Chapter II : Initial Protocol Review and Approval	Document Code: **IRB-SOP-1120-IPR-002-06**	
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Authored by:	MMC SOP Team (adapted from the DOH SOP)
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***REVIEW: This Standard Operating Procedure is reviewed every 3 years or earlier as indicated.**

2.1 Protocol Submission

2.1.1 Purpose

To describe the initial review procedures of the Makati Medical Center Institutional Review Board (MMC IRB) from the time that the MMC IRB receives the protocol and related documents until the approval letter is sent by the MMC IRB to the Principal Investigator (PI).

2.1.2 Scope

The MMC IRB accepts the protocols for review for researches done in Makati Medical Center (MMC) and protocols done by Makati Medical Center active and associate active staff, house staff in areas outside the hospital premises.

2.1.3 Responsibility

The MMC IRB Secretariat manages all protocol submissions to the MMC IRB. It covers the actions to be done from the time of submission to the filing of the original protocol package in the Active Study File cabinet and the preparation of copies of the documents for distribution to the reviewers.

2.1.4 Process Flow/Steps

NO	ACTIVITY	RESPONSIBILITY
1	Receive the initial protocol package for review and check the completeness of the document requirements **(Form 2.2)** together with the IRB Application Form (**Form 2.1A)** signed by the Principal Investigator and the Protocol Summary sheet **(Form 2.5)**. *For investigator-initiated protocols, the research committee of each Department ensures that the Technical Reviewer has signed the Protocol Evaluation Form (**Form 2.7B**) and an endorsement by the department/ unit is provided. ⬇	Secretariat
2	Assign a permanent code to the package. ⬇	Secretariat
3	Make a duplicate of the application form(**Form 2.1A)** and give the duplicate to the person submitting the package and attach the original copy to the protocol package to be kept in the IRB. ⬇	Secretariat
4	Log the received protocol in the IRB database. ⬇	Secretariat
5	Assign type of review and primary reviewers **(Form 2.6)** ⬇	Member Secretary/ Chair
6	Prepare protocol package for distribution to the reviewers. ⬇	Secretariat

7	File the original package in a properly coded Protocol File folder and place it in the Active Study File cabinet.	Secretariat

Detailed instructions

2.1.4.1 Submissions are accepted on the 3rd and 4th weeks of the month. All protocols, which are determined to undergo a full board review, are scheduled for review and deliberation on the next scheduled meeting. Turnaround time from protocol submission to communication of MMC IRB decision is 4 weeks. Submitted protocols need technical approval and ethical review.

A. For Makati Medical Center protocols, the Department Research Review Committee should have addressed the technical issues apparent to the study protocol. The IRB Secretariat will provide the Board-approved criteria for the guidance of the different Departments in their review of the protocols. The research committee head or research adviser endorses the protocols to MMC IRB for ethical review and approval by accomplishing the Research Proposal Evaluation Form (REFORM).
B. For non-Makati Medical Center protocols, the research protocol undergoes technical and ethical review.

Upon submission of the initial protocol for Makati Medical Center IRB review, the principal investigator or his/her representative should ensure that the protocol follows the standard protocol format and contains a Protocol Summary Sheet **(Form 2.5)**

Secretariat checks the completeness of the documents being submitted based on the IRB checklist **(Form 2.2).**

A protocol package has to include the following:

A. Five (5) copies of all documents submitted for review and five.
B. Letter of intent with itemized documents submitted. This document identifies the items submitted and specifies the

purpose of submission. The letter is addressed to the chair of the MMC IRB.

C. Curriculum vitae and Good Clinical Practice Certificate (updated every 3 years) of the principal investigator and other co-investigators of the study to present the qualifications of the principal investigator and co-investigators
D. Certification of Food and Drug Administration (FDA) approval to conduct the trial in the Philippines. This is only applicable to studies involving products that may be intended to be marketed in the Philippines. According to the FDA Circular No. 2012-007, "all clinical trials, from Phase I to IV, including amendment(s) thereto, require mandatory approval from the FDA." A parallel review may be done by MMC-IRB while awaiting FDA approval is allowed.
E. Detailed protocol. This is a document that describes the background, objectives, inclusion and exclusion criteria, study design, methodology, and sample size of the study to be reviewed.
F. Informed consent forms in English, Tagalog and other dialect if applicable (See attached Guidelines on Submitting an Informed Consent Form). These are the forms utilized in obtaining permission from the individual to participate in the study.
G. Assent Forms (if applicable). These are the forms used to attain authorization of a study participant incapable of providing an informed consent.
H. Case Report Forms or Data Collection Forms. These are printed or electronic documents used to gather all the information necessary for the study.
I. Diary Cards and other materials related to the study (e.g. recruitment materials, etc.).
J. Study Budget is the total amount of money for a study.
K. Accomplished Application Form **(Form 2.1A),** Protocol Summary Form **(Form 2.5)**, Protocol Evaluation **(Form 2.7A and 2.7B)**, Gantt Chart (to indicate the timeline of the study) and Flow Chart of the Protocol (to illustrate the methodology of the study). These are for both the sponsored and investigator-initiated protocols.

L. 5 copies of the Investigator's Brochure (for drug trials)/ printed references (for investigator-initiated protocols).
M. CD or DVD copy of Protocol and other documents attached e.g. Powerpoint presentation of the summary of the research, Informed Consent, Case Report Form and Investigator's Brochure or Journal Reports, Literature Review for Trainees if applicable.
N. Protocol Review Fee for sponsored study protocols conducted by consultants and/or from outside Makati Medical Center.
The fee is payable to "Makati Medical Center." This fee is non-refundable and non-transferable once review is initiated. Should there be an intent by the company to publish a trainee-initiated protocol, all applicable fee is applied (e.g., IRB review fee).

2.1.4.2 Assign a code to the package. The code will be communicated to the principal investigator in subsequent communications regarding the protocol.

2.1.4.3 Ensure that the Principal Investigator has signed the Makati Medical Center IRB Application Form for Protocol Review **(Form 2.1A),** make a copy of the filled-out application form, keep the original copy for the IRB files and give the duplicate to the principal investigator (PI) or his/her representative.

2.1.4.4 Log the protocol in the IRB database. Enter in the IRB database the names of the primary reviewers. Prepare a transmittal letter with the name of the reviewer, the date of actual delivery to be signed by the reviewer or a representative upon receipt.

2.1.4.5 Member-Secretary assigns the primary reviewers for approval by the chair.
A. Primary reviewers are selected on the basis of expertise related to the protocol. Research proposals are given to all members; both medical and non medical or lay members, institutional and non-institutional members for review. The medical/ scientific members analyze the scientific and ethical procedures in the protocol while the lay/ non-institutional members focus their

assessment on the informed consent form. The Informed Consent Form can be reviewed by both the lay and paramedical/ nurse/ pharmacist member. Review assignments should take into consideration the appropriate mix of old and new members.

B. Member-Secretariat/Chair, using **Form 2.6**, nominates two or more MMC IRB members (Medical member with related expertise to review the protocol and a non-medical person to review the informed consent.)The assignments will be equitably distributed taking in consideration the expertise of the reviewers. Secretariat sends the protocol and related documents to the selected primary reviewers. An independent consultant may be invited to provide expert opinion about a protocol.

2.1.4.6 Prepare the copies of protocol for distribution to the reviewers. Include copies of the “Protocol Evaluation Forms" **(Form 2.7A and 2.7B)** and the “Informed Consent Evaluation Form" **(Form 2.8)** in the package.

For protocols requiring review, make sufficient (five) copies of the protocol package for the IRB files, for each of the primary reviewers, and for each IRB member.

2.1.4.7 Secretariat files the protocol.

A. Put the original copies in a protocol file folder
B. Put the code of the protocol on the side of the file folder
C. File the folder in the Active Study Files cabinet

2.2 Protocol Screening

2.2.1 Purpose

To describe the process of determining the type of review a protocol undergoes and to assign the primary reviewers.

2.2.2 Scope

This applies to all submission to the MMC IRB for review and approval.

2.2.3 Responsibility

The Secretariat Staff manages the screening process. The Member-Secretary recommends the type of review for the protocol submitted according to the criteria. This is also the process when the primary reviewers and independent consultants are assigned to review the research proposal. The Chair approves the recommendation of the Member-Secretary.

2.2.4 Process Flow

NO.	ACTIVITY	RESPONSIBILITY
1	Recommendation of type of review using the Type of Review Form **(Form 2.6)** ⬇	Member-Secretary
2	Identification of primary reviewers and independent consultant (if necessary) assigned to review the research proposal. ⬇	Member-Secretary
3	Approval of the type of review **(Form 2.6)** and assigned primary reviewers and independent consultant. ⬇	Chair
4	Type of Review form **(Form 2.6)** is kept in the protocol file.	Secretariat

Detailed Instructions

2.2.4.1 Upon submission of the protocol and the requirements, the secretariat provides the Member-Secretary with the Type of Review Form (**Form 2.6)**.

- Member-Secretary recommends the type of review according the criteria provided:
  - **Initial Submission**

ISFB	FULL BOARD REVIEW
1	Clinical trials about investigational new drugs, biologics or device in various phases (Phase 1, 2, 3)
2	Phase 4 intervention research involving drugs, biologics or device
3	Protocols including questionnaires and social interventions that are confidential in nature (about private behavior, e.g. related to sexual preferences etc., or about sensitive issues that may cause social stigma) that may cause psychological, legal, economic and other social harm
4	Protocols involving vulnerable subjects (individuals whose willingness to volunteer in a clinical trial may be unduly influenced by the expectation of benefits associated with participation or of a retaliatory response in case of refusal to participate, patients with incurable diseases, persons in nursing homes, unemployed or impoverished persons, patients in emergency situations, ethnic minority groups, homeless persons, nomads, refugees, minors and those incapable of giving consent) that require additional protection from the IRB during review
5	Protocols that involve collection of identifiable biological specimens for research
ISER	**EXPEDITED REVIEW (SPARES)**
1	Protocols of a non-confidential nature (not of a private character, e.g. relate to sexual preference etc., or not about a sensitive issue that may cause social stigma), not likely to harm the status or interests of the study participants and not likely to offend the sensibilities nor cause psychological stress of the people involved.
2	Protocols not involving vulnerable subjects (individuals whose willingness to volunteer in a clinical trial may be unduly influenced by the expectation of benefits associated with participation or of a retaliatory response in case of refusal to participate, patients with incurable diseases, persons in nursing homes, unemployed or impoverished persons, patients in emergency situations, ethnic minority groups, homeless persons, nomads, refugees, minors and those incapable of giving consent).
3	Protocols that involve collection of anonymized biological specimens for research purposes by non-invasive means (e.g. collection of small amounts of blood, body fluids or excreta non-invasively, collection of hair or nail clippings in a non-disfiguring or non-threatening manner).

