

# WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health

2014





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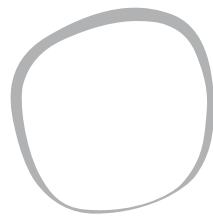
Various organizations were represented in the process by observers who provided valuable inputs, including Carolyn Blake of the Swiss Centre for International Health, Kim Dickson of the United Nations Fund for Children, Allisyn Moran of the United States Agency for International Development and Mesfin Teklu of World Vision.

WHO staff members involved included Annie Portela, Rajiv Bahl, Matthews Mathai, Shamim Ahmad Qazi, Nigel Rollins, Avni Amin, Metin Gülmezoglu, KC Tang, Rajat Khosla, Seipati Mothebesoane-Anoh, Gunta Lazdane and Martin Weber. Nicole Grillon was responsible for the administrative organization. Special thanks are offered to Susan L. Norris of the Guidelines Review Committee Secretariat who provided input through all phases of the process.

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Cicely Marston and Annie Portela wrote this report. Tina Miller and Cecilia Capello reviewed it. The GDG members, Rajiv Bahl, Cecilia Capello, Metin Gülmezoglu, Matthews Mathai, Tina Miller, Susan Norris and Amit Srivastava reviewed it.

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# Executive summary

In 2003 the World Health Organization (WHO) published *Working with individuals, families and communities to improve maternal and newborn health* (the IFC Framework) that promotes integrating the health promotion approach set out in the Ottawa Charter into national maternal and newborn health strategies. Ten years after the original framework was published, it is time to update the evidence for the key interventions and for community participation, using the methods set out by the WHO Guideline Review Committee. In June 2012 a steering group met for the first time to discuss the IFC Framework, propose priority research questions, define priority outcomes, and discuss methods for searching, retrieving, and synthesising the evidence likely to be available for the research questions.

The steering group identified 16 priority research questions, including the one that this guideline paper addresses: what are the impacts on MNH of community mobilization through facilitated participatory learning and action cycles with women's groups?

This guideline was developed with a guideline development group (GDG), made up of external participants. The first meeting of the GDG to review this recommendation was held in July 2013 at the WHO office in Geneva. The group did not reach a final recommendation, and instead requested more information from the researchers and the technical secretariat. A reduced number of GDG members held a second discussion via the web in November 2013 and agreed a final recommendation, summarized below.

## RECOMMENDATION SUMMARY

### Preamble

The GDG requested that the following text precede this recommendation as well as other recommendations that will be made in the broader set of guidelines on health promotion interventions for maternal and newborn health.

This intervention can be seen as applying human rights and community participation principles, which are recognized in a number of legal instruments and key WHO policy documents, and are considered within the IFC Framework and WHO strategies to be fundamental components of maternal and newborn health strategies. It is one of a number of interventions that take a human-rights-based approach, including those aiming to increase access to timely and appropriate health care, to address underlying determinants of health, to address gender and equity, and to achieve participatory processes. This guideline aims to inform country programmes about one of these interventions and the extent to which it contributes to improved maternal and newborn health.

The GDG advised that any intervention designed to increase access to health services should be implemented in tandem with strategies to improve health services. Where the quality of services is poor, women may understandably choose not to use them despite mobilization efforts.

Recommendation	Quality of Evidence	Strength of Recommendation
<p>Implementation of community mobilization through facilitated participatory learning and action cycles with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services.</p> <p>Implementation of facilitated participatory learning and action cycles with women's groups should focus on creating a space for discussion where women are able to identify priority problems and advocate for local solutions for maternal and newborn health.</p>	<p>MODERATE for newborn mortality;</p> <p>LOW for maternal mortality;</p> <p>LOW for care-seeking outcomes.</p>	<p>STRONG for newborn health</p>

**Remarks:**

Evidence about the positive effect of the intervention on newborn mortality was clearer than the evidence of its effect on maternal health and on care-seeking outcomes. More research is needed to improve our understanding of the effects on these other outcomes, and the effects in different contexts.

The GDG recommended that this intervention be implemented with close monitoring and evaluation to ensure high quality implementation, and with prior adaptation to the local context. Any intervention designed to increase access to health services should be implemented in tandem with strategies to improve health services. Where the quality of services is poor, women may understandably choose not to use them despite mobilization efforts.

The recommendation should be considered in conjunction with the implementation considerations indicated below.

**Considerations to be taken into account for implementation**

- To have an impact, the time period of the intervention should be no shorter than three years.
- There needs to be adequate coverage of the intervention in terms of density of groups in the population. There is some evidence that the intervention might be more successful where more than 30% of pregnant women participate, however the evidence at present is not definitive. The effect may also vary by context, e.g., may depend on prior existence, strength and cohesion of local social networks.
- High quality facilitators are key in establishing and maintaining groups and helping them to be effective; good training and support of facilitators is therefore essential.
- Although it is a 'community intervention', like any intervention at large scale, it must be supported by appropriate structures, systems and processes. For example, each facilitator should be responsible for no more than 8-10 groups per month to act effectively and resources must be in place to support this.
- Implementation should include awareness of the potential harms (gender violence, conflict with health providers or other community members, etc). Potential harms should be monitored throughout implementation so that they can be managed.

**The political/social context**

- Political support (national and local level) is essential.
- The intervention must be adapted to reflect each country's context, specific capacities and constraints.
- Implementing the intervention as part of national community health developmental strategies/plans or other community development structures is likely to enhance coverage and sustainability.
- The women's groups should not operate in isolation. To be effective they need the cooperation of the other social groups, e.g. recognizing the value of maternal and newborn health, providing responsive and accountable health services. Co-operation from non-health sectors may be crucial for implementing group plans e.g. road maintenance.

### Specific local factors that might be relevant to implementation

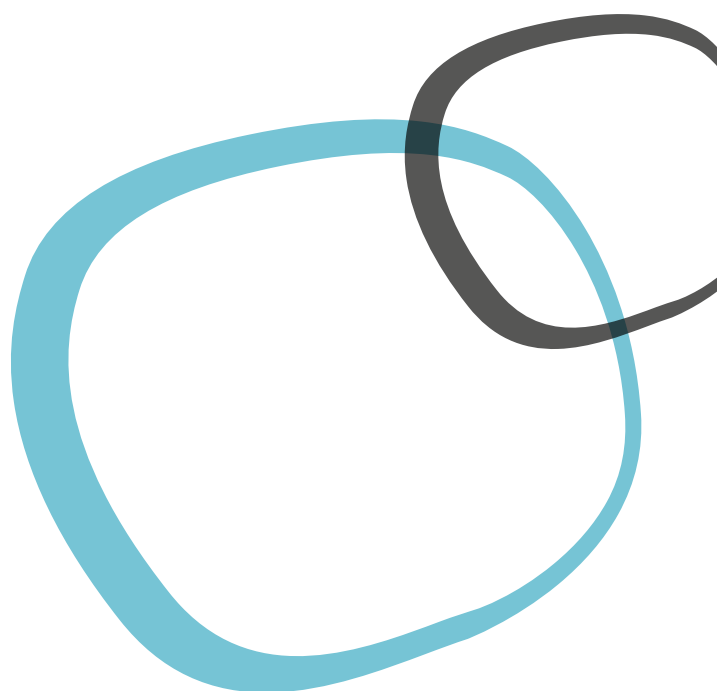
- History of participation in the communities, existence of other groups, local decision making structures and processes should be taken into account in design/implementation.
- Data are needed on local barriers and facilitators of implementation and acceptability of the intervention to women.
- Implementation should consider the role of men and other members of the community (e.g. religious groups, mothers-in-law) and how and when they participate in the process.
- The design of the process used with groups should be adapted according to the groups in question, e.g. accounting for levels of literacy/numeracy, preferences for oral versus visual methods, etc.
- Ethnic group mix, religion, caste and other social categories affecting group dynamics need to be considered in developing the approach (e.g. how and where groups are formed).

