Republic of the Philippines
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PHILHEALTH CIRCULAR
No. 2026 - 0016

TO : **ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED**

SUBJECT : **Quality Standards on Maternal Health Care: Antenatal Routine Laboratory Tests for Low Risk Pregnancy, Obstetric Sonography, Cesarean Section (CS) Delivery, and Two-way Referral System**

I. RATIONALE

In line with the objectives of the Universal Health Care (UHC) Act and PhilHealth's mandate to promote quality, equity, and financial risk protection, there is a need to define clear, evidence-based standards to guide clinical decision-making while respecting professional judgment. Providing guidance on the appropriate use of antenatal laboratory tests in low-risk pregnancy facilitates early identification of maternal conditions that may affect pregnancy outcomes, while guidance on obstetric ultrasound supports accurate pregnancy dating, early detection of complications, and timely care planning. Likewise, defining appropriate indications for emergency and planned CS delivery ensures that surgical intervention is performed only when medically justified, thereby reducing preventable risks to mothers and newborns. A functional two-way referral system ensures that pregnant women receive care at the appropriate level based on their clinical risk. Timely referral to higher-level facilities when needed, and safe return to primary or community-based care once stable, helps maintain continuity of care and strengthens coordination within the health system.

II. OBJECTIVES

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This PhilHealth Circular is issued to harmonize clinical practice with nationally and internationally accepted standards of maternal care, promote responsible and consistent practice among PhilHealth-accredited health care providers, and support safe, appropriate, and high-quality maternal services across all levels of care.

This PhilHealth Circular aims to establish minimum standards of care and evidence-based clinical practices on Maternal Health Care, aligning with the Corporation's quality assurance program.

III. SCOPE

This PhilHealth Circular shall cover the following areas of maternal care:

A. Routine Laboratory Tests for Antenatal Care for Low Risk Pregnancy;
B. Use of Ultrasound in Pregnancy;
C. Indications for Cesarean Section Delivery; and
D. Two-way Referral System for Maternal Care.

Implementation of these standards shall be consistent with the service capability of accredited health care facilities.

IV. DEFINITION OF TERMS

A. Cesarean Section (CS) Delivery – a surgical procedure that involves delivering a baby through an abdominal incision (laparotomy) and a uterine incision (hysterotomy). The surgery is typically performed when vaginal birth poses a greater risk to the mother or baby, such as when complications arise during labor in an otherwise planned vaginal delivery or when a condition prevents a vaginal delivery (such as obstruction)[1].

B. High-risk Pregnancy – a pregnancy state where potential complications are noted on medical examination that could affect the mother, the baby, or both. High-risk pregnancies require management by a specialist to help ensure the best outcome for the mother and baby[2].

C. Low-risk Pregnancy – also known as *uncomplicated pregnancy,* refers to pregnancy state where, after thorough routine evaluation, no risk factors are identified on the woman and no signs and symptoms or pregnancy complications are noted[2].

D. Ultrasound in Obstetrics – a safe imaging technique that uses sound waves to create pictures of the baby and the mother's reproductive organs during pregnancy. It helps check the baby's growth and development, position and overall well-being and assists in monitoring the status of the pregnancy[3].

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V. POLICY STATEMENTS

A. Recommended Minimum Laboratory Tests for Antenatal Care for Low Risk Pregnancy (Adapted from DOH OHG for Adults 20-59 years old, 3rd edition

[1]Sung S, et al, Cesarean Delivery, StatPearls, 2024

[2]Department of Health (DOH) Department Circular 2021 No. 0005, "Adherence to the Definition of Low Risk Pregnancy and High Risk Pregnancy in the Implementation of Administrative Order No. 2012-0012", 04 January 2021

