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| **Audit Report Cover Sheet** |
| Your Name | RICHARD GANIZANI NYIRENDA |
| Date of re-audit | 1st May- 2nd October, 2012 |
| Location where audit took place | Mzimba District Hospital South |
| Audit Title |
| Re-audit Report on Implementation on Prevention of Mother to Child Transmission of HIV Services |
| Re-Audit Aims *List clearly and concisely the aims of your audit (100 words)* |
| The main aim of the re-audit was to re-assess the implementation in prevention of mother to child transmission of HIV services. PMTCT is the strategy to prevent passage of HIV from mother to child (De Cock, et al. 2000). Each part was re-audited according to its need as described below.Firstly, I re-audited the percentage of women who were HIV reactive but delivered whether they were on Anti-Retro Viral (ARVs) according to prong3 (MOH, 2011) or not. Furthermore, the prong3 encourages any pregnant, delivered and in lactating period to start ARVs instantly. This was measured against a standard of 98%.Secondly, I re-audited the percentage of HIV positive perinatal women who were on Cotrimoxazole Prophylaxis Therapy (CPT). This was also assessed against a standard of 98%.Thirdly, I re-audited the percentage of babies on Nevirapine prophylaxis (NVP) up to 6 weeks according to prong3 and were also assessed against a standard of 98%.Lastly, I looked at the gaps of current practice and ways of long lasting solutions from the re-audit team.  |
| Audit Overview Summary*Briefly state how you conducted your audit. What went well and what went less well? What were the problems and how would you overcome these in the future? (200 words)* |
| To start with, the re-audit involved 6 heath workers out of which, 3 were nurses and the other 3 were clinicians. After that, we selected all files of PMTCT of HIV for the months of June, July and August 2012 which were 33 files in total at Mzimba DHO. Thereafter, we formulated a questionnaire which looked at women on CPT, ARVs and babies on NVP.The re-audit went on well because, the DHMT welcomed it, the re-audit team was well organised, I was able to access internet using the dongle I was given, the DHMT was paying the internet as well and all along I have been communicating with my tutors when need arise.On the other hand, the problems were, lack of stationary, unable to cascade at health centre to lack of transportation worsened by shortage of fuel and also at times we could meet less frequently during working days as compared to weekends of which some members pray on Saturdays whilst others on Sundays. To overcome these problems in future, I feel like informing the DHMT in advance about the activity will assist so that they may consider it in the District Implementation Plan. |
| Summary of Findings*Summarise the main findings of your audit. (200 words)* |
| The re-audit looked at the implementation of PMTCT services of HIV at Mzimba DHO in particular, women on ARVs, CPT and babies on NVP. The outcomes were assessed against a standard of 98% as described below.Firstly, I looked at women who were on ARVs for the months of June, July and August. The outcome was 33out of 33 representing 100% which is above a standard of 98%.Secondly, I looked at women who were on CPT which was also assessed against a standard of 98%. The outcome was 33 out of 33 as well representing 100% which is also above a standard of 98%.Lastly, I looked at babies who were supposed to be on NVP up 6 weeks. The outcome was 35 out of 35 representing 100% hence meeting a standard of 100%.All in all, the implementation of PMTCT services at Mzimba District Hospital South are going well as in regards to strategies of PMTCT services. However, if we are to maintain the standards, they is need to pay attention to recommendations made both at national level, district level and also action plan.  |
| Relevance to Clinical Guidelines*State which guidelines are relevant to this audit. Include version number and/or date of guideline**Were guidelines followed in whole or in part in your chosen audit area?**Describe any problems encountered in implementing guidelines in your audit area, including how you would overcome these problems (200 words)* |
| References:1.0 National Prevention of Mother to Child Transmission of HIV, 2011.2.0 UNAIDS, WHO 2005. AIDS Epidemic update, December 2005: Geneva. 3.0 Orie, E.F., Songca, P.P., & Moodley, J. (2009). An audit of PMTCT services at a regional hospital in south Africa.SA FAM Pract; 51 (6)492-495.4.0 Professor Zephne Van Der Spuy-vol 18 suppl.2 2009 3-10 Reproductive Biomedicine Online;[www.rbmonline.com/Article/3880](http://www.rbmonline.com/Article/3880) on web 22 January 2009.5.0 Burns, N. and Grove, S.K. (1997). The Practice of Nursing Research Conduct , Critique and Utilization. Philadelphia: WB Saunders Company. 6.0 UNICEF (August 2003), “Evaluation of United Nation-supported pilot projects for the prevention of Mother To Child Transmission of HIV” 7.0 Malawi Integrated Guidelines for Providing HIV Services, 2011.8.0 Hargrove JW, Humphrey JH. Mortality among HIV positive women with high CD4 cell counts in Zimbabwe. AIDS 2010; 24(3):F11-49.0 Van Lettow M, Landes M, BEDELL R, et al. Uptake and outcomes of aprevention of mother to child transmission (PMTCT) programme for 387 mother –child pairs in Zomba district, Malawi. XVII International AIDS Conference 2010, Vienna 10.0 Bullough C. HIV infection, AIDS and maternal deaths. Tropical Doctor 2003; 33(4): 194-9611.0 Rosen field A, Yanda K. AIDS treatment and maternal mortality in resource-poor countries. Journal of American Medical Women’s Association 2002; 57(3): 167-68. 12.0 Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1-Transmission in the United States. 16 June 2003.During the audit, each guideline was partly used. However, most of the in information was abstracted from Malawi Integrated Guidelines for HIV Services, 2011 and National Prevention of Mother to Child Transmission of HIV, 2006. Some of the problems encountered during the audit were; lack of guidelines in the library for easy accessibility, inadequate of these guidelines and also at times unable to access internet.I hope these problems will be sorted out since I talked to DHMT and ART coordinator. |
| Recommendations*What are your recommendations for improvement in care and re-audit in your chosen audit area? (200 words)* |
| Management* 1. At National level
* The Ministry of Health in conjunction with the Reproductive Health Unit (RHU) should consider reformulate the maternity register. This so because the register is lacking column for registering the patients who are in labour or else have just delivered. For this reason, I had to go back to the files checking this information instead of taking from the register.
* The MOH and RHU should conduct regular supervisory visits to the district health offices in order to assess as to how the PMTCT services are in are being provided.
	1. At District Hospital
* The District Health Management Team should revise on the patient’s common pathway from antenatal to the labour ward. This is so because at the antenatal they don’t have register for PMTCT patients hence relying for the one in the ART clinic. For this reason, there are high chances of increasing the number of missed opportunities. This needs to be sorted in this way because antenatal clinic serves as an ideal entry point for high ANC attendance rates (91% for Q2 2010) and availability of HIV rapid testing at all ANC sites enables a high coverage of HIV infected women (HIV Program Q2, 2010).
* To train clerks in Provider Initiated Testing and Counseling especially the one in maternity because at times clinicians and midwives are committed with deliveries since it’s a very busy institution. I talked to the HIV Testing and Counseling (HTC) and agreed on the issue and assured to consider in the next training.

