefit from cleaner signposting and more cautious, evidence-matched wording so recommendations feel firmly grounded in the reported results. The edits are meaning preserving and medically aware, improving clarity and readability while keeping the study's core findings intact.*

# ABSTRACT

## BACKGROUND EXCERPT

~~About~~In Nepal's urban areas, approximately 75.5% of women ~~in Nepal's urban areas receive~~attended at least four ANC visits, ~~compared to 61.7% of women in the country's~~ whereas in rural areas~~.~~, this figure dropped to 61.7%. Similarly, ~~just~~only 34% of women in the lowest wealth quintile ~~give~~gave birth in ~~a~~ medical ~~facility~~facilities, compared to 90% of women in the ~~richest~~wealthiest group. ~~As a result of this inequality,~~This disparity results in the poor in emerging nations ~~suffer since~~suffering, as those who are better off can ~~make greater use of the~~access healthcare more readily than those who are less fortunate. This study ~~aims~~aimed to ~~examine~~analyse and ~~decompose~~break down the contributions of various socioeconomic factors ~~towards~~to MCH service inequality in Nepal in ~~the years~~ 2011 and 2016.

## METHOD EXCERPT

Inequality in MCH services was ~~estimated~~assessed using concentration curves and their corresponding indices ~~using~~, drawing on data from ~~the~~ Nepal Demographic Health Survey (NDHS) in 2011 and 2016. We ~~examined the~~analyzed inequality across three MCH service outcomes: ~~less~~fewer than ~~4~~four ANC visits, no postnatal checkups within ~~2~~two months of delivery, and no SBA delivery, and decomposed ~~them~~these across the observed characteristics of ~~the~~ mothers aged ~~between~~ 15 ~~and~~to 49. ~~Furthermore,~~Additionally, the Oaxaca-~~blinder~~Blinder decomposition approach was ~~used~~employed to measure and ~~decompose~~break down the inequality differential between the two ~~time~~ periods.

## RESULTS EXCERPT

Inequality in MCH services was ~~prevalent~~evident for all ~~3~~three MCH outcomes in 2011 and 2016~~, respectively.~~. However, the concentration indices for ~~<4~~fewer than four ANC visits, no SBA delivery, and no postnatal checkups within ~~2~~two months of birth increased from -0.2184, -0.1643, and -0.1284 to -0.1871, -0.0504, and -0.0218 ~~correspondingly, showing the decrease,~~ respectively, indicating a reduction in MCH ~~services~~service inequality over these two ~~time~~ periods. ~~Wealth~~The main contributors to this inequality were the wealth index,

~~women's~~women's literacy, place of ~~living, mother's~~residence, mother's employment status, and ~~problem of~~distance to ~~reach~~the nearest health facility ~~were the main contributors~~.

## CONCLUSION

~~We find~~Our findings indicate that MCH services are ~~clearly biased~~disproportionately skewed towards ~~the~~ women with higher living standards. ~~National~~To address disparities in living standards, women's education levels, and the issue of distance, national policies should ~~focus on~~prioritize empowering women through education and employment, ~~along with~~alongside the ~~creation~~development of health facilities and ~~improved~~enhanced educational institutions~~, in order to address inequalities in living standards, women's education levels, and the problem of distance. Leveraging~~. By leveraging these factors~~,~~ we can ~~reduce~~work towards reducing inequality in MCH services.

## BACKGROUND EXCERPT

The unequal distribution of healthcare services is a ~~prevalent~~significant issue in low- and middle-income countries, ~~resulting in~~leading to higher morbidity rates and ~~lower health service~~reduced utilization of health services among the less affluent segments of society ~~[1,2,3,4].~~[1,2,3,4]. Maternal and Child Health (MCH) services~~, in particular, are~~ serve as crucial indicators of healthcare inequality, as this disparity can ~~exist~~be found not only in low-income countries but also in some well-developed regions ~~[5].~~[5]. The provision of MCH services is ~~essential in~~vital for preventing maternal and newborn deaths~~, as well as~~ and promoting the well-being of future generations, ultimately ~~leading~~contributing to the economic prosperity.