### RESEARCH GAPS

It would be useful to have more information about:

- this intervention in urban areas
- this intervention in conjunction with stronger quality improvement measures for health services and the impact on care-seeking behaviour
- participatory learning and action cycles with other population groups (i.e., men, grandmothers, etc.)
- additional non-health benefits
- potential harms of these types of interventions
- strategies to address potential tension with men in those contexts where there is sensitivity to women's gatherings or potential harms
- barriers and facilitators for implementation
- acceptability of the intervention to women
- whether or not the intervention causes an increased value to be placed on women by women themselves and by the broader society
- processes and quality (e.g. facilitation) of implementation
- whether or not a certain proportion of pregnant women need to participate in the groups in order for them to have an impact on maternal and newborn health
- sustainability, how long external inputs are required and processes for scaling-up

It was suggested that qualitative data, e.g. from process evaluations, could be synthesized. The synthesis might help answer some of the outstanding questions about this intervention.





# Background

In 2003 the World Health Organization (WHO) published *Working with individuals, families and communities to improve maternal and newborn health*<sup>1</sup> (the IFC Framework) that promotes integrating the health promotion approach set out in the Ottawa Charter<sup>2</sup> into national maternal and newborn health (MNH) strategies.

The IFC Framework was developed in response to analysis and global statements indicating that, as well as strengthening services, MNH strategies need to improve the capacity of individuals, families and communities to provide appropriate care for pregnant women, mothers, and newborns in the home. It also addresses the reasons – over and above what happens in clinical services – why women do not reach good quality skilled care during pregnancy, childbirth and after birth. Ottawa Charter health promotion components<sup>3</sup> were ‘translated’ into MNH programme language, and 12 promising interventions – identified through reviews of country experiences and the literature – were categorized into four priority

areas.<sup>4</sup> Community and intersectoral participation was recommended to guide implementation. Exact interventions to be adapted by country programmes were to be identified through local assessment, but the framework highlighted the need for interventions to address all four priority areas at the same time. All six WHO Regions integrated this guidance into the regional maternal mortality reduction strategies.

Ten years after the original framework was published, it is time to update the evidence for the key interventions and for community participation,<sup>5</sup> using the methods set out by the WHO Guideline Review Committee<sup>6</sup> and outlined below. Work is underway on the broader guidelines on health promotion interventions for MNH, and will be completed in 2014.

In addition to the key interventions identified in the original framework in 2003, the technical secretariat was open to emerging evidence on other related interventions. One specific question about the effectiveness of community mobilization through participatory learning and action cycles with women’s groups was added to the prioritized research questions. This was included because of the interest generated by research on this topic, including a published systematic review and meta-analysis of randomized controlled trials.<sup>7</sup>

<sup>1</sup> Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2003 ([http://www.who.int/maternal\\_child\\_adolescent/documents/who\\_fch\\_rhr\\_0311/en/index.html](http://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311/en/index.html), accessed 30 March 2014).

<sup>2</sup> <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>, accessed 30 March 2014. The Charter was developed in the first International Conference on Health Promotion, held in Ottawa in November 1986 and presents actions to achieve Health for All by the year 2000 and beyond.


<sup>3</sup> For brevity, ‘health promotion as set out in the Ottawa Charter’ will be referred to as ‘health promotion’ in the remainder of this document. “Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.” [First International Conference on Health Promotion, Ottawa, 21 November 1986].

<sup>4</sup> The four priority areas include: developing capacities to stay healthy and make healthy decisions; increasing awareness of the rights, needs, and potential problems related to MNH; strengthening linkages for social support and with the health services; improving quality of care from the women and community perspective; and the interactions of services with women, families and communities.

<sup>5</sup> Intersectoral participation is being addressed through work being carried out by the department of Non-Communicable Diseases.

<sup>6</sup> Handbook for guideline development. Geneva: World Health Organization; 2012 ([http://www.who.int/kms/guidelines\\_review\\_committee/en/](http://www.who.int/kms/guidelines_review_committee/en/), accessed 30 March 2014).

<sup>7</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women’s groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736–46. doi:10.1016/S0140-6736(13)60685-6.



This report summarizes the final recommendation and the process for developing the guideline on the effectiveness of community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. That process included the discussions and conclusions of the Guideline Development Group held from 29 to 31 July 2013<sup>8</sup> at the WHO office in Geneva and in a virtual meeting held on 5 November 2013.

#### OBJECTIVE OF THE GUIDELINE

To provide a summary of the evidence found on the effectiveness of community mobilization through facilitated participatory learning and action cycles with women's groups in improving MNH outcomes.

#### TARGET AUDIENCE

The primary audience for this guideline is health programme managers, including governmental and non-governmental organizations, and policy makers who are responsible for designing maternal, newborn and child health programmes, primarily in low-income settings. The guideline is also aimed at health providers and teaching institutions, to increase knowledge of interventions important for: (i) improving maternal and newborn health; (ii) improving the care provided within the household by women and families; (iii) increasing community support for maternal and newborn health; and (iv) increasing access to, and use of, skilled care. Development programmes and organizations supporting women's empowerment and rights will also find this guideline of use.

#### QUESTION

What are the impacts on MNH of community mobilization through facilitated participatory learning and action cycles with women's groups?

#### POPULATION OF INTEREST

Women of reproductive age (15-49) and newborns in low- and middle-income settings.

#### INTERVENTION

Community mobilization through facilitated participatory learning and action cycles with women's groups. This involves a four phase participatory process facilitated by a trained facilitator, in which women's groups collectively decide priority actions, and try to organize activities accordingly. The cycle is structured as follows: Phase 1: identify and prioritize problems during pregnancy, childbirth and after birth; Phase 2: plan activities; Phase 3: implement strategies to address the priority problems; Phase 4: assess the activities.<sup>9</sup>

#### COMPARATOR

No intervention or an intervention with other measures to increase access to care.

#### CRITICAL OUTCOMES

The critical health outcomes considered were *antenatal care use, institutional birth and birth with a skilled attendant*. Important outcomes were *maternal mortality and neonatal mortality*.

<sup>8</sup> The report of the meeting held in July 2013 can be requested from the WHO Department of Maternal, Newborn, Child and Adolescent Health (WHO/MCA) at [mncah@who.int](mailto:mncah@who.int).

<sup>9</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736-46. doi:10.1016/S0140-6736(13)60685-6.

# Methods



## THE GUIDELINE DEVELOPMENT PROCESS

This guideline was developed using standard operational procedures in accordance with the process described in the WHO *Handbook for guideline development*. The process includes: (i) identifying critical questions and critical outcomes; (ii) evidence retrieval; (iii) assessing and synthesising evidence; (iv) formulating recommendations; and (v) planning for dissemination, implementation, evaluation, and updating the guideline.

## TECHNICAL GROUPS

Two technical groups were formed to support the development of the MNH health promotion guidelines, including this guideline:

### Steering group


- from the Department of Maternal, Newborn, Child and Adolescent Health (WHO/MCA): Annie Portela, Rajiv Bahl, and Matthews Mathai
- from the Department of Reproductive Health and Research (WHO/RHR): Avni Amin and Metin Gülmezoglu
- from the Department of Prevention of Non communicable Diseases (WHO/PND): KC Tang
- from the Department of Gender, Equity and Human Rights (WHO/GER): Rajat Khosla
- from the WHO Regional Offices: Seipati Mothebesoane-Anoh (Regional office of Africa), Gunta Lazdane (Regional Office of Europe) and Martin Weber (Regional Office of South-East Asia)
- Technical adviser to WHO: Cicely Marston of the London School of Hygiene and Tropical Medicine (LSHTM)

### Guideline development group (GDG)

This larger group is made up of international stakeholders and experts, including specialists in health promotion, gender and equity, community mobilization, health education and MNH programmes and service delivery. The group is responsible for developing recommendations, deciding on the strength of the recommendations and assessing the strength of the evidence supporting the recommendations.

