Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

APR 28 2021

ADMINISTRATIVE ORDER
No. ~~2020~~ 2021-0034

SUBJECT: National Policy on Essential Intrapartum Care at Primary Level Non-Specialist Birthing Centers

I. BACKGROUND AND RATIONALE

According to the Philippine Statistics Authority (PSA), the 2018 registered livebirths numbered 1,668,120. Majority of these births happened in health facilities and from women without risk factors. However, despite the absence of risk factors in majority of women, the course of labor and delivery can be unpredictable making the intrapartum period a critical phase.

In line with the *FOUR*mula One Plus for Health Strategy, the call for Universal Health Care and the commitment to accomplish the targets of Sustainable Development Goal 3, the Department of Health through the National Safe Motherhood Program, strengthens its policies on labor and childbirth. This is to further improve the quality of essential intrapartum care and ensure that women and their babies survive the complications that might occur during this critical phase. This policy therefore sets the tone for a positive labor and childbirth experience as it recognizes the balance between childbirth as a process within the woman's own capability and the provision of basic emergency obstetric and newborn care.

This Administrative Order details common practices used during labor and delivery guided by the World Health Organization's published *Recommendations: Intrapartum Care for a Positive Childbirth Experience (Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO)* and elevates the concept of positive experience of care as critical in ensuring high-quality labor and childbirth care provision towards improved women-centered outcomes and not just as complementary to the provision of basic emergency obstetric and newborn care (BEmONC). It emphasizes the critical role of skilled health professionals in ensuring high quality care and sets the new standard of care for women during this intrapartum period.

II. OBJECTIVE

This Order shall provide the technical guidelines in the provision of essential intrapartum care for positive childbirth experience.

III. SCOPE OF APPLICATION

This Order shall apply to all maternal and newborn care providers/skilled health professionals in primary care facilities and non-specialist birthing centers in Rural Health Units, Urban Health Centers, Local Government Unit (LGU) Hospitals and similar service providers in the private sector such as private practicing midwives, nurses and doctors.

IV. DEFINITION OF TERMS

A. **Active Phase of the First Stage of Labor** refers to the period characterized by regular uterine contractions with progressive cervical dilatation **from 4 cm** until full dilatation.

B. **Companion of Choice** refers to any person chosen by the woman to provide her with continuous support during labor and childbirth. This may be someone from the woman's family or social network such as her spouse/partner, a female friend or relative, a barangay health worker or traditional birth attendant.

C. **Doctor-led Continuity-of-Care** refers to a service delivery model where a doctor such as the Municipal (MHO) or City Health Officer (CHO) leads a team of nurses, midwives and barangay health workers in the provision of quality care to women throughout their antenatal, intrapartum and postnatal continuum.

D. **Health Facility Manager** refers to any person tasked to take charge of the upkeep of the health facility. This person could be the Municipal or City Health Officer, Chief of Hospital, Facility/Hospital Administrator, designated Nurse or Midwife.

E. **Healthy Pregnant** refers to a pregnant woman who has NO identified risk factor for herself or her baby. Such risk factors are defined in *AO 2016-0035 on the Provision of Quality Antenatal Care and DC 2021-0005 on the Definition of Low Risk Pregnancy and High Risk Pregnancy.*

F. **Intrapartum Period** refers to the act of giving birth that starts from the onset of labor to the end of the third stage of labor which is characterized by the delivery of the baby.

G. **Latent Phase of the First Stage of Labor** refers to the period characterized by irregular uterine contractions and variable changes of the cervical dilatation **up to 4 cm.**

H. **Non-Specialist Birthing Center** refers to a primary birthing center such as those based in Rural Health Units and Urban Health Centers, nurse and midwife-operated birthing centers as well as non-departmentalized primary hospitals whose capability is limited to provision of Basic Emergency Obstetric and Newborn Care.

I. **Positive Childbirth Experience** refers to an event that fulfills or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff.

J. **Respectful Maternity Care (RMC)** refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth.

K. **Second Stage of Labor** refers to the period between full cervical dilatation and birth of the baby during which the woman has an involuntary urge to bear down as a result of expulsive uterine contractions.