[3]Philippine Society of Ultrasound in Obstetrics and Gynecology (PSUOG), 2026

Pregnancy Trimesters	Laboratory Tests
First Trimester	1. Pregnancy Test 2. Complete Blood Count (CBC)/ Hemoglobin (Hgb) count 3. Blood typing/ Rhesus factor (Rh) group 4. Test for Human Immunodeficiency Virus (HIV), and Hepatitis B 5. Test for syphilis and other sexually transmitted infections (STIs) 6. Urinalysis
Second Trimester	1. Oral Glucose Tolerance Test (OGTT 75g) 2. CBC/ Hgb count 3. Urinalysis 4. Tests for Syphilis, HIV, Hepatitis B and other STIs if status is still unknown
Third Trimester	1. CBC 2. Urinalysis

Table 1: Antenatal Laboratory Screening Schedule

B. Routine Ultrasound in Low-risk Pregnancy

1. Ultrasound is part of routine antenatal care to all pregnant women as it can provide diagnostic and prognostic information regarding pregnancy confirmation and viability including rapid information regarding life-threatening conditions (e.g., ectopic pregnancy).

2. Ultrasound procedures shall be performed by board-certified Obstetrician-Gynecologist (OB-Gyn), board-certified Radiologist or formally trained (board-eligible) OB-Gyn and Radiologist.

3. With informed consent, ultrasound is performed during prenatal period at the following recommended timing windows:

   a. First ultrasound: 6-12 weeks of pregnancy
   b. Second ultrasound: 18-22 weeks of pregnancy
   c. Third ultrasound: 32-34 weeks of pregnancy

   For low-risk pregnancies, at least one (1) ultrasound examination during pregnancy is recommended. Additional scans may be performed when clinically indicated.

4. The objective of performing ultrasound during pregnancy is to obtain specific information such as but not limited to the following:

   a. Pregnancy viability
   b. Gestational age
   c. Detection of fetal anomalies
   d. Fetal growth monitoring for suspected fetal growth restriction

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e. Multiplicity (number of fetuses)
f. Detecting pregnancy-related complications (e.g., placenta previa)
g. Diagnosing ectopic pregnancy
h. Screening for risk of preterm labor and delivery

5. The ultrasound modalities may be performed are the following:

a. Transvaginal Ultrasound (TVUS)
b. Pelvic/ Abdominal Ultrasound

C. Indications for Cesarean Section (CS) Delivery

Prior to the performance of CS, the attending physician shall ensure that the patient or her authorized representative is appropriately informed about the procedure, including its indication, benefits, and possible risks, and that consent is obtained and documented in accordance with accepted medical practice and institutional policies, consistent with the clinical condition of the patient.

All procedures shall be carried out in accordance with institutional safety protocols to promote patient safety.

1. Indications for Planned (Elective) CS Delivery

a. Planned CS shall be scheduled before the onset of labor when vaginal delivery is contraindicated or deemed unsafe based on individualized risk assessment, in order to reduce potential complications for the mother and/or baby.

b. Maternal Indications

Previous Uterine Surgery (not in labor)	History of two (2) or more previous CS
	Prior uterine rupture
	Previous myomectomy
Maternal and Medical Conditions	Cardiovascular and Vascular Conditions: 1. Aortopathy with aortic root dilatation (i.e. Marfan Syndrome) 2. Chronic aortic dissection 3. Eisenmenger syndrome 4. Pulmonary arterial hypertension 5. Cerebral aneurysm 6. History of cerebrovascular accident/ stroke
	Antiphospholipid syndrome with associated maternal and fetal complications
	Warfarin use at the time of labor in patients with mechanical heart valves

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Maternal and Medical Conditions	Active genital herpes
	HIV with a high (viral load > 1,000 copies/mL) or unknown viral load
	Extensive genital condyloma causing obstruction or bleeding risk
Obstructive Maternal Conditions	Presence of tumor previa (i.e. myoma ovarian mass, cervical cancer that blocks the birth canal)
	Clinically significant pelvic deformities that hinder safe vaginal delivery
Infertility and Other Maternal Factors	Pregnancy achieved through assisted reproductive techniques (ART) with complications