4	Research involving data, documents or specimens that have been already collected or will be collected for ongoing medical treatment or diagnosis

- **Resubmission/ Amendments/ Reports**

RSFR	FULL BOARD REVIEW
1	Major revisions of the protocol and informed consent after initial review
2	Amendments that involve major changes from previously approved protocol or consent form (major changes in the inclusion/ exclusion criteria, safety issues, etc.)
3	Major amendments that change the risk/ benefit ratio
4	Major protocol violations
5	Progress/ Final reports that deviate from original approval given by the IRB
6	Onsite SAEs or SUSARs that may require protocol amendment or reconsent of participants
RSER	**EXPEDITED REVIEW (SPARES)**
	Proposed continuing reviews, protocol amendments and end of study reports that have minor modifications and no significant risk to study participants, such as:
1	• Administrative revisions, such as correction of typing errors
2	• Addition or deletion of non-procedural items, such as the addition of study personnel names, laboratories, etc.
3	• The research activity includes only minor changes from previously approved protocol.
4	• Minor protocol amendments that do not change the risk/ benefit assessment
5	• Progress/ Final reports that do not deviate from approval given by the IRB
6	• SAEs from foreign sites

EX	EXEMPTION CRITERIA
1	Study that does not involve human subjects or human data.
2	Study design is meta-analysis and/or systemic.
3	Case Reports

The type of review for post approval reports is based on the type of review the initial submission underwent. If the initial submission was reviewed through full board, the post approval reports (i.e. progress report, amendment, final report, etc.) also undergo full board review.

For protocols which are exempted from IRB review, the principal investigator is required to submit a copy of the protocol and a cover letter inquiring if the research requires IRB review and approval. The IRB Chair decides if the research requires IRB Approval. A letter is provided to the principal investigator regarding the decision of exemption. The principal investigator of researches exempted from IRB review submits a copy of the final paper to the IRB for the completion of the research.

2.2.4.2 The Member-Secretary recommends the assigned primary reviewers, selected based on the expertise related to the protocol. Research proposals are given both to the medical and non-medical or lay members, institutional and non-institutional members for review.

2.2.4.3 Chair signs the Type of Review form and the assigned primary reviewers **(Form 2.6)** to approve the recommendations of the Member-Secretary.

2.2.4.4 Type of Review Form **(Form 2.6)** is kept in the protocol file.

2.3 Protocol Evaluation

2.3.1 Purpose

To describe the procedures of protocol evaluation to review the scientific/ technical and ethical aspects of the protocol.

2.3.2 Scope

The Study Evaluation Forms **(Form 2.7A, 2.7B and 2.7C)** are designed to standardize the review process and to facilitate reporting of recommendation and comments given to each individual protocol and related documents.

There are two (2) Makati Medical Center IRB Evaluation Forms for protocol review:

A. Protocol Evaluation Forms **(Form 2.7A, 2.7B and 2.7C)**
B. Informed Consent Evaluation Form **(Form 2.8)**

This SOP applies to the use of the Study Assessment Forms in the review and assessment of protocols and related documents submitted to Makati Medical Center IRB for initial review and approval by the IRB.

2.3.3 Responsibility

It is the responsibility of the Makati Medical Center IRB reviewers to individually fill-out the evaluation forms **(Form 2.7A, 2.7B and 2.7C)** after reviewing each study protocol. Any comment, evaluation, recommendation and the initial decision of each reviewer regarding a protocol are all noted in these two forms. The Secretariat is responsible for recording and filing the Makati Medical Center IRB's action, relevant points and deliberation about a particular protocol, including the comments for specific action. The consensus/ agreement regarding the decisions on each reviewed protocol will be reflected in the Minutes of the meeting.

2.3.4 Process Flow/Steps

NO.	ACTIVITY	RESPONSIBILITY
1	Evaluate the scientific/ technical and ethical aspect of the protocol	Primary Reviewers

	⬇	
2	Fill out the Protocol Evaluation Forms **(Form 2.7A, 2.7B, 2.7C and 2.8)** during review of the study protocol and related documents. ⬇	Primary Reviewers
3	Submit accomplished Study Evaluation Forms **(Form 2.7A, 2.7B, 2.7C and 2.8)** to the Secretariat ⬇	Primary Reviewers
4	Check forms for completeness and submit to Member-Secretary and Chair. ⬇	Secretariat
5	Include the protocol in the agenda of the meeting if it is classified under full board review ⬇	Secretariat
6	Review the protocol either during the full board meeting or SPARES review ⬇	Primary Reviewers/ Members
7	Communicate the decision of the reviewers/ board to the principal investigator **(Form 2.9)** ⬇	Secretariat
8	Prepare an Approval letter **(Form 2.10)** ⬇	Secretariat
9	File copies of duly accomplished forms in the Study File Folder of the particular protocol ⬇	Secretariat
10	File index of document and protocol tracker **(Form 4.4A and 4.4B)** on each protocol folder for protocol tracking and to ensure completeness	Secretariat

	of documents.	

Detailed instruction

2.3.4.1 Protocol Review

The primary reviewers:

A. Use the Protocol Evaluation Form (**Form 2.7A, 2.7B and 2.7C)** for the protocol and the Informed Consent Evaluation Form (**Form 2.8**) to review the protocol and the consent form and write relevant comments.
   - Check Protocol Evaluation Form (Form 2.7B) for Technical Review by the Department/ Unit of Trainee.

B. Check the CV or information about the investigators (including GCP training for clinical trials), the study sites and other protocol related documents, including advertisements.
   1) Consider whether study and training background of the principal investigator/s are related to the study.
   2) Look for disclosure or declaration of potential conflicts of interest.
   3) Non-physician principal investigators should be advised by a physician when necessary.
   4) Determine if the facilities and infrastructure at study sites can accommodate the study.

C. Check the "Assent Form" if the protocol involves children or other vulnerable groups as study participants based on PHREB guidelines. The procedure for getting the assent of vulnerable participants should be clear (the objective of the study and the procedures to be done should be explained to the child or vulnerable participant separately).

D. Note the following technical and ethical Review Guidelines:
   1) Protocol manifests scientific validity and contains all the standard sections to ensure scientific soundness.
   2) In assessing the degree of risk against the benefit, determine whether the risks are reasonable in relation to anticipated benefits; and/or if the risks can be minimized.
   3) Study participants are selected equitably especially if randomization is not to be used. Study participant's

information sheet should be clear, complete and written in understandable language.

4) There is voluntary, non-coercive recruitment of study participants.
5) Informed Consent is adequate, easy to understand and properly documented.
6) There should be a translation of the Informed Consent document into the local dialect, which should be comprehensible by the general public.
7) Procedure for getting the Informed Consent is clear and unbiased.
8) Persons who are responsible for getting the Informed Consent are named and they introduce themselves to the study participants.
9) Research plan makes adequate provision for monitoring data collection to ensure the safety of study participants, where appropriate.
10) There are adequate provisions to protect the privacy of study participants and to maintain the confidentiality of data, where appropriate.
11) There is provision for compensation to study participants. There should be reasonable provision for medical/psychosocial support; treatment for study related injuries, as well as compensation for participation to cover expenses like transport and lost wages because of participation.
12) There are appropriate safeguards included to protect vulnerable study participants.
13) Contact persons or Investigators with address and phone numbers are included in the Informed Consent.
14) There is clear justification for the use of biological materials and a separate consent form for future use of biological specimens.
15) There are appropriate contracts or memoranda of understanding especially in collaborative studies.

E. For community studies, examine community involvement and impact/benefit of the study to the community and/or the

institution. If relevant, the reviewer looks for the following in the protocol:

1) Involvement of local researchers and institutions in the protocol design, analysis and publication of the results
2) Contribution to development of local capacity for research and treatment in benefit to local communities
3) Sharing of study results with the participants/ community
4) Cultural Considerations
    a. Approach prospective subjects for their individual consent only after obtaining permission from a community leader, a council of elders, or another designated authority.
    b. Community Consultation: If there is cause for concern about the acceptability of the research in the community, there is a formal consultation with representatives designated by the community.
    c. There is substantial support in the community concerned. (See Guideline 8 Commentary, *Risks to groups of persons*.
    d. There is an individual consent supplemented by community consultation.
5) Benefits
    a. There are expected benefits of the research to the community or to society at large, or contributions to scientific knowledge.
    b. The researcher gives no unjustifiable assurances about the benefits, risks or inconveniences of the research, for example, or induces a close relative or a community leader to influence a prospective subject's decision.
6) Research in populations and communities with limited resources
    a. The research is responsive to the health needs and the priorities of the population or community in which it is to be carried out.
    b. The intervention or product developed, or knowledge generated will be made reasonably available for the benefit of that population or community.
7) Ethical obligation of external sponsors to provide health-

care services

a. The research protocol specifies what health-care services will be made available, during and after the research, to the subjects themselves, to the community from which the subjects are drawn, or to the host country, and for how long.
b. The details the arrangements is agreed by the sponsor, officials of the host country, other interested parties, and, when appropriate, the community from which subjects are to be drawn. The agreed arrangements are specified in the consent process and document.
c. The source and amount of funding of the research are specified: the organization that is sponsoring the research and a detailed account of the sponsor's financial commitments to the research institution, the investigators, the research subjects, and, when relevant, the community.
d. Circumstances in which it might be inappropriate to publish findings, such as when the findings of an epidemiological, sociological or genetics study presents risks to the interests of a community or population or of a racially or ethnically defined group of people are considered.

2.3.4.2 MMC IRB primary reviewers individually fill out the following forms for each protocol.

Protocol Evaluation Form (**Form 2.7A, 2.7B and 2.7C)** ensures assessment of the scientific and ethical aspects of the protocol as follows:

A. Rationale and significance of the study
B. Objectives of the study
C. Review of literature
D. Sample size
E. Methodology and data management
F. Inclusion/exclusion criteria
G. Control arms (placebo, if any)
H. Withdrawal or discontinuation criteria

I. Vulnerability determination
J. Risk/ benefit assessment
K. Indemnity and Insurance

Informed Consent Evaluation Form (**Form 2.8)** checks if the following are complied with:

A. Full disclosure of information, including risks
B. Benefits that may be derived from the study
C. Use of understandable language
D. Voluntary participation
E. Confidentiality
F. Appropriate person is to sign the consent form
G. Indemnity and Insurance

2.3.4.3 Primary reviewer signs and submits the evaluation forms together with the reviewed protocol to the Secretariat.

- The IRB Chair provides decision on approval of the protocol either SPARES or Full Board Review. This is when the primary reviewers fail to review and return the protocols within 7 calendar days upon receipt.

2.3.4.4 Secretariat checks whether the forms are complete, compiles the checklists and submits these to the Member-Secretary and/or Chair.

- Member-Secretary and/or Chair reviews the compiled checklists.

2.3.4.5 In full board review, the Secretariat includes the protocol in the agenda of the next Makati Medical Center IRB meeting for discussion and decision (Please refer to Section 1.1.9.4 of MMC IRB SOP Chapter 1).

2.3.4.6 The Primary Reviewers/ Members review the protocol either during the full board meeting or SPARES review.

2.3.4.7 If there are revisions required, these are communicated to the Principal Investigator who has to resubmit the revised protocol and related documents before approval is given **(Form 2.9).**

In expedited review, the secretariat communicates the revisions required (if any) to the Principal Investigator who has to resubmit the revised protocol and related documents before approval is given. Approved expedited protocols are reported during the full board meeting for documentation.

2.3.4.8 An approval letter is prepared, signed by the Chair and sent to the Principal Investigator once a protocol is approved **(Form 2.10)**. For protocols that have Informed Consent Forms. An IRB Stamp of Approval is required before distribution of Informed Consent Forms to patients/participants.

