Annex 3

Recommendations to assure the quality, safety and efficacy of BCG vaccines


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Recommendations published by the WHO are intended to be scientific and advisory in nature. Each of the following sections constitutes guidance for national regulatory authorities (NRAs) and for manufacturers of biological products. If an NRA so desires, these Recommendations may be adopted as definitive national requirements, or modifications may be justified and made by the NRA. It is recommended that modifications to these Recommendations be made only on condition that such modifications ensure that the vaccine is at least as safe and efficacious as that prepared in accordance with the recommendations set out below. The parts of each section printed in small type are comments for additional guidance, intended for the benefit of manufacturers and NRAs.
Introduction

The last revision of the Requirements for dried bacille Calmette–Guérin (BCG) vaccine for human use was in 1985, and an amendment which updated the section on the expiry date was published in 1988 (1, 2). Recent WHO consultation meetings (3–6) have addressed issues concerning the improvement of vaccine characterization and quality control assays of BCG vaccine to reflect current state-of-the-art technology. In addition, a recommendation to replace the International Reference Preparation for BCG vaccine by substrain-specific Reference Reagents evaluated by collaborative studies has been proposed. This document provides: recommendations for the production and control of BCG vaccines (Part A); guidelines for nonclinical evaluation (Part B); guidelines for the content of the clinical development programme applicable to BCG vaccines (Part C); and recommendations for NRAs (Part D). The guidelines for nonclinical evaluation apply to classic BCG vaccine products that are still in need of such evaluation, including newly manufactured products requiring clinical trial studies or those produced following changes in the manufacturing process. The clinical part of this document aims to provide a basis for assessment of efficacy and safety of BCG vaccines in pre-licensing clinical trials as well as in post-marketing surveillance, monitoring consistency of production and clinical testing of new classic BCG vaccine products. If important changes have been introduced to an authorized production process, the need for preclinical and clinical testing should be considered on a case-by-case basis in consultation with the NRA(s) concerned.

General considerations

Tuberculosis (TB) was declared a global emergency by WHO in 1993, and Mycobacterium tuberculosis (M. tuberculosis) is now considered to be responsible for more adult deaths than any other pathogen. Vaccination with BCG still remains the standard for TB prevention in most countries because of its efficacy in preventing life-threatening forms of TB in infants and young children. It is inexpensive and usually requires only one administration in either newborns or adolescents (7, 8). As there is currently no suitable alternative, BCG will remain in use for the foreseeable future and may continue to be used as a prime vaccine in a prime-boost immunization schedule in conjunction with new TB vaccines (4).

BCG vaccine contains a live, attenuated strain of M. bovis that was originally isolated from cattle with tuberculosis and cultured for a period of 13 years and a total of 231 passages (7). The BCG vaccine was first used to immunize humans in 1921. Following its introduction into the WHO Expanded Programme on Immunization (EPI) in 1974, the vaccine soon reached global coverage rates exceeding 80% in countries endemic for TB (9).
Over the years, different BCG vaccine seed strains have evolved from the original vaccine strain for production. A number of BCG vaccine strains that are used worldwide differ in terms of their genetic and phenotypic properties, and their reactogenicity and immunogenicity profile when given to infants and children. With this background of a diversity of substrains, manufacturing processes, immunization schedules and levels of exposure to environmental mycobacteria and virulent *M. tuberculosis* infection, different levels of protective efficacy of BCG vaccines in adult populations have been reported (10). However, the data are insufficient to make recommendations on whether one strain should be preferred over the other (11). The United Nations agencies are the largest supplier of BCG vaccines, distributing more than 120 million doses each year to more than 100 countries. Worldwide, the most commonly used vaccine strains are currently Danish 1331, Tokyo 172-1 and Russian BCG-I because they are supplied by the United Nations Children’s Fund (UNICEF) which purchases the vaccines through a published prequalification process which determines their eligibility for use in national immunization programmes (12).

There has been particular concern over the safety of BCG vaccination in subjects infected with the human immunodeficiency virus (HIV) (8). WHO previously recommended that in countries with a high burden of TB, a single administration of BCG vaccine should be given to all healthy infants as soon as possible after birth, unless the child presented a symptomatic HIV infection (9). However, recent evidence shows that children who were HIV-infected when vaccinated with BCG at birth, and who later developed acquired immunodeficiency syndrome (AIDS), were at increased risk of developing disseminated BCG disease. Among these children, the benefits of potential prevention of severe TB are outweighed by the risks associated with the use of BCG vaccine; thus the use of BCG vaccines at birth in relation to HIV-infected infants should follow the recommendations of the Global Advisory Committee on Vaccine Safety (GACVS) (13, 14).

**Special considerations**

The formulation of international requirements for freeze-dried BCG vaccine is complicated by the following: (a) a number of different substrains derived from the original strain of BCG are used in vaccine manufacture; (b) a number of different manufacturing and testing procedures are employed; (c) it is difficult to identify a link between significant differences in vitro and in vivo between different BCG vaccine strains and any possible differences in protective efficacy against TB in humans; (d) vaccines are produced with different total bacterial content and numbers of culturable particles; and (e) vaccines intended for administration by different routes are prepared. Therefore, the following considerations should be borne in mind regarding the scope of these recommendations, BCG vaccine strains, and potency-related tests.
Scope of the Recommendations

These revised Recommendations refer to freeze-dried BCG vaccines prepared from substrains derived from original BCG for use in the prevention of TB. Where BCG vaccine is issued in liquid form, the application of these Recommendations is entirely the responsibility of the NRA. In that case, only the relevant parts of this document apply since the limited stability of liquid BCG limits the possibility of completing the full recommended control test schedule. Although many of the principles expressed in this document (e.g. manufacturing, quality control) are expected to apply also to new recombinant BCG and other live, attenuated mycobacterial vaccines modified by molecular biology techniques, these novel vaccines are outside the scope of these Recommendations. The same pertains to the use of BCG for immunotherapy (e.g. treatment of bladder cancer). However, applicability of issues on nonclinical and clinical evaluations should be considered on a case-by-case basis. These Recommendations have been formulated primarily to cover vaccines intended for intradermal and percutaneous administration. Although WHO recommends intradermal administration of the vaccine, preferably in the deltoid region of the arm using syringe and needle, other administration methods such as percutaneous application by the multiple puncture technique are practised in some countries (9, 15–17).

BCG vaccine strains

The original BCG vaccine strain was formerly distributed by the Pasteur Institute of Paris and subcultured in different countries using different culture conditions that were not standardized. Over the years, more than 14 substrains of BCG have evolved and have been used as BCG vaccine strains in different parts of the world (see Appendix 1). Recently, the various substrains have been studied by comparative genomics (18, 19). BCG vaccine strains were thus divided into the “early” strains, in which the original characteristics of “authentic Pasteur” were conserved with fewer deletions, insertions and mutations in the genome of the bacilli than the “late” strains. “Early” strains are represented by BCG Russia BCG-I, BCG Moreau-RJ, BCG Tokyo 172-1, BCG Sweden, and BCG Birkhaug; and the “late” strains include BCG Pasteur 1173P2, BCG Danish 1331, BCG Glaxo (Copenhagen 1077) and BCG Prague. The genomic sequences of BCG Pasteur 1173P2 as a “late” strain, and BCG Tokyo 172-1 and BCG Moreau as “early” strains were determined (18–20). There is insufficient direct evidence to suggest that various BCG substrains differ significantly in their efficacy to protect against TB in humans. However, evidence from animal and human studies indicates differences in the immune responses induced by different BCG vaccine strains (12, 21). Although the “early” strains may confer better protection against
TB in some animal studies (18, 22), commonly administered BCG vaccine strains including both evolutionary “early” and “late” strains induce comparable protective immunity against TB (23).

Only master seed lots that have been shown to be acceptable by laboratory and clinical tests on batches derived from them should be used for the production of working seed lots and/or final product. A suitable seed lot of BCG should yield vaccines that give protection in experimental animals, produce a relatively high level of immunological responses to \textit{M. tuberculosis} antigens including tuberculin sensitivity in humans, and have an acceptably low frequency of adverse reactions (see section A.3.1).

Some manufacturers of freeze-dried BCG vaccine have modified their master seed lot strain to make it more suitable for their particular production procedure. The seed lots prepared in this way may not retain the same immunogenic properties, and should be used only with the approval of the NRA.

In practice, a product prepared from BCG seed lots may generally be investigated in humans only for the properties of producing tuberculin sensitivity and vaccination lesions. The former should be measured by the distribution of tuberculin reactions according to size in persons vaccinated with a given dose of BCG vaccine. A low dose of tuberculin should be employed (e.g. equivalent to 5 IU of the First WHO International Standard for purified protein derivative (PPD) of \textit{M. tuberculosis}, or 2 tuberculin units (TU) of a batch of PPD RT23 with Tween 80).

Currently three substrain-specific Reference Reagents for BCG vaccines are available: BCG Danish 1331, Tokyo 172-1 and Russian BCG-I.

**Potency-related tests**

There is some evidence that BCG seed lots that have been shown to produce vaccines with protective potency in laboratory animals and tuberculin sensitivity in humans will give effective protection against TB in humans. It should be noted that tuberculin sensitivity is a marker for cell-mediated immune responses to mycobacteria and not a direct indicator of protective immunity. A number of alternative laboratory tests have been developed primarily for research purposes but, to date, none have been proved reliable indicators of protective immune conversion following administration of different vaccines.

Studies in animals should include protection tests, tests of vaccination lesions, and tests for tuberculin conversion. Immunizing efficacy should be measured in terms of degree of protection afforded to the test animals against a challenge with virulent \textit{M. tuberculosis}. Sensitizing efficacy should be measured by the average dose of vaccine that will convert a negative tuberculin reaction in guinea-pigs to a positive one, as well as by the reaction time during which
the conversion takes place. In these animal tests, the inclusion for comparative purposes of an in-house reference BCG vaccine prepared from a seed lot known to be effective in animals and humans is recommended.

