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SPECIAL ARTICLE

Global health systems strengthening: FIGO's strategic view on reducing maternal and newborn mortality worldwide

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Abstract

Objective: To demonstrate that successful health systems strengthening (HSS) projects have addressed disparities and inequities in maternal and perinatal care in low-income countries.

Methods: A comprehensive literature review covered the period between 1980 and 2022, focusing on successful HSS interventions within health systems' seven core components that improved maternal and perinatal care.

Results: The findings highlight the importance of integrating quality interventions into robust health systems, as this has been shown to reduce maternal and newborn mortality. However, several challenges, including service delivery gaps, poor data use, and funding deficits, continue to hinder the delivery of quality care. To improve maternal and newborn health outcomes, a comprehensive HSS strategy is essential, which should include infrastructure enhancement, workforce skill development, access to essential medicines, and active community engagement.

Conclusion: Effective health systems, leadership, and community engagement are crucial for a comprehensive HSS approach to catalyze progress toward universal health coverage and global improvements in maternal and newborn health.

KEYWORDS

health systems strengthening, low- and middle-income countries, maternal health, newborn care, sustainable development goals, universal health coverage

FIGO Committee on Health Systems Strengthening and Respectful Care and the FIGO Division of Maternal and Newborn Health.

The members of the FIGO Committee on Health Systems Strengthening and Respectful Care, 2023–2025 are listed in Appendix.

For affiliations refer to page 858.

1 | INTRODUCTION

Governments, foundations, businesses, and academic and civil society groups have gathered around the call to build a better world, setting a goal of a two-thirds reduction in maternal deaths by 2030.[1] Globally, between 2000 and 2020, the global maternal mortality rate (MMR) declined by 34.3%, from 339 deaths to 223 deaths per 100 000 live births.[1] Despite significant progress in reducing maternal deaths globally and the rise of relatively affordable and effective life-saving technologies, inequities in maternal and perinatal health persist and, in some cases, even widen within and between countries and subpopulations. Although the rise in maternal deaths affects mainly low-income countries (LICs), where the burden of 94% of worldwide maternal fatalities occurs, evidence from high-income countries (HICs) reveals that marginalized, racial, and immigrant populations are also at markedly elevated risk.[2]

A more comprehensive understanding of the factors contributing to maternal deaths, which encompass both direct and indirect causes, is pivotal to formulating effective policy and health program decisions.[1] The prevalence of direct causes, such as postpartum hemorrhage and hypertensive disorders, varies markedly by region, exposing the heterogeneity of health challenges faced by women around the globe. According to a WHO systematic analysis, postpartum hemorrhage accounts for 36.9% (95% confidence interval [CI] 24.1–51.6) of deaths in northern Africa but only for 16.3% (95% CI 11.1–24.6) in HICs. On the other hand, hypertensive disorders are a significant cause of maternal death in Latin America and the Caribbean, contributing to 22.1% (95% CI 19.9–24.6) of all maternal deaths in the region. Similarly, most maternal deaths due to sepsis are recorded in LICs, and the proportion of such deaths was highest at 13.7% (95% CI 3.3–35.9) in southern Asia.[3,4] Direct causes of maternal mortality vary by region. However, in all regions and income levels, an effective health system, as defined by WHO, characterized by organizations, people, and actions collectively endeavoring to maintain and restore health, is fundamental to addressing diverse challenges to maternal health and survival.[5]

Current trends indicate that the targeted reduction in MMRs by 2030 is unlikely, largely due to systemic healthcare deficiencies.[1] These include delays in the healthcare system in providing care, substandard care quality, shortages of critical supplies, and weak accountability within health systems. Strengthening these systems is crucial for significantly reducing maternal mortality worldwide.[1] Inseparable linkages between the health and well-being of the mother, the fetus, and the future newborn are well recognized. There is an acknowledged perspective of the critical intersection of maternal and fetal well-being, emphasizing the need for an integrated health system that caters to mothers and children across the pregnancy, birth, postpartum, and perinatal continuum.[6] This approach aims to avoid dichotomies between mothers and newborns regarding interventions, places of service delivery, or health issues. Evidence exists that maternal and perinatal mortality reduction efforts fail because of fragmented systems and a scarcity of resources that are disproportionately allocated toward emergency medical responses, overshadowing preventive care and the broader social determinants of health.[7]

