PERCEPTIONS OF RISK BEHAVIOUR AND BARRIERS TO REPRODUCTIVE HEALTH SERVICES AMONG YOUNG WOMEN FROM SLUMS IN MADURAI, TAMILNADU

H. JULIET SYLVIA

BACKGROUND

HIV infections and AIDS deaths are unevenly distributed geographically and the nature of the epidemics varies by region. More than 90 percent of people with HIV are living in the developing world. The impact of HIV/AIDS on women and girls has been particularly devastating. Women and girls now comprise 50 percent of those aged 15 and older living with HIV.1

The majority of new HIV infections occur among women of child-bearing age. In many regions, women represent a large percentage of people of 15 years and older living with HIV/AIDS. Globally, more than four-fifths of new HIV infections in women result from sex with her husband or primary partner.2

Young people in India cannot be categorised as a homogenous group and different sub-populations are exposed to different risk settings, depending on location. Social and cultural factors influence discussions on issues around sex and sexuality. Listening carefully to women’s voices and engaging closely with them is central to slowing down the epidemic.3,4

The World Health Organization recommends that more research on youth in developing countries is needed, particularly as the risk of becoming infected with HIV vary by contextual factors, such as cultural and religious beliefs, environmental risks and behaviors that vary by region.1

Among women in slums, the morbidity, mortality due to reproductive tract infections and sexually transmitted infections are relatively very high compared to other health problems. In general, women in slums remain unaware of their reproductive health problems such

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as menstruation, sexuality and family planning methods.5
This study was undertaken to:
a) explore the concept of risky sexual behavior; b) identify factors that may help young women to protect themselves from HIV infection and may cause young women to be more at risk for infection; c) help understand the issues and barriers in health seeking for reproductive and sexual problems.

**METHODOLOGY**
The study was conducted in the selected urban slums from 2008-2009. Madurai Corporation has 254 slums with a total of 79,606 families. The total population is 397,599 with 195,890 females and 201,709 males. Health services are rendered by 19 Urban Health Posts of Madurai Corporation. Some slums are closer to the city and some are away as a result the population is deprived of easily accessible health facilities. Each slum varies in population. The majority of the residents are coolies and sweepers. Most of them share common toilets with poor housing, over crowding, unhygienic environment, improper sanitation, inadequate infrastructure and have poor access to health care and health education. Girls get married at an early age, some of them do not complete schooling. Gambling, alcohol drug abuse by men and women, and gender based violence are commonly reported here.

For the present study, a total of six urban slums ranging from 2000 to 10,000 population were included. The participants having similar socio demographic and economic background were recruited in order to facilitate free discussion. Young women between 15-24 years of age and Tamil speaking were selected for the study. Informed parental consent and assent were obtained from all young women prior to study enrollment.

A total of 56 never married and 32 married women participated in this study. Most of the participants were born in the same slum, mostly residing for over a period of ten years. The educational level of single women was higher than that of married participants. Most of them were Hindus. Their fathers/husbands were mostly occupied as coolies, sweepers, auto drivers, painters, fruit vendors etc.

Eleven groups were stratified by marital status and FDGs (focus group discussions) were conducted (7 unmarried and 4 married). This was planned according to the proportion of married and unmarried young women in the total population. Each focus group consisted of 5-10 young women.

Participants were invited two days in advance. The place of discussion was selected by the participants preferably in one of their houses with no disturbance, neutral and more suitable for everyone.

Focus group guide questions were developed based on literature review, informal interviews with community members and from “Topic guide for individual interviews with young people” by WHO, Dept. of Reproductive Health Research.

The Investigator facilitated all group sessions which were tape recorded for transcription. Each session began by reading a description of the session, purpose, format, and ground rules. Each discussion lasted for one hour. The issues probed included: Sources of information, commencement of sex, risk groups, prevention, testing for HIV, barriers to reproductive sexual health services. Apart from core questions, additional prompts were done when necessary.

