ANOVA
HEALTH INSTITUTE

Setting A Pace

Integrated Annual Report
2018-2019

Table of Contents

Introduction: Scope and Boundary

The Anova Health Institute NPC is a non-profit company (Registration Number: 2009/014105/08) that is headquartered in Johannesburg and works in South Africa, Zambia and Haiti. This Integrated Report presents our financial, programmatic, environmental, social and governance performance for the period 1 October 2018 to 30 September 2019 and describes our goals, performance, responsibilities, policies, risks and plans.

Materiality

Anova's Executive Management and Board recognise the importance of materiality in determining the content and relevance of this report. Materiality refers to information about issues that substantively affect our ability to create value over the short, medium and long term. Our Executive Management and Board have reviewed the matters that materially impact our performance and sustainability. We have evaluated these in the context of our strategic objectives, stakeholder engagement and the "six capitals" (see page 3). Detailed reporting on material issues can be found in the sections on our programmes, impact and performance highlights; governance; and economic performance.

Material matters aligned to the six capitals

Financial capital:
- Ensuring and sustaining sources of income

Manufactured capital:
- Managing extensive suite of properties, vehicle fleet and other assets
- Ensuring health and safety of all our staff

Intellectual capital:
- Scaling up innovative programmes
- Storing, sharing and disseminating knowledge gained to ensure broad and sustained public benefit, now and into the future

Social and relationship capital:
- Managing relationships with government partners

Natural capital:
- Managing our impact on the environment

Human capital:
- Recruiting and retaining skilled human capital
- Maintaining and consolidating growth

In reviewing our material issues, we considered:
- Anova's values, strategies, goals and targets
- Our stakeholders' expectations, needs and views
- Our funders' expectations and contractual requirements
- Significant risks that could affect our performance, identified through our risk management process

The material priorities for this year are discussed further in our programme reporting, human resources and financial sections.

Board approval

This report was approved by the Anova Board on 19 November. The Board is responsible for ensuring this Integrated Report addresses all the issues that are material to our ability to deliver value for our stakeholders and fairly presents the performance of the Anova Health Institute.

Global reporting standards

Anova used the Global Reporting Initiative (GRI 102) guidelines to prepare this report in accordance with the Core option and has also applied the GRI NGO sector supplement. The GRI compliance index is documented in the GRI compliance table on pages 57-59 and is also available from our website, anovahealth.co.za.

Environmental impact

As an organisation Anova does not have a high impact on the environment. Our work is predominantly service-based, with a small construction component in this reporting period. We do not consider our environmental impact a material issue, but it is covered in the environmental report (page 44) and in the GRI compliance table (G102-12).

Accountability

Anova utilises integrated reporting as a means to demonstrate our commitment to transparency, public accountability, recording excellence and sustainable programming. The last Integrated Report was published in October 2019.

What are the six capitals?

The "six capitals" represent stocks of value that are impacted or transformed by our activities and outputs, as we seek to create value over time. The six capitals are:

1. Financial
2. Manufactured
3. Intellectual
4. Social and relationship
5. Natural
6. Human

They are used in integrated reporting to standardise the presentation of information across diverse organisations, and are as relevant to a not-for-profit service provider like Anova as they are to commercial entities. The six capitals framework ensures we consider all the forms of capital we use and are aware of (and report on) interdependencies between them. For more information see integratedreporting.org

Organisational Overview

The Anova Health Institute believes that everyone has the right to excellent health. This fundamental belief underpins everything we do. We seek to make this a reality by delivering innovative programmes that result in positive health outcomes for everyone in society, without regard for age, sex, gender, sexual preference or lifestyle choice. Good health is the result not only of access to health care, but also socio-economic, psychosocial and cultural factors, and for this reason we engage with communities and their leaders, as well as with health officials and health care workers.

Our capabilities include technical expertise in HIV and TB prevention, care and treatment; health systems strengthening; public health management; and working with key populations, in particular men and young men who have sex with men (MSM/YMSM) and transgender individuals and also people who inject drugs.

We work with stakeholders at all levels of the care continuum: provincial and district health authorities, district, sub-district and facility-level health care workers, traditional leaders, community members and activists. We take the lead in addressing the issues that are often "hidden in plain sight" and we apply solutions by expanding and enhancing existing service delivery and introducing new and innovative approaches. We use research, data and analytics to shine a light on programmes, identify gaps, understand what works and learn from experience.

At the end of the reporting year, Anova supported 837 452 patients on treatment.

Community engagement is vital to the success of all health programmes. Building capacity starts with health systems strengthening and extends to community systems strengthening. Community outreach workers are a critical link in the chain of care that will see the UNAIDS 90-90-90 goals become a reality; and Anova has been especially effective in leveraging the support of communities, particularly when it comes to accessing hard-to-reach populations.

In addition to our work within the confines of South Africa, we have worked in other African countries, specifically Zambia in this reporting period, as well as Haiti, through the EQUIP Consortium, of which Anova was a founding member. Working with local partners we have introduced PrEP and provided support to key populations such as sex workers and men who have sex with men.

Vision

To be the leading organisation in innovative health programmes that result in positive health outcomes

Ideology

We believe that everyone has the right to excellent health

CEO's Statement

The year 2018-19 was defined by APACE – a five-year grant programme by the US Government to fight HIV. APACE stands for "Accelerating Program Achievements to Control the Epidemic". Never has an acronym been more apt. Although we continued work on other key programmes, such as JabSmart and LINKAGES, the demands placed on the organisation by APACE permeated all of our functions and activities.

The mandarins who are given the task of thinking up names for programmes outdid themselves with APACE. The first year of the grant was characterised by working at a frenetic pace. Everything we did was accelerated. We moved to daily reporting of data; we ramped up testing services; we built clinics. Everyone at Anova worked tremendously hard to push target achievement and satisfy the stipulations of the grant. I couldn't be more proud of our team.

We took over HIV programming in three new districts, including the City of Cape Town. Our staff complement increased from 600 to 3 500. As well as recruiting many new employees, we also absorbed teams from other organisations that had been working in areas we took over. This involved effort and engagement to merge cultures and ensure everyone felt welcome and part of Anova. I am very grateful to our HR team and to the managers who worked overtime to make this happen. APACE required massive expansion of our physical infrastructure. From 194 supported health facilities in 2017-18, we increased the number to 518. We now manage 10 125.33m^2 of property, in four provinces. Not only did we expand to accommodate new teams, many existing employees found themselves being moved around, often at short notice, as we tried to use our space and manage our teams as efficiently as possible. I'd like to say a big thank you to all staff who rolled their sleeves up, packed their desks and cheerfully relocated.

Anova has always had a reputation for data quality and effective data management. This has become a key feature of our effort to accelerate achievements and upskill our Department of Health partners. Without meaningful and reliable data, it would be impossible to know if our programme activities are working or not. APACE has set stretching targets, and it is necessary to continually revise our processes to ensure we deliver the numbers required of us. Our data teams put in long hours over the year cleaning data, organising files and file storage, archiving files, and improving data quality. In Capricorn District, for example, we trained the entire district on data quality improvement. Capricorn's reports now contain salient content, based on an understanding of data that was previously lacking.

Of course, we could not achieve anything on our own. Ending this epidemic will only happen through teamwork and collaboration between departments of health at national, provincial, district and sub-district level; communities; traditional leaders; influencers; civil society; and NGOs like us. We have worked very hard over the years, and particularly in this first year of APACE, to develop and nurture these critical relationships. We have gained the trust of local community leaders and district and provincial AIDS councils, and Anova is seen as a key partner, not only technically but socially.

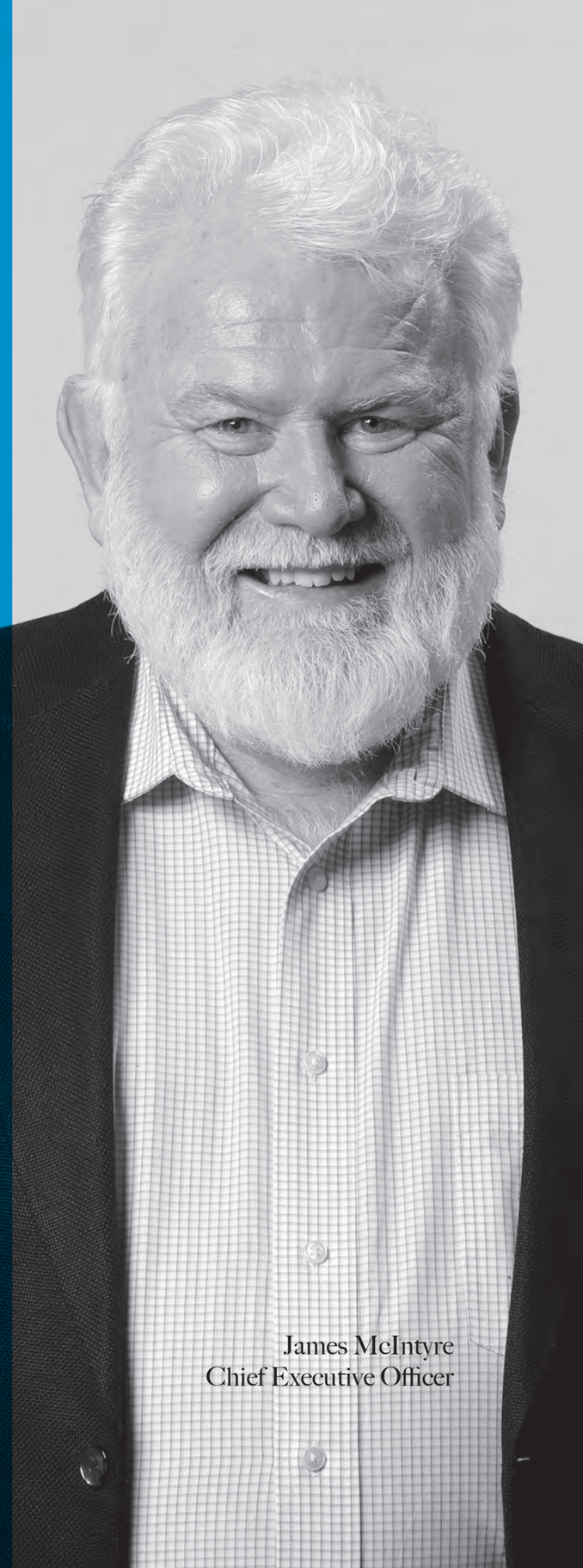
While APACE is a national programme intended to reach into all corners of society, Anova has always demonstrated a particularly strong commitment to the health of men who have sex with men (MSM) and other key populations. We have not wavered from this goal.

We continued to provide prevention services to MSM and transgender individuals and shifted our focus in a number of clinics from only MSM to men's health more broadly. However, the Ivan Toms Centre in Cape Town remains exclusively for MSM and transgender services. We also continued to provide services to people who inject drugs in Johannesburg through JabSmart.

Anova is an expert in health systems strengthening and technical support to health care facilities and professionals. We are not builders. However, when we were asked by PEPFAR, halfway through the year, to facilitate the construction of a large number of units to provide additional clinic capacity, we willingly obliged. We undertook to project manage the erection of more than 70 permanent structures across eight provinces, and by the end of the financial year, we are proud to report that 23 of them were completed or nearly complete.

In this report we describe the efforts that characterised 2018-19 – a year of truly working at APACE.

We took over HIV programming in three new districts, including the City of Cape Town.



James McIntyre
Chief Executive Officer

Chairman's Statement

Although this integrated report covers the period 1 October 2018 to 30 September 2019, by the time this is published, South Africa will have battled another epidemic – the pandemic COVID-19. It is an ironic twist of fate that, despite being a middle-income economy, as a nation we are actually better equipped than many of our high-income counterparts to deal with this crisis. We have learned much from our response to HIV and TB, not only about strengthening the health system, but about community engagement and health communications. We know how to carry out testing at community level. We understand the importance of non-pharmaceutical interventions. We have a relatively treatment-literate population.

None of this would be possible without our 30 years' experience battling HIV/AIDS and TB. The capacity of our health care workers to diagnose and treat infectious diseases has been markedly increased due to HIV programming, made possible predominantly through international donor support.

Last year we were proud to announce that we were a recipient of the APACE grant from USAID/PEPFAR – Accelerating Program Achievements to Control the Epidemic. This grant runs from 2019 to 2023. APACE is focused on accelerating efforts to reach the 90-90-90 targets set by UNAIDS. These targets aim for a world where, by 2020, 90% of people living with HIV will know their HIV status, 90% of people who know they are HIV-positive will have access to treatment, and 90% of those on treatment will have suppressed viral loads.

In South Africa, as the first year of APACE got under way,

- 90% of people living with HIV knew their status;
- 62% of people living with HIV were on treatment; and
- 54% of people living with HIV were virally suppressed.

Attainment of the first target is good news; but we have some way to go if the other targets are to be achieved by the end of 2020. President Cyril Ramaphosa, in his first State of the Nation address in February 2018, announced his intention to initiate an additional two million people on HIV treatment by 2020 – the "missing two million". APACE is designed to do just that.

I am grateful to my fellow Board members for their guidance and support, as we have shepherded Anova through this exhilarating but testing time. On behalf of the Board, I express my sincere gratitude to the Anova executive team and the entire staff and management team for stepping up to the challenge of APACE and continuing to provide South Africans with outstanding health care, and the health system with technical support and guidance. We are truly setting a pace.

