Introduction

In 1976, a WHO Working Group on the Standardization of Human Blood Products and Related Substances (*1*) considered the need for international requirements for the processing and control of whole human blood and blood products. It emphasized that, as the quality of the source material played an important part in determining the quality of the final products, such requirements should cover all the stages in the process, from the collection of the source materials to the quality control of the final product. In response to the Working Group's recommendations, the Requirements for the Collection, Processing and Quality Control of Human Blood and Blood Products were published in 1978 (*2*). These Requirements were updated and revised in 1988 (*3*), and WHO recommendations concerning testing for antibodies to human immunodeficiency virus (HIV, *4*) were taken into account. This Annex contains a further revision of the Requirements, applicable to the quality control of blood, blood components and plasma derivatives.

A number of other WHO publications have dealt with whole blood and its components, among them guidelines intended mainly for blood transfusion services (*5*). Guidelines of a more general nature, such as the Guidelines for National Authorities on Quality Assurance for Biological Products, have also been published (*6*). The latter call for a quality-assurance system based on the existence of a national structure that is independent of the manufacturer and is responsible for granting licences for biological products, defining procedures for product release and setting up a post-marketing surveillance system. These Guidelines should be followed by any country having or wishing to set up an organization for the collection and fractionation of blood and blood components.

The names of the many experts who provided advice and data taken into account in this revision of the Requirements are listed in the Acknowledgements section, page 96.

General considerations

The setting up of an organization for the collection and fractionation of human blood and blood components calls for a great deal of expertise and considerable investment. Any country contemplating the establishment of such an organization should carry out a careful cost-benefit analysis to determine whether the investment is justified. A logical developmental sequence for a comprehensive organization starts with the collection and distribution of whole blood, progressing later to the separation of whole blood into components and then the fractionation of plasma pools. It is not always possible to be specific about the details of the procedures employed, the in-process controls or the tests applied at each stage of production, in particular for whole blood and component cells. In addition, although the general principle of fractionation of plasma is well established, there are in practice numerous variations in the details of the various production steps. Therefore, any country wishing to begin the collection and fractionation of blood and blood components should send personnel for training to a plant that is operating successfully. WHO may be able to help in arranging such training.

One of the basic questions to be answered by a country considering whether to start fractionation of plasma is whether there is a suitable donor population of sufficient size to guarantee an adequate supply of source material. It is not possible to set a lower limit for the quantity of source material that would be necessary to make such an operation economic because too many factors are involved. However, in order to maintain competence in production and to avoid certain contamination risks, it is important to have sufficient source material to maintain the fractionation facility in continuous operation.

In a comprehensive organization, the greatest expense is that involved in setting up the fractionation plant, but it is also possible to regard the collection of source material and its fractionation as quite separate operations. A country may wish to establish collection centres for separating the cell components and then send the plasma to an established fractionation plant in another country, from where the products could be returned to the original country. The costs of such an operation might be less than those involved in establishing and operating a fractionation plant.

The general prevalence of certain infectious diseases, such as various forms of hepatitis and parasitic diseases, and of HIV infection differs so markedly in different geographical regions that each national authority must decide for itself whether it is cost-effective to apply the most sensitive test to each blood donation and whether it is feasible to collect suitable source material. A brief protocol for the collection of source material is in any case mandatory (see Appendix). Great emphasis should be placed on the production of fractions by a process that experience has shown results in the least risk of contamination. For example, immunoglobulin prepared by the cold ethanol fractionation method of Cohn has a well established

clinical record of being free from contamination with HIV and hepatitis B virus (HBV), as have albumin products prepared by the same method, stabilized and heated for 10 hours at 60 °C (5). Nevertheless, extreme care is required in manufacture to ensure that these products are free from infectious viruses, and it cannot be assumed that different fractionation methods will be equally effective. When a fractionation process is introduced or significant modifications are made to an existing production process, the process or the modifications should be validated or revalidated by appropriate procedures, including the use of marker viruses and, where applicable, special *in vitro* and *in vivo* testing.

Blood can harbour a number of different viruses, and the use of medicinal products derived from human blood has led to transmission of viruses such as HBV and HIV. The risk of virus transmission by blood and blood products can be diminished by the testing of all individual donations. Policies for mandatory testing shall be determined by the national control authority, and should be reviewed regularly and modified according to the current state of knowledge.

Special care and appropriate measures approved by the national control authority must be taken to protect the health of the staff of blood collection and fractionation facilities.

