RECOVERY AND RESILIENCE

INTEGRATED ANNUAL REPORT
2020-2021

UNCOMPROMISING EXCELLENCE.
COMMITMENT TO CARE.

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INTRODUCTION: SCOPE AND BOUNDARY

The Anova Health Institute NPC is a non-profit company (Registration Number: 2009/014103/08) that is headquartered in Johannesburg and works in South Africa and Zambia. This Integrated Report presents our financial, programmatic, environmental, social and governance performance for the period 1 October 2020 to 30 September 2021 and describes our goals, performance, responsibilities, policies, risks and plans.

MATERIALITY

The concept of materiality informs the content and relevance of this report. Materiality is defined as information about issues that have a meaningful and considerable impact on our ability to create value over the short, medium and long term. The matters that materially impact our performance and sustainability have been considered by our Executive Management and Board; and we have evaluated them in the context of our strategic objectives, stakeholder engagement and the "six capitals" (see p. 5). We report in detail on material issues in the sections on our programmes, 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

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:
- Ensuring health and safety of all our staff
- Recruiting and retaining skilled human capital
- Maintaining and consolidating growth
- Managing the implications of funding cycles and associated fluctuations in resource requirements

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 the year covered by this report are discussed further in our programme reporting, human resources and financial sections.

BOARD APPROVAL

This report was approved by the Anova Board on [date]. 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 pp. 71-73 and is also available from our website, anovahealth.co.za.

ENVIRONMENTAL IMPACT

As a service-based organisation Anova has a low impact on the environment. It is covered in the environmental report (p. 60) 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 2021.

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 organisation like Anova as they are to commercial entities.

This 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 is committed to changing lives through good health. Our focus has historically been HIV, TB and related conditions, but in 2019-20 the COVID-19 pandemic caused us to expand our services into other aspects of health care, a pattern which continued in 2020-21. We supported provincial departments of health to respond to the crisis through assistance with COVID-19 screening and vaccination. As in 2019-20, we were particularly mindful of the physical and mental health needs of our staff. Anova provides direct service delivery (DSD) and technical support to provincial and district departments of health, and in this capacity many of our staff are frontline workers. We did our best to minimise the risk of infection from COVID-19 and to provide practical and emotional support to those who were infected.

As an organisation, our core expertise is in HIV and TB prevention, care and treatment; health systems strengthening; public health management; and key populations, particularly men who have sex with men (MSM) and people who inject drugs (PWID).

In pursuit of our objectives, we work with stakeholders on all levels, including the National Department of Health (NDoH), provincial and district health authorities, district, subdistrict and facility-level managers and health care workers, traditional leaders, community members and activists. We continually look for innovative solutions to age-old and new problems. COVID-19 is an example of an unforeseen challenge, and our response was swift and expedient. Our ability to identify emergent issues and trends – a result of our sophisticated data and analytic skills – results in timely and effective problem solving and implementation.

We work in four provinces in South Africa – Gauteng, Limpopo, Mpumalanga and the Western Cape, and in five districts, including two metros – City of Cape Town, City of Joburg, Sedibeng, Capricorn, and Mopani. We supported 924,025 people on antiretroviral treatment (ART) in 2020-21, an increase of 8% over the previous year. Of these, 32% are male and 68% are female. Our work extends beyond the borders of South Africa, as we support pre-exposure prophylaxis (PrEP) roll-out in Zambia through the EQUIP Consortium, of which Anova was a founding member.

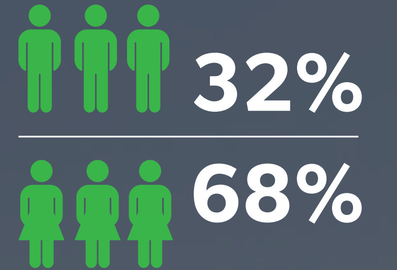
VISION

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

We supported
924,025
people on ART



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CHAIR'S STATEMENT

If 2019-20 was a year like no other, 2020-21 was a year very much like the one that preceded it. However, this year we were more prepared. By the start of our financial year, we had been living with COVID-19 for six months. Although the second and third waves of COVID-19 were yet to hit us, the measures we put in place during the first wave of infection and hard lockdown were well bedded in and working. The Board remained governance driven, ensuring that we could continue to provide essential services, and that our staff were well looked after and had the infrastructure and resources to do their jobs.

At Anova, we are motivated by our purpose and vision, and our strategy was a beacon that continued to guide us. We adapted some processes to accommodate the pandemic circumstances, but the outlook of the business did not change strategically. 2020-21 was a year marked by recovery and resilience. Anova is a key government partner in the provision of health care, and together we worked hard to bring patients back into clinics and back onto their medication. We also assisted with vaccine roll-out when that became available to the general public. A key internal focus of the organisation was staff wellbeing, which we as a Board strongly encouraged.

As a result of our drive and focus, our performance recovered from the impact of COVID-19 and we did exceptionally well, although we may not have met all targets. The Board is very proud of the accomplishments of the senior team and indeed of all our employees.

We continue to operate in a challenging financial and political environment. The US election in November created an air of uncertainty, as we are heavily reliant on funding from the US government. Fortunately, the election of President Biden has not affected the current APACE programme. However, the Board is cognisant of the organisation's dependence on this single source of income, and a key concern is organisational sustainability and the need to continually seek new funders. We welcome initiatives that have begun this year, and appreciate the continued support of all our funders.

As an organisation grows, particularly as rapidly as Anova has over the past few years, there is sometimes a lag in policy/procedure development and revision. The Board is careful to maintain an arms-length distance from operational matters, but scrutinises the day-to-day running of the business from a governance perspective. This oversight helped to identify issues as they emerged and we made sure corrective actions were taken where necessary. A number of policies and procedures were updated during the year, to keep pace with the changing needs of the organisation. We also ensure compliance with all legislation and standards. The pattern of the APACE funding meant that the organisation underwent an expected process of contraction this year, in preparation for a smaller staff complement in 2021-22, and so it was very important that all labour processes were carefully followed, to manage reputational risk.

Another key focus for the Board was succession planning. With the upcoming retirement of founder James McIntyre, we made sure succession planning policies were in place, and devised a strategy for the transition. Helen Struthers moved into the role of joint CEO with James, from her position as Chief Operating Officer (COO), and we began the search for a new COO. The role of APACE Chief of Party was transferred from Helen to Moya Mabitsi, and we appointed three Deputy Chiefs of Party. The Board took responsibility for notifying all stakeholders of James's retirement via formal communiqué . We reassured funders and partners that there would be continuity of leadership, with Helen stepping into the CEO post, and feedback from senior management stakeholder engagement was universally positive.

All appreciated the early notification and the uninterrupted chain of command. As we look to the future, we will continue to oversee succession planning and stakeholder engagement and support our senior leadership as they guide the organisation into the post-APACE world.

As a result of our drive and focus, our performance recovered from the impact of COVID-19 and we did exceptionally well.

I'd like to welcome to the Board Dr Sipho Kabane, whose appointment was approved in July. Sipho brings a wealth of experience in public health and will be a valuable addition to the Board.

In conclusion, I'd like to thank all Anova's management and staff for their tireless efforts and unwavering enthusiasm in very difficult circumstances. We are grateful to USAID for the continued funding, and to all our funders for their support. We value our relationships with our partners in provincial departments of health and local government and thank them all for engaging with us to deliver excellent health care to all our patients. Lastly, I'd like to say a special thank you to James for leading the organisation from inception to become the largest non-US based implementing partner in the world. He has built an organisation we are all proud of and will retire leaving it in good heart. Thank you James and, on behalf of the Board, I wish you all the best in your retirement.

René Kenosi

CHIEF EXECUTIVE OFFICER'S STATEMENT

This year marks the halfway point of the USAID-funded APACE programme, "Accelerating Program Achievements to Control the Epidemic", which runs from 2018-2023. The second year of APACE, 2019-20, was noteworthy, "even extraordinary", because of the COVID-19 pandemic that defined 2020 globally. The pandemic continued into 2021 – but by the start of our financial year (1 October) we had learned to live with it. The systems we put in place to accommodate government COVID-19 protocols and the needs of our employees were robust and stood up to the continued pressure of living with a pandemic. Our IT Department did a stellar job of enabling staff to work from home, where roles permitted, but it was time to contemplate a return to the office, in a managed and safe way. Remote working can be isolating, and we were concerned about the mental health of our staff. Employee wellbeing became a focus for the year.

Another key theme was succession planning. With my impending retirement, we needed to have a structure in place that would see us through the transition period and into the future. We put considerable effort into bolstering support units and strengthening the way we manage our business. Not-for-profit organisations have often been criticised for a lack of business acumen and managerial skill. However, Anova's staff complement and annual income place us firmly in the category of "large company", and we have always taken a professional, disciplined and systematic approach to the way we run the business of health care. Helen Struthers, our Chief Operating Officer (COO), became joint CEO with me, and we set out to recruit a new COO. We further developed and consolidated our senior team, with key appointments and promotions. We encouraged managers to engage in more strategic thinking, and many took on new responsibilities. An area where we made significant progress was in data management and analytics. Our strategic information team was strengthened and our ability to gather, analyse, and use data strategically, while always a hallmark of Anova, was considerably enhanced. The introduction of the Protection of Personal Information Act (POPIA) was a major challenge, as Anova could no longer have access to patient-level data from services. We responded by raising standards for insights and reporting and building trust with our funders through transparency in reporting.

COVID-19 had a devastating impact on health outcomes in 2019-20, as patients stayed away from clinics out of fear and we had to find alternative and unconventional ways to distribute medication. Many people migrated interprovincially as schools closed and jobs were lost, making it hard to keep track of patients on treatment. But the damage done was not irreversible. In 2020-21, despite second and third waves of COVID-19, while these issues did not disappear completely, we recovered a lot of lost ground in terms of medication adherence and data capture.

2020-21 was a tough year, coming on top of the very difficult 2019-20. Two years of a relentless pandemic tested everyone's resilience, not just at Anova but among all our partners and stakeholders, and, indeed, in South Africa as a whole. But it has also made us aware of the inevitability of change. Everyone copes with change in their own way, and this was a year for reflecting on strategies for change management, both as an organisation and as individuals. This will stand us in good stead as we look ahead to the final years of APACE and the future beyond my retirement.

In this, my final CEO's statement, I would like to express my gratitude to the Anova Board, for its enthusiasm, engagement and support throughout my tenure as CEO. I thank my senior management team for their dedication and passion for the work, and all our employees for their commitment and willingness to go the extra mile. I am grateful for the long-standing relationships I have enjoyed with our funders and partners in government and elsewhere. It hasn't always been an easy ride, but there has always been a spirit of respect and collaboration and shared determination to meet our collective objectives. I reserve special thanks for my colleague, fellow founder, joint CEO and friend, Helen Struthers, for her support and tenacity over the past 13 years. I wish her all the best for the future. I know she will steer the ship on a straight path.

In this, my final CEO's statement, I would like to express my gratitude to the Anova Board, for its enthusiasm, engagement and support throughout my tenure as CEO. I thank my senior management team for their dedication and passion for the work, and all our employees for their commitment and willingness to go the extra mile.

Prof. James McIntyre

STAKEHOLDER ENGAGEMENT

Anova maintains an open and ongoing dialogue with all our stakeholders. Our stakeholder community is diverse and encompasses formal groups like government committees and informal bodies such as traditional, community leaders and patient representatives. Because each entity has its own value system and priorities, it is important that we engage at the right level, serving the right interests, and meeting each group's needs. Without effective stakeholder engagement we would not be able to implement our programmes – or at least not as effectively as we do. We succeed together. The following table illustrates the stakeholder groups we engage with and the nature of the engagement, each group's expectations, and our response.

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 some districts we collaborate on discrete aspects of an overall programme	• 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 • Transformation	• 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.	• Career pathing • 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 STRATEGY

Anova is implementing a five-year strategy, which covers the period 2018–2023. Despite the upheaval caused by two years of COVID-19, we have not deviated from our strategic focus, even if we have had to find new and different ways to deliver on our strategy. Our community and stakeholder engagement has undergone shifts in its nature and frequency, the most notable being the move to remote and virtual meetings via online conferencing platforms like Microsoft Teams. We have adjusted our working practices to protect our employees and our patients. But we have never wavered from these 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.

Our strategic enablers remain:

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

This year, discussions of strategy included succession planning, as discussed in the CEO's statement (p. 11), Chair's statement (p. 9), and Governance chapter (p. 46). But in managing the change in leadership, we have remained mindful of our strategic objectives, which inform and support all our activities at Anova. We continually assess and review our strategy at Board level and plot our performance against it, reviewing any changes or constraints in the political, economic, social, and technology (PEST) environments that might require accommodation. The last review took place on 24th March, 2022, and the Board, together with senior management, concluded that the strategy remains relevant. We continue to monitor our progress against it.

SUCCESS STORIES

The shock of COVID-19 on the public health system was significant in 2019-20, and impacted on retention of patients in HIV care. Clinics experienced staffing shortages due to infection or self-isolation and patients were reluctant to leave their homes and visit public spaces to collect medication. The immediate fear of dying from COVID-19 loomed much larger than the more remote risk of HIV progressing to an Aids-related illness. As the first wave of COVID-19 passed and daily life regained some semblance of normality, albeit an altered one, patients started to come back. Renewed willingness to engage with the health system, combined with intense efforts on the part of our teams and our health care partners, resulted in some notable successes. We are very proud of what we achieved this year, 2020-21, in spite of less than optimal conditions. Here are some of our success stories.

RETURN TO CARE AND TRANSITION TO TLD

Our largest district, the **City of Johannesburg** (CoJ) saw a committed return to care. We experienced net gains in patients on treatment, which means that, not only did existing patients return, we initiated new patients on ARV. We saw a month-on-month decline in missed appointments, averaging c. 4% for the year, ahead of target.

Our programme in **Capricorn, Limpopo,** grew by 6% year on year. We were particularly successful in transitioning patients onto the newly introduced combination ARV, TLD (tenofovir, lamivudine and dolutegravir combination). Stock-outs pre-COVID-19 resulted in considerable pressure to convert patients to the new regime once it was back in stock, so it was rewarding to see the high take-up rate. The Welcome Back campaign, a pre-existing government campaign to encourage patients to return to care, was scaled up in light of COVID-19 and Anova was particularly successful in leveraging Welcome Back messaging and bringing people back to care.

Mopani, Limpopo, also saw improvements in numbers of patients returning to facilities, from 99,436 in quarter 4 2019-20 to 104,590 in quarter 4 2020-21, even though Limpopo was badly affected by the second wave of COVID-19 in December and January. The Welcome Back campaign was underway, involving facilities and community leaders. Gatherings were about to start in the community when the second wave hit. But local radio was used effectively to spread the message, "You are welcome back [to health care facilities] – they are ready to serve you."

One of the reasons the Welcome Back campaign was so successful was Anova's effort to change the attitudes of health care workers and encourage them to modify their language with regard to patients who fall out of treatment. These individuals often carry a lot of internal stigma, which can act as a barrier to seeking further treatment. Words like "defaulter" and "TB suspect" are negative and discriminatory. If someone is made to feel they are in the wrong, they are much less likely to want to return to the source of the condemnation. We helped to change the way health care workers speak to and about patients to be more understanding and supportive.

Language Matters

How we speak to clients and colleagues impacts on client-provider relationships, building trust in the health service and client adherence and retention in care.

Anova staff are encouraged to take on key changes in the language they use when dealing with and discussing clients:

1. Treatment Compliance: TB and ART programmes

Old	compliant/comply/compliance	New	adherent/adhere/adherence

2. Treatment Defaulter: ART and TB programmes

Old	defaulted/defaulter	New	interrupted treatment/treatment interrupted/ client who had a treatment interruption

3. Interactions with clients who have symptoms suggestive of TB

Old	TB suspect	New	Person under investigation for TB, person with symptoms suggestive of TB

All clients who are re-engaging in HIV services should be welcomed back according to the MSF welcome handshake model:

Source: MSF Welcome Service Toolkit.

In particular, all Anova staff should be aware of the language they use when interacting with, or discussing, particular client groups who are especially vulnerable to stigma and negative healthcare experiences. These groups include:

- Foreign clients
- LGBTQI+ clients
- Children, adolescents and young people
- Those with multiple partners or complex relationships
- Male clients
- Mothers with newly diagnosed infant/child

Please refer to the ***"Anova Brief: Use of sensitive language and provision of client-centred care and services"*** in full for more guidance on how to engage with these groups and why our language needs to change.

