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SPECIAL ARTICLE

Obstetrics

FIGO good practice recommendations on optimizing models of care for the prevention and mitigation of preterm birth

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Abstract

The global challenge of preterm birth persists with little or no progress being made to reduce its prevalence or mitigate its consequences, especially in low-resource settings where health systems are less well developed. Improved delivery of respectful person-centered care employing effective care models delivered by skilled healthcare professionals is essential for addressing these needs. These FIGO good practice recommendations provide an overview of the evidence regarding the effectiveness of the various care models for preventing and managing preterm birth across global contexts. We also highlight that continuity of care within existing, context-appropriate care models (such as midwifery-led care and group care), in primary as well as secondary care, is pivotal to delivering high quality care across the pregnancy continuum—prior to conception, through pregnancy and birth, and preparation for a subsequent pregnancy—to improve care to prevent and manage preterm birth.

KEYWORDS

continuity of care, FIGO guidelines, models of care, preterm birth, prevention

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1 | INTRODUCTION

Preterm birth remains a global challenge adversely impacting maternal and child health and welfare. There are 13.4 million preterm births annually, of which about a million do not survive.¹ Prevalence rates range between 5% and 18% of live births, with higher rates recorded for low- and middle-income countries (LMICs) where health systems are less well developed. Of the survivors of preterm birth, many are left with medium- or long-term conditions and impairments. The sustainable development goals (SDGs) and the United Nations' Global strategy (2016–2030) provide a framework for countries to achieve the highest attainable standards of health for all women, children, and adolescents to “Survive, Thrive and Transform.”² Attaining these standards will require concerted efforts to reduce the causes and consequences of preterm birth globally.

Effective approaches to care that are evidenced to mitigate the multifactorial risks of preterm birth are emerging from studies, mainly in high-resource contexts^{3–5} possessing strong and resilient health systems. Contextualizing and improving the implementation of these interventions everywhere, particularly in limited resource settings is a global challenge. To improve the implementation of these interventions globally, the recently published FIGO PremPrep-5 initiative⁶ aims to promote the implementation of five of the simplest and most effective interventions to mitigate preterm birth, namely antenatal maternal steroid administration (to reduce preterm birth complications such as respiratory distress syndrome and necrotizing enterocolitis), magnesium sulfate therapy (to provide neuroprotection for the baby),⁷ delayed cord clamping,⁸ early feeding with breast milk, and immediate kangaroo care.

The delivery of such care requires context-appropriate effective models of care. Given the global differences in models of care, exploration of what works, for who, and in which circumstances will be important to improve the capacity of different models of care to be effective in reducing preterm birth. These FIGO good practice recommendations provide a brief overview of the published models of care relevant to preventing preterm birth, summarize the main evidence regarding the effectiveness of these models, and highlight the contextual differences and similarities. Considering the multidisciplinary of carers involved in delivering care, a description is given of how continuity of integrated care may improve the implementation, as well as the coverage, of evidenced interventions to reduce preterm birth in different global contexts. We conclude by providing practice and research recommendations in different contexts to optimize care models for preterm birth.

2 | ESSENTIAL CARE CONTENT FOR PRETERM BIRTH

The “Born Too Soon” report published in 2023¹ highlights the need for health systems to focus on delivering human rights and respectful, family-centered care to deliver high-quality services with the capacity to mitigate preterm birth. The report highlights

that operationalizing this care ethos will also require empowering women and families, addressing the shortage of healthcare providers, and strengthening policy action and accountability. These will require care models that promote a mutually satisfactory trusting relationship between the service users and the care-givers. The provision of high-quality maternity care to prevent and mitigate preterm birth should span the continuum of preconception, pregnancy, intrapartum, and postnatal periods. Care should cover primary and secondary prevention prior to and during pregnancy (Figure 1).⁹ Such care should include pregnancy risk assessment for preterm birth,¹⁰ heightened screening for women deemed to be at risk, appropriate drug/nutrient supplementation, and timely triaging of patients to care services provided by practitioners with appropriate expertise. Such care should also include the formulation of birth plans (including in utero transfer¹¹) and the delivery of effective interventions during labor and delivery^{3–5} (Figure 1). Delivering such care requires optimizing local affordable care models that ensure universal coverage for all women, especially vulnerable populations with unequal access to health care. Care should be configured to address the needs of women at primary, secondary, and tertiary care levels.