L. **Third Stage of Labor** refers to the time from the birth of the baby to the expulsion of the placenta and membranes.

V. GENERAL GUIDELINES

A. All health workers implementing safe motherhood program in communities as well as those providing services in health facilities shall provide quality care during labor and childbirth to ensure a positive childbirth experience.

B. To ensure a sense of personal achievement and control of the physiological labor and birth, pregnant women shall be involved in decision-making even when medical interventions are needed or wanted.

C. A doctor-led continuity-of-care throughout the antenatal, intrapartum and postnatal continuum should be the norm in all settings for better accountability and client safety.

D. For healthy pregnant women presenting in labor, admission for maternal and fetal status monitoring shall be at the onset of active phase of the first stage of labor (4 cm with 3-4 contractions in 10 minutes). However, if the place of residence is far from the facility or if the woman prefers to be in the health facility, she may be accommodated in a maternity waiting area to await active labor and supported appropriately. Any intervention to accelerate labor and childbirth is not allowed.

VI. SPECIFIC GUIDELINES

A. Provision of respectful maternity care

1. In accordance with human rights-based approach to health, all primary care facilities and non-specialist birthing centers staff shall provide respectful care to improve women's experience of labor and childbirth and address health inequalities.

2. At all times, all primary care facilities and non-specialist birthing centers shall:

    a. Allow women to have their companion of choice throughout labor and childbirth in accordance with facility policy:

        i. Whenever possible, birthing centers shall allow companions of choice to take part in the provision of care during labor and childbirth. This is a cost-effective and sensitive way to address concerns of privacy, cultural preferences and resource use.
        ii. Birthing centers shall ensure the availability of health workers support to women who want to have a birth companion but are unable to have one for various reasons. A Barangay Health Worker may be assigned to provide such support among others.

    b. Practice courtesy through gentle actions and use of respectful gender sensitive language:

        i. Introduce self to the woman and her companion and address them by their names.

ii. Offer the woman and her companion the information they need in clear and concise manner. Likewise, make her understand that she has a choice and her choices are respected.
iii. Explain the procedure to the woman and always obtain a written consent from the woman or her companion.
iv. Always maintain visual and auditory privacy and confidentiality even in wards.
v. Likewise, health facility managers shall endeavor to ensure a respectful and dignified working environment for their staff.

B. Doctor-led continuity-of-care

1. The Municipal and City Health Officers as operators of the Birthing Center shall supervise and monitor their respective team(s) of health workers composed of nurses and midwives and Barangay Health Workers (BHWs) in the provision of care throughout the antenatal, intrapartum and postnatal continuum. This shall include provision of continuing care to women after hospital discharge. Likewise, they shall maintain an efficient link with a Health Care Provider Network (HCPN) for systematic referral when necessary.

2. Client's preference relative to continuity of care, e.g. clients who prefer not to be followed-up at home, after hospital discharge by the RHU or Health Center staff shall be respected.

C. Monitoring of pregnant women presenting in spontaneous labor

1. On presentation at a facility, a maternal and fetal assessment shall be done by a doctor (preferably trained on BEmONC), to ensure that undiagnosed or developing complications are identified and the woman is appropriately referred early to a hospital with capability to provide comprehensive emergency obstetric and newborn care (CEmONC).

2. Non-doctors such as BEmONC-trained nurses and midwives, performing maternal and fetal assessment shall be supervised by a doctor or specialist partner in the case of a private practicing midwife. Supervision may be done with the doctor either physically present at the facility or by remote communication, e.g. video call, telephone call, chat, or text messaging.

3. Routine observations to assess maternal and fetal well-being shall be performed as needed on all women awaiting admission to the labor room.

D. Provide appropriate care to women during the latent and active first stage of labor

1. Depending on a woman's preference, the following relaxation techniques may be provided to healthy pregnant women requesting pain relief during labor:

a. Manual techniques, such as gentle massage or application of warm packs
b. Progressive muscle relaxation
c. Deep breathing exercise
d. Listening to relaxing soft music
e. Mindfulness exercises
f. Other non-pharmacological pain relief options or cultural traditional practices that women might find soothing.

