3. OUTPUT INDICATORS

3.1 Male Condom Distribution Rate

Sub-Saharan Africa has been the worst hit region by the HIV and AIDS epidemic with heterosexual transmission responsible for the spread of the HIV-virus. The goal of all HIV and AIDS programmes is to limit the spread of the virus. Currently, one of the most effective ways of achieving this is by using condoms during sexual intercourse.

The male condom distribution rate measures the number of condoms that are distributed by the health department through facilities over the course of a year, for every male 15 years and older. In 2004 the average for SA was 7.5 condoms distributed per male over 15 years. This has increased steadily but slowly over the past 3 years from an average of 6.4 in 2001.10

District View: The variation in distribution rate across the country is illustrated in the graph and map. The Cape Metropole (WC) has the highest distribution rate at 20.3. Sixteen of the 53 (30%) districts have a distribution rate of less than 5, including two districts in Mpumalanga for which there are no data available.

The five districts with the lowest distribution rate are all in Gauteng with Sedibeng and Metsweding districts both distributing less than one condom per male per year.11

Map 4: Male Condom Distribution by District in South Africa

11 It is thought that the Gauteng values may be low due to data inaccuracies.
Figure 9: Male Condom Distribution Rate by District

12 Data for Nkangala and G Sibande were not available in the DHIS at the time of writing.
**Rural Nodes:** The average male condom distribution rate in the rural nodes is 8.7 which is higher than the national average of 7.5. Three of the five rural nodes with the best distribution rate are in the Eastern Cape. On the other hand, three of the five rural nodes with the lowest distribution rate are in KwaZulu-Natal. This is of concern, given that the HIV prevalence in KwaZulu-Natal is the highest in the country.

**Figure 10: Male Condom Distribution Rate in the Rural Nodes**

![Male condom distribution rate, 2004](image)

**Metro View:** The distribution rate in the metros varies ten fold, from 2 in Tshwane (GT) to 20.3 in the Cape Metro (WC). Two of the Gauteng metros show distribution rates of less than three condoms which is lower than the rural nodes.

**Figure 11: Male Condom Distribution Rate by Metro District**

![Male condom distribution rate, 2004](image)
3.2 Immunisation

One of the objectives of child health programmes is to reduce illness and death in infants and children. One of the ways of achieving this is by preventing and controlling communicable diseases. The immunisation of children is the most effective way of preventing and controlling a number of diseases including tuberculosis, diphtheria, tetanus, pertussis (whooping cough), polio, hepatitis B and Haemophilus influenzae. Two of the indicators used to measure the effectiveness of immunisation programmes are immunisation coverage and immunisation drop out rate.

3.2.1 Immunisation Coverage

Immunisation coverage measures the percentage of all children under one year of age who have completed their primary course of immunisation. They will have received a BCG injection (for tuberculosis), four doses of OPV drops for polio, three doses of DPT-Hib vaccine for diphtheria, pertussis, tetanus, and Haemophilus influenzae, three hepatitis-B vaccines and one measles vaccine before they are one year old. The national target for immunisation coverage is 90% and in 2004 the average coverage achieved was 84%.

Immunisation coverage is one of the indicators that is based on population. This indicator measures how many children received all their required immunisations by the time they reached 1 year of age out of all the children aged 1 year or less. This estimate of the total number of children under 1 year may be inaccurate for three reasons. Firstly, it is dependent on the accuracy of the census data from which it is estimated and we are aware that the last census in 2001 had particular problems with the numbers of children under 5. Secondly, the estimate is based on the total population and some people who have medical aid insurance may obtain their immunisations