3 | MODELS OF CARE FOR MATERNAL, NEWBORN, AND CHILD HEALTH TO MITIGATE PRETERM BIRTH

A model of care is defined as a recognized and standardized care pathway that identifies the healthcare providers, locations, and structure of care delivered within that pathway.¹³ Several maternal and newborn care models have been described to mitigate preterm birth and other associated pregnancy conditions, such as gestational hypertension, pregnancy anemia, gestational diabetes, small-for-gestational-age, and stillbirth. Maternity care models differ by country, region, and context and there is no consensus regarding a framework for their classification and evaluation, largely due to the availability and allocation of resources for health services, complexities of care delivery, as well as carers involved, and the differences in the organization and delivery of health services.

Baseline care, often described as “standard care,” defines care delivered to all pregnant women regardless of risk factors. Standard care is usually provided at primary and secondary levels, within the public as well as the private sector. Models of care are often classified by the predominant or exclusive health professional delivering such care, with typical examples being midwife-led or physician-led (consultant or family doctor) care.¹⁴ Recent systematic reviews have attempted to categorize maternity care models into private obstetrician (specialist) care, private midwifery care, and public hospital medical or midwifery care. Care may also be shared between different health professionals (medical and midwifery). Care is combined when community and hospital care providers contribute, depending on the degree of complexity of the pregnancy.¹³ The common definitions of models of care are outlined in Table 1.

