

CQUIN Capability Maturity Model for Integration of HIV **Services** into Routine Healthcare

CQUIN uses **services integration** to mean *integration at the point of care*. Integration of HIV prevention, testing, linkage, care and treatment services into routine healthcare settings typically means that some or all HIV services are provided by non-specialist healthcare workers in space shared with other programs, rather than in stand-alone HIV clinical services, pharmacies, and/or labs.¹

There are multiple models of integrated service delivery including integration of HIV into outpatient primary care departments (OPD/PHC) and integration of HIV and non-communicable disease services in the context of “chronic care clinics”. HIV services (including prevention, testing and linkage services) are also often integrated into Integrated Management of Maternal, Neonatal and Child Health (IMNCH), family planning, TB and primary care settings. Each model for recipients of care should have referral protocols for more specialized HIV services; these may be designed as hub-and-spoke referral systems or within-facility referral systems depending on the context.

It is important to note that **integration of services is a means to an end,² not an end in itself**. Not all countries will choose to integrate HIV services into outpatient, primary care, MNCH and other selected services, and the extent of integration is not in itself a reflection of overall HIV program maturity. Those countries that *do* prioritize integration are likely to design different models for different levels of the health system; thus, integrated services are likely to look different at primary, secondary, and tertiary health facilities. All countries are likely to retain some specialized HIV care and treatment services – for example, some services for people with advanced HIV disease are unlikely to be integrated into primary care settings.

Given this context, the capability maturity model for integration of HIV services is intended only for countries and contexts in which services integration has been prioritized, and describes the *maturity of integrated services*, not the maturity of a national HIV program.

Domain A: Policies	The country has decided to integrate HIV services into routine healthcare settings, ³ but existing national policies create obstacles to this initiative ⁴ AND These policy obstacles have not yet been addressed OR National policies have not yet been reviewed to ascertain if they may create obstacles		The country has decided to integrate HIV services into routine healthcare settings, but existing national policies create obstacles to this initiative AND Efforts are underway to update national policies to facilitate integration of HIV services into routine healthcare settings		The country has decided to integrate HIV services into routine healthcare settings, and existing national policies do not create obstacles OR Policies have been updated to facilitate integration of HIV services into routine healthcare settings

¹ This is distinct from *integration of non-HIV services into HIV programs*, which is a different initiative

² For example, objectives such as efficiency, sustainability, coverage and/or quality

³ For example, integration of HIV care and treatment services into public health facilities’ outpatient primary care departments or chronic care clinics instead of stand-alone ART clinics and/or community-based drop-in centers.

⁴ For example, policies that do not allow multi-month prescribing, multi-month dispensing, out-of-facility refills and/or fast-track refill appointments for HIV, NCDs, FP and other health conditions.

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<p>Domain B: National Integration Scale-up Plan</p>	No national integration scale-up plan for HIV services is in place and development has not begun	<p>A national integration scale-up plan for HIV services is in development, with discussions and meetings ongoing</p> <p>OR</p> <p>A national integration scale-up plan for HIV services is available in draft form but has not been finalized</p>	A national integration scale-up plan for HIV services has been finalized BUT does not detail all 12 strategic choices listed in the footnote ⁵	A national integration scale-up plan for HIV services that includes all the relevant strategic choices has been finalized, BUT is not yet being actively implemented and monitored	A national integration scale-up plan for HIV services that includes all the relevant strategic choices is being actively implemented and monitored
<p>Domain C: Scale-up of integration enablers</p>	<p>None of the following integration-specific enabling activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • prescribing and dispensing policies⁶ • in-service training • demand creation • community engagement • revised M&E strategies • quality management strategies 	<p>Implementation of 1 of the following integration-specific enabling activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • prescribing and dispensing policies • in-service training • demand creation • community engagement • revised M&E strategies • quality management strategies 	<p>Implementation of 2-3 of the following integration-specific enabling activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • prescribing and dispensing policies • in-service training • demand creation • community engagement • revised M&E strategies • quality management strategies 	<p>Implementation of 4 of the following integration-specific enabling activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • prescribing and dispensing policies • in-service training • demand creation • community engagement • revised M&E strategies • quality management strategies 	<p>Implementation of 5 of the following integration-specific enabling activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • prescribing and dispensing policies • in-service training • demand creation • community engagement • revised M&E strategies • quality management strategies
<p>Domain D: Meaningful Community Engagement</p>	Recipients of care are not involved in planning, implementation, or evaluation of integration	<p>Recipients of care are meaningfully engaged in one of the following domains:</p> <ol style="list-style-type: none"> 1. Planning/policy 2. Implementation 3. Evaluation 4. Financing 	<p>Recipients of care are meaningfully engaged in two to three of the following domains:</p> <ol style="list-style-type: none"> 1. Planning/policy 2. Implementation 3. Evaluation 4. Financing 	<p>Recipients of care are involved in all four of the following domains:</p> <ol style="list-style-type: none"> 1. Planning/policy 2. Implementation 3. Evaluation 4. Financing 	<p>The Ministry of Health provides a platform for ROC to present their CLM activities and findings, for example during TWGs or other related meetings</p> <p>AND</p> <p>Ministry of Health works together with ROC</p>