2. Women not manifesting any sign and symptom of complication are considered low risk (*Please refer to AO 2016-0035 for the definition of low-risk pregnancy)* and shall be allowed the following activities according to their preferences during labor:

    a. Oral fluid and food intake
    b. Mobility such as walking
    c. Assume upright position

3. Birthing center staff shall Inform all women in labor that a standard duration of the latent phase of the first stage can vary widely from one woman to another. However, the duration of active phase of the first stage (from 4 cm until full cervical dilatation) usually does not extend beyond 12 hours in primigravids, and usually does not extend beyond 10 hours in multigravids.

4. During the active stage of labor, birthing center staff shall provide supportive care to pregnant women with spontaneous labor onset to experience labor and childbirth according to each individual woman's natural reproductive process **without** interventions to shorten the duration of labor, provided that:

    a. The condition of the mother and baby is stable,
    b. There is progressive cervical dilatation, and
    c. The expected duration of labor is within the recommended limits: 12 hours in primigravids; 10 hours in multigravids.

E. Monitoring the progress of labor

1. The partograph shall be used as a tool to monitor the progress of labor in birthing centers with no specialists and whose capability is limited to provision of basic emergency obstetric and newborn care. This includes birthing centers based in Rural Health Units, Urban Health Centers, non-departmentalized primary hospitals, and doctor, nurse or midwife – operated birthing centers as well as birthing centers located in geographically isolated and difficult to reach areas.

2. As an integral part of quality intrapartum care, fetal condition shall be assessed on admission as well as regularly throughout labor, by monitoring the fetal heart rate using Doppler Ultrasound device.

    a. **Interval**: Auscultate every 15–30 minutes in active first stage of labor, and every 5 minutes in the second stage of labor.
    b. **Duration**: Each auscultation should last for 1 full minute; if the fetal heart rate (FHR) is not in the normal range (i.e. 120–160 beats per minute (bpm)), position the woman on her left side and give oxygen and then repeat auscultation after 15 minutes to cover at least 3 uterine contractions. If the fetal heart rate (FHR) is less than 120 or more than 160 bpm, prepare for immediate referral.
    c. **Timing**: Auscultate after a uterine contraction.

3. Digital vaginal examination at interval of 4 hours is recommended for routine assessment of active phase of the first stage of labor. It may be done earlier than 4 hours if necessary. Vaginal examinations of the same woman by multiple caregivers around the same time or at different time points should be avoided to prevent infection.

4. Birthing center staff shall promptly refer a woman with a spontaneous labor onset to a hospital with CEmONC (Comprehensive Emergency Obstetric and Newborn Care) capability within the Provincial or City Health Care Provider Network (HCPN) such as the Provincial Hospitals, Regional Hospitals and Private Hospitals with the same capability when her cervical dilatation rate threshold is depicted by the partograph to be **below 1 cm/hour** during the active phase of the first stage of labor using 4 cm cervical dilatation as the alert line or when any other maternal or fetal abnormality is identified.

5. When making referrals, birthing center staff shall:

    a. Explain to the patient and her companion the reason for referral.
    b. Promptly notify the ambulance or patient transport vehicle (PTV) driver about the referral.
    c. Make an advance call to the referral hospital about the patient to inform the receiving staff about the referral and her condition.
    d. Notify the health staff assigned to accompany the patient to the hospital.
    e. Administer initial (loading) dose of appropriate life-saving drug (*AO 2015-0020 on administration of life saving drugs*) before transport and record in the patient's chart and referral sheet.
    f. Properly endorse the patient to the referral hospital by preparing an appropriate referral letter with the following enclosures: 1.) patient's records or chart including the partograph, 2.) patient's Birth Plan (*Mother-Baby Book*).