The following external experts served as GDG members for this recommendation: Mike Mbizvo (GDG chair) and David Houeto (African Region); Asha George, Lisa Howard-Grabman and Raul Mercer (Region of the Americas); Omrana Pasha (Eastern Mediterranean Region); Isabelle Cazottes, Ernestina Coast/Eleri Jones and Lars Äke Persson (European Region); Rachmalina Soerachman (South-East Asia Region); Jessica Davis (Western Pacific Region).

According to WHO regulations, all external advisers must declare their relevant interests before participating in WHO meetings. All GDG members were required to complete a declaration of interest form before the meeting, which was reviewed by WHO staff. The GDG members also verbally declared interests including intellectual and potential conflicts of interest. No participants had commercial or financial interests to declare however most indicated that they were involved in academic, programmatic or intellectual work directly related to the topics of the meeting. Full participation in the GDG meeting discussions was deemed appropriate for all, with the following exceptions in view of the recommendation to be made: two participants (Anthony Costello and Audrey Prost) were principal investigators of the supporting research as well as the main authors of the meta-analysis and systematic review used as the basis of the evidence. For this reason it was agreed they would not participate in the recommendation



decision or in any voting deemed necessary to reach consensus. Mesfin Teklu was also asked to participate as an observer in light of ongoing discussions about how, if a recommendation were to be made, World Vision might support WHO work in developing a module on community mobilization through women's groups. Other organizations represented in the process by observers include Carolyn Blake of the Swiss Centre for International Health, Kim Dickson of the United Nations Fund for Children, Allisyn Moran of the United States Agency for International Development.

#### IDENTIFYING PRIORITY QUESTIONS AND OUTCOMES

Members of the steering group met to discuss the WHO IFC Framework, propose a list of priority research questions, define priority outcomes, and discuss methods for searching, retrieving, and synthesising the health promotion evidence likely to be available. External experts who participated included Belinda Burford, independent consultant; Lisa Howard-Grabman (Training Resources Group, Inc.); and Carlo Santarelli (Enfants du Monde), as well as Cicely Marston of LSHTM.

The group agreed that the critical outcomes for the interventions identified for all of the health promotion for MNH guidelines, including community mobilization activities, were care-seeking with a skilled attendant at birth or institutional birth, as well as care-seeking during pregnancy and after birth for the woman and newborn. Important outcomes were measured include maternal mortality and morbidity and newborn mortality and morbidity. The rationale is that these interventions are designed to impact on care-seeking or on care practices in the home and so care-seeking is a more direct measure of their effect. The major determinant in mortality and morbidity reduction, by contrast, would be quality of care in the facility and the ability of the services to respond to need, which are not directly addressed by the interventions of interest.

#### The body of evidence

Evidence was provided through three main sources, all produced by linked research groups<sup>10</sup>:

- A published systematic review and meta-analysis of randomized controlled trials of women's groups practising participatory learning and action.<sup>11</sup> Seven trials conducted in Bangladesh, India, Malawi and Nepal were included in the systematic review.
- An additional unpublished meta-analysis of secondary outcomes (institutional birth, birth with a skilled attendant, any antenatal care, recommended number of antenatal care visits) was carried out by Tim Colburn and Audrey Prost of University College London. This used the same methods as the original review and was conducted at the request of WHO.
- At the request of WHO, an additional background document detailing the context and conditions in which the seven trials were conducted was produced by members of the same research group (Rosato, Prost and Costello, unpublished). This document highlighted factors that influence implementation and outcomes and was updated following the July meeting and a request by the GDG to address more explicitly the potential harms and benefits, and the implementation process in two sites.<sup>12</sup>

An independent external review of the studies was summarized by Cicely Marston. This included her comments, those of John Cleland, and a summary of a published commentary by Bahl and Kirkwood.<sup>13</sup> Julian Higgins subsequently provided an additional review of the evidence.

<sup>10</sup> The seven studies included in the meta-analysis were conducted and published by members of the same team that also conducted the systematic review and meta-analysis.

<sup>11</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736–46. doi:10.1016/S0140-6736(13)60685-6.

<sup>12</sup> The Rosato et al document is available upon request from WHO/MCA at [mncah@who.int](mailto:mncah@who.int).

<sup>13</sup> Kirkwood B, Bahl R. Can women's groups reduce maternal and newborn deaths? *Lancet*. 2013;381(9879):e12–4. doi: 10.1016/S0140-6736(13)60985-X.

The systematic reviews, meta-analyses, and GRADE<sup>14</sup> profiles all followed the methods recommended by the WHO Guidelines Review Committee. Naira Kalra conducted the assessment of the evidence which was reviewed by Belinda Burford, Cicely Marston and Annie Portela.

**Assessing the evidence**

The GRADE approach for assessing and grading the quality of evidence was used. In this approach, quality of the set of included studies reporting results for a specific outcome is graded as high, moderate, low or very low. The quality grade summarises the extent to which one can be confident that the pooled estimate of effect size in the studies reflects the true effect (see Appendix 2). The following criteria were used to assess quality:

- What study design was used? For instance, individual or cluster randomised, controlled trials (RCTs); observational studies.

- What is the overall risk of bias for the group of studies under consideration? To assess this, the following are examined: allocation concealment in RCTs; comparability of groups in observational studies; risk of measurement bias (e.g. use of blinding, use of objective outcomes); extent of loss to follow-up; appropriateness of analysis (e.g. intention to treat, adjustment for cluster randomization in cluster RCTs, adjustment for confounding in observational studies).
- Consistency: are the studies consistent? Are results similar across the set of available studies? (e.g. did most studies show meaningful benefit or did some show benefits and others harm? Were benefits of similar magnitude in the different studies?).
- Precision: how precise is the pooled estimate for the studies? Does the estimate have wide confidence intervals?
- Directness: do included studies evaluate interventions relevant to the question of interest?

**Table 1 Levels of evidence summarized**

Level of evidence	Summary
High	Further research is very unlikely to change confidence in the estimate of effect.
Moderate	Further research is likely to have an important impact on confidence in the effect.
Low	Further research is very likely to have an important impact on estimate of effect and is likely to change the estimate.
Very low	Any estimate of effect is very uncertain.

**Formulation of the recommendation**

The recommendation is based on the evidence summaries, the Rosato et al context and conditions paper, the GRADE tables and information on benefits and risks, values and preferences, and costs which were presented to the GDG at a meeting held in WHO Headquarters in Geneva, Switzerland in July 2013. The GDG reviewed and discussed this information and deliberated over the wording of the recommendation. To facilitate the discussion, the WHO team had produced various draft recommendations for the participants to review. A worksheet with the draft of different wording options for the recommendation was distributed to allow individual GDG members to indicate which version they supported and to suggest any modifications. These sheets were compiled and discussed by the group. Remarks or considerations for implementation as well as research gaps were also indicated on the worksheets.

The GDG did not agree on a final recommendation for the community mobilization intervention at the July meeting, and instead requested more information from the researchers and technical secretariat. That information was prepared and presented at a virtual meeting held by Web-Ex in November 2013 with a reduced number of GDG participants, as some were not available.