As a District, the PMTCT has also been included in the male championship programme to look at the improvement of PMTCT services in MDHS as a whole not only at the District Hospital. Hence it is a responsibility of every member involved to participate actively.Action plan* They should be availability of RH guidelines in all stages of patient’s common pathway which are easily accessed.
* Quarterly review of the changes being implemented by the auditing team until they is improvement on missed opportunities.
* To make sure every midwife in the maternity ward should be the one trained in PMTCT of HIV services.
 |
| Personal Reflection*What did you learn about the audit process, and what will you do differently next time? How will this affect your clinical practice? (200 words)* |
| During the re-audit, I Learnt that audit is the quality improvement process that seeks to improve patients care and outcome in this case in terms of providing PMTCT of HIV services. Since re-audit has been done and I have achieved the desired goal, I feel the next step is to maintain the implementation of changes and also to take note of recommendations. I looked at the women on ARVs, CPT and babies on NVP up to 6 weeks of which they were assessed against against a standard of 98%.Additionally, audit and re-audit requires good team work, good communication, good judgment on choosing topic and you should have an aim when conducting an audit with standards which you should be measuring against.The other point, I feel to include cascading at health centers of all facilities could be more important. This could give a reflection of some gaps which otherwise might be missed. By doing so I feel I will be able to come up with their problems as well they do encounter when providing the PMTCT of HIV services.To add on that, when given opportunity to audit may be another topic, I feel including patients during the audit will assist to come up with first hand information. However, for this one it was difficult since I worked on retrospective data.Lastly, informing the DHMT before the sitting of District Implementation Plan should I be given another audit will be more important so that they may consider it as an activity when allocating funds. |
| Signature : RICHARD GANIZANI NYIRENDADate: 28th September, 2012 |

