4. **Output Indicators**

4.1 **Male Condom Distribution Rate**

The male condom distribution rate is the number of condoms distributed via public health facilities by the Departments of Health in a year to males 15 years and older. The average number of condoms distributed in SA has steadily increased from 5.9 per man per year in 2003 to 8.8 in 2005.

**District View**

The variation in condom distribution per district is shown in Figure 27. The condom distribution rate varied from 26.8 in Cape Town, which has been by far the most pro-active district in the country, to 0.5 in Nkangala. Of the three districts in Mpumalanga province, two districts, Nkangala and Gert Sibande, have the worst distribution rates in the country, distributing less than one condom per male. Conversely however, the third district in Mpumalanga (Ehlanzeni), had the 2nd highest distribution rate in SA.

**Map 6: Male condom distribution rate in South Africa, 2005/06**
Figure 27: Male condom distribution rate by district, 2005/06
Section A: Indicator Comparisons by District

Metro View
All the metro districts performed below the SA average, with the exception of Cape Town, which distributed three times as many condoms (26.8) as did eThekwini (8.6), the next best metro. Ekurhuleni only distributed four condoms per male, less than many of the rural districts distributed.

Figure 28: Male condom distribution rate by metro district

Rural Nodes
The average number of condoms distributed for each male in the rural nodes (10.1) was higher than the South African average and was the same as the average in the metropolitan districts (10.1). Eight of the rural districts, including all four of the Eastern Cape rural node districts, were above the national average for male condom distribution. This is encouraging, bearing in mind the relative difficulties of access and distribution in rural areas.

Figure 29: Male condom distribution rate in the rural nodes
Change in Condom Distribution

Seven of the 53 districts show a decrease in the number of condoms distributed between 2003 and 2005. Three of these districts, including eThekwini Metropole, are from KwaZulu-Natal. This is of concern, given that the prevalence of HIV is highest in this province. Twelve districts demonstrated an increase of less than one condom per male per year. Cape Town, the best performing district also had the highest increase of 11.8 condoms more per male per year between 2003 and 2005.

Figure 30: Change in condom distribution rate by district, 2003/04 - 2005/06
The rate of male condom distribution increased from 2003 to 2005 by 2.9 condoms per male 15 years and older for South Africa. In the rural node districts the rate of distribution increased by an average of 1.9 condoms per male over 15 years. There was a decrease in condom distribution in two rural node districts, Zululand and Thabo Mofutsanyane. Bohlabela had the greatest increase in condom distribution rate.
4.2 Immunisation

Immunisation coverage and drop out rate (DTP1-3)

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. Improvements in these indicators contribute to a decrease in childhood mortality and morbidity and contribute to the achievement of the Millennium Development Goals.

4.2.1 Immunisation Coverage

Immunisation coverage measures the percentage of children under one year who have completed their primary course of immunisation. The national target of 90% was achieved during the year and this is one of the success stories of PHC in South Africa. Linked to this was the great achievement of South Africa being declared a polio free country in 2006.

District View

The variation in immunisation coverage across the 53 districts can be seen in Figure 32. The average immunisation coverage in SA for 2005 was 90%. Metsweding (GP) and Waterberg (LP) had the lowest coverage of 66% while Chris Hani (EC) an ISRD district had the highest immunisation coverage of 121%. Half the districts in SA (26) immunised more than 90% of children under 1 year while only 0 districts had immunisation coverages of less than 80%.

Ten districts had immunisation coverage rates of more than 100%. The most likely reason for this is an under-estimation in the denominator, the number of children under 1 year old. There have been problems with this age estimate due to known under-counting of children in both the 1996 and 2001 censuses, which affects population projections for all future years.