13 The population figures used in this section have as for all the other indicators, been taken from the DHIS 2004 population mid-year estimates done by HISP, which are based on Census 1996 and Census 2001. These estimates are very close to the StatsSA estimates and although under-estimation of children under 5 years was recognised as a problem from the start, matching “official” StatsSA estimates was seen as important. However, using NDoH immunisation data and other sources, StatsSA started working on district population estimates in collaboration with the NDoH and have as of November 2005, made district draft estimates available, after a range of data problems had been investigated and to some extent corrected. In Appendix 5, these new population estimates are shown by district and are used in the calculation of the ‘new’ immunisation rate. This ‘new’ immunisation coverage is significantly different to the one shown in this section which uses the old population estimates; not only to the overall values, but also in the rank order of the districts. It illustrates how extensively population based indicators such as immunisation rate are affected by the population estimates.
in private health facilities. Coverage may therefore be understated where there are higher proportions of people who have access to private health facilities, for example in the metro areas. Thirdly, population based indicators do not take into account the daily migration of people across district boundaries. For example a mother may live in one health district but work in a second health district and take her child to the clinic in the second district.

Map 5: Immunisation Coverage of Children under 1 Year Old by District

District View: The variation in immunisation coverage across the country can be seen in the map and graph. It is encouraging to note that 15 districts have coverage rates of 90% or more. However, a number of these may have inflated coverage rates as a result of migration as previously discussed. An example of this is the cross-boundary district of Kgalagadi (NC/NW) with a coverage of 128%.

It is surprising to note that two Gauteng districts, Metsweding and West Rand, have the lowest immunisation coverage in the country, with coverages of 54% and 56% respectively.
Figure 13: Immunisation Coverage by District

Immunisation coverage under 1 year, 2004
**Rural Nodes:** In the graph illustrating the coverage in the rural node districts, it can be seen that five of these demonstrate an immunisation cover of over 90%. Three of these nodes are cross-boundary nodes where there is lots of cross boundary movement and consequent possible data distortion. All of these health districts, with the exception of Zululand, are achieving coverage rates of around 80% and above. Four of the rural districts are in the top 10 districts overall and only one is in the bottom 10. This is a remarkable achievement indicating that the basics of child health services are well received by the communities. In general the rural districts are performing better on this indicator than the other districts. Eight districts that are better resourced than the rural districts, have immunisation cover rates lower than the lowest of the rural nodes, which is an indictment on these districts.

**Figure 14: Immunisation Coverage in the Rural Nodes**

**Metro View:** Three metros have achieved the national target of 90%. These include the Nelson Mandela Metro (EC), Cape Town Metro (WC) and Tshwane (GT). Generally the metros have achieved relatively good rates with the exception of Ekuhruleni.

**Figure 15: Immunisation Coverage by Metro District**
Provincial View: The immunisation coverage across provinces varies considerably. The Eastern Cape, which has probably the poorest infrastructure of all the provinces, has achieved the highest coverage rate using the 2004 population estimates. However, as can be seen on page 83, Figure 61, the Eastern Cape drops right down to last place, when the revised population estimates are used. Although the 2004 Census StatsSA figures are known to be an under count, there is no formal confirmation that the new estimates are accurate, or accepted. It is concerning to note the poor coverage in Gauteng, in spite of the considerable resources and infrastructure available in the province. Mpumalanga has the lowest coverage rate (76%). This can no doubt be in part attributed to the fact that the per capita expenditure on PHC in Mpumalanga is lowest in the country.

Figure 16: Immunisation Coverage compared by Province
3.2.2 Immunisation Drop Out Rate (DTP1-3)

The immunisation drop out rate measures the percentage of children who dropped out between the first and third dose of DTP-Hib vaccine. In other words, it measures out of 100 children who received their first DPT-Hib vaccine, how many did not receive the third dose. The advantage of this “drop-out” indicator is that both the numerator and denominator are available from routine health data and are not subject to the complications of population-based indicators. The national target for this immunisation drop out rate is less than 10%.\textsuperscript{14} During 2004 the average drop out rate was 7.2%.