Group consensus was used to reformulate the proposed draft recommendation. The definition of group consensus that applied was that the majority agreed and those that disagreed did not have any strong objections. To reiterate, the primary authors of the systematic review, observers, WHO staff and the external staff involved in the collection and grading of the evidence participated in the discussions but were not eligible to participate in the decision on the final recommendation.

In deciding on the strength of the recommendations, the GDG used the assessment criteria described in Table 2.

<sup>14</sup> GRADE – Grading of Recommendations Assessment, Development and Evaluation - a system for assessing the quality of evidence.



**Table 2 Assessment criteria for the strength of the recommendation**

Strength of recommendation	Rationale
Strong	The guideline development group is confident that the desirable effects of adherence to the recommendation outweigh the undesirable effects.
Weak	The guideline development group concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects. However, the recommendation is only applicable to a specific group, population or setting OR where new evidence may result in changing the balance of risk to benefit OR where the benefits may not warrant the cost or resource requirements in all settings.
No recommendation	Further research is required before any recommendation can be made.

The final recommendations and meeting reports were reviewed by the WHO steering group and the GDG members. Once approved, the WHO Guideline Review Committee and two peer reviewers reviewed the draft guideline document and provided feedback. The steering group reviewed the comments and made appropriate modifications, respecting where needed the decisions of the GDG.

#### REVIEW AND UPDATE OF THE RECOMMENDATIONS

These recommendations will be updated after five years as more evidence becomes available. WHO and partners intend to seek funds to develop protocols and support research to address the evidence and information gaps identified by the GDG.

#### PLANNED DISSEMINATION OF GUIDELINES

WHO/MCA has developed a plan to disseminate the recommendation put forward here. The immediate plan is to distribute the guideline to WHO regional and country offices and key partners and to place them on the web. Second, a steering committee will be formed to support the development of an intervention module on community mobilization using methods for participatory learning and action. This will focus on mobilizing actions by women and community groups to improve maternal, newborn and child health as part of the WHO and UNICEF package “Caring for the newborn and child in the community”.



# Evidence and recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health



## INTRODUCTION

The pathways of influence of this complex intervention can be difficult to assess. Through a participatory process facilitated by a trained facilitator, women's groups decide priority actions, and try to organize activities accordingly. While there is detailed information available about how to run group successfully, there was little information on how these groups might affect the critical and important outcomes examined here. Clearly activities will be prioritized differently and will have different effects depending on local contexts and conditions.

Complexity itself is not necessarily a problem – maternal and newborn health depends on a web of influences, which may well be better addressed by an intervention that embraces complexity than by one following an overly simplistic agenda. The likely different characteristics of women's groups in different locations may help explain the high statistical heterogeneity found in the meta-analysis (see below). The pathways linking women's groups in such diverse groups of people in geographically disparate locations to reduced maternal and neonatal mortality remain relatively unexplored in terms of what actually occurred on the ground in those locations. The intervention explicitly aims to change social structures but there were few data available about whether and how social norms and social change had been achieved in practice. The diversity of experience has the potential to provide very rich data to inform future interventions and further information about the individual studies.

## SUMMARY OF EVIDENCE

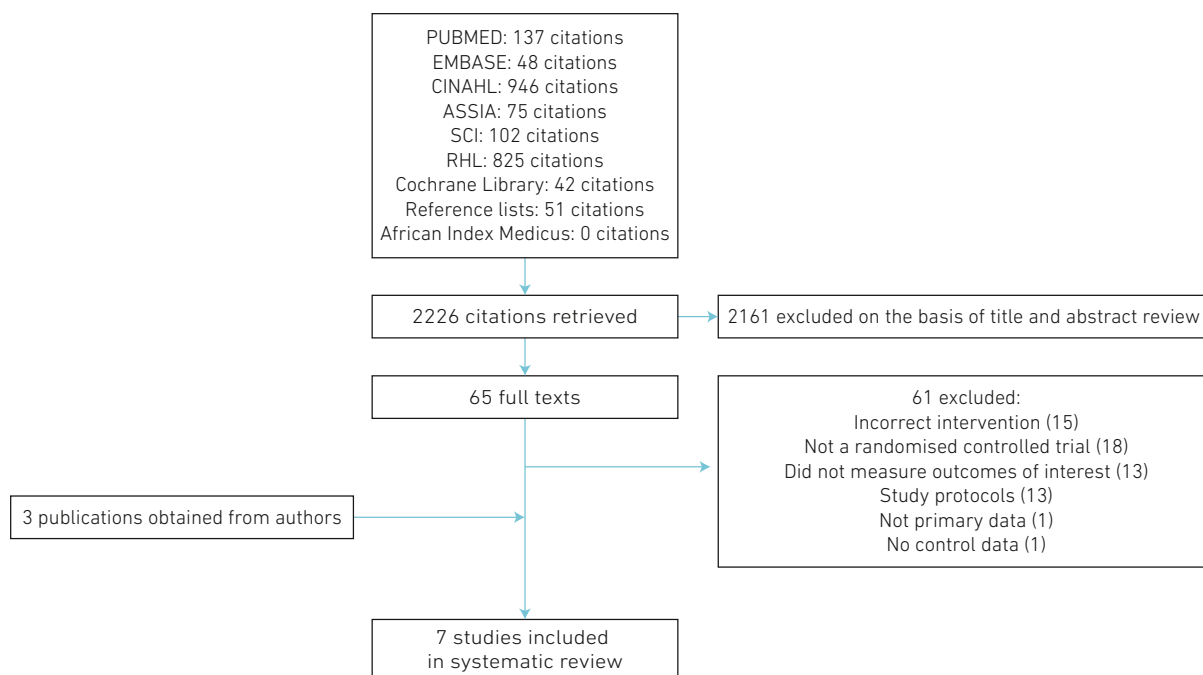
Seven studies met the inclusion criteria and were included in the final analysis (see Figure 1). The studies were from Nepal,<sup>15</sup> India,<sup>16</sup> Bangladesh,<sup>17</sup> and Malawi.<sup>18</sup> In their published meta-analysis,<sup>19</sup> Prost et al divided the studies into 'high coverage' (>30% of pregnant women in the intervention area reached by the intervention) and 'low coverage' trials (the other studies) for some analyses. We retain the terminology here.

- <sup>15</sup> Manandhar DS, Osrin D, Shrestha BP, Mesko N, Morrison J, Tumbahangphe KM et al. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: a cluster-randomised controlled trial. *Lancet*. 2004;364(9438):970–9.
- <sup>16</sup> Tripathy P, Nair N, Barnett S, Mahapatra R, Borghi J, Rath S et al. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *Lancet*. 2010;375(9721):1182–92. doi:10.1016/S0140-6736(09)62042-0.; More NS, Bapat U, Das S, Alcock G, Patil S, Porel M et al. Community mobilization in Mumbai slums to improve perinatal care and outcomes: a cluster randomized controlled trial. *PLoS Med*. 2012;9(7):e1001257. doi:10.1371/journal.pmed.1001257.
- <sup>17</sup> Azad K, Barnett S, Banerjee B, Shaha S, Khan K, Rego AR et al. Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial. *Lancet*. 2010; 375(9721):1193–202. doi:10.1016/S0140-6736(10)60142-0.; Fottrell et al unpublished manuscript (published version not available at time of Julu meeting), now published as Fottrell E, Azad K, Kuddus A, Younes L, Shaha S, Nahar T et al. The effect of increased coverage of participatory women's groups on neonatal mortality in Bangladesh: a cluster randomized trial. *JAMA Pediatr*. 2013;167(9):816–25. doi:10.1001/jamapediatrics.2013.2534.
- <sup>18</sup> Lewycka S, Mwansambo C, Rosato M, Kazembe P, Phiri T, Mganga A et al. Effect of women's groups and volunteer peer counselling on rates of mortality, morbidity, and health behaviours in mothers and children in rural Malawi (MaiMwana): a factorial, cluster-randomised controlled trial. *Lancet*. 2013;381(9879):1721–35. doi:10.1016/S0140-6736(12)61959-X.; Colbourn T, Nambiar B, Bondo A, Makwenda C, Tsetekani E, Makonda-Ridley A et al. Effects of quality improvement in health facilities and community mobilization through women's groups on maternal, neonatal and perinatal mortality in three districts of Malawi: MaiKhanda, a cluster randomized controlled effectiveness trial. *Int Health*. 2013;5(3):180–95. doi: 10.1093/inthealth/ iht011.
- <sup>19</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736–46. doi:10.1016/S0140-6736(13)60685-6.