Map 7: Immunisation coverage in South Africa, 2005/06

This primary course includes the BCG injection for tuberculosis, four doses of OPV drops for poliomyelitis, three injections of DPT-Hib vaccine for diphtheria, pertussis, tetanus and Haemophilus influenzae, three hepatitis vaccines and one measles vaccine before the age of 1 year.
Figure 32: Immunisation coverage by district, 2005/06
**Metro View**

The average immunisation coverage in the metropoles is 89%, slightly lower than the national average of 90%. Three of the metros (Nelson Mandela, Tshwane and Cape Town) have achieved coverage rates higher than 90% with all metros being above 80%.

**Figure 33: Immunisation coverage by metro district, 2005/06**

![Immunisation coverage by metro district, 2005/06](image)

**Rural Nodes**

The average immunisation rate in the rural node districts was 98%, above both the national (90%) average and the metro average (89%).

The greatest increases were noted in O.R. Tambo, Chris Hani and Ugu. However, as these districts reported immunisation coverage rates of over 100%, as did Alfred Nzo, these increases should be interpreted cautiously as they may be inflating the overall immunisation rate for the rural nodes. In particular in Alfred Nzo, the sub-district Umzimvubu, has an unexplained immunisation rate of 200%. This may be the result of a significant decrease in the population denominator of children under 1 year, following the recent incorporation of this district into KwaZulu-Natal from the Eastern Cape.

Only three of the rural district nodes have immunisation rates below the national target of 90%.

**Figure 34: Immunisation coverage in the rural nodes, 2005/06**

![Immunisation coverage in the rural nodes, 2005/06](image)
**Change in immunisation coverage**

There was general improvement in the immunisation coverage with 46 of the 53 districts showing improvement. However, coverage decreased by 12% in Pixley ka Seme (NC) and by 10% in the Nelson Mandela metropole (EC). The ISRDP districts (O.R. Thambo, Chris Hani and Ugu) were responsible for three of the five highest increases in SA.

Figure 35: Change in immunisation coverage by district, 2003/04 - 2005/06
Section A: Indicator Comparisons by District

Figure 36: Change in immunisation coverage in the rural nodes, 2003/04 - 2005/06
4.2.2 Immunisation Drop Out Rates (DTP1-3)

The immunisation drop out measures the percentage of children who dropped out between the first and the third dose of the DTP-Hib vaccine. It measures out of 100 children who received their first DTP-Hib vaccine, how many did not receive their third dose. The advantage of this indicator over the immunisation coverage indicator is that both the numerator and the denominator are available from routine health data and are not subject to the complications inherent in using an estimated population-based denominator.

**District View**

The national target for immunisation drop out rates is less than 10%. In 2005 the average in SA was 4.7%. Only 2 districts, Sedibeng (GP) and uMgungundlovu (KZN), had drop out rates above the national target. More than half of the districts had drop out rates of less than 5%. These are very good statistics and are comparable with the best results around the world.

Two districts, Motheo (FS) and Ugu (KZN) demonstrated negative results indicating that more children were immunised with DTP 3 than DTP 1. This is probably the result of movement of mothers and their children between districts. The ISRDP districts Chris Hani (EC) and Central Karoo (WC) demonstrated very low drop out rates of 0.9% and 1.0% respectively.

Map 8: Immunisation drop out rate (DTP1-3) in South Africa, 2005/06
The metro districts vary in drop out rates from zero in Tshwane to 8.3% in eThekwini. The three lowest rates are all in Gauteng. Nelson Mandela, Cape Town and eThekwini metros have rates higher than the national average. One reason for this may be due to population mobility with mothers in urban areas sending their babies to live with their grandmothers and extended families in more rural districts.
Section A: Indicator Comparisons by District

Figure 38: Immunisation drop out rate by metro district (DTP1-3), 2005/06

<table>
<thead>
<tr>
<th>District</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC</td>
<td>3</td>
</tr>
<tr>
<td>FP</td>
<td>4</td>
</tr>
<tr>
<td>GP</td>
<td>5</td>
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<tr>
<td>KZN</td>
<td>6</td>
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<tr>
<td>LP</td>
<td>7</td>
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<td>MP</td>
<td>8</td>
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<td>NC</td>
<td>9</td>
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<tr>
<td>NW</td>
<td>10</td>
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<tr>
<td>WC</td>
<td>11</td>
</tr>
<tr>
<td>SA</td>
<td>12</td>
</tr>
</tbody>
</table>

Rural Nodes

The South African national average drop out rate of 4.7% was matched by the rural node districts. None of the rural node districts exceeded the national target of 10% with only four of the districts having a drop out rate of above 5%.