⁵ The national services-level integration plan should detail the following 12 strategic choices: 1. Which integration models are prioritized and why? 2. Which elements of differentiated service delivery for people established on treatment across HIV and other health conditions (or example multi-month scripting, out of facility refills, multi-month dispensing), will be retained? 3. What does success look like at each level of the health system and how will it be measured? 4. Where should each model be implemented (e.g., type of facility or community service delivery point)? 5. How will referrals to specialized HIV services work (eligibility criteria, referral protocols, documentation, tracking)? 6. Coverage targets (facility level); 7. Timeline for scale-up; 8. Funding source(s); 9. Community engagement and communication strategies; 10. Training plan, starting with integrating HIV into in-service training for TB, FP, IMNCH, reproductive health, and primary care; 11. Plan for updating M&E system; 12. Plan for updating QM system

⁶ As in Domain 1, policies that allow multi-month prescribing, multi-month dispensing, out-of-facility refills and/or fast-track refill appointments for HIV, NCDs, FP and other health conditions.

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	<p>strategies as defined in the footnotes below ^{7 8 9 10}</p> <p>OR</p> <p>There are insufficient data to determine the level of ROC engagement</p>				<p>organizations, through social contracting, to support their resource mobilization efforts</p> <p>AND</p> <p>There is evidence that CLM findings are used to adjust policies and integrated services at national level and all levels of implementation.</p> <p>OR</p> <p>The country team has assessed CE using the Community Engagement Toolkit within the last 12 months and scored dark green in $\geq 90\%$ of the policy domains, $\geq 90\%$ of the programmatic domains, and $\geq 90\%$ of the community domains</p>
<p>Domain E:</p> <p>Facility-level integration coverage</p>	<p>There are no facility-level integration coverage targets in the national integration scale up plan (or equivalent)</p> <p>OR</p> <p>There are insufficient data to determine facility-level integration coverage (the % of HF providing integrated HIV services)</p>	<p>Less than 25% of districts have met their facility-level integration coverage targets</p>	<p>25-49% of districts have met their facility-level integration targets</p>	<p>50-75% of districts have met their facility-level integration targets</p>	<p>More than 75% of districts have met their facility-level integration targets</p>
<p>Domain F:</p>	<p>National guidance does not specify that recipients of</p>	<p>National guidance specifies that recipients of care should</p>	<p>25-49% of districts have met their facility-level targets for</p>	<p>50-75% of districts have met their facility-level targets for</p>	<p>More than 75% of districts have met their facility-level</p>

⁷ Criteria for policy and planning: Recipients of care (ROC) are members of the national TWGs on HIV prevention, testing, linkage and treatment (or equivalent) and attended $\geq 75\%$ of TWG meetings

⁸ Criteria for implementation: ROC of care participate in integration-specific demand creation (e.g., as peer educators, counselors, etc.) at $\geq 50\%$ of HF providing integrated HIV services and/or ROC are engaged in service provision (e.g., counseling, adherence, support, navigation, education, screening) at $\geq 50\%$ of HF providing integrated HIV services

⁹ Criteria for evaluation: ROC are meaningfully engaged in evaluation of integrated HIV service delivery models, including participation in $\geq 50\%$ of meetings on M&E of integration and/or $\geq 50\%$ of integration impact assessment exercises

¹⁰ Criteria for Financing: Recipients of care participated in $> 75\%$ of funding application meetings for external funding (Global Fund, USG G2G, etc) and other domestic funding discussions.