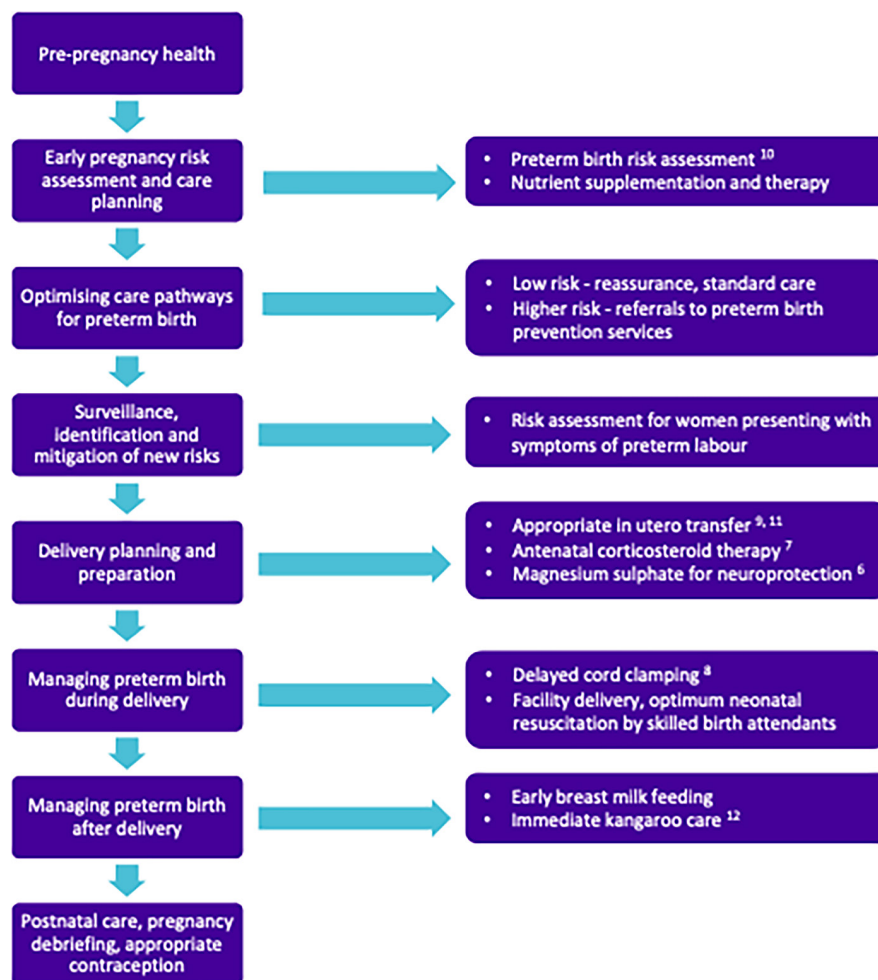


FIGURE 1 Models of care delivering evidenced interventions across the prepregnancy, pregnancy, labor/delivery, and postnatal care periods.^{6–12}

Midwife-led care is when the same midwife, or a small group of the same midwives, supports a woman throughout the antenatal, intrapartum, and postnatal periods.¹⁴ Some models of midwife-led care provide continuity to a defined group of women through a team of midwives sharing a caseload, often called “team” midwifery. Employing this model, a woman will receive her care from a varied but limited number of midwives in the team. Other models, often termed “caseload midwifery,” aim to offer greater relationship continuity, by ensuring that childbearing women receive their ante-, intra- and postnatal care from one midwife or their practice partner.¹⁵ When a care model is provided by a group of professionals to groups of users together, the approach has been described as Group Care.

In practical terms, however, most care in the maternity setting is usually provided by a multiprofessional team at different gestational timepoints across the primary or secondary care divide. The specific input of these professionals usually depends on whether women are deemed to be at low or high risk of adverse pregnancy outcomes such as preterm birth. Given the multiplicity of classifications of care models in different global contexts it is not

surprising that most studies evaluating the effectiveness of different models of care have failed to consistently determine their effectiveness and value. Reports of the effectiveness of the various care models in improving birth outcomes, including preterm birth, are conflicting.

4 | CONTINUITY OF CARE AND CARE INTEGRATION TO MITIGATE PRETERM BIRTH

Most reports that have suggested some improved health outcomes have largely described the effectiveness of the continuity of exclusive or alternative care models employed throughout pregnancy. However, the extent to which care continuity is practised in published work is not always clear. An attempt has been made to define three core components and principles of care continuity: management continuity, informational continuity, and relationship continuity.¹⁶ Management continuity relates to the communication of facts and judgments between professionals and patients; informational continuity concerns

TABLE 1 Models of care categories and their definitions.

	Model of care category	Description
Public care	General Practitioner (GP) obstetrician care	• Antenatal care provided by a GP obstetrician • Intrapartum care provided in public/private hospital by GP obstetrician in collaboration with hospital midwives • Postnatal care provided in the hospital/home/community by GP obstetrician and hospital midwives
	Shared care	• Antenatal care provided by community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff • Intrapartum and postnatal care provided by hospital midwives and doctors, in conjunction with community doctor/midwife
	Combined care	• Antenatal care provided by private maternity service provider (doctor and/or midwife) in the community • Intrapartum, early postnatal care provided in public hospital by hospital midwives and doctors • Postnatal care in home or community by hospital midwives
	Public hospital maternity care	• Antenatal care provided in hospital clinics by midwives and/or doctors and/or multidisciplinary team • Intrapartum and postnatal care provided by midwives and doctors in collaboration • Postnatal care in home/community by hospital midwives
	Public hospital high-risk maternity care	• Antenatal care for women with medical high-risk/complex pregnancies by specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives • Intrapartum and postnatal care provided by hospital doctors and midwives • Postnatal care in home/community by hospital midwives
	Team midwifery care	• Antenatal, intrapartum, and postnatal care provided by small team of rostered midwives in collaboration with doctors for identified risk factors • Intrapartum care provided in hospital or birth center • Postnatal care in home or community by the team midwives
	Midwifery Group Practice caseload care	• Antenatal, intrapartum, and postnatal care provided by a known primary midwife with secondary backup midwife/midwives, in collaboration with doctors for identified risk factors, in the hospital, community or home • Intrapartum care in hospital, birth center, or home
	Group antenatal care	• Care provided by a group of professionals to groups of users together
Private care	Obstetrician (specialist) care	• Antenatal care provided by private specialist obstetrician • Intrapartum care provided in either a private or public hospital by private specialist obstetrician and hospital midwives in collaboration • Postnatal care provided in the hospital by the private specialist obstetrician and hospital midwives
	Midwifery care	• Antenatal, intrapartum, and postnatal care provided by a private midwife or group of midwives, in collaboration with doctors in the event of identified risk factors, in a range of locations including the home
	Obstetrician and midwife joint care	• Antenatal, intrapartum, and postnatal care provided by a privately practicing obstetrician and midwife • Intrapartum care provided in either private or public hospital by privately practicing midwife and/or private obstetrician in collaboration with hospital midwifery staff • Postnatal care usually provided in the hospital, may continue in the home or hotel by a private midwife