Currently there is no biomarker which directly correlates to clinical efficacy of BCG vaccine. These Recommendations are intended to be used for ensuring the manufacture of consistent lots. This means that new lots should not significantly differ from those that have already been shown to be safe and effective in humans.

At present, for batch control purposes, much reliance is placed on tests for the estimation of the total bacterial content and for the number of culturable particles. It is not possible to specify single requirements for the total bacterial content and for the number of culturable particles for all vaccines (24), since different substrains and methods of manufacture may yield different specifications for these parameters. For example, although the number of culturable bacteria in a single human dose may differ for different vaccines, these vaccines may show satisfactory properties as regards their ability to induce adequate sensitivity to tuberculin and their safety in humans. It is therefore essential that clinical studies for dose optimization in humans be carried out to estimate suitable total bacterial contents and the number of culturable particles for a particular manufacturer's product. For a particular vaccine, the difference between the lower and upper specification for the number of culturable particles should not be larger than fourfold. In addition, it is necessary to perform animal experiments that give an indication of the safety and efficacy of the vaccines to the satisfaction of the NRA.

Part A. Manufacturing recommendations

A.1 Definitions

A.1.1 International name and proper name

The international name should be “freeze-dried BCG vaccine”. The proper name should be the equivalent of the international name in the language of the country of origin. The use of the international name should be limited to vaccines that satisfy the recommendations formulated below.

A.1.2 Descriptive definition

Freeze-dried BCG vaccine is a freeze-dried preparation containing live bacteria derived from a culture of the bacillus of Calmette and Guérin, known as BCG, intended for intradermal injection. The name of the freeze-dried vaccine intended for percutaneous vaccination, should be “freeze-dried BCG vaccine, percutaneous”. The preparation should satisfy all the recommendations formulated below.
A.1.3  International Reference Preparations and Reference Reagents

The First WHO International Reference Preparation for BCG vaccine was established in 1965 and the First WHO International Standard for PPD of *M. tuberculosis* was established in 1951. Because of the age of these preparations, the need for replacements has been recognized, especially for the First WHO International Reference Preparation for BCG vaccine which is a live bacterial preparation. WHO has initiated the development of replacements. These were presented to the WHO Expert Committee on Biological Standardization in 2009 and 2010 as candidates for the First WHO International Reference Reagents for BCG vaccines of substrain Danish 1331, Tokyo 172-1 and Russian BCG-I (25, 26). These materials are available through the WHO web site (http://www.who.int/entity/bloodproducts/catalogue/BlooFeb2013.pdf). These International Reference Reagents cover the major proportion of BCG vaccine strains currently used in production. The establishment of substrain Moreau-RJ as the WHO International Reference Reagent for BCG vaccine is currently in progress and is scheduled for submission to the Committee in 2012 for adoption. These preparations are intended as International Reference Reagents, if required, for:

- periodical consistency monitoring of quantitative assays such as viability estimates (such as culturable particle count and modified ATP assays);
- residual virulence/local reactogenicity assays and protection assays in animal models for nonclinical evaluation.

They are also intended:

- as reference BCG substrains;
- for identity tests using multiplex polymerase chain reaction (PCR) as included in the collaborative study or in other molecular biology techniques.

The National Institute for Biological Standards and Control (NIBSC), England, distributes the WHO International Reference Reagents for BCG vaccines.

A.1.4  Terminology

The definitions given below apply to the terms as used in these Recommendations. They may have different meanings in other contexts.

**Final bulk:** the homogeneous finished liquid vaccine present in a single container from which the final containers are filled, either directly or through one or more intermediate containers derived from the initial single container.

**Final lot:** a number of sealed, final containers that are equivalent with respect to the risk of contamination during filling and, when it is performed,
freeze-drying. A final lot should therefore have been filled from a single container and freeze-dried in one continuous working session.

**In-house reference:** a batch of vaccine prepared from the same BCG strain as the tested vaccine and used in parallel to the vaccine tested in:

- quantitative assays such as viability estimates (such as culturable particle count and modified ATP assays);
- residual virulence assays.

**Master seed lot:** a bacterial suspension of a single substrain originated from the bacillus of Calmette and Guérin that has been processed as a single lot and is of uniform composition. A seed lot should be maintained in the freeze-dried form stored at −20 °C or below (in the liquid form it is stored at −80 °C or below) in order to maintain viability. In each manufacturing establishment, a master seed lot is that from which material is drawn for inoculating media for the preparation of working seed lots or single harvests.

**Single harvest:** the material obtained from one batch of cultures that have been inoculated with the working seed lot (or with the inoculum derived from it), harvested and processed together.

**Working seed lot:** a quantity of bacterial organisms of a single substrain derived from the master seed lot by growing the organisms and maintaining them in aliquots in the freeze-dried form stored at −20 °C or below (in the liquid form stored at −80 °C or below). The working seed lot should be prepared from the master seed lot by as few cultural passages as possible (e.g. 3–6 passages from the master seed lot), having the same characteristics as the master seed lot and intended for inoculating media for the preparation of single harvests.

### A.2 General manufacturing recommendations

The general manufacturing recommendations for manufacturing establishments contained in WHO’s Good manufacturing practices: main principles for pharmaceutical products (27) and Good manufacturing practices for biological products (28) should apply to establishments manufacturing BCG vaccine. In addition, the compliance with current good manufacturing practices should apply with the addition of the following.

Details of standard operating procedures for the preparation and testing of BCG vaccines adopted by the manufacturer, together with evidence of appropriate validation of each production step, should be submitted for the approval of the NRA. As required, proposals for the modification of manufacturing and control methods should also be submitted for approval to the NRA before they are implemented.

The NRA should satisfy itself that adequate control of the manufacturing, shipping and storage of the BCG vaccine has been achieved. NRAs may consider...
that a formal clinical lot-to-lot consistency study is not necessary if there are adequate and satisfactory data provided to support consistency of manufacture. However, several different lots of the product should be used in randomized studies and should elicit comparable immune responses in similar populations.

The degree of consistency in producing satisfactory final lots is an important factor in judging the efficacy and safety of a particular manufacturer’s product.

The data that should be considered in determining the consistency of production should include the results obtained with consecutive vaccine lots when tested as described in Part A, section 6 (e.g. the test for viability in Part A, section 6.7, and the thermal stability test in Part A, section 6.8).

More than two consecutive vaccine lots should have been satisfactorily prepared before any vaccine from a given manufacturer, or resulting from a new method of manufacture, is released. In subsequent routine production, if a specified proportion of vaccine lots or a specified number of consecutive vaccine lots fails to meet the requirements, the manufacture of BCG vaccine should be discontinued and should not be resumed until a thorough investigation has been made and the cause or causes of the failures determined to the satisfaction of the NRA.

Conventionally, production of BCG vaccine should take place in a dedicated area, completely separate from areas used for production of other medicines or vaccines, and using dedicated separate equipment. Such areas should be so situated and ventilated that the hazard of contamination is reduced to a minimum. No animals should be permitted in the vaccine production areas. Tests for the control of vaccine that require cultures to be made of contaminating microorganisms should be carried out in a completely separate area. Tests in which animals are used should also be carried out in a completely separate area.

For the purposes of these requirements, the processes of vaccine production that should take place in dedicated facilities are all operations up to and including the sealing of the vaccine in the final containers.

In some countries, the production of BCG vaccine – although isolated – is carried out in a building in which other work takes place. This should be done only after consultation with, and with the approval of, the NRA. If production takes place in part of a building, the work carried out in other parts of the building should be of such a nature that there is no possibility of cross-contamination with the BCG vaccine.

No cultures of microorganisms other than the BCG vaccine strain approved by the NRA for vaccine production should be introduced into the manufacturing areas. In particular, no strains of other mycobacterial species, whether pathogenic or not, should be permitted in the BCG vaccine production area.
BCG is susceptible to sunlight. Therefore, the procedures for the preparation of the vaccine should be so designed that all cultures and vaccines are protected from direct sunlight and ultraviolet light at all stages of manufacture, testing and storage, until the vaccine is issued.

BCG vaccine should be produced by a staff consisting of healthy persons who do not work with other infectious agents; in particular, they should not work with virulent strains of *M. tuberculosis*, nor should they be exposed to a known risk of tuberculosis infection. Precautions should also be taken to ensure that no worker should be employed in the preparation of BCG vaccine unless he or she has been shown by medical examination to be free from TB. The scope and nature of the medical examination should be at the discretion of the NRA. It may include a radiological examination and/or a validated immunological blood assay that should be repeated at intervals or when there is reason to suspect illness. The frequency of radiological examination should be at the discretion of the NRA, taking into consideration the incidence of TB in the country.

It is advisable to keep radiation exposure to a minimum, but the examination should be of sufficient frequency to detect the appearance of early active TB. It is estimated that, if workers in BCG vaccine laboratories were given one or two conventional X-ray examinations of the chest each year, not using fluoroscopic methods, and if the best available techniques were employed to minimize the radiation dose, the doses received would be considerably lower than the maximum permissible doses for workers occupationally exposed to radiation that have been set by the International Commission on Radiological Protection (29, 30).

Should an examination reveal signs of TB or suspected TB in a worker, he or she should no longer be allowed to work in the production areas and the rest of the staff should be examined for possible TB infection. In addition, all cultures should be discarded and the production areas decontaminated. If it is confirmed that the worker has TB, all vaccine made while he or she was in the production areas should be discarded, and all distributed batches should be recalled.

Persons not normally employed in the production areas should be excluded from them unless, after a medical examination, including radiological examination, they are shown to be free from TB. In particular, persons working with mycobacteria other than the BCG seed strain should be excluded at all times.

