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PRACTICE QUESTIONS

State of Qatar Department of Healthcare Professions (DHP) Ministry of Public Health (MOPH)

MIDWI

Registered Midwife

EDITION

Original Demo

QUESTIONS

15

ISSUED

October 14, 2026

Before you begin

What this is

15 practice questions for State of Qatar Department of Healthcare Professions (DHP) Ministry of Public Health (MOPH) MIDWI, each with its answer key and an explanation. Answer a question before you read its key - the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, MIDWI
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

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QUESTION 1

SINGLE CHOICE

A postnatal woman is reviewed on day 10 after an uncomplicated spontaneous vaginal delivery. Which finding, reported by the woman, would be considered a deviation from normal puerperal recovery and warrant further assessment?

- ☐ A Lochia that has changed from red to pinkish-brown in colour
- ☐ B Mild lower abdominal cramping during breastfeeding
- ☒ C A gush of bright-red vaginal bleeding after sitting up from rest, soaking a pad within 30 minutes
- ☐ D Fatigue and difficulty sleeping due to night-time feeds

ANSWER C

WHY Option C is correct. Secondary postpartum haemorrhage presents with fresh, heavy bleeding, often after a brief period of lochia reduction, and is a deviation from normal puerperium requiring urgent assessment. Options A (normal lochia progression through rubra to serosa), B (common 'after-pains' due to oxytocin release with feeding), and D (common postnatal fatigue) all reflect expected physiological findings and do not warrant urgent review.

QUESTION 2

SINGLE CHOICE

A woman delivered vaginally 20 minutes ago. Estimated blood loss is 600 mL and the uterus is soft and poorly contracted. The midwife has already emptied the bladder and performed uterine massage. What is the most appropriate next pharmacological intervention?

- ☒ **A** Administer oxytocin 10 IU intramuscularly
- ☐ **B** Administer methylergometrine 0.2 mg intravenously as a bolus
- ☐ **C** Administer misoprostol 800 µg per rectum
- ☐ **D** Administer tranexamic acid 1 g orally

ANSWER A

WHY Uterine atony is the most likely cause and the first-line uterotonic is oxytocin 10 IU intramuscularly (or 5 IU IV slowly). Methylergometrine is contraindicated intravenously as a bolus because of the risk of severe hypertension, and it is also contraindicated in hypertension. Misoprostol is a second-line agent, and tranexamic acid 1 g IV (not oral) is an adjunct, not the next uterotonic.

QUESTION 3

SINGLE CHOICE

During the initial assessment of a term newborn, the midwife observes that the baby's body is pink but the hands and feet are blue, the heart rate is 132 beats per minute, there is grimace to stimulation, the baby has active flexion of all four limbs, and the respiratory effort is a strong cry. What is the correct Apgar score?

- ☐ **A** 8
- ☒ **B** 9
- ☐ **C** 10
- ☐ **D** 7

ANSWER B

WHY Apgar scoring assigns: Appearance - body pink but extremities acrocyanotic = 1; Pulse >100 bpm = 2; Grimace to stimulation = 1; Activity (muscle tone) - active flexion of limbs = 1; Respiratory effort - strong cry = 2. Total = 1+2+1+1+2 = 9.

QUESTION 4

SINGLE CHOICE

A postnatal woman is reviewed 30 minutes after a spontaneous vaginal delivery because of heavy bleeding. On assessment her uterus is soft and poorly contracted and estimated blood loss is 700 ml. What is the first-line pharmacological management?

- ☐ A Intramuscular carboprost (Hemabate)
- ☒ B Intravenous oxytocin infusion
- ☐ C Intramuscular ergometrine alone
- ☐ D Sublingual misoprostol

ANSWER B

WHY Uterine atony is the most common cause of primary postpartum haemorrhage. The first-line uterotonic is intravenous oxytocin (typically 10 IU in 1 L of fluid at an appropriate rate, or per local protocol). If oxytocin fails, second-line agents (e.g., ergometrine, carboprost, misoprostol) and further escalation follow.

QUESTION 5

SINGLE CHOICE

A 24-year-old primigravida attends her booking visit in Qatar at 10 weeks' gestation. She is healthy with no past medical or family history of note. According to DHP/MoPH antenatal care recommendations, which haemoglobinopathy screening test should be offered routinely as part of her booking bloods?

- ☐ A Haemoglobin electrophoresis only
- ☐ B Sickle solubility test (e.g. Sickledex) only
- ☒ C Complete blood count and haemoglobin electrophoresis
- ☐ D No haemoglobinopathy screening is required because she is not from a high-risk ethnic background

ANSWER C

WHY Because Qatar has a high prevalence of haemoglobinopathies, DHP/MoPH antenatal guidance recommends offering universal haemoglobinopathy screening at booking, which includes a complete blood count alongside haemoglobin electrophoresis (rather than the sickle solubility test alone, which only detects HbS and can miss other variants and co-inheritance). Ethnic background is not used to determine eligibility.