Table 2: Maternal Indications for Planned CS Delivery

c. Fetal Indications

Malpresentation or Malposition (not in labor)	Persistent breech presentation at term (38 – 39 weeks age of gestation)
	Persistent transverse lie at term (38 – 39 weeks age of gestation)
Fetal Size and Structural Conditions	Fetal macrosomia refers to a fetus or newborn with an estimated or actual birth weight of ≥4,000 grams, based on overall clinical assessment and/or ultrasonographic findings. In the absence of a recent ultrasound documenting macrosomia, suspected fetal macrosomia may still be considered when supported by appropriate clinical evaluation and documentation, including findings such as disproportionately increased symphysis-fundal height for gestational age, abdominal examination suggestive of large-for-age fetus, Leopold's maneuvers suggestive of increased fetal size or difficulty defining fetal poles, clinical fetal weight estimation methods (e.g., Johnson's Rule), and relevant maternal risk factors (e.g., diabetes mellitus, previous macrosomic infant, post-term pregnancy, maternal obesity, or multiparity).
	Intrauterine fetal growth restriction (IUGR) associated with abnormal fetal surveillance or when labor may worsen fetal survival

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Fetal Size and Structural Conditions	Congenital fetal anomalies or fetal tumors that can obstruct vaginal delivery
Multiple Gestation	Twin pregnancy with 1. non-cephalic first twin 2. monoamniotic twins 3. conjoined twins
	Higher order multiple pregnancies (triplets and more)

Table 3: Fetal Indications for Planned CS Delivery

d. Placental Indications

Placental abnormalities diagnosed antenatally where vaginal delivery is unsafe	Placenta previa
	Placenta accreta spectrum
	Vasa previa

Table 4: Placental Indications for Planned CS Delivery

2. Indications for Emergency CS Delivery

a. Emergency CS shall be performed upon clinical indication of an immediate threat to the life and health of the mother or fetus. The decision shall not be based solely on a single risk factor, unless there is clear evidence of compromise, failure to respond to appropriate initial management, or vaginal delivery is deemed unsafe.

b. Maternal Indications

Labor Dystocia	Arrest in cervical dilatation
	Prolonged second stage of labor
	Arrest or failure of descent
	Failed induction of labor exceeding twelve (12) hours after appropriate management measures
Previous uterine surgery in labor, if not a candidate for trial of labor after cesarean (TOLAC) or vaginal birth after cesarean (VBAC)	Previous CS
	Prior uterine rupture
	Previous myomectomy
Severe Maternal Medical Conditions with Maternal Instability	Hypertensive and Hematologic Disorders: 1. Uncontrolled preeclampsia with severe features 2. Eclampsia (or impending eclampsia) 3. HELLP (Hemolysis, Elevated Liver enzymes, Low Platelet count) syndrome 4. Antiphospholipid syndrome

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Severe Maternal Medical Conditions with Maternal Instability	Cardiovascular and Vascular Conditions: 1. Aortopathy with aortic root dilatation (i.e. Marfan Syndrome) 2. Aortic dissection 3. Cerebral aneurysm 4. History of cerebrovascular accident/ stroke 5. Eisenmenger Syndrome 6. Pulmonary arterial hypertension 7. Severe right ventricular failure 8. Severe symptomatic aortic stenosis 9. Severe mitral stenosis 10. Advanced peripartum cardiomyopathy 11. Vascular type Ehlers-Danlos syndrome Or any critical cardiac or pulmonary condition posing an immediate threat during labor
	Warfarin use at the time of labor in patients with mechanical heart valves
Maternal Infections	Active primary HSV infection in the third trimester with ruptured membranes at the onset of labor
	HIV infection with high viral load (>1,000copies/ml) or an unknown viral load
	Other severe intrauterine or pelvic infections remote from vaginal delivery
Other Maternal Emergency Conditions	Suspected or confirmed uterine rupture
	Severe obstetric bleeding
	Maternal shock or collapse
	Perimortem CS

Table 5: Maternal Indications for Emergency CS Delivery

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c. Fetal Indications

Acute Fetal Compromise (when delivery is not imminent)	Non-reassuring fetal heart rate patterns
Malpresentation or Malposition in Labor	Breech presentation
	Transverse lie / Shoulder presentation
	Face (mentum or chin posterior) presentation
	Brow presentation