A.3 **Control of source materials**

A.3.1 **Seed lot system**

The production of vaccine should be based on the seed lot system. A seed lot prepared from a strain approved by the NRA (see Part D, section 1.1) should be prepared under conditions satisfying the requirements of Part A, sections 2, 3 and 4.
The BCG vaccine strain used should be identified by historical records that include information on its origin and subsequent manipulation. It would be preferable for the master seed lot to have protection proven clinically through clinical studies on a batch derived from it by a production process that is representative of the commercial process. It is also recommended to use a batch derived from such a clinically “validated” seed lot as an in-house reference in the laboratory to help ensure consistency in production.

If a working seed lot is being used, the total number of passages for a single production harvest should not exceed 12, including the passages necessary for preparing the working seed lot.

A.3.2 Tests on seed lot
A.3.2.1 Antimicrobial sensitivity test
An antimicrobial sensitivity test should be carried out as part of the ongoing characterization of BCG vaccine strains. It would be appropriate to test this property at the level of master or working seed lot.

A.3.2.2 Delayed hypersensitivity test
When a new working seed lot is established, a suitable test for delayed hypersensitivity in guinea-pigs is carried out; the vaccine is shown to be not significantly different in activity from the in-house reference.

A.3.2.3 Identity test
The bacteria in the master and working seed lots are identified as *M. bovis* BCG using microbiological techniques (e.g. morphological appearance of the bacilli in stained smears and the characteristic appearance of the colonies grown on solid media). Manufacturers are encouraged to carry out the test using molecular biology techniques (e.g. PCR test) to identify the specific substrain of BCG. The techniques will also provide relevant information to ensure genetic consistency in production, from master seed through working seed and to final product (4).

A.3.2.4 Test for bacterial and fungal contamination
Each master and working seed lot should be tested for bacterial and fungal contamination by appropriate tests, as specified in Part A, section 5.2 of General requirements for the sterility of biological substances (31), or by the validated methods approved by the NRA.

A.3.2.5 Test for absence of virulent mycobacteria
The test for absence of virulent mycobacteria, described in Part A, section 4.2.3, should be made in at least 10 healthy guinea-pigs injected with a quantity of
vaccine not less than 50 single human doses and should be observed for at least six weeks. If none of the animals shows signs of progressive TB and at least 90% survive the observation period (i.e. should one of the 10 animals die), the seed lot should be considered to be free from virulent mycobacteria.

If more than 10% of the guinea-pigs die during the observation period (i.e. should two out of 10 animals die) and freedom from progressive TB disease is verified, the test should be repeated on at least 10 more guinea-pigs. On the second occasion, the seed lot passes the test if not more than 10% of the animals die during the observation period (i.e. should one of the 10 animals die) and the autopsy does not reveal any sign of TB.

A.3.2.6 Test for excessive dermal reactivity

The test for excessive dermal reactivity, described in Part A, section 6.4.2, should be made in six healthy guinea-pigs, each weighing not less than 250 g and having received no treatment likely to interfere with the test. Each guinea-pig should be injected intradermally, according to a randomized plan, with 0.1 ml of the reconstituted vaccine and of vaccine dilutions 1:10 and 1:100. The same dilutions of the appropriate international Reference Reagent or in-house reference should be injected into the same guinea-pigs at randomly selected sites. The guinea-pigs should be observed for at least four weeks. The vaccine complies with the test if the reactions it produces at the sites of injection are not markedly different from those produced by the appropriate international Reference Reagent or in-house reference.

A.3.3 Production culture medium

The production culture medium should contain no substances known to cause toxic or allergic reactions in humans. The use of material originating from animals should be discouraged. However, if constituents derived from animals are necessary, approval of the NRA should be sought and the materials should comply with current policy on TSEs (32–37). A risk assessment for TSE would need to be included for the materials of the culture medium. WHO's revised Guidelines on transmissible spongiform encephalopathies in relation to biological and pharmaceutical products (32) provide guidance on risk assessments for master and working seeds and should be consulted. Substances used in that medium should meet such specifications as the NRA may prescribe.

A.4 Control of vaccine production

A.4.1 Control of single harvests

All cultures should be examined visually, and any that have grown in an uncharacteristic manner should not be used for vaccine production.
A.4.2 Control of final bulk

A.4.2.1 Final bulk

The final bulk should be prepared from a single harvest or by pooling a number of single harvests.

A.4.2.2 Test for bacterial and fungal contamination

The final bulk should be tested for bacterial and fungal contamination by appropriate tests as specified in Part A, section 5.2 of the General requirements for the sterility of biological substances (31), or by the validated methods approved by the NRA. No vaccine lot should be passed for use unless the final bulk has been shown to be free from such contamination.

A.4.2.3 Test for absence of virulent mycobacteria

The test for absence of virulent mycobacteria should be carried out on each final bulk or final lot.

At least six healthy guinea-pigs, all of the same sex, each weighing 250–400 g should be used. They should not have received any treatment or diet, such as antibiotics, that is likely to interfere with the test. A sample of the final bulk intended for this test should be stored at 4 °C for not more than 72 hours after harvest.

A dose of BCG organisms corresponding to at least 50 single human doses of vaccine intended for intradermal injection should be injected into each guinea-pig by the subcutaneous or intramuscular route. The guinea-pigs should be observed for at least six weeks. If, during that time, they remain healthy, gain weight, show no signs of progressive TB and not more than one dies, the final bulk should be considered to be free from virulent mycobacteria.

At the end of the observation period, the animals should be killed and examined postmortem for macroscopic evidence of progressive TB disease. Similarly, any animals that die before the end of the observation period should be subjected to a postmortem examination.

Should one third of the guinea-pigs die (i.e. should two out of six animals die) during the observation period (and freedom from progressive TB disease is verified), the test should be repeated on at least six more guinea-pigs. On the second occasion, the vaccine lot passes the test if not more than one

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1 When a more concentrated vaccine, intended for administration by the percutaneous route, is tested, a dilution factor approved by the NRA should be applied so that the mass of BCG injected corresponds to at least 50 human doses of intradermal vaccine.
animal dies during the observation period and the autopsy does not reveal any sign of TB.

Should a vaccine lot fail to satisfy the requirements of this test because animals die from causes other than TB, the procedure to be followed by the manufacturer should be determined with the approval of the NRA.

If signs of TB disease are seen, the vaccine lot should be rejected, all subsequent vaccine lots should be withheld, and all current vaccine stocks should be held pending further investigation. The manufacture of BCG vaccine should be discontinued and it should not be resumed until a thorough investigation has been made and the cause or causes of the failure determined and appropriate actions have been taken. Production should be allowed to resume only upon the approval of the NRA.

A.4.2.4 Test for bacterial concentration
The bacterial concentration of the final bulk should be estimated by a validated method approved by the NRA and should have a value within a range approved by the NRA (see Part D, section 1.2).

Based on manufacturers’ experience, the opacity method is the method of choice. The International Reference Preparation of Opacity,\(^2\) or an equivalent Reference Preparation approved by the NRA, may be employed in comparative tests.

Clumping issues should be considered during validation of the assay.

A.4.2.5 Test for number of culturable particles
The number of culturable particles on a solid medium of each final bulk should be determined by an appropriate method approved by the NRA. Alternatively, a bioluminescence or other biochemical method can be used (38, 39), provided that the method is properly validated against the culturable particle test for the production step in question. If properly validated, such tests can be used as equivalent methods. Regular calibration with the reference method as agreed with the NRA would be relevant.

The medium used in this test should be such that the number of culturable particles may be determined at an optimal time point (usually 3–5 weeks) after the medium has been inoculated with dilutions of the vaccine.

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\(^2\) The International Reference Preparation of Opacity is in the custody of the NIBSC, Potters Bar, England, which supplies samples on request.
There are various methods of determining the number of culturable particles in BCG vaccine, and it is essential that only one culture method be used for all the vaccine lots produced by a manufacturer (5). It is also desirable for assay validation that the clumping issue should be considered and that tests should be carried out in parallel with the appropriate international Reference Reagent or in-house reference, e.g. the same vaccine production that has been used in clinical trials and has assured safety (including immunogenicity) and efficacy.

A.4.2.6 Substances added to the final bulk
Substances used in preparing the final bulk should meet such specifications as the NRA may prescribe. In particular, the NRA should approve the source(s) of any animal-derived raw materials which should comply with the WHO Guidelines on tissue infectivity distribution in transmissible spongiform encephalopathies (34).

Substances added to improve the efficiency of the freeze-drying process or to aid the stability of the freeze-dried product should be sterile and of high and consistent quality, and should be used at suitable concentrations in the vaccine.

A.5 Filling and containers
The general requirements concerning filling and containers given in Good manufacturing practices for biological products (28) should apply to vaccine filled in the final form.

The containers should be in a form that renders the process of reconstitution as simple as possible. Their packaging should be such that the reconstituted vaccine is protected from direct sunlight.

A.6 Control tests on final lot
Tests on the final lot should be performed after reconstitution, except for appearance and residual moisture tests. The diluent supplied or recommended for reconstitution should be used, unless such diluent would interfere with any of the tests, in which case some other suitable fluid should be used. The vaccine should be reconstituted to the concentration at which it is to be used for injection into humans; however, an exception may be made in the case of the test for absence of virulent mycobacteria (Part A, section 6.4.1), when a higher concentration of reconstituted vaccine may be necessary. It would be appropriate to monitor periodically the antimicrobial sensitivity in final lots.

A.6.1 Inspection of final containers
Every container in each final lot should be inspected visually, and those showing abnormalities should be discarded.
The appearance of the freeze-dried vaccine and the reconstituted vaccine should be described with respect to form and colour. If reconstitution with the product diluent does not allow for the detection of particulates, an alternative diluent may be used.