Map 6: Immunisation Drop Out Rate in South Africa by District

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{immunisation_drop_out_rate_map}
\caption{Immunisation drop out rate (DTP1-3), 2004}
\end{figure}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Legend & & & & & \\
\hline
less than 2.5 & 2.5 - 5.0 & 5.1 - 7.5 & 7.6 - 10.0 & more than 10 & \\
\hline
\end{tabular}
\end{table}

\textsuperscript{14} Target as set out in the Draft National Minimum Indicator Data Set for Hospital, CHC and PHC services.
Figure 17: Immunisation Drop Out Rate by District

Immunisation drop out rate (DTP1-3), 2004

[Bar chart showing the percentage drop out rates for various districts in South Africa, with specific values for districts such as -5.7, -1.6, and -0.3.]
**District View:**

It is encouraging that only six of the 53 districts in the country have a drop out rate higher than 10%. Three districts have negative values. Negative values indicate that more children were given their third than their first DTP-Hib immunisation. This probably occurs due to the normal movement of people between districts.

It is concerning that KwaZulu-Natal has five out of the 15 districts with the highest dropout rates. One of these, uMgungundlovu which incorporates the provincial capital of Pietermaritzburg, is urbanized and has infrastructure and resources. It is also surprising that Central Karoo which has a high per capita expenditure of R325 also has a drop out rate of 12.4%.

**Figure 18: Immunisation Drop Out Rate by Rural Node**

The graph shows the variation in drop out rate from 12.4% in the Central Karoo (WC) to 3.4% in Chris Hani (EC).

**Rural Nodes:**

The graph shows the variation in drop out rate from 12.4% in the Central Karoo (WC) to 3.4% in Chris Hani (EC).

**Figure 19: Immunisation Drop Out Rate by Metro District**
Metro View: The drop out rates across the metros shows a similar pattern to that for immunisation coverage. Tshwane (GT) has the lowest drop out rate, 4.4% and eThekweni (KZN) demonstrates a rate of double this at 8.2%.

Figure 20: Immunisation Drop Out Rate by Province

![Bar chart showing the immunisation drop out rate (DTP1-3) by province in South Africa in 2004. The chart displays the percentage drop out rate across different provinces, with the x-axis representing the percentage and the y-axis listing each province. The provinces are ordered as follows: South Africa, Northern Cape, Free State, Mpumalanga, Western Cape, Gauteng, North West, Eastern Cape, Limpopo, and KwaZulu-Natal. The drop out rates vary significantly, with the highest rate in KwaZulu-Natal at 8.7% and the lowest rate in the Northern Cape at 0.7%.]

Provincial View: The graph shows the variation in drop out rate from a high of 8.7% in KwaZulu-Natal to a low of 0.7% in the Northern Cape.
3.3 Caesarean Section Rate

The caesarean section rate measures the proportion of deliveries in which a caesarean section was performed. In other words it measures out of every 100 deliveries the number of women who had a caesarean section. This is a facility based indicator (number of deliveries in a facility) and not a population based indicator (Total deliveries including home deliveries). In 2004 the national average for all hospitals in South Africa was 16.0. This indicator includes data from district hospitals as well as level 2 and 3 hospitals, which will influence the rates in each district. In other words, districts with a number of level 2 and 3 hospitals will tend to have higher caesarean section rates.

Map 7: Map of Caesarean Section Rate in South Africa by District

In the map the variation in the caesarean section rate across the country can be seen. The variation in rate is dependent upon a number of factors. These factors include the number and type of hospitals in each district and the availability of doctors.

Districts with secondary and tertiary level hospitals should have higher caesarean section rates as a result of more complicated cases from outside of the district being referred to these hospitals. The effects of this can be seen in that the ten districts with the highest caesarean section rate all contain a regional referral centre. Frances Baard in the Northern Cape is an example of this. The provincial capital, Kimberley which has the major referral hospital of the province and a caesarean section rate of 22%, is located in this district. Five of the ten districts with the highest caesarean section rate in the country are in KwaZulu-Natal, with eThekwini having the highest rate of 27.2%.

In general the districts with the lowest caesarean section rates are the rural districts of the Eastern and Northern Cape provinces and the North West province. These districts have a large number of small district (first) level hospitals. The three districts with the lowest
Caesarean section rate can be clearly seen in the map. Metsweding (GT) does not have a hospital and therefore has a caesarean section rate of zero. Xhariep (FS) and Bophirima (NW) have small district level hospitals and a low caesarean section rate.

