**INPUT**

- Mobile supervision team (clinician and counsellor)
- Permanent presence of counsellors in most clinics
- Resources for trainings and meetings (Transport, incentives, etc.)
- Lobby MoH to accept the CAG model

**PROCESS**

- CAG eligibility criteria
- Rotation system for drug collection
- 6-monthly clinical consultation & CD4 control
- Flexible application of medical CAG eligibility criteria
- Group established CAG entry requirements
- Mutual adherence support
- Social control through ‘Code of conduct’
- CAG members participate in HIV related activities in clinics and community
- Often parallel patient flow for CAG members in clinics bypassing clinician
- Problems with group formation, rotation system and relationships in groups
- Counsellor key role to form and monitor groups

**OUTPUT**

- Better access to drugs
- Improved retention in care
- Creation of ‘Protective, environment’
- Empowerment of patients
- Improved quality of care provided that supervision is in place
- Decreased stigma
- Improved health seeking behaviour
- Better HIV awareness
- Risk to exclude most vulnerable target groups
- Risk of inequity towards patients not in CAG