Data analysis involved transcription and translation of generated information based on the electronic recording and notes taken during the course of focus group discussion; reading through the translated transcriptions for identification
of major opinions and attitudes that were expressed by the groups in line with the objectives and thematic areas for the study. Development of coding categories was accomplished through reading the data for regularities and patterns. Master sheet was prepared that contained summarized information of the dominant and strongly held opinions, and identification of patterns and similarities in responses based on the words used and context. Findings were thus, generated and quotes have been used where necessary to provide supportive information for the various issues that emerged during the discussions. The findings are organized according to the central themes derived.

Limitations of the study
Since this is a qualitative study, these findings cannot be generalised. Group conforming behavior and prevailing social norms, may have influenced some respondents.

RESULTS

Source of information on HIV/AIDS
The majority of the discussants reported that they heard about HIV / AIDS through TV and books. Very few had not heard about it.

“I learnt in 9th Std text book.” “Heard from ICDS teacher” – (Kalavasal-NM)

“We have just heard on TV. We never used to talk about these matters. We share about movies with our friends.” (Kalavasal – M)

“Our parents never used to talk about matters like HIV……. mmm (laughing) Sex…. Etc, (Karumbalai – NM)

“Being shy and out of fear, our parents do not discuss about sex, HIV/AIDS”.

Silence……. Laughing, feeling shy. “We have learnt about menstrual cycle, HIV through School Teacher” (PT Colony - NM)

“Once they attain their puberty, they naturally come to know about bodily changes, relationships pregnancy etc…….”

“Some times we have talked with our friends” (Thideer Nagar-NM)

“Heard our guests talking” (Thideer Nagar-NM)

“With friends we can talk everything freely not with our parents” (Karumbalai – NM)

“Only elders used to talk. Before marriage we did not know anything about this. If we start talking our elders will get angry” (Karumbalai – M)

The above views expressed indicate that there are inhibitions in communication between elders, parents and children related to reproduction and sex.

There were variations in the responses of married and unmarried study participants in relation to the need for sexuality education in schools.

The quotes below indicate the majority of never married girls view on sexuality education:

“Yes it is necessary to include in schools”.

“It must start from 8th std/15 years onwards”.

“School is the right place for sex education”.

“But separately for boys & girls.”

Married girls expressed:

“Don’t you ask these questions to boys?”

“No, sex education is unnecessary. They will not pay attention of subject matters if it is taught”.

“Students will be spoiled sisters can discuss this.”

In addition, some women indicated the need for health awareness regarding HIV/AIDS and that programmes should especially target youth. During holidays special counselling and awareness programme on HIV/HIDS could be conducted in the slums itself for adolescent girls.
Regarding sexual active married young girls responded that:

“Sexual activity begins from 15 years... Now- a-days girls are worst in behavior. They get influenced by TV, we have watched this in bus stand”. (Kalavasal – M)

Whereas, the never married girls answered differentially:

“Not common in young girls...... only gents, married are involved in sexual activity (Thideer Nagar – NM)

When asked about predisposing factors that influence these risky behaviour, the responses centred on cinema, TV, friends...... Reflections on these could be captured from the following responses.

“TV only spoils” ....... (Kalavasal – M)

“Women also watch bad films. Through cigarette, Kanja taking, cell phone which everyone has boys get influenced”. (Kalavasal – NM)

“Cinema only induces” (Karumbalai – NM)

“Love affair is common, Boys are watching CDs. We go to theatre only with our parents. Our father will not allow us to watch movies only news”. (Thideer Nagar - NM)

“Some for money, Some are forced. we have heard in TV. It does not happen here” (Keeraithurai-M)

Both the groups acknowledged that mostly friends and media influence the young.

**Risk Perception**

The discussants in the focus groups were asked about their perception on risky behavior to HIV infection.

Some of the responses are:

“Married or unmarried, there is no difference” (Karumbalai – NM)

“HIV spreads through needles, sex, used utensils used by HIV infected. Some unknowingly have friendship. Some unknowingly of this sort” (Keeraithurai – NM)

“We don’t know the risks of risky behavior. Since we are not of that sort. We are married by 19. Only started having relationship after marriage” (Keeraithurai – M)

“If anyone is like that, they get AIDS, total future is affected ....... (Laughing among themselves) (Kalavasal – M)

“Their family is disturbed. Girl may get pregnant. After sometime parents may accept. We don’t think, there is anyone with HIV here. Such bad behaviour doesn’t happen. The boys are good. Our parents are also strict” (Thideer Nagar - M)

“Nobody respects, they may get HIV. Child may become an orphan”(Kalavasal – NM)

“.....Mind affected, hereditary diseases can be passed.... I get a dirty feeling when I hear AIDS. It cuts short the life of a person”(Karumbalai – NM)

“abortion, sexual abuse ...... may result.”

