

Prep-for-Labor: Overview of FIGO's labor and delivery triage bundles of care to optimize maternal and newborn outcomes

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Abstract

Childbirth is an intense event in which decisions may need to be made in seconds to guarantee the health of both mother and newborn. Despite health systems and care approaches varying widely according to real-life scenarios, availability of facilities, beliefs, resources, staff, and geography, among others, optimal outcomes should be ensured worldwide. Triageing low-risk pregnancies from high-risk pregnancies is the first step to ensure proper allocation of resources. From this need, we developed FIGO's Prep-For-Labor triage methods, a series of 2-minute labor and delivery bundles of care, with special regard given to low- and middle-income countries and rural settings. Around 80% of women, once properly triaged, can pursue vaginal delivery with minimal intervention, while those at risk can either be managed on site or transferred promptly to an advanced care site. FIGO's bundles of care and good practice recommendations for labor and delivery and immediate newborn triage cover four clinical scenarios: (1) preterm labor; (2) induced or spontaneous labor at term; (3) cesarean delivery; and (4) newborn care. From rapid triage of the mother (low vs high risk) to the list of required equipment, description of skilled staff, and coordination of resources, the recommendations for care are introduced across these four areas in this overview article. Implementing the proposed management steps described in each summary can improve maternal and neonatal outcomes.

KEYWORDS

cesarean delivery, childbirth, labor, neonatal care, preterm birth, triage

1 | INTRODUCTION

Childbirth is a short, intense period where healthcare providers are confronted with critical and potentially life-altering decisions for both mother and newborn. The current article is based on FIGO's Prep-for-Labor methods of triage, with the goal of improving maternal and

newborn clinical outcomes. The obstetric care team, including the physician, midwife, nurse, medical assistant, and as needed the anesthesiologist and pediatrician, work together as an effective functional unit where both mother and newborn can achieve an optimal outcome. While the composition of the care team may differ depending on the setting and available resources,¹ there is a need for well-established protocols to triage emergent clinical care in labor and delivery.

*Complete list of members presented in Appendix A.

We propose a call to action to implement the proposed 2-minute labor and delivery care bundles described in this Supplement to effectively manage acute care for the mother, optimize the childbirth experience, and improve delivery outcomes, particularly in low- and middle-income countries (LMICs) and rural settings. It also employs the universally used newborn Apgar score for assessment at 1 minute and confirmed by 5 minutes. The aim is to enable low-risk patient management on site, leading to labor/delivery and newborn care with minimal intervention, while focusing on the high-risk patient and newborn that may need transfer to an advanced site, as feasible.

The bundles of care cover: (1) preterm labor; (2) induced or spontaneous labor at term; (3) cesarean delivery; and (4) newborn care. These will require a stable care setting, personnel with an appropriate skill set, and adequate staffing levels, equipment, and medical and surgical tools.

2 | PROTOCOLS FOR EFFECTIVE TIMELY CARE

The ability to provide effective and acute care to mothers and newborns varies based on the country, region, and available resources. In LMICs, the obstetric department is often represented by a level I clinical facility, often coordinated with a level II–IV hospital, starting in early pregnancy to reduce the high-risk case load in the primary clinical facility. In high-income countries, a hospital has both highly trained staff for high-risk maternal care and a neonatal intensive care unit (NICU) for newborns with serious conditions. However, the current reality is that even in those integrated settings, effective care may be limited due to a high volume of patients. The level of care and the need for integration has been previously addressed by the authors and others.^{2–5} At present, the shortage of trained, available personnel is still significant in LMICs, which contributes to disparate outcomes among clinical facilities.

3 | TRIAGE

It must be recognized that managing patients with different clinical presentations, ranging from term labor to emergencies requiring cesarean delivery, premature labor, complications, and onsite newborn care allows limited time to address patient symptoms and act. Table 1 provides a list to enable maternal/fetal assessment upon arrival at a care site. Table 2 identifies the high-risk maternal conditions that dictate whether management can be carried out on site or whether patient transfer is required, when feasible and practical. This is applicable to mother and/or newborn.

Pregnancy is a continuum during which the short duration of childbirth—compared to the 9 months of gestation—is the most critical time for survival of both the mother and fetus and has major consequences that can last a lifetime.⁶ Careful antenatal care and treatment of associated pathologies occurring during pregnancy can significantly reduce maternal and fetal risk during labor. Additionally, third-trimester obstetric emergencies represent a unique context in which two lives (mother and fetus) may be at risk and all efforts and actions

TABLE 1 Prep-For-Labor triage questionnaire on arrival.