Nepal serves as a ~~notable~~prime example of health inequality~~since~~, with its ~~health~~healthcare facilities ~~have not been able~~failing to ~~reach~~adequately serve the entire population~~properly. Around~~. Approximately 16.67% of ~~Nepal's populace falls~~Nepal's population lives below the poverty line, ~~with~~and 95% of ~~them residing~~these individuals live in rural areas ~~[6, 7].~~[6, 7]. Moreover, 60% of rural households require ~~over~~more than 30 minutes to ~~reach~~access the nearest government health facility ~~[8].~~[8]. To address this ~~inequity~~disparity, the ~~Nepal~~Nepalese government has ~~introduced~~launched health sector programs aimed at ensuring ~~equity in~~equitable health services ~~for~~across various ~~socio-economic~~socioeconomic groups ~~[9].~~[9]. One such ~~program~~initiative, the Safe Motherhood program (Aama program), provides monetary incentives of Nrs. 400 to mothers who ~~complete~~completed four antenatal care visits,

~~covers~~covered transportation costs ~~for mothers~~, and ~~offers~~offered free institutional delivery. Health workers also ~~receive~~received Nrs. 300 incentives for delivering these ~~packages [10].~~services [10]. The continuation of these programs has resulted in a 25% increase in antenatal care visits, a 12% increase in postnatal checkups, and a 22% increase in institutional deliveries from 2011 to 2016 ~~[8].~~[8]. Despite ~~this progress~~these advancements, a significant ~~proportion~~number of infant and child deaths still occur in the lowest and second lowest wealth quintiles ~~of Nepal [8].~~in Nepal [8]. The infant mortality ~~rate~~ and child mortality ~~rate~~rates in the lowest wealth quintile ~~are~~were 50 and 12 per 1000 live births, respectively, compared to 20 and 4 per 1000 live births in the highest wealth quintile. ~~Moreover, many~~Additionally, numerous studies have ~~documented sluggish~~reported slow progress in improving maternal and newborn health ~~[11, 12].~~[11, 12]. These findings have ~~spurred~~prompted researchers from various ~~disciplines~~fields to ~~investigate~~explore the ~~possible reasons behind such~~underlying causes of slow progress and health inequality in Nepal.

~~The existing health inequality~~Existing research on health inequality has ~~primarily focused on measuring~~predominantly concentrated on assessing health morbidity or ~~health service~~the utilization of health services. The concentration index and its decomposition are ~~commonly used methods to accurately~~frequently employed to measure health inequality. For ~~instance, in a study of child malnutrition in Vietnam~~example, Wagstaff et al. ~~[13] found~~[13] discovered that ~~the~~parental education ~~status of parents~~ and household consumption disproportionately ~~affected~~impacted the poor in a study on child malnutrition in Vietnam. Subsequent studies have ~~used variations of~~adapted this methodology and ~~different~~used various proxies for child health in developing ~~nations. They~~countries. These studies have ~~mostly~~largely identified wealth status, immunization coverage, parental education, and access to health facilities as ~~major~~significant contributors to ~~inequality in child health [14,15,16].~~child health inequality [14,15,16]. Inequality in adult health is also ~~prevalent~~evident in general and mental health, tobacco consumption, and smoking habits, with lower quintiles experiencing poorer health outcomes ~~[1, 17, 18].~~[1, 17, 18]. This health inequality can also be ~~attributed~~linked to the unobserved characteristics of health service consumers ~~[19, 20]. Studies have~~[19, 20]. Research has shown that preventive ~~health care~~healthcare services, which are essential for ~~all~~everyone, are ~~excessively~~disproportionately utilized by ~~people~~individuals with higher living standards than their counterparts.