There is increased interest in making strategic investments in health policy and health systems strengthening (HSS), defined as an array of initiatives and strategies that improve one or more of the health system's functions and lead to better health through access, coverage, quality, or efficiency improvements.[8,9] The latest evidence suggests that in addition to increasing funding and rapidly expanding health service coverage, governments and national societies of obstetricians and gynecologists should focus on engaging key stakeholders and incorporating results from pilot projects to inform policy and strengthen health systems.[10] Therefore, strengthening our health systems holistically along the continuum of pregnancy, birth, and postpartum must be a priority.[11] This paper chronicles efforts to marshal all sectors in enhancing health program effectiveness, focusing on HSS to improve health policies and services for women, newborns, and infants. In this paper, we review evidence for successful HSS programs, aim to stimulate debate on their merits and present a structured yet straightforward approach that could empower governments, national societies of obstetricians and gynecologists, and development agencies to improve maternal and perinatal care appropriately.

2 | SEARCH METHODS

To ensure a comprehensive review of successful evidence of HSS programs, the present review was based on literature searches of PubMed (MEDLINE), Google Scholar, and the Cochrane Database of Systematic Reviews, covering literature between 1980 and 2022. Our search strategy utilized a combination of Medical Subject Heading (MeSH) and free-text terms to capture studies related to HSS, maternal and newborn care, and the context of low-resource countries. The terms were strategically combined using Boolean operators to optimize the search. Specifically, the following term combinations were used: ("Health Systems Strengthening" OR "maternal and newborn care" OR "developing countries") AND ("postpartum hemorrhage" OR "maternal sepsis" OR "unsafe abortion" OR "pre-eclampsia" OR "maternal mortality") AND ("developing country" OR "least developed countries" OR "under-developed nations" OR "third-world countries"). To augment our database inquiry, we included recommendations from subject matter experts and cross-referenced bibliographies from relevant articles. The search was confined to English-language publications (Figure 1).

3 | WHAT IS A HEALTH SYSTEM?

A health system encompasses a network of organizations, institutions, resources, and individuals, all unified by the fundamental goal of enhancing equitable health outcomes for the population. The

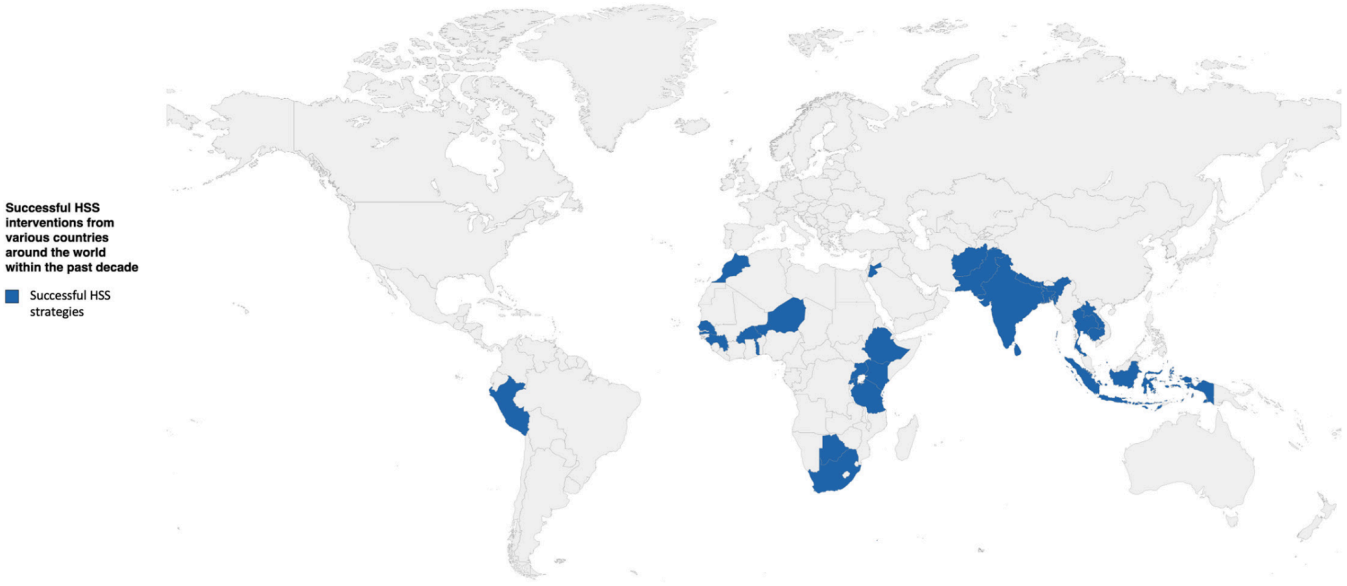

FIGURE 1 Geographical distribution of published reports on successful health systems strengthening (HSS) interventions from various low-income countries over the past decade (2010–2020).

actions of a health system should be effective without overburdening people with greater healthcare costs and more effective investments in health systems and services.