RE-AUDIT REPORT ON IMPLEMENTATION ON PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV SERVICES

ABBREVIATIONS

AIDS-Acquired Immune Deficiency Syndrome

HIV-Human immunodeficiency Virus

MSDH-Mzimba South District Hospital

PMTCT-Prevention of Mother to Child Transmission

WHO-World Health Organization

MDGs-Millennium Development Goals

MOH-Ministry of Health

ART-Anti-Retroviral Therapy

CPT-Cotrimoxazole Prophylaxis Therapy

NVP-Nevirapine

DHMT-District Health Management Team

%-Percentage

UNICEF-United Nations Children’s Fund

HCW-Health Care Workers

ANC-Antenatal Clinic

RH-Reproductive Health

UNAIDS-Joint United Nations Programme on HIV/AIDS

 OPERATIONAL DEFINITIONS

Patient refers to an HIV positive woman who is pregnant, delivered or lactating up to 6 weeks post delivery

Safe Obstetric Practices refers to safe measures to be taken in an HIV pregnant woman until the puerperium period.

PMTCT is the strategy to prevent the passage of HIV from mother to child

MTCT refers the transmission of HIV from mother to child

ABSTRACT

* Objective: to assess and the implementation of PMTCT services at Mzimba DHO south.
* Methods: a criterion based audit was conducted at MDHS. A retrospective review of 33 case notes was conducted and the results compared with the standard for implementation of PMTCT services and of audit as well. The results of re-audit have been evaluated after 3 months from the audit and presented in a table and bar chart. Recommendations have been made.
* Results: there is a significant improvement in the three standards as each scored 100% which is above the standard of 98%.
* Conclusion: criterion based re-audit has improved the implementation of PMTCT services at MDHS. However, recommendations need to be taken note of and action to be taken in order to reduce the missed opportunities we are having which is a big challenge.
1. Aims
* Goal

The main of the re-audit is to improve the implementation of Prevention of Mother to Child Transmission services (PMTCT) of Human Immunodeficiency Virus (HIV) at Mzimba District Hospital South. PMTCT services need to be improved because HIV is one of the most indirect causes of maternal mortality in developing countries. Even in developed countries, HIV/AIDS remains a cause of maternal mortality but current treatment practices, which support the use of appropriate ARVs in pregnancy women, (Bullough, 2003), are reducing the rates of AIDS complications seen during pregnancy (Rosen field A, et al., 2002), (Public Health Service Task Force, 2002).

* Specific objective

To find the percentage of women tested reactive and started on ARVs and CPT. Additionally, to find the percentage of exposed babies on NVP. All these have been measured against a standard of 98%.

To evaluate the current practice as regards to implementation of PMTCT services of HIV and compare to audit data which I got as base line data.

To identify gaps and correct them or find long lasting solutions in relation to meeting Millennium Development Goal number 6 by 2015.

1. Introduction

The HIV pandemic remains a major public health problem worldwide, with especially devastating effects in sub-Sahara Africa. In 2005, approximately 65% of the estimated 40.3 million adults and children living with HIV were from sub-Sahara Africa.

Acquired Immune Deficiency Syndrome (AIDS), caused by HIV disproportionately affects Africa. It is the leading cause of death in Africa and a major cause of maternal mortality. HIV/AIDS impacts on every aspect of reproductive health and presents considerable challenges to health systems. Fertility is particularly valued in Africa and voluntarily childlessness in unusual.

The majority of people living with HIV are aged 15 to 49 years, and nearly 50% are women of reproductive age. Heterosexual transmission is the most common mode of transmission by which the virus spreads in developing countries, resulting in large numbers of HIV infected women of child bearing age. The paediatric HIV is largely the result of MTCT, (UNAIDS, 2005).