Item	Information collected by staff
Patient arrival	<ul style="list-style-type: none"> Establish basic effective communication with the patient using verbal and nonverbal language Use a rapid rate of questioning to help provide important decisions for plan of care <p><i>Determine:</i></p> <ul style="list-style-type: none"> Stable/conscious Y/N Pain Y/N Blood pressure: normal/hypertension/hypotension Temperature: normal/fever/hypothermia Heart rate: normal/bradycardia/tachycardia Respiratory rate: normal/dyspnea
Definition of labor	<p><i>Labor diagnosis:</i></p> <ul style="list-style-type: none"> Contractions Y/N CTG normal/bradycardia/tachycardia Fetal size/position vertex/other Single/twin Cervix open cm/closed Rupture of membranes Y/N Chorioamnionitis Y/N
Parity	<ul style="list-style-type: none"> Nulliparous Multiparous
Gestational age	<ul style="list-style-type: none"> >34 weeks of gestation manage on site unless pathology <34 weeks consider transfer unless care on site feasible
Previous cesarean delivery	<ul style="list-style-type: none"> Previous cesarean Y/N Repeat cesarean feasible on-site Y/N Trial of labor feasible on-site Y/N
Infection/fever	<ul style="list-style-type: none"> Infection Y/N Currently treated Y/N Chronic Y/N Severe; if yes, consider transfer

must be ready to be performed in a short time and in the correct order. Labor and delivery can take up to 2 days, while cesarean delivery is rapid but requires advanced staff and equipment. Once a patient starts laboring, it is not possible to determine with certainty that there will not be failure to progress, abnormal fetal heart rate, or dystocia, and the need to perform an urgent or emergent cesarean. The common obstetric complications leading to high morbidity and mortality are fetal distress, sepsis, hypertensive disorders, obstructed labor, and risk of postpartum hemorrhage. The ability to identify those risk factors in any setting before or upon patient arrival is improved using the Prep-for-Labor bundles of care described in the articles in this Supplement and requires minimal time during this highly dynamic process.

Description of the requirements is key to addressing any resources that are missing or, if this is not possible, for timely referral to a higher-level center.

4 | THE PREP-FOR-LABOR FRAMEWORK

The first step in the Prep-for-Labor concept is defining the site of care as a primary, intermediate, or advanced care site, based on the available

TABLE 2 Definition of high-risk maternal conditions.

Maternal condition	Definition
Vaginal bleeding	<ul style="list-style-type: none"> • Signs of shock Y/N • Bleeding quantity. Visual/ pad • PPH drugs to treat/stabilize/transfer • No bleeding: patient self-report home/pad count • Hemoglobin >9 or <9
High blood pressure (>160/100 and without eclampsia seizures, otherwise treatment should be immediate)	<p><i>Ask about high blood pressure and assess Y/N</i></p> <ul style="list-style-type: none"> • Headache • Seizure • Severe chest pain • Dyspnea • Epigastric pain • Edema <p><i>If severe: consider transfer</i></p> <p>If above symptoms are excluded, ask about:</p> <ul style="list-style-type: none"> • current medications • previous treatments • blood and urine tests
Thrombosis	<p><i>Assess leg pain (Homans sign), leg temperature Y/N</i></p> <ul style="list-style-type: none"> • Assess risk factors • Current medications • Coagulation profile • Consider transfer if thrombosis is suspected and the center does not have an ICU

resources and the level of skilled personnel available for both mother and newborn. Therefore, patients presenting in labor at a primary or intermediate clinical facility can be rapidly screened and triaged. Assessment of whether it is appropriate for the patient to be managed on site based on available staff or prompt transfer to a higher-level facility should occur. In this rapid process, any specific missed step that is not promptly corrected can have serious and mostly irreversible consequences, since there is only a short period of time to transfer a patient to a safer setting.⁵ Childbirth events occur rapidly, in certain cases in an unpredictable sequence, and therefore the focus must remain on assessing the level of complexity of the patient and what is needed to provide targeted care.⁷ Even a short delay, in certain conditions, can result in severe morbidity or mortality.