Fetal Size and Structural Conditions	Fetal macrosomia refers to a fetus or newborn with an estimated or actual birth weight of ≥4,000 grams, based on overall clinical assessment and/or ultrasonographic findings. In the absence of a recent ultrasound documenting macrosomia, suspected fetal macrosomia may still be considered when supported by appropriate clinical evaluation and documentation, including findings such as disproportionately increased symphysis-fundal height for gestational age, abdominal examination suggestive of large-for-age fetus, Leopold's maneuvers suggestive of increased fetal size or difficulty defining fetal poles, clinical fetal weight estimation methods (e.g., Johnson's Rule), and relevant maternal risk factors (e.g., diabetes mellitus, previous macrosomic infant, post-term pregnancy, maternal obesity, or multiparity).
	Obstructive congenital anomalies
	Post-Zavanelli Maneuver
Multiple Gestation (in labor)	Twin pregnancy with 1. non-cephalic first twin 2. monoamniotic twins 3. conjoined twins
	Higher order multiple pregnancies (triplets and more)
Failed Assisted Vaginal Delivery	Failed vacuum extraction
	Failed forceps delivery

Table 6: Fetal Indications for Emergency CS Delivery

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d. Placental and Umbilical Indications

Placental Abnormalities associated with acute maternal or fetal compromise, or with significant bleeding	Placenta previa
	Abruptio placenta
	Placenta accreta spectrum
	Vasa previa
Umbilical Cord Complications	Umbilical cord prolapse

Table 7: Placental and Umbilical Indications for Emergency CS Delivery

D. Two-Way Referral System

1. A two-way referral system shall be observed to ensure patients receive care appropriate to their clinical risk level. Once stable, patients shall be safely transitioned back to primary care through coordinated follow-up between providers.

2. The referring facility shall ensure that a referral form, including a clinical summary and documentation of the initial management provided, is given to the receiving facility.

3. The receiving facility shall provide a feedback report to the referring provider upon the patient's stabilization or discharge to support clinical continuity.

4. Referral to Higher Level Health Care Providers (HCPs)

   a. For purposes of this circular, higher level HCPs refer to OB-Gyn, or to a General Practitioner (GP) with appropriate obstetric-gynecology training in areas where no OB-Gyn is available, and a well-equipped facility with capability for comprehensive emergency obstetrics and newborn care (CEmONC)[4].

   b. Referral shall be undertaken during the antenatal, intrapartum, or postpartum period when clinical conditions arise that exceed the capability of the health care provider.

   c. Primigravid (G1) and grand multigravid (G5 and above) pregnancies shall be recognized as requiring closer assessment and appropriate referral to a higher-level health care provider, consistent with DOH policy, clinical findings, and the capability of the attending provider or facility[2,4].

   d. Other high-risk conditions identified in Department of Health Department Circular No. 2021-0005 (Annex A) shall likewise warrant appropriate referral or escalation of care with a specialist or higher-level health care provider.

   e. Antenatal Referral

      The following conditions, as identified in PhilHealth Circular No. 20 s. 2008, Expanded Coverage of PhilHealth Normal Spontaneous Deliver/Maternity Care Package in PhilHelath Accredited Hospitals and Non-Hospital Facilities (Lying-In Clinics) warrant referral:

      e.1. Maternal age below 19 years old at the date of delivery
      e.2. First pregnancy in patients with age 35 years and older at the date of delivery