Only Ugu had a negative drop out rate, indicating that more children were given their third than their first DTP-Hib immunisation. This value is in line with the fact that Ugu reported an immunisation coverage of over 100%, implying that children moved into the area after their births, possibly as part of population mobility from urban to rural areas for young children.

Figure 39: Immunisation drop out rate (DTP1-3) by rural node, 2005/06

<table>
<thead>
<tr>
<th>District</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>EC</td>
<td>3</td>
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<tr>
<td>FP</td>
<td>4</td>
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<td>WC</td>
<td>11</td>
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<tr>
<td>SA</td>
<td>12</td>
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</tbody>
</table>

4.3 Caesarean Section Rate

The Caesarean section rate measures the proportion of deliveries in which a Caesarean section was performed. This is a facility based indicator and not a population based indicator. In other words it uses deliveries that take place in a facility as the denominator as opposed to using all births (both facility and home deliveries).
In 2005 the national average for all hospitals in South Africa was 8.4%. This indicator includes data from district (level 1) hospitals as well as level 2 and 3 hospitals. As these level 2 and 3 hospitals tend to have more complicated deliveries, they tend to have higher Caesarean section rates, and the districts in which they are situated therefore will tend to have overall higher Caesarean section rates.

As can be seen in the Figure 40 there is a wide variation in the Caesarean section rates in all of the 53 districts, with Xhariep (FS) the lowest with 4.4% and uMgungundlovu (KwaZulu-Natal) the highest at 35.2%. There are no public sector hospitals in Metsweding (GP) resulting in no data for this district.

Most of the districts with the highest Caesarean section rates contain a level 2 or level 3 referral hospital. Five of the ten districts with the highest Caesarean section rates are in KwaZulu-Natal. Probably the high HIV prevalence rates in this province contribute to these high rates, but it is likely that different districts and provinces are following different protocols and guidelines in regard to Caesarean section. It would be useful to do health systems research to unpack the reasons for these large differences.

There are also wide variations between districts in the same province. A Caesarean section is one of the most basic operations and should be performed in every hospital. It is therefore likely that sub-optimal care is being delivered in some districts (i.e. those with low Caesarean section rates) and over treatment, with unnecessary complications of the operation, in some districts (i.e. those with high Caesarean section rates).

The current national target of 11%, is clearly not an accurate reflection of what the reality is and should be. It probably needs a panel of experts to review this target to develop a more appropriate guideline.

It is of concern that two of five districts with the lowest Caesarean section rates are in very remote parts of the Eastern Cape (Ukhalamba and Alfred Nzo), where referrals are more difficult and time consuming.
Figure 40: Caesarean section rate by district, 2005/06
As would be expected, the metro districts which contain most of the level 3 (provincial and national) hospitals, have a higher average (23.4%) than the SA average of 18.4%. There is a steep gradient between those metros with the highest rates (Cape Town and eThekwini) over 30% and the Gauteng metros with Ekurhuleni having the lowest rate of 14.1%. However, the high rate in Cape Town is partly due to the poor data quality with an underestimation of the number of deliveries in facilities, that comprises the denominator.

The national Caesarean section rate average in 2005 for all hospitals in South Africa was 8.4% while the average in the rural nodes was 14.7%. Ugu, with a Caesarean section rate of 27.4%, and O.R. Tambo (21.1%) were both above the SA average. This may be accounted for by the fact that Ugu has one regional (level 2) hospital, while O.R. Tambo has three regional (level 2) hospitals. However, Port Shepstone hospital in Ugu has a high risk obstetric unit and receives patients from the Eastern Cape. While this does not follow the standard referral guidelines, these patients are still treated in this hospital.