While more resources are needed to treat all women fully/completely, governments are also looking for strategies to achieve more with existing resources.[5] The essence of a health system is encapsulated in six foundational "building blocks": service delivery; workforce; information systems; access to essential medicines; financing; and leadership with governance.[12] To fortify health systems, particularly in maternal and perinatal care, it is imperative to systematically address constraints within these six domains, ensuring that every woman is treated with dignity and respect while also exploring strategies to maximize the impact of current resources. WHO characterizes HSS as "the process of improving these six fundamental building blocks and managing their interplay to achieve more equitable and sustained improvements across health services and outcomes." With the pursuit of universal health coverage in alignment with the Sustainable Development Goals, WHO has recently integrated "community engagement" as the seventh pillar, recognizing the essential role of people's engagement in a well-functioning health system.[13]

4 | OPTIMIZING HEALTH SERVICE DELIVERY

Central to the objectives of health systems is the dual aim of improving health outcomes and health equity, all while ensuring responsiveness, financial equity, and resource efficiency. There are also important intermediate goals, such as the route from inputs to health outcomes through achieving greater access to and coverage for effective health interventions without compromising efforts to ensure provider quality and safety.[12] In the context of low- and middle-income countries (LMICs), the persistent high burden of maternal and perinatal deaths within healthcare facilities highlights an urgent need for system-wide applications of evidence-based interventions. Health service delivery, therefore, must prioritize providing effective, safe, evidence-based, and high-quality health interventions, both personal and non-personal, tailored to those who need them. The human element, the health workforce, is integral, encompassing all staff working under the principles of responsiveness, fairness, and efficiency to maximize health outcomes, given the available resources and circumstances. Meanwhile, robust health information systems are key to generating, analyzing, disseminating, and utilizing reliable and timely data on health determinants, performance, and status.

Ensuring the availability and accessibility of medical products, vaccines, and technologies is critical to ensure quality, safety, effectiveness, and cost-effectiveness. Financial structures within health systems must protect individuals from the economic shocks of healthcare costs, facilitating access without the risk of financial catastrophe or impoverishment. Leadership and governance are tasked with delivering strategic policy frameworks that encapsulate these values and objectives (Box 1).[12,14]

5 | WHAT IS THE EVIDENCE OF THE IMPACT OF HEALTH SYSTEMS STRENGTHENING ON MATERNAL AND NEWBORN MORTALITY?

Using the literature, in Table 1, we compiled a list of successful HSS interventions from various countries worldwide within the past decade. Notably, Rwanda, among the few countries that achieved

BOX 1 Constructing robust foundations: The "Health System Seven Building Blocks" approach to worldwide health strengthening

1. Health service delivery.
2. Health workforce.
3. Health information systems.
4. Access to medical products, vaccines, and technologies.
5. Health financing.
6. Leadership and governance.
7. Community engagement.

the Millennium Development Goal 5's target of a 75% reduction in maternal mortality, exemplifies the potential impact of HSS.[1] Their success can be primarily attributed to the nation's robust political commitment and systematic enhancement across the health system's seven fundamental pillars. The Rwanda Reproductive Health Vision 2020, an ambitious post-genocide initiative focusing on health equity, implemented numerous reforms between 2003 and 2010, including national health insurance, performance-based financing, a village community health worker program, and expanded vaccinations and disease control efforts for HIV and malaria.[11,15] Such reforms resulted in a staggering 51% decline in maternal mortality, from 1100 to 540 deaths per 100 000 live births between 2000 and 2008, and an annual reduction of under-5 mortality by 12.8% between 2005 and 2010.[16] These advances, underscored by improved health coverage through community insurance and strategic retention of health staff, suggest that substantial, well-coordinated aid that aligns with national policies can achieve significant health system improvements (Table 1).[11,15]