In total, 68 potential studies were reviewed, 65 identified through database searches and three obtained from investigators, which examined interventions with participatory women's groups in low- and middle-income countries. The four criteria for

inclusion were that they were RCTs, the intervention contained the stages of a participatory learning and action cycle; most of the participants were women aged 15–49 years; study outcomes included maternal mortality, neonatal mortality and stillbirths.<sup>20</sup>

**Figure 1** Items retrieved in searches



In the July meeting held at WHO, the GDG requested that the researchers provide more information about how the programme functioned in at least two sites. The context and conditions paper prepared by Rosato et al was updated for the November discussion to provide this additional detail for two sites (India and Malawi) including: the sequence of discussion topics in the women's groups meetings, priority problems identified by women, and priority actions identified and implemented.

### Care-seeking outcomes

The unpublished meta-analysis by Prost et al. of non-mortality outcomes (using the same methods as their published meta-analysis<sup>21</sup>) found no evidence of an effect of the intervention with women's groups

on the odds of giving birth in an institution or with a skilled attendant. There was also no effect on use of antenatal care (receiving any/receiving recommended number of visits).

The following outcomes (not pre-defined as of interest for this process) were also reported: there was no effect of the women's groups on birth attendants washing their hands during births at home, but evidence of an effect on the use of clean delivery kits during childbirth at home (OR: 2.11, 95% CI: 1.14 - 3.08),<sup>22</sup> and on breastfeeding practices, including breastfeeding within one hour of birth (OR: 1.15, 95% CI 1.05 -1.25) and exclusive breastfeeding for the first 4-6 weeks of life (OR: 1.07, 95% CI: 1.01 -1.14).

Evidence for care-seeking outcomes was graded as 'low' to 'very low' quality.

### Maternal mortality

There was a reduction in maternal mortality with confidence intervals close to 'no effect' (OR: 0.63, 95% CI: 0.32-0.94). It would be expected that better access to skilled care would be a key driver of decline in mortality but there is no evidence that this occurred (e.g. through better awareness of danger signs, availability

<sup>20</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736–46. doi:10.1016/S0140-6736(13)60685-6.

<sup>21</sup> Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. Women's groups practising participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *Lancet*. 2013;381(9879):1736–46. doi:10.1016/S0140-6736(13)60685-6.

<sup>22</sup> OR = odds ratio, 95% CI = 95% confidence interval

of funds and transport). Also only two out of the four high-coverage trials (studies where >30% of pregnant women in the intervention area were reached by the intervention) showed an effect on maternal mortality. One was in Nepal, where 13 deaths were observed in total (and 2 in intervention areas). With such small numbers, a question was raised about whether normal statistical methods were appropriate. The other was in the MaiMwana study in Malawi, where, as Kirkwood and Bahl have noted,<sup>23</sup> the results of the post-hoc analysis are puzzling because although they record an impact in women's group only areas, they record a lack of impact in areas where they were testing women's groups plus a peer counselling intervention. The MaiMwana study authors suggest that possible baseline differences in the groups might help explain this (e.g. more urbanized population, making the interventions more difficult to implement, or more remote from health facilities) yet educational and occupational profiles in the dual and single intervention clusters are similar, as are the proportion of births in a health facility or attended by a skilled attendant. It was considered difficult to reach any firm conclusions about this particular trial, pending further explanation of this conundrum.

The evidence for maternal mortality was graded as 'low'.

### Neonatal mortality

There was a reduction in neonatal mortality (OR: 0.77, 95% CI: 0.65-0.90). The impact of the women's group intervention was considered plausible for neonatal mortality as other evidence suggests that improvements in home births and essential care of the newborn can reduce deaths. All four high-coverage trials (where >30% of pregnant women in the intervention area were reached by the intervention) report effects on this outcome. As noted above, evidence of behavioural pathways leading towards reduced neonatal deaths is not clear but there was increased use of home delivery kits and improved breastfeeding practices.

The evidence for neonatal mortality was graded as 'moderate'. One of the reasons for this grade was that most of the work was conducted in rural areas, making it potentially difficult to apply to other areas.

If the recommendation were to focus on rural areas, the GRADE for the relevant evidence would be modified. The evidence for rural areas alone was direct and consistent – the indirectness and inconsistency that resulted in lowering GRADE were introduced by the urban study. The group considered there was insufficient information from urban settings, and it is possible that the intervention could have different effects in urban versus rural areas. Nonetheless, the group expressed its preference not to make

the recommendation for rural areas only because urban areas can also experience poor access and marginalization. The GDG did recommend that more research be carried out in urban areas.

### BALANCE OF BENEFITS AND HARMS

For the July meeting, little information was available about potential harms; participants felt that this was important particularly as other actors and groups could feel challenged. One GDG member cited a study in Bangladesh<sup>24</sup> that showed an initial increase in domestic violence, which later decreased. Some GDG members cautioned that because the Bangladesh study was about micro credit programmes, this might have introduced an additional layer of norms or gender power relations to address. GDG members noted that additional literature exists on the topic. Participants also noted that non-health benefits may not have been clearly enumerated. The GDG requested that the Rosato et al paper be revised to include additional information on potential harms and benefits. This was added and shared for the November meeting.

### VALUES AND PREFERENCES

The GDG indicated they expected the intervention would vary in different settings and that women's groups, as a social, context-specific intervention might not be appropriate in all settings. The Rosato et al. paper notes that in some contexts women's participation was limited by gender norms, religious values, and time pressures. A careful context analysis should precede any introduction, which should take into account any existing groups, political structures, research gaps and other considerations.

### RESOURCE USE

It is difficult to assess the costs of the intervention. Cost data are available in Prost et al., however costs depend on context, and in this case any costing must also take into account the facilitators' time, and how they are trained and supervised – elements all considered key to the quality of implementation and the success of the intervention. The systematic review reported a wide range of costs in different settings, from \$2770 in India to \$22 961 in Nepal per newborn life saved.

### GDG NOTE ON APPROPRIATENESS OF GRADE FOR THIS TYPE OF INTERVENTION

The group noted that they were uncomfortable with the GRADE terminology (e.g. 'low' quality). They also questioned the applicability of GRADE in assessing health promotion interventions where context would

<sup>23</sup> Kirkwood B, Bahl R. Can women's groups reduce maternal and newborn deaths? *Lancet*. 2013;381(9879):e12-4. doi: 10.1016/S0140-6736(13)60985-X.

