Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

AUG 01 2019

ADMINISTRATIVE ORDER
No. 2019- 0026

SUBJECT: **National Policy in the Provision of Birthing Assistance to Primigravid and Grand Multigravid Women**

I. BACKGROUND AND RATIONALE

Gravidity and parity are associated with risks in pregnancy and delivery. Specialists in the field of obstetrics have observed primigravidas, regardless of age to be at significantly higher risk for prolonged first and second stage of labor, increased chances of fetal distress and need for intensive monitoring as compared to the multigravidas. Primigravidas are also at increased risk for emergency caesarian section. Likewise, the chances of postpartum hemorrhage and perinatal mortality is high among this group. This claim is confirmed by a study conducted in Karachi, Pakistan on *Primiparity as an Intrapartum Risk Factor (Nazia Hashim, Sonia Naqvi, Majida Khanam, Hassan Fatima Jafry (Sir Syed Hospital & Medical College for Girls, Karachi. Journal of Pakistan Medical Association, July 2012).* The study concluded with a recommendation to counsel primigravid women on skilled health professional supervised antenatal care and delivery and discourage delivery outside hospital premises.

Multigravida and grand-multiparity remain to be an obstetric risk. Women in this group are found to be more likely to develop premature rupture of labor membranes, hypertensive diseases in pregnancy, placenta previa and other medical conditions. Likewise, postpartum hemorrhage, anemia and sepsis are common among this group. Fetal distress, birth asphyxia and birth weight outside the normal range are also observed to be significantly higher in grand-multiparous women, and this may explain the higher perinatal mortality found in this group. (*Grand-multiparity: Is it still an obstetric risk? Adeola F. Afolabi, Adewale S. Adeyemi* Department of Obstetrics and Gynaecology, College of Health Sciences, Ladoke Akintola University of Technology, Osogbo, Nigeria, May 2013).*

Many studies and local specialists conclude that while grand-multiparity is on a downward trend, it still remains an obstetric risk, therefore, the importance of advising and encouraging women to give birth in a well - equipped facility with comprehensive emergency obstetric and newborn care (CEmONC) capability should be emphasized among the obstetric specialist population and birthing center staff so as to reduce the complications that are found to be associated with the condition.

It is in the light of the above findings and the call for quality maternal and newborn care that this Order is being issued.

II. OBJECTIVE

This Order provides technical guidance to maternity care providers and Birthing Center staff on the provision of birthing assistance to all primigravid and grand multigravid women, regardless of age.

III. SCOPE OF APPLICATION

This Order shall apply to all providers of maternal care services in the public and private sector and at all levels of the health care delivery system.

IV. DEFINITION OF TERMS

1. **Gravidity** (Gravida) refers to the number of times a woman has been pregnant regardless of the outcome.

2. **Primigravida** refers to a woman who is pregnant for the first time. In the clinical area, this is referred to as G1 or gravida 1.

3. **Multigravida** refers to a woman who is pregnant for at least a second time. In the clinical area, this is referred to as G2 or gravida 2 (second pregnancy), G3 or gravida 3 (third pregnancy), G4 or gravida 4 (fourth pregnancy) regardless of the outcome of the pregnancy.

4. **Grand multigravida** refers to a woman who is pregnant for the 5^{th} time or more regardless of the outcome.

5. **Parity** refers to the number of times a woman has given birth to a fetus who is at least 24 weeks age of gestation (AOG) regardless of whether the baby was born alive or stillborn.

6. **Nullipara** – refers to a woman who has never given birth to a livebirth or stillbirth. In the clinical area this is referred to as P0 or para 0. Thus, a woman who had 1 pregnancy but has not given birth is referred to as G1P0 or gravida 1 para 0.

7. **Primipara** refers to a woman who had 1 pregnancy that resulted in a fetus that attained a weight of at least 500 grams or a gestational age of 24 weeks, regardless of whether the baby was born alive or stillbirth and whether it was single or multiple birth. In the clinical area, this is referred to as P1 or para 1. Thus, a woman who had 1 pregnancy and 1 birth is referred to as G1P1 or gravida 1 para 1.

8. **Multipara** refers to a woman who has given birth at least twice to a livebirth or stillbirth, weighing at least 500 grams and having an estimated age of gestation of at least 24 weeks.

9. **Grand-multipara** is a woman who has given birth 5 or more times to a livebirth or stillbirth, weighing at least 500 grams and having an estimated age of gestation of at least 24 weeks.

V. GUIDING PRINCIPLE

To ensure that the risks associated with primigravida and grand multigravida are appropriately addressed, all primigravid (G1) and grand multigravid (G5 and above) women shall be directly supervised by a doctor, preferably a specialist in obstetrics during antenatal, delivery and postnatal period in a well-equipped facility with capability for comprehensive emergency obstetrics and newborn care (CEmONC).

