Maternal WOICE Tool: postnatal care

Maternal Morbidity Working Group (MMWG), World Health Organization Department of Reproductive Health and Research

Pilot version P.18.07.A.

	PPC SECTION 1: PATIENT HISTORY	
	Today's date (yyyy/mm/dd)	
Q1	**Interviewer Name**	
	Informed Consent. *Please read the attached consent form to the patient. If the patient agrees to participate have her sign or fingerprint the form and take a picture of the signature/fingerprint with your tablet for documentation purposes. If the patient declines to participate, please attempt to ask her Q5-17.*	
Q2	**Interview ID Number.** *ID number is located at the top right hand corner of the patient's consent form.*	**#**_____
	Sorting Information. *Please read the following: "I would like to start by asking you some questions about your pregnancy. If don't understand a question or would like me to repeat it please feel free to stop and ask me."*	
S-1	How did your pregnancy end?	□ stillbirth □ live birth(s) (single or multiples) □ multiples: stillbirth(s) & live birth(s) □ miscarriage (<28 wks) or termination of pregnancy
S-2	Is the baby alive today?	_____No _____Yes
S-3	What was the date of delivery?	(mm/dd/yyyy) _____
	Social & Demographic Information. *Please read the following: "Now, I will ask you some general questions about your life. If you don't understand a question or would like me to repeat it please feel free to stop and ask me."*	
Q3	In what month and year were you born? *If unknown, please enter Jan 1950*	month: _____ year:_____ □ I don't know
Q4	How old were you at your last birthday?	
Q5	What is the highest level of school you attended?	□ none □ primary □ secondary □ higher
Q6	What is your current marital status? *Please select one of the following choices:* *(If single, ask: ever married?)*	Never married/Single _____ Currently married _____ Separated _____ Divorced _____ Widowed _____ Cohabiting _____ Other (please specify) _____
Q7	Have you worked in the last 12 months?	_____ No _____Yes
Q8	Were you paid for this work?	_____ No _____Yes
Q9	What district/county/parish/subnational level are you staying in?	Answers vary per site

Q10	How long did it take you to get from your house to your health facility today?	□ <15 mins □ 15-30 mins □ 30 mins - 1hr □ >1hr
Q11	Now I would like you to read this sentence to me: "The child is reading a book." IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	____ cannot read at all ____ able to read only parts of the sentence ____ able to read whole sentence ____ no card with required language ____ blind/visually impaired ____ other
	Obstetric History. *Please read the following: "We are working on a project to get a better idea of how women feel throughout and after their pregnancies in order to improve what we know and how we can better serve you and other pregnant women in the future. Now I would like to ask you some questions about other times you have been pregnant, if any. Again, please ask me if you don't understand the question."*	
Q12	How many babies have you given birth to (that lived or died) after 28 weeks or 7 months of pregnancy?	
Q13	How many babies did you lose before 28 weeks or 7 months of pregnancy?	
Q14	How many children have you given birth to that are now alive? (including this pregnancy)	
Q15	How many times have you been pregnant? (including times when you did not give birth to the baby/ies)	
	Most Recent Pregnancy/Delivery. *Please read the following: "The following questions are about your latest pregnancy and your experience"*	
P-1	How far along in the pregnancy were you when you delivered?	Please select one of the following choices: □ More than one month before it was due (<37 wks) □ After the due date (> 42 wks) □ When it was due (37-42 wks) □ Don't know_____
P-2	How is your baby?	Please select one of the following choices: □ Good health, has had a medical check-up □ Good health, has NOT had a medical check-up □ Not healthy, has had a medical check-up (Please ask question P-3) □ Not healthy, has NOT had a medical check-up □ Don't know_____
P-3	What was the baby diagnosed with during the medical check-up?	□:_____
P-4	Was the delivery by Caesarean section, that is, did they have to cut your belly open to take the baby out?	_____ No _____Yes
P-5	*(For live births and still living children only)* Are you still breastfeeding the baby/babies?	_____ No _____Yes (skip to QX)
P-6	Did you ever breastfeed this baby/babies?	_____No (skip to QX) _____Yes
P-7	Since delivery, when did your most recent menstrual period start?	(mm/yyyy) _____ □ estimated □ sure □ none
	Most Recent Pregnancy/Delivery. *Please read the following: "Now I would like to ask you some more intimate questions, if you do not feel comfortable answering them please let me know at any time."*	