In South Africa, as the first year of APACE got under way,

90% of people living with HIV knew their status;

62% of people living with HIV were on treatment; and

54% of people living with HIV were virally suppressed.

Joel Dikgole
Chairman

Strategy

2018-19 Strategic Areas

As an organisation, Anova has been on a steady growth trajectory since our inception over 10 years ago. The pace of growth has accelerated in the past few years, and our strategy has responded accordingly, but we have remained true to our core values and our organisational objectives. However, our strategy has been and continues to be flexible enough to meet the technical and developmental needs of our government partners.

In early 2018, the Board and executive management team prepared for the APACE grant, which runs from October 2018 to September 2023. We set out a five-year strategy, encompassing four key strategic objectives:

1. Develop and implement impactful and sustainable health programmes, in alignment with relevant national and global plans.
2. Foster effective engagement with stakeholders and strategic partners, via collaboration and business continuity, thought leadership, innovative solutions, quality research, knowledge and sharing.
3. Develop and implement organisation-wide strategies and policies to embed transformation.
4. Mobilise, deploy and manage resources and systems effectively and efficiently, to ensure and support the implementation of good governance and effective monitoring and evaluation towards sustaining programmes.

Four approaches were identified as being strategic enablers:

1. People-centred
2. Data-driven
3. Evidence-informed
4. Productive partnerships

2019-20 Strategic Areas

The strategy set out above covers the period until 2023. However, strategic reviews take place every six months at Board level and the strategy is assessed annually. Together, the Board and executive management team conduct an analysis of our environment, donor feedback, progress against targets, and resource management. Through this process we are able to determine if our strategy is still wholly relevant or if we need to adapt it to changing circumstances. Our last review concluded that the strategy remains relevant and we continue to monitor our performance and progress against it.

The pace of growth has accelerated in the past few years, and our strategy has responded accordingly, but we have remained true to our core values and our organisational objectives.

Stakeholder Engagement

Anova's work spans social and cultural boundaries. Our stakeholders come from a wide variety of environments and have differing needs and expectations of us. But we all share the goal of finding solutions to the pressing health care problems of the day and improving the quality of health and life for all South Africans.

Without effective stakeholder engagement we would not be able to implement our programmes, projects and campaigns. Here we outline the stakeholder groups with whom we engage and describe the nature of the engagement, their expectations of us, and our response.

Without effective stakeholder engagement we would not be able to implement our programmes, projects and campaigns.

Stakeholder group	Overview	Capital impacted	Impact and engagement	Expectations/ concerns	How we respond
Beneficiaries	All people served by Anova's health programmes, including HIV prevention, treatment initiation, reproductive health and psychosocial support	• Social and relationship	Anova takes a bottom-up approach, talking to communities and local government and building programmes from the ground up. Beneficiaries' acceptance of and engagement with our teams and interventions is critical to outcomes.	• Improved access to quality and comprehensive health services • Access to information	• Staff interactions at facilities and within the community and at events • Information sharing via our social media platforms, pamphlets and brochures
Government partners (DoH)	National, provincial and district departments of health	• Social and relationship • Intellectual	Anova works together with health authorities at all levels to build capacity and provide technical support, direct service delivery, training and mentoring.	• Enabling environment for policy implementation • Skilled health workforce	• Technical assistance at all levels • Supporting site visits • Joint health planning with the district
NGO partners	HIV programming and health systems strengthening is divided by donors among multiple NGOs, according to capacity and expertise. In our Capex programme we had to work closely with other NGOs who were providing technical support in areas where we were not active	• Social and relationship • Intellectual	Anova partners with other health-related NGOs to share skills and provide complementary resources. Partners collaborate to deliver optimal outcomes and meet donor needs.	• Alignment of activities to avoid duplication • Scaling up of innovative projects	• Regular partner meetings • Sharing best practice through seminars and workshops
Anova Board	Executive and non-executive directors of the organisation	• Human • Financial	The Board is committed to an active role in the governance and oversight of Anova but does not intervene unduly in the daily management of the organisation, trusting in the skill and competency of the management team.	• Strategy development • Performance management • Financial accountability	• Extensive updates at Board and sub-committee meetings • Detailed discussions with senior management
Employees	All staff who deliver Anova's programmes and provide central services	• Human • Manufactured • Social and relationship	Anova has a culture of teamwork and collaboration. The atmosphere is supportive and employees feel valued.	• Job security • Working conditions and environment • Developing staff	• Regular communication with staff via digital media • Quarterly newsletter • Identifying and promoting training opportunities for staff
Funders	Bilateral and multilateral donors, foundations, private donors	• Financial • Social and relationship	Our donors are a critical component of our work. They provide the resources and set the agenda for programme delivery, working in conjunction with the South African Government.	• Project relevance and timeous, high-quality delivery on objectives • Exemplary financial compliance	• Regular progress meetings • Detailed site visits to projects and the areas we work in • Comprehensive financial reporting • High-quality data

Our programmes, impact, and performance highlights

Anova/APACE

2018-19 was defined by APACE – Accelerating Program Achievements to Control the Epidemic. The United States Government, via its PEPFAR programme, has invested heavily in South Africa since 2004. Anova has been a PEPFAR and USAID partner since our inception in 2009, and we are delighted to be part of the USAID APACE programme, which was designed to aid the South African Government in reaching the UNAIDS 90-90-90 targets by 2020.

It is important that the South African health system is ready and able to pick up the reins from the PEPFAR programme, as funding from USAID and CDC steadily decreases over the next few years. Anova strives to implement sustainable programmes that can be successfully transitioned to the South African Government. PEPFAR has made a significant investment in South Africa and the gains made must be maintained. We are confident that the acceleration taking place under APACE is reducing the epidemic. APACE looks at focus areas and puts resources behind the gaps.

Employee numbers

The first year of APACE was about picking up the pace…at a dizzying rate. Staff numbers increased from 600 to c. 3500, including both full-time and fixed-term employees. In the City of Johannesburg alone, we transformed a team of under 200 staff supporting ~70 clinics to one of 2 000 workers supporting all 121 facilities in the district. Anova was also requested to take on the City of Cape Town programme in April 2019, adding to the workload.

As an organisation we had to learn new ways of recruiting large cohorts of staff, as conventional one-to-one recruitment was clearly impossible. As the year went on, the pace continued relentlessly. Our management team was stretched and challenged in new ways daily, but we are proud to say we rose to the challenge and continually revised and adapted our plans to meet the ever-changing situational requirements. Read more in the HR report on page 45.

Change management

APACE expansion was not just about Anova staffing. We have been able to add value in other critical ways. APACE enabled us to support the Department of Health with resources and infrastructure such as extra nurses, clinic space and equipment. We invested significant amounts in basics like filing, which can create obstructive bottlenecks if not well organised. The files in 71 clinics in City of Johannesburg were successfully cleaned up, a task which involved long hours of de-duplication, indexing and archiving.

90-90-90

By **2020**,
90% of all people living with HIV will know their HIV status.
90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
90% of all people receiving antiretroviral therapy will have viral suppression.

I'm amazed at our resilience, the fact that we built a team so quickly and produced results at the same time.

Diana Mokoena,
Programme Manager,
City of Johannesburg

2017-18 **856** employees ▶ **2018-19** **3 211** employees ▶ **363%** increase

Through our CAPEX infrastructure project, we built and delivered 23 new supplementary clinic buildings during the reporting period (out of a total of 70) in eight provinces. Based on the "ideal clinic" concept, these are permanent structures that give overstretched clinics additional space to allow rooms to be efficiently utilised and dedicated to proper streams. By providing better infrastructure, overall quality of care is increased. See page 28 for more information.

We also developed and acquired new tools, such as REDCap data collection. We trained our own employees as well as DoH staff on these tools. We explored different ways of planning shift staffing and managing procurement. Change was constant. Our engagement with USAID was daily, and through that we refined and enhanced our pliability and consequently met every fresh challenge with vigour and enthusiasm

REDCap is a free, secure method of flexible yet robust data collection. It was originally developed in 2004 at Vanderbilt University for clinical researchers who needed a tool to support their research studies. REDCap is now used by thousands of non-profit and government organisations around the world. The consortium of developers continues to actively develop the software, relying on the feedback of the global research community.

Engagement

APACE is a joint effort. There are numerous partners working with USAID/PEPFAR to deliver APACE, and collaboration is key. Where appropriate, we have engaged with community partners. We've plugged testers into acute, after-hours services and raised awareness in communities. We've worked with other organisations to ensure high levels of testing. We've recruited the private sector to carry out testing, to ensure saturation. The government talks about the "missing two million", the number of people living with HIV in South Africa who are not yet on treatment. Through APACE, we are determined to find them and initiate them on treatment.

Limpopo

Our programme

Anova's engagement in Limpopo encompasses two districts: Mopani and Capricorn. Mopani was an old friend, as we had been active in Mopani District since inception as part of our previous Health Systems Strengthening programme. We enjoyed well-established relationships and simply had to ramp up activities to support a larger number of clinics with a bigger team.

In Capricorn, however, we had to start from scratch. We had no relationship with the district Department of Health and our team worked hard to build trust and cooperation. We replaced another PEPFAR partner and acquired nearly 300 staff whom we had to transition to Anova's culture, while at the same time proving ourselves with the district management team and aligning our priorities with theirs.

We were fortunate to have a few months prior to the start of APACE during which we conducted a baseline study to determine what the critical, first-stage actions were. Once the programme began in October 2018 we were in a strong position to hit the ground running. In each of the five sub-districts in Capricorn, there is a coordinator and a team. Technical advisers provide support at district level, while HIV Testing Services (HTS) carry out testing strategies at facility and district level. A Community Care and Support worker conducts case finding in communities, workplaces and farms; and Community Health Workers conduct outreach from facilities via referrals.

A Quality Improvement adviser assists sub-district coordinators and Technical Advisers with quality improvement; and an adolescent Technical Adviser engages with the district-level adolescent programme. We provide psychosocial support to complement the clinical programme via a social worker and a dietician assists with dietary advice.

In Capricorn, we are the lead partner on the district AIDS Council, a body chaired by the Executive Mayor that includes government, civil society, faith-based organisations, traditional health practitioners and traditional leaders, SAPS, and representatives from the various sectors. We ensure the quality of partner reports before they are presented to the district technical committee. We also support local AIDS councils within municipalities.

At provincial level, covering both districts, we provide pharmacy support, clinical lab interface and Monitoring & Evaluation support for data analysis. At district level we support facilities with data management and we identify where quality improvement is needed.

Orange Babies

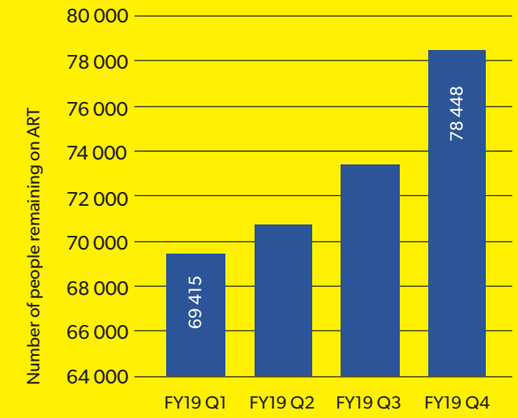
In Mopani, in addition to APACE, our Orange Babies programme conducts screening and referral in the community health centre. We provide HIV testing, STI and TB screening, and we run postnatal clubs, support groups and dialogue clubs with grandparents. Support groups for adolescents engage virally suppressed and unsuppressed youths; and Family Free organises home visits for patients who, for whatever reason, are not seeking care in facilities. Our mobile health unit provides testing, screening and pap smears in a community context, and an APACE nurse can initiate treatment immediately for anyone testing positive. Orange Babies also runs community programmes such as career guidance and library resources for youth.

Our impact

Mopani District was already enjoying success in terms of target attainment, with "green" status for all targets (testing, initiation, retention). Therefore, our focus in year one of APACE was on improving quality of care. Anova is responsible for very little direct service delivery in Mopani now and focuses on technical advice, building the skill and capacity of the local health workforce. In Capricorn, by contrast, all three targets were in

Anova's engagement in Limpopo encompasses two districts: Mopani and Capricorn. Mopani was an old friend, as we had been active in Mopani District since inception as part of our previous Health Systems Strengthening programme.

2nd 90 Growth in Capricorn District



need of attention. We had to build systems from the ground up. We introduced a Site Improvement Management System – SIMS – which gives a view of a facility as a whole. We charted the entire patient journey, including supporting services such as HR. We conducted file audits, and found and traced patients who hadn't been screened for TB, were not suppressed, were underdosed, etc. We rolled our sleeves up and provided direct service delivery as well as technical advice. We trained 220 counsellors on index testing, which had not been done prior to our arrival. There are now 51 facilities carrying out index testing. We were instrumental in implementing the National Department of Health's Operation Phuthuma, a 10-Point Plan for Acceleration, launched on 1 April 2019, which included measures to improve quality of care.

As a result of these achievements in Capricorn and our regular, transparent communication with the district Department of Health, we now have an excellent stakeholder relationship and are seen as a valued partner. We are known and respected as a solutions provider, whatever the problem. We have developed standardised tools for reporting that can be used by all partners. We work together with the Regional Training Centre to ensure all nurses and counsellors attend workshops and receive on-site training and capacity building.

In Mopani, relations continue to be strong and stable. The focus in Mopani is now mainly on retaining patients in care.