# CONCLUSIONS

In Nepal, the distribution and use of health services ~~has~~have historically ~~been pro-rich.~~favoured the affluent sections of society. Health policies alone are ~~not adequate in tackling the~~ inadequate to tackle health-related ~~inequality~~inequalities and slow progress in ~~MNH~~maternal and neonatal health ~~in Nepal since the inequality in different socio-economic~~(MNH) because disparities in various socioeconomic characteristics ~~contribute~~lead to ~~the disparity in~~unequal access to health ~~service utilization. Despite the decreasing trend of~~services. Although health inequality~~, it~~ is ~~necessary to tackle the~~ declining, addressing income inequality ~~as well as inequalities~~and disparities in ~~the~~ health service determinants ~~which were found to have major contribution in creating~~ is crucial, as these significantly contribute to the gap between the rich and poor in terms of maternal and child health (MCH ~~services)~~ service utilization. ~~First, narrowing the gap in living standards of mothers~~It is essential ~~in addition to the current~~to narrow the gap in mothers' living standards alongside existing safe motherhood programs and health system strengthening ~~programs~~initiatives that have been ~~facilitating easy~~improving access to ~~better utilization of~~ health services. ~~Next~~Moreover, policies that ensure equitable access to higher education for ~~every mother as well as~~all mothers, coupled with awareness campaigns ~~catering her~~targeting family members~~,~~ can ~~be an effective measure to narrow down the gap~~effectively reduce disparities in health service utilization. Interventions that empower women and mothers can help ~~reduce the inequality~~diminish inequalities in enabling factors such as education and occupation~~,~~ which~~,~~ in turn, can ~~further have transitive effect in narrowing down~~positively impact the reduction of the health~~-~~ inequality gap in Nepal.

# WHAT WE CHANGED / WHY / RELEVANCE TO MEDICAL SCIENCES

| Change type | What our copyeditors did | Why it was needed | Why it matters in Medical Sciences |
|---|---|---|---|
| **Acronym clarity** | Ensured consistent first-use expansion + reuse of key acronyms (e.g., MCH, ANC, SBA, NDHS, MNH) across Abstract/Background/Conclusions. | Acronyms appeared early and repeatedly, but inconsistent first-use/recurrence can slow comprehension. | Medical/public-health reviewers expect acronyms to be introduced once, used consistently, and remain unambiguous for fast scanning. |
| **Statistics-heavy readability** | Restructured number-dense sentences so results read cleanly (comparators, determinants, and key findings separated for easier scanning). | Several sentences compressed many outcomes + indices + determinants in one run, making the narrative hard to follow on first read. | Quant-heavy sections are judged on clarity and interpretability; improved readability reduces reviewer friction and misinterpretation risk. |
| **Outcome definition consistency** | Tightened parallel wording for the three outcome measures and their time windows (e.g., "within two months of delivery/birth") to keep definitions consistent. | Minor variation in phrasing can create ambiguity about what exactly was measured. | In health research, outcome definitions must be precise and consistent for methods credibility and reproducibility. |
| **Evidence-** | Refined | Some statements | Overclaiming |

| | | | |
|---|---|---|---|
| **aligned interpretation (tone control)** | broad/policy-forward wording to be more cautious and journal-appropriate, while keeping the author's message intact. | read wider than the immediate evidence base and needed safer framing. | often triggers major revisions; evidence-matched tone improves acceptance chances and clinical/public-health credibility. |
| **American English + style consistency** | Standardised spelling/usage to American English and removed UK variants (e.g., "analyse" → "analyze"), maintaining a single house style. | The sample specifies American English, so mixed spelling signals inconsistency. | Consistent language norms increase professional polish and prevent "avoidable edits" during journal production. |
| **Number formatting + units** | Standardised numeric presentation (e.g., "per 1,000 live births") and long numeric sequences for readability and consistency. | Inconsistent number formats make results harder to scan and compare. | Reviewers often scrutinise numbers first; consistent formatting reduces confusion and improves perceived rigor. |
| **Punctuation + flow (signposting)** | Split/reshaped long sentences (especially in Conclusions) and improved signposting so key recommendations land clearly. | Long sentences can bury the "so what" and weaken the ending's impact. | Clear signposting helps editors/reviewers evaluate the contribution quickly and strengthens policy relevance without sounding rhetorical. |
| **Transparency (Track Changes +** | Delivered edits in Track Changes + Comments so | This sample is meant to demonstrate | Builds trust and speeds revisions especially in |

| Comments) | authors can see *what changed* and *why* at a glance. | editorial decisions, not just produce a clean file. | medical manuscripts where wording affects interpretation. |
|---|---|---|---|

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# THANK YOU

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