P-8	Have you had sexual intercourse since delivery?	_______No (skip to Q19) _______Yes
P-9	How many weeks after delivery did you resume sexual intercourse with your partner(s)?	______________
Q16	Since delivery, have you been satisfied with your sex life?	_______ No ________Yes (Please skip to Q19)
Q17	Since delivery, the problem(s) with your sex life is: *(Please select all the choices that apply)*	1) Problem with little or no interest in sex ______ 2) Problem with decreased genital sensation (feeling) _______ 3) Problem with decreased vaginal lubrication (dryness) ______ 4) Problem reaching orgasm ______ 5) Problem with pain during sex _______ 6) Other (please specify): _______________
Q18	*If more than one option is chosen for Q17, then please ask the patient* "which problem is the most bothersome?" *and circle the corresponding answer.*	
	Risk factors/Environment. *Please read the following: "The next few questions I will ask may be a bit difficult, so please feel free to ask for a break or stop at any time. I want to remind you that this is confidential and no one will know how you answered. Also, if after this section you'd like to talk more about the questions, I will give you information on where to seek help. We are asking these questions to better understand your health situation and those of other women who might have similar experiences in the future." If the patient does not want to answer, you can skip the remaining questions and offer her access to the services available (see note at the end of the page)*	
Q19	Since delivery, have you used any of the following substances: tobacco products, alcoholic beverages, cannabis, inhalants for non-medical use?	_______No _______Yes
Q20	Since delivery, have you used any substances: sedatives or sleeping pills, hallucinogens, opioids, and/or any drugs by injection, etc., for non-medical use?	_______No (& No on Q19, Please skip to Q25) _______Yes
	If she answers yes to Q19 or Q20 please ask the remaining questions:	
Q21	Since delivery, have you failed to do what was normally expected of you because of your consumption of any of the substances mentioned above?	_______No _______Yes
Q22	Since delivery, has your use of any of the aforementioned substances led to health, social, legal, or financial problems?	_______No _______Yes
Q23	Since delivery, has a friend or relative or anyone else *ever* expressed concern about your use of any substance?	_______No _______Yes
Q24	Since delivery, have you ever tried to cut down on using any substance, but failed?	_______No _______Yes
	If woman answers yes to Q19 or to Q20, please [Insert specific local instructions for health worker on how to handle case of drug abuse and referral here.]	

Violence.
Violence is a key, and often neglected, consideration in many women's experience of maternal morbidity. However, it is essential that questions on this topic do not put the woman at greater risk of harm. This section of the WOICE tool should be developed carefully using locally-appropriate instructions following the guidance described in the relevant WHO guidance: WHO, UN Women, UNFPA. (2014). "Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook." **Further guidance and information can be sought from reproductivehealth@who.int**
End of Module 1: Patient History **Thank you for answering the questions, we will now move on to the 2nd module of the questionnaire.**

PPC SECTION 2: PATIENT SYMPTOMS

WHODAS. *Please read the following: "Now, I would like to ask you some more questions about your everyday activities. This part of the interview is about difficulties people have because of health conditions. (Hand flashcard #1 to respondent) By health condition I mean diseases or illness, or other health problems that may be short or long lasting; injuries; mental or emotional problems; and problems with alcohol or drugs. Remember to keep all of your health problems in mind as you answer the questions.*

When I ask you about difficulties in doing an activity think about...(Point to flashcard #1):

- *increased effort*
- *discomfort or pain*
- *slowness*
- *changes in the way you do the activity*

When answering, I'd like you to think back over the past 30 days. I would also like you to answer these questions thinking about how much difficulty you have had, on average, over the past 30 days, while doing the activity as you usually do it. (Hand flashcard #2 to respondent)

Use this scale when responding. (Read scale aloud): None, mild, moderate, severe, extreme or cannot do. (Ensure that the respondent can easily see flashcards #1 and #2 throughout the interview. Please continue to next question…)"