Source: Adapted from Donnelly et al.¹³

the timely availability of relevant information; and relationship continuity defines a therapeutic relationship of the patient with one or more health professionals over time. The interplay between these components is complex, and in relation to midwifery-led continuity of care (MLCoC), women appear to prioritize care consistency (management

and informational continuity) over and above carer continuity.^{17,18} It is plausible that the provision of all these components within a care model is most likely to improve the perception of care by patients, as well as care givers, and may make the most impact on pregnancy outcomes including preterm birth.

Any model of care that aims to provide continuity to prevent preterm birth needs to be integrated into broader antenatal care to address all the major fetomaternal risks during pregnancy in each care context. Health service integration refers to the “managerial or operational changes to health systems to bring together inputs, delivery, management, and organization of particular service functions, in order to provide clients with a continuum of preventative and curative services, according to their needs over time and across different levels of the health system.”¹⁹ Integration improves access and facilitates use of services and experiences. There are emerging reports that such care integration has benefits.²⁰ Integrating preterm birth prevention interventions into antenatal care services to mitigate other diseases of high prevalence (such as intermittent preventative treatment in pregnancy for malaria and prevention of mother-to-child transmission of HIV interventions) may be associated with improved maternal and infant health outcomes. This approach ensures that care is no longer delivered as vertical disease specific programs thereby ensuring better outcomes, as reported in South Africa for programs integrating tuberculosis and antiretroviral treatment services. Integrated services at 33 clinics by the Western Cape Health Department in South Africa was significantly associated with lowered risk of death, reduced by 50%–60% and a 35% reduction in loss to follow-up.²¹ Integrating antenatal preterm birth risk assessment and prevention interventions into other mainstream care packages is likely to improve care access, utilization, and treatments.

5 | EVIDENCE OF EFFECTIVENESS OF CONTINUITY OF CARE MODELS FOR PRETERM BIRTH

In addition to the prevailing standard care, the most evaluated of these models of care continuity is midwifery-led continuity of care (MLCoC). A recent Cochrane systematic review showed no benefit of MLCoC in reducing preterm birth. There may be little or no difference in preterm birth (<37 weeks) (6% under both care models, average RR 0.95; 95% CI, 0.78–1.16; 10 studies, 13 850 participants; low-certainty evidence).²² In one systematic review,²³ 11 of 12 studies showed that women receiving Group Care had equivalent or improved pregnancy outcomes compared with traditional care, including decreased incidence of preterm birth, increased birth weight, improved weight gain during pregnancy, increased adequacy of prenatal care, and greater prenatal knowledge. However, a subsequent systematic review did not record similar findings.²⁴ One recent randomized controlled study showed that Group Care reduced preterm birth rates with increasing user engagement with that care model.²⁵ Community-based care, with a focus on continuity of carer, has also been reported to result in improved birth outcomes including preterm birth.²⁶ Taken together, these studies with widely varying strength of evidence grading show that most care models that deliver continuity of care are associated with some better birth

outcomes generally and, in a limited number of studies, preterm birth specifically.²⁷

There is no evidence that any specific continuity of care model has altered the rising rates of modifiable causes of iatrogenic preterm birth specifically—an increasing problem about which this Committee has previously published FIGO good practice recommendations.²⁸

Even when models of care have not been shown to improve birth outcomes, virtually all of them have been repeatedly shown in most studies to demonstrate higher rates of maternal^{14,22,29–34} and health professional satisfaction^{35–37} across the continuum of prenatal and postnatal care, and for high-risk as well low-risk pregnancies, when delivered in continuity. Taken together, care continuity of existing care models in most contexts is associated with more favorable outcomes and patient and carer experience. Continuity of care and carer therefore seem to be good practice ideals that should be strived for, regardless of whether they lead to measurable improvements in birth outcomes.