The transport of source materials from blood collecting centres and hospitals to fractionation facilities requires special consideration. Refrigeration at the temperature range appropriate for the product must be efficient and reliable and proved to be so by monitoring. Thermal insulation must provide an adequate safeguard against a temporary failure of refrigeration. Containers of liquid source material should be filled so as to minimize frothing due to shaking. Because of the potentially infective nature of these biological materials, suitable protection should be provided against breakage, spillage and leakage of containers.

In these Requirements, the word "human" has been omitted from the names of products derived from human blood. Products of animal origin are immunogenic, and their administration to humans should be avoided whenever equivalent products of human origin can be used instead. The proper name of any blood product of non-human origin should include the species of origin.

These Requirements consist of four parts:

- Part A. Requirements for the collection of source materials
- Part B. Requirements for single-donor and small-pool products
- Part C. Requirements for large-pool products
- Part D. National control requirements.

Each deals with a separate aspect of collection, processing and quality control, but all the parts are intended to be taken together to constitute a single document. It will not be possible to rely on any blood product unless the relevant requirements for each step are complied with, and any attempt

to make them less stringent may have serious consequences for the safety of the final product.

Parts A-D are divided into sections, each of which constitutes a recommendation. The parts of each section printed in normal type have been written in the form of requirements, so that, if a health administration so desires, they may be adopted as they stand as definitive national requirements. The parts of each section printed in small type are comments or recommendations for guidance.

Should individual countries wish to adopt these Requirements as the basis for their national regulations concerning blood products and related substances, it is recommended that modifications be made only on condition that the modified requirements ensure at least an equal degree of safety and potency of the products. It is desirable that the World Health Organization should be informed of any such changes.

Increasing demand for blood products is resulting in the extensive movement of such products from one country to another. Internationally accepted requirements are therefore necessary so that countries without any regulations on blood products and related substances may refer to them when importing such products.

International Biological Standards and Reference Reagents

Rapid technological developments in the measurement of the biological activity of blood products and related substances require the establishment of international biological reference materials. The first two such materials (for anti-A and anti-B blood-typing sera) were established in 1950, and further reference materials have been established since. A number of materials are currently under investigation for use in the preparation of new standards.

The activity of blood products must be expressed in International Units where an International Standard exists. WHO publishes a list of such standards (revised from time to time and most recently in 1990) under the title *Biological substances: International Standards and Reference Reagents.*

Definitions

The following definitions are intended for use in this document and are not necessarily valid for other purposes.

Blood collection: a procedure whereby a single donation of blood is collected in an anticoagulant and/or stabilizing solution.

Processing: any procedure that takes place after the blood is collected.

Plasmapheresis, apheresis and cytapheresis: procedures whereby whole blood is separated by physical means into components and one or more of them returned to the donor.

Closed blood-collection and processing system: a system for collecting and processing blood in containers that have been connected together by the manufacturer before sterilization, so that there is no possibility of bacterial or viral contamination from outside after collection of blood from the donor.

Donor: a person who gives blood or one of its components.

Single-donor materials

Whole blood (sometimes referred to as "blood"): blood collected in an anticoagulant solution with or without the addition of nutrients such as glucose or adenine. Whole blood is collected in units of 450 ml.

Blood component: any part of blood separated from the rest by means of physical procedures.

Plasma: the liquid portion remaining after separation of the cellular elements from blood collected in a receptacle containing an anticoagulant, or separated by continuous filtration or centrifugation of anticoagulated blood in an apheresis procedure.

Plasma, frozen: a plasma separated more than 8 h after collection of the blood and stored below -20 °C.

Plasma, fresh-frozen: a plasma separated within 8 h of donation, frozen rapidly and stored below -20 °C (and preferably below -30 °C).

Plasma, platelet-rich: a plasma containing at least 70% of the platelets of the original whole blood.

Plasma, freeze-dried: any one of the above forms of plasma that has been freeze-dried for preservation.

Plasma, recovered: plasma recovered from a whole blood donation.

Cryoprecipitated factor VIII: a crude preparation containing factor VIII that is obtained from single units (or small pools) of plasma derived either from whole blood or by plasmapheresis, by means of a process involving freezing, thawing and precipitation.

Serum: the liquid part of coagulated blood or plasma.

Red cells: whole blood from which most of the plasma has been removed and having an erythrocyte volume fraction greater than 0.7.

Red cells suspended in additive solution: red cells to which a preservative solution, for example containing adenine, glucose and mannitol, is added to permit storage for longer periods; the resulting suspension has an erythrocyte volume fraction of approximately 0.6–0.7.

Red cells, washed: red cells from which most of the plasma has been removed by one or more stages of washing with an isotonic solution.

Red cells, leukocyte-depleted: a unit of a red-cell preparation containing fewer than 1.2×10^9 leukocytes.