ANOVA HEALTH INSTITUTE

In the **City of Cape Town** the percentage of patients on the TLD regime doubled, from 35% to 70%. An ironic positive consequence of COVID-19 was more space in clinics, so we were better able to evaluate and determine who was stable and needed minimal intervention and who needed more care. Those at risk of falling out of care were easier to identify and support. We experienced greater numbers returning than were lost to care in the City of Cape Town, and also enjoyed net new growth. The Western Cape Department of Health, unlike the other provincial departments of health in South Africa, designates a unique identifier to each patient. If someone comes back into the health system, even after a lengthy absence, they are recognised and not considered a new patient. So we know with certainty that new patients initiated on treatment are genuinely new, and not returners. At the start of the year we had 215,000 patients on treatment, and 219,000 at year-end.

INDEX TESTING

Index testing is defined by the National Department of Health (NDoH) as "a voluntary process whereby counsellors and/or health care workers (HCWs) ask index HIV positive clients to list all their: (1) sexual partner/s; (2)injecting drug partner/s in the past year; and (3) biological children, to offer them voluntary HIV testing following the approved algorithm". Index testing is an important component of our HIV testing strategy. Case finding from routine testing has proven to be low. By focusing on index testing we are better able to find those more likely to test positive. **Sedibeng** enjoyed notable success with index testing and was the leading district for this indicator among the districts Anova supports. Sedibeng is recognised as a leader at a national level in terms of implementing innovations around index testing. Case-finding managers also observed that, in the course of index testing, some new HIV-positive patients in discordant couples had tested negative previously.

This inspired the team to focus on discordant couples to try to understand what was happening, uncovering an HIV management issue: the original positive partner may not have been virally suppressed. **Capricorn** was also successful with index testing, and developed a risk assessment tool to find high-risk patients and offer them testing, a tool which was adopted by the provincial DoH.

MEN'S HEALTH

"Mina" means "I" or "me" in isiZulu, but the men's health campaign Mina draws on the principle of "ubuntu" – "I am because we are" – to encourage men to take responsibility for their health and, in so doing, be vectors of positive change in their communities. The DoH campaign's full name is "Mina. For Men. For Health"; it is supported by USAID and PEPFAR, and Anova is a key implementing partner. Mina is active in 400 public health facilities in South Africa. In 2020-21, we rolled out Mina in 48 facilities in **CoJ**, 24 in **Capricorn** and 5 in **Mopani**.

In **Sedibeng**, we introduced Mina in quarter 2, and men in the district responded immediately, revealing a huge appetite for the information and services we provide as part of Mina. We set up men's corners in two facilities and we have plans to expand to 13 more facilities in 2021-22.
In **City of Johannesburg**, there are six men's corners, and coaches managed to reach a lot of men. Feedback from men in the district has been very positive.

DECANTING

Decanting refers to the process of shifting stable patients on chronic medication from clinic-based medication collection to external pick-up points. This has been a DoH objective for some time, as a means to decongest clinics and make space for new patients, and to encourage adherence by removing a barrier to staying on treatment – the inconvenience of long waiting times in clinics and loss of working time for simple medicine pick-up. COVID-19 accelerated the decanting process, as we were forced to ramp up alternative distribution methods to counter the reluctance of patients to visit clinics.

We increased the number of medication pick-up points in both **Mopani and Capricorn**. There are not many Clicks or Dischem pharmacy outlets in the districts (commonly used in more populous areas), so we partner with post offices, travel offices and private doctors. We have installed 11 smart lockers across the two districts, but they are awaiting DoH approval, which we hope will be granted in the next financial year. Mopani is a particularly rural district, and the team identified patients who live a long way from the nearest clinic, setting up pick-up points within easier reach of patients' homes. In some instances the local chief was engaged to assist in providing a venue. A total of 53% of patients collect their medication from pick-up points.

In **City of Joburg**, we have more than 160 retention counsellors responsible for case management. Each case manager works with patients for six months before starting ARVs. A significant number of people were virally suppressed after six months and could be decanted to non-hospital-out-of-facility medication pick-up points. Unfortunately, looting and vandalism in Joburg in July meant that some of the facility pick-up points; such as pharmacy dispensing units (PDUs) run by other NGOs had to be shut down. Anova was asked to receive these patients back into our clinics, which affected our decanting targets and set the programme back. But our case management success shows that we have the clinical infrastructure to support decanting, when collection facilities are restored.

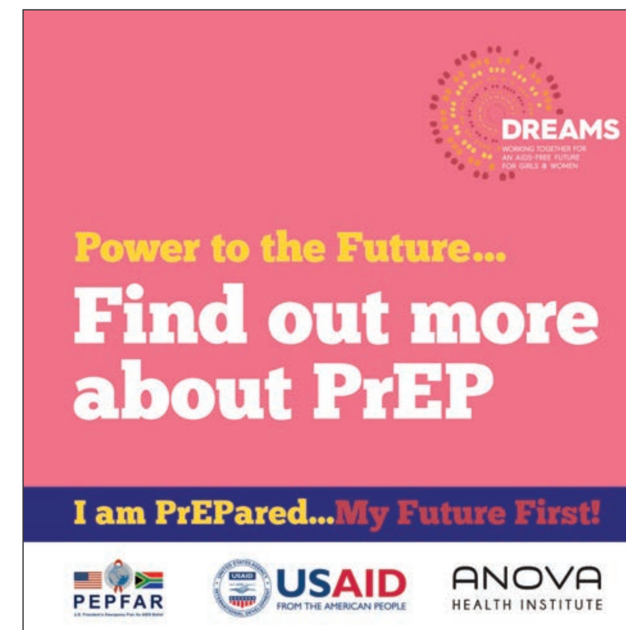
In **City of Cape Town,** we have 38 trailers which serve as out-of-facility pick-up points. These are mobile and we use them where they are needed. We often deploy them close to clinics, so that patients can avoid entering the clinic to collect their medication.

To support decanting, the DoH introduced "Sync", an electronic prescription platform that monitors a medication pick-up journey of decanted patients. Initially implemented in Gauteng, it was rolled out in Limpopo **(Capricorn and Mopani districts)** this year. Nurses in clinics have Sync on their computers and are linked with external pick-up points. Clinic staff can see which patients have not collected their medication packs. The system tracks and traces parcels; any not collected within seven days of their due date are flagged and patients followed up. Nurses can correct any errors on the system immediately, reducing prescription rejection rates.

DREAMS

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) programme is a USAID initiative that aims to reduce rates of new HIV infections among adolescent girls and young women (AGYW) in countries with a high HIV burden. South Africa is one of 10 sub-Saharan countries implementing the programme, and Anova is an implementing partner. We rolled out DREAMS in the **City of Cape Town, City of Joburg, Sedibeng, Capricorn and Mopani** districts, with the adolescent programme lead in each district taking responsibility and orienting the teams about the programme. As DREAMS is predominantly an HIV prevention intervention, the main indicator is PrEP take-up in adolescent girls and young women. Unfortunately, the Limpopo DoH has not yet granted approval for PrEP to be dispensed in clinics, though our implementing partners in the community are able to initiate PrEP.

We introduced DREAMS ambassadors in April and they have had a noticeable positive effect on the performance of the programme. Ambassadors are peers from within the community who provide education on PrEP and on ART for those on treatment. DREAMS is now in all but two of our facilities, and PrEP take-up has spread from young women to men. We work with community partners to implement DREAMS, who refer adolescent girls and young women to facilities when indicated.

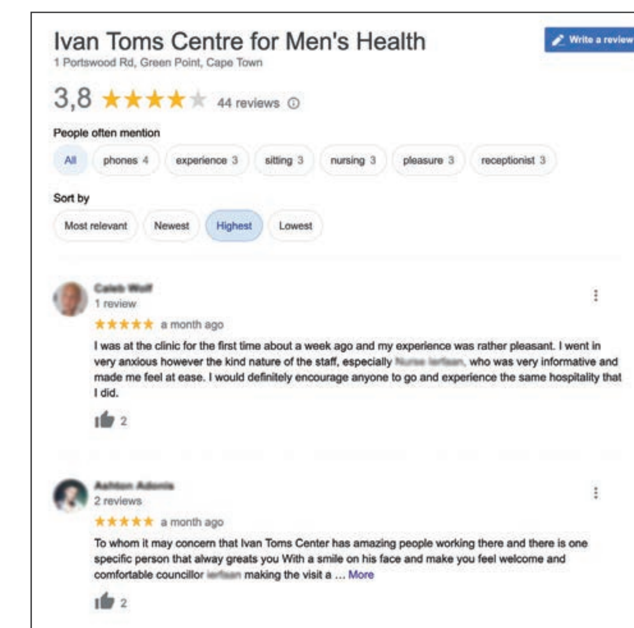


MEN WHO HAVE SEX WITH MEN (MSM)

We experienced a high level of engagement with services among the MSM communities we serve. Counterintuitively, COVID-19 may have been a positive force for good, as there was greater health awareness and more understanding of risk, and more people came for services. The clinic became a safe space. Anova's long-standing expertise in serving MSM and our accumulated knowledge of interventions and how to deliver them continued to deliver high-quality results this year.

Our MSM programmes in **Capricorn,** Limpopo, and **Gert Sibande District** in Mpumalanga reached all our targets – HIV testing, reach, linkage to care, ART initiation, and retention in care. We are proud to report that across both districts retention in care was 100%. We also reached targets related to stigma and discrimination, such as training and sensitisation of health care workers and government officials.

The Ivan Toms Centre for Men's Health in the **City of Cape Town** tripled growth in patient numbers compared with the previous year. We achieved 75% of our case-finding target, a major gain after the challenges of the first year of COVID-19, and by year-end we were achieving 90-95% of monthly targets and had arrived at the pace necessary to hit our case-finding targets. Retention in care is also healthy with 90% of clinic-based patients retained (slightly lower for mobile clients, inevitably). From a qualitative perspective, clients are talking about the programme to their peers, and leaving five-star reviews on Google. We have received an increasing number of positive emails from clients. Our goal is to deliver a high-quality experience, and feedback shows that we are succeeding.



JABSMART

JabSmart is our HIV and harm reduction programme for people who inject drugs (PWID). It operates in all CoJ subdistricts and Emfuleni in Sedibeng. This year we introduced a psychosocial team of social workers and auxiliary social workers and set up support groups and adherence groups.

Women-only groups helped us attract more women to the programme and the support groups overall helped increase adherence to ART and opium substitute therapy (OST) treatment. Total client numbers grew, despite the challenges presented by COVID-19 for this population in particular, and we are especially heartened by the increase in family reunifications, thanks to the psychosocial team.

STRATEGIC INFORMATION

One of the key successes of the year was the evolution in our use and understanding of data. It was not a revolution; Anova has always been highly regarded by funders for data integrity and quality. But we made significant leaps forward this year in the way we use data strategically. We made some structural changes to our Strategic Information team, and the team engaged heavily with programme teams to understand their needs and challenges with regard to data. Within the districts we also revised monitoring and evaluation responsibilities and created a central capacity-building role to upskill our "boots on the ground". COVID-19 made our data-driven approach even more relevant and, with greater engagement with data, we have strengthened and enhanced our activities in this arena.

We worked closely with our major donor, USAID, to understand what its country representatives need to report up the line. USAID also changed the manner in which it wanted reports to be presented, requesting a more data-driven approach. We have been transparent with our data and open about where our challenges lie. This has built trust with the donor.

The next step was to make the data that was coming in more accessible to those who need to use it. We wanted to make data "tell a story". To do this, we raised the standards for reporting and shifted mindsets to using data for insights. Previously, we collected a lot of data, but it was not in a format that was practical or sensible to end users. It enabled us to report what was required of us, but didn't reveal information that could be actioned strategically. However, this shift was not a simple task. As is clear from our programme reports, the districts we work in are diverse, and so are the people who work there. Historically, there was some friction between the central data team and the districts. We had to align all the programme teams; we needed everyone to agree on a single source of truth. We made it clear that data is to be shared and accessed by everyone.

Transparency and relationship building between the SI team and the districts has played a big role in our improved leverage of data.

We also needed to build the capacity of our data capturers, and those who work for DoH. We are committed to strengthening DoH systems; we don't want to create parallel systems. We have built internal modules on REDCap for indicators that the DoH data system – Tier – does not capture, to enable us to monitor our performance, and to report on indicators that USAID requires but Tier does not collect (for example: Tier does not record the source of someone who undergoes an HIV test – whether they are a TB patient, an index contact, etc. So we capture that via an internal REDCap module). But our ultimate mission is to provide technical advice to the DoH and build its capacity.

GROWING DEMAND FOR DATA

Our SI team developed a series of dashboards, and created the Anova data hub on Microsoft Teams – an electronic platform that everyone can access. The hub gives a holistic view of our programmes. When programme managers saw the dashboards, their appetite for data grew and they soon began demanding more. Now programme managers make weekly and sometimes even daily decisions regarding resource allocation (i.e. to facilities) and programme priorities based on real-time information they derive from the data. Teams have even been diverted en route to a destination, when a report showed a greater need for them in a different facility than the one to which they were headed.

An example of a successful collaboration with SI is the community engagement team. Historically, it captured its own data, because community activities are outside of the facility-based Tier system. When the SI team reached out to the community team on a fact-finding mission to identify its needs, the result was the development of a REDCap tool for community engagement. Now, among other indicators, community engagement can disaggregate patients who test traditionally (in a clinic), in the community, and via self-screening.

IMPROVED DECISION-MAKING

We have moved from districts that were semi-autonomous in terms of data, to programme managers who don't want to make decisions without the data to back them up, because they now have systems in place that facilitate access to data. We have integrated data management into our decision-making processes, because data is now in a format managers and staff understand. They know the importance of their key indicators. Data has always been important; now it is important *and* meaningful. And we are better able to meet our donors' requirements.

REDCap is a secure web application for building and managing online databases. REDCap can be used to collect any type of data in any environment, but it is specifically geared to support online and offline data capture for research studies and operations. REDCap is a consortium of thousands of active institutional partners in over 100 countries who utilise and support their own individual REDCap systems. Anova uses REDCap as a platform to capture data needed for donor reporting or internal purposes that is not captured by the government systems, such as Tier, that we support. We do not use REDCap to create a parallel reporting system, as we believe in strengthening government systems.

APACE PROGRAMMES

APACE (Accelerating Program Achievements to Control the Epidemic) is a five-year US government-funded programme designed to help South Africa meet the UNAIDS 90-90-90 targets:

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.

These targets were not universally met by 2020, but the goal of reaching 90-90-90 still stands. HIV infection is not static. There is not a finite number of people living with HIV, as new infections are still occurring, which makes case finding a key pillar of the strategy. Keeping people on treatment and virally suppressed is the best method of new HIV prevention, so finding HIV-positive individuals and initiating them on treatment promptly is vital.

This was the third year of Anova's APACE programme, and the second year of managing a major HIV treatment programme in the middle of a global pandemic. Last year, service delivery was severely interrupted by government-decreed stay-at-home orders ("lockdowns"). At Anova, we also had to prioritise the health and welfare of our staff and of our DoH partners. Many of our employees contracted the virus, or were forced to self-isolate due to exposure, affecting staffing levels in facilities. Sadly, some of our team lost loved ones and we lost colleagues. In spite of the challenges, we kept the programme going. As we entered this year, we had learned how to accommodate the altered working environment and patient concerns. The systems and procedures we put in place last year proved robust, and we continued to refine and enhance them. We did not see a repeat of Alert Level 5 under the national State of Disaster Act, so patients did not stay away in droves the way they did in the first year of the pandemic. Clinics also did not close for days on end for deep cleaning.

However, this year was marked not only by COVID-19 but by unrest in the country. The winter months saw former President Jacob Zuma imprisoned for contempt of court. Supporters responded by rioting and looting. Not all the districts we work in were impacted, but the City of Joburg suffered considerable disturbances. The City of Cape Town was affected not by riots but by taxi violence. Disputes over routes between rival taxi operators brought certain areas to a standstill and cost lives. Many people were unable to get to work, and patients were unable to get to clinics or other medicine pick-up points. External pick-up points were vandalised in both Johannesburg and Cape Town, so we had to find alternative ways of getting medication to patients.

In spite of all these obstacles, our performance against target bounced back. You can read some of our success stories starting on p. 16. In this chapter we look at the APACE programme in each district where we operate. Despite having common aims and objectives, the programme manifests differently in every district. The City of Joburg and City of Cape Town are large metros; Mopani is rural and population density is low. Sedibeng appears rural, but is close to Johannesburg and its predominant economic sector is manufacture of fabricated metal and chemicals. Capricorn houses the capital of Limpopo, Polokwane, and the main economic activities are farming, mining and manufacturing. Unemployment is extremely high, at 48%. With such diverse districts under our remit, a one-size-fits-all approach would be impractical. Our programme managers and teams come from the districts where they work, and they adapt programme tactics to meet the needs of the communities they serve, while pursuing a shared goal. They are sensitive to the social and cultural characteristics of their districts, and strive to find locally appropriate and acceptable solutions to the problems that arise. Therefore, each district in this report tells a unique story.