***NB When the reviewers fail to return their review of the protocol on time, approval is obtained at the level of the Chair.*

2.3.4.9 A copy of the signed letter is retained in the protocol file folder.

2.3.4.10 The Secretariat updates the protocol database, tracker **(Form 4.4A and Form 4.4.B)** and index**.**

2.4 Full Board Review

2.4.1 Purpose

To describe the procedures when protocol submissions are classified for full board review.

2.4.2 Scope

This SOP applies to the review and approval of study protocols or amendments with medium to high risk to study participants and major revisions in the protocol or informed consent. The submission procedures are the same as first time submission.

2.4.3 Responsibility

It is the responsibility of the Secretariat to manage the document submission, send protocol documents to the primary reviewers, refer the protocol to full board meeting for discussion and decision, communicate the review results to the Principal Investigator, keep copies of the documents in the protocol files and update the protocol entry in the IRB database.

The Secretariat is responsible for receiving, verifying and managing the contents of both the hard copies and the electronic version (if any) of the submitted protocol package. In addition, the Secretariat should create a specific protocol file, make copies of the file and then distribute the copies to the Makati Medical Center IRB reviewers, together with a cover letter where the due date for returning the reviewed protocol is indicated as well as the schedule of meeting when the protocol will be discussed.

It is the responsibility of the assigned reviewers to thoroughly review the study protocols, give their decision, observation and comments and put all of this in the Study Assessment Forms **(Form 2.7A, 2.7B and 2.8)** before returning the reviewed protocol and assessment form to the Secretariat on the due date. Reviewers are present during the meeting for final deliberation and discussion.

2.4.4 Process Flow/Steps

NO	ACTIVITY	RESPONSIBILITY
1	Receive the submitted documents (with **Form 2.2, or 2.4**) and forwards to the Chair or Member-Secretary	Secretariat
2	Determine that the protocol qualifies for Full Board review **(Form 2.6)**	Member-Secretary/ Chair
3	Assign reviewers to review the protocol and related documents	Member-Secretary/ Chair
4	Review the protocol documents using the assessment forms **(Form 2.7A, 2.7B and 2.8)** and submit the decision/ recommendation to the Secretariat	Primary Reviewers
5	Include the protocol in the meeting agenda **(Form 4.1)** for discussion to arrive at a decision through full board	Secretariat/ Members
6	Communicate board decision to the principal investigator **(Form 2.9)**	Secretariat/ Chair
7	If modifications are required, revise the protocol or related document and resubmit to the IRB **(Form 2.4)**	Principal Investigator
8	Check and review revisions and refer to full board for decision	Primary Reviewers
9	After board approval, prepare the Approval Letter **(Form 2.10)** to be signed by the Chair and sent to the Principal Investigator	Secretariat

10	Send requirement checklist on Clinical Trial Agreement **(Form 2.3)** to the Principal Investigator (if applicable).	Secretariat
11	Keep copies of all documents in the protocol files. Update index **(Form 4.4A and 4.4B)** and the protocol entry in the MMC IRB database	Secretariat

Detailed Instructions

2.4.4.1 Secretariat:

A. Receives the Application Form for Protocol Review **(Form 2.1A/B/C)** submitted by the Principal Investigator including the protocol package.
B. Check the completeness of the protocol package using the checklist **(Form 2.2 / 2.4)**.
C. Upon receiving the package, indicates the date and affix staff's signature.
D. Returns the signed acknowledgment form back to the representative of the principal investigators.

2.4.4.2 Member-Secretariat/ Chair

- Determines if the protocol qualifies for a full board review **(Form 2.6)** based on the criteria.

2.4.4.3 Select primary reviewers with appropriate qualifications (clinician/ scientist with expertise related to the protocol and a non medical person to review the consent form.) An independent consultant may be invited to provide expert opinion. (refer to 2.1.4.5)

A. Send the protocol files together with the assessment forms **(Form 2.7A, 2.7B and 2.8)** to the primary reviewers/ independent consultant.
B. Note the due date for submitting the results (accomplished checklists) and the protocols back to the IRB Secretariat.
C. For primary reviewers not present during the scheduled full board review, the accomplished assessment forms are returned

to the IRB Secretariat. If possible, the decisions of the primary reviewers who cannot attend the full board review are forwarded to the IRB Secretariat before the meeting.

2.4.4.4 Protocol Review is conducted as described under section 2.2 "Protocol Evaluation"

After reviewing the protocol and the documents, the new system entails that the final decision for the protocol will be made through voting. The chair will ask the board members by show of hands and in which the decision will favor the majority. Various decision points are as follows: Approved, Minor revision, Major revision, Disapproved, Pending Decision for the Protocol and the Informed Consent Form.

A. Record the decision by marking the appropriate block in the assessment form: Approved, Minor revision, Major revision for resubmission, Disapproved or Pending Decision.
B. Include comments and reasons for disapproval.
C. Check the completeness and correctness of marked items in the assessment forms.
D. Indicate the date and affix the reviewer's signature in the decision form **(Form 2.7B and 2.8)**.
E. Submit the completed forms to the Secretariat together with the protocol documents. Secretariat only accepts completely filled out forms **(Form 2.7B and 2.8)**.

2.4.4.5 Include the protocol in the next meeting agenda.

2.4.4.5.1 MMC IRB Meeting Schedule

A. Regular MMC IRB meeting is conducted every third Tuesday of the month. The meeting starts at 12:30 pm and ends at 3:00pm, depending on the number of documents to be reviewed.
B. A special meeting may be held upon the decision of the chair of the MMC IRB.

C. One (1) week notice shall be given to all MMC IRB members on the schedule of the meeting. The agenda shall also be provided with this notice.

Conduct of Meeting

A. Only the members of the MMC IRB and IRB Secretariat are allowed to attend the meeting unless otherwise specified. The principal investigator or designated representatives and Independent Consultants, are asked to be present for a particular portion of the meeting when specific protocol is reviewed.
B. Principal Investigators or study proponents are invited to present a summary of the protocol and to respond to clarifications.
C. Before the conduct of the meeting and review of every protocol or report, the chair determines the quorum and conflict of interest.
D. Chair may give a 5 to 10-minute break to maintain the integrity of quorum. The members are encouraged to refrain from leaving at any time during a review to maintain the quorum.
E. Meeting may be suspended or terminated early once quorum is lost.
F. Discussion during the meeting are organized into 2 parts:
   1) Technical and Ethical Issues and 2) Informed Consent Form
G. Primary reviewers who are not able to attend the meeting should submit the protocol and the completed assessment forms with the comments, recommendations and decision. The Chair or member-secretary may speak in behalf of the absent reviewer.

2.4.4.5.2 The MMC IRB members conduct a full board meeting to discuss and make a decision about the protocol and related documents.

A. For Makati Medical Center proposals, a member of the Department Research Committee shall sit in the full board meeting as a consultant to explain technical issues. For non-Makati Medical Center proposals, the IRB may request for comments/ approval from other IRB independent consultants to provide additional inputs as deemed necessary.
B. The members of the IRB attending the full board meeting arrive at a decision by consensus on the protocol as follows:
   1) Approved
   2) Minor modification
   3) Major Modification
   4) Disapproved
   5) Pending Decision
C. If consensus cannot be reached, the members will vote on the approval of the particular proposal. At least 50% plus one or majority of the members present is needed for approval. Record of voting is shown (i.e., for, against, abstention).

Meeting Decisions (Please refer to Section 1.1.9.4 of MMC IRB SOP Chapter 1)

- If the study is approved:
  - the MMC IRB determines the frequency of continuing review.

2.4.4.6 The Secretariat sends an Action Letter/ Approval Letter (**Form 2.10**) with a list of approved documents to the principal investigator.

A. Letter **(Form 2.10)** contains identification of the document approved with version numbers and dates, the frequency of continuing review and the responsibilities of the principal investigator throughout the course of the study.
B. If the decision is not to approve the study, the Secretariat immediately notifies the principal investigator in writing about the decision and the reason for not approving the study **(Form 2.9)**.

- If the principal investigator wishes to appeal the IRB decision, he/she may do so through a written request submitted to the Makati Medical Center IRB.

2.4.4.7 If the decision is to revise and resubmit modifications to any of the documents, the Secretariat prepares a letter to the Principal Investigator and identifies the necessary revisions. The Principal Investigator resubmits the revised documents to MMC IRB **(Form 2.4 and 2.9)**. The Principal Investigator is required to resubmit research protocol within 12 calendar days after the release of the Notification of IRB Decision **(Form 2.9).** If the resubmission is not provided 6 months from the release of the Notification of IRB Decision (Form 2.9), the research is considered inactive.

2.4.4.8 Documents that require revision are sent to the primary reviewers for evaluation.

A. Reviewers evaluate the document that requires revision.
B. Primary reviewers recommend approval if the issues are satisfactorily addressed.

2.4.4.9 Principal Investigator is informed of the board decision. **(Form 2.9).**

2.4.4.10 All meeting deliberations, decision regarding a protocol are noted in the meeting minutes and copies of the assessment forms are kept in relevant sections of the protocol file.

The IRB database protocol index **(Form 4.5)** and tracker **(Form 4.4A and 4.4B)** are to record the decision.

- All information regarding the date of the Makati Medical Center IRB decision, date when decision was written and signed by the Chair, and date when it was delivered to the principal investigator, is entered in the IRB database.

2.5 Expedited Review by SPARES

2.5.1 Purpose

To describe the procedures for the review of protocols that qualify for expedited review

2.5.2 Scope

This SOP applies to the review and approval of study protocols or amendments with minimal risk to study participants and minor revisions in the protocol or informed consent.

This also applies to protocols initially reviewed under full board for minor modifications.

2.5.3 Responsibility

It is the responsibility of the Secretariat to manage the document submission, send protocol documents to the primary reviewers, refer the protocol to the primary reviewers for discussion and decision, communicate the review results to the Principal Investigator, keep copies of the documents in the protocol files and update the protocol entry in the IRB database.

It is the responsibility of primary reviewers to assess and make recommendations for appropriate reaction any protocol that qualifies for the expedited process. The same assessment forms used for full board review should be used to evaluate the scientific and ethical merits of the protocol **(Form 2.7A, 2.7B and 2.8)**.

2.5.4 Process Flow/ Steps

NO.	ACTIVITY	RESPONSIBILITY
1	Receive the submitted documents, check for completeness and forward to the Chair or Member-Secretary **(Form 2.1, 2.2, 2.4 and 2.5)** ⬇	Secretariat
2	Determine that the protocol is for expedited review **(Form 2.6)** and assigns reviewers. ⬇	Member-Secretary/ Chair
3	Do the expedited review and submit the decision to the Secretariat **(Form 2.7A, 2.7B, 2.7C and 2.8)** ⬇	Reviewers
4	Communicate the decision for approval or revision to the Principal Investigator **(Form 2.9)** ⬇	Secretariat
5	If modifications are required, revise the protocol or related document and resubmit to the IRB **(Form 2.3/ 2.7C)** ⬇	Principal Investigator
6	Review revisions and recommend if for approval **(Form 2.7C)**. ⬇	Reviewers
7	Prepare an Approval Letter to be signed by the Chair and sent to the Principal Investigator **(Form 2.10)**. ⬇	Secretariat
8	Report results of expedited review to full board ⬇	Secretariat
9	Keep copies of related documents in the files. ⬇	Secretariat

10	Update the IRB database, protocol tracker (**Form 4.4A and 4.4B**) and index.	Secretariat

Detailed instructions

2.5.4.1 Secretariat

A. Receives the application documents submitted by investigators **(Form 2.1A/B/C)**.
B. Checks items received using the checklist as guide **(Form 2.2 and 2.4)**.
C. Signs a copy of the application form (**Form 2.1A/B/C)** to acknowledge receipt of the documents and return a copy to the principal investigator or a duly designated representative.