Performance highlights

In Capricorn, our expertise in data management is key to the success of the overall programme in the district. Data analysis capacity was severely limited on our arrival, and we trained the entire district on data quality improvement. Now Capricorn district writes sound reports with meaningful content, based on a deep understanding of the data.

When we arrived there was no adolescent programme. We now have an adolescent expert as part of our technical team, and support for adolescents includes testing days at Technical and Vocational Colleges. In both districts we have successfully decanted stable patients to external pick-up points for medication, such as Clicks and Dischem. Those patients who prefer to come to the clinic have been encouraged to attend adherence clubs. This decongests clinics and improves the overall efficiency of the system.

One notable improvement has been in loss to follow-up. When Anova took over Capricorn District, the rate was above 50%. It is now 26% and moving in the right direction. One sub-district has reduced its loss to follow-up from above 30% to 13%. Managing loss to follow-up is a key factor in achieving the third 90. We have achieved this through the appointment of tracing officers, working together with community health workers. We have actively transferred the skills and the ownership to the sisters in charge within facilities, thus ensuring sustainability.

Mopani has achieved its testing and initiation target and looks set to achieve its retention target by the end of 2020.

Sedibeng

Our programme

Sedibeng District is situated to the south of Johannesburg, comprising three local municipalities: Emfuleni, Lesedi and Midvaal, and bordering three provinces: Free State, Mpumalanga and North West Province. It has a population of just under one million. We took over Sedibeng as part of APACE in October 2018. Our first task was to establish the trust of facility staff and community health workers, who viewed Anova with some suspicion. The district was suffering from a leadership vacuum, with many senior positions filled only by acting heads. We had to negotiate the political dynamics of a management crisis and lay counsellors resistant to authority.

Our impact

Anova was able to bring some order to Sedibeng. There are many outstanding issues still to resolve; for example, the retention battle has not yet been won. But we have introduced a number of initiatives that have started to bear fruit. We put in place a case management approach, offering one-to-one support, with follow-up by a community health worker.

We have identified patients eligible for decanting and brought in pharmacists to determine additional pick-up points for clients to collect their medication. Project Last Mile mapped potential pick-up locations but it was up to Anova pharmacists to conduct the negotiations. Anova provided training and ensured compliance with suitability criteria, e.g. storage facilities, tax regulations, data management. This was a labour-intensive exercise: to launch 10 new pick-up points, our team had to evaluate 100. Then we had to market them to patients in facilities to create the demand.

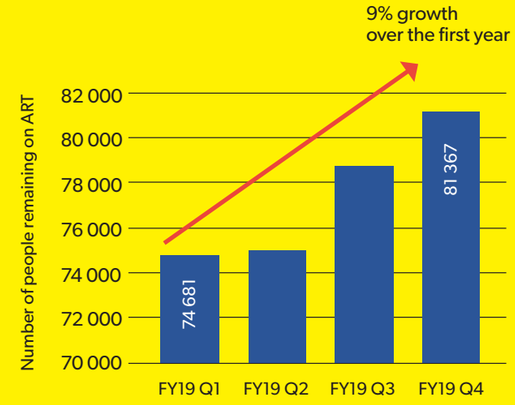
Performance highlights

Although Sedibeng is not yet meeting all its targets, the first year of APACE resulted in notable shifts in the trajectories, as a result of our campaigns. We have engaged with community partners and sensitised facility staff to reassure patients that defaulting on treatment does not have to mean the end of their treatment journey. In this way, patients are more willing to re-engage with care after a lapse.

To increase testing rates, we introduced testers to acute services after hours, and marketed the service heavily to raise awareness of the drive within the community. In the last quarter of the year, we also enlisted private sector GPs to conduct testing, in a bid to fully saturate the area. Our most significant achievement in Sedibeng is the growth in the number of people retained in care.

Sedibeng District is situated to the south of Johannesburg, comprising three local municipalities: Emfuleni, Lesedi and Midvaal, and bordering three provinces: Free State, Mpumalanga and North West Province.

Patients retained in ART care in Sedibeng District



City of Johannesburg

Our programme

The City of Johannesburg is well known to Anova. We had been supporting Joburg since 2009 but, prior to APACE, we were operational in just four of the seven sub-districts. Until 2014 our work consisted mostly of health systems strengthening and capacity building. We worked closely with clinic-based staff who were at the forefront of service delivery. In 2016 the UNAIDS 90-90-90 strategy was launched and the Department of Health introduced the "ideal clinic" concept, in an effort to position the health system for National Health Insurance. The ideal clinic is premised on appropriate staffing ratios – medical staff, administrative staff, etc. – and clinics are assessed against a checklist to determine the necessary interventions to bring the clinic to "ideal" standard.

At this stage we began to support systems strengthening at leadership level and not solely at point of service delivery. We developed a one-year, accredited training course for managers resulting in a valued qualification. We knew it was not enough to build the capacity of the health care workers; we had to improve the system.

As a result of this work, we entered APACE with strong relationships at district level. This enabled us to expand and transition smoothly into the additional three sub-districts and ramp up all our activities in Joburg in line with APACE resources and targets, with a dedicated focus on achieving 90-90-90 by 2020. Almost overnight, we went from a technical support team of under 200, supporting c. 70 clinics, to 2 000 people supporting all 121 facilities in the district. APACE followed on immediately from our previous grant, but with the additional sub-districts to service we had to find offices, hire staff, and engage new stakeholders. The Johannesburg programme is based in clinics and hospitals, where we provide technical support in diagnosis and treatment initiation and direct service delivery.

Because of the need to expand the staff complement so drastically and so rapidly, many of the new recruits were seasoned health care professionals but lacking in HIV experience. Therefore we embarked on extensive training, in areas such as NIMART, TIER.Net and counselling. The pace was furious from day one and continued relentlessly all year.

Our impact

Through APACE, we are able to achieve much more than we could in previous programmes. Enhanced resources – not only additional nurses but clinic space and equipment – have enabled us to reach more people living with HIV. In common with other districts, we have invested significant amounts of time and money into cleaning up filing rooms, with a total of 71 clinics successfully reorganised.

The interface between Anova staff and the Department's facility staff is not always easy and relationships vary from facility to facility. Anova employees are typified by extraordinarily high levels of passion and dedication. For many reasons, this commitment is not always mirrored by health care workers in the public sector. Our approach has been constantly to focus on our shared goals and acknowledge all staff equally.

Over and over, from patients and fellow health care workers, we hear that Anova staff are friendly and kind. People feel we listen to them. We have had a profound impact in the way we engage people and how we make them feel.

Performance highlights

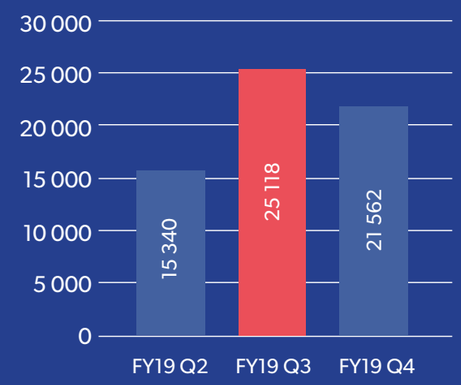
In the City of Johannesburg, it is estimated that c. 600 000 people are living with HIV. Of those, c. 400 000 are on treatment. To reach the goal of 90% of HIV+ individuals in care, we have engaged private sector GPs in an effort to target cash-paying private clients and bring them back into the public sector fold. Private sector patients are often not accurately accounted for in epidemiological data, so it is important to ensure we have the full picture.

Metropolitan areas like Johannesburg are likely to have a greater proportion of private sector patients than rural areas.

I am so incredibly proud of my team. They are a bunch of amazing, driven, hardworking, awesome people...to produce the results and impact that we do often under trying circumstances. They keep going against all odds because they believe in the work they do and they care about the patients and you can see that.

Diana Mokoena,
Programme Head,
City of Johannesburg

Net new additional patients retained on ART at the end of the period in Johannesburg



Quarter 3 of 2018-19 was the highlight of a year already full of accomplishments. Anova achieved the best results of all USAID partners with an additional 25 000 patients on ART. We maintained the pace in Quarter 4 with nearly 22 000 new patients.

City of Cape Town

Our programme

It is often said that, when it comes to health care, South Africa is not one nation, but nine. Our decentralised health system means that each province is a mini-country. Nowhere is this more the case than in the Western Cape, as we took over the City of Cape Town programme in May 2019 from another partner. We absorbed 480 people, who needed to be reorganised and assimilated into our culture. As an organisation we had to quickly foster relationships and develop collaborations with the provincial Department of Health and with the employees who joined us after many years with their previous employer.

Therefore, unlike in Mopani and Johannesburg, where we were a familiar and established partner, in the City of Cape Town we spent May to September 2019 in a process of adaptation. We introduced new systems and re-built the culture. It was important to perform, but first, teams needed to be motivated and a solid management structure put in place.

We saw our challenge in the City of Cape Town as four-fold: Firstly we needed to build a functional structure, then to build the culture. Thirdly we had to develop a strategy for delivery and for working with patients, and finally develop a strategy that speaks to the context of the communities served.

If the job of the provincial Department is to construct the building, our job is to provide the scaffolding that holds things up while the construction is underway. We have achieved this via the power of our data systems. Although TIER.Net is a nationwide system, the Western Cape also has its own systems. A provincial health data centre coordinates these multiple sources of data and delivers a single view. Unlike the other eight provinces, a unique patient identifier exists in the Western Cape. This is a valuable tool, but requires a different approach to data management. In the period leading up to the end of the year, Anova started working with data scientists to eliminate parallel data systems and transform data.

Our impact

In Cape Town, 200 000 people are on antiretroviral treatment. They are seen once every two months, giving a total of 5 000 patients who are seen every day. A further 200 new people on treatment need to be added each day to meet the targets.

Follow-up tracing in the Western Cape is decentralised. Rather than a call centre, each clinic is responsible for its own tracing. Anova operates 40 contact tracing teams across the province. Anova is seen as signalling "true north" in the Western Cape. We strike a balance between being supportive and being disruptive. We identify blind spots and then roll our sleeves up to help remedy them.

Performance highlights

Because of our late entry to APACE in the City of Cape Town and the circumstances that surrounded it, stabilising the work team was a major achievement. We took a vision of patient-centred care and turned it into a reality, through a series of small steps and efficient systems. We built and strengthened relationships at all levels. We invested continuously in our alliances with both provincial and district departments of health. As a Johannesburg-based organisation, we were initially greeted with suspicion, but using honesty, diplomacy and emotional intelligence we were able to build trust.

Men Who Have Sex with Men

Health4Men

Our programme

Anova has been associated with men's health – particularly the health of men who have sex with men (MSM) – since our inception. While it has not represented the largest proportion of our budget spend or resource allocation, our pioneering work with this population has earned us a reputation for changing the narrative around men's health and HIV prevention in the country. We were at the forefront of the national introduction of PrEP (pre-exposure prophylaxis) and have made sexual health services both accessible and acceptable to men who have sex with men, including young men.

Health4Men is an HIV prevention programme targeting both MSM and transgender individuals (TG), supported by the Global Fund, through the National AIDS Convention of South Africa (NACOSA) in Mpumalanga and Limpopo. In the Western Cape the programme is supported by LINKAGES (see below) and in the APACE programme districts by USAID through EPIC. Health4Men provides HIV prevention tools, such as condoms and lubricant, IEC materials, and screening for HIV, STIs and TB.

Health4Men is peer-led. Our testers include MSM and TG; but some clients prefer not to engage with peers. So the team includes non-peer individuals as well, ensuring an environment in which everyone feels safe and comfortable and is willing to engage.

Our impact

Our target was to test 80% of MSM and TG reached. We define "reach" as the provision of all three prevention tools – condoms, IEC materials, and screening. Some men come to facilities for condoms but are not ready to test. Our job is to respect their decision, engage with them, and encourage them to test when they are ready. Young men and trans individuals are often more reticent than older MSM to test. Young men are a particularly important target for PrEP, as they are more likely to be negative, but they must know their status before PrEP can be initiated.

In addition to providing prevention services to MSM and TG – our direct beneficiaries, Health4Men also has a positive impact on the extended community. We have conducted community dialogues with SAPS, with

In the Western Cape, Anova is seen as being in the vanguard. Whatever arises, "they know about it already". We know about index testing, PrEP, etc. There is a sense that if you want to know new things about HIV, go to Anova.

Nelis Grobelaar,
Programme Head,
City of Cape Town

social workers, and with social development workers. Through this outreach MSM and TG are now included in social welfare programmes where appropriate. We have also assisted with disclosure sessions for families, including parental dialogues with young MSM and TG. We conduct home visits and assess psychosocial needs of clients; and provide couples counselling, couples testing and support for disclosure and identity issues. In many areas where we work, there was no suitable health care for MSM or TG. Discrimination and stigma historically alienated many men who were in need of services. Health care workers were unfamiliar with the appropriate language to use or the correct biomedical and behavioural strategies. The training for nurses and other health workers provided by Anova and the designation of "competent sites" has enabled men to access facilities that are "MSM-friendly".

Men's health

In the City of Johannesburg, our clinics that were previously dedicated to MSM transitioned to a broader definition of men's health, welcoming men of any sexual persuasion. In theory this removes stigma, but in reality not all MSM want to access sexual health services side by side with straight men. Our team has managed this transition and the opposition to it with diplomacy and professionalism; but the resistance from clients demonstrates the need for dedicated clinics for MSM.

