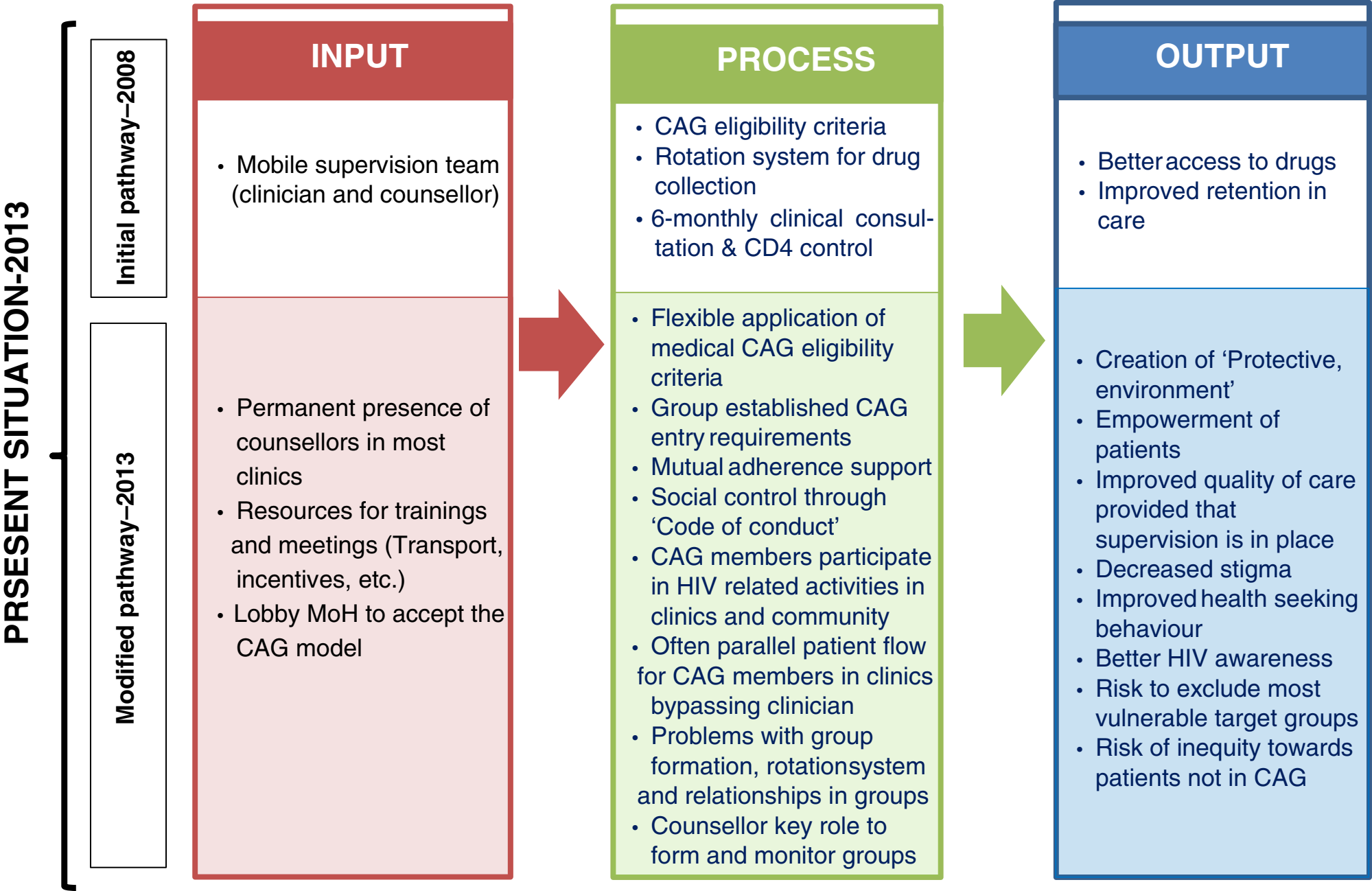
PRSENT SITUATION-2013
Initial pathway–2008
Modified pathway–2013
INPUT
• Mobile supervision team (clinician and counsellor)
• Permanent presence of counsellors in most clinics
• Resources for trainings and meetings (Transport, incentives, etc.)
• Lobby MoH to accept the CAG model
PROCESS
• CAG eligibility 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, rotationsystem 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