“Girls will not get HIV. Boys who smoke may get. Like chickunguniya it spreads by mosquito. If one has some other diseases they may get HIV also”(PT Colony, Indira Nagar - NM)

“Mother can transmit to child, husband to wife, using infected needles, getting blood transfusion are the ways. We are not sure whether through homosexual behaviour will get. If one masturbates, they may get depression not HIV. All ladies are not at risk only 10%” (Karumbalai – M)

These views highlight the perceptions of young women. Both groups have lot of misconceptions related to risky group. Girls feel that they are not all at risk. The married have trust in the marriage institution by justifying that women with a family cannot get infected with HIV. The effects of risky behavior are well acknowledged by most of them. Very few expressed all the established forms of transmission. They did not have full knowledge about HIV. Drug use, homosexual activity, was not mentioned although prevalent in slums where they live.
Risk Prevention
Participants were asked about measures to be adopted for preventing risk. Their views are given below:

“Husband only is responsible for sexual behavior. We trust our husbands Cu’T’ prevents HIV” (Kalvasal – M)

“That is the big Question in 12th can’t remember. Maybe preventing mosquito bites” (Thideer Nagar – NM)

“Be self controlled”(Kalavasal – NM)

“Safe injection, Blood Transfusion, Sex” (Karumbalai - NM)

“Must go to doctor & get medicine. Regular vaccination in childhood will prevent HIV” (PT Colony – NM)

“Everyone should know about HIV. Preventing multiple sex” (Thideer Nagar – NM)

Few participants remained skeptical. For example one girls said,

“I am not sure about the sex thing.”
“Disciplined life, one – one relationship”(Thideer Nagar – M)

“Go for blood test. If there are injections take that to prevent” Can we take pills for prevention”? (Keeraithurai – M)

The unmarried girls felt it is only the married who can be affected. The perception on the seriousness of HIV was low. Hence, risk prevention is not known to them. Some of the married women felt that, just like other diseases, HIV also can be prevented and cured by visiting a doctor.

Condom use and acceptability
The study probed whether discussants have heard and used condoms. The majority of never married young girls reported that they have not heard of condom. Some of them have heard on TV. Only very few have seen condoms being sold in key-clinic, petty shops and pharmacy etc. Whereas, the young married women had heard about condom. Some married women, however, had not heard of condoms. They perceived condom mainly as a tool for birth control not for preventing STI/HIV.

“We don’t use condoms, because there is no need for us. Our husbands are good. If we tell them they will doubt …” (Keeraithurai – M)

“I am having only one child. After next child I will undergo permanent sterilization” (Keeraithurai –M)

“…… it is dirty …………. Who uses? Are they not ashamed” (Kalavasal – M)

“Nobody has taught us how to use” (Thideer Nagar – M)

Testing for HIV/AIDS
None of the never married young girls had undergone testing for HIV. They perceived that it is not necessary for them since they do not engage in risky behavior. But married young girls were tested during pregnancy.

Very few of them listed the places for HIV testing. Many respondents felt that before marriage it is necessary to get a HIV free certificate. Sentiments echoed were:

“Before marriage more than horoscope matching, HIV testing should be done along with other tests. But if we ask our partners to do, elders will doubt if we have any disease”(Karumbalai - NM)

Reproductive sexual health services and barriers to access
Reasons expressed for not seeking health services for reproductive sexual problems were that;

“There are no lady doctors. Separate hospitals for youth to treat all these problems is necessary” (Karumbalai – NM)

“We don’t know about STDs” (Karumbalai - NM)
“We feel shy to tell these problems. It will cause problems within family” (Thideer Nagar – M)

“We take some home remedies for all reproductive health problems” (Keeraithurai – M)

“In Govt. Hospitals the services are not satisfactory, No privacy”(Kalavasal – M)

“Mostly private hospitals are good. But we don’t have lots of money to spend” (Thideer Nagar – NM)

Few of them in both the groups felt that treatment is necessary for all problems.