QUESTION 6

SINGLE CHOICE

A 32-year-old gravida 2 at 34 weeks' gestation has a blood pressure of 158/104 mmHg on two readings 4 hours apart and 2+ proteinuria on dipstick. She has no visual disturbances, epigastric pain, or headache. What is the most appropriate initial classification and action?

- ☐ A Mild pre-eclampsia - admit, monitor BP and urine, and plan delivery after 37 weeks
- ☒ B Severe pre-eclampsia - admit, start antihypertensives and magnesium sulphate, and deliver after stabilisation regardless of gestation
- ☐ C Gestational hypertension - review weekly as outpatient
- ☐ D Chronic hypertension - refer to physician for antihypertensive review

ANSWER B

WHY BP $\geq 160/110$ mmHg or severe features (this patient has BP of 158/104, but with significant proteinuria and a clear management need) along with end-organ involvement suggests severe pre-eclampsia. Regardless of gestation, the standard of care is admission, antihypertensive treatment, magnesium sulphate for seizure prophylaxis, and delivery once the mother is stabilised. Mild pre-eclampsia is defined as BP 140/90 to 159/109 with proteinuria and delivery is typically at 37 weeks; this patient's readings approach severe range and warrant urgent in-hospital management.

QUESTION 7 SINGLE CHOICE

A woman in active labour at 5 cm dilatation has continuous cardiotocography in place. The baseline fetal heart rate is 150 bpm, baseline variability is 6-10 bpm, there are accelerations present, and no decelerations are observed. The toco shows contractions every 3 minutes lasting 50 seconds. According to the FIGO/ACOG intrapartum CTG classification, this tracing is best categorised as:

- ☒ **A** Category I - normal (reassuring)
- ☐ **B** Category II - indeterminate (non-reassuring but not pathological)
- ☐ **C** Category III - abnormal (pathological)
- ☐ **D** Not classifiable because a baseline must be established over 20 minutes

ANSWER A

WHY Category I (normal/reassuring) tracings require: baseline 110-160 bpm, baseline variability 6-25 bpm, accelerations present or absent, no decelerations, and may have early decelerations. All features in this scenario (baseline 150, variability 6-10, accelerations, no decelerations) satisfy Category I. Category II would include features such as minimal variability or variable decelerations; Category III requires absent variability with recurrent late decelerations, bradycardia or a sinusoidal pattern.

QUESTION 8 SINGLE CHOICE

A term newborn is 6 hours old. The midwife performs the initial newborn examination. Which of the following findings requires URGENT referral for further assessment?

- ☐ **A** Mongolian blue spot over the buttocks
- ☐ **B** Single palmar crease (simian crease) on both hands
- ☒ **C** Central cyanosis that does not improve with oxygen
- ☐ **D** Capillary naevus ('stork mark') on the upper eyelids

ANSWER C

WHY Central cyanosis (blue tongue, lips and mucous membranes) that persists with oxygen is a sign of possible congenital cyanotic heart disease or persistent pulmonary hypertension and requires urgent paediatric assessment. Mongolian blue spots, single palmar creases (often a normal variant) and stork marks are benign findings not requiring urgent intervention.

QUESTION 9

SINGLE CHOICE

A midwife is preparing to administer methylergometrine (methylergonovine) 0.2 mg intramuscularly to a postpartum woman for uterine atony following delivery of the placenta. Which assessment finding must be confirmed as ABSENT before this drug is administered?

- ☐ A Allergy to penicillins
- ☐ B History of pregnancy-induced hypertension only, without eclampsia
- ☒ C Elevated blood pressure (160/110 mmHg or above) or current eclampsia/pre-eclampsia
- ☐ D Cervical laceration extending into the lower uterine segment

ANSWER C

WHY Methylergometrine is a potent oxytocic and vasoconstrictor; it is contraindicated in women with hypertension, pre-eclampsia, eclampsia or any condition in which a rise in blood pressure would be dangerous, because it can precipitate severe hypertension, stroke or myocardial ischaemia. It must not be given before the placenta is delivered, but cervical laceration per se is not the contraindication. Penicillin allergy is irrelevant. Mild past pregnancy-induced hypertension without current hypertensive disease does not absolutely preclude use, though many guidelines avoid the drug in this group.

QUESTION 10

SINGLE CHOICE

On day 5 postpartum, a breastfeeding mother reports that her nipples are cracked and bleeding and that her baby feeds very often but seems unsatisfied. Breast examination shows the baby is latching onto the nipple only, with cracked, abraded nipple tips. Which is the most appropriate midwifery action?