A key challenge with providing continuity of care to mitigate preterm birth and other pregnancy outcomes is whether health systems can afford the related costs. This has been identified as a potential challenge in implementing MLCoC care, particularly in low-resource countries with limited nursing and midwifery staff. Few studies have conducted limited evaluation of the health economics and workforce implications of implementing MLCoC, especially in relation to team and caseload midwifery^{38,39} and for women at high risk of adverse outcomes including preterm birth. These limited studies have also applied inconsistent methods of economic evaluation, limiting the generalizability of their findings.⁴⁰ Group antenatal care lends itself to use in low-resource settings where staffing is limited and has been reported in a few studies as being effective in improving birth outcomes with no additional healthcare costs.⁴¹ However, the need for more research about patients' health outcomes as well as the economic and workforce implications of transitioning prenatal care into group settings is needed.⁴² Overall, more robust cost-effectiveness evidence is essential to inform decision makers, and to implement sustainable systems change in comparative maternity models for pregnant women at risk and to address health inequity.

6 | PRACTICE RECOMMENDATIONS

No specific model of care has been consistently shown to mitigate preterm birth across different care contexts. However, in practical terms, and across all global contexts and health systems the following practical steps can be taken to integrate continuity of care into existing care models:

- Define the existing and sustainable antenatal care model(s), in primary, secondary, and tertiary care settings that require optimization for enhanced screening, risk identification,¹⁰ and prevention

of preterm birth and preterm labor, as well as for mitigation of its consequences during birth and postnatally. Defining models of care in every region/country, particularly in LMICs where this has not been fully realized, holds immense potential. It will not only provide a better understanding of the needs in terms of the number and training of care providers at different levels but also pave the way for the introduction of continuity. Once these models are well-established and standardized, we will be able to study their effectiveness, which is a crucial step toward reducing and improving outcomes in preterm birth.

- Determine how the existing and sustainable care model(s) at all levels of care can be employed to triage patients deemed at high risk of preterm birth to perinatal teams with skills in managing preterm birth prevention and mitigation services.
- Incorporate and optimize continuity of care and carer for the existing and funded care model, by ensuring that care is provided by named skilled and trained professionals able to address the patients' needs by providing evidenced advice and prophylaxis/treatments (management continuity), counseling and signposting of important

pregnancy health information to the mothers (informational continuity), and developing a professional respectful, trusting, and reassuring relationship (relationship continuity).

- Ensure that preterm birth prevention care is integrated into antenatal care services for other prevalent maternal conditions and risks to improve maternal engagement and compliance with care components.
- Define multidisciplinary local/regional care pathways for referral and management of women at high risk of preterm birth.
- Develop context-relevant guidelines for the prevention and management of preterm birth for implementation via existing care models.
- Ensure that women who have experienced extreme or very preterm birth are offered postnatal counseling, debriefing and support, and preconception discussions, preferably by skilled practitioners likely to be involved in their care in the next pregnancy to improve relational continuity.

These practice recommendations are outlined in Figure 2.