2.5.4.2 Member-Secretariat/Chair determine that the protocol is for expedited review (Form 2.6) based on the criteria.

Select primary reviewers with appropriate qualifications (clinician/ scientist with expertise related to the protocol and a non medical person to review the consent form.) An independent consultant may be invited to provide expert opinion. (Refer to 2.1.4.5)

A. Send the protocol files together with the assessment form **(Form 2.7A, 2.7B and 2.8)** to the primary reviewers/ independent consultant.
B. Note the due date for submitting the results (accomplished checklists) and the protocols back to the IRB Secretariat.

2.5.4.3 Primary reviewers carry out the expedited review on the protocol and related documents (patient information sheet, consent form, advertisements, etc.) as described under section 2.2 “Protocol Evaluation”

- If a consensus cannot be reached, the Chair refers the protocol to the IRB board for a full board review.

2.5.4.4 Protocol Evaluation Decision (Please refer to Section 1.1.9.4 of MMC IRB SOP Chapter 1)

A. If the study is approved,

1) Secretariat sends an Action Letter/ Approval Letter (**Form 2.10**) with a list of approved documents to the principal investigator.
2) Letter contains identification of the documents approved with version numbers and dates, the frequency of continuing review and the responsibilities of the principal investigator throughout the course of the study.

B. If the protocol is disapproved, the Secretariat notifies the principal investigator in writing about the decision and the reason for not approving the study (**Form 2.9**)
   1) If the principal investigator wishes to appeal the IRB decision, he/she may do so through a Letter of Intent submitted to the MMC IRB Chair (please refer to section 1.1.9.5 in MMC IRB SOP Chapter 1).

C. If the decision is to revise and resubmit modifications to any of the documents, the Secretariat prepares a letter to the Principal Investigator and identifies the necessary revisions to the documents before resubmission to the MMC IRB **(Form 2.4 and 2.9).** The Principal Investigator is required to resubmit study protocol 12 calendar days after the release of the Notification of IRB Decision **(Form 2.9).** A reminder letter is provided to the Principal Investigator who fails to resubmit within 12 calendar days. If the resubmission is not provided 6 months from the release of the Notification of IRB Decision (Form 2.9), the research is considered inactive.

D. If the protocol is for major revision, the resubmission undergoes full board review. The following are the criteria for major revisions which may be issues related to, but not limited, to the following:
   1. No equipoise
   2. Nature of Study
   3. Major Issues related to Vulnerability of Subjects
   4. Objectives or methodology are not appropriate
   5. Major criteria in evaluation not satisfactory.
   6. Risk-benefit assessment is not appropriate

2.5.4.5 If modifications are required, Principal Investigators revise the protocol or related document and resubmit to the MMC IRB.

2.5.4.6 Documents are sent to the primary reviewers for evaluation.

A. Reviewers evaluate the document.
B. Primary reviewers recommend approval if there are no issues.

2.5.4.7 Decision is communicated to the principal investigators **(Form 2.9)**.

A. Turnaround time to communicate board decision is four weeks from the time the protocol was submitted.
B. Dated received copy of the approval letter is kept in file.

2.5.4.8 Approved Expedited protocols are reported to full board for information purposes.

2.5.4.9 All meeting deliberations, decision regarding a protocol are noted in the meeting minutes and copies of the assessment forms are kept in relevant sections of the protocol file.

2.5.4.10 The MMC IRB database, protocol index and tracker are to record the decision.

- All information regarding the date of the Makati Medical Center IRB decision, date when decision was written and signed by the Chair, and date when it was delivered to the principal investigator, is entered in the IRB database.

2.6 Review of a Medical Device Protocol

2.6.1 Purpose

To describe procedures in the review of medical device protocols submitted to the IRB.

2.6.2 Scope

This SOP provides instructions for review and approval of medical device protocols intended for human participants submitted to the Makati Medical Center IRB.

Medical device protocols are reviewed through the same expedited or full board procedures depending on the level of risks involved in the study. An investigational new device is given a Significant Risk (SR) or Non Significant Risk (NSR) classification by the regulators in the sponsor country. (Refer to Appendix: Guide for Study Device Classifications). This information should be provided by the sponsor to the IRB. The IRB should make provisions to minimize the risks to human participants during review of the protocol and related documents.

2.6.3 Responsibility

It is the responsibility of the IRB members to review medical device protocols in accordance with international and national guidelines and regulations.

2.6.4 Process Flow/Steps

NO.	ACTIVITY	RESPONSIBILIT
1	Receive the submitted documents, check for completeness and forward to the Chair or Member-Secretary **(Form 2.1, 2.2, 2.4, 2.5)**. ⬇	Secretariat
2	Determine if the protocol is for Expedited or Full Board review depending on Significant Risk or Non Significant Risk determination **(Form 2.6)**. ⬇	Member-Secretary/ Chair
3	Assign primary reviewers to review the protocol and related documents. ⬇	Member-Secretary/ Chair
4	Conduct the review using the assessment forms (**Form 2.7A, 2.7B, 2.7C, 2.8 and 2.11**) and submit the decision/ recommendation to the Secretariat. ⬇	Primary Reviewers
5a	Expedited Review: Communicate the decision from expedited reviewers for approval or revision **(Form 2.9 and Form 2.10)** to the Principal Investigator. ⬇	Secretariat
5b	Full Board Review: Include the protocol in the meeting agenda **(Form 4.1)** for discussion and decision by full board. ⬇	Secretariat
6	If modifications are required **(Form 2.9)**, revise the protocol or related document and resubmit **(Form 2.1, 2.4, 2.7A and 2.7C)** to the IRB. ⬇	Principal Investigator

7	Check and review revisions. **(Form 2.7C)**	Primary Reviewers
8	Prepare an Approval Letter to be signed by the Chair and sent to the Principal Investigator. **(Form 2.10)**	Secretariat
9	Keep copies of related documents in the files.	Secretariat
10	Update the protocol entry in the IRB database.	Secretariat

Detailed Instructions

2.6.4.1 The Secretariat receives the submitted documents and forward to the Chair or Member-Secretary (**Form 2.1, 2.2, 2.4, 2.5**).

2.6.4.2 Member - secretary and Chair checks the information/communication from the principal investigator related to the Significant Risk (SR) or Non Significant Risk (NSR) determination by regulators (FDA) from the sponsor country. The protocol is assigned to expedited review or full board review depending on the risk assessment.

Unless the FDA has already made a risk determination for the study, the **convened** full Institutional Review Board (IRB) must review the sponsor's Significant Risk or Non Significant risk determination for every investigational medical device study reviewed and modify the determination if the IRB disagrees with the sponsor.

For a device study to be eligible for expedited review, it must either be: 1. exempt from IDE requirements or 2. previously determined to be an NSR study by the FDA or full IRB **AND** present no more than minimized risk to the subject (probability and magnitude of harm or discomfort are not greater than, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.)

2.6.4.3 Primary reviewers with appropriate expertise are assigned to review the protocol and related documents. It is advisable that a bioengineer with appropriate experience related to the medical device together with a medical doctor with related clinical experience are assigned to review the protocol while a lay person/ non medical member reviews the consent form.

2.6.4.4 The Primary Reviewers use the MMC IRB Evaluation forms (**Form 2.7A, 2.7B, 2.8, and 2.11**.

When reviewing a medical device protocol, the reviewer should also consider the following **(Device Assessment Form 2.11)**:

A. Proposed investigational plan (use of the device in the study)
B. Description of the device/ Product information including handling and storage requirements.
C. Copies of all labeling for investigational use
D. Reports of prior investigations conducted with the device
E. FDA Approval, IDE number
F. Risk assessment determination for new investigational device (Significant Risk or Non Significant Risk) and the rationale
G. Choice of comparator and justification (if applicable)
H. Summary of the necessary training and the experience needed to use the investigational device.
I. Device control, access and accountability.
J. List of additional procedures (example: surgery), medical device or medication to be used as part of the investigational study.
K. Risk-benefit assessment
L. Safety and effectiveness/ performance assessments
M. Prohibition against promotion or commercialization of, and certain other practices relative to, investigational devices.
N. References.

2.6.4.5a Primary reviewers make a decision in expedited review or make a recommendation for discussion during the next full board meeting. (Please refer to Section 1.1.9.4 of MMC IRB SOP Chapter 1)

2.6.4.5b For full board review, a decision is made after discussion. (Please refer to Section 1.1.9.4 of MMC IRB SOP Chapter 1)

- If an IRB determines that an investigation involves an SR device that the sponsor thought was an NSR device, it must notify the investigator and, if appropriate, the sponsor. If this occurs, the sponsor may not begin the investigation until an FDA approval is obtained.

2.6.4.6 If the protocols are for revision, they are sent back to the principal investigator for modification **(Form 2.9)**.

2.6.4.7 Documents are resubmitted **(Form 2.1, 2.4, 2.7A and 2.7C)** and reviewed by primary reviewers through expedited channel for minor revision or sent to full board for review of major revisions.

2.6.4.8 Approval decision is reached; the approval letter **(Form 2.10)** is prepared, signed by the Chair and communicated to the principal investigator. The frequency of continuing review is indicated in the approval letter.

2.6.4.9 The relevant documents are kept in the protocol file.

2.6.4.10 The IRB entry on the protocol database, tracker, and index about the protocol are updated.

2.7 Subcommittee PAnels for Investigator-Initiated REsearch ProtocolS (SPARES)

2.7.1 Purpose

To describe the mechanics of the Subcommittee PAnels for Investigator-Initiated REsearch ProtocolS (SPARES)

2.7.2 Scope

This SOP applies to the review and approval or study protocols within the scope of function of the SPARES.

2.7.3 Responsibility

It is the responsibility of SPARES members to review investigator-initiated protocols which include prospective studies, retrospective studies, chart reviews, simple descriptive studies, surveys or questionnaires, or other protocols involving minimal or no risk to study participants. The subcommittee reviews Adverse Events arising from the conduct of the protocol in consultation with the Adverse Events Committee. This includes review, approval and monitoring of the study protocols.

2.7.4 Process Flow/ Steps

NO.	ACTIVITY	RESPONSIBLITY
1	Determines if the study protocol will undergo the review of the SPARES subcommittee.	IRB Chair
2	Schedules a meeting with all members once a month at his discretion or alternatively, if desired, may decide on the protocol following consultations with the other members (ideally 1-2 weeks before the regular meeting).	Chair of the Subcommittee
3	Each SPARE reviewer is given 1-2 weeks to review the protocols.	IRB Secretariat
4	Protocol deliberation reaches a decision point: • **Approved** • **Minor revision** (the resubmission of the protocol will undergo expedited review by the	SPARES

	SPARES committee which initially reviewed and approved the protocol) • **Major revision** (the resubmission of the protocol will undergo full board review) • **Disapproved** • **Pending Decision**	
5	Announces the decisions on the various protocols during the regular IRB meetings held once a month.	Chair/ Vice Chair

Detailed instructions

2.7.4.1 The IRB chair assigns the study protocol under the review of the SPARES subcommittee. The scope of function of SPARES will cover:
A. Prospective research initiated by trainees.
B. All protocols falling under EXPEDITED review process
C. Retrospective studies
D. Chart reviews
E. Simple descriptive surveys or questionnaires.
F. Other protocols involving minimal risk, subjects or participants.