Red cells, leukocyte-poor: a unit of a red-cell preparation containing fewer than 5×10^6 leukocytes.

Red cells, frozen: red cells that have been stored continuously at -65 °C or below, and to which a cryoprotective agent such as glycerol has been added before freezing.

Red cells, deglycerolized: frozen red cells that have been thawed and from which glycerol has been removed by washing.

Platelets: platelets obtained either by separation of whole blood, buffy coat or platelet-rich plasma or by apheresis and suspended in a small volume of plasma from the same donation.

Leukocytes: leukocytes obtained either by the separation of whole blood or by apheresis and suspended in a small volume of plasma from the same donation.

Large-pool products

Bulk material: plasma, powder, paste or liquid material prepared by the fractionation of pooled plasma.

Final bulk: a sterile solution prepared from bulk material and bearing the corresponding batch number. It is used to fill the final containers.

> In some countries, the final bulk is distributed into containers through a sterilizing filter. If the total final bulk is not distributed into containers in one session, each of the filling lots is given a sub-batch number.

Filling lot (final lot): a collection of sealed final containers that are homogeneous with respect to composition and the risk of contamination during filling and (where appropriate) drying or other further processing such as heat treatment. A filling lot must therefore have been filled and (where appropriate) dried in one working session.

Part A. Requirements for the collection of source materials

1. Premises

The premises shall be of suitable size, construction and location to facilitate their proper operation, cleaning and maintenance in accordance with accepted rules of hygiene. They shall comply with the requirements of Good Manufacturing Practices for Pharmaceutical (*7*) and Biological (*8*) Products and in addition provide adequate space, lighting and ventilation for the following activities where applicable:

- The medical examination of individuals in private to determine their fitness as donors of blood and/or blood components and to provide an opportunity for the confidential self-exclusion of unsuitable potential donors.
- The withdrawal of blood from donors and, where applicable, the re-infusion of blood components with minimum risk of contamination and errors.
- The care of donors, including the treatment of those who suffer adverse reactions.
- The storage of whole blood and blood components in quarantine pending completion of processing and testing.
- The laboratory testing of blood and blood components.
- The processing and distribution of whole blood and blood components in a manner that prevents contamination and loss of potency.
- The performance of all steps in apheresis procedures, if applicable.
- The performance of labelling, packaging and other finishing operations in a manner that prevents errors.
- The storage of equipment.
- The separate storage of quarantined and finished products.
- The documentation, recording and storage of data on the donor, the donated blood and the ultimate recipient.

Mobile teams can be used for the collection of blood. Although the premises used by such teams may not comply with the more stringent requirements for centres built specially for the purpose, they must be adequate to ensure the safety of the donor, the collected blood or blood components and the staff participating in blood collection. The safety of the subsequent users of the premises should also not be forgotten.

2. Equipment

The equipment used in the collection, processing, storage and distribution of blood and blood components shall be calibrated, tested and validated before initial use, and shall be kept clean and maintained and checked regularly. The requirements of Good Manufacturing Practices for Pharmaceutical (*7*) and Biological (*8*) Products shall apply in every particular.

The equipment employed to sterilize materials used in the collection of blood or blood components or for the disposal of contaminated products shall ensure that contaminating microorganisms are destroyed and shall be validated for this purpose. The effectiveness of the sterilization procedure shall be not less than that achieved by a temperature of 121.5 °C maintained for 20 min by means of saturated steam at a pressure of 103 kPa (1.05 kgf/cm^2 or 15 lbf/in^2) or by a temperature of 170 °C maintained for 2 h with dry heat.

All contaminated material should be made safe before disposal. Disposal should comply with the relevant local laws.

Tests for sterility are given in the revised Requirements for Biological Substances No. 6 (General Requirements for the Sterility of Biological Substances) (9, pp. 40–61).

3. Personnel

An organization for the collection of blood or blood components shall be under the direction of a designated and appropriately qualified person who shall be responsible for ensuring that all operations are carried out properly and competently. The director shall have adequate knowledge and experience of the scientific and medical principles involved in the procurement of blood and, if applicable, the separation of blood components and the collection of such components by apheresis.

The director shall be responsible for ensuring that employees are adequately trained and acquire practical experience and that they are aware of the application of accepted good practice to their respective functions.

The director should have the authority to enforce or to delegate the enforcement of discipline among relevant employees.

The persons responsible for the collection of the blood and blood components shall be supervised by licensed physicians who shall be responsible for all medical decisions, for review of the procedures manual and for the quality-control programme, including techniques, equipment, procedures and staff.