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<p>One-stop shop laboratory services</p>	<p>care should receive “one stop shop” lab services, <i>i.e.</i>, samples for HIV-specific diagnostic and treatment monitoring collected at the same time and place as other (non-HIV) tests¹⁰</p> <p>OR</p> <p>There are no facility-level coverage targets for one-stop shop lab services in the national integration scale up plan (or equivalent)</p> <p>OR</p> <p>There are insufficient data to determine facility-level coverage of integrated lab services (the % of HF providing one-stop shop lab services for recipients of care)</p>	<p>receive “one stop shop” lab services,</p> <p>AND</p> <p>Less than 25% of districts have met their facility-level coverage targets for provision of one-stop shop lab services</p>	<p>provision of one-stop shop lab services</p>	<p>provision of one-stop shop lab services</p>	<p>targets for provision of one-stop shop lab services</p>
<p>Domain G: One-stop shop pharmacy services</p>	<p>National guidance does not specify that recipients of care should receive “one stop shop” pharmacy services, <i>i.e.</i>, HIV-specific medications are dispensed at the same time and place as non-HIV medications</p> <p>OR</p> <p>There are no facility-level coverage targets for one-stop shop pharmacy services in the national integration scale up plan (or equivalent)</p> <p>OR</p>	<p>National guidance specifies that recipients of care should receive “one stop shop” pharmacy services,</p> <p>AND</p> <p>Less than 25% of districts have met their facility-level coverage targets for provision of one-stop shop pharmacy services</p>	<p>25-49% of districts have met their facility-level targets for provision of one-stop shop pharmacy services</p>	<p>50-75% of districts have met their facility-level targets for provision of one-stop shop pharmacy services</p>	<p>More than 75% of districts have met their facility-level targets for provision of one-stop shop pharmacy services</p>

¹⁰ Tests should include both routine laboratory assays and point-of-care (POC) diagnostics (e.g., HIV rapid tests, Malaria RDTs, Pregnancy test), with POC tracked by the lab for completeness. For example, an individual with HIV and diabetes should have their viral load, NCD monitoring (blood glucose, HbA1c, lipid profile, liver function tests and creatinine tests) collected at the same time/place

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	There are insufficient data to determine facility-level coverage of integrated pharmacy services (the % of HF providing one-stop shop pharmacy services for recipients of care)				
Domain H: Linkage to prioritized DSD models ¹¹	National policies and guidance for differentiated service delivery (DSD) have not been updated to align with the re-prioritization of service delivery required by reduced funding envelopes	National DSD policies have been updated to align with re-prioritization decisions, and some DSD models are being discontinued in some or all settings ¹² BUT No national operational guidance has been developed to support people receiving services in discontinued models to shift to alternative models of care ¹³	National operational guidance has been developed to support people receiving HIV services in discontinued models to shift to alternative models BUT The country does not have data from the past year to describe linkage rates (e.g., the % of people enrolled in discontinued models who successfully link to alternative models) OR Linkage rate data from the past year are available but < 75% of people in discontinued models successfully link to alternative models	National operational guidance has been developed to support people receiving HIV services in discontinued models to shift to alternative models AND Linkage rate data from the past year are available AND ≥ 75% of people in discontinued models successfully linked to alternative models	Criteria for the light green stage are met AND ≥ 75% of people in discontinued models successfully linked to alternative models AND The country can disaggregate retention rates for people shifting from discontinued models vs. people whose models were not discontinued ¹⁴ AND Retention rates for people shifting from discontinued models are non-inferior to rates for people whose DSD models were not discontinued
Domain I: AHD 1: Operational Guidance and Scale up	The country has decided to integrate AHD services into routine healthcare settings, but national integration guidance documents ¹⁵ do not exist	Updated national operational guidance for integration of AHD services into routine healthcare is in development,	Updated national guidance documents provide detailed implementation guidance for integration of AHD services into routine healthcare and	Updated national guidance documents provide detailed and specific implementation guidance for integration of	Updated national guidance documents provide detailed and specific implementation guidance for integration of

¹¹ Skip this domain if no changes are being made to differentiated treatment services

¹² For example, some countries are discontinuing some DART models entirely (e.g., community-based ART dispensing, drop-in-centers for KP, 6MMD) while others are limiting some DART models to specific settings (e.g., tertiary hospitals, urban settings, settings with high numbers of KP, etc.)