CITY OF JOBURG

The City of Joburg, or CoJ, reaped the rewards of two years of hard work. Quarter 1, October to December, often sees a dip in patient numbers, as Johannesburg is home to many interprovincial migrants. When December rolls around many residents decamp back to rural homes. This year, however, there was no December dip. We saw a net gain in patients on treatment in quarter 1. Over the year, we ended each quarter on track.

2020-21 was a roller coaster year for our CoJ team. After the successful first quarter, the second and third waves of COVID-19 hit. Johannesburg was not as badly affected by the second wave as Cape Town, but the third wave badly impacted Gauteng province. Provincial borders were closed. Then the rioting began, and many of our staff who live in Soweto and other affected areas were unable to procure basic food supplies, as many local convenience stores were looted. In spite of the unrest, staff still wanted to come to work. Those who could buy food brought donations to work for colleagues. Anova donated money for food parcels. Through it all, we continued to support the DoH with direct service delivery (DSD) and technical advice (TA).

We also kept on top of our data. We had permanent data capturers in every clinic, and a roving team that served as a clean-up crew. Each month we reviewed the lists of missed appointments and interrogated them – was it a missed appointment or a data recording error? Once that was determined, patients who missed appointments were phoned or visited. In this way we were able to see a month-to-month decline in missed appointments and an overperformance relative to our target. Historically we had pieces of the puzzle, but we didn't have a holistic view. Proper systems for collecting and reporting improved and standardised our approach across subdistricts.

Furthermore, we began to engage with data in a way we had not previously. Dashboards are now available on Microsoft Teams, a shared online platform, which allow facility managers to see exactly how their clinic is performing. For example, because we can drill down to clinic level results/performance, we can see whether index testing is offered to enough contacts of newly diagnosed HIV-positive patients. In some clinics we saw that the acceptance rate (i.e. if the index patient is willing to share information about contacts) was only 50% or 60% (80% is average). We investigated the possible reasons for this shortfall, and identified gaps in knowledge and skill. We arranged training where needed, in this case for lay counsellors. We introduced weekly Monitoring & Evaluation (M&E) meetings, which encouraged staff to interrogate the data and use insights from it to improve quality.

Our men's corners, linked to Mina (see p. 17) are popular, but we are limited by space in clinics and availability of male nurses. Feedback from male patients has been overwhelmingly positive, and we hope to expand beyond the current six facilities next year.

CITY OF CAPE TOWN

If the first year of living with COVID-19 was a shock, in the second year we learned to cope. That said, the second wave of COVID-19 (in December 2020 – January 21) hit Cape Town very hard. Intensive care units were full, and our teams lost family members. Health system resources, which had gradually begun to recover a sense of balance, once again shifted away from HIV and back to COVID-19. It became too risky to concentrate services in facilities, so core functions were impacted. It was a challenging time for our management team and all employees. By the time the third wave came, we were much better prepared, and we were not hit as hard. Overall, 2020-21 was a year in which we turned the challenges of the previous year into opportunities. Patients returned to treatment. They learned, with our help, that even in the midst of the COVID-19 pandemic, they needed to take their antiretrovirals (ARVs). We worked in partnership with our patients. If the first year of COVID-19 made HIV seem irrelevant, this year there was an understanding that epidemic control is important, whatever the epidemic. We saw greater numbers returning to care than lost from care. We also learned a lot about resistance to treatment through observation of vaccine reluctance, and we have revisited stigma and our understanding of it. A key focus for the year was transitioning patients to the tenofovir, lamivudine and dolutegravir combination ARV (TLD). (See Success Stories, p. 16).

We increased the proportion of patients on TLD, a simple, once-daily pill, from 35% to 70%. Part of the transition process was to measure viral load, so we know which patients are high or low risk and who to transition.

We made great strides in better understanding and using our data. We have developed a clinic-based scorecard, which has decentralised the data and empowered facilities. Data must be understood – and believed – by the teams, before they will leverage the insights available to improve their effectiveness. Now facility managers have direct and prompt sight of key indicators for the past week, such as number of new HIV-positive patients, how many were lost from care, number of patients decanted, how many need viral loads done, etc. The scorecard tells the story of the clinic week to week. Accountability is greater, and clinic staff are able to direct resources where they are needed most.

We've also gained a greater understanding of modelling, which has helped us to comprehend the epidemic better. We know we have a gap of c. 80,000 people who need to be initiated on treatment. Analysing and managing gaps enables us to know what we need to do to close them, rather than just striving for targets.

Index testing has been a priority for case finding, and we have worked hard to translate the national strategy into a daily activity that counsellors feel comfortable with and carry out correctly. We have implemented additional supervision and coaching to ensure staff understand the value of index testing and can have the right conversations with patients. We have also implemented self-screening, which does not replace conventional testing but complements it. Currently self-screening is not done at home but in facilities, in an assisted manner. It helps reduce the pressure on clinics, but the ultimate aim is to decrease the time between testing, diagnosing infection, and initiating treatment.

CAPRICORN

The year held its ups and downs for Capricorn District, but it ended on a positive note. Although we were more prepared when the second wave of COVID-19 hit, we were still affected because some clinics closed due to a high number of DoH staff infected or self-isolating. Limpopo felt the second wave more fiercely than the first. Fortunately, we did not have a high rate of infection among our staff, but many were exposed and had to self-isolate, which impacted our resources.

We supported the DoH with COVID-19 measures, over and above our normal HIV work. We assisted with vaccine roll-out, and many of our lay counsellors and data capturers were seconded to help. We attempted to use the vaccination programme as an opportunity to conduct HIV testing, but case-finding rates were low. We were also disappointed with our index testing results. However, another prong of our case-finding strategy – extended hours – was more successful. During these hours clinics were staffed entirely by Anova employees for HIV testing services enabling patients to come for an HIV test after work, which was more convenient for them. The third and final case-finding prong was a screening tool which we developed for use when vitals are taken in a clinic. By screening for sexual behaviour, we ensure we are testing the right people. This has become a key case-finding modality for us.

We were very successful in bringing patients back into care and in transitioning to TLD. In the first wave of COVID-19, we started pre-packing medication and focusing on decanting stable patients, which was already part of the strategy. COVID-19 simply accelerated it. Now 68% of decanted patients collect their medication from external pick-up points. The introduction of Sync (see p. 18) has helped this process. Overall the programme grew by 6%.

We hired a coordinator for Mina, the government-intiated men's programme which we implement, and we rolled out in 24 facilities in Capricorn. We are also proud of our adolescent programme. Twelve facilities are fully-fledged adolescent-friendly clinics. We introduced DREAMS (see p. 44), working with community partners – Wits RHI, Future Families, NACOSA, and EDC. These partners refer adolescent girls and young women to facilities when indicated, and we refer these patients to community based PrEP, which is not yet approved for use in clinics in Limpopo for young women.

We learned how to use data more effectively this year, through the use of better visualisation tools. Facility-level dashboards allow us to review programme progress subdistrict by subdistrict, and managers use the information to make more informed decisions about resource allocation. For example, if the data reveals a treatment gap of 50 people, a case-finding team will be despatched to that subdistrict. Our deeper engagement with data enabled us to identify that 6000 patients we thought were lost from care across Capricorn and Mopani were in fact decanted and still successfully in care.

Anova is held in high regard by patients in Capricorn. We are considered the partner of choice, and patients will often seek us out in facilities. We appreciate the faith patients have in us, and aim to ensure the sustainability of the HIV programme for all Capricorn patients, wherever they receive services.

MOPANI

Like neighbouring Capricorn District, Mopani was badly affected by the second wave of COVID-19. Although there were no clinic closures, a lot of staff – both Anova and DoH – were self-isolating. Sadly, we lost two staff members to COVID-19. Before that, patients had begun to return to clinics, and there were very few missed appointments. The Welcome Back campaign was effective, although we had to cancel planned community gatherings due to the second wave. Patients did not hesitate to come to COVID-19-compliant clinics for their medication, where they lined up outside in the fresh air and were screened at the gate. Our staff gave health talks in facilities and educated patients on COVID-19 screening and signs and symptoms of infection. We assisted the DoH with patient screening. Limpopo was spared the rioting that affected the metros in July, and the third wave of COVID-19 did not have a big impact.

We introduced DREAMS to Mopani in conjunction with community partners (see Capricorn, p. 25). Although DREAMS is aimed at young women, young men are beginning to get involved. DREAMS is predominantly about HIV prevention, but any HIV-positive young people identified are linked to care. At that point they may join one of our Youth Care Clubs (see p. 43), support groups for HIV-positive adolescents and young men and women. We have Youth Care Clubs in 28 facilities, and we have seen a marked improvement in viral load suppression among youth attending the clubs. We introduced Mina, the men's programme, to five facilities in Mopani.

We were assisted in monitoring our progress and planning our activities by frequent provision of high-quality data. We have a view across the district and are able to see if a particular subdistrict is gaining or losing patients week on week (for example). We drill down to facility level to see patient trends and we can spot errors in data immediately, because we are more familiar with patterns. Because we can see specific locations and problems, we can allocate resources to address the issues, and this happened regularly. The capabilities of our data capturers have increased significantly, and they have deeper insight into the data they are working with, as a result of effective training we have carried out. We conducted a gap analysis and ensured training was specific to local needs.

2020-21 was a year in which we had to adapt. Thanks to improvements in data, we looked across our facilities and prioritised quick wins, identifying where we could achieve the most impact relative to effort. This was often – but not exclusively – in larger facilities. We then conducted regular reviews to stay on track. Our staff worked extremely hard. Those who could work from home did, but much of our work is on the ground. The data team, TB care team, and contact tracers were all at work, regardless of the risk of COVID-19. We increased the number of patients on treatment compared to the previous year. Overall, it was a year of recovery.

SEDIBENG

It was a challenging year for Sedibeng District. As discussed in the introduction to this chapter, Sedibeng's economy is based on steel manufacture, and the district suffered an economic setback in the wake of the global slowdown caused by COVID-19. Many patients lost their jobs, and some migrated to other provinces, resulting in considerable loss to follow-up. Our team also

had relatives or partners who lost jobs. We were prepared for another year of living with COVID-19, but we were not unaffected by it. We lost colleagues to the virus, and that had an adverse effect on staff morale. Rioting and looting affected Sedibeng in July, and impacted on the ability of our employees to get to work. It also resulted in some clinic closures, and external medication pick-up points at malls were looted. Community health workers and public works employees went on strike and patient medical records kept within clinics were destroyed. We recreated patient records, but inevitably our data was affected. This district has also suffered historically from an interrupted electricity supply. When Eskom reintroduced load shedding (rolling, planned power cuts to relieve pressure on the national electricity grid), Sedibeng suffered more than most because it is a non-paying municipality.

Despite these challenges, we met our key targets, retained our staff, and came up with innovative solutions to both usual and unusual problems. We proved ourselves to be infinitely adaptable. Sedibeng District as a health authority has not had a permanent District Chief Director (DoH) for some years; there have only been acting heads. The absence of authority and tenure has led to a lack of commitment in certain areas. As a result, Anova often steps into the breach, for example, by printing documents for facilities when printer cartridges were not procured. Despite the management issues at the DoH, we worked well with DoH staff on the ground. Our team was committed to helping them meet their targets, which in turn helped us to close the gaps and meet our targets.

One of the solutions we came up with to an unusual problem concerned data capturing. We discovered that the challenges of power cuts and internet outages were less severe over weekends, so we arranged with facilities to come in then and catch up. We were able to close the gap in data capture caused by the multiple interruptions to our work. We also worked extended hours, finishing work at 6.00pm instead of 4.00pm, to make up time lost. Where necessary, Anova purchased critical equipment for back electricity supply.

We were successful in case finding, and met all our HIV testing targets. Our patients understood the importance of testing and did not use others as a "proxy" (i.e., "my girlfriend tested negative, so that means I am negative"). We focused on index testing and led the country in index testing results. We noticed an issue with discordant couples and, on further investigation, found the problem (see p. 17). We will implement the solution in the year to come.

Projects we are particularly proud of include Mina, the men's health programme, and DREAMS, the HIV prevention programme for adolescent girls. We introduced Mina and its men's corners in two facilities, and we have plans to extend this to 13 more facilities next year. DREAMS dovetailed with our existing PrEP programme, and as a result PrEP take-up has spread from men to young women. DREAMS operates in all but two facilities.

Our greater engagement with data allowed us to make decisions and plan activities in response to information coming through on a weekly basis. We interacted with facility managers and helped them to understand the data flows. For example, it's not enough to refill a leaking bucket; it's important to plug the leak. We were successful at case finding, but we were not retaining all our patients. Through interrogating the data, we were able to zoom in and identify which facilities needed more attention. Then we worked with the DoH to resolve the issues at a local level.

Anova is highly regarded in Sedibeng by both patients and DoH staff. We deliver a consistently high-quality service and take a holistic view of the patient. In keeping with this approach, we did not alter the way we serve patients because of COVID-19 but we did support COVID-19-related activities, such as vaccination. We ensured all government standard operating procedures (SOPs) were upheld. Our response to issues as they emerged was dynamic, flexible, and informed by data, which has always been our approach.

COMMUNITY ENGAGEMENT

As part of APACE, we support all the district programmes with community engagement. In the first year of the pandemic, we assisted the DoH with COVID-19 screening. This year, our focus shifted to vaccination support activities. We deployed staff to assist in three key areas: vaccination itself; queue marshalling to ensure social distancing was maintained; and registration on the electronic vaccination data system (EVDS). For older people with a lower level of computer literacy, the EVDS process could be quite daunting. We also mobilised communities towards vaccination, providing printed information and verbal communication regarding vaccination sites, opening times, what to expect, etc. As there was a lot of misinformation in circulation, we were keen to ensure that accurate information was available and effectively communicated. We worked in community halls, in gazebos and in our mobile units, even in pop-up sites in shopping malls. All of our engagement was in support of the National DoH Vaccination Drive. We did not operate stand-alone sites.

The second and third waves of COVID-19 negatively impacted our community outreach programmes. Our staff were badly affected in both waves, either through direct infection with COVID-19 or the need to self-isolate due to exposure. Our community activities included HIV testing, ART initiation, tracing those who are lost to follow-up, and bringing them back into care. We distributed Welcome Back campaign materials, but as COVID-19 infection rates rose, communities became reluctant to welcome us into their homes and community spaces, so HIV testing became a challenge. We had to move away from areas we had specifically targeted to find hard-to-reach cases and test the general population, and case finding of HIV-positive individuals was affected. Tracing those loss from care was difficult, as some relocated elsewhere (similar to the previous year) and others would not allow any interaction, saying they were in quarantine.

However, a positive outcome of the pandemic was an increase in HIV self-screening. We set up sites on busy street corners in City of Johannesburg, City of Cape Town, and Sedibeng. Many people preferred self-screening because it uses an oral swab. More men than usual came forward for testing, and we tested many people who had not tested for over a year.

We also improved our data capturing and reporting for community engagement. In the past we did not have an integrated reporting structure across the districts. This year we consolidated the tools used in different districts to create one system, unifying data capturing and reporting for community activities across Anova. Now, on a weekly basis, we are able to interrogate the data and compare performance across the teams. This informs our strategies and improves outcomes. For example, we pulled our teams from areas of low case-finding yields to areas of high results. In City of Johannesburg we learned that Region B had reached saturation level for HIV testing. We shifted our focus to Regions A, C, F and G, and escalated our presence. We test via three modalities – traditional testing, self-screening, and index testing. Our nurses take the files to the relevant facility when they initiate someone on ART.

It was a difficult year, but the team was resilient. We never backed off from providing services. We were agile and continued to adapt to the ever-changing situation.

Client with an HIV self test kit

OTHER PROGRAMMES

APACE is our largest programme and we are the largest implementing partner of APACE in South Africa. This inevitably influences the perception of Anova among stakeholders. However, it is not our only programme. We have worked with key populations since our inception, and we continue to serve men who have sex with men (MSM) with HIV testing, PrEP, ART, and psychosocial support. We work with people who inject drugs (PWID) in Gauteng province, providing HIV services and needle exchange. We work with paediatric HIV cases; we undertake community engagement; and we initiated a pilot project involving HIV care in the private sector. This chapter describes these activities.