Performance highlights

The Health4Men brand is well recognised and trusted and PrEP is particularly successful. Our "safe space testing" was hugely productive. Through the creation of MSM and TG networks, we ran workshops by invitation and provided testing services. These workshops were with very small groups, and therefore were expensive to run; but they were highly effective because they targeted the right population. Out of a group of six, two or three individuals might test positive.

The success of our larger events increased our visibility and raised awareness. Large-scale events reaching over 100 MSM facilitated condom distribution and introductions leading to safe space testing on a small scale. We carried out safe space testing in all provinces. We also used events to recruit peers, particularly MSM connected with local Pride events and local AIDS councils. These individuals are highly motivated and engaged and their involvement with Anova has been a positive influence on communities.

Health4Men - Western Cape / LINKAGES

Our programme

Anova's partnership with LINKAGES began on 1 Oct 2018 and built on our USAID-funded Health4Men work in the Western Cape. LINKAGES is an FHI 360 programme and Anova is a sub-recipient. Our partnership with FHI 360 has enabled us to expand men's health services in the Western Cape. We took this opportunity to review our strategy, and have undergone a shift in priorities. Anova was a pioneer of large-scale, community-based testing. This year we focused on refined case finding and concentrated on the long term rather than immediate initiation. We have changed our staff composition to include peer navigators and case finders, and have prioritised index testing.

We provide ART and PrEP in mobile clinics, as well as in the highly regarded Ivan Toms Centre in Cape Town. Anova was the first to roll out PrEP in communities, and we have worked relentlessly to rapidly accelerate uptake. Although PrEP has been government policy since 2016, scale-up has been limited. We are strong advocates of the role of PrEP in HIV prevention, particularly for MSM. We started the year considering our evolution from Health4Men to LINKAGES in the Western Cape, and ended it with a deep understanding of the role of PrEP in the context of ART. We foresee a time when there will be more people on PrEP than ART. As we re-hired and restructured to accommodate the LINKAGES partnership, we were at pains to make sure our organogram and our approach were reflective of the Western Cape. The Ivan Toms Centre is entirely nurse-driven, and testing is counsellor-driven. It was one of the first sites to introduce self-testing, which is a facilitated service; we do not distribute tests for off-site use. But some clients prefer the self-determination that accompanies self-testing. At Cape Town Pride in September 2019, where we rolled out self-testing, 199 self-tests were conducted. Self-testing allows us to offer more tests with fewer staff.

Our impact

We are unlikely to continue to find thousands of HIV-positive MSM in the Western Cape. The success of Health4Men means we have largely done that. Our goal now is to find the hard-to-reach undiagnosed men who may be very infective. Where we have had a notable impact is with PrEP. We have helped to establish PrEP as normative, healthy behaviour for MSM and TG, thus limiting the spread of HIV. We have resisted the clinicalisation of PrEP. If adherence to PrEP becomes over-monitored, individuals are less likely to want to use it. We have learned how to scale up PREP in a client-centred way. We understand the education needs of clients and how best to deliver relevant messaging. The lessons we have learned in the Ivan Toms Centre can now be applied in our mobile clinics and throughout the country.

Performance highlights

2018-19 was a year of change and reinvention. We continue to offer comprehensive care to MSM. We are particularly proud of surpassing our target for PrEP initiation. The all-inclusive, MSM/TG-friendly services we offer for free, including PrEP, cryotherapy and ART, represent a highlight for our clients.

Paediatrics and adolescents

Our programme

Anova's paediatric and adolescent programme has been running since 2015. Its goal is to strengthen paediatric and adolescent HIV care in the age group 0-19, including testing, treatment initiation, linkage to care, and retention in care. This ELMA-funded paediatric and adolescent project complements the APACE programme, and works through the APACE team to scale up core services to this critical age group. Our project is part of a consortium of like-minded partners, called the Unfinished Business initiative, which is a coordinated, multi-grantee effort to find HIV-positive children and adolescents and provide testing, quality support services and life-long treatment.

Historically, children and adolescents were included in general HIV care programmes. There were pockets of dedicated support but no strategic focus on this age group. Unfinished Business has brought together stakeholders within the DoH and elsewhere, to identify and fill gaps in care. We have introduced psychosocial care and developed tools that cater specifically to young people. Our team consists of clinical technical assistants – doctors and skilled nurses, nurse mentors, and psychosocial and linkage officers.

Despite a successful national PMTCT programme, we have not eradicated HIV among children and adolescents. HIV-positive children represent a mix of neonatal/breastfeeding infections as well as children whose mothers did not benefit from PMTCT. These children may now be seven to 10 years old and they have survived so far without ART, but need to be brought into care. This group is our main focus, as they are difficult to find. Unless they are sick, they do not attend health care facilities. One of our strategies includes testing all children who come to a clinic, for whatever reason.

Among teenagers, we are still seeing new infections. We are working to strengthen school health collaboration to better reach these young people. Paediatric disclosure is another problematic issue. It can be a significant barrier to treatment adherence and retention in care. Through our participation in Kidz Alive, we support nurses and counsellors to prepare parents or caregivers to go through with testing and to support families with disclosure. Children often guess their HIV status but no one will confirm their suspicions. Our programme encourages age-appropriate stages of disclosure.

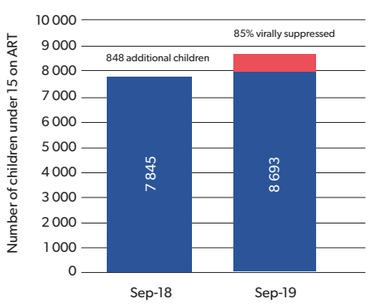
Our impact

When we started in 2015, we provided support at district level, and soon established ourselves as leaders in that environment. We are now extending our voice and influence to provincial and national level.
We introduced PrEP for adolescent women. This can be an uphill battle if a facility does not embrace the intervention. Young people are also reluctant to start PrEP, and we see a high drop-off rate. We're still working to understand all the psychosocial issues involved.
We work with community-based organisations who provide services to orphans and vulnerable children. They refer children to us for clinical care, and we draw on them for psychosocial support and other services, in a system of bilateral pathways. This was piloted in a number of sub-districts before being rolled out more widely.

Performance highlights

2018-19 was a year of intensity and scale-up for everyone at Anova. For the paediatric and adolescent programme, the highlight was growing the team within APACE. We started the year with a small staff complement, and worked hard to grow the team. By the end of the reporting year we were fully resourced and able to carry out all our activities and support the APACE teams.

The tools, pathways and procedures we have introduced have been welcomed by the DoH and APACE staff. We have successfully advocated to NDoH to adopt these scale-up strategies. We have gained traction in rolling out a core package of paediatric and adolescent services in national facilities.



Increase in number of children on ART in Johannesburg over the year

At community and facility level, our technical support has been warmly received. Health care workers, who often lack the skills and the time to manage complex cases, are relieved to have an expert referral point. Local caregivers and health care workers have benefited from the psychosocial services we provide, particularly in terms of testing support. Nurses know they can call on our paediatric and adolescent services when testing children, particularly for help with consent issues. Our nurses are seen as clinical support on the ground with difficult cases.

Research and pilot programmes

While Anova is not primarily a research institute, a research agenda informs all of our programmes. We are ruthless in our pursuit of data quality, are committed to effective monitoring and evaluation, and seize appropriate opportunities to test and pilot programme concepts. This enables us to model interventions before taking them to scale and to work with funders to continually improve HIV services.

Empowerment

Our programme

One such project is our empowerment programme for MSM and TG. Working in Ethekwini and Pietermaritzburg Districts in Kwa-Zulu Natal, Nelspruit in Mpumalanga, and Ekurhuleni in Gauteng, we supplied HIV testing services, PrEP, prevention, condom demonstrations and ART. We provided testing facilities at large events in the city centres of these districts and conducted outreach into communities and taverns.

Our integrated, comprehensive package of services and our futuristic approach has contributed to controlling the epidemic in this population in these areas, as well as teaching us lessons about the effectiveness of particular interventions.

Although MSM and TG in the community were the primary beneficiaries, the secondary beneficial reach of this programme was considerable, impacting on those who associate with these two groups, e.g. women who have sex with women and people who inject drugs, as well as health care workers and small community-based organisations operating in this space. We have worked to build the capacity of the Department of Health to ensure sustainability of our approach and we have mobilised MSM through community-based activities.
I Heart Isidayi, our community centre in Durban, was a safe space where men could gather to share ideas, access computers for job-hunting and CV printing, and support each other. Counsellors provided HIV testing, counselling, IEC materials, condoms and lube. Professional nurses in Durban and Nelspruit initiated PrEP and ART. Via a platform called "core groups", we allowed MSM to share their daily experiences of dealing with stigma and discrimination and through this supportive environment they were able to help other men acknowledge their sexuality and disclose to their families. Another platform, called "care groups", was an educational intervention that provided peer education on safer sex.

Our impact

Before the empowerment programme began, the MSM and TG communities in these locales were hidden. Individuals were not connected openly with one another. Our programme brought MSM together and created social networks, instilling positive behaviour change, especially health-seeking behaviour, through appropriate and targeted messaging. We created a space where men can socialise with their peers, engage with the issues that matter to them, and, on a practical front, apply for jobs. Community dialogues have mobilised communities where MSM were previously invisible and allowed them to talk about their sexual orientation, increasing understanding and changing perception. Historically, MSM and TG communities have suffered disproportionate numbers of AIDS-related deaths and have often presented for care with low CD4 counts. Undoubtedly, this intervention has saved lives. Empowerment programmes have traditionally been the preserve of urban environments. We were able to implement our empowerment programme in hostile environments, in traditional communities where stigma was rife. We demonstrated the ability to penetrate settings beyond those originally envisaged for this intervention and to have an impact.

Performance highlights

The social network strategy we used to recruit men in Pietermaritzburg was a key achievement. We worked with MSM in the community who acted as gatekeepers. They were issued with coupons to encourage HIV testing and were paid R50 per person they referred for a test which was completed. This strategy exposed hidden networks and helped to penetrate these networks in rural areas.

The safe spaces we created enabled MSM to access condoms, lube and HIV testing free of charge, resulting in increased testing yield. Our sites pioneered PrEP and ART in these areas and we significantly improved access to testing and treatment.

We also introduced a biometric system for HIV testing services in key populations. Biometrics are physical characteristics used as identifiers. They include fingerprints, facial recognition, iris recognition, and other forms of authentication. The only previous use of biometrics had been for surveillance, where names are not used. We pioneered biometrics in a programme context, carrying out fingerprint scans on all clients, whether presenting for prevention or ART. The fingerprint provided a unique identifier, attached to a name and ID number. This improved the quality of data and eliminated duplicates, making the programme more efficient.

More importantly, it proved the acceptability of biometrics among MSM. We were the first to do this programmatically in South Africa.

We proved that biometrics are acceptable in communities and can be scaled up. This learning can and should be translated into general population programming and interventions.

Peer navigation

Our programme

Peer navigation was a research study designed to determine the effectiveness of peer navigation in promoting clinical engagement among MSM, especially those who are positive and not engaging in care. Research sites included Nelspruit (in Mpumalanga) and Ekurhuleni (in Gauteng). The aim was epidemic control via ART initiation and viral load suppression. The programme encouraged and strengthened peer support and, as a result of peer navigation, ART initiations increased. Men who had been peer-navigated into the programme often became peers themselves as they "graduated", and so there was a virtuous cycle of expanding reach.

Our impact

Prior to the introduction of the peer navigation programme, linkage to care was inconsistent for vulnerable populations. Through our programme MSM became adept at negotiating their way through the health care system, even in the face of considerable discrimination. Health care workers were trained to engage sensitively and learned how to take a sexual history.

The peer navigation programme, allied to Health4Men, brought networks of young MSM together. Whereas they had previously been isolated, through peer navigation they started to interact and care for each other. Because we created synergy with Health4Men, health facilities were able to cope with the surge of young people coming into care.

Ultimately, viral load suppression was greater among men who engaged in the programme through peer navigation.

Performance highlights

Our programme proved that peer navigation is an effective way of reaching and engaging young MSM. Our significant achievement is the high volume of MSM and TG initiated on treatment and retained in care as an immediate result of the programme. We also proved the direct link between testing and initiation.

We illustrated that peer navigation and empowerment are scalable interventions. With adaptations for specific local contexts, both could be rolled out as national programmes.

Infrastructure programme

Our programme

As planning began for APACE, it became clear the national infrastructure was inadequate to accommodate the rapid increase in HIV testing. Many facilities around the country were old and hadn't been upgraded for some time. To achieve the targeted results, it was apparent that all provinces needed more clinical space. Initially, the intention was to erect 300 temporary, modular structures in all 27 priority districts, in a collaboration between USAID and CDC.

Anova was engaged as an implementing partner for this ambitious project. In a tripartite agreement, we created a technical working group involving Anova, NDoH, and USAID/CDC.

By the end of 2018, the project plan had evolved. The original specification for 300 structures was based on park homes, which are low-cost and quick to build, but have a short life span (a mere seven years). More permanent structures were required; and a solution was found in the form of modular structures made from fabricated steel, which had been used previously by Gauteng Provincial Government. They can be erected quickly but are classed as permanent, and have a life span of 50 years. Fabricated steel buildings are considerably more expensive than park homes, but the lifetime value is much greater. In a massive change of scope, the plan for 300 park homes was changed to 70 permanent structures. Furthermore, rather than looking at HIV testing in isolation, we began to look holistically at the health system within the clinic, using the "ideal clinic" model. We categorised care into streams: acute,

It is such a great pleasure and I am happy that we arrived finally to the decision to hand over these units and...they look exceptionally constructed and indeed the community will definitely benefit. Working with you was a real pleasure.