Figure 21: Caesarean Section Rate by District
Rural Nodes: The graph illustrates the variation in the caesarean section rate across the rural nodes. There is a three fold increase between Ugu district (KZN) which has the highest rate of 23.3% and Ukhahlamba (EC) which has the lowest rate of 7.6%. In their own way both of these rates are problematic and need further investigation as to why on the one hand Ugu is so high and on the other why Ukhahlamba is so low. All the rural districts in the Eastern Cape and Limpopo have low caesarean section rates of close to 10% or below. This is likely to reflect a poor quality of maternity services in these districts.

Figure 22: Caesarean Section Rate in the Rural Nodes

<table>
<thead>
<tr>
<th>Rural Nodes</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>7.6%</td>
</tr>
<tr>
<td>ISRDP average</td>
<td>10.1%</td>
</tr>
<tr>
<td>Ugu DM</td>
<td>23.3%</td>
</tr>
<tr>
<td>T Mofutsanyane DM</td>
<td>13.1%</td>
</tr>
<tr>
<td>Zululand DM</td>
<td>11.9%</td>
</tr>
<tr>
<td>Umzinyathi DM</td>
<td>12.2%</td>
</tr>
<tr>
<td>Central Karoo DM</td>
<td>12.7%</td>
</tr>
<tr>
<td>Kgalagadi DM</td>
<td>10.0%</td>
</tr>
<tr>
<td>Umkhanaykude DM</td>
<td>11.2%</td>
</tr>
<tr>
<td>O Tambo DM</td>
<td>10.5%</td>
</tr>
<tr>
<td>Bohlabela DM</td>
<td>12.0%</td>
</tr>
<tr>
<td>Sekhukhune DM</td>
<td>12.5%</td>
</tr>
<tr>
<td>A Nzo DM</td>
<td>8.9%</td>
</tr>
<tr>
<td>C Hani DM</td>
<td>8.8%</td>
</tr>
<tr>
<td>Ukhahlamba DM</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Metro View: The rates between the metros doubles from 13.9 in Ekurhuleni (GT) to 27.2 in eThekwini (KZN). It is noticeable that the highest rate is in the metro in KwaZulu-Natal. It may be that the high HIV rate in the province is influencing the high caesarean section rates.

Figure 23: Caesarean Section Rate by Metro District
Provincial View: The highest caesarean section rate is in KwaZulu-Natal at 21.0 and most districts in the province are performing high rates of caesarean sections. The reason for this needs investigation.

Figure 24: Caesarean Section Rate by Province
3.4 PMTCT Indicators

The PMTCT programme has a number of components. The first step is to get as many pregnant women as possible to take an HIV test. The second is to identify the mothers who are HIV positive.15

Once HIV positive mothers have been identified in the PMTCT programme, the success of the programme is measured by the nevirapine uptake rate among these women and the nevirapine uptake rate amongst their babies. However, the data available for these four indicators has to be considered with caution for a number of reasons including:

◆ In some provinces PMTCT data are collected in a system that runs in parallel to the DHIS. These data are then exported to the DHIS and in the process no verification of the data occurs.
◆ The data for a number of districts had to be excluded as the data were either missing or were obviously incorrect.
◆ In a number of cases the data for the two indicators are not compatible. For example, Gert Sibande district (MP) had a nevirapine uptake among pregnant HIV +ve women of 82%, yet no information for nevirapine uptake rate among babies born to HIV +ve women.

3.4.1 Proportion of Antenatal Clients Tested for HIV

The aim of the PMTCT programme is to reduce the transmission of the HIV-virus from the mother to the baby during pregnancy, labour and infancy, through intervening in those mothers who are HIV positive. The first step in this process is to get mothers to take the HIV test.