F. Procedures that are NOT recommended

1. Routine perineal or pubic shaving.

    a. Birthing center staff shall explain to the woman why this procedure is not recommended, while also informing her that her preference will be respected.
    b. In situations where a woman chooses to have perineal or pubic shaving prior to birth, she shall be advised to arrange to be shaved wherever and by whomever she is most comfortable with: i.) at home shortly before the time of labor and childbirth by self or family member, ii.) at the Birthing Center by a health personnel.

2. Administration of enema

    a. The administration of enema has not shown to reduce the duration of labor nor confer any other clinical benefits. Birthing center staff shall explain to the woman that enema is not necessary, it is considered invasive and causes discomfort to women.

G. Provision of care during the second stage of labor

1. Birthing center staff shall inform the woman that the duration of the second stage varies from one woman to another. Among primigravids, birth is usually completed within 2 hours whereas among multigravids, birth is usually completed within 1 hour.

2. If the second stage of labor is reached, a nurse or midwife trained on BEmONC (basic emergency obstetric and newborn care) should reassess the patient within 1 hour and notify her or his doctor supervisor or partner specialist of any finding. Under the direct (physical presence) or indirect (telephone/electronic instruction) supervision of the doctor or partner specialist, appropriate intervention must be done within 2 hours.

3. Birthing center staff shall allow the adoption of a birth position of the individual woman's choice, including upright positions. It is important that any particular position is not forced on the woman and that she is encouraged and supported to adopt any position that she finds most comfortable.

    a. Birthing center staff shall ensure that the well-being of the baby is adequately monitored in the woman's chosen position. Should a change in position be necessary to ensure adequate fetal monitoring, the reason should be clearly communicated to the woman.
    b. A practical approach to positioning in the second stage for women desiring an upright birth position might be to adapt to a semi-recumbent or all-fours position just before expulsion of the fetus, to facilitate perineal techniques to reduce perineal tears and blood loss.
    c. The birthing center staff shall appropriately adjust to the woman's preferred birthing position.

4. Birthing center staff shall encourage and support women in their expulsive phase of the second stage of labor to follow their own urge to push.

    a. Apply "hands on" guarding of the perineum during this stage to avoid sudden expulsion of the presenting part and thus reduce perineal trauma and facilitate spontaneous birth.
    b. Routine or liberal use of episiotomy should be avoided for women undergoing spontaneous vaginal birth.
    c. If the performance of episiotomy is inevitable, this should be done by a doctor using effective local anaesthesia and after the woman's informed consent is sought. Likewise, suturing of the episiotomy shall be done immediately after the delivery of the baby and while the anesthesia is still in effect to prevent excessive bleeding.

H. Active management of the third (3^{rd}) stage of labor (AMTSL) shall be performed to prevent postpartum hemorrhage.

1. The use of uterotonics for the prevention of postpartum hemorrhage (PPH) during the third stage of labor is recommended for all births.

    a. Oxytocin 10 IU intramuscularly given after the delivery of the baby and after ruling out of the presence of a second (2^{nd}) baby or after the delivery of the placenta is recommended for the prevention of postpartum hemorrhage (PPH).
    b. The oral use of methylergometrine is NOT recommended.

2. Controlled cord traction characterized by a gentle non-directional traction of the cord with suprapubic countertraction when the uterus is contracted by a skilled health professional is recommended.

3. Properly timed umbilical cord clamping (done when pulsation stops or within 1 – 3 minutes after birth) is recommended for improved maternal and infant health and nutrition outcomes. Milking the cord is NOT recommended.

4. Gentle uterine massage may be applied over the uterine fundus after delivery of the placenta.

I. Provision of Essential Newborn Care (*Please refer to AO 2009-0025 for a detailed instruction on Essential Newborn Care)*:

1. Immediate and thorough drying within the first 30 seconds. Suctioning of the mouth and nose shall NOT be performed among newborns born through clear amniotic fluid and who start breathing on their own after birth.

2. Initiation of skin-to-skin contact. Newborns without complications shall be kept in skin-to-skin contact with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.