All of the other rural nodes fall below the South African average which may reflect the greater proportion of lower-risk deliveries, or the lack of skilled supervision to develop local obstetric services in these areas.
Change in Caesarean section rate

Between 2003 and 2005 there was a 2.2% increase in the Caesarean section rate, from 16.2% to 18.4%, countrywide. Only eight districts had a decrease in their rates of which three districts were in the Northern Cape. One of these three is Pixley ka Seme which has one of the lowest rates in the country and one would have expected an increase in this district.

The very high increase in Cape Town should be disregarded as it is almost certainly due to poor data quality and a lack of monitoring of the data by managers at all levels of the system.

Figure 43: Change in Caesarean section rate by district, 2003/04 - 2005/06
Rural Nodes

Compared to the overall increase of 2.2% for SA there was a slightly greater increase of 3.1% in the rural node districts. However, the Caesarean section rate in O.R. Tambo increased by a massive 9.5% (the 3rd biggest increase in SA) and in Ugu by 4.9%.

Figure 44: Change in Caesarean section rate in the rural nodes, 2003/04 - 2005/06

4.4 PMTCT Indicators

Since 2001 the Department of Health has been implementing a prevention of mother to child HIV transmission (PMTCT) programme. For a PMTCT programme to be successful pregnant women must follow several sequential steps:

◆ attend an antenatal clinic equipped to offer VCT;
◆ accept pre-test counselling and HIV testing;
◆ receive their test results;
◆ accept ARV prophylaxis for themselves and their babies;
◆ correctly receive and administer therapy;
◆ receive infant feeding counselling and make an appropriate infant feeding choice;
◆ participate in postpartum follow up care.

At each step, losses occur which decrease the overall effectiveness of the programme

The South African PMTCT programme was largely introduced as a vertical programme to allow for central control and faster implementation; however the result is that it does not function integrally with broader maternal and child health services. The indicators presented in this report suggest that many opportunities to prevent mother to child transmission are being missed.
4.4.1 Proportion of antenatal clients tested for HIV

HIV testing provides the entry point to the PMTCT programme and it is therefore assessed as a key indicator of PMTCT implementation. This indicator measures the proportion of women who attend antenatal clinic who are tested for HIV. The national target is that all (100%) clinics in South Africa should offer PMTCT. Ideally every pregnant woman should be tested.

District View

There is a large variation in the indicator ranging from a low of 23.4% in Gert Sibande district in Mpumalanga to a high of over 100% in the Cape Town Metro. The highest rates of testing uptake are seen in the Western Cape with all six districts achieving a testing uptake rate above 75%. This clearly shows that where a programme is prioritised it can achieve significant results quickly.

The data available from the Eastern Cape districts was generally of poor quality. At one end of the spectrum there was no data at all from Chris Hani and Amathole, whilst at the other end Alfred Nzo and O.R. Tambo had over 140% of pregnant mothers tested. Part of the problem with the Eastern Cape data quality is the confusion with the denominator, number of 1st ANC visits, especially as the data element was divided into visits before and after 20 weeks gestation. Clearly there is inadequate monitoring of this priority programme by managers throughout the Eastern Cape.

In Mpumalanga none of the three districts achieved a testing rate of more than 35%. This indicates a lack of prioritisation of this programme.

Map 10: Proportion of antenatal clients tested for HIV in South Africa, 2005/06
Section A: Indicator Comparisons by District

Figure 45: Proportion of antenatal clients tested for HIV in South Africa, 2005/06 by district

Metro View

Generally the metro results for the proportion of pregnant women tested are disappointing. Only the Cape Town metro achieved above 70% while Ekurhuleni is below 30%. These are unacceptable results for a priority preventive programme where the objective is to get all mothers tested.

Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
Rural Nodes

The unrealistically high percentages reported by two Eastern Cape districts, Alfred Nzo and O.R. Tambo and the lack of data from Chris Hani give a clear indication that the health information and monitoring systems in the Eastern Cape need improvement. However, compared with the metropolitan districts, overall the rural node districts appear to be performing relatively well.

Change in Proportion of clients tested

The need for HIV testing to be integrated as a routine part of antenatal care, specifically with the introduction of “opt-out” testing is clear. This has been shown in other African countries, most notably Botswana, to dramatically increase uptake of antenatal HIV testing.

Although most districts have improved on the testing rates, all eleven districts in KwaZulu-Natal have deteriorated where the Western Cape did not have data available in 2004 so no comparisons can be made. The changes in Alfred Nzo and O.R. Tambo are obviously the results of poor quality data.

8 Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
9 Opt-out testing refers to where all pregnant mothers are routinely tested for HIV, unless the mother expressly chooses not to be tested and “opts out.”
Figure 48: Change in proportion of antenatal clients tested by district, 2004/05 - 2005/06

Section A: Indicator Comparisons by District

Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
Rural Nodes\textsuperscript{11} The differences in the four KwaZulu-Natal districts from 2004 to 2005 varied between an absolute decline of 14.5\% to 30.1\%. However, it should be noted that this indicator was previously calculated as a proportion of women counselled for testing rather than as a proportion of all women attending ANC for first time.

The relatively large increase in Greater Sekhukhune in comparison to the smaller increase in Bohlabela brought these districts more in line with one another, with 42.7\% and 41\% respectively of the women attending first time antenatal care opting to test for HIV.

The largest increase in antenatal care attendees opting to test for HIV was found in Kgalagadi, where the percentage of women testing increased from 7.1\% to 36.2\%.

Figure 49: Change in proportion of antenatal clients tested for HIV in the rural nodes, 2004/05 - 2005/06\textsuperscript{12}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure49}
\caption{Change in proportion antenatal clients tested for HIV, 2004/05 - 2005/06}
\end{figure}

\begin{itemize}
\item No data available for Chris Hani (2005) and Central Karoo (2004).
\item Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
\end{itemize}
4.4.2 HIV Prevalence amongst antenatal clients tested

The routine data collected from clinics and entered into the District Health Information System (DHIS) provides a picture of HIV prevalence at district level. The HIV prevalence amongst antenatal clients tested, measures the percentage of ANC clients who accept to be tested for HIV and then test positive. However, it is possible that pregnant women at higher risk were less likely to accept testing, which would lower the overall result of women who tested HIV+ve.

The HIV prevalence amongst antenatal clients from the DHIS is 29%. This is a slight increase on what was found in 2004 (25.4%) possibly due to an increase in the completeness of this data and an increase in the number of districts reporting. The HIV prevalence in the DHIS by province was slightly lower than what was found in the national antenatal sero-prevalence survey. Caution should be used when interpreting HIV prevalence rates in districts where the difference between the annual antenatal survey and the DHIS data are large and where less than 50% of women agreed to HIV testing, especially in some districts of Mpumalanga and the Eastern Cape, as this prevalence is unlikely to be representative of the true HIV prevalence in these districts. However, overall the HIV prevalence found in the DHIS corresponds well to the national antenatal HIV sero-prevalence survey (30.2%).

District View

The districts with the highest HIV prevalence are in KwaZulu-Natal. The Western and Northern Cape districts generally are amongst the districts with the lowest prevalence. The Free State districts are all clustered between 25% and 28% prevalence with the exception of Xhariep which has a much lower prevalence of 18%.

The results for Amathole (EC) of less than 10% prevalence look suspiciously low when compared to the other 6 districts in the Eastern Cape, which all have prevalence rates above 20%.

Map 11: HIV prevalence amongst antenatal clients tested in South Africa, 2005/06

![Map of South Africa showing HIV prevalence amongst antenatal clients tested, 2005/06](image)
Figure 50: HIV Prevalence amongst antenatal clients tested by district, 2005/06\(^\text{13}\)

Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.