2.7.4.2 The assigned subcommittee chair schedules a meeting with all members once a month at his/her discretion or alternatively, if desired, may decide on the protocol following consultations with the other members (ideally 1-2 weeks before the regular meeting).

2.7.4.3 Each SPARE reviewer is given 1-2 weeks to review the protocols.

2.7.4.4 Protocol Deliberation reaches a decision point following the decision algorithm of the MMC IRB review process - namely:
A. Approved.
B. Minor modification (the resubmission of the protocol will undergo expedited review).
C. Major modification (the resubmission of the protocol will undergo full board review or another SPARES meeting).
D. Disapproved.
E. Pending Decision

2.7.4.5 The subcommittee Chair or Vice Chair announces the decisions on the various protocols during the regular IRB meetings held once a month.

2.8 Review of Resubmission

2.8.1 Purpose

To describe the procedures for the review of resubmissions.

2.8.2 Scope

This SOP applies to the review and approval of resubmitted documents (i.e, protocols, informed consent forms, and answers to IRB inquiries) and other revisions made on the study protocol prior to the initial approval.

2.8.3 Responsibility

It is the responsibility of the Secretariat to manage the document submission, send protocol documents to the primary reviewers, refer the protocol to full board meeting for discussion and decision, communicate the review results to the Principal Investigator, keep copies of the documents in the protocol files and update the protocol entry in the IRB database.

It is the responsibility of the primary reviewers to review and provide recommendations on the resubmissions.

The principal investigator is required to resubmit the study protocol with the response to the IRB inquiries 12 calendar days after the release of the Notification of IRB Decision **(Form 2.9).** If the resubmission is not provided 6 months from the release of the Notification of IRB Decision (Form 2.9), the research is considered inactive.

2.8.4 Process Flow/ Steps

NO	ACTIVITY	RESPONSIBILITY
1	Receive the submitted documents (with **Form 2.1, 2.7A, and 2.7C)** check for completeness of the requiremetns **(Form 2.4)** and forward to the Chair or Member-Secretary ⬇	Secretariat
2	Determine the type of review **(Form 2.6)** for the resubmission according to the decision **(Form 2.9)** made during the previous review.	Member-Secretary/ Chair

	⬇	
3	For full board or SPARES review: Include the resubmission in the Agenda and distribute the documents to the originally assigned reviewers. For expedited review: distribute the protocols to the originally assigned reviewers. ⬇	Secretariat
4	Deliberate and review the resubmission. ⬇	IRB Members/ Reviewers
5	Collect the evaluation forms **(Form 2.7C)** and prepare the Notification of IRB Decision **(Form 2.9)** or Approval letter **(Form 2.10).** ⬇	Secretariat
6	Signs the Notification of IRB Decision **(Form 2.9)** or Approval Letter **(Form 2.10).** ⬇	SPARES Chair/ Chair
7	Provide a copy of the Notification of IRB Decision **(Form 2.9)** or Approval Letter **(Form 2.10)** to the principal investigator**.** ⬇	Secretariat
8	Keep a copy of the related documents in file. ⬇	Secretariat
9	Update the IRB database, protocol tracker (**Form 4.4A and 4.4B**) and index.	Secretariat

Detailed Instructions

2.8.4.1 The Secretariat receives the documents for resubmission including the required forms **(Form 2.1, 2.7A, and 2.7C).** Using the List of Requirements for Resubmission **(Form 2.4),** the Secretariat checks for completeness.

2.8.4.2 The Member-Secretary recommends the type of review for the resubmission according to the decision **(Form 2.9)** made during the previous review. The Chair approves the recommended type of review.

2.8.4.3 For full board or SPARES review, the Secretariat includes the resubmission in the Agenda. The secretariat distributes the

documents to the originally assigned reviewers for full board, SPARES and expedited review. The Principal Investigator is no longer required to attend the meeting. The Independent Consultant is invited to attend when needed.

2.8.4.4 For expedited and SPARES review, the reviewers are given one (1) week to review the resubmission. For full board review, the documents for review are provided at least two weeks prior to the IRB meeting. During the IRB meeting, the board members and reviewers deliberate on the resubmission. The reviewers arrive at a decision – Approval, Minor Modification, Major Modification, Disapproval and Pending Decision.

2.8.4.5 The Secretariat collects the evaluation forms. If the decision is for modification, the secretariat, prepares the Notification of IRB Decision **(Form 2.9).** If the decision is approval of the resubmission, the Approval Letter **(Form 2.10)** is prepared.

2.8.4.6 For SPARES review, the SPARES Chair signs the Notification of IRB Decision **(Form 2.9).** This is noted by the IRB Chair.

For the full board and expedited review, the Chair signs the Notification of IRB Decision **(Form 2.9)** or the Approval Letter **(Form 2.10).**

2.8.4.7 The Secretariat provides the principal investigator with the copy of the Notification of IRB Decision **(Form 2.9)** or the Approval Letter **(Form 2.10).**

2.8.4.8 The Secretariat keeps a copy of the related documents (i.e., IRB forms, resubmission, etc.) in file.

2.8.8.9 The Secretariat updates the IRB database, protocol tracker (**Form 4.4A and 4.4B**) and index.

2.9 Policy on Protocol Review for Compassionate Use of Stem Cell Therapy and Others

2.9.1 BACKGROUND: COMPASSIONATE OR EXPANDED ACCESS USE

The Department of Health (DOH) of the Philippines allows administering stem cell therapy under compassionate grounds. While stem cell therapy is generally an unproven therapy for many indications, the DOH recognizes its role in some cancers of the blood and bone marrow, and primary immune-deficiencies treated by autologous or allogenic stem cell transplants. These treatments should only be given by trained professionals working in accredited facilities. When expanded access for a therapy is contemplated, even for individual patient use, the Food and Drugs Administration (FDA) requires institutional review board (IRB) review.

As mandated in FDA Circular # 2013-017 and DOH AO #2013-0012, the Makati Medical Center Institutional Review Board (MMC-IRB) must give its approval for administration of stem cell therapy by the MMC-Cellular Therapeutics Center (MMC-CTC) under compassionate grounds.

The MMC-IRB and its members need to understand and consider other pathways such as “compassionate use” or “expanded access” under which patients outside of clinical trials may receive innovative stem cell-based interventions. Below are some of the circumstances involved:

1. Stem cell interventions not initially amenable to a clinical trials approach
2. Expanded access to investigational stem cell products
3. Off label uses of FDA-approved stem cell products

“Compassionate Use” refers to the treatment of a seriously ill patient using an unapproved agent or modality where no other available treatments are satisfactory. Such use of an investigational drug, biologic or device is allowed only after prior review and approval by the IRB, and in most circumstances, prior approval by the FDA as well. Prior approval is needed even if only one patient is to be treated.

Expanded Access
Treatment INDs or Individual Patient Access to Investigational Drugs/Devices for Serious Diseases - are primarily intended to give seriously ill patients access to

experimental drugs or devices where no comparable or satisfactory alternative treatment is available. Although the sponsor is expected to continue conventional clinical trials and pursue marketing approvals with due diligence, expanded access studies involve systematic use of experimental treatments, and with very rare exceptions, require the same review and approval as research.

According to new US FDA policies made effective October 13, 2009, physicians may now request access to investigational drugs and biological products to treat individual patients and intermediate-size patient populations between 10 and 100. Its revised rules for expanded access are intended to "improve access to investigational drugs for patients with serious or immediately life-threatening diseases or conditions who lack other therapeutic options and who may benefit from such therapies."

Physicians can request FDA permission to administer investigational biological products (such as more-than-minimally manipulated stem cells and their derivatives) as long as these products are currently being tested elsewhere in a clinical trial and only if expanded access will not interfere with the conduct of clinical investigations.

Innovative therapies do not aim to produce generalizable knowledge but are aimed primarily at providing new forms of clinical care that have a reasonable chance of success for individual patients with few or no acceptable medical alternatives.

The terms *expanded access*, *access*, and *treatment use* are used interchangeably to refer to use of an investigational drug when the primary purpose is to diagnose, monitor, or treat a patient's disease or condition. The distinction between expanded access and the use of an investigational drug in the usual studies covered under an IND is that expanded access uses are not primarily intended to obtain information about the safety or effectiveness of a drug.

In order to request compassionate use or expanded access for individual patients or intermediate-size patient populations, the MMC-CTC must submit an application that includes the following:

1. the rationale for intended use
2. patient selection criteria
3. a description of the manufacturing facility

4. the method of administration to the patient
5. safety/toxicology information
6. plan of follow-up and monitoring
7. endorsement or letter of support by attending physician/department or section
8. review and approval by the MMC-CTC Subcommittee on Ethics

To render a favorable decision, the IRB must be convinced by the requesting physician or entity:

1. That the **probable risk to the patient from the investigational drug is not greater than the probable risk from the disease or condition**. The patient's physician and the requesting laboratory should make this determination based on the information about the drug available to the physician and the physician's knowledge of the patient's clinical situation.
2. that **the potential benefit justifies the potential risks of the treatment use with the drug and that those risks are not unreasonable in the context of the disease or condition to be treated.**
3. that the patient has a serious or life-threatening disease or condition and no other comparable or satisfactory therapeutic options
4. that providing access will not interfere with development of the drug for the expanded access use
5. that the patient cannot obtain the drug under another IND or protocol e.g., in a clinical study of the drug.

2.9.2 Objectives of Aforementioned Policy

To guide the MMC-IRB in reviewing protocols for diagnostic or therapeutic modalities under compassionate grounds

To identify the criteria that qualifies individuals for such compassionate use

To define the process to render a decision for compassionate use of any diagnostic or therapeutic modality

2.9.3 Scope

This policy applies to all requests for compassionate use of any diagnostic or therapeutic intervention submitted to the MMC-IRB to be conducted at MMC and/or to be performed outside MMC by an affiliated investigator.

The policy is initially developed to guide the IRB on protocols for stem cell therapy. It is expected that the same policy will be applied to other similar requests and protocols.

2.9.4 Responsibility

The Department Heads/ Managers of involved departments and principal investigators ensure the implementation of this policy.

2.9.5 Definition of Terms

Compassionate Use – use of a treatment outside a clinical trial in patients with serious or life-threatening diseases for which no other treatment is available or expected to be effective.