5 | RAPID TRIAGE SHOWN TO BE EFFECTIVE IN IMPROVING MATERNAL AND NEWBORN OUTCOMES

In large-scale studies, using an effective triage method reduced risk for mother and newborn by early identification of patients who required advanced care and by promptly transferring those patients to advanced level II–IV centers.⁸ This minimized the risk in complex cases and enabled the level I clinical facility to offer effective care to most low-risk cases. The low intensity triage method (2 minutes) is an effective patient screening method for reducing complication rates by receipt of prompt suitable care or rapid transfer as the need arises. Consequently, most low-risk patients can have

a pleasant, comfortable environment requiring minimal intervention during labor.⁹ The method effectively shifts staff and tools to those patients requiring advanced care, maximizing site efficacy, and reducing morbidity and mortality. Prep-For-Labor is a rapid pragmatic triage questionnaire providing a detailed list of Y/N responses to diagnosis questions as a patient arrives at the care site. It covers both low- and high-risk conditions assessing both maternal and fetal conditions. Once this initial assessment has been made, the accompanying four papers in this Supplement^{10–13} provide detailed diagnostic and management steps covering low- and high-risk scenarios, and preterm, cesarean, and newborn care. The questions could also be translated into images suggesting conditions that the patient could point to, followed by verbal communication for confirmation and action. Table 1 addresses a patient's condition at arrival, delineating maternal and fetal condition in a prompt manner. Obtain maternal blood pressure, temperature, pulse, respiration rate, heart rate, uterine size, fetal position and heart rate, and contractions; if found to be normal, a vaginal delivery is feasible in approximately 80% of cases. Table 1 also addresses whether there is fever/infection. Table 2 focuses on high-risk maternal conditions (bleeding, hypertension, or thrombosis) for which subsequent questions should be pursued, combined with clinical examination defining whether the case can be handled on site or transferred to a higher-level center. With correct use of the checks given in Tables 1 and 2, staff can easily evaluate whether they have the required staff and tools to offer effective care. Cesarean delivery requires a rigorous setting¹⁴; therefore, if the facility is not equipped, the patient should be transferred to a higher-level center. Following triage, the consequent decision-making must be progressive and ready to achieve a goal. However, childbirth is highly dynamic, and awareness of the changing situation must be ongoing. Nevertheless, the need to change clinical setting is unlikely if the triage process was performed well and supported low-risk patient management on site. In 80%–85% cases, once the triage has clearly defined a low-risk case, childbirth can be handled satisfactorily in a primary setting.

6 | CARE COORDINATION WITHIN THE TEAM AND PARTNER FACILITIES TO OPTIMIZE MATERNAL AND NEWBORN OUTCOMES

The key issue is coordination within an established integrated healthcare network. The earlier care is coordinated and carried out then the more successful it will be; if no risk factors are identified, then delivery can proceed with minimal medical intervention. A leader must be established within a clinical facility based on seniority/experience to enable the team to work as a cohesive unit. This is key for the Prep-for-Labor bundle of care to be successful since it is a highly active and changing process. The suggested approach is “lead and follow up”, where each party plays an important and meaningful role. This is an established principle already applied in the operating room. Predefining such roles is critical for overall success. For

example, one team member should oversee patient triage/intake, report information to the rest of the team, declare the urgency of the situation, and provide suggestions for further action. Other members will determine whether the necessary staff, medications, and surgical instruments are available as needed.^{4,15,16} Even with limited resources, this minimizes intervention during low-risk labor and delivery while focusing on patients in whom more intense scrutiny and care are needed.

7 | CHILDBIRTH PREP-FOR-LABOR BUNDLES OF CARE

The proposed childbirth bundles are divided into: (1) preterm labor; (2) induced or spontaneous labor at term; (3) cesarean delivery; and (4) newborn care, which is rarely but importantly integrated with childbirth here. Many items in the bundle are binary (Yes/No answers), enabling a rapid decision-making process since the patient's condition may change rapidly. Overall, these bundles provide up-to-date evidence on how to proceed, enabling optimized maternal and newborn outcomes.