MEN WHO HAVE SEX WITH MEN – CAPRICORN AND GERT SIBANDE DISTRICTS

We work with MSM in two districts: Capricorn in Limpopo and Gert Sibande in Mpumalanga, funded by the Global Fund, and with transgender individuals in Capricorn. The focus is bio-behavioural prevention, in other words – behaviour change interventions and PrEP. However, we initiate ART when it is indicated. We work within DoH facilities, using Anova nurses and a body of MSM peers, who are paid a stipend. Our nurses conduct ART initiation in the facilities and in our mobile clinics.

This year, despite COVID-19, we met all our targets, including HIV testing, linkage to care, ART initiation, and retention in care. We also addressed issues of stigma and discrimination. We conducted training and sensitisation with health care workers and government officials, and worked with families dealing with stigma, often assisting in family reunification. We are pleased to report that we met all of our targets in this sphere. In spite of the second and third waves of COVID-19, which affected other programmes, we did not experience a drop-off in use of services or a loss of patients in care. In fact, there was high engagement with services among MSM. We concluded that our population became more health-aware as a result of the pandemic and more concerned about managing their health risks overall.

MEN WHO HAVE SEX WITH MEN – CITY OF CAPE TOWN (EpiC)

Anova has run the Ivan Toms Centre for Men's Health in Green Point since 2008. We provide HIV testing, PrEP and ART initiation and care to men who have sex with men in the Cape Town metro area, and we are part of the EpiC consortium, funded by USAID through FHI 360. We also have mobile units that conduct community outreach. These are not mobile clinics but standard vehicles, and we set up tents in the designated areas each day. Mobile teams consist of a nurse, a community mobiliser, and a tester. Although case finding is a priority, the teams not only conduct testing, they initiate PrEP and ART. Each team is responsible for its own cohort, but the Ivan Toms Centre is the home base.

Retention is managed centrally via dedicated retention managers. Retention of clinic-based patients this year was 90%. Among mobile patients it was 75%. This lower retention rate is not surprising, as the goal of the mobile unit is to reach high-risk, challenging populations.

Serving these populations is not without risk. We experienced two incidents of violence in the year, where the mobile team was held up at gunpoint and vehicles stolen. We are relieved to report that no one was hurt.

Because the second wave of COVID-19 was centred on Cape Town, we experienced more infections among staff than we did in the first wave. However, by this time the processes we put in place were sufficiently rigorous that we never had to close the clinic. The taxi violence in July caused more disruption to services. Our management team rose early every day to assess the situation and determine how to get our employees to work. We used a range of options, including private taxis such as Uber and group transport. But our patients were also unable to travel to the clinic, and we responded by delivering ART to patients at home. Unfortunately, we were unable to extend

that service to PrEP patients. We had to balance resource constraints, targets, and staff safety and health.

Like other programmes, our use of data became more efficient, particularly with regard to resource deployment. We reviewed data daily to determine the direction of outreach. At times, our teams were redirected while they were on the road to the locations where they were most needed, as we were able to see areas of under- or overperformance. Our decision-making became lean and responsive. We also used data from social networking to refine our case-finding strategies, working through risk profiles of social media users (e.g., evidence of multiple partners) and pairing these with our data, to find HIV-positive MSM.

Index testing, by contrast, is less successful in the MSM community. We carry out index testing systematically and a senior member of staff is responsible for overseeing the process, but index testing is challenging in this population. The sexual activity of MSM is often characterised by anonymous "hook-ups", and the index patient may not know the contact details or even the name of a recent partner or partners. Patients are protective of their privacy and often prefer to contact their partners themselves rather than involve Anova. 2020-21 was a good year for the Ivan Toms Centre. We tripled our growth compared to 2019-20, and increased our case-finding rates due to the huge efforts of our team. PrEP use has been steady, but we do not focus on PrEP retention, as it is normal for users to cycle on and off PrEP, unlike ART, where persistency is critical. Qualitative feedback has been predominantly positive. Our patients demonstrate longevity and talk about us to their friends and on social media. We regularly receive five-star reviews on Google. We remodelled the clinic last year to provide our patients with a more comfortable and professional space, and our focus is always on quality of experience and quality of customer service.

JABSMART – HIV SERVICES FOR PEOPLE WHO INJECT DRUGS

JabSmart is a programme, funded by the Global Fund through NACOSA with Anova as Sub-awardee, that provides HIV and harm reduction services to people who inject drugs (PWID). Services include HIV testing, linkage to care, ART initiation, opium substitute therapy (OST), and condom and needle distribution. The programme operates in all subdistricts of City of Joburg and Emfuleni subdistrict in Sedibeng.

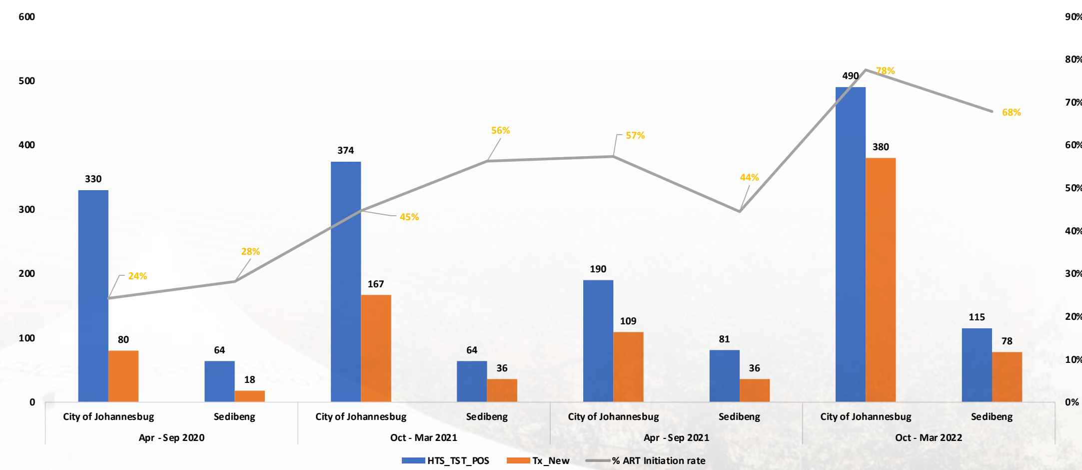
The programme is peer-driven, and peer educators are individuals who are either PWID, former injectors, or people with experience of injection drug use, perhaps via a family member. Some are on the OST programme, some are not. Peers are the bedrock of the programme; peers enable us to navigate the spaces PWID inhabit, find them, and channel them to our package of services. We have a total of 30 peers, and four or five work in each subdistrict.

This year was filled with successes, despite being a difficult year in many ways. COVID-19 restrictions, while not as severe as in 2019-20, meant that some shelters were closed, and many PWID were displaced. Hustling for cash was inevitably more difficult under lockdown conditions, and the protests and riots in the winter also affected our clients, shifting them from their usual spots. Health care provision was disturbed and some clients lapsed on their treatments. We had to start afresh to find PWID, which we did via a community mapping exercise.

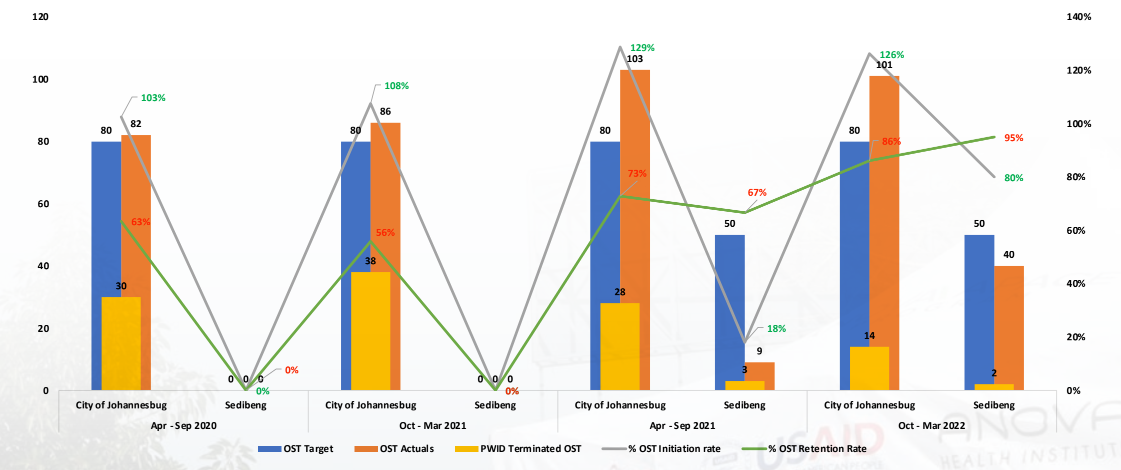
We were also badly affected by COVID-19 internally. Many of our staff were infected or had to self-isolate. Fortunately we did not lose anyone this year. For most of the year we were functioning at 50-60% of staffing capacity, yet, despite these challenges, the team remained highly motivated to serve our clients. As soon as the vaccine programme was rolled out, all our staff were vaccinated. We also assisted with vaccination in the community. We did not administer vaccines, but provided transport to vaccination sites for our clients, receiving funds from our donor for this purpose.

Despite these setbacks, we achieved a considerable amount this year, in terms of client numbers, engagement, and relationship building with the DoH. In a ground-breaking expansion of the OST programme, we opened an OST clinic at the Johan Heyns Community Health Centre in the Hendrik Van Der Bijl Hospital, in Vanderbijlpark, the

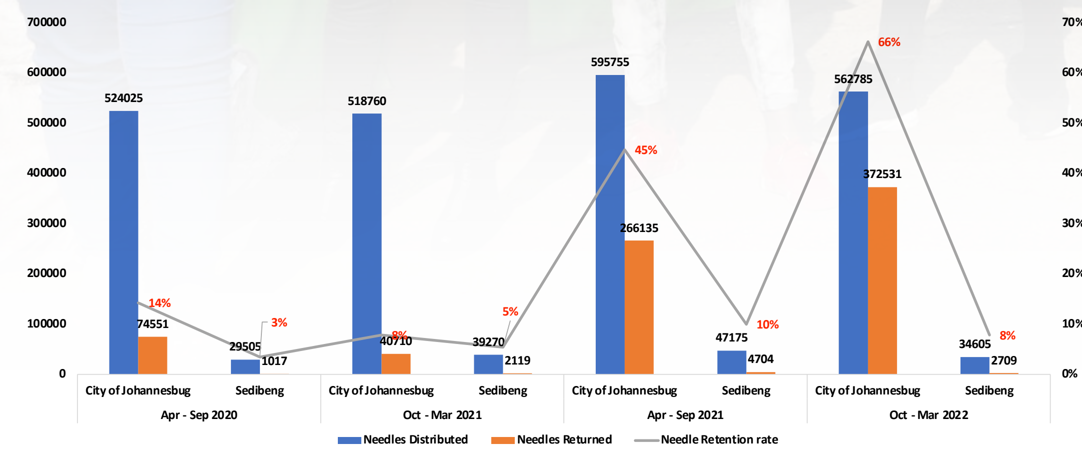
ART LINKAGE PERFORMANCE



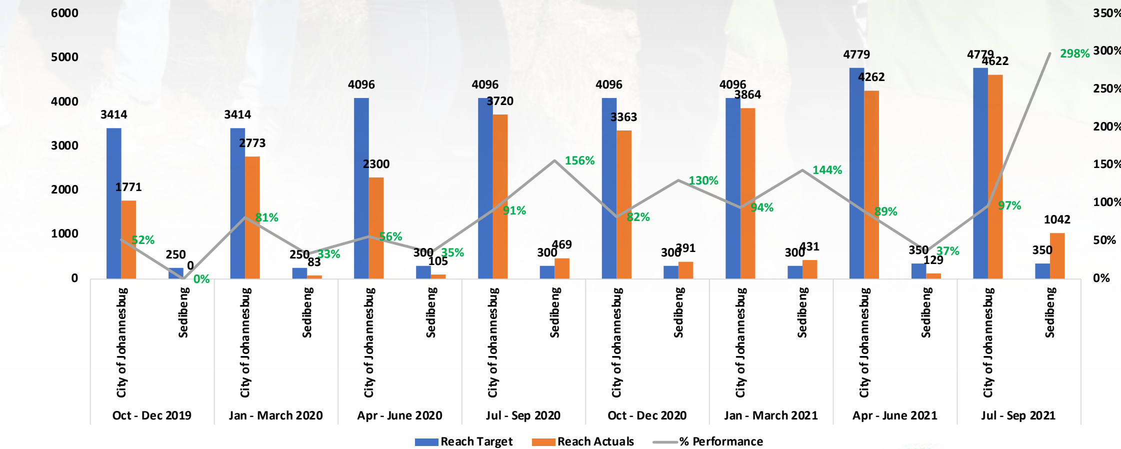
OPIOID SUBSTITUTION THERAPY



NEEDLE DISTRIBUTION VS RETURNED/RECOVERED



PWID REACHED TARGET VS ACTUALS



first of its kind in Sedibeng. It officially opened on 1 October, 2021, but the work to establish it was done in 2020-21.

Even with the dispersal of our clients and the need to start over in our efforts to locate them, we met or exceeded our reach and HIV testing targets. We increased the number of clients initiated on ART and on OST. Notably, the number of female clients served by the programme increased. We also brought about more family reunifications this year.

We introduced several new initiatives that had a positive influence on our reach and impact. We established a psychosocial team, consisting of three social workers and three social auxiliary workers, two thirds of them female. They were instrumental in our success with family reunifications. They also started up support groups and adherence groups for clients, and tailored specific groups to the needs of women, resulting in more women accessing our services. Women's support groups not only dealt with ART but general women's issues and built trust among our women clients. With the support of our funder we provided food parcels to women attending groups, as many of them were struggling to feed families at home. Our peer educators helped us identify suitable sites to hold the groups, and most were run in facilities or in our site offices. We believe the number of clients adhering to ART and OST treatment can be directly attributed to these groups.

We also enjoyed an uptick in support from the DoH in both City of Joburg and Sedibeng districts. In the past, we have experienced resistance from DoH, as JabSmart was perceived as promoting drug use. In Sedibeng there was also some backlash from the community. But DoH is now buying in to our activities, and NDoH is showing more interest in key populations. Sedibeng DoH HAST department (HIV, Aids, STIs and TB) used its influence to help overcome community objections through public engagement. JabSmart works closely with our programme teams in CoJ and Sedibeng; they provide feedback as to where the need for our services is greatest, and help us navigate the district structures. We have also provided sensitisation training directly to facilities in both districts. We are encouraged by the show of support from government and look forward to growing the programme further.

PAEDIATRIC AND ADOLESCENT CARE

Our paediatric and adolescent project, funded by the ELMA Foundation, aims to strengthen case finding, linkage to care, and retention in care. The focus is the City of Joburg, but we share best practices with the other districts. This year we received a grant specifically for COVID-19 mitigation, which ran from January–December 2021. The impact of the pandemic meant that many of the usual activities were disrupted. Child immunisation fell behind, and there was a drive to catch up. We were able to integrate community HIV testing and PMTCT screening into the immunisation drive. We worked with community-based organisations (CBOs), schools and clinics to conduct outreach activities. We also had a grant from Positive Action for HIV testing in children, as there was a big drop in children testing in the first year of COVID-19. As part of this project, we introduced community-based index testing for children. We found that in fact facility-based index testing is more effective for children, but it was a useful lesson to learn.

Through Positive Action we were also able to employ eight child and youth care workers who support children at household level with homework, school enrolment if they have dropped out, job applications, food assistance, etc., all factors that may impact on adherence. They have achieved 95% retention in care.