In Uganda, the scale-up of quality improvement processes between 2014 and 2016 led to a 20% and 25% decrease in maternal and perinatal mortality, respectively.[17] These improvements resulted from multi-partner initiatives that combined institutionalizing evidence-based clinical practices in high-mortality regions, healthcare financing reforms, and community-engaged activities. Kenya's experience implementing a transportation voucher scheme for antepartum clinic visits in 2016 further demonstrated the positive impact of HSS interventions.[18] The strategy aimed to alleviate economic barriers for poorer women, leading to an increase in facility-based births, a factor in reducing maternal and neonatal mortality. This initiative was carefully designed in response to evidence indicating that income, transportation, and lack of birth preparedness were significant obstacles to accessing birthing facilities (Table 1).[18] Transportation vouchers improved healthcare accessibility, resulting in a marked increase in health facility deliveries. Despite these successes, comprehensive data on the cost-effectiveness of HSS strategies remain limited. There is a clear need for more rigorous investigations into these interventions' economic efficiency and overall value to inform future health policy decisions.[7]

6 | A COMPREHENSIVE FRAMEWORK FOR ENHANCING MATERNAL AND PERINATAL HEALTH THROUGH HEALTH SYSTEMS STRENGTHENING

Our literature review suggested that HSS should establish clear outcomes with mother- and baby-centered strategies, assuring adequate resource mobilization and political governance. Figure 2 outlines a strategic framework designed to augment all levels of healthcare systems, thereby improving maternal and perinatal health outcomes. This blueprint underscores the pivotal role of political leadership and mobilization of resources to ensure effective coverage and establish monitoring mechanisms to which governmental, national societies of obstetricians, gynecologists, and non-governmental organizations can adhere. To bolster facility utilization by mothers, their families, and newborns, HSS must be integrated with policies to improve the infrastructure by providing trained personnel, cutting-edge technology, and critical equipment and supplies to ensure a well-equipped and highly skilled workforce.

6.1 | The crucial role of the healthcare workforce

A key focus of quality enhancement in regions with high maternal and newborn mortality rates is the availability of healthcare providers and their expertise, proficiency, knowledge, and skill diversity. Independent of the hospital location (urban or remote), it is fundamental to increase the network of facilities staffed by capable healthcare workers offering high-quality care with a functional referral system 24/7 linking these facilities.[19] A recent scoping review emphasized that enhancing the skills of providers and managers in LMICs should be synergized with other strategies, such as supervision and collaborative problem-solving, to amplify their effectiveness. As training is linked to career advancement, a lack of training opportunities for practicing healthcare personnel contributed to poor motivation and work performance.[6] In addition, promoting respectful care is increasingly recognized as a critical element in improving the utilization and quality of maternity care for a positive childbirth experience.[20]

In Rwanda, a strategic project aimed at increasing the number of trained health providers, particularly in rural service areas, included comprehensive interventions, such as professional development, supervision, and competitive compensation packages. This approach has been linked to improvements in both the provision and quality of health services.[11,15,21] Similarly, training healthcare providers in emergency obstetric care has been associated with improved quality of care for mothers and newborns in Kenya.[19] Diverse countries such as Burkina Faso, Cambodia, Indonesia, and Morocco have emphasized midwives' education, certification, and deployment as a core constituent of their HSS strategies.[22] Finally, the issue of the "health of healthcare providers" requires further attention. In LMICs, in urban and rural areas, health workers face highly stressful work circumstances and must deal daily with situations that adversely

TABLE 1 Previous experience in health systems strengthening in the last two decades in different countries worldwide.