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\(^{13}\) Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
Metro View
There is a wide range in the prevalence rate in the metro districts from Cape Town with a prevalence of 14.5%, to eThekwini with a prevalence of 39.9%.

Figure 51: HIV prevalence amongst antenatal clients tested by metro district, 2005/06

Rural Nodes
Three of the four KwaZulu-Natal rural districts have the highest HIV prevalence of the rural nodes, with Zululand at 30.9% Umkhayakude at 32.5% and Ugu at 38.3%.

Figure 52: HIV prevalence amongst ANC clients tested for HIV in the rural nodes, 2005/06

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Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
Change in HIV prevalence rates

The large changes at both ends of the spectrum with a huge decrease in Francis Baard, (from 38.7% to 16.7% prevalence rates) and a large increase in prevalence rate in Namakwa, both districts in the NC, are likely to be due to poor quality data or inadequate numbers of women tested.

Figure 53: Change in HIV prevalence among antenatal clients tested by district, 2004/05 - 2005/06

Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
### Rural Nodes

Seven of the rural nodes, including all four KwaZulu-Natal nodes showed an increase in prevalence rate from the DHIS.

#### Figure 54: Change in HIV prevalence rate among antenatal clients tested in the rural nodes, 2004/05 - 2005/06

<table>
<thead>
<tr>
<th>District</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td></td>
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<tr>
<td>ISRDP average</td>
<td></td>
</tr>
<tr>
<td>Bohlabela</td>
<td></td>
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<tr>
<td>O.R. Tambo</td>
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<tr>
<td>Ukhahlamba</td>
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<tr>
<td>Thabo</td>
<td></td>
</tr>
<tr>
<td>Central Karoo</td>
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</tr>
<tr>
<td>Umzinyathi</td>
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<tr>
<td>Kgalagadi</td>
<td></td>
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<tr>
<td>Ugu</td>
<td></td>
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<tr>
<td>Zululand</td>
<td></td>
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<tr>
<td>Alfred Nzo</td>
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<tr>
<td>Chris Hani</td>
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<tr>
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<td>Greater Sekhukhune</td>
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<tr>
<td>No data</td>
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</tbody>
</table>

Values for SA, the rural nodes and metro averages cannot be calculated due to lack of underlying data.
4.4.3 Nevirapine uptake rate among pregnant HIV+ve women

The provision of nevirapine is the next important step in the PMTCT programme. The indicators highlight that large missed opportunities are occurring in the provision of nevirapine with only half (51.7%) of the women testing HIV+ve accessing nevirapine. This low coverage of the prophylaxis component of PMTCT will have a significant impact on the overall effectiveness of the programme.

There could be several reasons for this low rate including problems with data recording and compilation, as nevirapine is dispensed in both antenatal clinics and labour ward settings. Fears of disclosing their status may have resulted in women self-administering nevirapine at home and not informing labour ward staff, hence the dose would not be recorded in the routine records.

District View

Wide variation can be seen in the coverage of nevirapine between districts and within provinces, most notably in the Eastern Cape with three districts having a coverage above 70% and one, Alfred Nzo, only 16.5%. However the indicators for Nelson Mandela Metro and Amathole look very high and must be viewed with suspicion.

The low uptake of nevirapine highlights the importance of moving away from an ‘all or nothing’ PMTCT regimen where a single dose of nevirapine is taken or nothing. Consideration should be given to adopting a dual or triple drug regimen for this programme which, based on daily doses opposed to a once off dose, is likely to lead to higher adherence and coverage. A dual dose has been successfully piloted in the Western Cape with promising results in the reduction of mother to child transmission of HIV.