	In the past 30 days, how much difficulty did you have in:	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or cannot do**
Q30	Standing for long periods such as 30 minutes?	1	2	3	4	5
Q31	Taking care of your household responsibilities?	1	2	3	4	5
Q32	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
Q33	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1	2	3	4	5
Q34	How much have you been emotionally affected by your health problems?	1	2	3	4	5
	In the past 30 days, how much difficulty did you have in:	**None**	**Mild**	**Moderate**	**Severe**	**Extreme or cannot do**
Q35	Concentrating on doing something for ten minutes?	1	2	3	4	5
Q36	Walking a long distance such as a kilometre [or equivalent]?	1	2	3	4	5
Q37	Washing your whole body?	1	2	3	4	5
Q38	Getting dressed?	1	2	3	4	5
Q39	Dealing with people you do not know?	1	2	3	4	5
Q40	Maintaining a friendship?	1	2	3	4	5
Q41	Your day-to-day work/school?	1	2	3	4	5

Q42	Overall, in the past 30 days, how many days were these difficulties present?			Record number of days_____		
Q43	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?			Record number of days_____		
Q44	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?			Record number of days_____		
Q45	In the past 30 days, how would you rate your overall health?	1 Very Good		2 Good	3 Neither poor nor good	4 Poor	5 Very poor

General Symptom(s). *Please read the following: "The next few questions I will ask about how you have been feeling, physically, since delivery. Feel free to ask for a break or stop at any time."*		
In the last 2 weeks, have you experienced any of the following: *(Please check box if yes, and proceed to next column. If no, skip to next symptom)*		
□ chills	□ nausea	□ fever
□ headache	□ light-headedness	
□ stiff neck	□ muscle spasms	□ tremor
□ sweating profusely/night sweats, unrelated to the heat (diaphoresis)		
□ chest pain	□ decreased exercise tolerance or fatigue	□ heart beating very fast/too fast (palpitations)
□ blurry vision/flashing lights/floaters/seeing stars or spots/having visual disturbance or loss		
□ red/inflamed or bleeding gums	□ cough	□ difficulty breathing
□ breathing faster than usual		
□ vomiting	□ vomiting with blood	□ abdominal discomfort or pain
□ changes in appetite or eating habits		
□ pain during urination (dysuria)	□ abnormal urination	□ changes in bowel habits
□ rectal pressure/pain		
□ skin rash or lesion	□ itching (pruritus)	

	□ breast tenderness or redness	□ feel breast lump (mass) or swelling	
	□ joint pain (arthralgia/arthritis)	□ tenderness in leg or calf	□ sudden swelling in leg(s) or calf(-ves)
	□ back pain		
	□ vaginal bleeding (after sex)	□ painful intercourse (dyspareunia)	□ pelvic pain
	□ vaginal discharge (abnormal in color and/or smell)	□ vaginal bleeding (unprovoked & more than a regular period)	
	In the last 2 weeks, have you EVER experienced:	**If yes, how bothersome did you find the experience?**	**If yes, do you still have it today?**
P-10	□ a bulge or pressure in your vagina?	□ no bother □ slightly bothered (no change in social habit but change in hygiene) □ bothered (avoiding some social engagements, change in hygiene) □ very bothered (avoiding most social engagements, change in hygiene) □ very much bothered (avoiding all social engagement, change in hygiene)	_____ No _____Yes
P-11	□ problems urinating (including leakage, urgency, frequency, unable to empty bladder)?	□ no bother □ slightly bothered (no change in social habit but change in hygiene) □ bothered (avoiding some social engagements, change in hygiene) □ very bothered (avoiding most social engagements, change in hygiene) □ very much bothered (avoiding all social engagement, change in hygiene)	_____ No _____Yes
P-12	□ problems moving bowels or leaking stool or flatulence (gas)?	□ no bother □ slightly bothered (no change in social habit but change in hygiene) □ bothered (avoiding some social engagements, change in hygiene) □ very bothered (avoiding most social engagements, change in hygiene) □ very much bothered (avoiding all social engagement, change in hygiene)	_____ No _____Yes