A.6.2 **Identity test**
An identity test should be performed on samples of the vaccine from each final lot. The identity test for final lots should be used to identify the product as BCG as approved by the NRA. The identity of each final lot of vaccine should be verified by the morphological appearance of the bacilli in stained smears and by the characteristic appearance of the colonies grown on solid media. A validated nucleic acid amplification technique (such as PCR) should preferably be used.

A.6.3 **Test for bacterial and fungal contamination**
Samples from each final lot should be tested for bacterial and fungal contamination by appropriate tests as specified in Part A, section 5.2 of the General requirements for the sterility of biological substances (31), or by the validated methods approved by the NRA.

A.6.4 **Safety tests**
A.6.4.1 **Test for absence of virulent mycobacteria**
Provided the test for virulent mycobacteria has been carried out with satisfactory results on the final bulk vaccine, it may be omitted on the final lot.

If the test for the absence of virulent mycobacteria, applied to the final bulk, is unsatisfactory (and freedom from progressive TB disease is verified), it should be repeated with a sample of a final lot (see Part A, section 4.2.3).

A.6.4.2 **Test for excessive dermal reactivity**
Provided the test has been carried out with satisfactory results on the working seed lot and on at least three consecutive final lots produced from it, the test may be omitted on the final lot.

Historically the omission of the test with satisfactory results on five consecutive final lots has been accepted by the authorities (40).

A.6.5 **Test for bacterial concentration**
The total bacterial content of the reconstituted vaccine should be estimated for each vaccine lot by a validated method approved by the NRA, and should have a value within a range approved by the NRA (see Part D, section 1.2).
The estimation of total bacterial content may be made either directly, by determining the dry weight of organisms, or indirectly by an opacity method that has been calibrated in relation to the dry weight of the organisms.

The clumping issue should be considered during validation of the assay.

A.6.6  **Test for residual moisture**

The average moisture content of a freeze-dried vaccine should be determined by a validated method accepted by the NRA. Values should be within limits of the preparations shown to be adequately stable in the stability studies of the vaccine.

A.6.7  **Tests for viability**

A.6.7.1  **Test for number of culturable particles**

The number of culturable particles of each final lot should be determined by an appropriate method approved by the NRA (see Part A, section 4.2.5). The viable count should have a value within a range approved by the NRA that should not be wider than a fourfold difference between the lower and upper levels of the specification for numbers of culturable particles (see Part D, section 1.2). By comparison with the results of the test for number of culturable particles carried out on final bulk, as described in Part A, section 4.2.5, the percentage survival on freeze-drying may be calculated and this value should be not less than one approved by the NRA. The appropriate international Reference Reagent or in-house reference should be used for every test in order to validate the assay.

The purpose of including the appropriate international Reference Reagent or in-house reference is to have a check on the quality and consistency of the culture medium and the accuracy of the technique used for the determination of the number of culturable particles. It is not intended to adjust the count of the vaccine by comparison with the Reference Preparation.

The clumping issue should be considered during validation of the assay.

The survival rate after freeze-drying is usually not less than 20%.

A.6.7.2  **Rapid test for viability**

As an alternative to the colony counting method, a bioluminescence or other biochemical method can be used provided that the method is properly validated against the culturable particle test for the production step in question. If properly validated, such tests may be considered by the NRA to replace the culturable particle test.
The bioluminescence reaction occurring in fireflies depends on the presence of adenosine triphosphate (ATP), luciferin luciferase, oxygen and magnesium ions. This reaction can be reproduced in vitro by mixing these components. If all components except ATP are present in excess, the amount of light emitted is proportional to the amount of ATP coming from the vaccine.

Since ATP is present in all living cells and is immediately destroyed when the cell dies, ATP is a reliable marker for living cells.

Studies have shown that, if properly validated, measurement of ATP using the bioluminescence reaction can be used to estimate the viable count of freeze-dried BCG vaccine within 1–2 days as accurately as other, more time-consuming methods, once the mean content of ATP per culturable particle has been estimated for a given vaccine production.

A.6.8  **Thermal stability test**

The thermal stability test is part of the characterization and consistency demonstration of vaccine production. The requirement for this test should be at the discretion of the NRA and, if required, each final lot should be tested for thermal stability by a validated method approved by the NRA. If the production consistency is demonstrated, this test may be omitted on the final lot subject to NRA approval (6).

If performed, the test should involve the determination of the number of culturable particles before and after the samples have been held at appropriate temperatures and for appropriate periods.

For example, the thermal stability test may be carried out by taking samples of the vaccine and incubating them at 37 °C for 28 days. The percentage decrease in the number of culturable particles is then compared with that of samples of the same vaccine lot stored at 2–8 °C. The number of culturable particles in the vaccine after heating should be not less than 20% of that stored at 2–8 °C (41). The absolute value should be approved by the NRA. The viability test should also be performed with the appropriate international Reference Reagent or in-house reference for checking validity of the assay. One method of determining the number of culturable particles should be adhered to, as suggested in Part A, section 4.2.5.

The purpose of including the appropriate international Reference Reagent or in-house reference is to check the quality and consistency of the medium used for determination of the number of culturable particles. It is not intended to adjust the count of the vaccine by comparison with the Reference Preparation.
All manufacturers should keep their product for the approved storage period and should determine the number of culturable particles from time to time to demonstrate that the number is being maintained at an adequate level.

In some countries, the thermal stability test is carried out only after the vaccine has been stored for 3–4 weeks after freeze-drying, since it is considered that the degree of stability during the first three weeks may not be related to the long-term stability of the product.

As a guide to stability, some manufacturers of freeze-dried BCG vaccine determine the residual moisture content of the final vaccine, since failure to achieve a certain degree of desiccation results in an unstable product. However, such a test cannot be regarded as an alternative to tests involving the determination of the number of culturable particles.

A.7  Records
The recommendations in section 8 of Good manufacturing practices for biological products (28) should apply.

Written records should be kept of all seed lots, all cultures intended for vaccine production, all single harvests, all final bulk vaccines, and all vaccine in the final containers produced by the manufacturing establishments, including all tests irrespective of their results.

The records should be of a type approved by the NRA. An example of a suitable protocol is given in Appendix 2.

A.8  Retained samples
The recommendations in section 9.5 of Good manufacturing practices for biological products (28) should apply.

It is desirable that samples should be retained for at least one year after the expiry date of the final lot.

A.9  Labelling
The recommendations in section 7 of Good manufacturing practices for biological products (28) should apply, including the following guidance.

The label, and/or the packaging insert in some countries, printed on or affixed to each container should show the volume and nature of the diluent. Also, this label, or the label on the carton holding several final containers, or the leaflet accompanying the containers, should carry the following additional information:

- the fact that the vaccine fulfils the requirements of this document;
- instructions for use of the vaccine and information concerning contraindications and the reactions that may follow vaccination;
• the volume and nature of the diluent to be added to reconstitute the vaccine, specifying that only the diluent supplied by the manufacturer should be used;
• the conditions recommended during storage and transport, with information on the reduced stability of the vaccine if exposed to temperatures higher than that stated on the label;
• warnings that the vaccine should be protected from direct sunlight;
• a statement that the reconstituted vaccine should be used as soon as possible, or should be stored at 2–8 °C, protected from direct sunlight and used within six hours (42);
• information on antimicrobial sensitivity.

The label for the diluent should state “Reconstituting fluid for BCG vaccine [proprietary name]”.

A.10 Distribution and transport
The recommendations given in section 8 of Good manufacturing practices for biological products (28) should be followed, along with the guidance provided in Safe vaccine handling, cold chain and immunizations (43). Further guidance is provided in Model guidance for the storage and transport of time- and temperature-sensitive pharmaceutical products (44).

It is desirable that samples should be retained for at least one year after the expiry date of the final lot.

A.11 Stability, storage and expiry date
A.11.1 Stability testing
Adequate stability studies form an essential part of vaccine development. The recommendations provided in WHO’s Guidelines for stability evaluation of vaccines should be followed (46). Stability testing should be performed at different stages of production if stored for a given time period, namely as appropriate for single harvests or pool of single harvests, final bulk or final lot. Stability-indicating parameters should be defined or selected appropriately according to the stage of production. It is advisable to assign a storage period to all in-process materials during vaccine production, particularly intermediates such as single harvests and final bulk, and a shelf-life period to the final lots.

BCG vaccines require special precautions to ensure sufficient stability. In this connection the most important measures are lyophilization, the use of an effective stabilizer, and proper sealing of vaccine containers.
Historically the use of ampoules sealed under vacuum was the most common practice for increasing stability. However, vacuum-sealing is difficult compared to sealing in the presence of inert gas. There were no significant differences between BCG vaccines sealed under vacuum and under nitrogen or carbon dioxide at either 4 °C or 37 °C (41). Manufacturers now prepare BCG vaccines in vials/ampoules and, under well-validated conditions, the product is adequately stable.

A.11.2 **Storage conditions**

The *Guideline for establishing or improving primary and intermediate vaccine stores* (47) should apply.

Storage conditions should be based on stability studies and approved by the NRA. Before being distributed by the manufacturing establishment, or before being issued from a depot for the storage of vaccine, all vaccines in their final containers should be stored constantly at 2–8 °C (41, 48) and vaccine diluents should be stored as recommended by the manufacturer. Freeze-dried BCG vaccines, regardless of their substrain, are sensitive to ultraviolet and fluorescent light. They should be protected from direct sunlight (41).

BCG vaccines are sensitive to light as well as to heat. Normally, these vaccines are supplied in vials/ampoules made from dark brown glass, which gives them some protection against light damage, but care should still be taken to keep them covered and protected from strong light at all times (48).

Freeze-dried BCG vaccines may be kept frozen at –15 °C to –25 °C if cold chain space permits, but this is neither essential nor recommended (41).