Stem Cell Therapy – a procedure that uses stem cells to treat or prevent conditions and diseases

Standard of Care – intervention generally accepted by experts and health care practitioners. (National Ethical Guidelines for Health Research 2011)

2.9.6 Criteria

These are the specific considerations in the compassionate use of stem cell therapy. The criteria that will allow access to compassionate treatment are:

1. The lack of an effective alternative treatment
2. Danger to the patient's life or serious damage to his or her health or a case of serious disease in rapid progression if no further intervention is done
3. Accountability by the prescribing physician and the director of the Cellular Therapeutics Laboratory

2.9.7 Process Flow/ Step

NO	ACTIVITY	RESPONSIBILITY
1	Receive the submitted documents (with **Form 2.2, or 2.4**) and forwards to the Chair or Member-Secretary	Secretariat
2	Determine that the protocol qualifies for Full Board review **(Form 2.6)**	Member-Secretary/ Chair
3	Assign reviewers to review the protocol and related documents	Member-Secretary/ Chair

4	Review the protocol documents using the guidelines in reviewing protocols on compassionate use.	Primary Reviewers
5	Include the protocol in the meeting agenda **(Form 4.1)** for discussion to arrive at a decision through full board	Secretariat/ Members
6	Communicate board decision to the principal investigator **(Form 2.9)**	Secretariat/ Chair
7	Keep copies of all documents in the protocol files. Update index **(Form 4.4A and 4.4B)** and the protocol entry in the MMC IRB database	Secretariat

Detailed Instructions:

2.9.7.1 The IRB Secretariat receives the submitted documents **(including Forms 2.1, 2.2, 2.5.2.7A, 2.7B, 2.8).** In addition to the documents specified in Form 2.2, the following are also required:

A. Letter for Intent from the Patient
B. Medical Abstract
C. Endorsement letter from the Attending Physician or an indication that there is no other possible management.
D. Informed Consent Form signed by the patient.
E. Minutes of the Meeting specifying the decision/ recommendation of the Cellular Therapeutics Ethics Committee.

The submitted documents are forwarded to the Member-Secretary and Chair for the determination of type of review.

2.9.7.2 Utilizing Form 2.6, the Member-Secretary recommends the type of review the study must undergo and the primary reviewers.

2.9.7.3 The Chair approves the recommendations from the Member-Secretary

using Form 2.6.

2.9.7.4 The study protocol is distributed to the primary reviewers and IRB Members for review. The guidelines in reviewing protocols on compassionate use are applied in the evaluation of the study protocols.

Guidelines

In compliance with the Food and Drug Administration (FDA) Circular 2013-0017 issued last 8 July 2013, "all human cells, tissues and cellular and tissue-based products (HCT/P's) are required to be registered under the Philippines regulatory agency." The therapy may only be conducted in accredited and licensed facilities. (FDA Circular No 2013-020)

To qualify for compassionate use, the patient must:

1. Have been given a diagnosis of a likely fatal illness. Examples include COPD, Coronary Artery Disease and Congestive Heart Failure
2. Have written statement from a board-certified physician in the same area of specialty of the likely fatal disease which states that the patient is end stage with an incurable disease, that no other types of care are available or other reasonable alternatives have failed, and the patient's condition is expected to worsen.
   (ICMS Compassionate Use in Stem Cell Therapies)

Compassionate use or humanitarian use of an investigational treatment is reviewed by an ethical review committee as though it were research. Informed consent should be obtained according to the legal requirements and cultural standards of the community in which the intervention is carried out.

The IRB is responsible for reviewing the following:

1. Ethical aspect of the research and therapy
2. Scientific rationale, design and data collection on safety and efficacy of stem cell and cell based or cellular therapy programs
3. Documentation and reporting of adverse events observed in patients receiving stem cell and cell-based or cellular treatments.

Free and informed consent should be obtained from the recipient of compassionate use prior to the start of the therapy. The informed consent should comply with the following universal ethical standards:

1. Comprehensive informed consent to include all possible benefits, side effects, costs (if any), provisions for withdrawal, plan of follow up and monitoring, and all unknowns
2. Informed consent that should contain safeguards so that consent can be obtained without undue influence
3. A copy of the consent provided to participants or patients, among others.

2.9.7.5 The Secretariat, with the approval from the Chair, includes the protocol in the meeting agenda (Form 4.1) for discussion to arrive a decision through full board.

The request is discussed in Full board (with mandatory attendance by a lay member). Decision points are Approved, Major Revisions, Minor Revisions, Disapproved.

2.9.7.6 The IRB Secretariat prepares the communication (Form 2.9) to the principal investigator specifying the board decision. The Chair signs the notification before sending the document to the Principal Investigator.

2.9.7.7 A copy of the notification (Form 2.9) and all other documents are kept in the protocol files. The Secretariat updated the trackers, index (Form 4.4.A, 4.4B and 4.5) and IRB database.

2.10 Clinical Trial Agreement (CTA)

2.10.1 Purpose

To describe the relationship of the Makati Medical Center Institutional Review Board procedures related to the signing process of a Clinical Trial Agreement (CTA). A clinical trial agreement acts as the legal protection of the sponsor, the institution and other individuals involved in the trial.

2.10.2 Scope

A clinical trial agreement is the contractual agreement between the Sponsor, the Investigator and Institution for clinical trials to avoid FDA compliance actions and later disputes over terms and obligations. A basic fee called Institutional Fee is applied for review of the agreement – legal and other pertinent issues.

The MMC IRB has no oversight functions over a legal agreement between the study sponsor and the institution.

2.10.3 Responsibility

The chair endorses to the Medical Director the protocols ethically cleared and approved by the MMR IRB.

The medical director, representing the Makati Medical Center, signs the clinical trial agreement upon the endorsement of the Makati Medical Center Institutional Review Board Chair and legal review of the legal officer.

2.10.4 Process Flow/ Steps

NO.	ACTIVITY	RESPONSIBILITY
1	Receive the copies of the CTA and official receipt of payment of the institutional fee **(Form 2.3)**. ⬇	Secretariat
2	Endorse the CTA to the medical director that the study involved has been ethically approved by the MMC IRB. ⬇	Chair
3	Send CTA for legal review and approval of the	Medical Director

	legal officer. ⬇	
4	Review and approve the CTA. ⬇	Legal Counsel
5	Sign the CTA and return the CTA to MMC IRB ⬇	Medical Director
6	Release the CTA to the principal investigator, keep a copy of the CTA on file and update the protocol index and database.	Secretariat

Detailed Instructions:

2.10.4.1 The secretariat receives the requirements for the signing of the Clinical Trial Agreement and checks if the requirements are complete by using the **Form 2.3**.

2.10.4.2 The Chair endorses the CTA to the Medical Director if the study involved has been ethically approved by the MMC IRB.

2.10.4.3 The medical director sends the CTA to the legal counsel for legal review.

2.10.4.4 The legal counsel reviews and approves the CTA.

2.10.4.5 The medical director signs the CTA and returns the CTA to MMC IRB.

2.10.4.6 The MMC IRB Secretariat keeps a copy of the CTA on file. The protocol index and database are updated.

2.11 Single Joint Research Ethics Board (SJREB) Review

2.12.1 Purpose

To describe the relationship of the Makati Medical Center Institutional Review Board procedures related to the Single Joint Research Ethics Board (SJREB).

2.12.2 Scope

This SOP is applied to all protocols submitted to SJREB for review and approval. Standard Operating Procedures on protocol review still apply.

2.12.3 Responsibility

It is the responsibility of the Makati Medical Center Institutional Review Board to participate in the SJREB review. The SJREB is a review mechanism for Philippine Health Research Ethics Board accredited DOH Hospitals. SJREB is applicable to non-DOH Research Ethics Committees (RECs) that will accept the results of the SJREB review. Site RECs are required to agree and abide with the procedures that the SJREB follows.

2.12.4 Process Flow/ Steps

NO.	ACTIVITY	RESPONSIBILITY
1	Parallel submission of protocol to SJREB and MMC IRB. ⬇	Principal Investigator
2	Receives invite from SJREB for the joint review of the submitted protocol. ⬇	Secretariat
3	Provides a letter of intent to SJREB to specify the IRB's interest in participating in the joint review of the submitted protocol. ⬇	MMC IRB
4	Conduct of a preliminary review of the protocol prior to SJREB review meeting. ⬇	IRB Chair (or designated member) and SPARES committee assigned for the month

5	Presents of all issues identified in the SPJREB Meeting ⬇	IRB Chair or the designated representative
6	Receive communications (e.g., status of the review, approval letter, etc.) from SJREB ⬇	MMC IRB
7	Review of protocol with decision from SJREB ⬇	Primary Reviewers
8	Communicate the decision of the review to the Principal Investigator ⬇	Secretariat
9	Keep copies of the protocol and protocol-related documents in the protocol file ⬇	Secretariat
10	Update the IRB database, protocol tracker (**Form 4.4A and 4.4B**) and index.	Secretariat

Detailed Instructions

2.11.4.1 Parallel submission of protocol documents to SJREB and MMC IRB is done. *Refer to Section 2.1 Protocol Submission.*

2.11.4.2 Sites that are selected by the sponsor for the conduct of multi-site researches are invited to send a representative to participate in the review during the SJREB meeting.

2.11.4.3 MMC IRB submits a letter of intent to SJREB to join in the deliberation by the SJREB. A membership list with Curriculum Vitae is submitted to SJREB. The participating Research Committee identifies the representative qualified to do scientific and ethical review for various types of protocols.

2.11.4.4 All protocols for Single Joint Review undergo preliminary review by the IRB Chair (or designated member) and SPARES committee assigned by the month. There is a quorum of at least three (3) reviewers. An Independent Consultant may be request to join at the discretion of the IRB Chair. The preliminary review follows the SOP Chapter 2 Initial Protocol Review and Approval.

2.11.4.5 All issues identified are presented by the IRB Chair or the designated representative in the SJREB meeting.

2.11.4.6 The MMC IRB is updated of the status of the Single Joint review of the protocol. The Joint Review is conducted for the initial review and renewal of approval of the researches. The MMC IRB retains review functions related to post approval submissions. IRB accepts the decision of the SJREB unless there are ethical issues that need to be addressed.

2.11.4.7 The proceedings of the review are similar to the conduct of the Full Board (Section 2.5) or the SPARES review (Section 2.7).

2.11.4.8 The Secretariat prepares the communication to inform the Principal Investigator of the review decision. The IRB Chair signs the communication (Form 2.9 or Form 2.10).

2.11.4.9 The Secretariat keeps the protocol and all protocol-related documents in the protocol file.

2.11.4.10 The Secretariat updated the IRB database and protocol tracker (Form 4.4A and 4.4B) and index.

2.12.1 Objectives:

A. To comply with the Philippine Health Research Ethics Board (PHREB) Resolution No. 20-001 Series of 2020 on the Review of Research Proposals on COVID-19.
B. To minimize health risks and safeguard the welfare of administrative staff, members of the Makati Medical Center- Institutional Review Board (MMC-IRB), reviewers and investigators submitting the protocol.
C. To provide guidelines for the conduct of research ethics review through electronic means.

2.12.2 Extent of distribution

The departments/ division involved in the review of research protocols.

2.12.3 Scope

This policy applies to all consultants, fellows, residents, medical interns, pharmaceutical companies, healthcare professionals and other (affiliated) investigators who plan to conduct researches subject for the review and approval of the MMC-IRB, MMC-IRB Secretariat Staff and MMC IRB Members. This includes the process from the online submission of the research proposal to the review of the post-approval submissions.