The personnel responsible for the processing, storage, distribution and quality control of blood, blood components and plasma shall be adequate in number and each member of the personnel shall have a suitable educational background and training or experience that will ensure competent performance of assigned functions so that the final product has the required safety, purity, potency and efficacy.

4. Donors

4.1 *Donor selection*

The provision of blood, blood components and plasma derivatives from voluntary, non-remunerated donors should be the aim of all countries.

In selecting individuals for blood donation, it is most important to determine whether the person is in good health, in order to protect the donor against damage to his or her own health and to protect the recipient against exposure to diseases or to medicinal products from the blood or blood products. It should be recognized that the donor selection process contributes significantly to the safety of blood products derived from large plasma pools. The following provisions apply to donations of blood or blood components not intended for autologous use.

The health of a donor shall be determined by a licensed physician or a person under the direct supervision of a licensed physician, and the donor shall be free from any disease transmissible by blood transfusion in so far as can be determined by history-taking and examination (see section 4.3). Donors shall be healthy persons of either sex between the ages of 18 and 65 years.

> In some countries, there is no upper limit to the age of the donor. With parental consent the minimum age may be lowered to 16 years.
>
> Red blood cells from donors with glucose-6-phosphate dehydrogenase deficiency, sickle-cell trait or other inherited erythrocyte abnormalities may give rise to transfusion reactions under certain circumstances. Decisions regarding the suitability of such donors should be made by the national control authority.

A donor should be considered for plasmapheresis only where the procedures involved result in products or services shown to serve accepted medical purposes, including prophylaxis, therapy and diagnosis, as verified by valid scientific evidence. All donors should be certified as acceptable, at the time of each plasmapheresis procedure, by a registered physician or by trained personnel under the direct supervision of the physician.

Those eligible for apheresis donation include: (a) healthy persons who fulfil the general criteria for blood donors; (b) persons with antibody levels that have been increased, either naturally or by immunization; (c) subject to (a) above, persons with plasma that is of value for diagnostic or reference purposes; and (d) persons whose blood may be used in the preparation of certain vaccines.

> When a potential donor does not fulfil the general criteria for blood donation, the acceptance of her or him as a donor for a specific component of blood should be at the discretion of the responsible physician. Where appropriate, the physician should have access to an ethical committee.

Donor education and selection programmes are intended to prevent potentially infectious units of blood and plasma from being collected. It is essential that such programmes are comprehensible and readily accessible to all potential donors.

To reduce the likelihood of transmitting infections, all potential donors should be informed of factors in their history or behaviour that may increase their risk of being infected. The national control authority must determine the appropriate exclusion criteria for the country concerned.

Persons in the following categories shall be excluded from acting as donors:

- those with clinical or laboratory evidence of infectious disease, e.g. infection with hepatitis viruses, HIV-1 or HIV-2;
- past or present intravenous drug abusers;
- men who have had a sexual relationship with another man;

- men and women who have engaged in prostitution;
- those with haemophilia or other clotting-factor defects who have received clotting-factor preparations;
- sexual partners of any of the above.

In some countries, the sexual partners of those at risk of transmitting infections are excluded from acting as donors for only one year.

Persons who have received blood transfusions should be excluded from acting as donors for at least one year.

Donors should be made aware before donating blood that it will be tested for the presence of serological markers of infection. It is advisable that the right to test donations and the legal implications of testing donations should be clarified by the appropriate authority.

4.2 *Donation frequency and volume*

4.2.1 *Whole blood*

The frequency of whole-blood donations shall not exceed once every two months, with a maximum volume in any consecutive 12-month period of 3 l.

A standard donation should not be collected from persons weighing less than 50 kg.

A *standard donation* is 450 ml; an optimum blood/anticoagulant ratio is 7 to 1.

The frequency of donation may have to be modified on an individual basis. In general, premenopausal women should not donate blood as frequently as men.

4.2.2 *Plasma*

Plasma donors can be divided into three groups: those who donate at a frequency comparable to that allowed for whole-blood donations; those who donate two to three times as frequently as whole-blood donors; and those who donate at a maximum of twice a week. The first group shall be accepted on the basis of the general criteria for blood donors.

The maximum volume of plasma that may be removed from a donor during one plasmapheresis procedure shall be determined by the national health authority, and shall depend on whether the plasma is obtained by manual or automated plasmapheresis.

In some countries, the volume of plasma collected during a manual procedure is the quantity obtained from 1.0–1.2 l of whole blood. The volume of plasma collected during an automated procedure depends on the equipment used.

It is difficult to specify the maximum volumes of plasma that can be safely collected from donors until more definitive data are available on the effects of plasmapheresis on donors. The limits imposed in different countries vary, and depend on the nutritional status of the donor.