VI. IMPLEMENTING GUIDELINES

Women in their first pregnancy (primigravida) and fifth pregnancy (grand multigravida) shall be given special attention. Thus, all health workers in the public and private sector providing maternal and newborn care shall be governed by the following service provision guidelines:

1. Ensure strict adherence to the antenatal care policy (Administrative Order 2016-0035: *Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services* and its amendment AO 2016-0035-A).

    a. Guided by the Pregnancy Tracking Protocol, community health workers, shall make regular home visits as required and timely referral to the Municipal Health Officer or Health Center Doctor for the required check-ups; and

    b. Provide guidance in complying with the Birth Plan as provided for in the Mother – Baby Book to ensure that arrangements have been made relative to:
        1) Desired Birthing Center and birth attendant and if necessary, a maternity waiting home or home stay with a relative.
        2) In case referral becomes necessary, the nearest hospital and contact number has been secured.
        3) Funds for birth related and emergency expenses are made available and the health worker has oriented the woman and her family on PhilHealth membership and enrolment at the point of service.
        4) Transport service from home to facility.
        5) Desired birth companion, and
        6) At least 2 stand-by blood donors.

        The Birth Plan also provide motivation for women to prepare for personal things that they need and their babies on delivery.

2. Doctor-supervised focused antenatal care shall be observed and practiced. This is to ensure that women are:

a. Appropriately tracked during the entire course of their pregnancy.
b. Screened for conditions and diseases such as anemia, sexually transmitted infections (STIs) particularly syphilis, HIV infection, hepatitis B infection, mental health problems, and / or signs of stress or domestic violence.
c. Pregnancy related complications particularly hypertensive disorders of pregnancy are recognized and managed.
d. Underlying and concurrent illness are recognized and treated.
e. Preventive measures including tetanus-diptheria immunization, deworming, iron and folic acid supplementation, calcium carbonate supplementation, iodine oil capsule supplementation; and in malaria endemic areas, intermittent preventive treatment of malaria in pregnancy (IPTp) and insecticide treated bed nets (ITN) are provided.
f. Advice and support to the woman and her family for developing healthy home behaviors and a Birth Plan are provided.

3. In instances where antenatal care is provided in a non-hospital doctor-managed Birthing Center such as the Rural Health, *primigravid and grand multigravida women shall be referred for a supervised antenatal care, delivery and postnatal care by a specialist in a CEmONC provider facility (Level II or III hospital) guided by the health system referral protocol as defined in Administrative Order No. 2014-0046 (Defining the Service Delivery Network (SDN) for Universal Health Care or Kalusugan Pangkalahatan on the establishment of the Service Delivery Network) and Department Memorandum No. 2014-0313 (Adoption of the Guidelines in Establishing Service Delivery Network).*

4. Upon his or her prudent assessment of the case and in extreme situations where an appropriate referral facility or specialist is not available, a doctor who is a general practitioner and trained on basic emergency obstetric and newborn care may assist in the delivery of G1 and G5 or higher gravidity in a well-equipped birthing center.

5. To ensure that the risks associated with primigravida and grand multigravida are appropriately managed, Birthing Centers managed by Midwives and Nurses shall be required to refrain from handling primigravid and grand multigravid women. In situations where the area is geographically difficult and no appropriate referral facility is available, they shall be referred to the nearest Rural Health Unit where a doctor is available. Proper arrangements with a referral facility and half-way home type of maternity care shall be made during the antenatal period to ensure that optimum care possible is provided for their safe delivery.

6. All Birthing Center staff shall observe and practice extraordinary prudence and judicious judgment to give counsel and inform the woman specially if she lives in a geographically isolated and disadvantaged area or cultural community, of the signs and symptoms of complications of pregnancy in preparation for delivery. At all times, the health care provider as well as the women, shall be vigilant in detecting and reporting early signs and symptoms of complications, immediately manage the complication or refer to a Level II or Level III hospital.

VII. ROLES AND RESPONSIBILITIES

The Department of Health (DOH) shall provide leadership in the implementation of this guideline configured as follows:

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

    a. Provide the technical oversight in the implementation of this Administrative Order; and
    b. Monitor and evaluate the national implementation of this policy in coordination with the Professional Regulation Commission Board of Nursing and Board of Midwifery and other critical stakeholders.

2. The Centers for Health Development (CHD) through its Technical Division, Local Health Systems Division and the Regulation Licensing and Enforcement Division shall:

    a. Ensure compliance to this policy by public and private Birthing Center operators;
    b. Monitor and evaluate the regional and LGU implementation of the policy; and
    c. Present a consolidated regional report during the National Safe Motherhood Program implementation reviews.

3. In addition to their regular functions, the Development Management Officers (DMOs), shall provide technical assistance to public and private birthing operators and staff in the implementation of this policy.

4. As the primary implementer of the policy, Local Government Unit (LGUs) health officers at Provincial and Municipal levels, shall ensure that public and private birthing centers in their respective area of jurisdiction comply with the provisions of this policy.

5. Relevant Professional Organizations shall participate in advocacy activities to popularize the provisions of this policy.

VIII. EFFECTIVITY

This Order shall take effect immediately.

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Secretary of Health