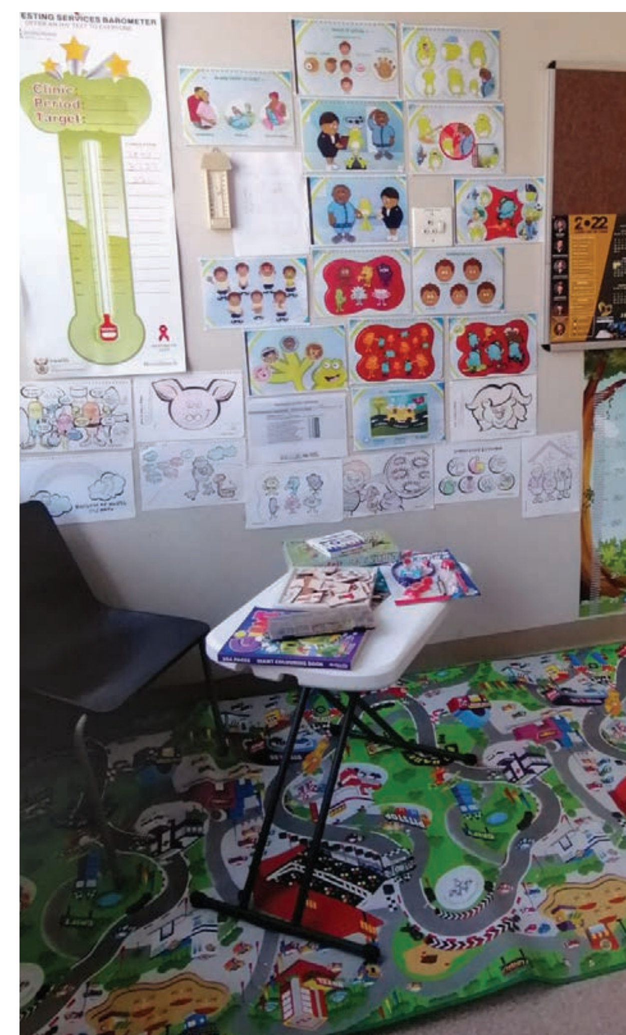
In City of Joburg we rolled out child/adolescent family care days. These are specific days of the month where members of a family can be booked together. They receive a package of psychosocial support and clinical mentoring.

We developed an HIV screening tool for children and received funding from ELMA to research it. We had originally created the tool some years ago to find children in facilities, but the tool was not sufficiently selective. We optimised it, and submitted a research protocol for approval...and then COVID-19 arrived. This year we were able to get the study off the ground in City of Joburg and Mopani. Our aim is to determine the profile of an HIV-positive child, and identify where and when they seroconverted, if they were born negative. We want to find ways of finding these children more simply.

For adolescents, we introduced a mobile service and worked with CBOs and DREAMS partners to offer testing and PrEP. We assisted in the running of virtual support groups for youth by paying for cell phone data. These groups, conducted via WhatsApp, helped to keep youth in care and supported them when it was not possible to run in-person groups.

NDoH has put together a package of interventions for paediatric and adolescent patients designed to drive achievement of the 90-90-90 targets. It is a service delivery framework and focuses on the "how" of reaching these targets, aligned with international guidance. Anova has been a key contributor to the development of this matrix, which was rolled out this year. We supported Gauteng province by running a workshop for the districts and working with the districts to roll out the package to subdistricts.

A child-friendly space



We also supported KidzAlive, a child-focused intervention that aims to improve children's health outcomes. We were involved in training and implementation, working to build the capacity of heath care workers to care for children and to talk to children and their caregivers. KidzAlive makes children participants in their own health care and helps caregivers to support adherence to treatment and to disclose a child's status to the child in an age-appropriate manner. Child-friendly spaces within clinics are encouraged, and health care workers are provided with portable tools they can use to create a child-friendly space and then pack it away again.

The sharp drop in children in care experienced in 2019-20 due to COVID-19 was thankfully not repeated this year, but the recovery was not complete. Children in care were more affected by COVID-19 than adults, partly due to school closures and household movements. However, we have made good use of data to identify facilities where retention of children in care has been challenging and we have targeted those facilities to reduce loss to follow-up. We have also made progress in accessing age-disaggregated data and we are able to include this in our reporting. This is important because children aged 15-19 are exposed to very different risks than adults, but historically the DoH has categorised everyone over 15 as "adult".

YOUR CARE NETWORK

Your Care Network is a network of private GPs who offer free HIV testing services and free antiretroviral treatment. The service is for people who do not have medical aid and who have not been on HIV antiretroviral treatment previously. The idea for Your Care was first formulated in 2018, as a way to reach the missing 2.8 million HIV-positive individuals (according to government estimates) not in care. The intention was to open up the private sector to patients who don't have medical insurance but don't use government facilities – the working uninsured. As a radically new initiative, it took time to secure all the necessary approvals. The pilot programme launched in January 2021 and is funded by APACE. GPs are paid a fee per patient, not per service rendered. Payment is outcomes-based, e.g.,

GPs receive a payment if a target viral load is achieved in their total patient cohort for the year. This incentivises them to ensure a consistently high standard of care. The programme aims to fill the gap between the overburdened public sector and underworked private sector GPs. As a blended project, incorporating private and public sector funding, it links to the nascent National Health Insurance (NHI). USAID pays for the GP consultation and the South African Government pays for the ARVs and laboratory services.

GPs who sign up for Your Care Network must have the certificate in HIV management at a minimum. They are given further training by the Foundation for Professional Development (FPD). GP practices are also provided with counsellors by the programme. The programme is managed by PPO Serve, a shared services hub for clinicians.

USAID approached Anova to be a partner in this pilot programme because the key to its success is effective marketing, and we are renowned for our ability to market HIV services in an accessible manner to targeted populations. Prospective patients need to be made aware that this service exists in the private sector. We conducted a radio advertising campaign and distributed flyers and face masks at traffic intersections. As a result of these marketing campaigns, HIV testing numbers in the Your Care Network exploded.

We distributed

300 000
Leaflets

5 200
Masks

5 200
Sanitiser bottles

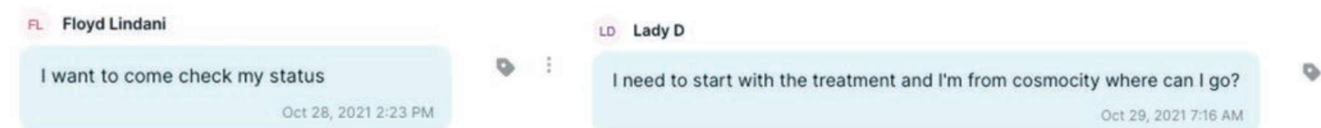
We developed a chat bot on WhatsApp, and more than 2500 patients have used it. The chatbot is available 24/7, is automated and contains HIV and TB content, but our staff behind the scenes answer questions that go beyond the algorithm of the bot. In total, 35,000 messages have been exchanged.

When COVID-19 infections increased in the various waves, our data shows that there was a corresponding dip in patient consultations. Our testing numbers in response to the marketing campaigns signal a very encouraging start to the programme.

YELLOW DOT DOCTOR

The Yellow Dot Doctor campaign targets doctors in private practice with education, sensitisation and awareness of MSM health information. The goal of the campaign is to facilitate the uptake of services of MSM patients and ensure that doctors are appropriately screening, diagnosing and retaining MSM patients in care. The campaign also aims to raise awareness among MSM that Yellow Dot Doctors exist, catering to the specific needs of MSM.

Yellow Dot Doctor paid media campaign



Your Care Network bot chats

TECHNICAL SUPPORT AND GOVERNMENT LIAISON

Anova supports the NDoH provincial, districts and municipal departments of health in two ways. We provide direct service delivery (DSD), which involves placing our nurses and other health care workers in facilities to work alongside DoH teams, and going out into communities with nurses, counsellors, and data capturers, as in our community engagement programme, JabSmart harm reduction programme, and Ivan Toms men's health mobile units. The second important part of our remit is technical assistance and support to the DoH. One of the key pillars of the APACE programme – and indeed of our work since inception – is strengthening the South African health system. Technical support happens at all levels. Nurses doing DSD are sharing their skills and technical expertise with their DoH colleagues on the job. All our programme managers are highly skilled, competent and experienced health care workers who build capacity on a daily basis not only of their teams but of their counterparts in the DoH.

In addition to programme staff, we have a team of technical experts in various specialist fields who support the programmes and departments of health. We have expertise in postnatal and paediatric care, adolescents, quality improvement, and PMTCT (prevention of mother-to-child transmission). We also have staff dedicated to government liaison, who are skilled at navigating and nurturing the complex relationships between the public and not-for-profit sectors. Without those relationships we couldn't do what we do.

PAEDIATRICS

While the City of Joburg has a dedicated technical paediatric specialist supported by the ELMA Foundation, the scope of that funding does not extend to the other districts where we work. We have a technical specialist whose job it is to replicate the CoJ initiatives elsewhere, linking in with the district programmes. This year our focus has been on how best to implement and monitor specific interventions and on the development of tools that can be used in multiple contexts. We learned, through a small research study we conducted with health care workers, that integrated care – the treatment of mother and baby at the same time, in the same room – is a priority, because there is a consequential relationship between the two. Our next task is to develop a model of delivering individual care in an integrated context.

In the past, we looked after the needs of mother and baby pairs in postnatal clubs, but COVID-19 restrictions forced these groups into the virtual space. Our aim this year was not to grow the clubs, although they have grown, but to identify which features are the most relevant and important to mothers. We've learned that patients may form groups naturally, but they don't want to be allocated to a group. Facilities also lack adequate space. WhatsApp groups have replaced in-person groups for connecting moms and supporting integrated care. In areas where postnatal clubs have lapsed, we are in the process of reviewing the medical files of the members to see how they are doing.

One of the key objectives for the year was to improve the monitoring of viral loads for pregnant and breastfeeding mothers, in accordance with new DoH guidelines. It is estimated that 75% of HIV-positive babies contract the virus via breastfeeding, so keeping track of viral loads for breastfeeding mothers is vital but difficult. The Tier data system did not flag pregnant or breastfeeding women, so we have added a "gatekeeping" code to Tier that identifies them. However, it has been a challenge to ensure that data capturers add the codes to the system. We introduced measures, such as providing clinics with stamps for the files of pregnant and neonatal women, but take-up has been disappointing. We continue to problem-solve around this issue, because if we can't identify the viral loads done on breastfeeding women at the lab, we can't prioritise a response.

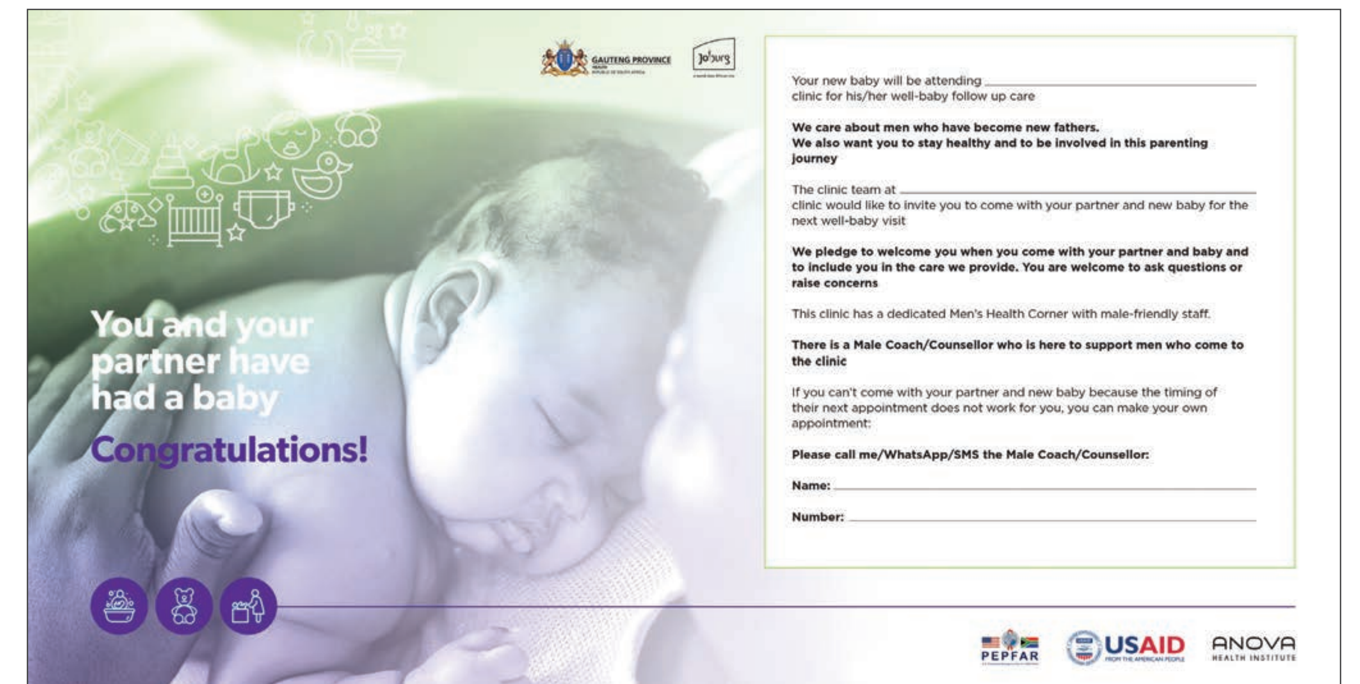
A highlight for the year was the completion of a study we conducted with the public health specialist in our Strategic Information team and the Medical Research Council (MRC) into maternal and child health improvement, at the Maphuta L. Malatji Hospital in Phalaborwa. We conducted a risk assessment of postnatal complications as mothers were discharged after delivery. Mothers were phoned by a nurse after seven days. Although the study found that it is hard to accurately assess risk, service utilisation was higher in the group that received a phone call. It was a small study, with 800 participants, but gave us a strong indication that further research is needed in this area. There is an opportunity to create a risk screening tool and improve the service delivery model.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION AND INVOLVEMENT OF FATHERS

Anova provides specialist support to high-risk clinics and vulnerable, high-risk mothers with high viral loads who need intensive management. We see c. 100 patients a month with advanced disease needs at Chris Hani Baragwanath Hospital in Soweto and Charlotte Maxeke Johannesburg Academic Hospital. This year, only two babies from that group were born HIV-positive. We also provided general support for PMTCT at South Rand Hospital. We use our clinical work to inform new projects that the district programmes can incorporate.

FATHERHOOD GROUPS

One new project involved reaching men through antenatal and immunisation clinics to engage them with fatherhood via fatherhood groups. We launched the project in July in the township of Alexandra in Johannesburg. The staff at the facility have been responsive but maternal and child health spaces are female-driven and don't appeal to men, so it has been a challenge to attract men into the project. We have created links with men's corners, but collaboration with Mina, the men's health programme, has been patchy, because the ethos of Mina is a focus on the individual male, outside of the family context. Men come in with their female partner and are linked to a male coach. It's important they don't feel "tricked" into HIV services when they have come to talk about becoming a father. We've learned that we

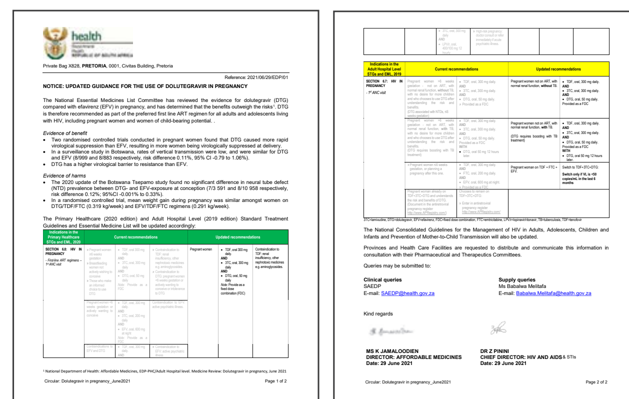


need to engage men and win their trust before introducing them to HIV services. By the third visit, on average, men tend to warm to the idea of using HIV services. We're busy developing tools that men will respond to. The pilot site welcomes c.15 men per week, and about half of them take up PrEP. We conducted focus groups to assess men's views of the fatherhood groups. Feedback about the groups was unanimously positive, but men expressed very negative thoughts about HIV. Many had experienced childhood trauma related to HIV. One of the goals of the fatherhood project is to build the capacity of health care workers to work with men at an appropriate pace and not frighten them off.

NATIONAL GUIDELINES

Anova was a key contributor to the Essential Medicines List (EML) review committee for dolutegravir. Dolutegravir is an ARV that had been banned for use in pregnant women, in favour of efavirenz, because neural tube defects had been found in a study in Botswana. Data was updated in July 2020, resolving this concern and pronouncing dolutegravir safe to use in pregnancy, but South African guidelines still prohibited its use. Anova lobbied hard to have the restriction dropped, because there are 300,000 HIV-positive pregnant women in South Africa every year who were denied access to the combination ARV TLD. This was the only population where men outnumbered women in switching to TLD. Our experts reviewed global literature, both published/peer-reviewed and grey literature (materials and research produced by organisations outside of the traditional commercial or academic publishing and distribution channels). The Botswana study was the only one that highlighted this issue. But Botswana does not routinely offer folate to pregnant women, and this could have accounted for the neural tube defects (of which there were only four). We argued that women were being denied access to optimal ARVs on the basis of their reproductive potential. The baby's health was being prioritised over the woman's. The circular announcing the revised guidelines was issued on 29 June 2021. Now all pregnant women can be switched to TLD, thanks to Anova.