This indicator measures the proportion of women coming for their first antenatal visit who are tested for HIV. The national target is that all (100%) pregnant women should be tested for HIV. There were no data available in the DHIS for the Western Cape and KwaZulu-Natal provinces and data for these provinces were obtained directly from the programme managers. For all districts of the Eastern Cape there were either no data available or those which were available were obviously unreliable and have been disregarded for the purposes of this barometer.

Map 8: Proportion of Antenatal Clients Tested for HIV by District

15 Although strictly speaking the prevalence of HIV amongst pregnant mothers is more a health status (impact) indicator than a health output indicator, for the purposes of grouping all the PMTCT indicators together, it has been included in this section.
Figure 25: Proportion of Antenatal Clients tested for HIV in the Districts

Proportion antenatal clients tested for HIV, 2004

16 Data either incorrect or not available at time of writing for Frances Baard, Namakwa, A Nzo, O Tambo, Ukhahlamba, N Mandela Metro, Cacadu, C Hani and Amathole.
District View: Both the Western Cape and KwaZulu-Natal provinces are approaching the target of 100% with most districts in these two provinces achieving a testing rate of over 80%. In KZN the rate ranged from 90% in iLembe to 72% in uMgungundlovu. The Western Cape has prioritised the PMTCT programme and the proportion of clients tested ranged, from 76% in the Boland and Central Karoo to over 100% in the City of Cape Town.

In Gauteng the proportion of antenatal clients tested for HIV varies from 62% in the City of Johannesburg to 15% in the Ekhuruleni Metro. Similar rates have been recorded for the districts of the Free State and North West districts. The Limpopo districts were clustered between 20 and 40%. In Mpumalanga and Northern Cape no district achieved a testing rate of 20%.

Clearly, with the exception of the Western Cape and KwaZulu-Natal districts, much more prioritisation needs to be given to the PMTCT programme.

Rural Nodes: The rates for the rural nodes will not be discussed due to lack of data.

Metro View: The vast differences amongst the metro districts are clearly shown in the graph below.

Figure 26: Proportion of Antenatal Clients Tested for HIV by Metro District

![Graph showing proportion of antenatal clients tested for HIV by metro district, with a large variation between regions.](image-url)
3.4.2 HIV Prevalence among Antenatal Clients Tested

Each year the National Department of Health conducts a National HIV and Syphilis Antenatal Sero-Prevalence Survey across the country. This survey provides information on HIV prevalence amongst women attending ANC clinics at a national and provincial level.

The routine data collected from clinics and entered into the District Health Information System provide a picture of the HIV prevalence at a district level. The HIV prevalence amongst antenatal clients tested, measures the percentage of antenatal clients who accept to be tested for HIV, and then test positive.

The average HIV prevalence rate obtained in the 2004 National HIV and Syphilis Antenatal Sero-Prevalence Survey was 29.5%. The information from the District Health Information System gives a national average of 25.3% for HIV prevalence. However, the DHIS does not have records for 100% of pregnant women tested; it is possible that women at a higher risk were less likely to be tested and therefore lowering the overall result of women who tested HIV +ve.

In the Western Cape and KwaZulu-Natal districts where around 90% of all pregnant were tested, (and specifically in the City of Cape Town and Eden districts where 100% of women were tested), the results were lower than the provincial average obtained in the National sero-prevalence survey.

Map 9: HIV Prevalence of Antenatal Clients by District

Data for Western Cape and KwaZulu-Natal obtained directly from the province.
Figure 27: HIV Prevalence among Antenatal Clients by District

Data for Western Cape and KwaZulu-Natal obtained directly from the province, time frame is 2004/5 financial year. Data for the other districts were obtained from the DHIS. No data were available for Namakwa.
District View: The variation in the HIV prevalence rate across the districts can be seen in the graph. The rate varies from 39% in eThekweni (KZN) to 6.3% in the West Coast (WC). (Data for Namakwa appear to be missing). Seven of the 10 KwaZulu-Natal districts have prevalence rates over 30%. This district level information confirms the prevalence rate of 40.7% for KwaZulu-Natal from the National HIV and Syphilis Antenatal Survey for 2004. Similarly the HIV prevalence rates in the Western Cape districts from the DHIS are the lowest in the country just as the provincial prevalence rate of the Western Cape from the antenatal sero-prevalence survey is the lowest in the country.