If a plasma donor donates a unit of whole blood or if the red blood cells are

not returned in an apheresis procedure, the next donation shall be deferred by eight weeks unless special circumstances warrant approval by the responsible physician of plasmapheresis at an earlier date.

In general, plasma collected by therapeutic plasmapheresis shall not be used for fractionation.

4.3 *Medical history*

4.3.1 *General*

Before each donation, questions shall be asked so as to ensure that the donor is in normal health and has not suffered, or is not suffering, from any serious illness.

A donor who appears to be suffering from symptoms of acute or chronic disease or who is receiving oral or parenteral medication, with the exception of vitamins, postmenopausal hormone therapy or oral contraceptives, shall not be accepted unless approved by a physician.

A donor who appears to be under the influence of any drug including alcohol or who does not appear to be providing reliable answers to medical history questions shall not be accepted.

4.3.2 *Infectious diseases*

Potential donors with a history that places them at increased risk of transmitting infection shall not donate blood or plasma for an appropriate time period. A donor shall be permanently excluded if one of his or her previous blood donations was believed to be responsible for transmitting disease.

> In most countries, questions concerning the signs and symptoms of HIV infection will be part of the routine assessment of medical history and appropriate monitoring for HIV, as defined by the national control authority, will be included. As a result of this assessment, a potential donor may be disqualified.

Donors shall not have a history of: positive laboratory test results for hepatitis or corresponding symptoms and signs; close contact with an individual with hepatitis within the previous year; receipt within the previous year of human blood or any blood component or fraction that might be a source of transmission of infectious agents; or tattooing, scarification or ear piercing (unless performed under sterile conditions) within the previous year.

> Acupuncture within the previous year may also present a risk if not carried out under sterile conditions.
>
> In some countries, potential donors with a history of viral hepatitis or of a positive test for hepatitis B surface antigen (HBsAg) or antibodies to hepatitis C virus (anti-HCV) are permanently excluded. In others, such donors are accepted providing that recovery occurred more than one year previously and that the reaction for HBsAg and anti-HCV in a sensitive test is negative.

The requirements concerning viral hepatitis may be varied, at the discretion of the national control authority, according to the local epidemiological circumstances.

The collection both of single-donor products (whole blood and its components) and of plasma for pooling for the manufacture of plasma fractions capable of transmitting hepatitis or HIV should be avoided if a group of potential donors shows a prevalence of acute or chronic hepatitis B, hepatitis C or HIV infection higher than that found in the general donor population. Specific approval may be given by national control authorities for the use of donations from such populations to provide plasma for the manufacture of hepatitis B vaccine or hepatitis B immunoglobulin.

In areas with a low incidence of transfusion-transmitted disease, whole blood or blood components should not be used for transfusion if obtained from source material collected in an area where there is a high incidence of blood-borne infectious disease.

Blood and plasma shall be tested for the presence of HBsAg, anti-HIV and anti-HCV by the methods described in Part B, section 7.2; the tests used should be approved by the national control authority or other appropriate authority.

Anyone whose blood has been shown to be reactive for infectious disease markers by approved screening tests shall be excluded as a donor. Selection as a donor may later be permitted if sufficient data are available from tests approved by the national control authority to indicate that the original results were non-specific.

National health authorities shall develop policies designed to prevent the transmission of infectious diseases based on the prevalence of these diseases in the donor population and the susceptibility of recipients to them.

In countries where malaria is not endemic, donors of cellular blood products should have a negative history of malaria exposure during the previous six months and a negative history of clinical malaria, or a history of malaria prophylaxis if they have resided in, or visited, an endemic area within the three years preceding the donation. Such restrictions may be less important in countries where the prevalence of endemic malaria is high among both donors and recipients, except when blood products are required by visitors from non-endemic areas. Malaria history is not pertinent to plasma donation for source material that will be fractionated.

Particular attention should be paid to skin decontamination procedures before blood collection.

Many parasitic, bacterial and viral diseases, including trypanosomiasis, toxoplasmosis, syphilis and brucellosis, can be transmitted by blood. Precautions shoud be taken to avoid blood collection during the viraemic phase of viral diseases like measles and rubella. Potential donors who have lived in or recently travelled to areas where human T-cell lymphotropic virus infections and haemorrhagic fever are endemic should be investigated for evidence of such infections.

Anyone who has received pituitary hormones of human origin should be permanently excluded as a donor because of possible infection with the agent causing Creutzfeldt-Jakob disease, although transmission of this agent through blood products has not been proved.

4.3.3 *Minor surgery*

Donors shall not have undergone tooth extraction or other minor surgery during a period of 72 h before donation.