Definition of Terms:

Philippine Health Research Ethics Board (PHREB)	-	The national policy making body in health research ethics in the Philippines.
PHREB Resolution No. 20-001 Series of 2020 on the Review of Research Proposals on COVID-19	-	An ad referendum released by PHREB on 13 April 2020 authorizing all Research Ethics Committees regardless of accreditation to suspend application of pertinent provisions of Standard Operating Procedures necessary to conduct online meetings to review research during the COVID-19 pandemic.
COVID-19		Coronavirus disease; defined by the World Health Organization as an infectious disease “caused by a newly

		discovered coronavirus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes"' imposing limitations in human movement.
Exempted from review		Protocol submissions that are exempted for review are those that are under the following exemption criteria: **EX** / **EXEMPTION CRITERIA** **1** Study that does not involve human subjects or human data. **2** Study design is meta-analysis and/or systemic. **3** Case Reports
Principal Investigator		The main proponent of the research at the site tasked in conducting and overseeing protocol activities in compliance with vital research guidelines.
Protocol Screening		A process of determining type of review and assigning reviewers.
Designated Staff of Research Team		An administrative staff that is part of the research team that is sometimes delegated to submit documents or inquire protocol status updates to IRB.
Clinical Research Officer/Assistant		A clinical staff that is part of the Clinical Research Orgaqnization research team that are delegated to submit protocol documents or inquire status updates with regards to IRB operations, settlement of review fees and setting up contracts with MMC and MMC-IRB.
Coding		The process of assigning the MMC-IRB code to an initial protocol submission package.
Electronic Log Book		A log consisting of all submissions accepted within a day, with information as to the date when documents are received, submission type, name of sender and name of staff who received the document.
Electronic Master list Database		A master list database found inside the MMC intranet containing basic information of particular research

		protocol; only the Secretariat staff has access to edit and print the contents of the database
Electronic Protocol Folder		A folder inside a secured internet-based cloud that contains all submitted protocol documents.
Official email		The account issued by Makati Medical Center for IRB use in communicating confidential information and storing documents that are part of a protocol package.
Type of Review		The classification of the review of a submission whether for full board or expedited based on a defined criterion
Primary Reviewers		A small group of IRB members assigned to present the protocol before the Board and provide initial assessment of the technical and ethical soundness of the protocol package.
Independent Consultants		Expert reviewer; individuals that are experts in a particular field who are invited to evaluate the technical and ethical soundness of the protocol that require such expertise in addition to those available within the MMC-IRB
Virtual Meetings		Meetings done through the use of a secured online platform to replace the need for the physical presence of members and staff during meetings.
IT Host		An IT staff designated to assist departments in scheduling and facilitating meetings. The IT host also safeguards security of the online meeting room.
Virtual Conference Reservation Application		A Microsoft application developed by the IT team to schedule meetings using the licensed accounts owned by MMC.
ZOOM		A “cloud-based video conferencing’’ application.
Meeting ID		A log-in detail required in joining a virtual meeting via ZOOM.
Meeting Password		A log-in detail required in joining a virtual meeting via ZOOM which also provides security in an online meeting

		room.
Visual Aids		Includes the PowerPoint presentations of each initial protocol submission for review, agenda of the meeting and discussion of other matters.
Quorum		The minimum number of IRB members that must be present during meetings to make the proceedings valid.
Conflict of Interest		A member or reviewer holds interest on the study reviewed affecting his/her evaluation and protection of study participants.
Agenda of the Meeting		A document containing the meeting flow and a detailed list of protocol submissions for review and other important matters to be discussed in the meeting.
Minutes of the Meeting		A detailed account of the review and decision of protocol submissions.
Approved Protocols		Protocols that acquired approval from the Board and may start with the implementation/conduct protocol activities
Full Board Review		Major revisions of the protocol and informed consent after initial review/ Amendments that involve major changes from previously approved protocol or consent form (major changes in the inclusion/ exclusion criteria, safety issues, etc.)/ Major amendments that change the risk/ benefit ratio/ Major protocol violations/ Progress/ Final reports that deviate from original approval given by the IRB/ Onsite SAEs or SUSARs that may require protocol amendment or reconsent of participants.
Expedited Review		Proposed initial submissions, continuing reviews, protocol amendments and end of study reports that have minor modifications and no significant risk to study participant.
Other Matters		Includes details regarding the next meeting schedules, financial reports and announcements involving seminars, trainings, and invitations for the Board.
Decision letters		Notification of IRB Decision (NOID) and approval letters

		containing details of the IRB review of the protocol given to the proponents of a research.

2.12.4 Policy Statement

The MMC-IRB shall receive and screen submission of research proposals with complete pertinent requirements as well as post approval documents through electronic means only during the pandemic. Decision for the application of research protocol and post approval monitoring documents is facilitated through email and virtual meetings during a pandemic emergency.

Process Flow Map

NO.	ACTIVITY	RESPONSIBILITY
1	Submits the protocol and complete pertinent requirements as well as post-approval monitoring documents for IRB review via electronic means to the official IRB email address	Principal Investigator/Designated staff of the research team/Clinical Research Officer & Assistant
2	Receives and screens protocol submissions/post-approval monitoring documents for completeness	IRB Secretariat Staff
3	Assigns permanent code to the protocol submission package	IRB Secretariat Staff
4	Encodes and logs received protocol submissions in the electronic log book and electronic masterlist database	IRB Secretariat Staff
5	Prepares electronic protocol folder	IRB Secretariat Staff
6	Forwards submission package to Member-Secretary	IRB Secretariat Staff

7	Assigning of Type of Review and Primary Reviewers	Member-Secretary
8	Approves the Member-Secretary's recommendation of Type of Review and Primary Reviewers	IRB Chair
9	Encoding and logging of received protocol in IRB database.	IRB Secretariat Staff
10	Decks the submission for review	IRB Secretariat Staff

Detailed Instructions:

2.12.4.1 Principal Investigator/Designated staff of the research team/ Clinical Research Officer & Assistant complies with the IRB Requirements and submit via email to irbmmc.admin@makatimed.net.ph

2.12.4.2 The Secretariat Staff checks the completeness of the documents based on the requirement checklist within two (2) days upon receipt of the submission.

A preliminary screening is done by the Secretariat based on an established criteria to determine if the submission is exempted from review or needs to undergo Full board/expedited review.

Sends acknowledgement receipt to the sender.

2.12.4.3 The Secretariat Staff assigns a permanent MMCIRB code to the submission package.

2.12.4.4 Complete submissions are entered into the electronic log book and electronic masterlist database.

2.12.4.5 Creates an electronic folder inside the MMC-IRB OneDrive t contain all documents in the submission.

2.12.4.6 IRB Secretariat Staff sends the protocol submission package to the Member-Secretary via email to inquire about the appropriate type of review and assignment of primary reviewers.

2.12.4.7 Within two (2) working days, upon receipt of the submission, the Member-Secretary identifies primary reviewers and independent consultants (if necessary) to review the submission. The Secretariat staff forwards the recommendation to the IRB Chair for review and approval.

2.12.4.8 The Chair approves/gives suggestions or corrections to the Member-Secretary's recommendations within two (2) days upon receipt of the submission.

2.12.4.9 The IRB Secretariat decks the submission for review in the upcomig meeting.

2.12.5 Setting of Online Meeting and Quorum Check

NO.	ACTIVITY	RESPONSIBILITY
1	Schedules the meeting through ZOOM virtual reservation ⬇	IRB Secretariat Staff
2	Receives confirmation of successful reservation of online meeting room. ⬇	IRB Secretariat Staff
3	Sends notice of meeting for a quorum and coordinates meeting details to the Board ⬇	IRB Secretariat Staff
4	Confirmation of attendance in the meeting	Chair, Member-Secretary, and IRB Members

2.12.5.1 IRB Secretariat books an available slot for the online meeting at least one (1) week prior to the standard schedule of IRB review meeting (every 3rd Tuesday of the month for full board review, and depending on the schedule set by the IRB SPARES Chair for expedited review).

2.12.5.2 The IRB Secretariat receives a confirmation from IT regarding successful reservation and is given the ZOOM meeting ID and password.

2.12.5.3 Within one (1) working day upon the receipt of confirmation and meeting details, the IRB Secretariat asks the availability of the members of the Board through a quorum check in the official MMC-IRB Viber. Group

2.12.5.4 Within one (1) working day upon receipt of the notice of the meeting, the Chair, Member-Secretary and IRB Members must confirm availability/inform his/her absence on the scheduled meeting.

2.12.6 Preparation of Meeting Materials and Submissions for Review

NO.	ACTIVITY		RESPONSIBILITY
1	Collection and record documents submitted to the IRB		IRB Administrative Staff
2	Preparation of draft of the meeting agenda		IRB Administrative Staff
3	Reviewes initial draft of meeting agenda		Member-Secretary
4	**Disapproved:** Needs revision	**Approved**: Prepare agenda for distribution	IRB Administrative Staff
5	Review final draft if meeting agenda		IRB Administrative Staff
6	Distribute Agenda to the IRB Members		IRB Administrative Staff

Detailed Instructions

2.12.6.1 The Administrative Staff collects and records electronic submissions within the 3rd and 4th week of the month to be included in the next month's meeting agenda.

2.12.6.2 The Administrative Staff drafts the meeting agenda by putting all submissions received within the given period for discussion or information of the IRB

2.12.6.3 The Secretariat submits a complete draft of the meeting agenda to the Member- Secretary at least two (2) weeks before the meeting for corrections/revisions.

The Member-Secretary provides the result of the initial review of the agenda within three (3) working days upon

2.12.6.4 Within one (1) working day upon receipt of the revised/reviewed meeting agenda, the final draft is sent to the Chair for corrections/revisions.

The Chair reviews the agenda within three (3) working days upon receipt.

The Chair signs the final corrected/reviewed draft of the agenda.

2.12.6.5 Within two (2) working days upon receipt of the final draft of the agenda from the Chair, the agenda is distributed to the members.

2.12.7 Preparation of Meeting Minutes

NO.	ACTIVITY	RESPONSIBILITY
1	Organize and document the meeting procedures and the items taken up based on the meeting agenda (Form 4.1)	IRB Staff
2	Preparation of the draft of live minutes of the meeting	IRB Staff

Detailed Instructions

2.12.7.1 Organize and document the meeting procedures and the items taken up based on the meeting agenda (Form 4.1)

2.12.7.2 Preparation of the draft of live minutes of the meeting.

2.12.8 Distribution of Submissions for Review

NO.	ACTIVITY	RESPONSIBILITY
1	Upload the soft copy of the files for review (initial proposal, SAEs, post approval monitoring)	IRB Staff
2	Create a soft copy of folders containing the protocols for review.	IRB Staff
3	Send the protocols to the designated reviewers in a zip folder.	IRB Staff

Detailed Instructions

2.12.8.1 IRB Staff uploads the soft copy of the files for review (initial proposal, SAEs, post approval monitoring).

2.12.8.2 IRB Staff creates a folder in the computer containing the protocols for review.

2.12.8.3 IRB Staff sends the protocols to the designated reviewers in a zip folder.

2.12.9 Online Review Meeting (Before the meeting)

NO.	ACTIVITY	RESPONSIBILITY
1	Contact IT to prepare a schedule for a zoom meeting. ⬇	IRB Staff
2	Prepare the Meeting Agenda for the month. ⬇	IRB Staff
3	Prepare the Minutes of the meeting.	IRB Staff
4	⬇ Upload, prepare, and send the soft copy of the files that will be distributed to the reviewers.	IRB Staff
5	⬇ Remind the IRB Members, Independent Consultants/Expert Reviewers, and the Principal Investigators regarding the schedule of the IRB Meeting.	IRB Staff

Detailed Instructions

2.12.9.1 The IRB Staff contacts the IT to prepare a schedule of the IRB Full Board/SPARES/Special Meeting.

2.12.9.2 The IRB Secretariat prepares the Agenda of the Meeting for the month.

2.12.9.3 The IRB Staff prepares the Minutes of the Meeting for the month.

2.12.9.4 The IRB Staff uploads, prepares, and sends the files that will be distributed to the reviewers.

2.12.9.5 The IRB Staff reminds the IRB Members, Independent Consultants/Expert Reviewers, and Principal Investigators regarding the schedule of the IRB Meeting.