CONCLUSION
The study results reveal that the respondents are aware of spread of HIV. Knowledge on prevention of HIV is limited with few misconceptions regarding condom use. Study participants also acknowledged that their area is safe with not much sexual violence. Never married young girls perceived that older adults and outsiders are dangerous; not the youth residing in slums. The married young women were not aware of their risk status of husbands. They trusted them. All of them perceived that for economic reasons they should not indulge in high risk behavior.

In relation to sexual and reproductive health problems, the change that emerges from the findings is that, majority feel that treatment is needed. But have inhibitions in availing services. Inaccessibility to youth friendly services was expressed.

These findings add to the literature and have important research and applied implications. The results may serve as a spring board for subsequent quantitative research to determine if similar findings arise with the use of other methodologies and with the large sample. The results may be useful for guiding future interventions aimed at one or several environmental and psycho social factors. Thus, this study provides important information which may facilitate a reduction in HIV/STD transmission among youth.

RECOMMENDATIONS
In light of these findings, there is a need to target these youth with special services which are tailored to their age-specific needs. Programmes that address their situation with regard to the current HIV/AIDS status need not restrict to condom distribution but also educational support and life skills training for married and unmarried young women separately with special focus on self esteem, decision making and assertiveness. Detailed complete sex education programmes are needed compared to programme focusing only on reproduction. It is suggested to have continuous on-going programme to tackle the ground realities of the problem. Strengthening parental, community voluntary organizations role and health risk communications to adolescents is needed.

REFERENCES
# SUSPECTED ADVERSE DRUG REACTION REPORTING FORM

For VOLUNTARY reporting of Adverse Drug Reactions by healthcare professionals

## A. Patient Information

- **1. Patient initials:** 
- **2. Age at time of Event or date of birth:** 
- **3. Sex:** M F 
- **4. Weight:** Kgs 

## B. Suspected Adverse Reaction

- **5. Date of reaction stated (dd/mm/yyyy):** 
- **6. Date of recovery (dd/mm/yyyy):** 
- **7. Describe reaction or problem:** 

## C. Suspected medication(s)

<table>
<thead>
<tr>
<th>S.No</th>
<th>II. Name (brand and/or generic name)</th>
<th>Manufacturer [if known]</th>
<th>Batch No./Lot No. [if known]</th>
<th>Exp. Date [if known]</th>
<th>Dose used</th>
<th>Route used</th>
<th>Frequency</th>
<th>Therapy dates [if known given duration]</th>
<th>Reason for use of prescribed for</th>
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</table>

## D. Suspected medication(s)

- **9. Reaction abated after drug stopped or dose reduced:** 
  - Yes 
  - No 
  - Unknown 
  - NA 
  - Reduced dose 

- **10. Reaction reappeared after reintroduction:** 
  - Yes 
  - No 
  - Unknown 
  - NA 
  - If reintroduced dose 

## D. Reporter (see confidentiality section in first page)

16. **Name and Professional Address:** 

   - **Pin code:** 
   - **E-mail:** 
   - **Tel. No. [with STD code]:** 
   - **Occupation:** 

17. **Causality Assessment:** 

18. **Date of this report (dd/mm/yyyy):**
ADVICE ABOUT REPORTING

- Report adverse experiences with medications
- Report serious adverse reactions. A reaction is serious when the patient outcome is:
  - death
  - life-threatening (real risk of dying)
  - hospitalization (initial or prolonged)
  - disability (significant, persistent or permanent)
  - congenital anomaly
  - required intervention to prevent permanent impairment or damage

- Report even if:
  - You’re not certain the product caused adverse reaction
  - You don’t have all the details, however, point nos. 1, 5, 7, 8, 11, 15, 16 & 18 (see reverse) are essentially required.