4.3.4 *Pregnancy and lactation*

Pregnant women shall be excluded from blood donation. In general, mothers shall also be excluded during lactation and for at least six months after full-term delivery.

> The interval before blood donation is permissible after pregnancy may be shorter in some cases, e.g. six weeks after an abortion during the first trimester.
>
> In some countries, donors are accepted when pregnant or during the period of lactation if their blood contains certain blood-group antibodies or is needed for autologous transfusion. The volume to be taken should be determined by the physician responsible.

4.3.5 *Prophylactic immunization*

Symptom-free donors who have recently been immunized may be accepted with the following exceptions:

- Those receiving attenuated vaccines for measles, mumps, yellow fever or poliomyelitis shall be excluded until two weeks after the last immunization or injection.
- Those receiving attenuated rubella (German measles) vaccine shall be excluded until four weeks after the last injection.
- Those receiving rabies vaccine for post-exposure treatment shall be excluded until one year after the last injection.
- Those receiving passive immunization with animal serum products shall be excluded until four weeks after the last injection.
- Those receiving hepatitis B vaccine need not be excluded unless the vaccine is being given because of exposure to a specific risk, in which case the donor shall be disqualified for at least 12 months after the last such exposure. If hepatitis B immunoglobulin has been administered, the period of deferral shall be at least 12 months because disease onset may be delayed.

4.4 ***Physical examination***

As determined by the national control authority, physical examination of donors may include measurement of weight, blood pressure, pulse rate and temperature. If these are measured and the results lie outside the ranges recommended below, the donor concerned shall be accepted only if approved by the licensed physician in charge.

- *Blood pressure:* systolic blood pressure between 12 and 24 kPa (90 and 180 mmHg); diastolic blood pressure between 6.67 and 13.3 kPa (50 and 100 mmHg).
- *Pulse:* between 50 and 110 beats per minute and regular. Lower values may be accepted in healthy athletes with endurance training.
- *Temperature:* oral temperature not exceeding 37.5 °C.
- *Weight:* donors weighing less than 50 kg may donate a volume of blood proportionally less than 450 ml in an appropriate volume of anticoagulant, provided that all other donor requirements are met.

Donors shall be free from any infectious skin disease at the venepuncture site and of skin punctures or scars indicative of abuse of intravenous drugs.

4.5 *Additional requirements applicable to donors for plasmapheresis*

All phases of apheresis, including explaining to donors what is involved in the process and obtaining their informed consent, should be performed under the direct supervision of a licensed physician or by trained personnel reporting to such a physician.

4.5.1 *First-time plasma donors*

When prospective plasma donors present themselves to a centre for the first time, initial screening shall begin only after the procedure of plasmapheresis has been explained and the donor has given consent.

The following information shall be permanently recorded:

- Personal information and identification. If the donor is to participate in an ongoing programme, an effective means of identification is especially important. The use of identity numbers, photographs or other equally effective measures should be considered.
- A preliminary medical history as required for blood donors, covering infectious diseases and the donor's general state of health.

If there are no contraindications to plasmapheresis, preliminary laboratory tests shall be carried out, namely reading of the erythrocyte volume fraction or haemoglobin concentration, determination of total serum protein and screening for protein and sugar in the urine. The haemoglobin concentration or erythrocyte volume fraction of the donor's blood shall be within normal limits, as defined by the national control authority or the national blood transfusion authority.

> Many countries specify minimum haemoglobin concentrations of 125 g/l for women and 135 g/l for men, or, for microhaematocrit determinations, minimum erythrocyte volume fractions of 0.38 for women and 0.41 for men.

If normal values are also obtained in the other laboratory tests, evaluation of the potential donor by the physician begins.

> In some countries, specially trained non-physicians are permitted to conduct these routine examinations under the supervision of a physician.

Donors participating in a programme in which plasmapheresis is more frequent than is blood donation for those eligible for whole-blood collection shall be examined by a licensed physician on the day of the first donation, or not more than one week before that donation. This examination shall include measurement of temperature and blood pressure, auscultation of the heart and lungs, palpation of the abdomen, assessment of neurological signs, urine analysis and blood sampling for tests required by the national control authority. Liver function tests (e.g. for alanine aminotransferase), tests for HBsAg, anti-HIV and anti-HCV, and quantification of plasma proteins by electrophoresis or another suitable method shall also be included. The physician shall obtain informed consent after explaining the procedure of plasmapheresis and describing the hazards and adverse reactions that may occur. At this stage, donors shall be given an opportunity to refuse participation. If they consent, it must be on the condition that their legal rights to recover damages are not waived.