2.12.10 Online Review Meeting (during the meeting)

NO.	ACTIVITY	RESPONSIBILITY
1	The IRB Staff makes sure that there is a quorum during the meeting.	IRB Staff
2	The IRB Chairman initiates to start the meeting if there is a quorum.	IRB Staff
3	The IRB Staff is flashing the screen of Minutes of the Meeting and Meeting Agenda.	IRB Staff
4	The IRB Staff reminds the Expert Reviewers and Principal Investigators to wait for their queue until the staff admit them in the zoom room.	IRB Staff
5	The IRB Reviewers reviews/deliberates the designated protocol for review and post approval review.	IRB Reviewers
6	The IRB Staff reports the other matters to the board.	IRB Staff
7	The IRB Chair adjourned the meeting.	IRB Chairman

Detailed Instructions:

2.12.10.1 The IRB Staff makes sure that there is a quorum during the meeting.

2.12.10.2 The IRB Chairman initiates to start the meeting if 50% of the quorum was met.

2.12.10.3 The IRB Staff flashes the screen containing the Meeting Agenda and the Minutes of the Meeting.

2.12.10.4 During the meeting, the IRB Staff reminds the Expert Reviewers/Independent Consultants and the Principal Investigators to stand-by and wait for their queue until they are admitted in the zoom room.

2.12.10.5 The IRB Reviewers reviews/deliberates the designated protocol for review and the post approval review.

2.12.10.6 The IRB Staff reports the other matters to the board.

2.12.10.7 The IRB Chairman adjourns the meeting of the month.

2.12.11 Online Review Meeting (after the meeting)

NO.	ACTIVITY	RESPONSIBILITY
1	Collection of accomplished assessment forms from the reviewers.	IRB Staff
2	Collection of meeting recording from IT	IRB Staff
3	Polishing of Minutes of the Meeting	IRB Staff
4	Correction/Approval of Minutes of the Meeting	IRB Chairman
5	Filing of Minutes of the Meeting, Agenda of the Meeting, and Accomplished evaluation forms.	IRB Staff
6	Distribution of Notification of IRB Decision to the principal investigators	IRB Staff

Detailed Instructions:

2.12.11.1 Checks completeness of accomplished evaluation forms and stores meeting materials in the cloud before deleting used files in the computer/laptop.
2.12.11.2 IRB Staff collects the recording of the zoom meeting from the IT for achieve.
2.12.11.3 IRB Staff polish the Minutes of the meeting to be sent to the IRB Chairman.
2.12.11.4 IRB Chairman edits the minutes of the meeting and approves it.
2.12.11.5 IRB Staff archives the approved Minutes of the Agenda, Agenda of the meeting, and accomplished evaluation forms of the reviewers.
2.12.11.6 The IRB Staff distributes the Notification of IRB Decision (Initial proposal, SAEs, Post approval monitoring) to the designated principal investigators.

Guidelines:

1. This policy adheres to the PHREB Resolution on the Review of Research Proposals on COVID-19. The MMC IRB is given authorization "to suspend application of pertinent provisions of their Standard Operating Procedures (SOPs) to the extent necessary to conduct online meetings to review research protocols and for other purposes."
   A. The minutes of the meeting are documented to ensure adequate recording of the review, deviation and other proceedings conducted by the board.
   B. "Due consideration must be given to the risks to privacy and confidentiality arising from the conduct of online meetings and the electronic transmission of documents";
   C. The MMC IRB "promptly reports to PHREB when such meetings are conducted and what challenges are encountered";
   D. The MMC IRB "considers immediate amendments to their SOPs to address the issues that are now being encountered because of the national health emergency and in anticipation of similar future contingencies."

2. In light of the current pandemic and restrictions with human movements, the management of submissions must all be done through electronic means and the following guidelines must be observed:
   - Only the Secretariat staff has access to the online storage platform, Microsoft OneDrive that is found inside the MMC Intranet.
   - All communications shall be recorded accurately and appropriately in the electronic log book and electronic masterlist database. Protocol-related communications are separated from administrative communications. Incoming communications shall be acted upon promptly.
   - Electronic submissions must be screened by the Secretariat Staff in the official MMC-IRB email from Monday-Friday, 08:00 AM- 5:00PM using only the official desktop/laptop computers of MMC-IRB.
   - The Secretariat staff should send an acknowledgement receipt to the sender of the submission with the following details:
     - completeness of submission or lacking requirements and;
     - designated IRB code.
   - Completed submissions are entered into the electronic logbook by the Secretariat with details of the following:

- designated MMC-IRB code;
- name of proponent;
- type of submission;
- date of submission and;
- name of receiver

- Electronic folders shall be created by the Secretariat only inside the official Internet-based storage platform (MMC-IRB OneDrive) to contain all documents in the submission.
  - The electronic folder shall be labeled with the designated MMC-IRB protocol code.
  - Secretariat Staff, Member-Secretary, Chair and IRB Members must only communicate matters involving protocol submissions via official email addresses on record.

3. Face-to-face meetings shall be replaced with virtual meetings:
   - Virtual meetings are conducted through ZOOM, using the online meeting room hosted by the IT Team. Meetings shall be presided by the Chair or designated substitute.
   - Only the members of the MMC-IRB, Secretariat Staff and the IT Host are allowed to attend the meeting unless otherwise specified. The principal investigator or designated representatives and Independent Consultants, are asked to be present for a particular portion of the meeting when specific protocol is reviewed.
   - The meeting must be recorded by the IT Host and must be turned over to the IRB Secretariat within three (3) working days after the meeting. Recording will be sent only to the Member-Secretary/Secretariat. After 3 business days, IT Host will permanently delete the recording in their cloud.
   - The IRB members and Secretariat Staff must secure good internet connection and clear audio during the meeting.
   - The IRB members must ensure that their backgrounds are free of unnecessary noise and shall ensure that their microphones are placed on mute when not delegated to share their comments. The Member-Secretary may also put the microphones on mute of other members when not in use.
     Meetings shall proceed only when quorum is declared, and shall be guided by the approved agenda.
   - The presence of a conflict of interest among the members shall be disclosed prior to the discussion of each protocol for review.

- Chair may give a 5 to 10-minute break to maintain the integrity of quorum. The members are encouraged to refrain from leaving at any time during a review to maintain the quorum.
- Meeting may be suspended or terminated early once quorum is lost.
- Discussion during the meeting are organized into 2 parts:
  - Technical and Ethical Issues and;
  - Informed Consent Form
- Decision shall be done through voting. IRB members can vote by using the "raise hand" option in ZOOM.
- Primary reviewers who are not able to attend the meeting should submit the protocol and the completed assessment forms with the comments, recommendations and decision via email to the Secretariat before the meeting starts. The submitted comments, recommendations and decision are flashed on the screen during the online meeting. The Chair or member-secretary may speak in behalf of the absent reviewer.
- The decision letters shall be electronically signed by the Chair.
- Approved documents such as Informed Consent Forms and recruitment materials shall bear the electronic stamp of IRB approval and signature of the Chair.

Responsibility:

A. Chair

It is the utmost responsibility of the Chair to lead the discussion of the Board and to maintain the integrity through compliance with important guidelines in the conduct of the ethical review of the researches.

For protocol with Clinical Trial Agreements for signature of the Medical Director, the chair endorses to the Medical Director the protocols ethically cleared and approved by the MMC IRB. It is also the responsibility of the Chair to approve the recommendations of the Member-Secretary and delegate important tasks and responsibilities to certain IRB members and staff, as deemed necessary.

B. Member Secretary

Member-Secretary is tasked to provide oversight of the Secretariat Staff to ensure that IRB operations are well-maintained. The Member-Secretary ~~also~~ serves as the Co-Host during virtual meetings and reports vital findings with regards to IRB

office operations to the Chair. It is also the responsibility of the Member-Secretary to delegate tasks to the Secretariat Staff, as deemed necessary.

C. IRB Members

It is the responsibility of the members assigned as primary reviewers to thoroughly review the study protocols, give their decision, observation and comments and put all of this in the Study Assessment Forms **(Form 2.7A, 2.7B and 2.8)** before returning the reviewed protocol and assessment form to the Secretariat on or before the due date via electronic means. Reviewers are present during the meeting for final deliberation and discussion.

It is ~~also~~ the responsibility of IRB members to immediately communicate any difficulties faced in the conduct of the online reviews.

D. Secretariat Staff

It is the responsibility of the Secretariat to manage the electronic document submission, send protocol documents to the primary reviewers, refer the protocol to full board meeting for discussion and decision, communicate the review results to the Principal Investigator, keep copies of the documents in the protocol files and update the protocol entry in the IRB database and ensure privacy and confidentiality of data.

Secretariat is responsible for receiving, verifying and managing the contents of the electronic version of the submitted protocol package. In addition, the Secretariat should create a specific protocol file, make copies of the file and then distribute the copies to the Makati Medical Center IRB reviewers, together with a cover letter where the due date for returning the reviewed protocol is indicated as well as the schedule of meeting when the protocol will be discussed.

Secretariat must also coordinate with the Member-Secretary to address certain issues and in managing difficulties encountered by the reviewers during the conduct of ethical review.

Required Education:

1. Good Clinical Practice (renewed every three years).

2. Knowledge in basic operation of computer applications and virtual platforms such as Zoom.

Attachment:

1. PHREB Resolution on the Review of Research Proposals on COVID-19 No. 20-001 Series of 2020
2. 2020 PHREB SOP Workbook

Reference/s:

1. Philippine Health Research Ethics Board. *PHREB Resolution on the Review of Research Proposals on COVID-19 No. 20-001 Series of 2020.* Retrieved from http://www.ethics.healthresearch.ph/index.php/phoca-downloads/category/18-phreb-resolutions
2. Philippine Health Research Ethics Board. *2020 PHREB SOP Workbook.* Retrieved from http://www.ethics.healthresearch.ph/index.php/phoca-downloads/category/19-2020-phreb-sop-workbook
3. World Health Organization. *Coronavirus.* Retrieved from https://www.who.int/health-topics/coronavirus#tab=tab_1
4. IT Advisory. *Guidelines on using Virtual Conference Reservation.* Retrieved from IT Advisory 08 May 2020

Review: The IRB Chair or designate reviews this policy every three (3) years or earlier as indicated.

History

Author	Version	Date
Agustin, John David S. Mercado, Kristine D.	1	

MMC IRB SOP Version 6
Document History (Chapter 2)

Author	Chapter	Version	Date	Summary of Changes
Darwin A. Dasig, M.D.	2	6	November 17, 2020	• Added Section 2.12 Submission, Review and Approval of Research Protocol and Post Approval Documents during Pandemic Emergency • **Section 2.3.4.2** Added Indemnity and Insurance in the evaluation tool. • **Section 2.1.4.1 and 2.5.4.7** Revised the turnaround time to 4 weeks