Reference	Country	Year	Method/Sample size	Interventions used	Outcomes
Bucagu et al. (2012)[11]	Rwanda	2001–2010	Systematic review + Rwanda DHS DHS 2000: $n = 10421$ DHS 2005: $n = 11321$ DHS 2011: $n = 13790$	Facility-based childbirth policy: built a network of 395 peripheral health centers, 40 district hospitals, and three referral hospitals. Family planning policy: sensitization of the population, outreach services, and specific performance-based incentives	Antenatal visits (at least four): 5.6% (2001–2005) ➔ 33.2% (2006–2010) Births with skilled attendance: 5.2% (2001–2005) ➔ 5.4% (2006–2010) Attended births in rural areas: 24.9% (2000) ➔ 34.6% (2005) ➔ 67.2% (2010) Contraceptive use: 30% (2001–2005) ➔ 70.2% (2006–2010)
Basinga et al. (2011)[9]	Rwanda	2006	Randomized trial $n = 166$ facilities (intervention group vs. traditional input)	Performance-based payment of healthcare providers	+23% institutional deliveries +56% of preventive care visits for children aged ≤23 months. +132% preventive care visits for children aged 24–59 months
Logie et al. (2008)[15]	Rwanda	2005–2009	Descriptive	Donor coordination of aid, linking it closely with the government plan Nationwide community-based health insurance from 1999 Performance-based pay initiative to improve the quality of health care	+73% (2006) reduction in fees paid by the patient and an increase in achievement of health needs
Sensalire et al. (2019)[17]	Uganda	2014–2016	A multi-partner initiative designed to reduce deaths stemming from pregnancy and childbirth rapidly	Implement birth preparedness, antenatal care, obstetric emergency skills, and surgery, including cesarian delivery and blood transfusion	−20% maternal mortality ratio in the intervention facilities −30% in institutional neonatal mortality rate −47% stillbirth rate −26% in perinatal mortality rate
Ochieng et al. (2022)[18]	Kenya	2016	Ex-post evaluation of the program to reduce maternal and neonatal deaths in Kenya, quasi-experimental study. 448 women aged 18–49 years	Implement a transportation voucher scheme for antepartum clinic visits and improve access to antenatal care	74% ➔ 95% women more likely to deliver at a health facility. 72% ➔ 88% women more likely to receive high-quality antenatal care
Namayi et al. (2020)[19]	Kenya	2018	Facility-based cross-sectional survey 55 nurses interviewed	Determine health providers' knowledge of routine maternal and newborn care and treatment of complications to tailor training programs	Training healthcare providers offering maternity systems on emergency obstetric care to provide quality care
Kung'u et al. (2018)[33]	Kenya	2000s	Community-based intervention packages 58000 pregnant women and newborns, and 3750 healthcare workers in Kenya's Kakamega County	Teamwork and simulation training Community health worker training	+ Maternal newborn health and nutrition knowledge + Quality of maternal newborn health and nutrition service + Nutrition and health status of pregnant women and newborns and − Maternal and neonatal morbidity and mortality

(Continues)

TABLE 1 (Continued)

Reference	Country	Year	Method/Sample size	Interventions used	Outcomes
Van Lerberghe et al. (2014)[22]	Burkina Faso	1990s–2012	Case study narratives	Implement national guidelines, triple midwife workforce, set maternal health targets, establish ambulance services, reimburse household expenditures for all births (normal deliveries, complications, and cesarean births, public investment in infrastructure)	Between 1990 and 2012: Functioning referral facilities and hospitals $n=40 \rightarrow 108$ Ratio expected births/facility $n=525 \rightarrow 376$ Medical doctors $n=314 \rightarrow 787$ Midwives $n=325 \rightarrow 1321$
Van Lerberghe et al. (2014)[22]	Cambodia	1990s–2013	Case study narratives	Implementing generalized quarterly in-service training and coordination workshops at the district level, introducing routine active management of the third stage of labor and MgSO4, allowing legal abortion, equity fund exemptions, donor investment, and increased government expenditure on health	Antenatal care uptake: 38% (2000)➔90% (2010) Births in health facilities: 9.8% (2000)➔66 (2012) Maternal mortality 510/100 000 (2000)➔170/100 000 (2013)
Van Lerberghe et al. (2014)[22]	Indonesia	1990s–2013	Case study narratives	Implementing in-service training programs, midwifery association, accreditation; quality circles, maternal death audits, pre-service training and deployment of midwives, health insurance safety net for the poor, special arrangements for remote populations, village maternity clinics established	Maternal mortality −56% (1990 ➔ 2013) Facility births 21% (1991) ➔ 63% (2012) Cesarean delivery rate trends 0.8% (1986–1989) ➔ 12.3% (2007–2011) Births attended by health professionals (doctors, midwives, and nurses) 32% (1991) ➔ 85% (2012) Deployment of midwives poorly coordinated with the parallel expansion of the hospital network
Van Lerberghe et al. (2014)[22]	Morocco	1980s–2010	Case study narratives	Implementing standardization of care, midwifery schools reopened long-term investment in infrastructure, budgets for midwife posts, and significant budget earmarks for maternal care Free healthcare services and public facilities, near-miss research programs	Maternal mortality 310/100 000 (1990) ➔ 120/100 000 (2013) Neonatal mortality 35/100 000 (1990) ➔ 20/100 000 (2013) Antenatal care 33.5% (1990) ➔ 77% (2010) Birth in a health facility 28% (1998) ➔ 73% (2010) BEmONC and CEmONC available in health centers 69% (mid-2000s) ➔ 85% (2010)
Mills A (2006)[38]	Thailand	2003	Review	Making service in rural areas more attractive through financial incentives	Improved recruitment, retention, and status of a rural doctor

