RWANDA FOOD AND DRUGS AUTHORITY	Department/Division/ Directorate	Food and Drugs Inspection and Safety Monitoring Department
Document Type: **Standard Operating Procedure**		Doc. Number : DIS/SOP/….
RWANDA FDA Rwanda Food and Drugs Authority	Title: **PROCEDURE FOR CONDUCTING INVESTGATION FOR SERIOUS/CLUSTER AEFI**	Revision Number : 0 Revision Date: : 23 February 2021 Effective Date : 01 March 2021 Review Due Date : 01 March 2023

RWANDA FOOD AND DRUGS AUTHORITY STANDARD OPERATING PROCEDURE (SOP) FOR CONDUCTING INVESTIGATION FOR SERIOUS /CLUSTER AEFI

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RWANDA FOOD AND DRUGS AUTHORITY	Department/Division/ Directorate	Drugs, Food Inspections and Compliance/ Pharmacovigilance and Safety Monitoring
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RWANDA FDA Rwanda Food and Drugs Authority	**Title**: PROCEDURE FOR CONDUCTING INVESTGATION FOR SERIOUS/CLUSTER AEFI	Revision Number : 18 March 2021 Revision Date: : 18 March 2021 Effective Date : 1 April 2021 Review Due Date : 01 March 2023

1. Purpose

To provide guidance for conducting investigation for serious and cluster adverse drug reaction (ADR) and Adverse events following Immunization (AEFI)

2. Scope

The SOP is applicable for the reported serious and cluster ADR and AEFI to Rwanda FDA

3. Responsibility

3.1 Division Manager for Pharmacovigilance and safety monitoring shall be responsible for coordinating and facilitating the assessment of aggregate reports.

3.2 The Pharmacovigilance specialists shall ensure that all aggregate reports are processed in accordance with this SOP.

4. Distribution

4.1 Director General

4.2 Heads of Department of Food and Drugs Inspection and Safety Monitoring

4.3 Division Manager of Pharmacovigilance & Safety Monitoring,

4.4 Pharmacovigilance and post market surveillance specialist

4.5 Quality assurance Analyst

5. Definitions of terms

ADR	Adverse Drug Reaction
AEFI	Adverse event following Immunization
NMRA	National Medicines Regulatory Authority
SOP	Standard Operating Procedures

Serious ADR/AEFI: Serious adverse reaction means an adverse reaction which results in death, is life-threatening, requires in-patient hospitalization or prolongation of existing hospitalization, results in persistent or significant disability or incapacity, or is a congenital anomaly/birth defect

Adverse drug reaction: A response to a medicine which is noxious and unintended, and which occurs at a dose normally used in human for prophylaxis, diagnosis or therapy of disease or for the modification of physiological function

Adverse event following Immunization: Any untoward medical occurrence which follows immunization and which does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable or unintended sign, abnormal laboratory finding, symptom or disease.

6. Procedures

6.1 Classifying serious AEFI

- ✔ The Pharmacovigilance specialist upon receipt, annotating and reviewing the received AEFI, they sort serious AFEI
- ✔ Serious AEFI are prioritized in analysis and additional data is requested to the reporter if necessary

6.2 Conducting investigations for serious AEFIs

- ✔ **The paharmacovigilance team and EPI team go to the field especially health facility and or community for further data collection using prescribed format**

6.2.1 Confirm information in AEFI report by interviewing health workers who attended to the patient and verifying information on report form obtaining any details missing from AEFI Report Form.

6.2.2 Collect data about the patient- check immunization history, obtain previous medical history, current illnesses or concomitant medication, prior history of similar reaction or other allergies, family history of similar events.

6.2.3 Collect data about the event- Clinical description of event, any relevant laboratory results about the AEFI and diagnosis of the event, treatment of the event, whether hospitalized, and outcome (e.g. recovered, ongoing problems, died etc.)

6.2.4 Collect data about the condition of other people who were vaccinated with same vaccine, whether there are other cases of the same condition and the vaccination status of these cases

6.2.5 Check the supply chain and storage conditions in general:

6.2.5.1 Refrigerator – what else is stored (note if similar containers stored next to vaccine vials which could be confused); whether vaccines/diluents stored with other drugs; whether any vials have lost their label;

6.2.5.2 Viability of the vaccine- Expiry date, VVM status;

6.2.5.3 Vaccine storage (including open vials), distribution, and disposal;

6.2.5.4 Do any open vials look contaminated?

6.2.5.5 Diluent storage and distribution.

6.2.6 Supply chain and storage conditions: About the suspected vaccine(s):

6.2.6.1 Storage of vaccine before it arrived at health facility, where it has come from higher up the cold chain e.g. sub-county depot. Check vaccine ledger;

6.2.6.2 Present storage condition, state of vaccine vial monitor, and temperature record of refrigerator. Check the record on of Fridge tag-2®

6.2.7 Observe and assess immunization service delivery:

6.2.7.1 Reconstitution (process and time kept). Ask if not able to observe;

6.2.7.2 Whether AD syringes are available and used;

6.2.7.3 Details of training in immunization practice, supervision and vaccinator(s)/health worker;

6.2.7.4 Health worker experience in immunization;

6.2.7.5 The aliquot number for multi dose vials;

6.2.7.6 Number of immunizations greater than normal?

6.2.8 Do a descriptive analysis (Time Place and Person): Who are the cases? Where did they come from? When did the event occur?

6.2.9 Formulate a working hypothesis: On the likely/possible cause(s) of the event. If working hypothesis indicates immunization -related errors, correct them

6.2.10 Test working hypothesis- Does descriptive analysis, other investigations (e.g. laboratory tests) support hypothesis?

7. Analysis of collected Information during Investigation

- ✔ After collection of enough information from the field, pharmacovigilance team submit all collected information to the national AEFI committee
- ✔ The national AEFI committee conduct thorough analysis of the submitted data
- ✔ The National AEFI committee conducts causality assessment to find out the real cause of the reported serious AEFI.

8. Conclude investigation:

8.1.1.1 Reach a conclusion on the possible cause.

8.1.1.2 Write a detailed report for submission to EPI

8.1.1.3 Take corrective action and recommend further action

8.1.1.4 Provide feedback to the caregiver and community

9. INVESTIGATING AEFI CLUSTERS

9.1 Cluster identification (i.e. cases with common characteristics) is done by gathering details (when and where) of vaccines administered including:

- detailed data on each patient;
- programme-related data (storage and handling, etc.); and
- Immunization practices and the relevant health workers' practices.

9.2 Collect and record information on Common exposures among the cases can be identified by reviewing:

- All data on vaccine(s) used (name, lot number, etc.);
- Data on other people in the area (also non-exposed); and
- Any potentially coincident factors in the community.

10. Interpretation of Results from AEFI clusters

10.1 If all cases received vaccines from the same health worker/facility and there are no other cases, an immunization error is likely.

10.2 If all cases received the same vaccine or lot, and there are no similar cases in the community, a problem with the vaccine or the respective lot is likely.

10.3 If the event is a known vaccine reaction but is found to occur at an increased rate, an immunization error or a vaccine problem are likely causes. Finally, if cases in the unvaccinated population are occurring at about the same rate/proportion as among the vaccinated from the same area in the same age group, the adverse event was probably coincidental