<sup>24</sup> Ahmed SM. Intimate partner violence against women ; experiences from a woman-focused development programme in Matlab, Bangladesh. *J Health Popul Nutr*. 2005;23(1):95-101.

always be expected to play a significant role in modifying effect sizes – for instance, size of effect would be expected to vary with existing levels of mortality and with social dimensions, so a precise estimate of effect is unlikely ever to be available, and the GRADE will almost inevitably therefore result in “low” grades for this type of intervention. They questioned the usefulness of RCT evidence alone for such a complex intervention, and called for qualitative evidence to help understand the diverse strategies of the groups and how they might have affected outcomes. They noted, however, the guidance provided by WHO indicated they should distinguish between the assessment of quality of the body of evidence and the strength of the recommendation – they should make their recommendations and justify or explain any recommendation that they felt differed from what the GRADE may reflect.

## CONCLUSION

No effects were shown of the intervention on the critical outcomes (institutional birth, birth with a skilled attendant, receiving the recommended number of antenatal care visits). Some effects of the intervention were measured on the important outcomes: decreased neonatal mortality and decreased maternal mortality. There was no effect measured on the remaining important outcomes (still births, receiving any antenatal care).

In July, the GDG found it difficult to formulate the recommendation. Women’s groups appear to contribute to improved maternal and newborn health, but the pathways and mechanisms through which this occurs are not clear. The GDG recognized that pathways will not necessarily be direct and can be complex. The group noted that there were likely to be positive effects of women’s groups over and above their effects on the measured outcomes. The fact that women in a group can share concerns is important. The women’s groups may create an “enabling environment” that empowers women but this is difficult to demonstrate empirically and was not measured in the research presented. An enabling environment may also involve expression of and demand for fundamental human rights, such as the right to be informed about services, to access quality care, to be treated with dignity, to be protected from violence, etc. If relevant changes occurred, they should be confirmed with supporting documentation from the research.

The group did not agree on a final recommendation in the July meeting for the reasons given in the sections above: lack of information on harms and on additional possible benefits beyond direct health benefits, and on how the intervention operates in practice. The researchers were asked to provide further information to address these points. The technical secretariat was also asked to revisit the GRADE table based on

additional information discussed in the meeting. The additional information was prepared and presented at the November meeting.

The group did not wish to limit the recommendation to rural settings (see table below). Moreover, they requested a strong statement on the need to address health services improvement in tandem with the intervention, the importance of monitoring and evaluation to ensure the quality of the intervention, and a list of implementation considerations and identified research gaps. The group also asked that an overarching statement be formulated to accompany the recommendation, to position it in terms of participation as a human right and a fundamental component of a health strategy. These guidelines are not intended to question the principle of participation in health programmes, but to shed light on its effects in practice.

The GDG speculated that the intervention might particularly benefit people in marginalized communities, or where women had low status, low access to care or lower levels of education. They also suggested that the intervention would require a minimum period of three years to take effect, and that a certain level of coverage was important to have impact. The group agreed that because quality of implementation is key to intervention effectiveness, any recommendation should be accompanied by a caution on implementation, including that it should take account of the specific context and health system. Strong links to the health services should also be established.

## FINAL RECOMMENDATION

### Preamble

This intervention can be seen as applying human rights and community participation principles, which are recognized in a number of legal instruments and key WHO policy documents, and are considered within the IFC Framework and WHO strategies to be fundamental components of maternal and newborn health strategies. Various interventions have been implemented which take a human-rights-based approach, including those aiming to increase access to timely and appropriate health care, to address underlying determinants of health, to address gender and equity, and to achieve participatory processes. This guideline aims to inform country programmes about one of these interventions and the extent to which it contributes to improved maternal and newborn health.

The GDG advised that any intervention to increase access to health services should be implemented in tandem with strategies to improve the quality of health services. Where the quality of services is poor, women may understandably choose not to use them despite mobilization efforts.

## Recommendation

Implementation of community mobilization through facilitated participatory learning and action cycles with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services.

Implementation of facilitated participatory learning and action cycles with women's groups should focus on creating a space for discussion where women are able to identify priority problems and advocate for local solutions for maternal and newborn health.

**Population:** Women of reproductive age (15-49) and newborns in low and middle-income countries

**Intervention:** Participatory learning and action with women's groups

**Comparator:** No intervention or intervention with other measures to increase access to care

Factor	Decision	Explanation
<p><b>Quality of the evidence</b></p> <p>(The higher the quality of the evidence, the more likely a strong recommendation is warranted.)</p>	<p>MODERATE for newborn mortality; LOW for maternal mortality; LOW for care-seeking outcomes.</p>	<p>We have moderate confidence in the effect estimate for neonatal mortality; our confidence in the effect estimate is limited for maternal mortality and care-seeking outcomes.</p> <p>Notes: The decision with respect to mortality estimates was 'downgraded' owing to indirectness of the evidence. This was because six of the seven studies in the meta-analysis were undertaken in rural settings, with only one trial assessing the intervention in an urban setting. If these recommendations were to focus only on rural areas, the decision for all of the mortality outcomes would be upgraded accordingly. There is some evidence that the intervention might be more successful where the groups were composed of more than 30% of pregnant women. However the evidence at present is not definitive. While the explanation is plausible, the association may have arisen by chance.</p>
<p><b>Balance of benefits versus harms and burdens</b></p> <p>(The larger the difference between the benefits and harms, the more likely a strong recommendation is warranted. The smaller the net benefit and the lower the certainty for that benefit, the more likely a conditional recommendation is warranted.)</p>	<p>Benefits outweigh harms</p> <p>Note: Three members of the GDG indicated their preference to say benefits clearly outweigh harms.</p>	<p>In addition to improved newborn health and improved newborn care practices, e.g. breastfeeding (which were not GRADED), a background document prepared by Rosato et al sets out additional perceived benefits reported in programme areas. These include increased community openness and concern about women's and children's health, increased community capacity to address health problems, and strengthened linkages between communities, frontline workers and health services.</p> <p>Potential harms identified in the Rosato et al document include tensions with men who felt excluded, and conflict among community members and the health service, particularly in the case when ambitious strategies were identified and not fully implemented.</p> <p>An article shared from Bangladesh (Ahmed 2005) describes how breaking traditional norms and behaviours ascribed to women did increase domestic violence in the initial stages, but this reduced over time. The authors attribute this to various social processes, including development of women's skills and men's changing views. Some GDG members cautioned that because the Bangladesh study was about micro credit programmes, this may introduce an additional layer of norms or power to address. GDG members noted that additional literature exists on the topic. The key point, however, is that potential harms should be monitored throughout implementation so that they can be managed.</p> <p>Finally, GDG members indicated that the full range of benefits or harms are rarely measured, and that documenting both more adequately would be important for future research.</p>

Factor	Decision	Explanation
<p><b>Values and preferences</b></p> <p>(The greater the variability or uncertainty in values and preferences, the more likely a conditional recommendation is warranted.)</p>	Some variability	<p>In some contexts women's participation was limited because of prevailing gender norms, religious values, and time constraints.</p> <p>Consideration of the political systems and processes are important. As mentioned above, in some contexts men supported women participating, in others they did not. Women themselves in many cases often reported that they valued participating while in others, they mentioned time constraints or other pressures.</p> <p>The GDG noted the importance of recognising that people's attitudes about the value of participation may change over time. Increasing the value given to participation within the community might be an end in itself.</p>
<p><b>Resource use</b></p> <p>(The higher the costs of an intervention, that is, the more resources consumed, the more likely a conditional recommendation is warranted.)</p>	N/A	<p>Cost data are available in Prost et al. Costs depend on context, and in this case, any costing must take into account facilitators' time, and how they are trained and supervised – elements all considered key to the quality of implementation and the success of the intervention. The systematic review reported a wide range of costs in different settings, from \$2'770 in India to \$22'961 in Nepal per newborn life saved.</p>

**Overall strength of the recommendation:** Strong for newborn health

**Remarks:**

Evidence about the positive effect of the intervention on newborn mortality was clearer than the evidence of its effect on maternal health and on care-seeking outcomes. More research is needed to improve our understanding of the effects on these other outcomes, and the effects in different contexts.