Nelly Shongwe,
Deputy Director Health Region A,
Johannesburg

chronic, preventive, and mother & child. Upgrading existing Department of Health structures was beyond the remit of this project, so all the structures we built were add-ons to functioning clinics, based on a needs analysis of the site.

The solution was tailored to the local need; it was not one-size-fits-all. We agreed with each district management team what the requirements were, i.e. storage, waiting room capacity, clinical space, multi-purpose areas (adherence clubs, etc.), and we provided all furniture and essential HIV testing equipment. Although we had initially hoped to complete the project by September 2019, the change of scope meant the timeline had to be extended. All approvals were finalised in February 2019 and construction commenced in April. Between April and the end of the reporting year, we completed 23 out of the planned 70 units. (At time of writing, 42 have been completed, with the remainder on target to be completed this year.)

The infrastructure programme was implemented in eight of nine South African provinces. Unfortunately, we were not able to reach agreement with the Limpopo DoH. Gauteng sites were not included in the original 70 sites. However, an additional seven sites in City of Johannesburg, Tshwane and Sedibeng have been added to the project specification.

Our impact

Because of the drastic reduction in sites, from the original 300 to 70, the site assessment was critical in determining how best to allocate resources. The exercise proved to be extremely useful, as some clinics realised they did not need additional space after all. Through the assessment, facility managers were able to focus on how to utilise their space more effectively. The result was improved efficiency of all sites, whether they received a new structure or not. Using historical data from clinics, including headcounts, we helped facilities reorganise themselves according to "ideal clinic" guidelines. We provided guidance to sites that were not earmarked for a new building as well as to those that were.

Performance highlights

As we handed over the structures, the reactions from district and operations managers were immensely rewarding. We provided a far superior environment to what they were used to and it was clear from their excitement that the result we delivered exceeded their expectations.

We also proved the concept: the quality of product and workmanship and the speed of implementation has set a precedent. If a similar type of built system is required in future, we know it can be built in a short time to a very high standard.

The programme has created the space to accommodate additional patients and improve on testing. It has allowed rooms to be dedicated to the relevant clinical streams and properly utilised, ultimately ensuring better quality of care overall.

JabSmart

Our progamme

JabSmart is a programme that aims to reduce the risk of people who inject drugs in Johannesburg becoming HIV-positive. South Africa's HIV epidemic has been labelled a generalised sexually transmitted epidemic. However, this description belies the fact that people who inject drugs (PWID) have a heightened risk from HIV as well as TB and other medical conditions, such as infection.

JabSmart provides a total package of care using a mobile clinic and peer outreach. All peer educators are PWID themselves and, equipped with backpacks filled with harm reduction packs – sterile water, wipes, needles, cookers, they meet clients and encourage them to access testing and treatment services. JabSmart provides STI management and wound care, but services are focused on HIV rather than broad health care.

Strategic Information

Our programme

One of Anova's key strengths is our ability to use data for programme improvement. Our data and analytics team is responsible for data and reporting, including governance, reporting requirements, and data management. At a technical level, monitoring and evaluation improves quality, identifies training needs, suggests job aids, and supports capacity building. At a public health level, analytics help determine programme impact and areas needing additional resource or a different activity focus.

Our data shines a light on priority questions, both from the donor and from the programmes. What is working? What is not working? Why are things not working? It enables us to look at target groups, by gender, age, facility, sub-district, etc. Detailed data analysis allows us to delve into individual cohorts, whose specifics may be lost in broader indicators. It draws attention to issues, such as quality of care, that may be overlooked in light of bigger priorities.

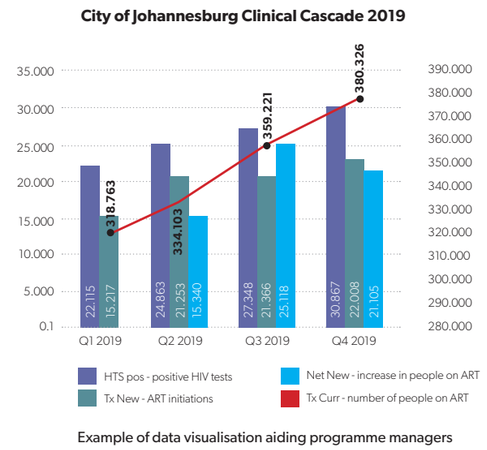
Data is a critical component of APACE, and is not always seen in a positive light. The intense focus on targets and monitoring puts pressure on programme staff. But the feedback provided by data has helped in site selection, activity implementation and results evaluation. Programme managers have become more data-literate and turn to data more often, for both historical and forward-looking information. Many positive changes have come about as a result of our data science, a fact that has not gone unnoticed by the donor.

Our impact

Our ability to get to the heart of issues, based on our understanding of the data, is highly valued by our partners, provincial departments of health and the donor. They have confidence in Anova's insight, which comes from a thorough interrogation of data. In a programming environment crowded with partners, our skill with data and analytics keeps us visible and relevant.

Performance highlights

Data science is the Cinderella of programming. It works quietly, in the background, largely unseen. Monitoring and Evaluation can feel more like foe than friend, as it flags gaps, especially in a target-driven programme like APACE. Inevitably, we must show progress – or lack thereof – towards targets. Our data comes into its own when we create visualisations. These help facility managers understand at a glance what is happening in their facility. It puts their hard work into context, and only then do they appreciate the facility data capturer.



Example of data visualisation aiding programme managers

Beyond South Africa

Anova's reach has extended beyond South Africa for several years. Through international platform EQUIP, Anova has supported activities in Zambia and Haiti, helping Zambia expand its facility-based PrEP programme for women and key populations and providing technical support to Haiti on PrEP.
We value the knowledge exchange that takes place through EQUIP. HIV is global, but the response must always be sensitive to the local context. At the same time, lessons can be learned from implementation of interventions in different settings. Anova's extensive expertise in PrEP is a valuable resource to be shared and our model translates effectively to other countries.

Governance

The Anova Health Institute is committed to establishing and upholding the highest standards of good governance and ethics. We have implemented robust governance practices, procedures and processes, which align with all relevant significant governance principles in King IV, as applied to non-governmental organisations, and all regulatory and statutory requirements.

Our structures have been reviewed to ensure compliance with the Companies Act No. 71 of 2008, as amended (the "Companies Act").
The Board provides strategic direction and ensures responsible, ethical and sustainable corporate governance. The Board and senior management have distinct and clearly defined responsibilities. The Chairperson provides overall leadership of the Board, while the CEO is responsible for the execution of the strategic direction, approved by the Board, through the delegation of authority.

The Management Executive Committee oversees the operational activities of Anova and monitors operating and financial performance. The Committee meets monthly and works with the CEO and COO to share responsibility for the operational activities of Anova. It contributes to strategic and operational plans, budgets and policies and procedures, and manages risk.

The Board

Mr Joel Dikgole
Chairperson*

Joel Dikgole (MBA, BCompt, MAP) is the Managing Director at JTD Consulting PTY. Previously, Joel was at the helm of the Wholesale and Retail Sector Education and Training Authority (W&RSETA) as Chief Executive Officer and led the SETA through challenges and remarkable successes during his 13-year tenure. Joel has great experience, intimate knowledge and a passion for skills development in the education and training sector.
He is also a former Council Member of the University of Johannesburg and currently serves on the Finance Board of the Diocese of Johannesburg (Anglican) as the Deputy Bursar – a position he has occupied for more than 15 years.

*Resigned at completion of three-year term, 11 November 2019

Prof James McIntyre
Chief Executive Officer

Prof James McIntyre (MBChB, FRCOG) is the CEO of Anova, Honorary Professor in the School of Public Health & Family Medicine at the University of Cape Town, and Vice-Chair of the US NIH-funded International Maternal Paediatric and Adolescent AIDS Clinical Trials (IMPAACT) Network. James previously worked for 25 years at the Chris Hani Baragwanath Hospital in Soweto, South Africa.

Dr Helen Struthers
Chief Operating Officer

Helen Struthers (MSc, MBA, PhD) is the COO of Anova and an Honorary Research Associate in the Division of Infectious Diseases & HIV Medicine, Department of Medicine at UCT. Helen has worked in the health sector since 2001, managing large donor-funded projects supporting the Department of Health to increase quality HIV services throughout the country and beyond.

Mrs Susan Kekana
Executive Director

Susan Kekana (Degree in Nursing) is Anova's Executive Government Liaison. She held Senior Management positions at both the Gauteng Department of Health and the City of Johannesburg. She is one of Anova's most senior and respected managers and has mentored many of our younger managers. Susan brings to the Board a wealth of experience in the public health sector.

Dr Moyahabo Mabitsi
Executive Director

Moyahabo Mabitsi (MBChB, Dip HIV Management, Dip Trop Medicine) is Anova's Executive Manager: Public Health Programmes. She oversees implementation of HIV- and TB-related public health programmes and provides strategic direction for the development and implementation of public health clinical programmes. Moya has substantial experience of HIV/TB/PMTCT clinical management, clinical mentorship, training facilitation, programme implementation, and performance monitoring and evaluation. She has been with Anova since 2010 and is a key liaison with the Department of Health at both district and provincial levels, as well as with funders.

Mr Nico Theron
Independent Non-Executive Director

Nico Theron (B.Luris) is a legal adviser who started his career as a State Prosecutor. He is the CEO of Alchemy Consolidated Business Holdings (PTY) Ltd and has extensive specialised expertise in business ethics, commercial matters, fraud and other crimes, human resource-related matters and drafting of papers in litigation and agreements.

Mrs René Kenosi
Independent Non-Executive Director

René Kenosi is a qualified chartered accountant who provides internal audit, risk management, corporate training, and management consulting services. She is a former Chair of the Independent Board for Auditors, and has served on many Boards and Audit committees and the Advisory Council for the Minister of Home Affairs.

Dr Moretlo Molefi
Independent Non-Executive Director*

Moretlo Molefi (MBChB, BSc) is a medical doctor and managing director of Telemedicine Africa (PTY) Ltd., an e-health consultancy focusing on e-health programme management, distance medical services, and telemedicine and m-health consulting. Moretlo has worked with South African Government departments and with international health organisations to develop ICT-based systems that support all levels of health care. She has held non-executive directorships on numerous corporate South African boards and has been an adviser to national and international health commissions.

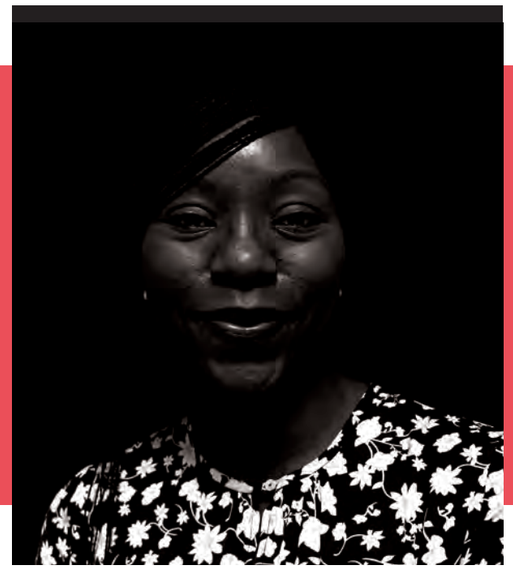
*Resigned 7 Feb 2019

Dr Mikateko Shisana
Independent Non-Executive Director

Mikateko Shisana (MBChB, MBA) is a medical practitioner with experience in the corporate sector at executive level. She has knowledge of occupational health and safety, public health, project management, research and ethical medical marketing. She was an executive member of the board of Lafarge Industries South Africa and a non-executive board member of Lafarge Mining South Africa from 2012 to 2017. Mikateko brings considerable stakeholder management experience from her exposure to diverse international environments.

Ms Liesl Lintvelt
Independent Non-Executive Director

Liesl Lintvelt (LLB) is a trial attorney at Moss & Associates in Johannesburg. She is an admitted attorney of the South African High Court, specialising in personal injury and medical negligence litigation. Liesl also mentors and trains candidate attorneys.



Ms Annabell Lebethe
Independent Non-Executive Director

Annabell Lebethe (MPM) has extensive experience in arts and culture management in the public sector. She is currently the CEO of Ditsong Museums of South Africa, and was formerly CEO of the Market Theatre Foundation and CEO of the National Arts Council (NAC). Annabell holds a Master's in Public Management and has served on numerous boards of public sector entities.

The Directors

The persons who have been Directors of the Company at any time during the period of this report are:

Independent Non-Executive Directors

Joel Dikgole (Chair)
Nico Theron
Moretlo Molefi
René Kenosi
Mikateko Shisana
Liesl Lintvelt
Annabell Lebethe

Executive Directors

James McIntyre (CEO)
Helen Struthers (COO)
Susan Kekana
Moyahabo Mabitsi

Independent Non-Executive Directors are appointed for a term of three years and may avail themselves for re-election for one additional three-year term, in accordance with the Anova Board Charter. The Independent Non-Executive Directors bring a diverse range of skills and expertise to the Board. These include financial, human relations, legal, public service and health service experience. Independent Non-Executive Directors receive fees for services on the Board and Board Committees, which are set via a Board Resolution annually, and are benchmarked with similar non-governmental organisations.