Our other achievement in terms of guidelines concerned PrEP. Truvada, the drug used for PrEP, is an ARV in use by millions of women, but there was a resistance to provide PrEP to pregnant and breastfeeding women, despite the fact that 30% of babies who are HIV-positive have been infected as a result of the mother's seroconversion during pregnancy and breastfeeding. There was no legitimate reason to exclude pregnant women. We submitted our arguments towards the end of the year, and approval happened shortly after the year-end. We are now moving forward with implementation, which we will report on next year.



health
Republic of South Africa

Private Bag X828, **PRETORIA**, 0001, Civitas Building, Pretoria

Reference: 2021/06/29/EDP/01

NOTICE: UPDATED GUIDANCE FOR THE USE OF DOLUTEGRAVIR IN PREGNANCY

The National Essential Medicines List Committee has reviewed the evidence for dolutegravir (DTG) compared with efavirenz (EFV) in pregnancy, and has determined that the benefits outweigh the risks[1]. DTG is therefore recommended as part of the preferred first line ART regimen for all adults and adolescents living with HIV, including pregnant women and women of child-bearing potential. .

Evidence of benefit

- Two randomised controlled trials conducted in pregnant women found that DTG caused more rapid virological suppression than EFV, resulting in more women being virologically suppressed at delivery.
- In a surveillance study in Botswana, rates of vertical transmission were low, and were similar for DTG and EFV (8/999 and 8/883 respectively, risk difference 0.11%, 95% CI -0.79 to 1.06%).
- DTG has a higher virological barrier to resistance than EFV.

Evidence of harms

- The 2020 update of the Botswana Tsepamo study found no significant difference in neural tube defect (NTD) prevalence between DTG- and EFV-exposure at conception (7/3 591 and 8/10 958 respectively, risk difference 0.12%; 95%CI -0.001% to 0.33%).
- In a randomised controlled trial, mean weight gain during pregnancy was similar amongst women on DTG/TDF/FTC (0.319 kg/week) and EFV/TDF/FTC regimens (0.291 kg/week).

The Primary Healthcare (2020 edition) and Adult Hospital Level (2019 edition) Standard Treatment Guidelines and Essential Medicine List will be updated accordingly:

Indications in the Primary Healthcare STGs and EML, 2020	Current recommendations			Updated recommendations		
SECTION 6.8: HIV IN PREGNANCY - *First-line ART regimens – 1st ANC visit*	» Pregnant women ≥6 weeks gestation » Breastfeeding women not actively wishing to conceive » Those who make an informed choice to use DTG	• TDF, oral 300 mg daily. AND • 3TC, oral, 300 mg daily AND • DTG, oral, 50 mg daily Note: Provide as a FDC	» Contraindication to TDF: renal insufficiency, other nephrotoxic medicines e.g. aminoglycosides. » Contraindication to DTG: pregnant women <6 weeks gestation or actively wanting to conceive or intolerance to DTG	Pregnant women	• TDF, oral 300 mg daily. AND • 3TC, oral, 300 mg daily AND • DTG, oral, 50 mg daily *Note:* Provide as a fixed dose combination (FDC)	Contraindication to TDF: renal insufficiency, other nephrotoxic medicines e.g. aminoglycosides.
	Pregnant women <6 weeks gestation or actively wanting to conceive	• TDF, oral, 300 mg daily. AND • 3TC, oral, 200 mg daily AND • EFV, oral, 600 mg at night Note: Provide as a FDC	Contraindication to EFV: active psychiatric illness.			
	Contraindications to EFV and DTG	• TDF, oral, 300 mg daily. AND • 3TC, oral, 300 mg daily AND • LPV/r, oral, 400/100 mg 12 hourly	» Contraindication to EFV: active psychiatric illness. » High-risk pregnancy: doctor consult or refer immediately if acute psychiatric illness.			

[1] National Department of Health: Affordable Medicines, EDP-PHC/Adult Hospital level. Medicine Review: Dolutegravir in pregnancy, June 2021

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Indications in the Adult Hospital Level STGs and EML, 2019	Current recommendations		Updated recommendations	
SECTION 6.7: HIV IN PREGNANCY - *1st ANC visit*	Pregnant women >6 weeks gestation - not on ART, with normal renal function, **without** TB, with no desire for more children and who chooses to use DTG after understanding the risk and benefits. (DTG associated with NTDs, ≤6 weeks gestation)	• TDF, oral, 300 mg daily. AND • 3TC, oral, 300 mg daily. AND • DTG, oral, 50 mg daily. » Provided as a FDC	Pregnant women not on ART, with normal renal function, **without** TB.	• TDF, oral, 300 mg daily. AND • 3TC, oral, 300 mg daily. AND • DTG, oral, 50 mg daily. Provided as a FDC
	Pregnant women >6 weeks gestation - not on ART, with normal renal function, **with** TB, with no desire for more children and who chooses to use DTG after understanding the risk and benefits. (DTG requires boosting with TB treatment)	• TDF, oral, 300 mg daily. AND • 3TC, oral, 300 mg daily. AND • DTG, oral, 50 mg daily. Provided as a FDC WITH • DTG, oral 50 mg 12 hours later.	Pregnant women not on ART, with normal renal function, **with** TB. (DTG requires boosting with TB treatment)	• TDF, oral, 300 mg daily. AND • 3TC, oral, 300 mg daily. AND • DTG, oral, 50 mg daily. Provided as a FDC WITH • DTG, oral 50 mg 12 hours later.
	» Pregnant women ≤6 weeks gestation, or planning a pregnancy after this one.	• TDF, oral, 300 mg daily. AND • FTC, oral, 200 mg daily. AND • EFV, oral, 600 mg at night. » Provided as a FDC	Pregnant woman on TDF + FTC + EFV.	Switch to TDF+3TC+DTG: **Switch only if VL is <50 copies/mL in the last 6 months**
	Pregnant woman already on TDF+3TC+DTG and understands the risk and benefits of DTG. (Document in the antiretroviral pregnancy register http://www.APRegistry.com/)	Chooses to remain on TDF+3TC+DTG: » Enter in antiretroviral pregnancy register http://www.APRegistry.com/		

3TC=lamivudine, DTG=dolutegravir, EFV=efavirenz, FDC=fixed dose combination, FTC=emtricitabine, LPV/r=lopinavir/ritonavir, TB=tuberculosis, TDF=tenofovir

The National Consolidated Guidelines for the Management of HIV in Adults, Adolescents, Children and Infants and Prevention of Mother-to-Child Transmission will also be updated.

Provinces and Health Care Facilities are requested to distribute and communicate this information in consultation with their Pharmaceutical and Therapeutics Committees.

Queries may be submitted to:

Clinical queries
SAEDP
E-mail: SAEDP@health.gov.za

Supply queries
Ms Babalwa Melitafa
E-mail: Babalwa.Melitafa@health.gov.za

Kind regards

MS K JAMALOODIEN
DIRECTOR: AFFORDABLE MEDICINES
Date: 29 June 2021

DR Z PININI
CHIEF DIRECTOR: HIV AND AIDS & STIs
Date: 29 June 2021

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https://www.knowledgehub.org.za/system/files elibdownloads/2021-07/Circular_Dolutegravir%20in%20pregnancy_29June2021.pdf

QUALITY IMPROVEMENT

Quality improvement (QI) and quality management are critical components of technical support. Many systems in regular use can be improved and optimised with a fresh approach, but staff immersed in DSD don't have the time or the perspective to identify where improvements can be made. Our QI specialist analyses programmes, systems, and activities to ascertain where a science-based approach can be implemented to good effect. This is "improvement science". It is similar to health systems strengthening (HSS) but encompasses more than HSS alone. Planning, control, and improvement together make up quality management (QM). Continuous quality improvement (the "yellow zone") is the hallmark of HSS, but without control, there is a risk that ethics and attitudes may slip into the "red zone" – unacceptable behaviours. Other areas only need planning and innovation (the "green zone").

To manage quality, our QI specialist sits with managers and teams and asks, "how far should we be by now?" Often facilities that have a real problem don't know where the problem lies. The red zone must be controlled, but many red zone issues have their origins outside of the health care system, and they are beyond our sphere of influence. So rather than focusing on the red zone, we concentrate on shifting yellow areas to green. Sometimes the issue is a lack of leadership. This is where Anova can make a difference, by building capacity and developing leadership skills in our DoH partners. We can also learn from the corporate sector, for example, customer retention principles can be applied to health care.

Index Testing conference

A highlight of the year for QI was our first Index Testing conference, in February. We knew it was important to have a discussion around index testing, since it is a lynchpin of the government's HIV strategy. We invited NDoH, academics, and researchers. Due to COVID-19, it was a virtual conference, and the turnout exceeded our expectations. This conference seemed to trigger something within NDoH and inspired it to take ownership of the process. A month later, NDoH told us it was working on its index testing collateral and developing SOPs and registers as a result of the conference. The newly published consent form follows Anova's conference recommendation. The conference and Anova's influence seemed to set the nation on track, whereas previously index testing was a delicate subject. Relationships were also strengthened as a result of the conference. We received a call from a government minister who was preparing to talk about case finding at the Worlds AIDS Forum in Durban and wanted to include index testing. She asked us for input, to make sure she had adequately covered the topic. Index testing is a discussion that is becoming easier to have with patients in facilities. DoH staff are becoming more skilled thanks to Anova's support, and index testing is a conversation that is no longer taboo.

All data tells a story

While programmes have advanced in their use of data for planning and decision-making, the *presentation* of data has matured, thanks to a deliberate effort by QI and close collaboration with SI. There is a new appetite for creating slides for the quarterly donor meeting; staff are excited about telling a story with the data. A further benefit of data quality and sophisticated presentation is that it facilitates abstract writing and publishing. The calibre of our slides has rubbed off on our partners at the Gauteng DoH, who approached us for help putting together slides of their own. Anova sees continuous quality improvement as a keystone of what we do and who we are. We not only believe in improving the quality of systems and service delivery within the DoH, we also emphasise building the capacity and quality of our staff, developing leaders from within our ranks and strengthening the influence and impact we as an organisation have on our partners and our environment.

ADOLESCENT TREATMENT, CARE AND SUPPORT – YOUTH CARE CLUBS

Adolescence is a time of sexual exploration and emotional turbulence. Young people have a keen desire to fit in and peer engagement is vital. Adherence to medication can be tedious for adolescents, and HIV-positive teens face a number of challenges on top of the usual adolescent problems. COVID-19 made things worse, with schools closed and young people cut off from their friends. The mental health of young people suffered, not only in South Africa but globally. We have two programmes that address the needs of adolescents – DREAMS (see p. 44), which is predominantly about HIV prevention, and Youth Care Clubs (YCCs), which cater for the needs of young people living with HIV.

YCCs were pioneered in Khayelitsha, in the Western Cape, by Médècins Sans Frontières (MSF). We introduced them to City of Joburg, working with the DoH and another implementing partner. There are now 40 clubs operating throughout CoJ. We run 39 YCCs in Mopani, and 10 in Capricorn. In Sedibeng, YCCs are due to launch in 2021-22, but this year we were busy getting everything in place. City of Cape Town is not yet running YCCs, but is keen to start. YCCs are part of our APACE programme, and we work with the district programmes, meeting on a monthly basis.

YCCs are age-banded, as the needs and interests of a 13-year-old are very different to those of an 18-year-old. The age bands are 10–15, 16–19, and

20–24. Groups are mixed in terms of gender, but there tend to be more girls than boys. The original MSF YCCs catered purely for virally suppressed adolescents, but our groups are open to all HIV-positive youth, including those newly diagnosed. Young people come to the clubs once a month, and they receive pre-packed meds, which is a big appeal of the clubs. In a "one-stop shop" approach, they are screened by a nurse for STIs, TB, mental health and nutrition, and then attend the club, which lasts about 45 minutes. After the session they see the nurse clinician, who can address any issues picked up in screening.

Group discussions cover challenges, difficulties, problem solving, and whatever participants want to talk about. There is a curriculum, but it is experiential. If the discussion goes in a particular direction, the group is allowed to explore it. Groups are facilitated ideally by DoH facility staff. We've done a lot of work to capacitate staff around facilitation skills, and it has helped improve retention in the groups. However, in reality, Anova staff run most of the groups. One of our challenges is securing buy-in from the clinics. We would like to see the YCCs become nationally mandated. Young people join the YCC for a year. They transition out as a cohort, but participants can carry on after a year if they like. There is not currently a peer programme, but it is something we are considering.

COVID-19 restrictions meant the groups went virtual. We rewrote the curriculum to be delivered via WhatsApp, developed a virtual workbook, and trained facilitators to use it.

Each facilitator managed their own WhatsApp group. We introduced a hard-copy newsletter – "Cool Communications", which was included in medication packs and covered ART, teen pregnancy, and other issues relevant to adolescents and youth. Our challenge was knowing how many youth were retained in the groups. In-person groups have returned to Mopani but the CoJ is still operating virtually.

The SI team has helped the Adolescent Treatment, Care and Support team to develop a data tool with meaningful indicators for the YCCs. This enables us to see how many young people are in the YCCs, if participants are virally suppressed, if they are decanted or come back to the clubs after decanting, etc. We can compare youth in YCCs to those who are not in the clubs in terms of viral load suppression. These insights enable us to identify problems and develop strategies to address them.

DREAMS

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) programme aims to reduce rates of HIV among adolescent girls and young women (AGYW), predominantly through provision of PrEP (pre-exposure prophylaxis). We rolled out DREAMS in all five districts. The adolescent programme lead in each district is responsible for orienting the programmes on DREAMS and its incorporation into the overall district programme. The main indicator is PrEP implementation in adolescent girls and young women, but we are unable to work towards targets in Capricorn and Mopani as the Limpopo DoH has not yet approved the dispensing of PrEP to adolescents in its facilities. Where appropriate, we refer girls to our DREAMS partners working in community, as they have agreements with the Department of Education and are able to initiate PrEP. COVID-19 impacted on the ability to attract young women as the avenues that bring them to us were not as functional – TVET and community colleges were not working at full capacity.

In April, we introduced DREAMS ambassadors. These are young people from the community who speak to their peers, providing education on PrEP and ART. Ambassadors are fully employed by Anova. Data on PrEP initiations since April indicates that ambassadors have positively impacted on the number of young women on PrEP.

GOVERNMENT LIAISON

Our mission is to improve the health of all South Africans and, to do that, we work with the largest provider of health care in the country – national and provincial departments of health. The role of the National Department of Health is "to improve health status through the prevention of illness, disease and the promotion of healthy lifestyles, and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability." As such, it is involved in strategies, structures, and the provision of guidelines and advice to health care practitioners and provincial departments of health. Health care delivery happens at provincial level and is further delegated to municipalities. South Africa has a very high burden of disease. We have the highest number of people living with HIV in the world, rank among the top eight countries for TB, and have high rates of non-communicable diseases (NCDs), such as hypertension and diabetes. COVID-19 placed an unbearable strain on our already overburdened health system.

Anova works with government health officials at all levels. We are considered a trusted partner and technical expert. Over the past two years, the government has relied on its partners, including Anova, more than usual. We have assisted with COVID-19 screening and vaccination, integrating screening into HIV and TB services. We were tasked with coordinating 24 partners to assist with vaccine roll-out. The vaccination programme put a lot of pressure on government resources, especially as hospitals were still dealing with COVID-19 cases. We could have diverted all our resources to support COVID-19 treatment and vaccination efforts, but our funding mandate is HIV services. At times, we had to facilitate conversations between DoH and USAID regarding use of resources, which we did successfully. Our relationship with national and provincial departments of health is extremely strong. There is a high level of trust and mutual respect. Communication between implementing partners, which we coordinate, is also good. This doesn't happen by accident. We have dedicated government liaison officers who work at multiple levels – from District Aids Councils to office of the Chief Directors and the office of the Premier. They have excellent track records in public health and long-standing relationships with key stakeholders, and their skill in navigating the political landscape and ensuring ongoing collaboration is what allows our teams on the ground to be effective.

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 nongovernmental 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, contribute to strategic and operational plans, policies and procedures and budgets; and manages risk.

The Board was instrumental in steering the organisation through the challenges of the COVID-19 era. Any board treads a fine line between supporting its senior management at too much distance and overly intervening in operational matters. A board that is too hands-off can leave its executive team feeling bewildered and adrift; too much involvement can compromise management's integrity and authority. We believe the Board fulfilled its governance mandate and provided the appropriate amount of support to the senior management of the organisation.