Precautions should also be taken to maintain the vaccine during transport and up to the time of use at the temperature and under the storage conditions recommended by the manufacturer.

A.11.3 **Expiry date**

The expiry date should be approved by the NRA and should be based on the stability of the final product, as well as on the results of the stability tests referred to in section A.11.1 above. It is established for each batch by adding the shelf-life period to the date of manufacture. Most freeze-dried BCG vaccines are stable at temperatures of 2–8 °C for at least two years (41) from the date of manufacture. The storage of final product at –20 °C to extend the shelf-life should be validated.

A.11.4 **Expiry of reconstituted vaccine**

Stability studies should be undertaken on reconstituted vaccine. Freeze-dried BCG vaccines become much more heat-sensitive after they have been
reconstituted with diluent (41). After multidose containers of freeze-dried BCG have been reconstituted, the vaccine should be used as soon as possible. Any reconstituted vaccine remaining should be stored at 2–8 °C until used, and the expiry time should be defined by stability studies (4, 42, 45).

Part B. Nonclinical evaluation of BCG vaccines

Details on the design, conduct, analysis and evaluation of nonclinical studies are available in the WHO Guidelines on nonclinical evaluation of vaccines (49).

Nonclinical testing of a new strain (i.e. a strain derived by selection from existing BCG strains in Appendix 1) or of a strain from a new manufacturer of a BCG vaccine is a prerequisite for initiation of clinical studies in humans. Nonclinical testing includes immunogenicity, protection studies (proof of concept) and safety testing in animals. The vaccine lots used in nonclinical studies should be adequately representative of the formulation intended for clinical investigation and, ideally, should be the same lots, manufactured according to current good manufacturing practice (cGMP), as those used in clinical studies. If this is not feasible, the lots used clinically should be comparable to those used in the nonclinical studies with respect to potency, stability and other characteristics of quality. The technical manufacturing consistency lots may often be used for these purposes.

New manufacturers of BCG vaccine for human use will need to refer to the range of nonclinical safety and characterization tests that are recommended for existing licensed BCG vaccines. Although there is currently no requirement for additional nonclinical testing beyond that already described for licensed BCG vaccines, the development of new variants of BCG, the potential for new fermentation technologies and the possibility of novel live vaccines against TB have shown that additional nonclinical studies beyond that required for licensed BCG vaccine can be helpful in demonstrating that a new BCG product has satisfactory nonclinical efficacy, safety and stability.

Guideline example on protective potency testing: Hartley guinea-pigs are used for potency testing. The guinea-pigs are vaccinated with a small amount of BCG ($\sim 10^3$ colony-forming units (CFU)). Eight weeks after the vaccination, the guinea-pigs are challenged with virulent \textit{M. tuberculosis} H37Rv (ATCC 27294) by the pulmonary route with a low dose (10–15 CFU) per animal. Five weeks after the infection, the guinea-pigs are killed and the spleen and the lung lobes are removed. These organs are homogenized separately. Appropriate dilutions are inoculated on to duplicate solid medium and incubated at 37 °C for three weeks. The number of \textit{M. tuberculosis} H37Rv colonies is counted, and is expressed as mean log$_{10}$ CFU per tissue. The CFU results are compared between the vaccinated and non-vaccinated groups (50).
If there are two pharmacologically relevant species for the clinical candidate (one rodent and one non-rodent), both species should be used for short-term (up to one month duration) toxicology studies. If the toxicological findings from these studies are similar in both species, longer-term studies in one species are usually considered sufficient; the rodent species should be considered unless there is a rationale for using non-rodents. Studies in two non-rodent species are not appropriate. Other in vivo studies should address both potency (such as tuberculin sensitivity and immunological tests) and safety issues (such as tests for excessive dermal reactivity and absence of virulent mycobacteria) of the classical BCG vaccines.

It may be of benefit for new BCG vaccine developers to consider the points raised in recent meetings establishing recommendations for new live vaccines against TB (51, 52).

**Part C. Clinical evaluation of BCG vaccines**

Clinical trials should adhere to the principles described in the Guidelines for good clinical practice (GCP) for trials on pharmaceutical products (53) and the general principles described in WHO's Guidelines on clinical evaluation of vaccines: regulatory expectations (54). All clinical trials should be approved by the relevant NRAs and local ethics committees. Continued licence of BCG vaccines should be viewed in the light of ongoing post-marketing data on the safety, immunogenicity and effectiveness of BCG vaccines in the target population.

Part C considers the provision of clinical data required (a) when a new candidate “classical” BCG vaccine derived from (the same master seed of) one of the recognized strains (see Appendix 1) is developed; (b) when there have been major changes to the manufacturing process of an established vaccine, including preparation of a new master seed lot of an established strain; (c) when technology transfer of existing vaccine is planned to a new manufacturer; and (d) when revalidation of existing vaccines used in national immunization programmes is considered.

Vaccines manufactured using a “new strain” (i.e. a strain derived by selection from existing BCG strains in Appendix 1) should require a full clinical development programme that provides evidence of safety, efficacy and the reactogenicity profile in all target age-groups.

Other vaccines against *M. tuberculosis* derived from *M. bovis* or other mycobacterial strains cannot be considered as BCG. They would require a full clinical development programme and are not included here.

**C.1 General considerations**

**C.1.1 Comparative or placebo-controlled clinical trials**

It would not be considered ethical to conduct a placebo-controlled trial of protective efficacy of a BCG vaccine in a TB-endemic area, particularly in
infants. A comparative trial with a licensed, or internationally accepted (WHO prequalified), BCG vaccine could be accepted.

C.1.2 **Value of PPD response**

It is recognized that the response to tuberculin PPD is not an indicator of a protective immune response. Nonetheless this has been used for more than 50 years to indicate a cellular immune response to an infection with *M. tuberculosis* or as evidence of “successful” BCG vaccination. At best, a PPD reaction is an indicator of exposure to antigens of TB, and the generation of a cellular immune response. Thus, it can be used in a PPD-naive population as an indicator of an immune response to the BCG vaccine (55). Other immunological measures may be more closely related to *M. tuberculosis* infection or vaccination, but currently none has been agreed as a correlate of protection from infection or disease.

C.1.3 **BCG in HIV-infected infants**

A very important safety consideration with regard to vaccination policy is to establish, during clinical trials, the potential for disseminated BCG disease in immunocompromised children. In this regard, the use of BCG vaccines at birth should follow the recommendations from the GACVS (13, 14). The GACVS recommendations consider the policies for immunization exclusion of infants known to be infected with HIV, infants symptomatic for HIV infection, and those infants born to mothers known to be HIV-infected and who therefore may be infected.

C.1.4 **Post-vaccination reactions and complications**

Vaccines intended for intradermal or percutaneous injection should be given strictly intradermally or percutaneously, and vaccinators should be trained accordingly. Incorrect vaccination technique can result in adverse reactions, including discharging ulcers, abscesses and keloid scars.

Current BCG vaccines have a known reactogenicity profile after intradermal inoculation (56). Local reaction at the vaccination site is normal after a BCG vaccination. It may take the form of a nodule that, in many cases, will break down and suppurate. The reaction developing at the vaccination site usually subsides within 2–5 months and in practically all children leaves a superficial scar of 2–10 mm in diameter. The nodule may persist and ulcerate. Swelling of regional lymph nodes may also be seen, and this may be regarded as a normal reaction, but the size should be limited.

Keloid and lupoid reactions may occur at the site of the vaccination. Children with such reactions should not be revaccinated. Inadvertent subcutaneous injections produce abscess formations and may lead to ugly retracted scars. Among the major complications, suppurative lymphadenitis has been observed.
In the case of certain vaccines, it has been revealed that there is a strong correlation between the incidence of these complications in newborns and the number of culturable particles in the vaccine.

The concentration of the vaccine should be shown to be effective and tolerated in the age groups for which the vaccine is intended.

A reduction of the dose for newborns may be based on the evidence and approved by the NRA (57).

The NRA should issue guidelines for the treatment of complications.

C.2 Special considerations
This section is limited to the clinical development of new “classical” BCG vaccines manufactured following these Recommendations and using strains of BCG that are derived from (the same master seed of) one of the strains recognized in Appendix 1.

The use of comparative studies with a licensed BCG vaccine can provide evidence of the similarity of safety and immune responses to a new classical BCG vaccine product.

The target population for the vaccine would be newborns or infants according to current recommendations on the use of BCG vaccines.

The nonclinical expectations for a new classical BCG vaccine are outlined in Part B.

For such a new classical BCG vaccine, these nonclinical studies should be conducted in comparison to an existing licensed BCG vaccine, preferably derived from the same BCG substrain. It would be expected that the results of preclinical studies would be similar for the new vaccine product and for the comparator.

The clinical development programme should ideally be designed to show the safety and protective efficacy of the vaccine. However, for such a new classical BCG vaccine product, comparative studies with an existing licensed BCG vaccine, using immunological responses as a marker for efficacy, may be acceptable to the responsible NRA.

Comparable PPD response (proportion of PPD converters, intensity of response) may be acceptable.

Clinical studies should provide evidence of safety in all the potential target populations, including those with a high incidence of diseases that may affect the safety or efficacy of the new vaccine product. In phase I and phase II studies this should include evaluation of:

- safety and reactogenicity in healthy adults (comparative);
- end-points;
- safety and reactogenicity – can include healthy HIV-infected adults;
- immune responses – non-inferior PPD response, and may include other immunological markers.

These studies are difficult to interpret as adults will most likely have received BCG vaccination at birth. Dose-finding studies may be considered unnecessary for these vaccines. The safety in HIV-infected individuals and in infants needs to be considered.

Dose-finding and age de-escalation can be included in these studies, but review at each step by a suitable independent safety committee should be considered. In phase III studies evaluation should be made of:

- safety and reactogenicity in infants (comparative)
- end-points
- safety and reactogenicity
- non-inferior PPD immune response.