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[4]Department of Health (DOH), Administrative Order No. 2019-0026, "National Policy in the Provision of Birthing Assistance to Primigravid and Grand Multigravid Women", 01 August 2019

e.3. Multiple pregnancy such as twins and triplets
e.4. Ovarian abnormality (e.g., ovarian cyst)
e.5. Uterine abnormality (e.g., myoma uteri)
e.6. Placental abnormality (e.g., placenta previa)
e.7. Abnormal fetal presentation (e.g., breech)
e.8. History of 3 or more miscarriages/abortion
e.9. History of 1 stillbirth
e.10. History of major obstetric and/or gynecologic operation (e.g., CS, uterine myomectomy)
e.11. History of medical conditions (e.g., hypertension, pre-eclampsia, eclampsia, heart disease, diabetes, thyroid disorder, morbid obesity, moderate to severe asthma, epilepsy, renal disease, bleeding disorder)
e.12. Other risk factors that may arise during present pregnancy (e.g., premature contractions, vaginal bleeding, infections requiring OB management) that warrant referral for further management.

f. Intrapartum Referral

f.1. All clinical situations that constitute indications for Emergency Cesarean Section (CS) shall warrant immediate referral or escalation of care to a higher level HCP.

f.2. The following intrapartum conditions, when identified during labor, warrant referral to a higher-level health care provider for further evaluation and management due to increased maternal or fetal risk:

f.2.1. Abnormal Maternal Vital Signs

f.2.1.1. SBP <90 or >160mmHg
f.2.1.2. DBP >100mmHg
f.2.1.3. HR <50 or >120bpm
f.2.1.4. RR <10 or >30cpm
f.2.1.5. O2 saturation <95%
f.2.1.6. Temperature >38°C

f.2.2. Premature Rupture of Membranes (PROM)
f.2.3. Intra-amniotic infection
f.2.4. Endocrine crisis or other acute maternal medical infection
f.2.5. Suspected uterine rupture
f.2.6. Cervical tear during 2nd stage
f.2.7. Multiple gestation identified unexpectedly

g. Postpartum Referral

The following postpartum conditions warrant referral to a higher level HCPs for further evaluation and management:

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g.1. Postpartum Hemorrhage and Related Condition

Postpartum hemorrhage secondary to uterine atony, retained placenta or suspected retained products of conception, uterine inversion, birth canal trauma associated with heavy bleeding, suspected coagulopathy, and other related conditions that cause postpartum hemorrhage.

g.2. Maternal Clinical Deterioration

Abnormal maternal vital signs or clinical signs suggestive of hemodynamic instability or worsening maternal condition.

g.3. Need for Advanced Interventions

Maternal conditions requiring higher-level management, such as but not limited to blood transfusion, uterine balloon tamponade, surgical intervention, or other advanced resuscitative measures beyond the capability of the attending facility.

5. Down-Referral to Lower-Level or Primary Health Care Providers

Down-referral to a lower-level or primary care provider may be undertaken when the mother has been appropriately managed, is clinically stable, and when continued care can be safely provided at the receiving health care provider.

a. Antepartum Down Referral. The following conditions are eligible/ may be considered for down-referral:

a.1. Low Risk Pregnancy

Singleton, cephalic, term pregnancy without identified high-risk factors.

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a.2. Managed Antenatal Complications Now Stable

Patients with previously identified complications (e.g., treated preeclampsia, controlled infection, or anemia on treatment) who are clinically stable and have been provided with clear follow-up instructions and warning signs.

a.3. Planned Delivery in a Midwife-Led Facility

Referral to a licensed midwife-led birthing facility may be undertaken when all the following criteria are met:

a.3.1. 19 to $\leq$35 years old
a.3.2. Gravida 2 to Gravida 4, with previous uncomplicated vaginal delivery

a.3.3. Singleton, cephalic, term pregnancy (>37 weeks but <40 weeks age of gestation)
a.3.4. No previous CS delivery
a.3.5. No identified medical comorbidities
a.3.6. Receiving facility is licensed and Basic Emergency Obstetric and Newborn Care (BEmONC)-linked

b. Postpartum Down Referral. The following conditions are eligible/ may be considered for down referral:

b.1. Stable Postpartum Mother

Patients with no active bleeding or infection, hemodynamically stable, successful initiation of breastfeeding, and no medical complications requiring physician management.

b.2. Previously Managed Postpartum Complications Now Stable

Patients with previously identified postpartum complications, such as but not limited to resolved postpartum hemorrhage, controlled infection, or wounds requiring routine care, provided that clinical stability has been established and clear follow-up instructions have been given.

b.3. Follow-up and Community Continuity of Care

The obstetrician may refer the patient back to midwife or YAKAP clinic providers for continued care, including succeeding visits, blood pressure monitoring, family planning, counseling, breastfeeding support, nutritional counseling and routing postnatal checks.