Obligations on both sides were fulfilled while all boundaries were respected. The strength of structures and relationships is only truly tested in crisis, and we believe the COVID-19 emergency proved us equal to the task.
Last year two Board members resigned at the end of their terms. We are delighted to announce the appointment of a new board member, Dr Sipho Kabane. Dr Kabane has extensive experience in public health and is the Registrar and Chief Executive at the Council for Medical Schemes. He will be a huge asset to the Board and to Anova. Dr Kabane's appointment was approved at the July board meeting. He will take up his position in 2021-22.

Mrs René Kenosi and Dr Mikateko Shisana had their terms renewed in December 2020.

SUCCESSION PLANNING

This year, a Board priority was succession planning, as Prof James McIntyre was entering his final year as CEO of Anova. We ensured policies were in place, and developed a strategy to manage the transition. Dr Helen Struthers, joint founder and COO, became joint CEO in April. We conducted discussions with members of the senior team regarding their future in the organisation. Dr Struthers moved out of the Chief of Party role for the APACE grant, which was transferred to Dr Moyahabo Mabitsi, who was previously Deputy Chief of Party. We created three new Deputy Chief of Party roles, to better manage the programme and support Dr Mabitsi.

We began the recruitment process for a new Chief Operating Officer, making a successful appointment before the year-end. The post was filled from 1 November 2021.

As part of the process of preparing for Prof McIntyre's retirement, we notified all stakeholders via a formal communiqué. As his successor is the co-founder of Anova, she is a well-known and respected figure among stakeholders. While some merely want to know the organisation will be well managed, others see inextricable links between organisations and individuals. For our stakeholders in the latter camp, the continuity represented by Dr Struthers is reassuring.

This year, a Board priority was succession planning, as Prof James McIntyre was entering his final year as CEO of Anova. We ensured policies were in place, and developed a strategy to manage the transition. Dr Helen Struthers, joint founder and COO, became joint CEO in April.

THE BOARD

MRS RENÉ KENOSI
CHAIRPERSON

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.

PROF JAMES MCINTYRE
JOINT 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
JOINT CHIEF EXECUTIVE OFFICER
(from 1 April; Chief Operating Officer 1 Oct – 30 Sept)

Helen Struthers (MSc, MBA, PhD) is the joint CEO and 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 Joburg. 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.

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.

MR JULIAN DU PLESSIS
INDEPENDENT NON-EXECUTIVE DIRECTOR

Julian du Plessis (MPhil, BCompt Honours) is a governance, risk and audit specialist with over 20 years of professional experience, including 10 years of internal audit and three years of risk management. He was Head of Internal Audit at Pick n Pay and AVBOB and Head of Risk Management at FirstRand Bank. Julian holds a Master's in Business Management and is a qualified Chartered Accountant.

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

René Kenosi
Mikateko Shisana
Liesl Lintvelt
Annabell Lebethe
Julian du Plessis

Executive Directors

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

Independent Non-Executive Directors are appointed for a term of three years and may put themselves up 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 nongovernmental 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 the 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 subcommittee. 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 2021 year

Members	Meeting Attendance						
	19 November	25 January	11 February	25 March	22 July	31 August	23 September
Independent Non-Executive Directors							
René Kenosi (Chair)	✔	✔	✔	✔	✔	✔	✔
Mikateko Shisana (Lead Independent)	✔	✔	✔	✔	✔	✔	✔
Liesl Lintvelt	✔	✔	✔	✔	✔	✔	✔
Annabell Lebethe	*	✔	✔	✔	✔	✔	*
Julian du Plessis	✔	✔	✔	✔	✔	✔	✔
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				
René Kenosi			Member	Member
Mikateko Shisana	Member	Member		Chair
Liesl Lintvelt	Member	Member	Chair	
Annabell Lebethe	Chair	Chair		Member
Julian du Plessis	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

Directors' attendance at Board sub-Committees

Remuneration Committee

Directors	Meetings			
	13 November	19 November	11 February	24 June
Liesl Lintvelt (Chair)	✓	✓	✓	✓
René Kenosi	✓	✓	✓	✓
Julian du Plessis	✓	✓	✓	✓
James McIntyre (attendee)	✓	✓	✓	✓
Helen Struthers (attendee)	✓	✓	✓	✓

Audit and Risk Committee

Directors	Meetings					
	22 October	18 March	25 March	24 June	31 August	23 September
Annabell Lebethe (Chair)	✓	✓	✓	✓	✓	*
Mikateko Shisana	✓	✓	✓	✓	✓	✓
Liesl Lintvelt	✓	✓	✓	✓	✓	✓
Julian du Plessis	✓	✓	✓	✓	✓	✓
Helen Struthers (Risk only)	✓	✓	✓	✓	✓	✓
James McIntyre (attendee)	✓	✓	✓	✓	*	*

Social and Ethics Committee

Directors	Meetings			
	14 October	22 October	18 March	22 July
Mikateko Shisana (Chair)	✓	✓	✓	✓
René Kenosi	✓	✓	✓	✓
Annabell Lebethe	✓	✓	✓	✓
Helen Struthers	✓	✓	✓	✓
James McIntyre	✓	✓	✓	✓
Susan Kekana	✓	✓	✓	✓
Moyahabo Mabitsi	✓	✓	✓	✓

* Absent with apologies

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 subcommittee.

OUR PEOPLE

Anova is an organisation defined by its people. Our product is health care, and health care is delivered by people. Systems, processes and procedures are essential for successful implementation of a large-scale health improvement programme, but those systems are only as good as the dedicated individuals and effective teams who make them work. To that end, the Human Resources (HR) department has a critical role to play in facilitating the successful execution of our mission. HR is responsible for talent acquisition; onboarding; performance management; employee wellbeing, engagement and motivation; compliance with all labour and health and safety legislation; and other recommended workplace guidelines. In the COVID-19 era, this has also meant ensuring government protocols are followed (in conjunction with our public health expert), and keeping a close eye on staff morale.

DEALING WITH COVID-19

As we entered the second year of the pandemic, we had become accustomed to the measures we needed to take to limit the spread of infection. We were much better prepared than in the first wave, but the second and third waves affected us more personally. Nearly everyone in the organisation either had COVID-19 or knew someone who did. We continued with daily check-ins, and strengthened some of the SOPs pertaining to exposure, infection and quarantine. The COVID-19 committee and COVID-19 coordinators in each district continued to function, and we recorded every COVID-19 case among our employees. In 2019-20 we had introduced a special leave policy – an extra 10 days of sick leave to cover infection or exposure, which remained in effect this year. By December 2021 443 employees had applied for leave and 2206 of these special leave days had been used.

When the COVID-19 vaccine arrived in South Africa at the beginning of 2021, government policy was to prioritise health care workers before rolling the vaccine out to the general public. Anova registered all staff, not only frontline workers, as health care workers and ensured everyone had the opportunity to receive the vaccine. Take-up was very high. Towards the end of the year, following a workplace risk assessment, we decided that, for the health and safety of all our staff and for the vulnerable people we work with, compulsory vaccination is appropriate. From 1 January 2022 vaccination is mandatory for all Anova staff and suppliers. Valid objections on medical, religious or personal grounds will be considered.

EMPLOYEE WELLNESS

Our staff are tremendously resilient. Living with a pandemic for such an extended period is difficult for everyone; for health care workers it is even harder, as they deal with the practicality of it on a daily basis. So we are proud of the way our teams responded and continued to prioritise their patients and support each other. Many of our employees come from the towns and villages they serve, and they are deeply committed to their communities, particularly in rural districts. To help our staff deal with the stress caused by COVID-19 on a mental health level, we revamped our Employee Assistance Programme (EAP), Healthy Company, to provide more mental health support. The majority of calls to the EAP related to grief, caused by the loss of family members, and financial insecurity, e.g., loss of a partner's or family member's source of income due to lockdown.

RESTRUCTURING

APACE funding is not structured in a straight line over the five-year grant period. Funding levels were on an upward trajectory for the first three years, and downward for the last two. Consequently, we went through a period of rapid expansion, reported on in our integrated annual report for 2018-19. In this, the third year of the grant, we had to prepare to contract our staff complement. Although the restructuring doesn't come into effect until 2021-22, this year was a time of planning and communicating with staff. All employees affected by restructuring (c.1000) were notified that they were at risk. The consultation process was conducted 80% virtually, due to COVID-19, and we categorised employees by function – nurses, counsellors, etc. "At risk" did not automatically imply that a particular role would be terminated, but the process inevitably created uncertainty and we lost 580 members of staff who chose to seek alternative employment before the completion of the process, in search of greater security.

We supported all employees through this period, acknowledging that retrenchment causes emotional and financial trauma. Everyone had access to Healthy Company for support and we also provided the services of a recruitment consultant to help staff prepare CVs, take part in mock job interviews, etc. Take-up hasn't been as good as we hoped but the service has been used.

TALENT ACQUISITION

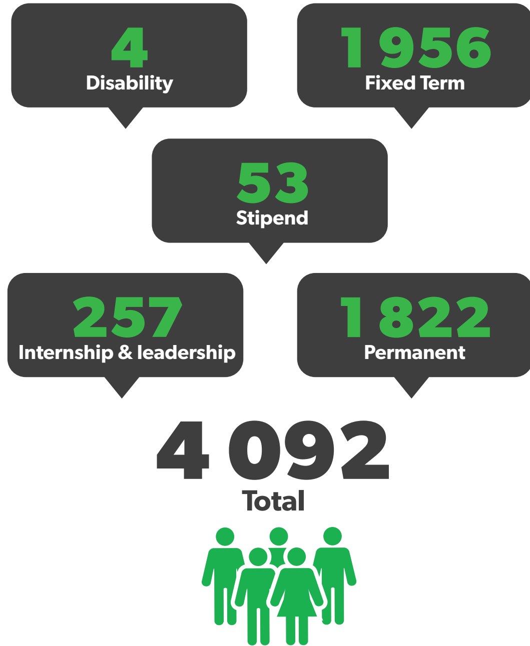
The retirement of our CEO has been discussed elsewhere in this report. With the move of the COO to joint CEO, HR's task in support of the succession planning was to recruit a new COO. The process was rigorous, and the new COO takes up the post from 1 October 2022. There were other senior roles to fill, and HR assisted with the creation of three Deputy Chiefs of Party, supporting the Chief of Party for APACE, as reported in the governance section. Because finding and retaining talent is so important to Anova, we created the role of talent acquisition specialist within HR, and installed candidate tracking software. We invested significantly in systems and systems support and rationalised processes where appropriate, to ensure we manage our talent efficiently and effectively.

SUCCESSFUL TRANSITION

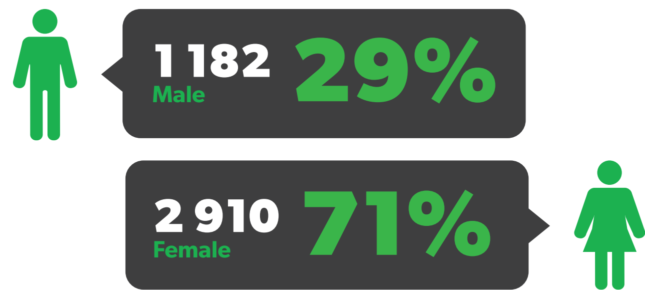
The transition of leadership and of the senior management structure was smooth and successful. We are grateful for the commitment of the Board and its unequivocal support of the process, and to all our employees for their willingness to engage and their continued dedication to Anova.

TOTAL STAFF EMPLOYED

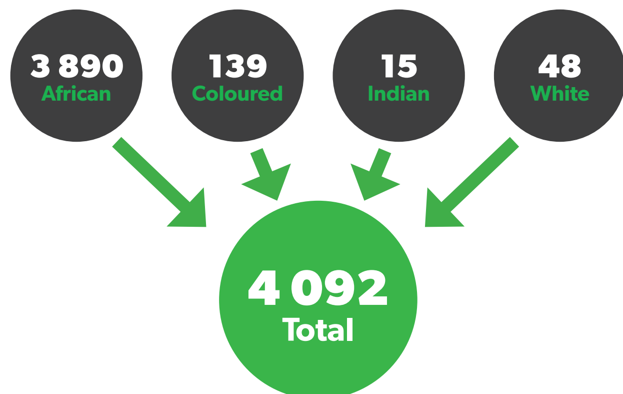
Employment Types



Employees by gender



Employees by race



ENVIRONMENT IMPACT

64
DOMESTIC FLIGHTS

5
INTERNATIONAL FLIGHTS

410 436
KWH

24 805.14
KG CO_2 EMISSIONS

745.17
KG CO_2 EMISSIONS

3 721.90
KG CO_2 EMISSIONS

29,272.21
TOTAL KG CO_2 EMISSIONS

FINANCIAL PERFORMANCE

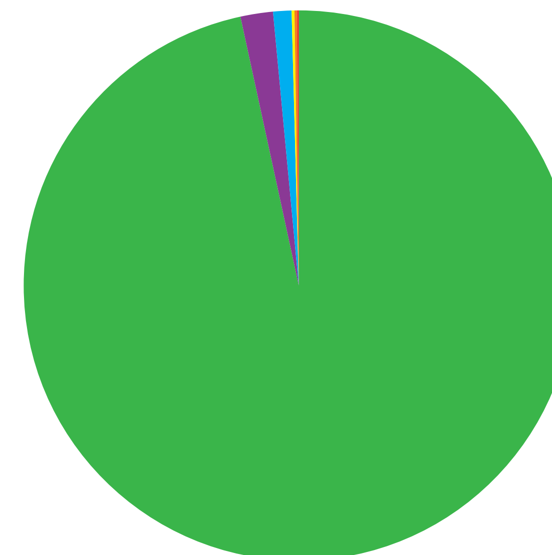
Grants income received decreased by 10.7% compared to the same period the previous year. The main contributor to the decrease was the USAID Accelerating Program Achievements to Control the Epidemic (APACE) grant that started in August 2018, which was structured to decrease in the last two years of the five-year funding cycle.

This decrease was partially offset by the increase in ELMA funding and Global Fund funding during this period.

Operational expenses were down 10.9% year on year due to the decreased activities for the APACE grant, partially offset by the annual cost-of-living increase incorporated into staff salaries effective from March 2021.

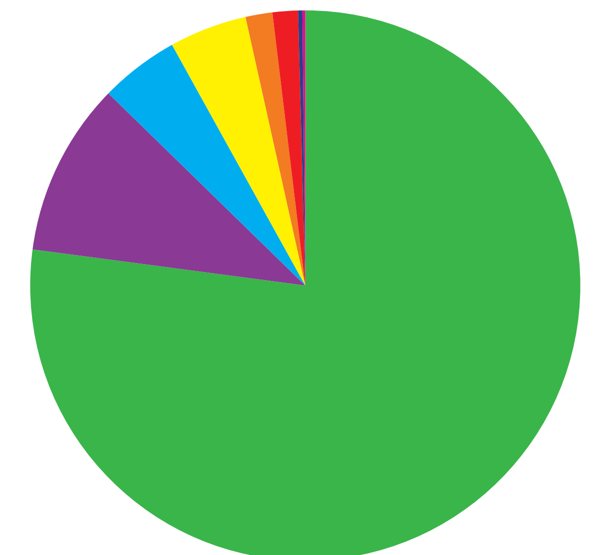
The increase in the net interest received for the year is the direct result of increased investment balances on Human Capital Provisions and other Core Investment accounts.

RESOURCE ALLOCATION BY COST CATEGORY:



	R Millions
USAID	1 164
Global Fund	23
ELMA	13
Sundry	2
Orange Babies	2
NIH	1

SOURCE OF INCOME BY FUNDING SOURCE:



	R Millions
Personnel costs	929
Other Direct costs	123
Sub-awardees & Contractual	56
Supplies	55
Travel and Transport	19
Capital Costs	18
Training costs	3
Seminars and conferences	2

ANOVA HEALTH INSTITUTE NPC
(REGISTRATION NUMBER: 2009/014103/08)

SUMMARISED ANNUAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 SEPTEMBER 2021

The Annual Financial Statements have been prepared under the supervision of Linda McConnell (Chief Finance Officer).
The Annual Financial Statements have been audited in terms of the Companies Act No. 71 of 2008 of South Africa.
The Annual Financial Statements can be obtained from the Anova Health Institute NPC offices.

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South Africa

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INDEPENDENT AUDITOR'S REPORT ON THE SUMMARISED FINANCIAL STATEMENTS

TO THE DIRECTORS OF ANOVA HEALTH INSTITUTE NPC

Opinion

The summarised financial statements Anova Health Institute NPC, which comprise the summarised statement of financial position as at 30 September 2021, the summarised statements of comprehensive income, changes in equity and cash flows for the year then ended, and related notes, are derived from the audited financial statements of Anova Health Institute NPC for the year ended 30 September 201.