TABLE 1 (Continued)

Reference	Country	Year	Method/Sample size	Interventions used	Outcomes
Hirose A (2015)[39]	Pakistan	2000s	Survey (9 research papers and a third commentary that stems from projects funded by the Maternal and Newborn Health Programme Research and Advocacy Fund (RAF), a program implemented within the health system context in Pakistan)	Improve the use of mass and social media, communication, research development, and diffusion of evidence. Introduction of Pakistan's Community Midwives (CMW) program	Inclusion of evidence-based drugs (misoprostol and chlorhexidine) in the essential drug list throughout the country Improved the skills of birth attendants in the community.
Koblinsky et al. (2010)[31]	Ethiopia	2005–2008	Reviews of available survey data Data 2008: 2448 mothers of children aged 0–11 months; family planning data were collected on a sample of 4080 women of reproductive age Data 2005: obtained from secondary analysis of the Ethiopian DHS 2005 data	Implement maternal health care Implement family planning Implement immediate postpartum visits	(2005 vs. 2008) 26% → 54% increase in any antenatal care 16% → 32% improvements in the contraceptive prevalence rate Postnatal care remained low at 7% and unchanged from 2005

Abbreviation: DHS, Demographic and Health Survey.

affect their mental and physical health. For instance, it is important to understand how a midwife in a remote rural area experiences a maternal death mentally and emotionally. Likewise, we must understand what can be done to bolster their psychological resilience and maintain professional confidence and performance.[23–25]

6.2 | Performance-based financing: A catalyst for change

Healthcare systems often have inefficiencies in their maternity-based health care arising from reduced remuneration and limited motivation of healthcare workers, particularly in LMICs. Remuneration may not depend on hours worked and how well staff manages maternity and obstetric services. The adoption of performance-based financing across 20 African nations signifies a transformative shift in the public health sector. Performance-based financing is predicated on compensating healthcare providers based to some extent on their performance.[8] A study in Rwanda demonstrated that performance-based financing was associated with higher utilization and quality of maternal and child health services and could be a useful intervention to accelerate progress toward the Millennium Development Goals.[9] Yet, for performance-based financing to be effective, it must rely on a functioning and responsive health system infrastructure that encompasses reforms in health financing, governance, and community engagement.[26]

6.3 | Addressing inequities: A commitment to universal health coverage

Achieving universal health coverage and improving maternal-neonatal health requires a commitment to combating inequities. For instance, it is well known that women with fewer resources are less likely to access health services. Similarly, skilled professional birth attendance differs according to maternal income, education, and geographical location. Equitable health and social care entails providing uniform access to care for all women, regardless of socioeconomic status, ethnicity, or beliefs. Respect includes treating mothers and families with dignity and without discrimination. To this end, health systems must be equipped to deliver interventions efficiently and fairly, reaching the most impoverished and vulnerable populations regardless of where they live. For example, strategies in Togo have shown the necessity of addressing geographical disparities in healthcare access since health professionals covered 90% of the necessities for urban populations and only 43% for rural areas,[27,28] while initiatives in Thailand have sought to enhance rural healthcare services through incentives for healthcare workers.[29] Indonesia had the goal of universal health coverage by 2019. In 2011, the national insurance program was expanded to include maternity insurance for 44% of pregnant women without coverage. These insurance programs have reduced the equity gap in accessing services but have not yet eliminated it. Thanks to