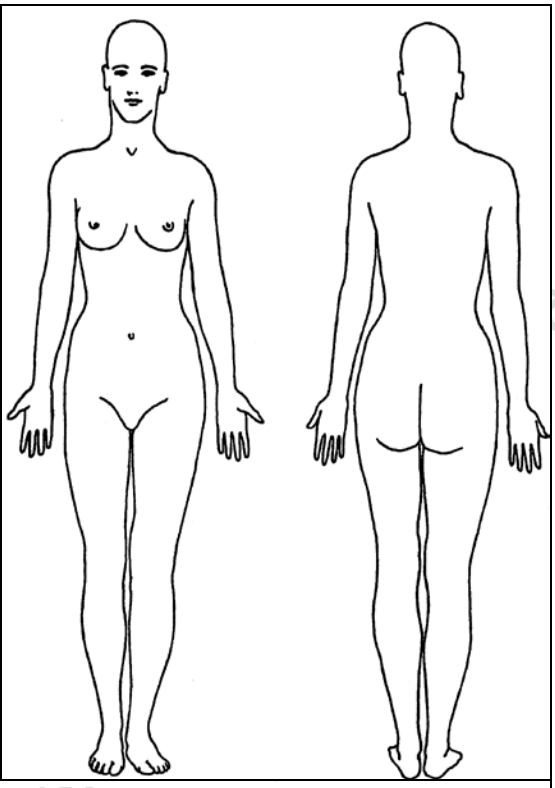
	In the last 2 weeks, have you EVER experienced any of the following:	
Q91	□ urinating blood	_____ No _____Yes
Q92	□ hemorrhoids/piles	_____ No _____Yes
Q93	□ night blindness (difficulty seeing in the dark)	_____ No _____Yes
Q94	□ loss of teeth	_____ No _____Yes
Q95	□ unintentional weight loss	_____ No _____Yes
Q96	□ gained too much weight (excessive weight gain: >1kg per week)	_____ No _____Yes
	After this delivery, have you EVER experienced any of the following?	
Q97	□ swollen hands	_____ No _____Yes
Q98	□ stroke	_____ No _____Yes
Q99	□ seizure/fit	_____ No _____Yes
P-13	□ a constant leakage of urine or stool from your vagina during the day and night	_____ No _____Yes
Q105	**Since delivery, were you told you have anything wrong/medical condition?**	_____No (Skip to Q107) _____Yes
Q106	*If yes, please specify:*	
Q109	**Do you have any other medical conditions or problems you would like to report?**	_____No (Skip to Q111) _____Yes
Q110		

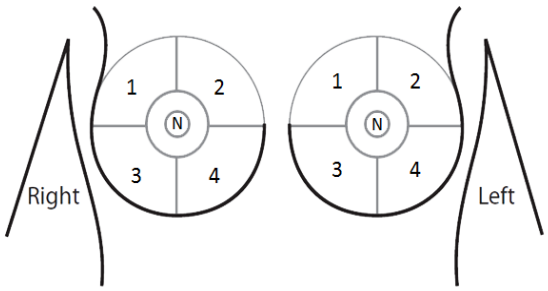
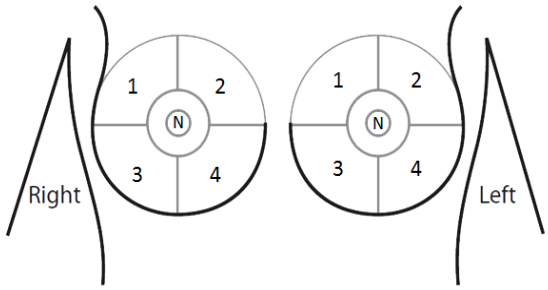
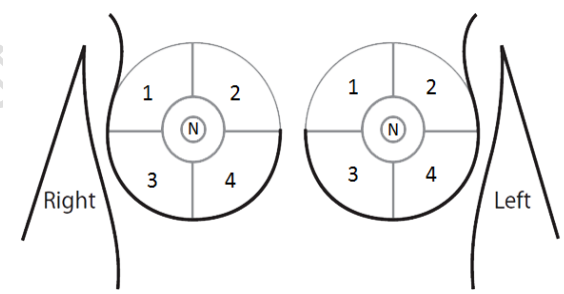
Mental Health. *Please read the following: "The next few questions I will ask about how you have been feeling/your mood since delivery, feel free to ask for a break or stop at any time. I want to remind you that this is confidential and no one will know how you answered. Also, if after this section you'd like to talk more about the questions, I will give you information on where to seek help.***"**