In some countries, the first plasmapheresis procedure may be performed before the results are available for the liver function tests, the serological tests for syphilis (if required by the national control authority) and the tests for HBsAg, anti-HCV and anti-HIV. The results of the tests for quantifying plasma proteins should be reviewed by the physician before subsequent plasmapheresis procedures.

4.5.2 *Donors who have undergone plasmapheresis previously in the same programme*

For donors who have already taken part in a plasmapheresis programme:

- The receptionist shall note the date of the last donation (at least two days must have elapsed since that time). No more than two donations shall be permitted within a seven-day period.
- The medical history and weight of the donor shall be recorded; blood pressure, temperature, pulse rate and haemoglobin concentration shall be measured by trained personnel. On the day of each donation, in addition to meeting the general requirements for donors, plasma donors shall be shown to have a total serum protein concentration of not less than 60 g/l.

The medical evaluation of plasma donors shall be repeated at regular intervals, as specified by the national control authority, and tests carried out as specified in section 4.5.3.

Whenever the result of a laboratory test is found to be outside the established normal limits or a donor exhibits any important abnormalities of history or on physical examination, the donor shall be excluded from the programme. The donor shall not be readmitted to the programme until the results of relevant tests have returned to normal and the responsible physician has given approval in writing. It is the responsibility of national health authorities to define normal ranges and standard deviations of test results on the basis of data from a sufficiently large sample of healthy individuals not undergoing plasmapheresis.

In the case of hepatitis C, the results of liver function tests frequently return to normal before rising again. Test results obtained over a period of adequate length must therefore be evaluated by the physician before the donor can be readmitted to the programme.

4.5.3 *Tests for plasma donors*

The following tests shall be performed at each donation:

- Measurement of haemoglobin concentration or erythrocyte volume fraction.
- Determination of total serum protein concentration, which shall be at least 60 g/l.
- An approved test for HBsAg, which shall be negative.
- An approved test for anti-HIV, which shall be negative.
- An approved test for anti-HCV, which shall be negative.

The following tests shall be performed initially and then every four months or after every 10 donations, whichever time interval is longer:

- If required by the national control authority, a serological test for syphilis, which shall be negative.
- Urine analysis for glucose and protein, which shall be negative.
- Serum protein electrophoresis: this shall be normal (unusual changes in a donor's results may be more significant than absolute values). The albumin and globulin concentrations may be calculated from the known total protein value, and shall be: albumin, minimum 35 g/l; IgM, minimum 0.5 g/l; IgG, between 5 and 20 g/l.
- Liver function tests.

  When determination of serum alanine aminotransferase is required, the enzyme concentration measured photometrically using approved reagents shall be no more than two standard deviations above an established normal mean.

4.6 ***Donors for platelet and leukocyte apheresis***

In general, platelet and leukocyte donors shall meet the general criteria for donors and the specific criteria for plasma donors (sections 4.1–4.5). In addition, platelet donors should not have taken aspirin or other platelet-active drugs for at least 72 h before donation.

The requirements to be satisfied in the performance of plateletpheresis and leukapheresis in order to ensure that there is no danger to donors and that the products obtained are of satisfactory quality are under active investigation in many countries. The following recommendations may be useful as guidance.

On the day of each donation, donors for plateletpheresis should have an absolute platelet number concentration ("count") of not less than 200×10^9/l and donors for leukapheresis should have an absolute granulocyte number

concentration of not less than 3×10^9/l. Both types of donor should have a normal differential leukocyte count and haemoglobin level.

Although levels of circulating platelets and leukocytes recover promptly in donors, data are not at present available from which the maximum numbers of platelets and leukocytes that can be safely collected from donors can be defined. The long-term effects of the repeated removal of cellular elements are not known.

Leukapheresis may entail the administration of drugs to donors and their exposure to colloidal agents to enhance the yield of granulocytes. Appropriate precautions should be taken to protect donors, such as investigation for latent diabetes by means of a glucose tolerance test if a donor is to be given corticosteroids.

Leukapheresis should be performed as part of the treatment of a patient with chronic myeloid leukaemia only if approved by the patient's attending physician. It is inadvisable to use the leukocytes from such patients.

4.7 *Donor immunization and plasma for special purposes*

4.7.1 *Plasmapheresis in donors with naturally acquired antibodies and other types of medically useful plasma*

Plasma may be collected by plasmapheresis from donors who have acquired immunity through natural infection or through active immunization with approved vaccines for their own protection, and from donors with plasma useful for diagnostic purposes as a result of acquired or congenital underlying conditions.