Map 12: Nevirapine uptake rate among pregnant HIV+ve women in South Africa, 2005/06

17 Low coverage – Alfred Nzo – mostly due to data in Umzimkulu, although below 30% in other sub-districts as well.
18 High value in Amathole seems mostly Buffalo City LSA with about double number of doses compared to number of HIV+ve ANC new.
Nevirapine uptake rate among pregnant HIV+ve women, 2005/06

Figure 55: Nevirapine uptake rate among pregnant HIV+ve women by district, 2005/06

South Africa
Nelson Mandela Bay Metro
Amathole
Cacadu
City of Cape Town
iLembe
Waterberg
Greater Sekhukhune
Cape Winelands
Umkhanyakude
Uthungulu
West Coast
Ugu
Boholabela
Eden
eThekwini
Umzinyathi
Pixley ka Seme
Vhembe
Uthukela
Overberg
Capricorn
Mopani
UMgungundlovu
Motheo
Central Karoo
Gert Sibande
Ethzireni
Sedibeng
Zululand
Nkangala
Amajuba
Sisonke
Xhariep
City of Johannesburg
Southern
Ukhahlamba
Ekurhuleni
Metswedging
Central
Chris Hani
O.R. Tambo
City of Tshwane
Frances Baard
Bophirima
Bojanala
West Rand
Thabo Mofutsanyane
Namakwa
Alfred Nzo
Fezile Dabi
Kgalagadi
Lejweleputswa
Siyanda

Percentage

0 10 20 30 40 50 60 70 80 90 100

EC  FS  GP  KZN  LP  MP  NC  NW  WC  SA
Metro View

The average for the Metros was slightly higher (54.1%) than the national average with three metros achieving an uptake of over 60% (Cape Town, Nelson Mandela and eThekwini). All three Gauteng metros were below the national average. In the DHB 2004 the low rates in Gauteng were ascribed to poor data flow from hospitals. If this is still the case it is an indictment of the management structures that this has not been remedied.

Figure 56: Nevirapine uptake rate among pregnant HIV+ve women by metro district, 2005/06

Rural Nodes

The average nevirapine uptake in the rural node districts (48.4%) was slightly lower than the SA average of 51.7%. These figures reflect poor continuity of care of HIV+ve pregnant women so while six of the rural node districts (which includes three of the four KwaZulu-Natal districts) were above the average for the country, they still fall short of the ideal.

Alfred Nzo and Kgalagadi districts with uptake rate around 16% were in the lowest five districts in South Africa. Clearly more attention needs to be given to the PMTCT programme if SA is to succeed in turning around the tide of HIV infections in children and make progress towards reaching the Millennium Development Goals.

Figure 57: Nevirapine uptake rate among pregnant HIV+ve women in the rural nodes, 2005/06

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9 Kgalagadi - note that the actual numbers of HIV+ve ANC new (denominator) are also very low - in addition to the numerator being zero in many places - numbers do look very low compared to number of 1st ANC visit.
4.4.4 Nevirapine uptake rate among babies born to women with HIV

The nevirapine uptake rate among babies measures the percentage of babies of HIV+ve mothers who received nevirapine within 72 hours of birth, out of the number of live births in facilities to HIV+ve women.

**District View**

Coverage of nevirapine to infants was generally found to be high, with 31 districts recording uptake rates of 90% or above. No realistic averages could be calculated because of unrealistically high values above 100% in a number of districts as well as no data being available from four districts. In addition, data for KZN and WC was received from provinces and not DHIS. The coverage was above 70% in all but two districts and above 70% in all of the Metros. It is important to note that this is an extreme over-estimation of the true coverage of all babies born of HIV+ve mothers. This uptake rate only includes infants born to women, who at the time of delivery were identified to be HIV+ve.

The data most likely excludes home deliveries, unless a mother brought the infant to a facility within 72 hours of birth and disclosed her status. It will also exclude women who do not disclose their HIV status to labour ward staff. It also excludes all the women who were not tested at all. To obtain a true reflection of nevirapine coverage to infants it would be advisable to use the HIV prevalence rate amongst pregnant women to determine the expected denominator of HIV exposed infants.
Nevirapine uptake rate among babies born to women with HIV by district, 2005/06

No averages could be calculated due to unrealistically high values over 100% in a number of districts as well as missing data from four districts.
Metro View

As can be seen in Figure 59, all the metros with exception of Nelson Mandela, were doing a good job of getting nevirapine to those babies identified. In this situation serious consideration should be given to improving the regimen by going for dual or triple therapy as opposed to the single dose of nevirapine.