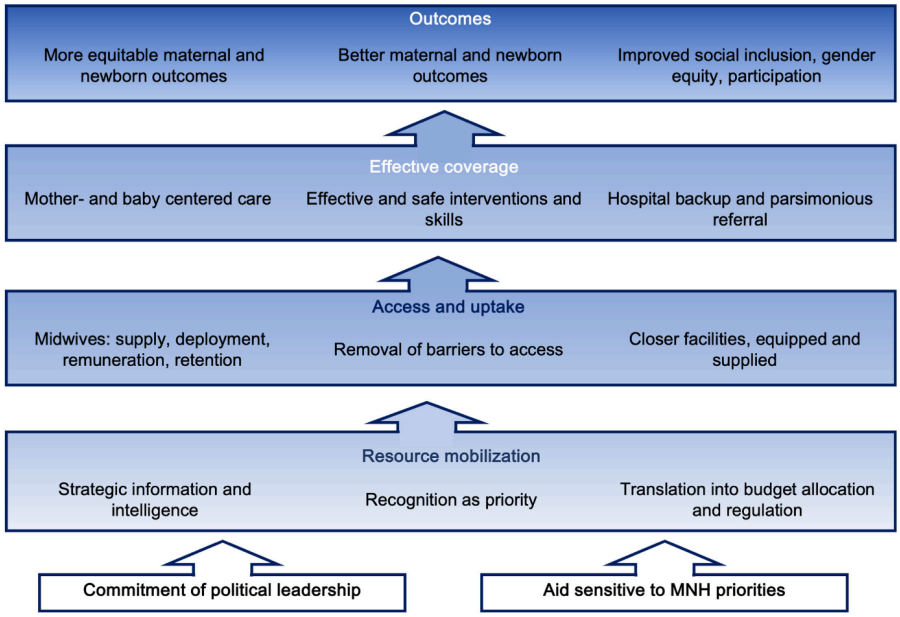

FIGURE 2 Health systems strengthening measures to improve maternal and newborn health (MNH). Adapted with permission from Van Lerbergue et al.[22]

universal health coverage,[22] Kenya's health indicators have steadily improved over the years.[18] Latin American countries (Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, Peru, Uruguay, and Venezuela) have developed a distinct approach to health system reforms, which combined demand-side changes to alleviate poverty and comprehensive primary healthcare to extend service access. These reforms fostered inclusion, citizen empowerment, and health equity, established legal rights to health and protection, and achieved universal health coverage.[30]

6.4 | Empowering communities in health systems strengthening

Community engagement is now considered the seventh pillar of HSS. The community has a vital role and should take an active role in improving their citizens' health outcomes. Community engagement should permeate various HSS dimensions, including planning, program implementation, monitoring, and advocacy.[14] WHO guidelines promote community-led health initiatives for universal health coverage, recognizing the community as a beneficiary and a driver of health system reform. Community-based interventions may encourage healthier practices and care-seeking among communities and families, as well as enrolling and training local community members, including doulas, to work alongside trained healthcare professionals and community member engagement in service distribution, including diagnosis, treatment, and referral. Various approaches exist, including doulas, community health workers, trained traditional birth attendants, health campaigns, school-based health promotion, home-based care, and even community franchise-operated clinics.[14,17]

The success of these programs is based on active community engagement and ownership, ensuring that local needs are appropriately addressed and reflected in health strategies.[10] The community is both the recipient of health services and a potential catalyst of change.[14] In Ethiopia, health extension programs at the community level, improved promotion of family planning and specific maternal interventions, such as misoprostol for active management of the third stage of labor, immediate postpartum visits, and enhanced coordination from the community referral level, were key to reducing maternal mortality in 2010. The community was crucial in implementing this program.[31]

7 | THE IMPERATIVE OF FIGO'S INVOLVEMENT IN HEALTH SYSTEMS

FIGO is a vanguard organization that promotes women's health and equity and is dedicated to improving women's and newborns' health outcomes, diminishing healthcare inequities, and elevating obstetrics and gynecology through global research, education, advocacy, and the fortification of professional capacities. Obstetrician members of FIGO societies stand at the frontline of clinical services, engaged in the essential care of women throughout pregnancy, childbirth, postpartum, and in the care of newborns. Our members practice within a diverse spectrum of health systems, collaborating with multidisciplinary teams to optimize care in different contexts. To achieve its vision, FIGO has delineated four pivotal strategic objectives within its 2021–2030 strategic plan[32]:

- Improve the health and well-being of women and girls across their life course worldwide.

- Enhance the status of all women, girls, and families, enabling them to realize their full potential in education, sexual and reproductive health and rights, professional opportunities, and personal well-being.
- Advance obstetrics and gynecology practice through education, training, research, and advocacy, employing the highest ethical and professional standards.
- Strengthen the role of FIGO in global health.

Engaging with health systems is instrumental to realizing these goals, acting as a powerful tool for augmenting members' continuing education and supporting political strategies in collaborations with governments, national societies of obstetricians and gynecologists, non-governmental organizations, and civil organizations.[31]