**Post-marketing risk management**

As it may not be practically possible to evaluate protective efficacy for a new classical BCG vaccine, the responsible NRA in the country of manufacture should require post-marketing surveillance activities for safety and effectiveness in a suitable environment. Sentinel surveillance sites in an endemic country may be considered.

In the past, the responsible NRA of a country of manufacture required a demonstration that adequate control of BCG vaccine had been achieved, by arranging for studies of some of the final lots to be performed at regular intervals in children.

Studies of immunological responses to *M. tuberculosis* antigens should be made, such as sensitivity to tuberculin. In at least 100 tuberculin-negative persons per year, records of tuberculin-induced reaction (distribution of tuberculin reactions by size) by a defined dose of tuberculin³ in vaccines, local skin lesions (nature and size of reaction at injection site), and the occurrence of untoward vaccination reactions should be obtained. Such tests should be performed in parallel on two or more vaccine lots in the same population group, one of the vaccine lots being preferably a reference vaccine.

³ An intradermal test with a dose of tuberculin equivalent to 5 IU of tuberculin PPD is suitable. A description of an appropriate method and a design for a study to assess BCG vaccines in humans are available on application to the World Health Organization, 1211 Geneva 27, Switzerland.
C.3 Post-marketing surveillance
The NRA in the country of manufacture may require periodic updates of reports on BCG safety and immunogenicity.

C.3.1 BCG vaccine used in a national immunization programme
As in all immunization programmes, the adverse events following immunization with BCG vaccines should be monitored and recorded.

The following events are important after BCG vaccination (58):
- injection site abscesses
- BCG lymphadenitis
- disseminated BCG diseases
- osteitis/osteomyelitis.

Appropriate training of health-care workers is important as some medical incidents can be related to immunization even if they have a delayed onset.

C.3.2 WHO prequalified BCG vaccines
Prequalified vaccines may be used in a wide range of countries worldwide. Periodic safety update reports supplied to WHO should include specific analysis of countries where the vaccine has been used.

Part D. Guidelines for NRAs

D.1 General
The general recommendations for NRAs provided in the Guidelines for national authorities on quality assurance for biological products (59) should apply. These specify that no new biological substance should be released until consistency of manufacturing and quality as demonstrated by a consistent release of batches has been established. The detailed production and control procedures, as well as any significant change in them that may affect the quality, safety or efficacy of BCG vaccine, should be discussed with and approved by the NRA. For control purposes, the NRA should obtain the WHO International Reference Reagents as comparators for potency-related testing and, where necessary, should establish national working Reference Preparation(s) calibrated against the international reference.

In addition, the NRA should provide a reference vaccine or approve one used by a manufacturer, and should give directions concerning the use of the reference vaccine in specified tests. The NRA should also give directions to
manufacturers concerning the BCG substrain to be used in vaccine production, the total content of bacteria, the number of culturable particles, and the stability required of the vaccine, and should specify the requirements to be fulfilled by the manufacturer in accordance with the provisions of Part A of this document, including those for consistency of quality in respect of the points referred to in Part A, section 2.

D.1.1 **BCG vaccine strain**

The substrain of BCG (maintained in the form of a seed lot) used in the production of vaccine should be derived from the original strain maintained by Calmette and Guérin and should be identified by historical records that include information on its origin and subsequent manipulation. On the basis of cultures and biochemical and animal tests, the BCG seed lot should show characteristics that conform to those of BCG and generally differ from those of other mycobacteria. The identity test should be supplemented by molecular biology techniques to identify the specific BCG substrain used. The seed lot should show consistency in the morphological appearance of colonies and genetic stability on serial subculture. It should also have been shown to yield vaccines that, upon administration by intradermal injection to children and adults, induce relevant immunological responses to *M. tuberculosis* antigens, including sensitivity to tuberculin, and with a low frequency of untoward effects. In addition, the seed lot should have been shown to give adequate protection against TB in experimental animals in tests for protective potency.

D.1.2 **Concentration of BCG vaccine**

The concentration of BCG vaccine varies with different vaccine products and is dependent on a number of factors, such as the substrain of BCG used and the method of manufacture. It is therefore essential for each manufacturer, as well as for each method of manufacture, for the optimum potency of vaccine to be ascertained by trials in tuberculin-negative subjects (newborns, older children, and adults) to determine the response to vaccination in respect of the induction of relevant immunological responses to *M. tuberculosis* antigens – including sensitivity to tuberculin, the production of acceptable local skin lesions, and the occurrence of a low frequency of untoward reactions. As a result of such trials, the NRA should give directions to the manufacturer concerning the total bacterial content and the number of culturable particles required for the vaccine.

If a manufacturer changes its procedure for preparing BCG vaccine, and if the NRA considers that the change might affect the final product, it may be necessary to conduct further clinical trials in order to determine the optimum content of BCG organisms in the new product.
D.2 Release and certification

A vaccine lot should be released only if it fulfils the national requirements and/or Part A of these Recommendations. Before any vaccine lot is released from a manufacturing establishment, the recommendations for consistency of production provided in the Guidelines for national authorities on quality assurance for biological products (59) should be met. In addition, the general recommendations for NRAs provided in the Guidelines for independent lot release of vaccines by regulatory authorities (60) should be followed. A protocol based on the model given in Appendix 2, signed by the responsible official of the manufacturing establishment, should be prepared and submitted to the NRA in support of a request for release of a vaccine for use.

A statement signed by the appropriate official of the NRA (or authority as appropriate) should be provided if requested by a manufacturing establishment and should certify whether or not the lot of vaccine in question meets all national requirements, as well as Part A of these Recommendations. The certificate should also state the date of manufacture, the lot number, the number under which the lot was released, and the number appearing on the labels of the containers. In addition, the date of the last satisfactory potency test, as well as the expiry date assigned on the basis of shelf-life, should be stated. A copy of the official national release document should be attached. The certificate should be based on the model given in Appendix 3. The purpose of the certificate is to facilitate the exchange of vaccines between countries.

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Recommendations were revised by Dr H.-N. Kang, World Health Organization, Geneva, Switzerland, taking into account information on current manufacturing and regulatory practice provided at the meeting attended by:

Dr M. Andre, Agence Française de Sécurité Sanitaire desProduits de Santé, Lyons, France; Dr L.F. Barker, Aeras Global Tuberculosis Vaccine Foundation, Rockville, MD, USA; Dr A. Bhardwaj, Central Research Institute, Kasuli, Himachal Pradesh, India; Dr M. Brennan, Aeras Global TB Vaccine Foundation, Rockville, MD, USA; Dr I.S. Budiharto, Bio Farma, Bandung, Indonesia; Dr L.R. Castello-Branco, Fundacao Ataulpho de Paiva, Brazilian League Against Tuberculosis, Rio de Janeiro, Brazil; Dr M. Chouchkova, National Center of Infectious and Parasitic Diseases, Sofia, Bulgaria; Dr H. Chun, Korea Food and Drug Administration, Seoul, Republic of Korea; Dr M. Corbel, National Institute for Biological Standards and Control, Potters Bar, England; Dr B. Eisele, Vakzine Projeckt Management GmbH, Hannover, Germany; Dr S. Gairola, Serum Institute of India, Hadapsar, India; Dr L. Grode, Vakzine Projeckt Management GmbH, Hannover, Germany; Dr K. Haslov, Statens Serum Institut, Copenhagen, Denmark; Dr M.M. Ho, National Institute for Biological Standards and Control, Potters Bar, England; Dr P. Hubrechts, Statens Serum Institut, Copenhagen, Denmark; Dr G. Hussey, South African TB Vaccine Initiative, Cape Town, South Africa; Dr H.-N. Kang, World Health Organization, Geneva, Switzerland; Dr I. Knezevic, World Health Organization, Geneva, Switzerland; Professor D. Levi, Tarassevich State Research Institute for Standardization and Control of Medical Biological Preparations, Moscow, Russian Federation; Dr Y. Lopez Vidal, Universidad Nacional Autonoma de Mexico, Copilco-Universidad, Mexico City, Mexico; Dr K. Markey, National Institute for Biological Standards and Control, Potters Bar, England; Dr C. Martin, Universidad de Zaragoza, Zaragoza, Spain; Dr S. Morris, FDA/CBER, Bethesda, MD, USA; Dr V. Öppling, Paul-Ehrlich-Institute, Langen, Germany; Dr M. Roumiantzef, Lyons, France; Dr. M. Seki, Japan BCG Laboratory, Tokyo, Japan; Dr K. Shibayama, National Institute of Infectious Diseases, Tokyo, Japan; Dr J. Southern, Advisor to Medicines Control Council in South Africa, Cape Town, South Africa; Mr A. Supasansatorn, Ministry of Public Health, Nonthaburi, Thailand; Dr S. Wahyuningsih, National Agency of Drug and Food Control, Jakarta Pusat, Indonesia; Dr K.B. Walker, National Institute for Biological Standards and Control, Potters Bar, England; Dr S. Yamamoto, Japan BCG Laboratory, Tokyo, Japan; Dr Z. Yan, Chengdu Institute of Biological Products, Chengdu, China; Dr L. Zhang, Chengdu Institute of Biological Products, Chengdu, China; Mrs A. Zhao, National Institute for the Control of Pharmaceutical & Biological Products, Beijing, China.