1. Background

The first case of AIDS was in Malawi was reported and confirmed in 1985. The median HIV prevalence increased until 1999 after which it declined. Presently, the HIV prevalence in adults among 15 to 49 years of age remains one of the highest in the world, estimated at approximately 14%, with a range from 12% to 17% (National Prevention of Mother to Child Transmission of HIV, 2006).

AIDS results in reduction of fecundity and fertility as well as compromising the outcome of the pregnancy (Van Der Spuy, 2009). In Malawi, HIV/AIDS is one of the indirect causes of maternal mortality. For this reason, it has to be combated to attain Millennium Development Goal (MDG) number 6.

Sentinel survey (2003), cited by MOH (2007) states that prevalence of HIV in antenatal mothers is 12.6%. Additionally, 30-45% of exposed infants, whose mothers do not for PMTCT services, will have HIV whereby 2% of exposed infants, whose mothers are on PMTCT, will have HIV.

MTCT is also referred to as vertical transmission or perinatal transmission (WHO, 2000 cited by MOH, 2003). It can occur during pregnancy, labour, and breastfeeding. It is responsible for more than 90% of childhood HIV infections worldwide, and is the second most common mode of transmission in Malawi. A significant population of HIV positive women may die within the next decade leaving behind orphaned children, who may also be infected with HIV.

Mothers and pregnant women need to know that without interventions there is a 25-50% risk of HIV transmission from HIV infected mothers to newborns. It is estimated that in the absence of breastfeeding, about 30% of MTCT occurs during pregnancy and 70% during labour and delivery.

In order to reduce rates of MTCT, PMTCT services have to achieve adequate coverage across the country, high rates of adherence to interventions (drug regimens, infant feeding and delivery in a health care setting) and sufficient follow up. To facilitate this, it is essential to address the learning needs of Health Care Workers that affect the quality of PMTCT services. Slow action or no action can result in millions of new infections and unnecessary deaths. Consequently, a great effort and dedication of resources will be to bring the epidemic under control.

PMTCT is the strategy to prevent passage of HIV from mother to child (De Cock, et al. 2000). It was initiated in 2001 as an intervention to address issues of MTCT in Malawi. However, it was officially launched in 2003 in Malawi. PMTCT has a prevalence rate of 12% at national level.

1. Problem statement.

Situation analysis of Mzimba District Hospital South (MDHS) from October-December 2011 showed that some HIV positive women did not start ARVs once confirmed. To add on that, 3.5% of 25,830 women were tested reactive of. This is contrary to prong3 amongst PMTCT strategies. Prong 3 involves starting lifelong ART for HIV infected pregnant and breastfeeding women, regardless of CD4 count and/or clinical stage (‘option B+’). It also encourages provision of NVP for babies born to HIV infected mothers up to 6 weeks and also encourages safe obstetric practices (Malawi integrated Guidelines for Providing HIV Services, 2011). I did an audit from October-December 2011 of results did not meet a standard of 98% hence I have done the re-audit from June-August 2012.

1. Published reports

UNICEF (August, 2003) did a research and collected data from pilot PMTCT programmes supported UNICEF between January 2000 and June 2002. Of more than half a million women who attended clinics in twelve countries, only 71% received counseling; of those who were counselled , only 70% took an HIV test ; among women tested HIV positive, only 41% received preventive drugs. Assuming that HIV prevalence among all women was similar to those who were tested, fewer than one in four HIV infected women who attended a clinic went on to receive the drugs they needed.

Orie et al., 2009 did an audit on PMTCT services at a regional hospital in South Africa. This showed that, out of 227 HIV positive women, only 131 (57.7%) were given 200mg NVP at >28 weeks gestation, (to take home and swallow once they had strong labour pains); 185 (81.5%) took NVP before delivery (i.e. the total number of both those that took NVP <2 hours and >2 hours before). 143(77.3%) took NVP >2 hours before delivery and 84 (37%) took NVP < 2 hours before delivery of the babies, 208(91.6%) were given NVP within 72%.