3. Properly timed cord clamping *(please refer to item H.3).*

4. Non separation of the Newborn from the Mother for early initiation of breastfeeding. All newborns, including low-birth-weight (LBW) babies shall be put to the breast when the mother and baby are clinically stable and ready, usually within 30-90 minutes after birth.

5. All newborns shall be given the following after their first full breastfeeding:

   a. One (1) mg of vitamin K intramuscularly after birth (i.e. after the first hour by which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated).
   b. Birth dose of hepatitis B and BCG vaccines.
   c. Eye prophylaxis using tetracycline or erythromycin.
   d. Bathing should be delayed until 24 hours after birth. If this is not possible due to cultural reasons, bathing should be delayed for at least six hours.
   e. Use of bonnet and appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of bonnet. The mother and baby should not be separated and should stay in the same room 24 hours a day.
   f. Monitor vital signs: Heart Rate, Respiratory Rate and Body Temperature

      i. Every 15 minutes for the first hour
      ii. Every 30 minutes for the succeeding hours until discharge.

J. Immediate postpartum care during the first 24 hours shall include the following:

1. All postpartum women shall have regular assessment of the following:

   a. Vaginal bleeding
   b. Uterine tone
   c. Fundal height
   d. Vital signs (blood pressure, heart rate, body temperature and respiratory rate) as follows:

      i. Every 15 mins for the first 2 hours
      ii. Every hour in the next 4 hours
      iii. Every 6 hours thereafter until discharge.

   e. Urine void should be documented within 6 hours.

2. Routine antibiotic prophylaxis is NOT recommended for women with uncomplicated vaginal birth as well as for women with episiotomy and 1st and 2nd degree laceration.

K. After an uncomplicated vaginal birth in a health care facility

1. All healthy mothers and newborns should receive care in the facility for at least 24 hours after birth. Before discharge –

   a. Baby should be breastfeeding well.
   b. Bleeding in the mother should be controlled.
   c. Mother and baby should have no signs of infection.

2. The woman shall be provided with instruction on postpartum/postnatal check-up schedule for her and her baby.

VII. ROLES AND RESPONSIBILITIES

A. Department of Health (DOH)

1. The Disease Prevention and Control Bureau (DPCB) through its National Safe Motherhood Program (NSMP) shall:

   a. Provide technical oversight in the implementation of this Administrative Order, and
   b. Monitor and evaluate the national implementation of this policy through its Program Coordinators at the Centers for Health Development.

2. The Centers for Health Development (CHDs) and Minister of Health (MOH) Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) through its Technical Division, Local Health System Division and Regulation Licensing and Enforcement Division shall:

   a. Ensure compliance to this policy by public and private non-specialist birthing centers; and
   b. Monitor and evaluate the regional and LGU implementation of the policy and apprise the National Safe Motherhood Program accordingly.

3. In addition to their regular functions, the Development Manager Officers (DMOs), shall provide technical assistance in the implementation of this policy as necessary.

B. Local Government Units (LGUs) as the primary implementer of the policy, shall ensure that health officers at provincial and municipal levels, as well as owners of private non-specialist operated birthing centers (e.g. nurse and midwife managed lying-ins) in their respective area of jurisdiction comply with the provisions of this policy.

C. Birthing Centers shall ensure access of patients to appropriate higher level services and interventions, as necessary, through a functional Health Care Provider Network (HCPN).

D. Health Partners shall provide necessary technical assistance and support to the implementation of this policy.

VIII. SEPARABILITY CLAUSE

If any clause, sentence, or provision of this Order shall be declared invalid or unconstitutional by any court of law or competent authority the other provisions not affected shall remain valid and effective.

IX. REPEALING CLAUSE

All orders, rules, regulations and other related issuances inconsistent with or contrary to this order are hereby repealed, amended or modified accordingly. All other provisions of existing issuances which are not affected by this order shall remain valid and in effect.

X. EFFECTIVITY

This Order shall take effect after fifteen (15) days following its publication in a newspaper of general circulation and upon filing three (3) certified copies to the University of the Philippines Law Center.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

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MAY 05 2021
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KMITS - RECORDS SECTION
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