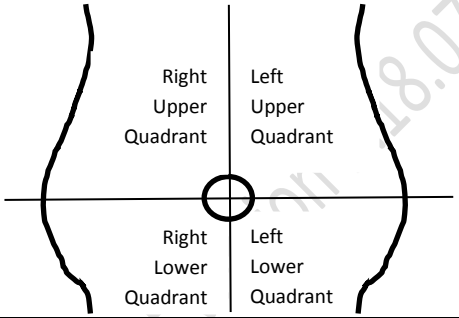
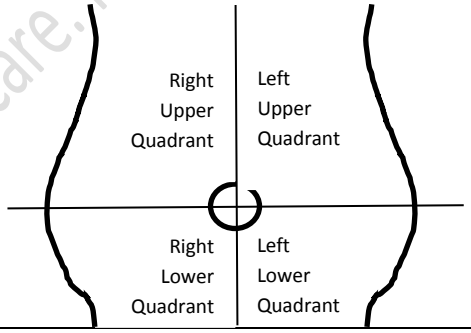
	Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Q111	Feeling nervous, anxious or on edge	0	1	2	3
Q112	Not being able to stop or control worrying	0	1	2	3
Q113	Worrying too much about different things	0	1	2	3
Q114	Trouble relaxing	0	1	2	3
Q115	Being so restless that it is hard to sit still	0	1	2	3
Q116	Becoming easily annoyed or irritable	0	1	2	3
Q117	Feeling afraid as if something awful might happen	0	1	2	3
	Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Q118	Little interest or pleasure in doing things	0	1	2	3
Q119	Feeling down, depressed or hopeless	0	1	2	3

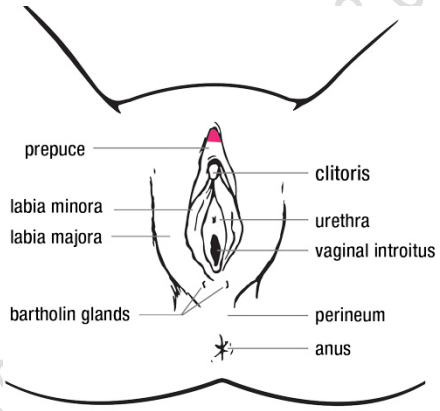
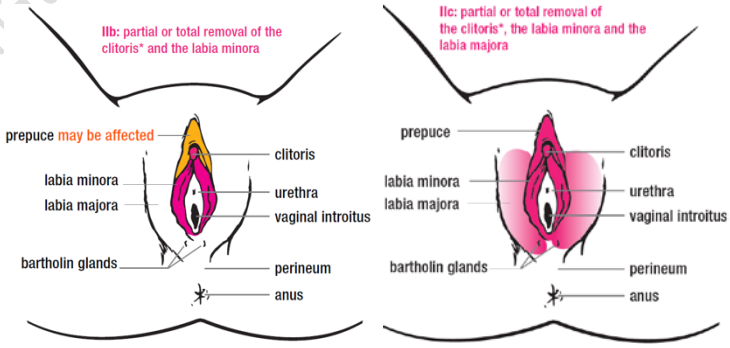
	If she scores greater than 0 to Q118 or Q119, please ask the remaining questions:				
Q120	Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
Q121	Feeling tired or having little energy	0	1	2	3
Q122	Poor appetite or overeating	0	1	2	3
Q123	Feeling bad about yourself or that you're a failure or have let yourself or your family down	0	1	2	3
Q124	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Q125	Moving or speaking so slowly that other people could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Q126	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Please add up all the points for Q111-Q117. Please add up all the points for Q118-Q126. If total score on EITHER set of questions is equal to 10 or higher, or woman responds positively to Q126, please refer the patients to [insert specific local instructions for Health Worker on how to handle mental health-related case referral.]				
	End of Module 2: Patient Symptoms **Thank you for answering the questions, we will now move on to the 3rd and final module of the questionnaire, the physical exam. Do you have any questions for me?**				