1. Methodology

6.1 Design: this was a descriptive study.

6.2 Setting: The study was conducted at Mzimba District Hospital which is in the northern region of Malawi. It was a quantitative study. Mzimba is the biggest District in the Northern Zone and in the country as a whole. It is now split into two, Mzimba DHO North which is responsible for 23 health facilities and oversees 2 CHAM hospitals while Mzimba DHO South is responsible for 31 health facilities and oversees 1 CHAM hospital and 2 CHAM rural hospitals. This was effective 2009 (Mzimba health bulletin 2008). The district is 270 kilometers away from the capital city, Lilongwe. MSDH offers secondary level of health care. The district has a population of 516,605 of which 118,819 are women of child bearing age and out of these, 25,830 deliveries are expected in a year (HMIS, 2011).

6.3 Sampling: The audit used 33 files of all mothers who were on PMTCT services for the months of June, July and August 2012 (table 9.2). I have done a quantitative study by working on retrospective data (patient’s files).

7.0 Audit process

First of all, I formulated a group of 6 people. Out of this group, 3 were nurses of which 2 were from maternity and 1 from antenatal while the other 3 were clinicians, 1 from ART, 1 from surgical and the other 1 from maternity. After that, I formulated the questionnaire which comprised the data as described in the next subtitle.

8.0 PRE-TESTING TOOL.

This was done between 8th to 20th February and used during audit as well hence this time I just used it.

9.0 Data collection

Data was collected between 1st September and 8th September, 2012 (appendix 2). The data was collected using the questionnaire that had both open and closed ended questions (appendix1). I developed the questionnaire for data collection because in a quantitative audit, data collection involves the generation of numerical data (Burns & Grove, 2001). The tool was developed in English.

9.1 Data analysis

The data collected was analyzed manually between 9th and 16th September, 2012 (appendix 2)

9.2 Re-audit findings

PMTCT DATA FROM JUNE-AUGUST 2012

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Months  | Admissions | Patients tested positive  | Patients on ARVs | Patients not on ARVs | Patients on CPT | Patients not on CPT | Babies on NVP | Babies not on NVP  | Missed Opportunities | Remarks |
| June | 280 | 14 | 14(100%) | 0 | 14 (100%) | 0 | 14 (100%) | 0 | 25(8.9%) | - |
| July | 267 | 6 | 6(100%) | 0 | 6(100%) | 0 | 6 (100%) | 0 | 23(8.6%) | - |
| August | 305 | 13 | 13 (100%) | 0 | 13(100%) | 0 | 15 (100%) | 0 | 25(8.1%) | Extra babies due to twins |

The above results showed that the re-audit has really improved the services of PMTCT at MSDH as compared to the last audit findings. This is so because in every area of my interest I have managed to score above the standard of 98% which I was measuring against as explained below.

Firstly, every patient who has been diagnosed reactive is in universal eligibility criteria to start ARVs according to option of B+ (Malawi Integrated Guidelines, 2011). From the above findings, every patient was initiated on ARVs according to data I found from the files hence scored 100%.This simply shows they is good work for PMTCT services at MSHD.

Secondly, every patient was on CPT according to findings from the 33 files as shown in table 9.2. This is also in line with the prong3 of PMTCT strategy under. Above all, the score is also 100% as compared to a standard of 98% which I was measuring against.

Lastly, every baby was initiated on NVP which meets the prong3 as well of PMTCT strategy and more especially above a 98% which I was measuring against. As we can see from the table, in the month of August, mothers were 13 but babies were 15. This was so because two mothers delivered twins.

Despite they is good outcome from the three areas re-audited, I feel they is more to do on the part of missed opportunities. After identifying it as a problem, I asked some nurse midwives together with the in charge and the clerk that why do we have such missed opportunities? The answer I got was some midwives were not delivering PMTCT services. The second question was why were they not delivery these services? The answer I got was they had little knowledge in such services. The third question was why were they lacking adequate knowledge? The answer was they were not trained in the new regimen which was effective on 1st July, 2011 in Malawi. The next question was why was it so? The answer I got was they were left out during the training sessions. The last question was why were they left out whilst they are in maternity? The answer was, by the time sessions were being conducted, they were in other departments and now that they have done rotations it’s when they is need for them to be implementing such services . After analyzing all this information, I concluded that nurses keep on rotating every year hence they is need to train every nurse midwife and clinician. For this reason, I talked to the ART coordinator and agreed on the idea and assured me to do so as the whole aim is to meet MDG number 6 by 2015

In summary, the findings have met a standard of 98% which I was measuring against as well as meeting the prong3 of PMTCT strategy 2011. To add on that, the results are much better than those of UNICEF (August, 2003) which are 72% hence below the standard. However, they is need to pay attention to missed opportunities. However, they is need to improve on missed opportunities because the can be a possibility that some were reactive hence getting the false results of PMTCT services as shown in the bar graphs below.