Rural Nodes: The rates for the rural nodes will not be discussed due to lack of data.

Metro View: The variation across the metros is threefold, from 39% in eThekweni (KZN) to 13% in the Western Cape. These rates are consistent with the provincial rates from the sero-prevalence survey of 40.7% for KwaZulu-Natal and 15.4% for the Western Cape, but at a slightly lower level.

Figure 28: HIV Prevalence among Antenatal Clients Tested by Metro District

Provincial View: The DHIS values for HIV prevalence at provincial level fall within the 95% CI of the antenatal survey results for 4 provinces (FS, MP, NC, NW) despite the differing methodologies of these data sources and issues of data quality and completeness.
3.4.3 Nevirapine Uptake Rate among Pregnant HIV +ve Women

This indicator measures the proportion of HIV positive pregnant women who were given nevirapine to take during late pregnancy and/or those to whom nevirapine was administered at the facility during labour. This indicator has some limitations as it is not possible to determine if all nevirapine tablets dispensed at the first ANC visit were used appropriately during labour. Some tablets may have been lost and others may have been taken too early in labour, or during false labour. In addition, women admitted to a facility in labour may be given a second nevirapine tablet, having taken a first one at home early in the labour process.

Map 10: Nevirapine Uptake Rate among Pregnant HIV +ve Women by District

The variation in uptake rate across the country is illustrated in the graph. Although nevirapine may be dispensed twice to some women, the uptake rates in Frances Baard (NC) and Cacadu (EC) are unlikely. Data capturing errors are most probably the cause of these values as well as those of the districts with missing data.

Excluding the districts named above, two districts from Mpumalanga province, Gert Sibanda and Nkangala have the highest nevirapine uptake rate among pregnant HIV +ve women, with rates above 80%. Although these rates are commendable they must be considered with caution, as these districts have performed poorly in many other key programmes.

At the other end of the scale, four of Gauteng’s six districts have data which are missing or below 6%. These low uptake rates for Gauteng reflect a problem with data flow from different levels of facilities and not necessarily a problem with the coverage of the PMTCT programme. Most births in the province take place in hospitals. Only in Sedibeng are hospitals submitting data through the DHIS. In the other districts in Gauteng the hospitals are not submitting data through the DHIS.

19 Data for KwaZulu-Natal and Western Cape were provided by the provincial programmes and were not obtained through the DHIS.
Figure 29: Nevirapine Uptake Rate of Pregnant HIV +ve women by District

20 Data for Kgalagadi, Metsweding, Namakwa, and West Rand Districts were not available at the time of writing.

21 Values for Frances Baard are too large (266) to plot and are unlikely and most probably due to data errors.
It is interesting to note that in KwaZulu-Natal and the Western Cape, provinces which have put considerable effort, energy and resources into the PMTCT programme, the variation in uptake rate across the districts of the provinces is very similar. In KwaZulu-Natal the rate varies across the districts from 49% to 71% and in the Western Cape from 45% to 73%. These rates are an example to other districts of what can be achieved if programmes are prioritised and receive sufficient resources.

**Rural Nodes:** In 2004, the average nevirapine uptake rate among pregnant HIV +ve women in the rural nodes was 40%. It is interesting to note that of the five rural nodes with the highest uptake rate, four are from KwaZulu-Natal. These rates vary from 62% in Zululand to 56% in Umkhanyakude. These rates are both a testimony to the commitment of staff in these nodes, but also an indictment on the better resourced districts with poor uptake rates which have both more capacity and better infrastructure. The low uptake rates of 12% in T Mofutsanyane and 17% in Alfred Nzo are of concern.

**Figure 30: Nevirapine Uptake Rate in Pregnant HIV +ve Women Across the Rural Nodes**

![Nevirapine Uptake Rate in Pregnant HIV +ve Women Across the Rural Nodes](image)

**Metro View:** The Gauteng metros all had very low rates for the reasons already described. The Nelson Mandela, eThekweni and Cape Town metros all had high uptake rates of 74%, 71% and 68% respectively.