Figure 59: Nevirapine uptake rate among babies born to women with HIV by metro district, 2005/06

Rural Nodes

Many of the rural node districts had uptake rates close to or over 100%. It is not clear why so many districts show values for this indicator of more than 100%. One possible reason is that many newborns are given nevirapine drops regardless if they were born at home or in a PHC facility and it may be recorded once after delivery and again when the babies are brought for check-up within first 72 hours post delivery.

Figure 60: Nevirapine uptake rate among babies born to women with HIV by rural node, 2005/06

21 No averages could be calculated due to unrealistically high values over 100% in a number of districts as well as missing data from four districts.
4.5 Primary health care utilisation rate

The primary health care utilisation rate is the average number of visits per person per year to a public PHC facility. In 2005 the average utilisation of primary health care services in SA was 2.1 visits per person and has been unchanged since 2003. The national target of 3.5 appears very high, but the injection of resources into the district health system and PHC over the next three years (Medium Term Expenditure Framework, MTEF) may improve both accessibility and quality and encourage an increase in usage.

District view

Figure 61 shows the variation in utilisation rate from 0.8 in Metsweding (GP) to 4.5 in the Central Karoo (WC), a rural node of SA. All six districts in Gauteng rank within the 10 lowest utilisation rates in the country. Clearly PHC is not getting the priority that it needs in this province.

By contrast, all the districts in the Northern Cape, Western Cape and North West have utilisation rates above the national average. Only two districts, Vhembe (LP) and Central Karoo (WC) have achieved utilisation rates higher than the national target.

Map 13: Primary health care utilisation rate in South Africa, 2005/06

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22 This rate is based on the total population and not the uninsured section of the population who are dependent on the public sector, and is therefore an underestimation of the real utilisation.
Utilisation rate, 2005/06

Figure 61: Primary health care utilisation rate by district, 2005/06
Metro View

The graph of the six metropoles below indicates that all metros in Gauteng (Johannesburg, Ekurhuleni and Tshwane) have the lowest utilisation rates, with Ekurhuleni the lowest ranked metro having declined since 2004. Nelson Mandela and Cape Town with utilisation rates of 3.3 and 2.7 respectively are higher than the national average. eThekwini has remained constant at an average of 1.9 visits for the last three years.

Figure 62: Primary health care utilisation rate by metro district, 2005/06

Rural Nodes

The average utilisation rate in the rural district nodes increased marginally from 2.0 to 2.1 and is the same as the national average. This implies that there is equity in access between the most deprived inaccessible areas in South Africa and those that have are more easily accessible.

The only rural node district above the national target was the Central Karoo with an average of 4.5 visits per person, the highest in South Africa. Nine of the districts showed an increase in utilisation during the year.

Figure 63: Primary health care utilisation rate by rural node, 2005/06
Change in utilisation rate

Because the utilisation rate is based on the total number of visits of patients for all possible health reasons, it represents the full spectrum of all PHC activity and is therefore slow to change. However the graph shows that the majority (31 of the 53 districts) showed an increase in utilisation rate since 2003. Southern district (NW) demonstrated the highest average increase in the number of people visiting a PHC facility (0.5) while two districts in the NC (Namakwa and Pixley ka Seme) had the largest declines in utilisation rates of 0.7 and 0.6 respectively. Of concern is the decline in utilisation rate of Ekurhuleni metro off a very low base.

Figure 64: Change primary health care in utilisation rate by district, 2003/04 - 2005/06
Overall, there was no notable increase in PHC utilisation rate across the rural nodes in KwaZulu-Natal. However, utilisation increased in all the Eastern Cape and Limpopo rural node districts.

Figure 65: Change in primary health care utilisation rate by rural node, 2005/06