Several draft Recommendations were subsequently prepared by Dr M.M. Ho, National Institute for Biological Standards and Control, Potters Bar, England, with support from the drafting group of Dr M. Corbel, Milton Keynes, England; Dr R. Dobbelraer, Lokeren, Belgium; Dr H.-N. Kang, World Health Organization, Geneva, Switzerland; Dr I. Knezevic, World Health Organization, Geneva, Switzerland; Professor D. Levi, Tarassevich State Research Institute for Standardization and Control of Medical Biological Preparations, Moscow, Russian Federation; Dr Y. Lopez Vidal, Universidad Nacional Autonoma de Mexico, Copilco-Universidad, Mexico City, Mexico; Dr K. Markey, National Institute for Biological Standards and Control, Potters Bar, England; Dr C. Martin, Universidad de Zaragoza, Zaragoza, Spain; Dr S. Morris, FDA/CBER, Bethesda, MD, USA; Dr V. Öppling, Paul-Ehrlich-Institute, Langen, Germany; Dr M. Roumiantzef, Lyons, France; Dr. M. Seki, Japan BCG Laboratory, Tokyo, Japan; Dr K. Shibayama, National Institute of Infectious Diseases, Tokyo, Japan; Dr J. Southern, Advisor to Medicines Control Council in South Africa, Cape Town, South Africa; Mr A. Supasansatorn, Ministry of Public Health, Nonthaburi, Thailand; Dr S. Wahyuningsih, National Agency of Drug and Food Control, Jakarta Pusat, Indonesia; Dr K.B. Walker, National Institute for Biological Standards and Control, Potters Bar, England; Dr S. Yamamoto, Japan BCG Laboratory, Tokyo, Japan; Dr Z. Yan, Chengdu Institute of Biological Products, Chengdu, China; Dr L. Zhang, Chengdu Institute of Biological Products, Chengdu, China; Mrs A. Zhao, National Institute for the Control of Pharmaceutical & Biological Products, Beijing, China.
Organization, Geneva, Switzerland; Dr J. Southern, Cape Town, South Africa; and Dr K.B. Walker, National Institute for Biological Standards and Control, Potters Bar, England.

Following the meeting of the drafting group in March 2011, held in Potters Bar, England, draft Recommendations were updated taking into account comments received from:

Dr M. Andre, Agence Française de Sécurité Sanitaire des Produits de Santé, Lyons, France; Dr M. Chouchkova, National Center of Infectious and Parasitic Diseases, Sofia, Bulgaria; Dr H. Dockrell, London School of Hygiene and Tropical Medicine, London, England; Dr S. Gairola, Serum Institute of India, Hadapsar, India; Dr P. Hubrechts, Statens Serum Institut, Copenhagen, Denmark; Dr J. Joung, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea; Dr M. Lagranderie, Institut Pasteur, Paris, France; Professor D. Levi, Tarassevich State Research Institute for Standardization and Control of Medical Biological Preparations, Moscow, Russian Federation; Dr Y. Lopez Vidal, Universidad Nacional Autonoma de Mexico, Facultad de Medicina, Mexico City, Mexico; Dr V. Öppling, Paul-Ehrlich-Institute, Langen, Germany; Mrs G. Trisnasari, Bio Farma, Bandung, Indonesia; Dr V. Vincent, Institut Pasteur, Paris, France; Dr S. Wahyuningsih, National Agency of Drug and Food Control, Jakarta Pusat, Indonesia; Dr T. Ying, China National Biotec Group, Beijing, China; Mrs A. Zhao, National Institute for the Control of Pharmaceutical & Biological Products, Beijing, China.

The draft Recommendations were posted on the WHO Biologicals web site for public consultation from 24 May to 23 June 2011. The WHO/BS/2011.2157 document was then prepared by Dr M.M. Ho, National Institute for Biological Standards and Control, Potters Bar, England; Dr H.-N. Kang, World Health Organization, Geneva, Switzerland; Dr J. Southern, Cape Town, South Africa; Dr K.B. Walker, National Institute for Biological Standards and Control, Potters Bar, England, taking into account comments received from the following reviewers:

Dr C. Ahn, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea; Dr M. Andre, Agence Française de Sécurité Sanitaire des Produits de Santé, Lyons, France; Dr M. Brennan, Aeras Global TB Vaccine Foundation, Rockville, MD, USA; Dr I.S. Budiharto, Bio Farma, Bandung, Indonesia; Ms Y. Choi, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea; Dr M. Chouchkova, National Center of Infectious and Parasitic Diseases, Sofia, Bulgaria; Dr S. Gairola, Serum Institute of India, Hadapsar, India; Dr K. Haslov, Statens Serum Institut, Copenhagen, Denmark; Dr H. Hozouri, Pasteur Institute of Iran, Tehran, Islamic Republic of Iran; Dr P. Hubrechts, Statens Serum Institut, Copenhagen, Denmark; Dr J. Joung, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea; Mr H. Kim, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea; Mr J.-G. Kim, Korea Food and Drug Administration, Chungchenburg-do, Republic of Korea;
Ms Y.L. Kim, Korea Food and Drug Administration, Chungchungbuk-do, Republic of Korea; Dr K. Lee, Korea Food and Drug Administration, Chungchungbuk-do, Republic of Korea; Dr Y. Lopez Vidal, Universidad Nacional Autonoma de Mexico, Copilco-Universidad, Mexico City, Mexico; Dr V. Öppling, Paul-Ehrlich-Institute, Langen, Germany; Dr M. Roumiantzeff, Lyons, France; Dr M. Seki, Japan BCG Laboratory, Tokyo, Japan; Dr J. Shin, World Health Organization, Geneva, Switzerland; Mr S.-C. Shin, Green Cross, Yongin, Republic of Korea; Dr V. Vincent, Institut Pasteur, Paris, France; Dr S. Yamamoto, Japan BCG Laboratory, Tokyo, Japan.

Further changes were made to WHO/BS/2011.2157 by the Expert Committee on Biological Standardization, resulting in the current document.

References


Appendix 1

History and genealogy of BCG substrains

**Early** strains

DU2 Group 2 Δ int

- BCG Sweden
- BCG Birkhaug

1926

**Late** strains

DU2 Group 3 Δ int

- BCG Prague
- BCG Glaxo
- BCG Danish
- BCG Mérieux

1954

Note: This diagram provides only a historical overview of the use of different substrains derived from BCG vaccine strain. It does not indicate any WHO "qualification" or "approval" of the strains or vaccines in the context of this document.

Appendix 2

Summary protocol for manufacturing and control of BCG vaccine

The following protocol is intended for guidance, and indicates the information that should be provided as a minimum by the manufacturer to the NRA. Information and tests may be added or omitted as required by the NRA, if applicable.

It is thus possible that a protocol for a specific product may differ in detail from the model provided. The essential point is that all relevant details demonstrating compliance with the licence and with the relevant WHO recommendations of a particular product should be given in the protocol submitted.

The section concerning the final product must be accompanied by a sample of the label and a copy of the leaflet that accompanies the vaccine container. If the protocol is being submitted in support of a request to permit importation, it must also be accompanied by a lot release certificate from the NRA or NCL of the country in which the vaccine was produced stating that the product meets national requirements as well as Part A of the recommendations of this document published by WHO.

Summary information on the finished product (final lot)

International name: ____________________________
Trade name: ________________________________
Product licence (marketing authorization) number: ____________________
Country: _________________________________
Name and address of manufacturer: ______________________________
Site of manufacture of final lot: _______________________________
Name and address of licence-holder
   (if different): _______________________________________
BCG substrain: _________________________________
Authority that approved the BCG substrain: _______________________
Date approved: ________________________________
Final bulk number: ______________________________
Volume of final bulk: __________________________
Final product: ____________________________________
Type of vaccine: Intradermal/Percutaneous/Other
Final lot number: __________________________________
Type of container: _______________________________
Number of doses per container: ________________________________________
Number of filled containers in this final lot: _____________________________
Date of manufacture of final lot: _______________________________________
Date on which last determination of the bacterial count was started, or date of start of period of validity: ____________________________
Shelf-life approved (months): _________________________________________
Expiry date: ___________________________________________________________________
Diluent: ___________________________________________________________________
Storage conditions: ___________________________________________________________________
Volume of single human dose: _________________________________________
Volume of vaccine per container: ________________________________________
Number of doses per container: _________________________________________
Summary of the composition (include a summary of the qualitative and quantitative composition of the vaccine per human dose): ___________________________________________________________________
Release date: ___________________________________________________________________

Production information

A genealogy of the lot numbers of all vaccine components used in the formulation of the final product will be informative.

The following sections are intended for the reporting of the results of the tests performed during the production of the vaccine, so that the complete document will provide evidence of consistency of production. Thus, if any test has to be repeated, this must be indicated. Any abnormal results should be recorded on a separate sheet.

Control of source materials (section A.3)

The information requested below is to be presented on each submission. Full details on master and working seed lots are required on first submission only and whenever a change has been introduced.