A full list of Directors' personal financial interests is tabled at each Board meeting. Any potential conflict is reviewed, and Directors recuse themselves from any discussion and decision on matters in which they have a material interest.

Upon appointment new Directors are offered an induction programme tailored to meet their specific requirements. All Directors are provided with the necessary documentation in order to familiarise themselves with the Company and matters affecting the Board.

The Board meets formally four times a year, with additional meetings held if required. The Chairperson, in consultation with the CEO, sets Board meeting agendas. Meetings are scheduled according to an approved annual work plan and management ensures that the Board members are provided with all of the relevant information in advance to enable the Board to reach objective and well-informed decisions. The Chairperson of each Board Committee reports back to the Board on Committee matters requiring approval by the Board after every Committee meeting. The minutes of all Committee meetings are circulated to all the Directors.

The Board reviews Board and Committee succession on an annual basis.

The Board has determined that formal Board and Committee evaluations will be carried out every two years. The formal evaluations of the Board include evaluations of Directors' and Chairperson's performance as well as attendance at Board meetings. In the intervening years when a formal review is not carried out, each Committee reviews its activities against the approved Terms of Reference and reports back to the Board on these matters.

Board Committees

As mandated by the Board Charter, three Board Committees assist the Board in fulfilling its objectives, although the Board remains ultimately responsible for any function it has delegated to a sub-Committee. The role and responsibilities of each Committee are set out in the Terms of Reference, which are reviewed on an annual basis and approved by the Board, ensuring the Board is satisfied that it has carried out its responsibilities appropriately.

Audit and Risk Committee

The Audit and Risk Committee has an independent role with accountability to both the Board and stakeholders. The Committee does not assume the functions of management, which remain the responsibility of the Executive Directors, officers and other members of senior management. The Committee Terms of Reference allow the Committee to investigate any activity of the Company and permit seeking information or advice from any employee or external consultant.

The Audit and Risk Committee nominates a registered auditor for appointment who, in the opinion of the Committee, is independent of the Company, determines the fees to be paid and the terms of engagement of the auditor and ensures that the appointment of the auditor complies with the Companies Act and other relevant legislation relating to the appointment of auditors.
In addition, the Committee reviews the annual audit reports and recommends acceptance of these reports to the Board. Key risk metrics and measures have been developed with risk indicators clearly defined. A key risk profile matrix has been developed with clearly defined risk indicators. The Audit and Risk Committee reviews this annually to assess risk and makes recommendations to management on risk mitigation strategies. The Committee is an integral component of the risk management process. Specifically, the Committee oversees financial reporting risks; internal financial controls; fraud risks as they relate to financial reporting; and IT risks as these relate to financial reporting.

Remuneration Committee

The Remuneration Committee oversees the setting and administering of remuneration at all levels in the Company; and the establishment of a Remuneration Policy that will promote the achievement of strategic objectives and encourage individual performance strategy.

The composition of the Committee is in line with the King IV recommendation whereby the majority of the members are Independent Non-Executive Directors. The CEO, COO and the Executive HR Manager are invited to attend all meetings except when their own remuneration is under consideration.
Anova is committed to remunerating staff in a way that ensures the organisation's ability to attract, retain and motivate a highly skilled and talented group of individuals. The Committee considered recommendations on approaches to performance management-based remuneration and approved annual salary increases after considering the Remuneration Policy and benchmarking information from other similar employers.

The Remuneration Committee has also been tasked with the role of nominations for Board members and is responsible for making recommendations for members to the Board.

Social and Ethics Committee

The purpose of the Social and Ethics Committee is to assist the Board in ensuring that Anova complies with the relevant statutory requirements of the Companies Act, as well as best practice recommendations in respect of social and ethical management. The Committee monitors Anova's activities, having regard to any relevant legislation, other legal requirements or prevailing codes of best practice, relating to social and economic development, good corporate citizenship, the environment, sustainability, labour and employment and company ethics.

The Committee comprises three Independent Non-Executive Directors, three Executive Directors, the Executive Programme Manager and the Executive HR Manager.

Code of ethics

Anova is committed to promoting the highest standards of ethical behaviour among its Directors, management and employees. The Company has a Code of Ethics, which forms part of each employment contract. The Code outlines conflicts of interest, the prevention of disclosure of company information, policies on the acceptance of donations and gifts and protection of the intellectual property of Anova.

Board meeting and Committee attendance

Board Meetings attended in 2018-19 year

Members	Attendance					
	08 November	07 February	26 March	08 April	11 July	05 September
Independent Non-Executive Directors						
Nico Theron	*	√	√	√	√	√
Joel Dikgole (Chair)	√	√	√	√	√	√
Moretlo Molefi	*	√	√			
René Kenosi	√	√	√	√	√	√
Mikateko Shisana	√	√	√	√	√	√
Liesl Lintvelt					√	√
Annabell Lebethe					√	*
Executive Directors						
James McIntyre (CEO)	√	√	√	√	√	√
Helen Struthers (COO)	√	√	√	√	√	√
Susan Kekana	√	√	√	√	√	√
Moyahabo Mabitsi		√	*	√	√	√

* Absent with apologies

Board Committee Membership

Directors	Audit and Risk Committee		Remuneration Committee	Social and Ethics Committee
	Audit	Risk		
Independent Non-Executive Directors				
Nico Theron	Member	Member	Chair	
Joel Dikgole			Member	Member
Moretlo Molefi*			Member	Chair
René Kenosi	Chair	Chair		Member
Mikateko Shisana	Member	Member		Chair
Liesl Lintvelt			Member	Member
Annabell Lebethe	Member	Member	Member	
Executive Directors				
James McIntyre	Attendee		Attendee	Attendee
Helen Struthers	Attendee	Member	Attendee	Attendee
Susan Kekana				Member
Moyahabo Mabitsi				Member
Prescribed Officers				
HR Manager			Attendee	Attendee
Finance Manager	Attendee	Attendee	Attendee	Attendee

* Resigned

Directors' attendance at Board sub-Committees

Remuneration Committee

Directors	Meetings				
	18 October	12 March	18 March	08 April	05 September
Nico Theron (Chair)	√	√	√	√	√
Moretlo Molefi	√				
Joel Dikgole	√	√	√	√	√
Liesl Lintvelt					√
Mikateko Shisana (by invitation)					√
James McIntyre (attendee)	√		√	√	√
Helen Struthers (attendee)	√		√	√	√

Audit and Risk Committee

Directors	Meetings		
	18 October	13 March	05 September
René Kenosi (Chair)	√	√	√
Nico Theron	√	√	√
Moretlo Molefi	*		
Mikateko Shisana	√	√	√
Annabell Lebethe			*
Helen Struthers (Risk only)	√	√	√
James McIntyre (attendee)	√	√	√

Social and Ethics Committee

Directors	Meetings				
	10 October	08 November	24 January	27 March	15 August
Moretlo Molefi (Chair)	*	*	√		
Joel Dikgole	√	√	√	√	√
René Kenosi	√	√	√	√	√
Mikateko Shisana (Chair)	√	√	√	√	√
Liesl Lintvelt					√
Helen Struthers	√	√	√	√	√
James McIntyre	√	√	√	√	√
Susan Kekana	√	√	√	√	√
Moyahabo Mabitsi	√	√	√	√	√

Publications

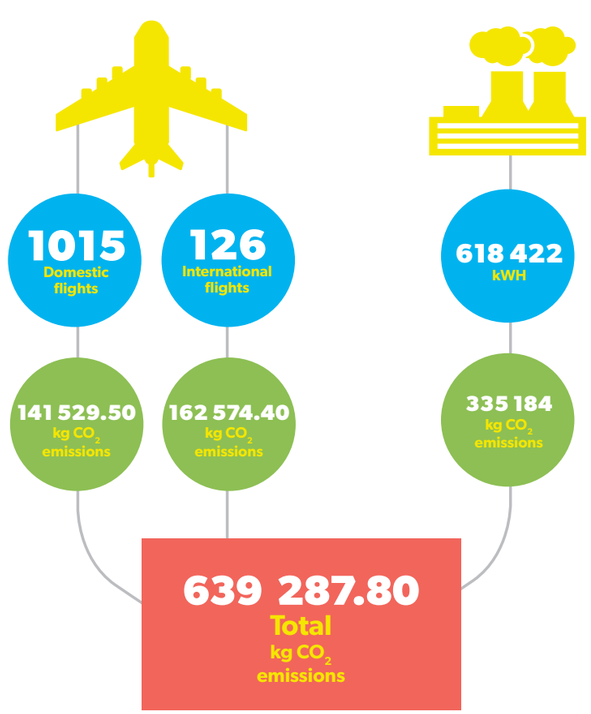
Authors	Title	Journal/Publisher
Bock, P, Gunst, C, Maschilla, L, Holtman, R, **Grobbelaar, N**, Wademan, D, Dunbar, R, Fatti, G, Kruger, J, Ford, N, Hoddinott, G, Meehan, SA	Retention in care and factors critical for effectively implementing antiretroviral adherence clubs in a rural district in South Africa	***J Int AIDS Soc.*** 2019; Oct;22(10): e25396
Boltz, V, Wei Shao, W, Bale, M, Halvas, EA, **McIntyre, JA,** Schooley, RT, Lockman, S, Currier, J, Sawe, F, Hogg, E, Hughes, MD, Kearney, M, Coffin, JM, Mellors, JW	Linked dual-class HIV resistance mutations are associated with treatment failure	***J Clin Invest*** 2019; 4: 19
Daniels J**, Struthers, H,** Lane, T, **Maleke, K, McIntyre, J,** Coates, T	**'**My tablets are on top of the fridge': The roles of relationship desire and medical mistrust in ART adherence for HIV positive MSM and transgender women living in rural South Africa	***AIDS Behav.*** 2019; 23(10): 2849-2858
Daniels, J, **Struthers, H, Maleke**, K, Catabay, C, Lane, T, **McIntyre, J**, Coates, T	Rural School Experiences of South African Gay and Transgender Youth	***J LGBTI Youth*** 2019; 16 (4) 355 – 379
Govender, NP, Meintjes, G, Mangena, P, Nel, J, Potgieter, S, Reddy, D, Rabie, H, Wilson, D, Black, J, Boulware, D, **Boyles, T**, Chiller, T, Dawood, H, Dlamini, S, Harrison, TS, Ive, P, Jarvis, J, Karstaedt, A, Madua, MC, Menezes, C, Moosa, MS, Motlekar, Z, Shroufi, A, Stacey, SL, Tsitsi, M, van Cutsem, G, Variava, E, Venter, M, Wake, R	Southern African HIV Clinicians Society guideline for the prevention, diagnosis and management of cryptococcal disease among HIV-infected persons: 2019 update	***S Afr J HIV Med.*** 2019; 20(1) 1608-9693
Hoffman, CM, Fritz, L, Matlakala, N, **Mbambazela, N, Railton, JP, McIntyre, JA**, Dubbink, JH, **Peters, RPH**	Community-based strategies to identify unmet need for care of individuals with sexually transmitted infection-associated symptoms in rural South Africa	***Trop Med Int Health*** 2019; 24: 987-93
Hoffman CM, Fritz L, **Radebe O**, Dubbink JH, **McIntyre JA**, Kock MM, **Peters RPH**	Rectal ***Trichomonas vaginalis*** infection in South African men who have sex with men	***Int J STD AIDS*** 2018; 14: 1444-1447
Hoffman CM, **Mbambazela N**, Sithole P, Morré SA, Dubbink JH**, Railton J, McIntyre JA**, Kock MM, **Peters RPH**	Provision of STI services in a mobile clinic reveals high unmet need in remote areas of South Africa: a cross-sectional study	***Sex Transm Dis*** 2019; 46: 206-12
Hoffman, RM, Angelidou, KN, Brummel, SS, Saidi, F, Violari, A, Dula, D, Mave, V, Fairlie, L, Theron, G, Kamateeka, M, Chipato, T, Chi, BH, Stranix-Chibanda, L, Nematadzira, T, Moodley, D, Bhattacharya, D, Gupta, A, Coletti, A, **McIntyre, JA,** Klingman, KL, Chakhtoura, N, Shapiro, DE, Fowler, MG, Currier JS & for the IMPAACT PROMISE 1077BF/FF team	Maternal health outcomes among HIV-infected breastfeeding women with high CD4 counts: results of a treatment strategy trial	***HIV Clinical Trials*** 2018; 19 (6) 209-224
Jobson, G, Khoza, S, Mbeng, R, Befula, N, **Struthers, HE**, Kerongo, G, **Peters, RPH**	Bridging the gap: reaching men for HIV testing through religious congregations in South Africa	***J Acquir Immun Defic Syndr*** 2019; 81: e160-e162
Jobson, GA, Mabitsi, M, Railton, J, Grobbelaar, CJ, McIntyre, JA, Struthers, HE, Peters, RPH	Targeted mentoring for HIV programme support in South Africa	***S Afr J HIV Med*** 2019; 20(1): 873
Jobson, G, Murphy, J, van Huyssteen, M, Myburgh, H, Hurter, T, Grobbelaar, CJ, Struthers, HE, McIntyre, JA, Peters, RPH	Understanding health worker data use in a South African antiretroviral therapy register	***Trop Med Int Health*** 2018; 23(100) 1207-1212
Kularatne, RS, Niit, R, Rowley, J, Kufa-Chakezha, T, **Peters, RPH**, Taylor, MM, Johnson, LF, Korenromp, EL	Adult gonorrhea, chlamydia and syphilis prevalence, incidence, treatment, and syndromic case reporting in South Africa: estimates using the Spectrum-STI model, 1990-2017	***PLoS One*** 2018; 13; e205863
Le, CN, Britto, P, Brummel, SS, Hoffman, RM, Li, JZ, Flynn, PM, Taha, TE, Coletti, A, Fowler, MG, Bosch, RJ, Gandhi, RT, Klingman, KL, **McIntyre, JA**, Currier, JS	Time to Viral Rebound and Safety after Antiretroviral Treatment Interruption in Postpartum Women Compared to Men	***AIDS*** 2019; 33(14) 2149-2156
Lilian, RR, Rees, K, Mabitsi, M, McIntyre, JA, Struthers, HE, Peters, RPH	Baseline CD4 and mortality trends in the South African HIV programme: analysis of routine data	***South Afr J HIV Med*** 2019; 20(1) 1-10
Lippman, SA, Gilmore, HJ, Lane, T, **Radebe, O,** Chen, YH, Mlotshwa, N, **Maleke, K, Manyuchi, AE**, **McIntyre, JA**	Ability to use oral fluid and fingerstick HIV self-testing (HIVST) among South African MSM	***PLoS One*** 2018 13(11) e0206849