The GDG recommended that this intervention be implemented with close monitoring and evaluation to ensure high quality implementation, and with prior adaptation to the local context. Any intervention designed to increase access to health services should be implemented in tandem with strategies to improve health services. Where the quality of services is poor, women may understandably choose not to use them despite mobilization efforts. The recommendation should be considered in conjunction with the implementation considerations indicated below.

**Considerations to be taken into account for implementation**

- To have an impact on health outcomes, the time period of the intervention should be no shorter than three years.
- There needs to be adequate coverage of the intervention in terms of density of groups in the population. There is some evidence that the intervention might be more successful where more than 30% of pregnant women participate, however the evidence at present is not definitive. The effect may also vary by context, e.g., may depend on prior existence, strength and cohesion of local social networks.
- High quality facilitators are key in establishing and maintaining groups and helping them to be effective; good training and support of facilitators is therefore essential.
- Although it is a 'community intervention', like any intervention at large scale, it must be supported by appropriate structures, systems and processes. For example, each facilitator should be responsible

for no more than 8-10 groups per month to act effectively and resources must be in place to support this.

- Implementation should include awareness of the potential harms (gender violence, conflict with health providers or other community members, etc). Potential harms should be monitored throughout implementation so that they can be managed.

**The political/social context**

- Political support (national and local level) is essential.
- The intervention must be adapted to reflect each country's context, specific capacities and constraints.
- Implementing the intervention as part of national community health developmental strategies/plans or other community development structures is likely to enhance coverage and sustainability.
- The women's groups should not operate in isolation. To be effective they need the cooperation of the other social groups, e.g. recognizing the value of maternal and newborn health, providing responsive



and accountable health services. Co-operation from non-health sectors may be crucial for implementing group plans e.g. road maintenance.

### **Specific local factors that might be relevant to implementation**

- History of participation in the communities, existence of other groups, local decision making structures and processes should be taken into account in design/implementation.
- Data are needed on local barriers and facilitators of implementation and acceptability of the intervention to women.
- Implementation should consider the role of men and other members of the community (e.g. religious groups, mothers-in-law) and how and when they participate in the process.
- The design of the process used with groups should be adapted according to the groups in question, e.g. accounting for levels of literacy/numeracy, preferences for oral versus visual methods, etc.
- Ethnic group mix, religion, caste and other social categories affecting group dynamics need to be considered in developing the approach (e.g. how and where groups are formed).

### **RESEARCH GAPS**

It would be useful to have more information about:

- this intervention in urban areas
- this intervention in conjunction with stronger quality improvement measures for health services and the impact on care-seeking behaviour
- participatory learning and action cycles with other population groups
- additional non-health benefits
- potential harms of these types of interventions
- strategies to address potential tension with men in those contexts where there is sensitivity to women's gatherings or potential harms
- barriers and facilitators for implementation
- acceptability of the intervention to women
- whether or not the intervention causes an increased value to be placed on women by women themselves and by the broader society
- processes and quality (e.g. facilitation) of implementation
- whether or not a certain proportion of pregnant women need to participate in the groups in order for them to have an impact on maternal and newborn health
- sustainability, how long external inputs are required and processes for scaling-up

It was suggested that qualitative data, e.g. from process evaluations, could be synthesized. The synthesis might help answer some of the outstanding questions about this intervention.



## Appendix 1: List of participants in the November and July meetings

### Meetings of the Guideline Development Group

**Strengthening the evidence base for health promotion interventions for maternal and newborn health – Recommendation on community mobilization through facilitated participatory learning and action cycles with women’s groups for maternal and newborn health**

**29-31 July 2013  
5 November 2013**

\* participation in July meeting only

\*\*participation in November meeting only

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## Appendix 2: Final GRADE Table

**Question:** What are the impacts on maternal and newborn health of community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health?

**Settings:** in low and middle-income countries.

**Bibliography:** Prost et al. (2013). Women's groups practicing participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. *The Lancet*, Volume 381, Issue 9879, Pages 1736 – 1746; Colbourn T and Prost A. (2013) Supplementary meta-analysis of women's group trials for WHO meeting – 29 July 2013. unpublished.



Quality assessment		No of patients					Effect		Quality	Importance		
		Design	Study Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Mobilization through participatory learning and action cycles with women's groups			Control	Relative (95% CI)
Maternal Mortality (follow-up 7– 11.5 months <sup>1</sup> ; assessed with: Death of a woman while pregnant or within 42 days of cessation of pregnancy from any cause related to the pregnancy or its management, but not from accidental causes. Confirmed using verbal autopsies.)												
7	randomized trials <sup>2</sup>	no serious risk of bias	no serious inconsistency <sup>4</sup>	serious <sup>5</sup>	serious <sup>6</sup>	none	162/57413 (0.28%)	190/56501 (0.34%)	OR 0.63 (0.32 to 0.94) <sup>7</sup>	1 fewer per 1000 (from 0 fewer to 2 fewer)	⊕⊕⊕⊕ LOW	IMPORTANT
Neonatal Mortality (follow-up 2– 9.5 weeks; assessed with: Death of a live born infant within 28 complete days of birth. Confirmed using verbal autopsies)												
7	randomized trials <sup>2</sup>	no serious risk of bias	no serious inconsistency <sup>8</sup>	serious <sup>5</sup>	no serious imprecision	none	1657/57413 (2.9%)	1969/56501 (3.5%)	OR 0.77 (0.65 to 0.9) <sup>9</sup>	8 fewer per 1000 (from 3 fewer to 12 fewer)	⊕⊕⊕⊕ MODERATE	IMPORTANT
Stillbirths (follow-up 2–9.5 weeks; assessed with: Verbal autopsies in which no sign of breathing, heartbeat or any other evidence of life was reported at birth)												
7	randomized trials <sup>2</sup>	no serious risk of bias <sup>3</sup>	no serious inconsistency	serious <sup>5</sup>	serious <sup>10</sup>	none <sup>11</sup>	1605/57413 (2.8%)	1576/56501 (2.8%)	OR 0.91 (0.79 to 1.03) <sup>12</sup>	2 fewer per 1000 (from 6 fewer to 1 more)	⊕⊕⊕⊕ LOW	IMPORTANT
Institutional delivery (follow-up 2– 9.5 weeks; assessed with: No. of deliveries at a health facility assessed using questionnaires and interviews)												
6	randomized trials <sup>2</sup>	serious <sup>3</sup>	no serious inconsistency	serious <sup>13</sup>	no serious imprecision	none	-	-	OR 1.03 (0.91 to 1.16) <sup>12</sup>	-	⊕⊕⊕⊕ LOW	CRITICAL

Quality assessment		No of patients					Effect		Quality	Importance	
No of studies	Design	Study Limitations	Inconsistency	Indirectness	Imprecision	Other considerations	Mobilization through participatory learning and action cycles with women's groups	Control			Relative (95% CI)
Giving birth with a skilled attendant (follow-up 2 - 9.5 weeks; assessed with: Questionnaires and interviews)											
5	randomized trials <sup>2</sup>	serious <sup>3</sup>	no serious inconsistency	serious <sup>4</sup>	serious <sup>10</sup>	none	-	-	OR 0.98 (0.83 to 1.14) <sup>12</sup>	⊕○○○ VERY LOW	CRITICAL
Receiving any antenatal care (follow-up 2 - 9.5 weeks; assessed with: Questionnaires and interviews)											
5	randomized trials <sup>2</sup>	serious <sup>3</sup>	no serious inconsistency	serious <sup>15</sup>	serious <sup>10</sup>	none	-	-	OR 1.11 (0.81 to 1.41) <sup>12</sup>	⊕○○○ VERY LOW	IMPORTANT
Receiving the recommended number of antenatal care visits (follow-up 2 - 9.5 weeks; assessed with: 3 or more ANC visits; assessed using questionnaires and interviews)											
5	randomized trials <sup>2</sup>	serious <sup>3</sup>	no serious inconsistency	serious <sup>15</sup>	serious <sup>10</sup>	none	-	-	OR 0.94 (0.73 to 1.16) <sup>12</sup>	⊕○○○ VERY LOW	CRITICAL

<sup>1</sup> Assessment from 7 months of gestation to 2.5 months after birth (post-partum). A majority of studies assessed outcomes at 6 weeks after birth.