Master seed lot

Origin of seed lot: _________________________________________
Master seed lot number: _________________________________________
Name and address of manufacturer: _________________________________________
Passage level: _________________________________________
Date of preparation of seed lot: _____________________________
Date of receipt of seed lot (if applicable): _____________________________
Date of reconstitution of seed lot ampoule: _____________________________
Date approved by the NRA: _________________________________________
Working seed lot

Working seed lot number: ________________________________
Name and address of manufacturer: ________________________________
Passage level: ________________________________
Date of reconstitution of seed lot ampoule: ________________________________
Date approved by the NRA: ________________________________

Tests on working seed lot production (section A.3.2)

Antimicrobial sensitivity test (section A.3.2.1)
Method used: ________________________________
Date test started: ________________________________
Date test completed: ________________________________
Results: ________________________________

Delayed hypersensitivity test (section A.3.2.2)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Reference vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Method used: ________________________________
Dilutions injected: ________________________________
Inoculation route: ________________________________
Number of guinea-pigs given injection: ________________________________
Observation period (specification): ________________________________
Date test started: ________________________________
Date test completed: ________________________________
Result: ________________________________

Identity test (section A.3.2.3)

Method used: ________________________________
Date test started: ________________________________
Date test completed: ________________________________
Results: ________________________________

Test for bacterial and fungal contamination (section A.3.2.4)

Method used: ________________________________
Number of containers tested: ________________________________
Volume of inoculum per container: ________________________________
Volume of medium per container: ________________________________
Observation period (specification): ________________________________
Incubation | Media used | Inoculum | Date test began | Date test ended | Results
---|---|---|---|---|---
20–25 °C | | | | | 
30–36 °C | | | | | 
Negative control | | | | | 

Test for absence of virulent mycobacteria (section A.3.2.5)

Method used: ____________________________
No. of human doses injected per guinea-pig: ____________________________
Inoculation route: ____________________________
No. of guinea-pigs given injection: ____________________________
Weight range of guinea-pigs: ____________________________
Observation period (specification): ____________________________
Date test started: ____________________________
Date test completed: ____________________________
Health of animals during test: ____________________________
Weight gains (losses): ____________________________
Result: ____________________________

Test for excessive dermal reactivity (section A.3.2.6)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Reference vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Method used: ____________________________
Dilutions injected: ____________________________
Inoculation route: ____________________________
No. of guinea-pigs given injection: ____________________________
Observation period (specification): ____________________________
Date test started: ____________________________
Date test completed: ____________________________
Mean diameter of lesions (for each dilution): ____________________________
Result: ____________________________

Production of culture medium (section A.3.3)

Any components of animal origin: ____________________________
Certificate for BSE/TSE-free: ____________________________
Control of vaccine production (section A.4)

Control of single harvests (section A.4.1)

Derived from master seed lot number: ________________________________
Working seed lot number: ________________________________
Passage level from master seed: ________________________________
Culture medium: ________________________________
Number and volume of containers inoculated: ________________________________
Date of inoculation: ________________________________
Temperature of incubation: ________________________________
Date of harvest: ________________________________
Results of visual inspection: ________________________________

Control of final bulk (section A.4.2)

Tests for bacterial and fungal contamination (section A.4.2.2)

Method used: ________________________________
Number of containers tested: ________________________________
Volume of inoculum per container: ________________________________
Volume of medium per container: ________________________________
Observation period (specification): ________________________________

<table>
<thead>
<tr>
<th>Incubation</th>
<th>Media used</th>
<th>Inoculum</th>
<th>Date test began</th>
<th>Date test ended</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–25 °C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30–36 °C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative control</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Test for absence of virulent mycobacteria (section A.4.2.3)
(if not performed on final lot)

Method used: ________________________________
No. of human doses injected per guinea-pig: ________________________________
Inoculation route: ________________________________
No. of guinea-pigs given injection: ________________________________
Weight range of guinea-pigs: ________________________________
Observation period (specification): ________________________________
Date test started: ________________________________
Date test completed: ________________________________
Health of animals during test: ________________________________
Weight gains (losses): __________________________
Result: ______________________________________

Test for bacterial concentration (section A.4.2.4)
Method used: ________________________________
Date test started: ____________________________
Date test completed: _________________________
Specification: ______________________________
Result: __________________________

Test for number of culturable particles (section A.4.2.5)
Method used: ______________________________
Date test started: __________________________
Date test completed: _________________________
Specification: ______________________________
Result: __________________________
Details of working Reference Preparation: ________________

Substances added (section A.4.2.6)
Any components of animal origin: _________________
Certificate for BSE/TSE-free: ______________________

Filling and containers (section A.5)
Lot number: ________________________________
Date of filling: ______________________________
Volume of final bulk filled: ______________________
Filling volume per container: ____________________
Number of containers filled (gross): ______________
Date of freeze-drying: __________________________
Number of containers rejected during inspection: ______________
Number of containers sampled: ______________________
Total number of containers (net): _______________
Maximum period of storage approved: ______________
Storage temperature and period: ______________________

Control tests on final lot (section A.6)
Inspection of final containers (section A.6.1)
Appearance: _________________________________
Date of test: _________________________________
Specification: _______________________________
Result: ____________________________
Recommended reconstitution fluid: ________________________________
Volume of reconstitution fluid per final container: ___________________

Identity test (section A.6.2)
Method used: _____________________________________________________
Date test started: _______________________________________________
Date test completed: ____________________________________________
Specification: _________________________________________________
Result: _______________________________________________________

Tests for bacterial and fungal contamination (section A.6.3)
Method used: ___________________________________________________
Number of containers tested: ______________________________________
Volume of inoculum per container: ________________________________
Volume of medium per container: _________________________________
Observation period (specification): _________________________________
Specification: _________________________________________________

<table>
<thead>
<tr>
<th>Incubation</th>
<th>Media used</th>
<th>Inoculum</th>
<th>Date test began</th>
<th>Date test ended</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–25 °C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30–36 °C</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Negative control</td>
<td></td>
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</tr>
</tbody>
</table>

Safety tests (section A.6.4)
Test for absence of virulent mycobacteria (section A.6.4.1)
(if not performed on final bulk)
Method used: ___________________________________________________
No. of human doses injected per guinea-pig: __________________________
Inoculation route: _______________________________________________
No. of guinea-pigs given injection: _________________________________
Weight range of guinea-pigs: _____________________________________
Observation period (specification): _________________________________
Date test started: ______________________________________________
Date test completed: ____________________________________________
Health of animals during test: _________________________________
Weight gains (losses): ____________________________
Specification: ____________________________________________
Result: ____________________________________________

Test for excessive dermal reactivity (section A.6.4.2) if applicable

<table>
<thead>
<tr>
<th>Method used:</th>
<th>Vaccine</th>
<th>Reference vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilutions injected:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inoculation route:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of guinea-pigs given injection:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation period (specification):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date test started:</td>
<td></td>
<td></td>
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<tr>
<td>Date test completed:</td>
<td></td>
<td></td>
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<tr>
<td>Mean diameter of lesions (for each dilution):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specification: ____________________________________________
Result: ____________________________________________

Test for bacterial concentration (section A.6.5)

Method used: ____________________________________________
Date test started: ____________________________________________
Date test completed: ____________________________________________
Specification: ____________________________________________
Result: ____________________________________________

Test for residual moisture (section A.6.6)

Method: ____________________________________________
Date: ____________________________________________
Specification: ____________________________________________
Result: ____________________________________________

Tests for viability (section A.6.7)
Test for number of culturable particles (section A.6.7.1)

Method used: ____________________________________________

<table>
<thead>
<tr>
<th>Medium:</th>
<th>Vaccine</th>
<th>Reference vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date test started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date test completed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of containers tested:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean count of culturable particles per ml:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean survival rate (%):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Before lyophilization</th>
<th>After lyophilization</th>
</tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Specification: ____________________________________________
Result: _________________________________________________
Details of working Reference Preparation: _______________________

Rapid test for viability (section A.6.7.2) if applicable

Method: __________________________________________________
Mean survival rate (%): ______________________________________
Date: _____________________________________________________
Specification: ____________________________________________
Result: _________________________________________________

Thermal stability test (section A.6.8)

Method used: ______________________________________________
Date test started: __________________________________________
Date test completed: _________________________________________

<table>
<thead>
<tr>
<th>No. of containers tested</th>
<th>Unheated containers</th>
<th>Heated containers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Culturable particles in each container per ml: ______________________
Mean survival rate (%): ______________________________________
Specification: _________________________________________________
Result: _____________________________________________________
Details of working Reference Preparation: _______________________

Submission addressed to NRA

Name of responsible person (typed) ________________________________

Certification by the person from the control laboratory of the manufacturing company taking over responsibility for the production and control of the vaccine:

I certify that lot no. _______________________ of BCG vaccine, whose number appears on the label of the final container, meets all national requirements and/or satisfies Part A¹ of the WHO Recommendations to assure the quality, safety and efficacy of BCG vaccines (2013)²

Signature: ___________________________________________________
Name (typed): _________________________________________________
Date: _______________________________________________________

¹ With the exception of provisions on distribution and shipping, which the NRA may not be in a position to assess.
Appendix 3

Model certificate for the release of BCG vaccine by NRAs

Lot release certificate

Certificate no. _______________

The following lot(s) of BCG vaccine produced by ________________\(^1\) in ________________,\(^2\) whose numbers appear on the labels of the final containers, complies with the relevant specification in the marketing authorization and provisions for the release of biological products\(^3\) and Part A\(^4\) of the WHO Recommendations to assure the quality, safety and efficacy of BCG vaccines (2013)\(^5\) and comply with WHO good manufacturing practices: main principles for pharmaceutical products;\(^6\) Good manufacturing practices for biological products;\(^7\) and Guidelines for independent lot release of vaccines by regulatory authorities.\(^8\)

The release decision is based on ________________\(^9\).

The certificate may include the following information:

- name and address of manufacturer;
- site(s) of manufacturing;
- trade name and common name of product;
- marketing authorization number;
- lot number(s) (including sub-lot numbers, packaging lot numbers if necessary);

---

\(^1\) Name of manufacturer.
\(^2\) Country of origin.
\(^3\) If any national requirements are not met, specify which one(s) and indicate why release of the lot(s) has nevertheless been authorized by the NRA.
\(^4\) With the exception of provisions on distribution and shipping, which the NRA may not be in a position to assess.
\(^9\) Evaluation of summary protocol, independent laboratory testing, and/or specific procedures laid down in defined document etc., as appropriate.
- type of container;
- number of doses per container;
- number of containers/lot size;
- date of start of period of validity (e.g. manufacturing date) and/or expiry date;
- storage condition;
- signature and function of the authorized person and authorized agent to issue the certificate;
- date of issue of certificate;
- certificate number.

The Director of the NRA (or other authority as appropriate):

Name (typed) ____________________________________________________________
Signature ______________________________________________________________
Date _______________________________________________________________