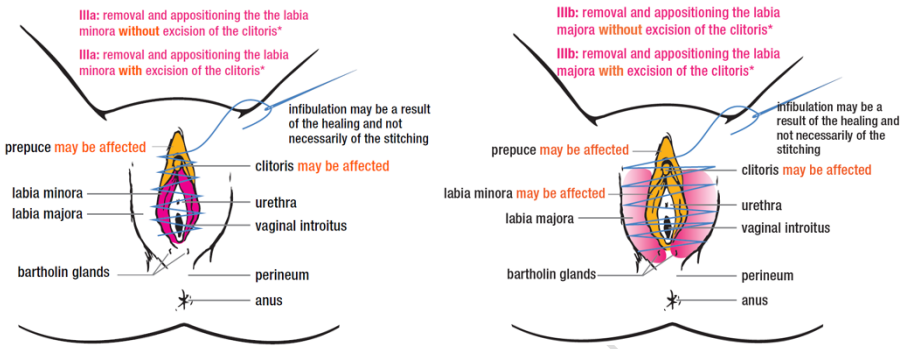
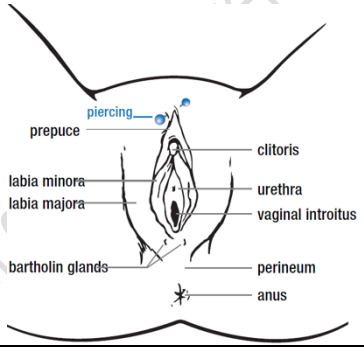
	PPC SECTION 3: SIGNS/PHYSICAL EXAM	
	General physical exam. *At this point in the survey, I will conduct the physical exam. First I will do a general exam, and then check your breasts, your belly and finally your pelvis and private area (if routine).*	
Q127	Body weight today:	_____ kg
Q128	Height:	_____ cm
Q129	Body temperature (oral or axillary):	_____ °C
Q129a	Where on the body was the temperature taken?	□ oral □ axillary □ other (please specify):_____
Q130	Pulse rate:	____/min
Q131	Respiratory rate:	____/min
Q132	Resting Systolic BP	
Q133	Resting Diastolic BP	
Q134	Does the woman present with any pre-existing conditions?	_____No _____Yes
	If yes, please specify:	
	□ diabetes	□ gestational diabetes
	□ hypertension	□ gestational hypertension
	□ STI	
	□ other (please specify): _____	
Q134	Is the woman currently on any medications?	
	If yes, please specify:	
	□ antibiotics	□ hypertensive medications
	□ antifungals (non-vaginal)	□ ARVs
	□ antifungals (vaginal)	
	□ other (please specify): _____	

Q143	When present, please mark the following diagram with the letters corresponding to the questions above:- R for rash(es)- L for lesion(s)- B for bruises - SH for self-harm- DV for domestic violence	
Q154	Does she present with any of the following? *(choose all that apply)*	
	□ pitting ankle oedema	□ pitting lower back oedema
	□ oedema of the hands and feet	□ leg swelling
	□ calf tenderness	□ none
	□ other *(please specify)*: _____	
P-14	Are there any signs of infection on the C-section or hysterectomy scar?	_____No _____Yes
P-16	Is the patient currently using contraception (based on her records)?	
P-17	If yes, please specify which method	
P-18	Has the patient accepted any contraceptive method TODAY?	
P-19	If yes, please specify which method	
	Breast exam **Triggered only if woman reports the following breast related symptoms:** **-** breast tenderness or redness, or feel breast lump (mass) or swelling - other clinical reason	
Q155	Does she present with cracked nipple(s)?	_____No _____Yes
Q156	Does she present with engorged breast(s)?	_____No _____ Yes, due to breastfeeding _____Yes, for other reasons
Q157	Does she present with localized breast tenderness?	_____No _____Yes (If yes, please mark where in the diagram below)

		
Q158	Does she present with breast abscess(es)?	_____No _____Yes (If yes, please mark where in the diagram below) 
Q159	Does she present with palpable breast lump(s)?	_____No _____Yes (If yes, please mark where in the diagram below) 

	Abdominal exam **Triggered only if woman reports the following symptoms:** - vomiting (with or without blood) - abdominal discomfort or pain - changes in appetite or eating habits -other clinical reason	
Q160	Does she present with abdominal tenderness?	_____No _____Yes (If yes, please mark where in the diagram below) 
Q161	Does she present with palpable abdominal masses?	_____No _____Yes (If yes, please mark where in the diagram below) 