¹³ For example, operational guidance, SOPs and tools re: referral processes and documentation, client education/information, and M&E of linkage to new models

¹⁴ This could be using routinely-collected patient-level data, data from a quality assessment project, or other ad hoc data collection

¹⁵ "Guidance documents" in this context may include national policies, guidelines, operational manuals, and/or standard operating protocols.

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	<p>OR</p> <p>National AHD integration guidance documents exist, but do not specify all the relevant strategic choices related to AHD integration listed in the footnote¹⁶</p> <p>OR</p> <p>National AHD integration guidance documents exist and specify all the relevant strategic choices but have not been updated to align with the re-prioritization of service delivery required by reduced funding envelopes</p>	<p>with discussions and meetings ongoing</p> <p>OR</p> <p>Updated national operational guidance for integration of AHD services into routine healthcare is available in draft form but has not been finalized</p>	<p>address all the strategic choices listed in the footnote¹³</p> <p>BUT</p> <p>Implementation of AHD integration activities has not yet begun</p> <p>AND</p> <p>Coverage targets are either off track or absent</p>	<p>AHD services into routine healthcare</p> <p>AND</p> <p>Address all the strategic choices listed in the footnote</p> <p>AND</p> <p>Implementation of 1-2 of the following AHD integration-specific activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • Development / Re-mapping of AHD hub-and-spoke referral systems • Provider training • Updated M&E system • Updated QM strategies 	<p>AHD services into routine healthcare</p> <p>AND</p> <p>Address all the strategic choices listed in the footnote</p> <p>AND</p> <p>Implementation of 3-4 of the following AHD integration-specific activities is (or is on track to be) completed by the specified timeline:</p> <ul style="list-style-type: none"> • Development / Re-mapping of AHD hub-and-spoke referral systems • Provider training • Updated M&E system • Updated QM strategies
<p>Domain J:</p> <p>AHD 2:</p> <p>Coverage and Quality</p>	<p>Less than 25% of HF providing ART offer the minimum AHD package of care, with operational referral pathways for complex care</p>	<p>25-49% of HF providing ART offer the minimum AHD package of care, with operational referral pathways for complex care</p>	<p>At least 50% of HF providing ART offer the minimum AHD package of care, with operational referral pathways for complex care</p>	<p>In addition to meeting the criteria for the yellow stage routine assessments of AHD service quality have been conducted in the past year</p> <p>BUT</p> <p>The country cannot disaggregate AHD data¹⁷ for HF providing integrated services</p> <p>OR</p>	<p>In addition to meeting the criteria for the yellow stage, the country can disaggregate AHD data for HF providing integrated services</p> <p>AND</p> <p>Routine assessments of AHD service quality have been conducted in the past year</p> <p>AND</p> <p>The quality of AHD services at HF providing integrated</p>

¹⁶ Guidance regarding integration of AHD services should specify all of the following 10 strategic choices: (1) how AHD identification should take place (CD4 screening and/or WHO clinical staging); (2) where/in what settings AHD identification should take place; (3) a “minimum package” of AHD services (e.g., a nationally agreed upon combination of screening, diagnostic and management services to support ROC with AHD; (4a) clearly defined criteria for where each element (diagnosis, screening, prophylaxis, management of OIs) of the AHD minimum package should be provided; (4b) clearly defined criteria for who can perform each element (diagnosis, screening, prophylaxis, OI management of the AHD minimum package); (5) Clearly mapped out referral strategies (hub-and-spoke systems); (6) Coverage targets (e.g., for the percentage of ART sites offering the minimum package of ART care with operational referral pathways for complex care); (7) Timeline for scale-up of integrated AHD services; (8) Training plan for integrated AHD services; (9) Plan for updating M&E system; (10) Plan for updating QM system

