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HvPI generates 2303 adverse transfusion reaction reports through its reporting system

Shardul Nautiyal, Mumbai, **Friday, July 24, 2015, 08:00 Hrs [IST]**

Taking forward the centralised programme of monitoring transfusion reactions, Haemovigilance Programme of India (HvPI) launched on December 10, 2012 by National Institute of Biologicals has till date reported 2303 adverse transfusion reaction reports.

Presently, 207 centres located in blood banks, medical colleges, government and private hospitals are enrolled under this programme. Data in transfusion reaction reporting form (TRRF) from various centres across the country enrolled under HvPI is being collected through a software, Haemo-Vigil indigenously developed by IT division of NIB.

Aimed at generating evidence based recommendations and advising CDSCO for safety related regulatory decisions, Dr Surinder Singh, director, NIB further explains that among the key attributes of the HvPI, the reporting system deployed is independent of any authority with NIB/Indian Pharmacopoeia Commission (IPC) being the co- ordinating centre between the reporters and regulators. Therefore, the other attributes of the system are that it is confidential, independent, offers expert analysis, is systems oriented and responsive.

He further says reports are evaluated by experts who understand the clinical circumstances and are trained to recognise underlying systems causes through a Haemovigilance Advisory Committee (HAC). Besides this, the identities of the patient, reporter and institution are never revealed to third party going by the clause for confidentiality.

As per the programme, traceability of events is done through proper documentation which in turn leads to effective recommendations to be accepted and acted upon and also by defining systematic documentation process.

HvPI, which was launched at the national level by NIB aims to identify trends in adverse reactions and events, thereby to form transfusion policy, target areas for improvement in practice, stimulate research, raise awareness of transfusion hazards, give an early warning of new complications to improve safety of transfusion for patients.

Such information is also key to introduce required changes in the applicable policies, improve standards, systems and processes, assist in the formulation of guidelines, and increase the safety and quality of the entire process from donation to transfusion. It is a boon for hospital deans and directors, major blood users among the clinicians and blood bank officers from all government, municipal and private hospitals, drug regulators, officials from other government and municipal agencies.