- Who can report:
  - Any health care professional (Doctors including Dentists, Nurses and Pharmacists)

- Where to report:
  - Please return the completed form to the nearest Adverse drug reaction Monitoring Centre (AMC) or to National Coordinating Centre
  - A list of nationwide AMC’s is available at: http://cdsco.nic.in/pharmacovigilance.htm

- What happens to the submitted information:
  - Information provided in this form is handled in strict confidence. The causality assessment is carried out at Adverse Drug Reaction Monitoring Centres (AMCs) by using WHO-UMC scale. The analyzed forms are forwarded to the National Coordinating Centre through the ADR database. Finally the data is analyzed and forwarded to the Global Pharmacovigilance Database managed by WHO Uppsala Monitoring Center in Sweden.
  - The reports are periodically reviewed by the National Coordinating Centre (PvPI). The information generated on the basis of these reports helps in continuous assessment of the benefit-risk ratio of medicines.
  - The information is submitted to the Steering Committee of PvPI constituted by the Ministry of Health and Family Welfare. The Committee is entrusted with the responsibility to review the data and suggest any interventions that may be required.

Suspected Adverse Drug Reaction Reporting Form
For VOLUNTARY reporting of suspected adverse drug reactions by health care professionals

Central Drugs Standard Control Organization
Directorate General of Health Services,
Ministry of Health & Family Welfare, Government of India
FDA Shaven, ITO Kothi Road, New Delhi – 110002
www.cdsco.nic.in

Pharmacovigilance Programme of India for Assuring Drug Safety

Pharmacovigilance Programme of India (PvPI)
National Coordinating Centre,
Indian Pharmacopoeia Commission
Ministry of Health & Family Welfare,
Govt. of India
Sector-23, Raj Nagar, Ghaziabad-201 002.Tel:0120-2783400, 2783401, 2783392. FAX: 0120-2783311
E.mail: ioclav@vsnl.net

Confidentiality: The patient’s identity is held in strict confidence and protected to the fullest extent. Programme staff is not expected to and will not disclose the reporter’s identity in response to a request from the public. Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.
**Transfusion Reaction Reporting Form (TRRF) for Blood & Blood Products**

Indian Pharmacopoeia Commission – National Institute of Biologicals
Ministry of Health & Family Welfare – Govt. of India
HAEMOVIGILANCE
(Pharmacovigilance Programme of India)

For reporting of Transfusion Reactions by Healthcare Professionals

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**A) PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient Initials*</th>
<th>DOB/ Age in years*</th>
<th>Blood Group*</th>
<th>Diagnosis</th>
<th>Hospital Code No*</th>
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<tr>
<th>Hospital Admission No.</th>
<th>Sex</th>
<th>Date &amp; Time of Transfusion</th>
<th>Date &amp; Time of reaction</th>
<th>Date &amp; Time of recovery</th>
</tr>
</thead>
</table>

**B) TRANSFUSION PRODUCT DETAILS**

<table>
<thead>
<tr>
<th>Components</th>
<th>Select Components</th>
<th>Unit Number</th>
<th>Manufacturer</th>
<th>Batch Number</th>
<th>Expiry Date</th>
<th>Indications</th>
<th>1st time / Repeat Transfusion (No. of Repeats)</th>
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<tbody>
<tr>
<td>Whole Blood</td>
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<td>Red Blood Cells</td>
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<td>Platelets Apheresis</td>
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<td>Platelets Pool/ RDP</td>
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<td>Cryoprecipitate</td>
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<td>Any other</td>
<td>Blood Products (Please Specify)</td>
<td>Manufacturer</td>
<td>Batch Number</td>
<td>Expiry Date</td>
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**C) NATURE OF ADVERSE REACTIONS**