¹⁷ For example, data from the updated M&E and QM systems described in the AHD1 domain

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				The country can disaggregate data but the quality of AHD services at HF providing integrated services is inferior to the quality at other HF	services is non-inferior to the quality at other HF
<p>Domain K: KP 1: Quality</p>	<p>There is no documented national strategy¹⁸ to ensure KP attending integrated services receive KP-friendly/KP-competent care</p> <p>OR</p> <p>A national strategy exists but has not been updated to account for service delivery changes required by decreased funding of KP services</p> <p>OR</p> <p>An updated national strategy exists or is in development, but implementation of the strategy has not begun</p>	<p>There is an updated documented national strategy to ensure KP attending integrated services receive KP-friendly/KP-competent care</p> <p>BUT</p> <p>There are no plans or resources to assess the quality of KP services in integrated settings using a structured service quality assessment (SQA) such as the CQUIN KP SQA tool</p>	<p>The national strategy to ensure KP attending integrated services receive KP-friendly/KP-competent care is being rolled out</p> <p>AND</p> <p>There are plans and resources to conduct routine SQA (at least annually) of KP services in integrated settings</p>	<p>The national strategy to ensure KP attending integrated services receive KP-friendly/KP-competent has been rolled out to $\geq 75\%$ of planned HF</p> <p>AND</p> <p>Routine assessments of KP service quality have been conducted in the past year</p> <p>BUT</p> <p>$< 50\%$ of HF assessing the quality of integrated KP services met national standards</p>	<p>The national strategy to ensure KP attending integrated services receive KP-friendly/KP-competent has been rolled out to $\geq 75\%$ of planned HF</p> <p>AND</p> <p>Routine assessments of KP service quality are being conducted</p> <p>AND</p> <p>$\geq 50\%$ of HF assessing the quality of integrated KP services met national standards</p>
<p>Domain L: KP 2: Coverage</p>	<p>National HIV guidelines do not define a minimum package of HIV services¹⁹ tailored for each of the country's priority KP groups (e.g., MSM, SW, PWID, TG)</p> <p>AND/OR</p> <p>There are no national coverage targets for KP (i.e., ART coverage targets for each priority KP group)</p>	<p>National HIV guidelines define a minimum package of HIV services for each priority KP group</p> <p>AND</p> <p>there are coverage targets for each KP group</p> <p>BUT</p>	<p>National HIV guidelines define a minimum package of HIV services for each priority KP group</p> <p>AND</p> <p>there are coverage targets for each KP group based on recent population size estimates</p> <p>AND</p>	<p>In addition to meeting the first three criteria for the yellow stage, 50-75% of coverage targets were met for every KP group in the past year</p>	<p>In addition to meeting the first three criteria for the yellow stage, over 75% of coverage targets were met for every KP group in the past year</p>

¹⁸ Strategy should include clear expectations on how KP should be treated when attending integrated services, defined components of what constitutes KP-friendly/KP-competent care and how they will be operationalized (e.g., necessary materials, training plans), clear enforcement procedures/processes and a HF coverage plan, based on epidemiological needs (e.g., tiered approach based on HF level, focus on areas with large numbers of key populations).

¹⁹By “minimum package” we mean the nationally agreed upon combination of screening, diagnostic and management services to support KP with HIV, adapted from existing global guidance on the package of care for each KP group.

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		<p>the targets are not based on recent population size estimates²⁰</p> <p>AND/OR</p> <p>the country does not monitor progress to targets at least annually</p>	<p>The country monitors progress towards national KP coverage targets at least annually</p> <p>BUT</p> <p>Coverage was <50% of coverage targets for at least one KP group in the past year</p>		
<p>Domain M: TB/HIV 1: TPT Quality</p>	<p>There is no national strategy, policy, guideline or SOP to ensure that PLHIV receiving ART at HF providing HIV services that are integrated into routine healthcare services (“integrated HIV services”) are receiving TPT as per national guidelines</p> <p>OR</p> <p>There is a national strategy, policy, guideline or SOP (as above) BUT There are no available data to determine the percentage of HF providing integrated HIV services and delivering TPT per national guidelines</p>	<p>National documents include</p> <ol style="list-style-type: none"> 1. implementation plans²¹ 2. operational guidance 3. quality standards <p>for providing TPT to recipients of care receiving ART at HF providing integrated HIV services</p> <p>BUT</p> <p>There is insufficient data to determine the percentage of HF providing integrated HIV services and delivering TPT per national guidelines</p>	<p>< 50% of HF providing integrated HIV services also provide TPT per national guidelines</p>	<p>50-75% of HF providing integrated HIV services also provide TPT per national guidelines</p>	<p>> 75% of HF providing integrated HIV services also provide TPT per national guidelines</p>