In our opinion, the accompanying summarised financial statements are consistent, in all material respects, with the audited financial statements of Anova Health Institute NPC, in accordance with the requirements set out in note 1 to the summarised financial statements, and the requirements of the Companies Act of South Africa as applicable to summarised financial statements.

Summarised Financial Statements

The summarised financial statements do not contain all the disclosures required by the International Financial Reporting Standards and the requirements of the Companies Act of South Africa as applicable to financial statements. Reading the summarised financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon. The summarised financial statements and the audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The Audited Financial Statements and our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated 3 June 2022. That report also includes the Report of the directors.

Directors' Responsibility for the Summarised Financial Statements

The directors are responsible for the preparation of the summarised financial statements in accordance with 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 the summarised financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on whether the summarised financial statements are consistent, in all material respects, with the audited financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing 810 (Revised), *Engagements to Report on Summarised Financial Statements*.

Deloitte & Touche

Deloitte & Touche
Registered Auditors
Per: Marlise Hedder
Partner
13 July 2022

National Executive: *R Redfearn Chief Executive Officer *GM Berry Chief Operating Officer JW Eshun Managing Director Businesses LN Mahluza Chief People Officer *N Sing Chief Risk Officer AP Theophanides Chief Sustainability Officer *NA le Riche Chief Growth Officer *ML Tshabalala Audit & Assurance AM Babu Consulting TA Odukoya Financial Advisory G Rammego Risk Advisory DI Kubeka Tax & Legal DP Ndlovu Chair of the Board

A full list of partners and directors is available on request * Partner and Registered Auditor

B-BBEE rating: Level 1 contribution in terms of the DTI Generic Scorecard as per the amended Codes of Good Practice

Associate of Deloitte Africa, a Member of Deloitte Touche Tohmatsu Limited

ANOVA HEALTH INSTITUTE NPC
SUMMARISED STATEMENT OF COMPREHENSIVE INCOME for the year ended 30 September 2021

	30/09/2021	30/09/2020
	R	R
Revenue	1 205 330 431	1 349 072 195
Other income	-	492 978
Operating expenses	(1 205 381 434)	(1 353 393 177)
Loss from operations	(51 003)	(3 828 004)
Interest paid	(1 533 479)	(66 855)
Interest received	6 006 870	5 727 447
Total comprehensive income for the year	4 422 388	1 832 588

ANOVA HEALTH INSTITUTE NPC
SUMMARISED STATEMENT OF FINANCIAL POSITION as at 30 September 2021

	30/09/2021	30/09/2020
	R	R
Assets		
Non-current assets		
Equipment, furniture and vehicles	37 142 100	36 174 320
Right of use assets	13 514 855	15 714 437
Total non-current assets	50 656 955	51 888 757
Current assets		
Trade and other receivables	35 067 336	26 349 108
Cash and cash equivalents	412 192 223	443 468 661
Total current assets	447 259 559	469 817 769
Total assets	497 916 514	521 706 526
Capital and liabilities		
Capital and reserves		
Capital donation	-	2 608 041
Accumulated surplus	35 878 905	28 848 476
Total capital and reserves	35 878 905	31 456 517
Non-current liabilities		
Lease liabilities	5 655 614	6 061 478
Total non-current liabilities	5 655 614	6 061 478
Current liabilities		
Trade and other payables	196 353 422	186 646 489
Grants received in advance	213 909 249	252 636 080
Deferred income	37 142 100	36 174 320
Lease liabilities	8 977 224	8 731 642
Total current liabilities	456 381 995	484 188 531
Total capital and liabilities	497 916 514	521 706 526

ANOVA HEALTH INSTITUTE NPC
SUMMARISED STATEMENT OF CHANGES IN EQUITY for the year ended 30 September 2021

	Capital donation	Accumulated surplus	Total
	R	R	R
Balance at 30 September 2019	2 608 041	27 015 888	29 623 929
Total comprehensive income for the year	-	1 832 588	1 832 588
Balance at 30 September 2020	2 608 041	28 848 476	31 456 517
Total comprehensive income for the year	-	4 422 388	4 422 388
Transfer of Capital Donation to Accumulated surplus	(2 608 041)	2 608 041	-
Balance at 30 September 2021	-	35 878 905	35 878 905

ANOVA HEALTH INSTITUTE NPC
SUMMARISED STATEMENT OF CASH FLOWS for the year ended 30 September 2021

	30/09/2021	30/09/2020
	R	R
Cash flows generated from operating activities		
Cash generated from operations	(4 753 829)	304 130 617
Interest received	6 006 870	5 727 447
Interest paid	(1 533 482)	(4 165)
Net cash generated from operating activities	(280 441)	309 853 899
Cash flows used in investing activities		
Additions to equipment, furniture and vehicles	(22 733 479)	(18 068 090)
Disposals of equipment, furniture and vehicles	3 987 172	-
Additions to Right of Use Asset	(13 409 313)	-
Disposals of Right of Use Asset	1 319 903	-
Net cash used in investing activities	(30 835 717)	(18 068 090)
Cash flows used in financing activities		
Lease repayments	(13 171 003)	(11 158 821)
Additions to Right of Use Liability	13 010 723	-
Net cash used in financing activities	(160 280)	(11 158 821)
Net increase / (decrease) in cash and cash equivalents	(31 276 438)	280 626 988
Cash and cash equivalents at beginning of the year	443 468 661	162 841 673
Cash and cash equivalents at end of the year	412 192 223	443 468 661

Anova Health Institute NPC
Summarised notes to the summarised financial statements for the year ended 30 September 2021

1. Basis of preparation
The summarised financial statements have been prepared in accordance with the framework concepts and the measurement and recognition requirements of International Financial Reporting Standards (IFRS) and its Interpretations adopted by the International Accounting Standards Board (IASB) in issue and effective for the entity at 30 September 2021 and the SAICA Financial Reporting Guides as issued by the Accounting Practices Committee and financial reporting pronouncements as issued by the Financial Reporting Standards Council, and also, at a minimum contain the information required by IAS 34 – Interim Financial Reporting and the Companies Act of South Africa, 2008. These summarised financial statements do not include all the information required for full annual financial statements and should be read in conjunction with the annual financial statements as at and for the year ended 30 September 2021.

These summarised financial statements have been prepared under the supervision of Linda McConnell (Chief Finance Officer) and were approved by the board of directors on 3 June 2022.

2. Accounting policies
The accounting policies adopted and methods of computation used in the preparation of the summarised financial statements are in accordance with IFRS and are consistent with those of the annual financial statements for the year ended 30 September 2020.

3. Events after the reporting period
No material facts or circumstances have occurred between the accounting date and the date of the annual financial statements.

4. Contingencies and commitments
There are no material contingencies or commitments that are required to be disclosed or provided for.

PUBLICATIONS

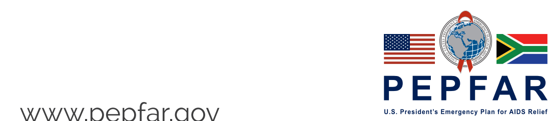
Authors	Title	Journal / Publisher
Nel J, Dlamini S, Meintjes G, Burton R, Black JM, **Davies N**, Hefer E, Maartens G, Mangena PM, Mathe MT, Moosa MY, Mulaudzi MB, Moorhouse M, Nash J, Nkonyane TC, Preiser W, Rassool MS, Stead D, van der Plas H, van Vuuren C, Venter WDF, Woods JF	Southern African HIV Clinicians Society guidelines for antiretroviral therapy in adults: 2020 update	South Afr J HIV Med. 2020;21(1):1115
Chen YH, Gilmore HJ, **Maleke K**, Lane T, **Zuma N, Radebe O, Manyuchi AE, McIntyre JA**, Lippman SA	Increases in HIV status disclosure and sexual communication between South African men who have sex with men and their partners following use of HIV self-testing kits	AIDS Care. 2021;33(10):1262-9
Sandfort TG, E LH, Marais A, Guo X, Sugarman J, Chen YQ, Cummings V, Dadabhai S, Dominguez K, Panchia R, Schnabel D, Zulu F, Reynolds D, **Radebe O**, Mbeda C, Kamba D, Kanyemba B, Ogendo A, Stirratt M, Chege W, Lucas J, Fawzy M, McKinstry LA, Eshleman SH	The feasibility of recruiting and retaining men who have sex with men and transgender women in a multinational prospective HIV prevention research cohort study in sub-Saharan Africa (HPTN 075)	J Int AIDS Soc. 2020;23 Suppl 6:e25600
Daniels J, **Struthers H**, Soler J, Ricco E, Blackmon J, Teklehaimanot S, **McIntyre J,** Coates T	Building self-advocacy in HIV care: the use of role-play to examine healthcare access for HIV-positive MSM in rural South Africa	Glob Health Promot. 2020:1757975920974008. https://doi.org/10.1177%2F1757975920974008
Lilian RR, Davies N, Gilbert L, McIntyre JA, Struthers HE, Rees K	CD4 testing after initiation of antiretroviral therapy: Analysis of routine data from the South African HIV programme	South Afr J HIV Med. 2020;21(1):1165
Gray, G., Van der Heever, A, Madhi, S.S., **McIntyre, J.,** Kana, B., Stevens, W., Sanne, I., Richards, G., Abdullah, F., Mendelson, M., Dasoo, A., Nel, J., Wulfsohn, A., Blunberg, L. Venter, F	The Scientists' Collective 10-point proposal for equitable and timeous access to COVID-19 vaccine in South Africa	S Afr Med J. Published online 14 December 2020. https:// doi.org/10.7196/ SAMJ.2021. v111i2.15498
Mapanga W, Norris SA, Chen WC, Blanchard C, Graham A, Baldwin-Ragaven L, **Boyles T,** Donde B, Greef L, Huddle K, Khumalo B, Leepile E, Lubuzo B, Makhutle R, Mayet Y, Tsitsi M, Mistri P, Mmoledi K, Ratshikana-Moloko M, Morer R, Pretorius L, Punwasi J, Richards GA, Ruff P, Shabalala D, Sibadela M, Soma N, Wong M, Joffe M	Consensus study on the health system and patient-related barriers for lung cancer management in South Africa	PLoS One. 2021;16(2):e0246716
Peters RPH; Maduna L; Kock MM; **McIntyre JA**; Klausner JD; Medina-Marino A	Single-Dose Azithromycin for Genital Lymphogranuloma Venereum Biovar Chlamydia trachomatis Infection in HIV-Infected Women in South Africa: An Observational Study	Sexually Transmitted Diseases. 48(2):e15-e17, February 2021

Authors	Title	Journal / Publisher
Peters RP, Feucht UD, de Vos L, Ngwepe P, **McIntyre JA,** Klausner JD, Medina-Marino A	Mother-to-child transmission of Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis in HIV-infected pregnant women in South Africa	Int J STD AIDS. 2021;32(9):799-805
van Liere G, **Lilian R, Dunlop J, Tait C, Rees K, Mabitsi M, Ranoto L, Struthers HE**, **McIntyre JA**, Peters RPH	High rate of loss to follow-up and virological non-suppression in HIV-infected children on antiretroviral therapy highlights the need to improve quality of care in South Africa	Epidemiol Infect. 2021;149:e88
Chetty T, Ramokolo V, **Rees K**, Kredo T, Balakrishna Y, Mathews C, Siegfried N	Rapid review of the effects of cloth and medical masks for preventing transmission of SARSCoV-2 in community and household settings	S Afr Med J. 2021; 111(3):227-233
Rees K, Dunlop JL, Patel-Abrahams S, Struthers H, McIntyre JA	Primary healthcare workers at risk during COVID-19: An analysis of infections in HIV service providers in five districts of South Africa	S Afr Med J. 2021;111(4):309-14
Mubekapi-Musadaidzwa C, Wademan D, Peton N, Hendricks P, Carolus G, Mbaezue R, Kelley KF, Kruger J, Jennings K, **Grobbelaar N**, Louis F, Beyers N, Ayles H, Fidler S, Hayes R, Bock P, Hoddinott G	Motivating people living with HIV to initiate antiretroviral treatment outside national guidelines in three clinics in the HPTN 071 (PopART) trial, South Africa	Afr J AIDS Res. 2021;20(1):32-41.
Myburgh H, Reynolds L, Hoddinott G, van Aswegen D, **Grobbelaar N**, Gunst C, Jennings K, Kruger J, Louis F, Mubekapi-Musadaidzwa C, Viljoen L, Wademan D, Bock P	Implementing 'universal' access to antiretroviral treatment in South Africa: a scoping review on research priorities	Health Policy Plan. 2021;36(6):923-38
Jobson GA, Railton J, Mutasa B, Ranoto L, Maluleke C, McIntyre J, Struthers H, Peters R	Indicator-focussed technical assistance in South Africa's HIV programme: A stepped-wedge evaluation	South Afr J HIV Med. 2021;22(1):1229
Kariuki SM, Selhorst P, Abrahams MR, **Rebe K**, Williamson C, Dorfman JR	Neutralization sensitivity of genital tract HIV-1: shift in selective milieu shapes the population available to transmit	AIDS. 2021;35(9):1365-73
Bisnauth MA, **Davies N, Monareng S, Buthelezi F, Struthers H, McIntyre J, Rees K**	Why do patients interrupt and return to antiretroviral therapy? Retention in HIV care from the patient's perspective in Johannesburg, South Africa	PLoS One. 2021;16(9):e0256540

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

www.pepfar.gov	
www.usaid.gov	
www.theglobalfund.org	
www.orangebabies.org.za	
www.macaidsfund.org	
www.impaactnetwork.org	
www.nih.gov NACOSA	
FHI360	

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

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APACE	Accelerating Program Achievements to Control the Epidemic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community-Based Organisation
CoJ	City of Johannesburg
CoCT	City of Cape Town
COVID-19	Coronavirus Disease 2019
DoH	Department of Health
DSD	Direct Service Delivery
EAP	Employee Assistance Programme
GRI	Global Reporting Initiative
HIV	Human Immunodeficiency Virus
IMPAACT	International Maternal Paediatric Adolescents AIDS Clinical Trials Group
MSM	Men Who Have Sex with Men
NACOSA	Networking HIV & Aids Community Of Southern Africa
NCD	Non-Communicable Disease
NDoH	National Department of Health
NGO	Non-Governmental Organisation
OST	Opium Substitute Therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	Pre-Exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis
TLD	Tenofovir, Lamivudine and Dolutegravir combination
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
YCC	Youth Care Club

GRI INDEX

Global Reporting Initiative (GRI) GRI Standards Content Index Anova Health Institute: 2018-19			
GENERAL STANDARD DISCLOSURES			
Strategy and Analysis			
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. 9, 11	The Chairman's report can be found on p. 9. The Chief Executive Officer's report can be found on p. 11
GRI 102-15	Description of key impacts, risks, and opportunities	p. 14	Risks and opportunities are discussed under "Our strategy"
		pp. 22-39	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	pp. 6-7 pp. 22-39	Anova's primary activities are described on pp. 6-7. Our programme activities are described in pp. 22-39
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. 6	Anova operated in South Africa and Zambia in this reporting period
GRI 102-5	Nature of ownership and legal form	p. 4	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. 6-7, 12-13	The description on pp. 6-7 and the list of stakeholders on p. 13 illustrate the geographic breakdown and beneficiaries served
GRI 102-7	Scale of the organisation	p. 7 p. 58 pp. 64-65	The scale of the organisation has been depicted by the number of beneficiaries served (p. 7), total staff (p. 58) and financial statements (pp. 64-65)

GRI 102-8	Employees – employment contract, gender, region	pp. 58-59	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. 46	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, 68-69	The organisations with which Anova partners, including local advocacy organisations are listed in our "stakeholders" (p.13) and under the section "partners" (pp. 68-69)

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	pp. 4-5	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. 4-5, 12-13, 14	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 xx.

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. 12-13	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. 4	Our reports are annual, and reflect our financial year, October 1, 2020 to September 30, 2021
GRI 102-51	Date of most recent previous report (if any)	GRI table	A report is produced annually. The last report was published in October 2021
GRI 102-52	Reporting cycle (such as annual, biennial)	p. 5	Annual
GRI 102-53	Contact point for questions regarding the report or its contents	p. 74	Anova CEO, Helen Struthers, can be contacted for any questions relating to this report. The email address is struthers@anovahealth.co.za
GRI 102-54	GRI content index for 'in accordance' - Core	GRI Index	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

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

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