10.0 Discussion

When we refer to the above data, every part which I re-audited is almost above the standard of 98% which is 100%. This simply means Mzimba DHO is above the standard of performance in delivering PMTCT services. We agreed, to continue implementing the changes in order maintain the standards.

The re-audit aimed at finding the standards of PMTCT services i.e., HIV reactive perinatal women starting ARVs and CPT and also initiating babies on NVP. In all these areas we were comparing to a standard level of 98%. In all areas we did well.

During the re-audit, they were some activities which went on well. For example: The DHMT welcomed our proposal of audit hence we proceeded with re-audit such that we went on with our activities without any controversy. To add on that, the re-audit team was well organized such that we finished the work in time. On top of that our clerk is well organized in arranging the files with its data such that we did not have tough time to find our files and start the re-audit. The other point is that we were given the dongles which on the other hand simplified our work. Additionally, I was able to communicate with my tutors and giving me guidance starting from the audit proposal. Lastly, the DHMT is supportive by paying internet services almost every month hence accessing information on journals is easy.

On the other hand, some things went on less well. For example, at times, there was problem to access internet due network faults. To add on that, printing had faults at times so we could move to town. Lastly, we had no chance to travel to health centers to cascade especially due to long distances and shortage of fuel which is a national wide problem hence we ended up cascading at the District Hospital only.

Lastly, rotations were made by the DHMT hence on 1st July hence at times it was difficult to lead in the implementation of changes.

Having finished the re-audit, I feel cascading at the health centers could give a true reflection of implementation of services at MDHS as a whole district.

11.0 Report writing

I wrote the report between 17th and 30th September, 2012. I delayed the report writing because I was also concentrating on the assignment of leadership self assessment tool which is also due on 19th October.

12.0 Submission of report and dissemination of results

I submitted reports on 1st and 2nd of October, 2012.

13.0 RESOURCES USED.

During the audit process, the following materials were used; plain papers for formulating the questionnaire, ball point pens and pencils for writing, internet for accessing information, laptop for writing, printer for printing the questionnaire and soft copy of this audit, reference books for referring, patients files for accessing PMTCT services information and nurses and clinicians for taking part during questionnaire.

14.0 Recommendations

14.1 Management

* 1. At National level
* The Ministry of Health in conjunction with the Reproductive Health Unit (RHU) should consider reformulate the maternity register. This so because the register is lacking column for registering the patients who are in labour or else have just delivered. For this reason, I had to go back to the files checking this information instead of taking from the register.
* The MOH and RHU should conduct regular supervisory visits to the district health offices in order to assess as to how the PMTCT services are in are being provided.
	1. At District Hospital.
* The District Health Management Team should revise on the patient’s common pathway from antenatal to the labour ward. This is so because at the antenatal they don’t have register for PMTCT patients hence relying for the one in the ART clinic. For this reason, there are high chances of increasing the number of missed opportunities. This needs to be sorted in this way because antenatal clinic serves as an ideal entry point for high ANC attendance rates (91% for Q2 2010) and availability of HIV rapid testing at all ANC sites enables a high coverage of HIV infected women (HIV Program Q2, 2010).
* To train clerks in Provider Initiated Testing and Counseling especially the one in maternity because at times clinicians and midwives are committed with deliveries since it’s a very busy institution. I talked to the HIV Testing and Counseling (HTC) and agreed on the issue and assured to consider in the next training.
* As a District, the PMTCT has also been included in the male championship programme to look at the improvement of PMTCT services in MDHS as a whole not only at the District Hospital. Hence it is a responsibility of every member involved to participate actively.