²⁰ Population size estimates include bio-behavioral surveys (BBS) and modeling studies. Recent is defined as a population size estimate conducted with the last 4 years.

²¹ For example, guidance regarding which clinicians should provide TPT, plans for training for staff newly tasked with TPT management, SOPs and tools to facilitate integration of TPT-related M&E

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<p>Domain N: TB/HIV 2: TPT Coverage</p>	<p>National HIV guidelines do not define a minimum package²² of TPT services for people living with HIV</p> <p>AND</p> <p>The country does not have data from the past year to describe TPT initiation amongst people newly enrolled on ART</p>	<p>National HIV guidelines define a minimum package for TPT for people living with HIV</p> <p>BUT</p> <p>The country has insufficient data from the past year to describe TPT initiation amongst people newly enrolled on ART</p>	<p>National HIV guidelines define a minimum package for TPT for people living with HIV</p> <p>AND</p> <p>The country has data from the past year to describe TPT initiation amongst people newly enrolled on ART</p> <p>BUT</p> <p>the country does not have data disaggregated for PLHIV enrolled on ART at HF providing HIV care and treatment services that are integrated into routine healthcare services or stand-alone services</p>	<p>National HIV guidelines define a minimum package for TPT for people living with HIV</p> <p>AND</p> <p>The country can disaggregate its data to describe TPT initiation for:</p> <ol style="list-style-type: none"> 1. People newly enrolled on ART at HF providing HIV care and treatment services that are integrated into routine healthcare services 2. People newly enrolled on ART at HF providing stand-alone HIV care and treatment services <p>BUT</p> <p>TPT initiation, disaggregated for people newly enrolled a HF is < 90% in one or both types of HF</p>	<p>The country can disaggregate its data to describe TPT initiation for:</p> <ol style="list-style-type: none"> 3. People newly enrolled on ART at HF providing HIV care and treatment services that are integrated into routine healthcare services 4. People newly enrolled on ART at HF providing stand-alone HIV care and treatment services <p>AND</p> <p>TPT initiation, disaggregated for people newly enrolled at both types of HF is $\geq 90\%$</p>
<p>Domain O: Quality of Integrated HIV Services</p>	<p>National quality standards for primary care/OPD do not include integrated HIV services</p> <p>AND/OR</p> <p>Services quality assessment (SQA) tools for primary care/OPD do not include integrated HIV services</p> <p>AND</p> <p>Neither is currently in development.</p>	<p>National primary care/OPD quality standards and an SQA tool include integrated HIV, but no evaluations of quality using the standards have been completed in the past 12 months.</p>	<p>The SQA tool has been used in the past year but fewer than 50% of facilities assessed met or exceeded national standards.</p>	<p>The SQA tool has been used to conduct at least one evaluation of integrated HIV service quality in the past 12 months, and $\geq 50\%$ of facilities assessed met or exceeded national quality standards, but the sample was NOT nationally representative.</p>	<p>The SQA tool has been used to conduct at least one evaluation of integrated HIV service quality using a <i>nationally representative sample</i> in the past 12 months, and more than $\geq 50\%$ of facilities assessed met or exceeded national quality standards.</p>

²²In this context, a “minimum package” of TPT services for people living with HIV would include: (1) eligibility criteria for TPT; (2) TPT regimen and dosing guidance; (3) recommendations for adherence monitoring and support; (4) operational guidance for providing TPT to recipients of care receiving HIV treatment integrated into routine healthcare services; and (5) recommendations for side effect/adverse event monitoring and support

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