Authors	Title	Journal/Publisher
Maduna, LD, Kock, MM, Medina-Marino, A, Klausner, JD, **Peters, RPH**	Impact of specimen storage temperature and time on the implementation of GeneXpert(R) testing for sexually transmitted infections in resource-constraint settings	***J Microbiol Methods*** 2019; 165:105719
Maduna, LD, Laumen, JGE, **Radebe, O**, Kock, MM, **Peters, RPH**	Failure of syndromic management due to drug-resistant ***Mycoplasma genitalium*** infection in South Africa: a case report	***Int J STD AIDS*** 2019; 30: 519-521
Makhakhe, NF, Meyer-Weitz, A, **Struthers, H, McIntyre, J**	The role of health and advocacy organisations in assisting female sex workers to gain access to health care in South Africa	***BMC Health Services Research*** 2019; 19(1), 746
Maleke, K, Daniels, J, Lane, T, **Struthers, H, McIntyre, J**, Coates, T	How social stigma sustains the HIV treatment gap for MSM in Mpumalanga, South Africa	***Glob Health Promot*** 2019; 26(4): 6-13
Naidoo, N, Matlakala, N, Railton, J, Khosa, S, Marincowitz, G, Igumbor, JO, **McIntyre, JA,** Struthers, HE, Peters, RPH	Provision of HIV services by community health workers should be strengthened to achieve full programme potential: a cross-sectional analysis in rural South Africa	***Trop Med Int Health*** 2019; 24(4) 401-408
Radebe, O, Lippman, SA, Lane, T, Gilmore, H, **Manyuchi, A, McIntyre, JA**	HIV Self-Screening distribution preferences and experiences among men who have sex with men in Mpumalanga: informing policy for South Africa	***S Afr Med J*** 2019; 109(4) 227-231
Rebe, K, Hoosen, N, McIntyre, JA	Strategies to improve access for MSM in low- and middle-income countries	***Curr Opin HIV AIDS*** 2019;14(5) 387 – 392
Scheibe, A, Young, K, Moses, L, Basson, RL, Versfeld, A, Spearman, CW, Sonderup, MW, Prabdial-Sing, N, Manamela, J, Puren, AJ, **Rebe, K,** Hausler, H	Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey	***Harm Reduc J*** 2019; 16(1) 28
Sebikari, D, Farhad, M, Fenton, T, Owor, M, Stringer, J, Qin, M, Chakhtoura, N, Chi, B, Saidi, F, Nevrekar, N, Violari, A, Chipato, T, **McIntyre, JA**, Moodley, D, Taha, T, Theron, G, Fowler, MG	Risk Factors for Adverse Birth Outcomes in the PROMISE 1077BF/1077FF Trial	***J Acquir Immun Defic Syndr*** 2019; 81(5) 521- 532
Thomas, PPM, Allam, RR, Ambrosino, E, Malogajski, J, Lal, JA, Morré, SA, **Peters, RPH**	An integrated care model with implementation roadmap to improve ***Chlamydia trachomatis*** management and control in India	***Front Public Health*** 2018; 6: 321
Tshisevhe, V, Mbelle, N, **Peters, RPH**	Cutaneous tuberculosis in HIV-infected individuals: lessons learnt from a case series	***South Afr J HIV Med*** 2019; 20: a895
Van Elsland, SL, **Peters, RPH**, **Grobbelaar, CJ,** Ketelo, P, Kok, MO, Cotton, M, van Furth, AM	Disclosure of HIV status to HIV-infected children in South Africa: A comprehensive analysis	***South Afr J HIV Med*** 2019; 20: 884
Van Elsland, SL, **Peters, RPH**, **Grobbelaar, CJ**, Ketelo, P, Kok, MO, Cotton, M, van Furth, AM	Paediatric ART Adherence in South Africa: A Comprehensive Analysis	***AIDS Behav*** 2019; 23(2) 475-488
Van Liere, G, Kock, MM, **Radebe, O**, **Struthers, HE**, Morré, S, **McIntyre, JA**, **Peters, RPH**	High rate of repeat sexually transmitted diseases among men who have sex with men in South Africa: a prospective cohort study	***Sex Transm Dis*** 2019; 24:987-93
Van Vliet, MM, Hendrickson, C, Nichols, BE, Boucher, CA, **Peters, RPH**, van de Vijver, DA	Epidemiological impact and cost-effectiveness of providing long-acting pre-exposure prophylaxis to injectable contraceptive users for HIV prevention in South Africa: a modelling study	***J Int AIDS Soc*** 2019**;** 22: e25427
Venter, JME, Mahlangu, PM Müller, EE, Lewis, DA, **Rebe, K, Struthers, H, McIntyre, J,** Kularatne, RS	Comparison of an in-house real-time duplex PCR assay with commercial HOLOGIC® APTIMA assays for the detection of Neisseria gonorrhoeae and Chlamydia trachomatis in urine and extra-genital specimens	***BMC Infectious Diseases*** 2019; 19:1: 6
Violari, A, Cotton, M, Kuhn, L, Schramm, D, Paximadis, M, Loubser, S, Shalekoff, S, Dias, B, Otwombe, K, Liberty, A, **McIntyre, J**, Babiker, A, Gibb, D, Tiemessen, C	A child with perinatal HIV infection and long-term sustained virological control following antiretroviral treatment cessation	***Nature Communications*** 2019; 10:412

Environmental Impact

Anova strives to be environmentally responsible and encourages a sustainable approach to energy consumption and waste management among all staff. Our offices make use of energy-efficient lighting and electronic communication is maximised to reduce paper waste. As our work predominantly involves service delivery and technical support, the majority of our energy consumption is a result of staff travel and office operations.

As part of the infrastructure project (see page 28) we appointed and managed independent environmental professionals to inspect and assess the proposed sites for compliance with environmental standards. In addition to evaluating suitability of the space to meet service delivery objectives, they conducted topography reviews and ensured that all other statutory requirements were assessed for each structure. They looked at service needs, such as storm water, sewerage, electricity and water connections; and we aimed to implement the project in as sustainable and minimally invasive manner as possible.



Our people: Human Resources report

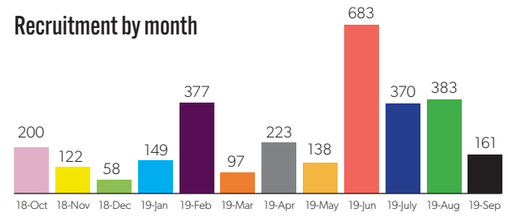
The Human Resource Department exists to help Anova Health Institute achieve its strategic mission, while ensuring employees are engaged and motivated to help the organisation succeed. HR's success is measured by our ability to align and integrate processes with the strategic mission. We do this by being flexible to business needs, identifying issues and executing corrective measures effectively.

HR has targeted its operational initiatives to align to the Anova Health Institute Strategic Plan by initially identifying ways to leverage and increase flexibility to improve internal efficiencies. HR is committed to using its resources and staff to be an active, consulting partner for the organisation.

What we delivered 2018-2019

Recruitment

The organisation grew exponentially in 2019. In response, HR had to work differently to meet the business needs. We developed a flexible recruitment process that facilitated contingent offers pending the results of a background check, which enabled management to fill critical positions faster, gave new employees the option to start sooner, and made us very competitive on time taken to fill positions. The HR team recruited 2 961 employees across all levels and functions and met the robust time demands of the APACE Siyenza Project by appointing ~1 200 employees in 90 days. 85% of recruitment this year was related to APACE.



Employee relations

With the rapid expansion we experienced this year, Human Resources faced typical challenges that come with growth. Although we did experience an increase in employee relations issues, our resolution rate for external arbitration was very good, at 70%. We took this opportunity to review and realign our policies with the changing character of the organisation.

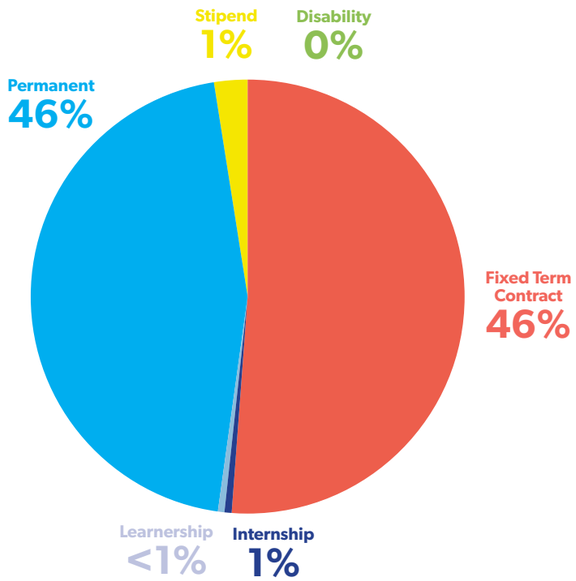
Training (Learning and Development)

Human Resources provided a wide range of training opportunities throughout the year to nearly 5 000 employees to build on their professional competencies, increase their knowledge, and improve their skill sets, to contribute to our mission, enhance their functional competence and increase opportunities for future growth.

Regional Area	Non Pivotal (General Training)	Pivotal (NQF-Aligned)	Grand Total
Gauteng	2 877	319	3 196
KwaZulu-Natal	1		1
Limpopo	1 217		1 217
Western Cape	463	30	493
Grand Total	**4 558**	**349**	**4 907**

Employees by Gender

Employees by Contract Type



Employment Types	No. of Employees
Disability	3
Fixed Term	1 658
Internship	30
Learnership	4
Permanent	1468
Stipend	48

Occupational Levels	No. of Employees
Junior Management	597
Middle Management	85
Semi-skilled	2 486
Senior Management	11
Top Management	5
Unskilled	27
Grand Total	3 211

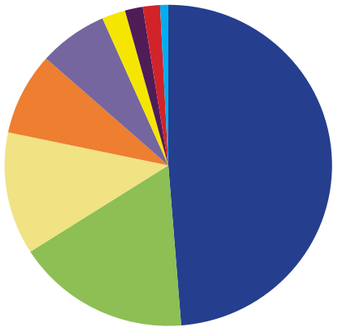
Anova has implemented 166 learnerships and employed 76 Youth Employment Services candidates to provide work experience.

Our employees by race

Our Economic Performance

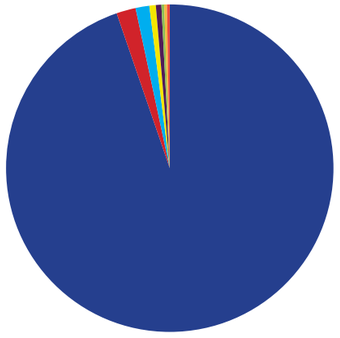
Grant income received has increased by 379.2% compared to the same period the previous year. The main contributor to the increase was the USAID Accelerating Program Achievements to Control the Epidemic (APACE) grant that started in August 2018. This increase was partially offset by the decrease in USAID funding for USAID Health Systems Strengthening (HSS) & Innovations grants that closed in December 2018, Centers for Disease Control and Prevention (CDC), Elton John AIDS Foundation, Global Fund funding and NIH funding, which also closed out during this period. Operational expenses are up 373.8% year on year due to the increased activities for the APACE grant and the annual cost-of-living increase incorporated into staff salaries effective from March 2019, partially offset by the reduction in activities in the grants closing out. The increase in the net interest received for the year is the direct result of increased investment balances on Human Capital Provisions and other Core Investment accounts.

Resource allocation by cost category:



	R Millions
Personnel Costs	540.1
Sub-awardees & Contractual	190.8
Construction	136.7
Other Direct Costs	91.8
Supplies	75.6
Capital Costs	25.7
Travel & Transport	19.6
Training Costs	18.8
Seminars & Conferences	8.9

Source of income by funding source:



Funders	R Millions 19-Sep
USAID	1 045
Global Fund	21
CDC	15
ELMA	7
EJAF	6
Family Free	3
NIH	3
Sundry	3

Independent auditor's report

To the Members of Anova Health Institute NPC

Our opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Anova Health Institute NPC (the Company) as at 30 September 2019, and its financial performance and cash flows for the year then ended in accordance with International Financial Reporting Standards and the requirements of the Companies Act of South Africa.