- ☐ A Advise stopping breastfeeding for 48 hours to allow the nipples to heal
- ☐ B Apply topical antibiotic ointment to both nipples and continue feeding
- ☒ C Observe a full breastfeed, assist the baby to achieve a deeper latch with more of the areola in the mouth, and review positioning
- ☐ D Recommend exclusive formula feeding until the baby is older

ANSWER C

WHY Cracked, painful nipples in the early postpartum period are most often due to poor attachment and positioning. The evidence-based midwifery response is to observe a feed, help the mother to position the baby so that more of the areola is taken into the mouth (asymmetric latch), and provide ongoing support. Stopping breastfeeding or switching to formula is not indicated unless initial corrective measures fail or infection develops.

QUESTION 11

SINGLE CHOICE

Intermittent auscultation of a term fetus in active labour reveals a baseline of 110 bpm, no accelerations, and no decelerations over a 10-minute window between contractions. What is the most appropriate midwife interpretation and initial action?

- ☐ A Normal category 1 trace; continue intermittent auscultation every 15-30 minutes
- ☒ B Suspected fetal bradycardia; change maternal position, give oxygen, stop oxytocin, and escalate immediately
- ☐ C Suspected fetal tachycardia; offer oral fluids and reassess in 1 hour
- ☐ D Non-reassuring variability only; apply a fetal scalp electrode and continue

ANSWER B

WHY A baseline fetal heart rate of 110 bpm or below for more than 10 minutes is classified as fetal bradycardia and requires immediate intrauterine resuscitation (lateral positioning, intravenous fluids, stopping uterotonics, oxygen), and urgent escalation to a medical officer. Options A, C and D misclassify this finding as reassuring or as a different category of compromise.

QUESTION 12

SINGLE CHOICE

According to the WHO and DHP/MOPH antenatal care recommendations for an uncomplicated pregnancy, how many routine antenatal contacts are recommended?

- ☐ A Four contacts
- ☐ B Six contacts
- ☒ C Eight contacts
- ☐ D Twelve contacts

ANSWER C

WHY The current WHO recommendation (2016 positive pregnancy experience model) is a minimum of eight antenatal contacts during pregnancy, replacing the older focused antenatal care model of four visits. The DHP/MOPH aligns with this recommendation.

QUESTION 13

SINGLE CHOICE

A woman in active labour at 4 cm dilatation requests non-pharmacological pain relief. She has no contraindications and the fetal heart rate tracing is normal. Which non-pharmacological method has the strongest evidence for reducing labour pain and improving maternal satisfaction?

- ☒ **A** Continuous immersion in warm water during active first stage of labour
- ☐ **B** Routine episiotomy at the time of crowning
- ☐ **C** Administration of intramuscular pethidine as baseline analgesia
- ☐ **D** General anaesthesia with isoflurane

ANSWER A

WHY Evidence-based midwifery practice (Cochrane reviews, WHO recommendations for positive childbirth experience) supports warm water immersion during the active first stage of labour as an effective non-pharmacological method that reduces perceived labour pain and use of pharmacological analgesia and increases maternal satisfaction, with no increase in adverse outcomes for low-risk women. Episiotomy is a surgical procedure, not analgesia. IM pethidine and general anaesthesia are pharmacological, not non-pharmacological.

QUESTION 14

SINGLE CHOICE

During continuous cardiotocography in active labour, the baseline fetal heart rate is 150 bpm, variability is 5-10 bpm, there are no accelerations, and variable decelerations are present lasting less than 60 seconds with quick return to baseline. How should the midwife classify this tracing according to the three-tier FIGO/CTG classification system?

- ☐ A Normal
- ☒ B Suspicious
- ☐ C Pathological
- ☐ D Pre-terminal

ANSWER B

WHY In the FIGO three-tier system, a tracing is 'suspicious' when one non-reassuring feature is present (such as absent accelerations, mild reduced variability, or variable decelerations without concerning features). It is 'normal' when all features are reassuring, and 'pathological' when two or more non-reassuring or any abnormal feature is present. Pre-terminal tracings show absent variability with repetitive decelerations or bradycardia.

QUESTION 15

SINGLE CHOICE

A multigravida at 34 weeks' gestation presents with a small amount of bright-red vaginal bleeding following a speculum examination. The bleeding has now stopped, the abdomen is soft and non-tender, and the cardiotocograph is reassuring. What is the most likely cause?

- ☐ A Placenta praevia
- ☐ B Placental abruption
- ☒ C Cervical ectropion or local trauma following the speculum examination
- ☐ D Vasa praevia

ANSWER C

WHY A small amount of fresh bleeding provoked by a speculum examination, in the presence of a soft, non-tender abdomen and a reassuring cardiotocograph, is most consistent with a benign cervical cause such as ectropion or local contact bleeding. Placenta praevia and vasa praevia typically present with painless, larger, often ongoing bleeding, and abruption presents with a tense, tender abdomen and a non-reassuring trace.