E. Monitoring and Evaluation

1. The health care provider shall be bound by the provisions of the Performance Commitment and subject to the rules on monitoring and evaluation of performance as provided in PhilHealth Circular No. 2018-0019 Health Care Provider Performance Assessment System (HCPPAS) Revision 2, including advisory dialogue with recognized medical societies when warranted.

2. Standards of care issued by authorized agencies/organizations shall be regularly monitored. As deemed necessary, a revision of the quality policy shall be made. Any updates, as a result of the review, shall be disseminated in another PhilHealth Circular.

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VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 11223 and R.A. No. 10606, and their respective Implementing Rules and Regulations.

VII. SEPARABILITY CLAUSE

Should parts of the policy be deemed invalid, or unenforceable, the rest of the policy unaffected by the provision is still in full force and effect.

VIII. REPEALING CLAUSE

All PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation. Three (3) certified true copies shall be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

BEVERLY LORRAINE C. HO, MD, MPH
Acting President and Chief Executive Officer

Date signed: 10/5/26

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Annex A: Characteristics of High Risk Pregnant Women

Characteristics of High Risk Pregnant Women
(adapted from the Department of Health Department Circular No. 2021-0005)

A. Manifest any of the Warning Signs and Symptoms of Pregnancy:

1. Vaginal spotting or bleeding
2. Severe nausea and vomiting
3. Significant decline in fetal movement (less than 10 in 12 hours during the second half of pregnancy)
4. Contractions in the third trimester
5. Leaking bag of water or premature rupture of the bag of water
6. Persistent severe headache, dizziness, or blurring of vision
7. Abdominal pain or epigastric pain
8. Edema of the hands, feet, or face
9. Fever and pallor
10. Seizures or loss of consciousness
11. Difficulty of breathing
12. Painful urination
13. Elevated blood pressure

B. Known to Suffer from Pre-Pregnancy Conditions:

1. Hypertension
2. Anemia
3. Diabetes mellitus
4. Cardiovascular disease
5. Obstructive or restrictive pulmonary diseases
6. Cancer
7. Tuberculosis
8. Malaria
9. Thyroid disorders
10. Hematologic disorders (thalassemia)
11. Connective tissue disorders
12. Musculoskeletal disorders
13. Renal diseases
14. HIV
15. Infections such as STIs, TORCH, and other systemic infections (e.g., hepatitis B)
16. Malnutrition
17. Previous caesarian section or other abdominal surgeries
18. Others such as:
    a. Seizure disorders
    b. Mental health conditions
    c. Asthma
    d. Poor obstetrical history characterized by:
    - Habitual abortion (2 consecutive abortions or 3 or more repeated abortions); and
    - Previous complicated pregnancy (prior preterm delivery, prior pregnancy resulting in stillbirth or neonatal death, previous birth of a fetus with congenital anomaly, patients with anti-phospholipid syndrome)

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C. Gravidity 1. Primigravid (G1) 2. Grand multigravida (G5 or more)
D. Age 1. Adolescent Pregnancy (10-19 years old) regardless of parity 2. Pregnancy among women more than 35 years old regardless of parity
E. Patients with Problems of Fetal Aging, Structure, and Size: 1. Age of gestation greater than or equal to 40 weeks 2. Fetal growth restriction 3. Macrosomia 4. Unsure of LMP or discrepancy in aging 5. Fetal congenital anomalies 6. Multiple gestation
F. Patients with disorders of amniotic fluid volume
G. Patients in preterm labor
H. Alcohol and Substance abuse
I. Absence of antenatal care

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