**Figure 31: Nevirapine Uptake Rate in Pregnant HIV +ve Women by Metro District**

![Nevirapine Uptake Rate in Pregnant HIV +ve Women by Metro District](image)

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22 Data for Kgalagadi not available at time of writing.
Provincial View: As illustrated in the graph, four provinces have uptake rates of over 45%. Of more concern are the four provinces which have rates between 29% and 37%. The low uptake rates in Gauteng have been explained. Uptake rates of only 29% in the Free State are concerning given the province’s successful ARV roll-out. If implemented well, the PMTCT programme is very effective at reducing HIV transmission to newborns and should be prioritised in the province together with the other components of the HIV and AIDS programme.

Figure 32: Nevirapine Uptake Rate in Pregnant HIV +ve Women Across the Provinces
3.4.4 Nevirapine Uptake Rate Among Newborn Babies of HIV +ve Women

The nevirapine uptake rate among babies measures the percentage of newborn babies of HIV positive women who received nevirapine suspension within 72 hours after birth. The national uptake rate among babies in 2004 was 90%, which is approaching the national target of 100%.

Many districts have uptake rates close to 100%. This is possible as the indicator measures the number of newborns given nevirapine drops (this includes both home and facility births) out of the number of newborns born in the facility. In many of the rural districts of South Africa, home births are not uncommon due to the difficulties experienced in accessing transport. Babies born at home do not receive nevirapine drops.

Map 11: Nevirapine Uptake Rate by District Among Newborn Babies of HIV +ve Women

District View: There is considerable variation across the districts for the nevirapine uptake rate among babies born to HIV +ve women. On the one hand seven districts had uptake rates in newborns of at least 100%. On the other hand Frances Baard had an uptake rate of 39%.

The districts for which these data could not be considered, as they were either missing or had been incorrectly captured, included all the districts of Mpumalanga, four Northern Cape districts and two districts from the Eastern Cape and Gauteng.

In KwaZulu-Natal and the Western Cape where the PMTCT programme is functioning well, the uptake rates amongst newborns are consistently higher than the uptake rate in pregnant women. In the Western Cape the rates are very high across the province and vary from 102% in Overberg to 94% in the West Coast. In KwaZulu-Natal the rates are slightly less consistent but still high, varying from 98% in uMgungundlovu to 77% in Zululand.
Figure 33: Nevirapine Uptake Rate in Newborn Babies Born to HIV +ve Women by District

Data either incorrect or not available at time of writing for Siyanda, Nkangala, Namakwa, N Mandela Metro, Metswedging, Kgalaqadi, Karoo, G Sibande, Ehlanzeni, A Nzo, West Rand.
The information from the Gauteng districts is difficult to interpret. In Ekurhuleni the nevirapine uptake among pregnant women is 1.4%, yet the nevirapine uptake among newborn babies is 100%. This is probably due to hospital data not being adequately submitted or captured.

**Rural Nodes:** The nevirapine uptake rate among babies born to HIV +ve women varies across the rural nodes from 111% in O Tambo (EC) to 43% at T Mofutsanyane (FS). The data from some rural nodes were not used due to obvious incorrectness.

**Figure 34: Nevirapine Uptake Rate In Newborn Babies Born To HIV +ve Women in the Rural Districts**

**Metro View:** Although data for the Nelson Mandela Metropole have not been included, there is consistency in the data across the metro districts.

**Figure 35: Nevirapine Uptake Rate in Newborn Babies Born to HIV +ve Women by Metro District**
Provincial View: The nevirapine uptake rate among babies born to HIV +ve women across the provinces varies from 99% in Gauteng to 70% in the Eastern Cape.

Figure 36: Nevirapine Uptake Rate in Newborn Babies Born to HIV +ve Women across the Provinces

At time of writing, no data were available for the Mpumalanga and Northern Cape provinces.