What we have audited

Anova Health Institue NPC's financial statements set out on pages 52 to 53 comprise:

- the statement of financial position as at 30 September 2019;
- the statement of comprehensive income for the year then ended;
- the statement of changes in equity for the year then ended;
- the statement of cash flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the ***Auditor's responsibilities for the audit of the financial statements*** section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the Company in accordance with the sections 290 and 291 of the Independent Regulatory Board for Auditors' ***Code of Professional Conduct for Registered Auditors (Revised January 2018)***, parts 1 and 3 of the Independent Regulatory Board for Auditors' ***Code of Professional Conduct for Registered Auditors (Revised November 2018)*** (together the IRBA Codes) and other independence requirements applicable to performing audits of financial statements in South Africa.

We have fulfilled our other ethical responsibilities, as applicable, in accordance with the IRBA Codes and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Codes are consistent with the corresponding sections of the International Ethics Standards Board for Accountants' ***Code of Ethics for Professional Accountants*** and the International Ethics Standards Board for Accountants' ***International Code of Ethics for Professional Accountants (including International Independence Standards)*** respectively.

Other information

The directors are responsible for the other information. The other information comprises the information included in the document titled "Anova Health Institute NPC audited annual financial statements for the year ended 30 September

2019", which includes the Directors' Report as required by the Companies Act of South Africa. The other information does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the directors for the financial statements

The directors are responsible for the preparation and fair presentation of the financial statements in accordance with International Financial Reporting Standards and the requirements of the Companies Act of South Africa, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In preparing the financial statements, the directors are responsible for assessing the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.

- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Company's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Company to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the directors regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

PricewaterhouseCoopers Inc.

PricewaterhouseCoopers Inc.
Director: Raj Dhanlall
Registered Auditor
Waterfall City, Midrand
3 April 2020

Statement of financial position

	Audited results as at 30 September 2019	Audited results as at 30 September 2018
ASSETS		
Non-current assets		
Equipment, Furniture and Vehicles	32 758 145	3 254 416
Total non-current assets	32 758 145	3 254 416
Current assets		
Trade and other receivables	57 683 507	7 224 662
Cash and cash equivalents	162 841 673	93 210 750
Total current assets	220 525 180	100 435 412
Total assets	253 283 325	103 689 828

	Audited results as at 30 September 2019	Audited results as at 30 September 2018
CAPITAL AND LIABILITIES		
Capital and reserves		
Capital donation	2 608 041	2 608 041
Revaluation reserve	-	-
Accumulated surplus	27 015 888	25 509 999
Total capital and reserves	29 623 929	28 118 040
Current liabilities		
Trade and other payables	150 634 304	52 150 669
Grants received in advance	40 266 947	20 166 703
Deferred income	32 758 145	3 254 416
Total current liabilities	223 659 396	75 571 788
Total capital and liabilities	253 283 325	103 689 828

Statement of comprehensive income

	Audited results for the year ended 30 September 2019	Audited results for the year ended 30 September 2018
Revenue	1 102 978 315	290 838 686
Other income	1 065 135	1 127 083
Operating expenses	(1 108 104 884)	(296 460 726)
Loss/surplus from operations	(4 061 434)	(4 494 957)
Interest received	5 567 323	4 575 780
Surplus for the year	1 505 889	80 823

Our Funders and Partners

Without the generous support of our funders and partners, the work we do in improving people's lives and reaching our vision and goals would not be possible. We would like to thank all of you for your unwavering commitment.

Funders:

PEPFAR U.S. President's Emergency Plan for AIDS Relief
www.pepfar.gov

USAID FROM THE AMERICAN PEOPLE
www.usaid.gov

The Global Fund To Fight AIDS, Tuberculosis and Malaria
www.theglobalfund.org

ELTON JOHN AIDS FOUNDATION
www.ejaf.org

ORANGE BABIES
www.orangebabies.org.za

MAC AIDS FUND
www.macaidsfund.org

CDC
www.cdc.gov

the ELMA foundation
www.elmaphilanthropies.org

IMPAACT International Maternal Pediatric Adolescent AIDS Clinical Trials Network
www.impaactnetwork.org

NIH National Institutes of Health
www.nih.gov

aidsfonds
www.aidsfonds.org

Partners:

South African

- CHoiCe Trust
- City of Cape Town
- City of Johannesburg
- Foundation for Professional Development
- HIVSA
- Hoedspruit Training Trust
- Human Sciences Research Council
- INERELA+
- Kheth'Impilo
- MatCH
- Right to Care
- Singizi Consulting
- South African Departments of Health & Social Development (National & Provincial)
- TB/HIV Care Association
- The Aurum Institute
- University of Cape Town – Division of Infectious Diseases & HIV Medicine, Department of Medicine
- University of Cape Town – School of Public Health and Family Medicine
- University of Limpopo
- University of Pretoria
- University of Stellenbosch
- Wits Reproductive Health & HIV Institute

International

- Boston University School of Public Health
- Erasmus University Rotterdam
- FHI 360
- Global Forum on MSM & HIV
- Johns Hopkins University
- Maastricht University Medical Centre
- National Institute for Communicable Diseases
- Partners in Hope
- Society for Family Health Namibia
- University College London
- University of California, Los Angeles
- University of California, San Francisco – Centre for AIDS Prevention Studies
- VU Medical Centre – Amsterdam

Glossary

AIDS	Acquired Immune Deficiency Syndrome
APACE	Accelerating Program Achievements to Control the Epidemic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community-Based Organisation
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
EMTCT	Elimination of Mother-to-Child Transmission
HBV	Hepatitis B Virus
HCT	HIV Counselling and Testing
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HSS	Health Systems Strengthening
IEC	Information, Education and Communication
IMPAACT	International Maternal Paediatric Adolescents AIDS Clinical Trials Group
LGBTIQ	Lesbian Gay Bisexual Transgender Intersexed Queer
M&E	Monitoring and Evaluation
MDR-TB	Multiple Drug-Resistant TB
MSM	Men Who Have Sex With Men
MSMW	Men Who Have Sex With Men and Women
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organisation
NIAID	National Institute of Allergy and Infectious Diseases
NIH	National Institutes of Health
NIMART	Nurse-Initiated Management of Anti-Retroviral Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PrEP	Pre-Exposure Prophylaxis
PLWH	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization
WSW	Women Who Have Sex with Women
XDR-TB	Extensively Drug-Resistant Tuberculosis
YMSM	Young Men Who Have Sex with Men

GRI Index

Global Reporting Initiative (GRI) GRI Standards Content Index Anova Health Institute: 2018-19			
GENERAL STANDARD DISCLOSURES			
Strategy andAnalysis			
Profile Disclosure	**Description**	**Reference**	**Explanation**
GRI 102-14	A statement from the most senior decision-maker of the organisation about the relevance of sustainability to the organisation and its strategy for addressing sustainability	pp 6, 8	The Chairman's report can be found on page 8. The Chief Executive Officer's report can be found on page 6
GRI 102-15	Description of key impacts, risks, and opportunities	p 10	Risks and opportunities are discussed under "strategic goals"
		from p 14	Impact of each programme is discussed along with the description of activities
Organisational Profile			
Profile Disclosure	**Description**	**Reference**	**Explanation**
GRI 102-1	Name of the organisation	cover	The name of the organisation is mentioned throughout the report. The back cover lists the organisation's locations and contact details
GRI 102-2	A description of the organisation's activities Primary brands, products, and services, including an explanation of any products or services that are banned in certain markets	p 4 pp 14-31	Anova's primary activities are described on page 4. Our programme activities are described in pages 14-31
GRI 102-3	Location of organisation's headquarters	Inside back cover	The location of Anova's headquarters is listed inside the back cover
GRI 102-4	Number of countries where the organisation operates, and names of countries with either major operations or that are specifically relevant to the sustainability issues covered in the report	p 2	Anova operated in South Africa, Zambia and Haiti in this reporting period
GRI 102-5	Nature of ownership and legal form	p 2	The Anova Health Institute NPC is a non-profit company (Registration Number: 2009/014105/08)
GRI 102-6	Markets served (including geographic breakdown, sectors served, and types of customers and beneficiaries)	pp 4, 12-13	The description on page 4 and the list of stakeholders page 13 illustrate the geographic breakdown and beneficiaries served
GRI 102-7	Scale of the organisation	pp 4 p 6 pp 52-53	The scale of the organisation has been depicted by the number of beneficiaries served (page 4), total staff (page 6) and financial statements (page 52-53)
GRI 102-8	Employees – employment contract, gender, region	pp 45-47	Discussed under "HR report"
GRI 102-41	Percentage of total employees covered by collective bargaining agreements	GRI table	None of Anova's employees belongs to a trade union

GRI 102-9	The organisation's supply chain	GRI table	The number and location of suppliers is not reported on. Anova has procurement policies which are designed to ensure best value for money, and promote B-BEEE, and generally uses local suppliers
GRI 102-10	Any significant changes during the reporting period regarding size, structure, ownership or supply chain	GRI table	No significant changes in this year
GRI 101-11	The precautionary approach	p 10	Anova's strategies and activities are aligned with the precautionary principle, to consider benefits and risks of any project, both human and environmental
GRI 102-12	Externally developed economic, environmental and social charters the organisation subscribes to or endorses	GRI table	Anova's activities are undertaken in line with all regulatory frameworks of the government departments with which we partner
GRI 102-13	Memberships of associations and national or international advocacy organisations	pp 13, 54-55	The organisations with which Anova partners, including local advocacy organisations are listed in our "stakeholders" (p 13) and under the section "partners" (p 54-55)
Identified Material Aspects and Boundaries			
Profile Disclosure	**Description**	**Reference**	**Explanation**
GRI 102-45	Entities included in the organisation's consolidated financial statements	GRI table	Anova is a single entity with activities and offices in nine provinces. The financial statements are for the whole organisation
GRI 102-46	Process for defining the content of the report and how the organisation has implemented the reporting principles for defining report content	p 2	Material aspects are informed by stakeholders' views and identified by management and the Board. Significance is determined only through discussions, as the organisation does not yet apply qualitative and quantitative tools
GRI 102-47	List of the material topics identified in the process of defining report content	pp 2-3, 10, 12-13	The process for defining the report content is described in the "scope and boundary" section, "our strategy" and "stakeholder engagement"
GRI 103-1-b	Specific limitations regarding the Topic Boundary within and outside the organisation	GRI table	This report attempts to cover all the material topics of Anova's operations. Notes have been made throughout the report if data from specific projects has been excluded
GRI 103-1-C	Specific limitations regarding the Topic Boundary outside the organisation	GRI table	The report does not cover aspects outside the organisation
GRI 102-48	The effect of any restatements of information provided in previous reports	GRI table	There are no restatements in this report
GRI 102-49	Significant changes from previous reporting periods in the List of Material Topics and Topic Boundaries	GRI table	Material matters have been amended and aligned to Six Capitals. See p 3
Stakeholder Engagement			
Profile Disclosure	**Description**	**Reference**	**Explanation**
GRI 102-40	List of stakeholder groups	p 13	The stakeholders are listed under "stakeholder engagement"
GRI 102-42	The basis for identification and selection of stakeholders with whom to engage	p 12	Anova attempts to engage with all its relevant stakeholders, as identified by management and provincial programme leaders

GRI 102-43	The organisation's approach to stakeholder engagement, including frequency of engagement by type and by stakeholder group	pp 13	Engagement with key stakeholders, such as donors, staff and government partners, is an ongoing process. Anova engages with our government stakeholders at provincial level at least monthly, and with our major donor weekly
GRI 102-44	Key topics and concerns that have been raised through stakeholder engagement, and how the organisation has responded to those key topics and concerns	p 13	Discussed under "stakeholder engagement"
GRI 102-50	Reporting period for information provided	p 2	Our reports are annual, and reflect our financial year, October 1, 2018 to September 30, 2019
GRI 102-51	Date of most recent previous report (if any)	GRI table	A report is produced annually. The last report was published in September 2019
GRI 102-52	Reporting cycle (such as annual, biennial)	GRI table	Annual
GRI 102-53	Contact point for questions regarding the report or its contents	GRI table cover	Anova CEO, James McIntyre, can be contacted for any questions relating to this report. The email address is mcintyre@anovahealth.co.za
GRI 102-54	GRI content index for 'in accordance' - Core	GRI table	This report has been prepared in accordance with GRI Standards – Core option
GRI 102-56	The organisation's policy and current practice with regard to seeking external assurance for the report	GRI table	No external assurance has been sought for indicators in this report. An external assurance report, statements or opinions may be considered for further reports

Contact us

Anova head office

12 Sherborne Rd
Parktown
Johannesburg
South Africa
2193

+27 (0) 11 581 5000 (tel)
+27 (0) 11 482 1115 (fax)

For a full list of Anova's offices, visit *www.anovahealth.co.za/contact-information*


info@anovahealth.co.za


www.anovahealth.co.za


AnovaHealthSA


@AnovaHealthSA

Published by Anova Health Institute NPC

Setting A Pace

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

USAID
FROM THE AMERICAN PEOPLE

ANOVA
HEALTH INSTITUTE