7.1 | Preterm labor: Timely diagnosis and management

The definition of preterm is labor at less than 37 weeks of gestation¹⁷; however, diagnosis is not always easy. The COVID-19 pandemic and its aftermath reduced access to antenatal care and timely ultrasound dating, reducing accuracy of gestational age. Therefore, the dilemma faced is whether attempts to stop labor should be made or if it is not feasible. Additional difficulties arise concerning antenatal steroid prophylaxis to improve newborn outcome. Preterm labor/birth requires prompt and intensive long-term newborn management, impacting the facility and staff. Is a NICU available on site or is transfer to an advanced care center needed? The Prep-for-Labor bundle of care can assess whether labor should be delayed/stopped or medical interventions ranging from labor induction to emergency cesarean are needed, balancing the prematurity risks. It should also define specific fetal conditions such as fetal distress, fever, and inflammatory response, and maternal conditions such as chorioamnionitis, premature rupture of membranes, sepsis, hemorrhage, hypertensive disorders requiring immediate attention, and medical interventions. In an ideal setting, each case of preterm labor requires rapid, integrated, and coordinated efforts, with a neonatology unit at levels II–IV if not available on site. The article by Ubom et al.¹⁰ provides an up-to-date approach and effective management of preterm pregnancy. The emphasis is on addressing gaps and offering solutions when management takes place at level I facilities in LMICs and in rural versus urban high-resource settings.

7.2 | Induced and spontaneous term labor and delivery

The timing of labor induction should be planned in the third trimester of pregnancy and not when a patient is already in labor. However, intervening risk factors may develop at any time during pregnancy, leading to the need for labor induction. The available clinical features of the patient are frequently limited, thereby the rapid Prep-for-Labor triage method defines the patient as low or high risk. Determining accurate gestational age by early ultrasound is optimal; however, following the COVID-19 pandemic, many facilities have limited access to this vital information. Standard timely antenatal tests must be performed following local protocols and additional specific tests can be used to diagnose and treat emerging pathologies of both mother and fetus. Timely scheduled follow-up, laboratory and/or imaging, and frequency of consultations may vary according to pregnancy progress and associated diagnosis. The World Health Organization recommends that at least six antenatal visits are performed during pregnancy followed by a postpartum visit. Therefore, from early pregnancy the patient must become an active participant in the shared decision-making. This is a window of opportunity for communicating about good health habits, prospects for labor and delivery, psychological factors related to motherhood, and contraception use for the postnatal period. Inaccurate gestational age can lead to erroneous decisions for planned birth or labor induction. For example, inducing a woman with gestational diabetes requires accurate dating to prevent iatrogenic prematurity. Similar considerations are needed for hypertension, fetal restriction, and twin pregnancies.

Patients at term in active labor are expected to reach suitable facilities to enable safe childbirth. If possible, labor should proceed spontaneously, with minimal intervention. However, reality frequently does not meet our expectations given that labor is a dynamic and irreversible process with many intervening variables, such as whether labor advances spontaneously or requires augmentation, rupture of membranes already done or to be performed, cervical dilatation, and good fetal position with reassuring fetal conditions.¹⁸ Additional management steps are defined by any maternal medical and surgical complications that can occur. The Prep-for-Labor checklist enables staff to make informed decisions about whether the site has the right staff and tools to address both induced and active labor cases. Ideally, an advanced site has been previously identified, enabling timely patient transfer as needed. The article by Borovac-Pinheiro et al.¹¹ provides up-to-date bundle of care information on managing spontaneous or induced labor. It is essential to continue to train staff regarding clinical and nonclinical aspects of obstetric healthcare management and teach them how to apply good teamwork and communication techniques. Implementation of the triage method will improve both maternal and newborn outcomes.

7.3 | Elective cesarean delivery and repeat steps to promote trial of labor after cesarean to enable vaginal birth

This surgical procedure aims to deliver a fetus when the vaginal route is not possible or feasible thereby preventing/minimizing maternal and/or fetal morbidity and mortality. Multiple cesareans are unjustified, and this epidemic must be halted.¹⁹ Cesarean delivery can be planned and optimally should be performed after 39 weeks of gestation (with good dating) or earlier if maternal and/or fetal conditions warrant it after 20 weeks. If planned, the facility must be informed ahead of time, and it is expected that on arrival the setup is ready for the patient. However, if the case is complex, the patient should be sent to a higher-level center. Similarly, if there is a planned trial of labor after cesarean (TOLAC), which is preferable when feasible, the designated facility should be ready to receive the patient. However, after two cesareans a trial of labor is not recommended. As with any abdominal surgery, the indications must be carefully considered, along with the consequences and risks. Indications for cesarean may be maternal and/or fetal. With increasing number of cesareans, the severity of complications continues to rise. Therefore, clinicians are increasingly facing placenta accreta spectrum, postpartum hemorrhage requiring cesarean hysterectomy, with increasing maternal mortality rates. Consequently, cesarean delivery procedures range from the low transverse method to severe cases requiring a multidisciplinary team.