Different stakeholders within health systems must undertake significant work precisely where maternal and neonatal care is urgently needed. A recent example of the HSS initiative is a report on health systems in Ethiopia, Kenya, Niger, and Senegal.[33] This study assessed diverse health system challenges to improve pregnant women's and newborns' health and nutrition, including barriers to safe maternal health care.[33] In such initiatives, non-governmental institutions, such as the Global Alliance for Improved Nutrition and the Ministries of Health of each participating country, were key to conceiving the rationale and devising methods for developing multi-country key maternal and neonatal health interventions. Moreover, they were key to identifying essential indicators for inputs, outcomes, and impacts, thereby facilitating the tracking of transformative changes prompted by these interventions. This type of interactive programming may be replicated in other contexts and used to develop models that link inputs to address gaps in the quality and uptake of maternal and neonatal care to outcomes related to improvements in maternal health service utilization and reduction in maternal and neonatal morbidity and mortality.[33]

FIGO champions the active involvement of its member societies in propelling enhancements in HSS, engaging robustly with all seven pillars of the health system. To this end, in 2021, FIGO established the Committee on Health Systems Strengthening and Respectful Care within the Maternal and Newborn Health Division.[34] This committee, consisting of dedicated members appointed by FIGO societies, pursues various goals, prominently emphasizing the healthcare workforce and service delivery at policy and practice levels across member states and within FIGO. It prioritizes universal health coverage and respectful maternity care, aiming to improve the visibility and influence of FIGO's efforts to examine health systems strengthening and respectful childbirth care across all the member societies. The committee's vision includes identifying key concerns, suggesting actionable interventions, and enhancing the evidence base for effective HSS strategies. These are critical in the short term for meeting the Sustainable Development Goals and nurturing a healthier future for women and children worldwide.

8 | THE COVID-19 CRISIS, ADAPTING HEALTH SYSTEMS FOR MATERNAL AND NEWBORN CARE: ROLES OF OBSTETRICIANS AND MIDWIVES

The COVID-19 pandemic has precipitated an alarming increase in MMRs, striking with ferocity among racial and ethnic minorities in rural areas and small cities, especially in LMICs. This unprecedented emergency has demonstrated not only gaps in effective maternal care but has also pointed out urgent areas for improvement to avoid preventable maternal deaths during health system overloads. The fundamental strategies for reducing maternal and newborn deaths are well-known and include comprehensive family planning, provisions for safe abortions, micro-nutrient supplementation, proficient care during pregnancy and childbirth, emergency obstetric services, and skilled postpartum and neonatal care.[35] Our review highlights the need to address geographic and logistical barriers to facility-based births in urban and rural areas. After COVID-19, an urgent need emerges for localized data to guide the fortification and conceptualization of maternal and child health systems.

The pandemic has highlighted the importance of investing in primary healthcare infrastructure. Midwives, as fundamental providers in the primary healthcare structure, play a key role in ensuring positive birthing experiences and comprehensive, safe abortion services, with a vast body of evidence supporting the benefits of such investments.[36] During the pandemic, a 3%–12% decline in maternal health indicators, such as antenatal care attendance, was noted, with sub-Saharan Africa notably affected. For instance, a study in Guinea implemented a strategy that encompassed training health workers in infection prevention, optimizing emergency primary healthcare reorganization of services and patient flow, and equipping healthcare facilities with necessary infection prevention control equipment (masks, hydroalcoholic solutions, hand-washing kits, personal protective equipment, and so on), and providing birthing kits to women in health facilities. The result of the study was an increase in the demand for maternal health services and tools to guide future public health interventions to improve the utilization of health services by populations in a health emergency context.[37]

The present study has some limitations. As stated, we focused only on successful maternal and newborn HSS programs. Due to selection bias in publishing and our goal of highlighting only successful programs, we may not have taken advantage of lessons learned from unsuccessful programs.

9 | CONCLUSIONS

Our review identifies some HSS interventions that have successfully improved maternal and perinatal health outcomes at individual, community, facility, and local or national policy levels. Strengthening health systems for women and newborns is paramount to attaining universal healthcare coverage in reproductive, maternal, perinatal, and newborn health. HSS stands as an essential component for countries committed

to reducing maternal and newborn mortality rates. To advance maternal and perinatal health, concerted and comprehensive strategies are vital, necessitating political will and the mobilization of resources to adopt a holistic and systematic approach toward universal health care. FIGO is committed to championing HSS for maternal and newborn care, actively contributing to reducing maternal and perinatal mortality and morbidity worldwide with optimism and dedication.

AUTHOR CONTRIBUTIONS

All listed authors contributed to the conception and design of the work, drafting, and revising the manuscript, and final approval of the version to be published. All authors agree to be accountable for all aspects of the published work.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data is available on request from the authors.

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APPENDIX

Members of the FIGO Committee on Health Systems Strengthening and Respectful Care, 2023–2025

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