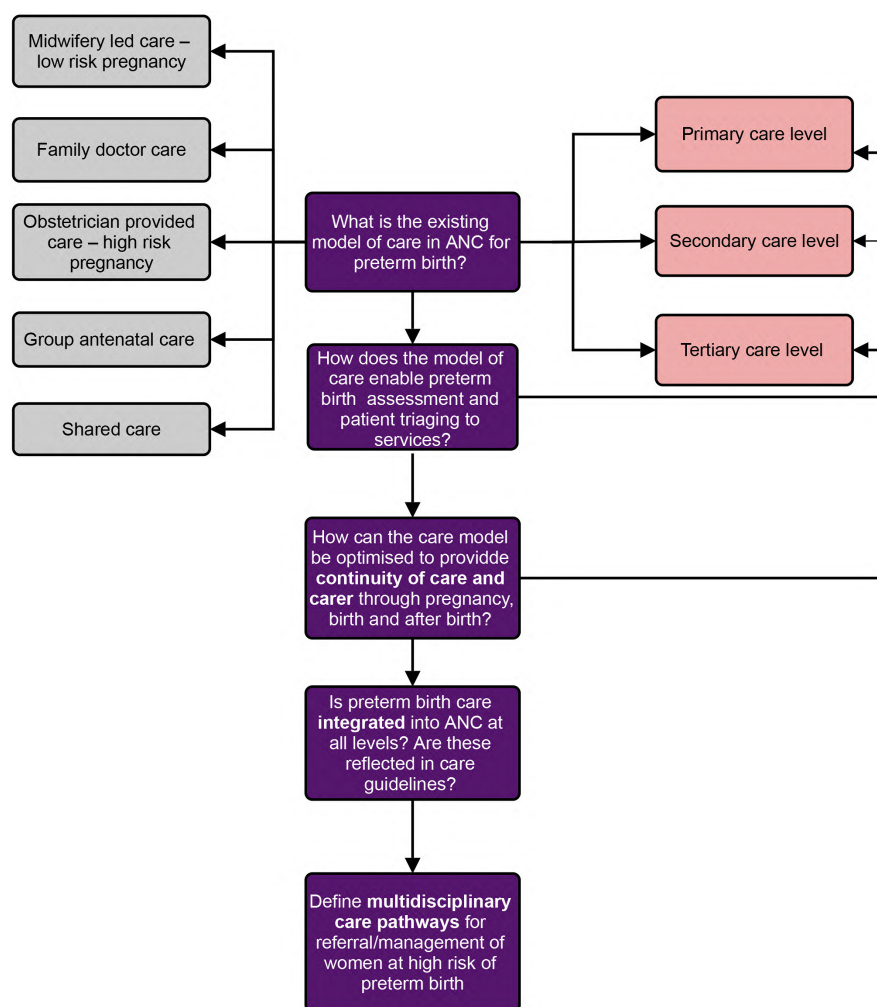


FIGURE 2 Practice recommendations for applying context-appropriate models of care to preterm birth prevention across primary, secondary, and tertiary care. ANC, antenatal care.

7 | RESEARCH RECOMMENDATIONS

- While there is consistent evidence of higher satisfaction levels among care users and givers for many models of care providing care continuity by a limited number of professionals, there remains a dearth of consistent high-quality evidence regarding the effectiveness of these models of care to mitigate preterm birth and other adverse fetomaternal outcomes in varied contexts and pregnancy risk cohorts. The extent to which many of these care models provide continuity of care and carer is also often not clearly defined. More research is needed to define the essential elements of care continuity within care models most likely to improve birth outcomes and mitigate preterm birth.
- In each care delivery context, health economic evaluations are needed to determine the comparative resource implications of existing and proposed models of care for preterm birth mitigation, and to determine whether each system can afford the changes required to improve care delivery.
- More research is also required to explore the impact of multi-professional continuity of care models delivered as a team, on preterm birth and other pregnancy outcomes, especially in the context of care provision for women with medical conditions or at increased risk of preterm birth. The effectiveness of preterm birth prevention services staffed by multidisciplinary teams comprising midwives, obstetricians, family practitioners (where appropriate), and social and bereavement services, in primary and secondary care, warrants further investigation.
- Implementation research co-developed with all stakeholders, including policy planners and funders, can enable intersectoral action that prioritizes investments to enhance service equity, quality, and coverage.

AUTHOR CONTRIBUTIONS

The FIGO Committee for Preterm Birth prioritized the concept and idea for the paper. DA wrote the first draft. All authors revised subsequent versions of the manuscript. All authors commented on the manuscript and approved the final version.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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