<sup>2</sup> Cluster RCTs.

<sup>3</sup> Serious study level limitations as participants and those responsible for recruitment and evaluation of individuals after cluster randomization were not blind to allocation status. There was incomplete outcome reporting in most trials; outcome data was obtained directly from the authors

<sup>4</sup> Statistically significant, moderate heterogeneity of results, I square=58.8%, p=0.024. The heterogeneity might be explained by the different proportions of pregnant women participating in groups in the different trials because examining the trials in two groups, those with over 30% pregnant women participating and those with under 30%, reduces the heterogeneity. The GDG accepted the different proportions of pregnant women as a plausible explanation for the heterogeneity so there is no downgrading on this criterion. Note, however, that this association between proportions of pregnant women participating and the heterogeneity, while plausible, may have arisen by chance and so this explanation should be treated with caution.

<sup>5</sup> Potential risk of indirectness as six out of seven studies in the meta-analysis were undertaken in rural settings and only one trial assessed the impact of the intervention on the urban poor. Separate recommendations should be made for each group to reduce indirectness. If the recommendation were to consider the evidence only in terms of rural areas, it could be upgraded as this would address the limitations due to indirectness of the evidence.

<sup>6</sup> Wide confidence intervals.

<sup>7</sup> Exposure to women's group is associated with a 37% reduction in maternal mortality.

<sup>8</sup> Statistically significant, substantial heterogeneity of results, I square=64.7%, p=0.009. The heterogeneity might be explained by the different proportions of pregnant women participating in groups in the different trials because examining the trials in two groups, those with over 30% pregnant women participating and those with under 30%, reduces the heterogeneity. The GDG accepted the different proportions of pregnant women as a plausible explanation for the heterogeneity so there is no downgrading on this criterion. Note, however, that this association between proportions of pregnant women participating and the heterogeneity, while plausible, may have arisen by chance and so this explanation should be treated with caution.

<sup>9</sup> Exposure to women's group is associated with a 23% reduction in neonatal mortality.

<sup>10</sup> Recommendation may differ if the lower versus the upper boundary of the CI represented the truth.

<sup>11</sup> One study does not report stillbirth outcomes in the paper. However, the Prost et al. meta-analysis uses results obtained directly from the authors.

<sup>12</sup> No evidence of effect (p>0.05).

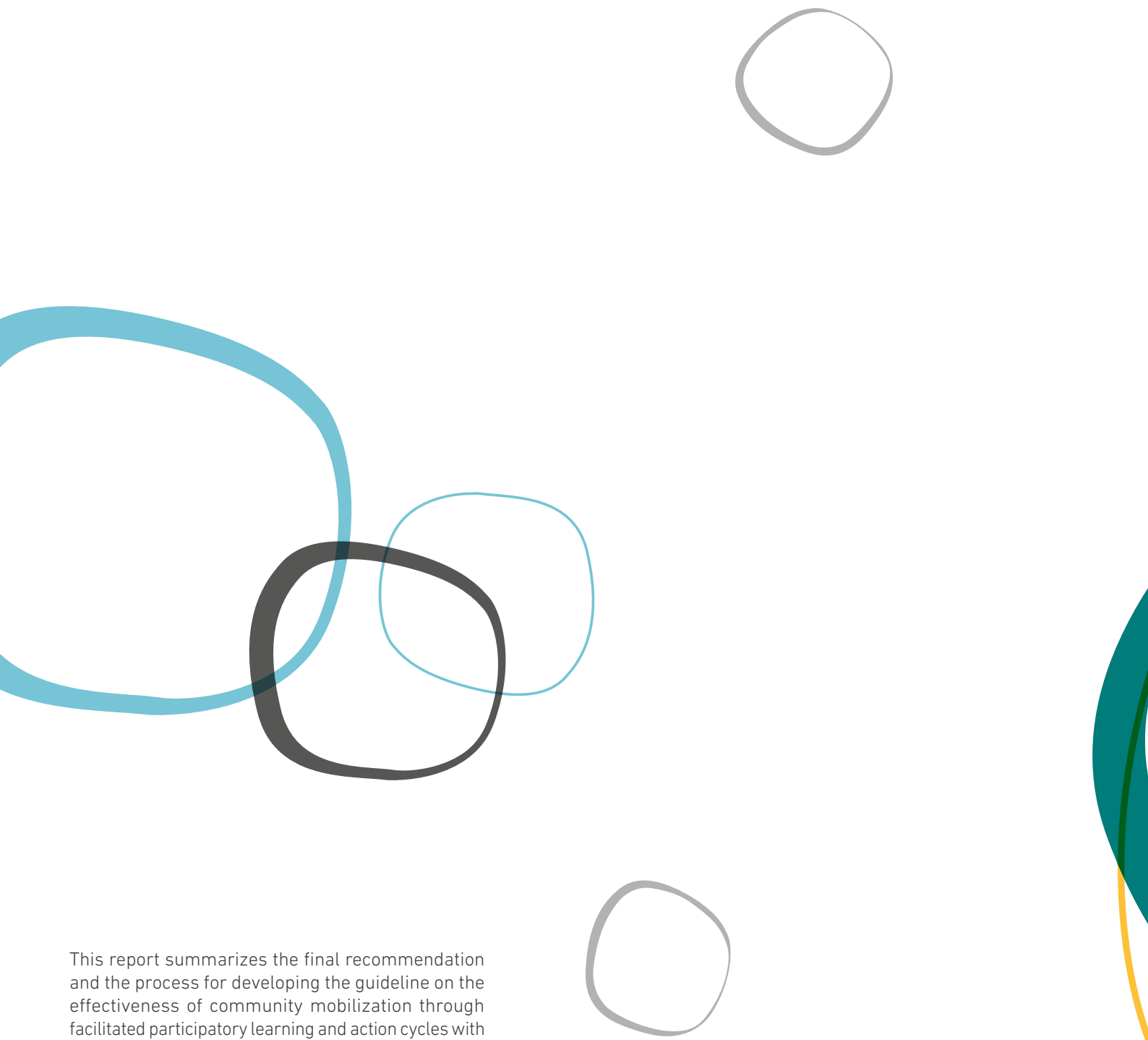
<sup>13</sup> Potential risk of indirectness as five out of six studies in the meta-analysis were undertaken in rural settings and only one trial assessed the impact of the intervention on the urban poor.

<sup>14</sup> Potential risk of indirectness as all five studies in the meta-analysis were undertaken in rural settings.

<sup>15</sup> Potential risk of indirectness as four out of five studies in the meta-analysis were undertaken in rural settings and only one trial assessed the impact of the intervention elsewhere.







This report summarizes the final recommendation and the process for developing the guideline on the effectiveness of community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health.



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