15.0 Action Plan

* They should be availability of RH guidelines in all stages of patient’s common pathway which are easily accessed.
* Quarterly review of the changes being implemented by the auditing team until they is improvement on missed opportunities.
* To make sure every midwife in the maternity ward should be the one trained in PMTCT of HIV services.

16.0 Conclusion

This study aimed at investigating the standard of implementing the PMTCT at Mzimba District Hospital South. The findings were much better in such a way that every area was above a standard of 98% which I was measuring against.

Therefore, I’m of the opinion that the changes which have been implemented should be sustained by each health worker and take into account the recommendations both at national and district level if Malawi is to the Millennium Development Goal number 6 by the year of 2015.

17.0 ACKNOWLEDGEMENTS.

The author of this paper would like to thank the Almighty GOD for strength and wisdom given to him during the period of the audit process. He would also like to extend his thanks to his audit tutors, Dr. D simkiss and Mr. M Lemerani, Mzimba South District Health Management Team and the maternity unit team, Mr. Burnet Chiona (registered nurse, maternity 2), Obed Nkhata (NMT), Mr. Noel Ndola (registered nurse, maternity 1), Mrs. Agnes Simkonda community health nurse, ANC), Mr. Blessings Kamanga (ART, clinician), Yolam c. Kameme (CO) and Mr. Wongani Zgambo (maternity clinician).

18.0 DECLARATION

I declare that this dissertation is solely out of my own work. It has not been presented anywhere for any qualification and is not being currently submitted elsewhere for any academic purposes.

Name of student : Richard Ganizani Nyirenda

Signature : Richard Ganizani Nyirenda

Date :

Name of supervisor: Dr Doug Simkiss

Signature :

Date :

Name of supervisor: Mr. Marshal Lemerani

Signature :

Date :

References:

1.0 National Prevention of Mother to Child Transmission of HIV, 2006.

2.0 UNAIDS, WHO 2005. AIDS Epidemic update, December 2005: Geneva.

3.0 Orie, E.F., Songca, P.P., & Moodley, J. (2009). An audit of PMTCT services at a regional hospital in south Africa.SA FAM Pract; 51 (6)492-495.

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5.0 Burns, N. and Grove, S.K. (1997). The Practice of Nursing Research Conduct, Critique and Utilization. Philadelphia: WB Saunders Company.

6.0 UNICEF (August 2003), “Evaluation of United Nation-supported pilot projects for the prevention of Mother to Child Transmission of HIV”

7.0 Malawi Integrated Guidelines for Providing HIV Services, 2011.

8.0 Hargrove JW, Humphrey JH. Mortality among HIV positive women with high CD4 cell counts in Zimbabwe. AIDS 2010; 24(3):F11-4

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11.0 Rosen field A, Yanda K. AIDS’s treatment and maternal mortality in resource-poor countries. Journal of American Medical Women’s Association 2002; 57(3): 167-68.

12.0 Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1-Transmission in the United States. 16 June 2003.

APPENDIX: 1

QUESTIONNAIRE FOR PMTCT SERVICES

|  |  |  |  |
| --- | --- | --- | --- |
| QUESTION NUMBER | QUESTION  | POSIBLE RESPONCES | SKIP |
| 1A | Did the woman start CPT instantly? | Yes……………..1No……………….2 | If no, go to 1B |
| 1B | If no, why? |  |  |
| 2A | Did the woman start ARVs instantly? | Yes………………1No………………...2 | If no, go to 2B |
| 2B | If no, why? |  |  |
| 3A | Did the baby start NVP instantly? | Yes………………1No………………..2 | If no, go to 3B |
| 3B | If no, why? |  |  |

TIME FRAME FOR RE-AUDIT

APPENDIX 2

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 1st Jun-1st September | 2nd-8th September  | 9th -16th September | 17th -30th September | 1st October | 2nd October |
| Implementing changes |  |  |  |  |  |  |
| Data collection |  |  |  |  |  |  |
| Data Analysis |  |  |  |  |  |  |
| Report writing |  |  |  |  |  |  |
| Submission of reports |  |  |  |  |  |  |
| Dissemination of results |  |  |  |  |  |  |