	Pelvic exam **Triggered only if only if suspected infection or woman reports the following symptoms:** - vaginal bleeding (after sex) - painful intercourse (dyspareunia) - pelvic pain - vaginal discharge (abnormal in color and/or smell) - vaginal bleeding (unprovoked & more than a regular period) - other clinical reason	
Q164	Does she present with any of the following types of FGM? (please check one)	□ None
		□ Type 1: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy) 
		□ Type 2: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision) 

	□ Type 3: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation) 	
	□ Type 4: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization 	
	Vulva, Vagina, Perineum	
Q165	Does she present with any of the following in the vulva? (Please check all that apply)	
	□ leakage of urine	□ excoriation
	□ labial swelling	□ none
	□ other (please specify): _____	
Q166	Does she present with any of the following in the vagina? (Please check all that apply)	
	□ lesion(s)	□ defects
	□ other (please specify): _____	□ none
Q167	Does she present with any of the following in the perineum? (Please check all that apply)	
	□ excoriation	□ tear
	□ swelling	□ broken down/infected episiotomy
	□ other (please specify): _____	□ none
Q168	Does she present with any abnormal vaginal discharge?	_____No _____Yes
Q169	If yes, please explain colour: _____	
P-20	Please perform a VIA	_____ Completed _____ Not completed
P-21	If VIA not performed, please explain why not?	

P-22	If completed, what were the results?	
P-15	Which of the following categories best describes her pelvic floor?	
	□ presenting uterus above hymenal tags	□ presenting uterus below hymenal tags
	□ presenting uterus at hymenal tags	□ presenting uterus complete eversion
	Records & Tests	
	INVESTIGATIONS - Routine Tests. *Please look through the patient's most up to date medical record to answer the following questions regarding the lab tests she had done.*	
	Has the patient had any of these tests? (If yes, please write in the most recent results)	
Q172	hemoglobin (hemocue)	_____ No _____Yes _____ Yes, but results not available If yes, please write in the results: _____ Hb
Q173	urine nitrite (dipstick)	_____No _____Yes *If yes, please write in the results:* _____ + _____ ++ _____ +++ _____ None
Q174	urine leucocytes (dipstick)	_____No _____Yes *If yes, please write in the results:* _____ + _____ ++ _____ +++ _____ None
Q175	HIV	_____ No _____Yes _____ Yes, but results not available If yes, please mark one of the results: ____ Negative _____ Positive _____ Inconclusive
Q176	malaria (RDT or smear)	_____ No _____Yes _____ Yes, but results not availableIf yes, please mark one of the results:____ Negative _____ Positive _____ Inconclusive
Q177	urine glucose	_____ No _____Yes _____ Yes, but results not available If yes, please write in the results: _____ + _____ ++ _____ +++ _____ None
Q178	urine protein (dipstick)	_____No _____Yes *If yes, please write in the results:* _____ + _____ ++ _____ +++ _____ None
Q179	blood (RBC)	_____No _____Yes *If yes, please write in the results:*_____ + _____ ++ _____ +++ _____ None
	INVESTIGATIONS - Selective Tests. *Please look through the patient's most up to date medical record to answer the following questions regarding the lab tests she had done.*	
Q178	glucometer (random blood sugar)	_____ No _____Yes _____ Yes, but results not available If yes, please write in the results: _____ mMol/L
P-23	VIA	_____ No _____Yes _____ Yes, but results not available If yes, please write in the results: _____
	[Include other tests relevant to setting here]	
Q183	**Did you or the nurse midwife prescribe/refer the woman to buy any medication today?**	_____No _____Yes
Q184	*If yes, please specify the medications(s):*	

Q191	**Did you or the nurse midwife diagnose the patient with any condition(s) today?**	_____No _____Yes
Q192	*If yes, please specify the condition(s):*	
Q193	**Do you or the nurse midwife have any other comments/notes on the patient?**	_____No _____Yes
Q194	*If yes, please specify:*	
	End of Module 3: Patient Signs **Thank you for participating in this survey, we have come to the end of the questionnaire.** **Do you have any questions for me?**	

Suggested citation

Maternal Morbidity Working Group (MMWG), World Health Organization Department of Reproductive Health and Research. (2018). Maternal WOICE Tool: postnatal care. Pilot version P.18.07.A.

Credits

The following tools and questionnaires have been used and/or adapted within the WOICE tool:

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