**Participatory women’s groups: ready for prime time?**

Conventional thinking behind global efforts to prevent the deaths of mothers and children younger than 5 years starts with the identification of an intervention with a clear biological pathway for reducing morbidity and mortality, such as a drug, vaccine, micronutrient, or health-related behaviour. The efficacy of this intervention is then tested in randomised trials, followed by meta-analyses of the trials’ findings. If results are encouraging, the intervention is scaled up, most frequently by integration with existing delivery platforms such as facility or community-based health services, or mass campaigns. The innovative approach taken by Audrey Prost and colleagues1 from the Institute of Child Health, London, UK, and from four low-income and middle-income countries, in The Lancet, brings a breath of fresh air to our field of knowledge. Based on the ideas of conscientisation—or creating critical consciousness—pioneered by the Brazilian educator Paulo Freire,2 they promoted the generic empowerment of women in poor communities, rather than recommending specific interventions or behaviours. People who promote somewhat ethereal ideas such as empowerment are seldom the same people as those who are keen on doing randomised controlled trials. The greatest accomplishment of this group of investigators is to combine both.

Prost and colleagues1 present a meta-analysis of seven randomised controlled trials of women’s groups carried out in Malawi, India, Bangladesh, and Nepal, and describe reductions in rates of maternal mortality (odds ratio 0.66–0.89) associated with exposure to women’s groups. Although the results of the meta-analysis are in general convincing, they also leave many unanswered questions.3 The sizeable estimates of reduction in maternal and newborn deaths (albeit with large 95% CI) are in contrast with the paucity of evidence of any improvement in coverage for most interventions that we would expect to mediate such an effect. In Prost and colleagues’ study,1 several of the original investigators did not measure potential changes in interventions that might have led to an effect. In some studies, and in the meta-analysis, the proportion of deaths prevented was often larger than that of pregnant women who participated—even if only once—in group meetings, suggesting some type of herd immunity that is hard to understand. Also, at least six of the seven studies were undertaken by the same group of researchers—and, although their methods seem to be thorough, it is always reassuring to have independent confirmation by other investigators.

Interventions with a strong behaviour-modification component often work well at small scale when closely
monitored by a research team, but less well when implemented at large scale; the investigators allowed for 30% loss in efficacy in their calculation of lives saved, but this percentage could be even larger. The absence of effect in the first Bangladesh study4 provides evidence that this might be the case—this study was the closest to real-life implementation conditions of the studies reviewed, with cluster sizes that were about three times larger than the other studies.

However, all biological pathways do not need to be understood precisely before preventive measures are promoted—if this was the case, antismoking campaigns would still be on the drawing board.

Women’s groups are politically correct. They are bottom-up approaches to address poverty and gender inequity, two fundamental social determinants of health. As such, audiences who strongly promote the rights of women and children will receive the results of the meta-analyses with enthusiasm. These international agencies and funders will act promptly to scale up participatory women’s groups by contracting grassroots non-governmental organisations at country level. Yet, based on past experience, one can predict that they will fail to evaluate the scale-up activities properly, and therefore miss the opportunity to learn much about how the approach works in real life. More traditional, biomedically oriented international agencies and funders will convene groups of academic experts to assess the new findings, who will tear apart the evidence and demand more randomised efficacy trials before recommending large-scale implementation.

One should never ask a barber if one needs a haircut. Likewise, one should never ask epidemiologists like ourselves whether more research is needed. Yet hundreds of thousands of mothers and millions of children younger than 5 years continue to die year after year, so a promising intervention such as participatory women’s groups can no longer be kept on the back burner. A prudent middle-of-the-road alternative is to scale up this approach vigorously in a selected number of countries, accompanied by rigorous evaluations.

Results from existing studies are encouraging, albeit challenging, and women’s groups seem to be cost effective and devoid of any important side-effects. It is now time to move on to large-scale effectiveness studies. Rolling out participatory interventions in a controlled manner in many districts within selected countries—eg, use of stepped wedge designs—would allow evaluation of their delivery, uptake, and effect. Such studies, by combining quantitative and qualitative methods, would also help us learn about how best to promote participation, and what are the mechanisms behind the intervention effects. They would shed light on whether women’s groups can have an effect in settings where mortality levels might not be as high as in those included in the efficacy studies, and help us learn more about how well contextual factors affect the work of women’s groups in reducing mortality.5

This approach would provide rigorous evidence about how participatory interventions, when scaled up, will deliver what they promise. Let us not allow yet another innovative, potentially life-saving intervention to be scaled up without proper evaluation.

*Cesar G Victora, Fernando C Barros
Universidade Federal de Pelotas, CP 464, Pelotas, RS, 96001–970, Brazil (CGV); and Catholic University of Pelotas, Pelotas, Brazil (FCB)
cvictora@gmail.com

We thank Jennifer Bryce for reviewing an earlier version of this Comment. We declare that we have no conflicts of interest.