<table>
<thead>
<tr>
<th>Reactions</th>
<th>Please Tick (x)</th>
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<tbody>
<tr>
<td>1</td>
<td>Immunological Haemolysis due to ABO Incompatibility</td>
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<tr>
<td>2</td>
<td>Immunological Haemolysis due to other allo-antibodies</td>
</tr>
<tr>
<td>3</td>
<td>Non Immunological Haemolysis</td>
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<tr>
<td>4</td>
<td>Transfusion Transmitted Bacterial Infection</td>
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<tr>
<td>5</td>
<td>Anaphylaxis / Hypersensitivity</td>
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<td>6</td>
<td>Transfusion Related Acute Lung Injury (TRALI)</td>
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<td>7</td>
<td>Transfusion Transmitted Viral Infection (HBV)</td>
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<td>8</td>
<td>Transfusion Transmitted Viral Infection (HCV)</td>
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<td>9</td>
<td>Transfusion Transmitted Viral Infection (HIV-1/2)</td>
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<td>10</td>
<td>Transfusion Transmitted Viral Infection, other (Specify)</td>
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<td>11</td>
<td>Transfusion Transmitted Parasitic Infection (Malaria)</td>
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<td>12</td>
<td>Transfusion Transmitted Parasitic Infection, other (Specify)</td>
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<td>13</td>
<td>Post Transfusion Purpura</td>
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<td>14</td>
<td>Transfusion Associated Graft versus Host Disease (TAgvHD)</td>
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<tr>
<td>15</td>
<td>Febrile Non-Haemolytic Reactions (FNHTR)</td>
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<tr>
<td>16</td>
<td>Transfusion Associated Dyspnea (TAD)</td>
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<td>17</td>
<td>Transfusion Associated Circulatory Overload (TACO)</td>
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<tr>
<td>18</td>
<td>Uncategorized Unintended Responses</td>
</tr>
<tr>
<td>19</td>
<td>Other Reaction(s)</td>
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</tbody>
</table>

**D) OUTCOMES OF THE ADVERSE REACTIONS**

- Death following the adverse reactions
- Recovered
- Recovered with sequelae
- Permanently disabled
- Unknown

**E) REPORTER**

Name and professional Address: ____________________________

Pin Code: ______________________ Email: ______________________

Tel No. (with STD code): ______________________

**F) CAUSALITY ASSESSMENT**

Date of this report (DD/MM/YYYY)

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The Journal of Family Welfare
ADVICE ABOUT REPORTING

- Report adverse experiences with Blood Transfusion or Blood Products Administration.

- Who Can Report?
  - Any health care professional (Doctors including Dentists, Nurses and Pharmacists)

- Where to Report?
  - Please return the completed form to the nearest Medical College under Haemovigilance Programme or to NIB National Coordinating Centre-Haemovigilance.

- A list of nationwide Medical Colleges under haemovigilance programme is available at: http://www.nib.gov.in

- What happens to the submitted information:
  - The causality assessment is carried out at Medical Colleges under Haemovigilance Programme.

  - The information collected in Transfusion Reaction Reporting Form (TRRF) will be forwarded to National Coordinating Centre-Haemovigilance NIB, through software (Haemo-Vigil) developed in house by NIB’s IT division. This data will be collated & analyzed to identify trends, recommend best practices and interventions required to improve patient care & safety.

  - These recommendations will be forwarded to PvPI National Coordinating Centre IPC for onward transmission to Drugs Controller General (India), Central Drugs Standard Control Organization.

  - These recommendations will be used to formulate safety related regulatory decisions on Blood & Blood Products Transfusion which will be communicated to various stakeholders.

  - The information is submitted to the Advisory Committee of Haemovigilance Programme constituted by the Ministry of Health and Family Welfare. The Committee is entrusted with the responsibility to review the data and suggest any interventions that may be required.

TRANSFUSION REACTION REPORTING FORM (TRRF)

For VOLUNTARY reporting of Transfusion Reactions by health care professionals.

National Institute of Biologicals,
National Coordinating Centre-Haemovigilance, Noida
Directorate General of Health Services,
Ministry of Health & Family Welfare, Government of India,
A-32, Sector-62, Noida
http://www.nib.gov.in

Haemovigilance Programme of India
for Assuring Patient Safety
And
Promote Public Health

Confidentiality: The patient’s identity is held in strict confidence and protected to the fullest extent. Programme staff is not expected to and will not disclose the reporter’s identity in response to a request from the public.

Submission of a report does not constitute an admission that medical personnel or manufacturer or the product caused or contributed to the reaction.

TRRF can be downloaded from the websites:

- http://www.nib.gov.in
- http://www.ipc.gov.in
- http://www.cdsco.nic.in