A decision process is required for a patient arriving in labor with possible maternal and/or fetal compromise that may or may not require a cesarean. Here the Prep-for-Labor triage provides essential information defining urgency, plan for action, and predicting whether a TOLAC is indicated and feasible, or whether cesarean should follow. It defines the specific surgical method to be used and whether the facility has adequate staff and equipment available for safe performance of the procedure. Once the decision is made, continuous awareness of the patient's progress is vital especially with the decision for TOLAC where the risk of uterine rupture is low yet still present. The article by Barnea et al.¹² provides practical step-wise guidance and effective decision tools for cesarean delivery, only when indicated and clinically necessary. The aim is to simplify the decision and intervention process to minimize surgical risks and facilitate recovery after surgery by providing a cesarean management overview, from simple to complex cases, to improve maternal and newborn outcomes.

7.4 | Newborn care: Practical approach for term and preterm birth

The goal here is to incorporate newborn care into obstetric care. This is important because in the case of fetal distress or preterm birth, advanced care of the newborn is needed. Once the baby is born, the Apgar score is determined at 1 minute and confirmed by 5 minutes. This defines if advanced care is needed, which requires

the skills of qualified pediatricians, whose availability on site is frequently limited. This must be an essential consideration where the Prep-for-Labor triage is implemented, in which there is a necessary integration between childbirth and newborn care. This critical aspect is frequently not presented in an obstetric setting. The article by Costa et al.¹³ aims to bridge this important gap in care. This is further reinforced because limited staff and tools on site can make a major difference in newborn care. The simple steps proposed are practical for many newborns who are low or moderate risk. However, when the risk to the newborn is high, based on Apgar score and further specific diagnostic criteria, transfer to an advanced care center with NICU is suggested. It is expected that by implementing simple and practical approaches, the ability to handle safely both term and close-to-term newborns covering approximately 80% of cases will significantly reduce newborn morbidity and mortality.

8 | HIGH-RISK MANAGEMENT

The high-risk conditions affecting vaginal or cesarean delivery are delineated in each of the four triage papers.¹⁰⁻¹³ They address low-versus high-risk events and suggest diagnosis and management on site or need for transfer. In each setting, prompt diagnosis of the condition and management of maternal and fetal complications are emphasized, including hypertension and pre-eclampsia, infections, prematurity, and prevention of postpartum hemorrhage. The rapid 2-minute triage aims to address those action items in a timely manner. By focusing on the specific condition, significant risk reduction can be achieved thereby improving maternal and newborn outcomes.^{18,20-22}

9 | CONCLUSION

These four bundles of care aim to identify rapidly and accurately low- versus high-risk patients. This enables low-risk patients to proceed toward vaginal delivery requiring minimal intervention, which occurs in an estimated 80% of cases. This enables staff in resource-limited settings and rural communities to focus on patients at risk. The Prep-for-Labor triage described in this Supplement can help staff make timely critical decisions on whether to keep or transfer a patient to a higher-level center, maximizing the quality of care and potentially saving lives. If transfer is not feasible in a timely manner, high-risk patients can be treated locally using evidence-based up-to-date measures that are shown to improve childbirth. Implementation of these Prep-for-Labor triage methods will reduce patient risk and significantly improve maternal and newborn outcomes.

AUTHOR CONTRIBUTIONS

Eytan R. Barnea, Martin Muller, and Wanda Nicholson conceived the article. Eytan R. Barnea, Martin Muller, Annalisa Inversetti,

Nicoletta Di Simone, Rodolfo Pacagnella, and Anderson Borovac-Pinheiro prepared the first draft. Wanda Nicholson supervised the manuscript.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

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

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How to cite this article: Barnea ER, Muller M, Di Simone N, et al. Prep-for-Labor: Overview of FIGO's labor and delivery triage bundles of care to optimize maternal and newborn outcomes. *Int J Gynecol Obstet.* 2023;00:1-6. doi:[10.1002/ijgo.15112](https://doi.org/10.1002/ijgo.15112)

APPENDIX A

FIGO CHILDBIRTH AND POSTPARTUM HEMORRHAGE COMMITTEE

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