Donors with medically useful plasma may be identified by screening whole blood donations and by examining patients convalescing from specific diseases or vaccinated individuals, e.g. veterinary students who have received rabies vaccine or military recruits who have been immunized with tetanus toxoid. Unnecessary immunizations can be avoided by this approach.

The following are examples of medically useful plasma:

- Antibody-rich plasma for control reagents in diagnostic tests, such as those for anti-HIV, hepatitis A and B, cytomegalovirus, rubella, measles and uncommon infectious agents; plasma should be collected in appropriately isolated premises when products are being prepared that are known to be capable of transmitting infection.
- Plasma containing antibodies to human cellular and serum antigens of diagnostic use, for example in HLA (human leukocyte antigen) typing reagents, erythrocyte typing reagents and immunoglobulin allotyping reagents.
- Plasma containing reagents useful for diagnostic tests, such as reagin, rheumatoid factors, heterophile antibody and C-reactive protein.
- Factor-deficient plasma for specific assays, such as factor-VIII-deficient plasma. Donors who have received factor VIII are at increased risk of transmitting hepatitis B, hepatitis C and HIV; their plasma should therefore be collected in appropriately isolated premises.

4.7.2 *Precautions to be taken when handling blood or blood products containing infectious agents*

All blood and plasma may contain unknown infectious agents and must be handled accordingly. In addition, special precautions must be taken when handling infected donors and blood products known to contain infectious agents. The precautions to be taken might include:

- isolation by means of the appropriate timing or location of the procedures, special labelling and quarantine of the products collected, use of protective packaging with double wrapping in impervious plastic;
- disinfection of all work surfaces and equipment with a disinfectant of known efficacy, such as freshly prepared 0.25% sodium hypochlorite solution;
- protection of staff by means of adequate training, avoidance of aerosols and use of gloves, gowns, masks and eye protection; it is strongly recommended that such staff also be protected by immunization with hepatitis B vaccine;
- fulfilment of the labelling, shipping and waste-disposal requirements appropriate to the etiological agents in question.

4.7.3 *Immunization of donors*

There is a clinically valid need for specific immunoglobulins and plasma for therapeutic, prophylactic and diagnostic uses. Deliberate immunization of healthy volunteers may be necessary in addition to collection of plasma from convalescent patients and donors selected by screening for high levels of specific antibodies. The immunization of donors requires informed consent in writing and shall take into consideration all the requirements of the previous sections.

Donors shall be immunized with antigens only when sufficient supplies of material of suitable quality cannot be obtained from other appropriate donors, from donations selected by screening, or in the form of safe and efficacious licensed monoclonal antibodies. Donors must be fully informed of the risk of any proposed immunization procedure, and pressure shall not be brought to bear on a donor to agree to immunization. Women capable of child-bearing shall not be immunized with erythrocytes or other antigens that may produce antibodies harmful to the fetus. Donors of blood and those undergoing plasmapheresis shall, if necessary, undergo investigations that can reveal hypersensitivity to a proposed antigen (see also Part B, section 6).

An approved schedule of immunization shall be used. Every effort shall be made to use the minimum dose of antigen and number of injections. In any immunization programme, the following shall be taken into consideration as a minimum: (a) the antibody assay; (b) the minimum level of antibody required; (c) data showing that the dose, the intervals between injections and the total dosage proposed for each antigen are appropriate; and (d) the criteria for considering a prospective donor a non-responder for a given antigen. No donor shall be hyperimmunized with more than one

immunizing preparation unless the safety of the multiple procedure is demonstrated.

Potential donors should be:

- informed by a licensed physician of the procedures, risks and possible sequelae and how to report any adverse effects, and encouraged to take part in a free discussion (which, in some countries, is achieved in small groups of potential donors);
- encouraged to seek advice from their family doctor before agreeing to immunization;
- informed that any licensed physician of their choice will be sent all the information about the proposed immunization procedure;
- informed that they are free to withdraw consent at any time.

All vaccines used for immunizing donors shall be registered or recognized by the national health authority, but may be administered at doses and with schedules differing from those recommended for routine prophylactic immunization. Erythrocyte and other cellular antigens shall be obtained from an establishment approved by the national control authority.

Donors shall be observed for approximately 30 min following any immunization in order to determine whether an adverse reaction has taken place. Because reactions often occur 2–3 h after immunization, donors shall be advised of this possibility and instructed to contact the facility's physician if a reaction is suspected in the first 12 h after immunization. Reactions may be local or systemic. Local reactions, which may be immediate or delayed, take the form of redness, swelling or pain at the injection site. Systemic reactions may include fever, chills, malaise, arthralgia, anorexia, shortness of breath and wheezing.

4.7.4 *Immunization with human erythrocytes*

Erythrocyte donors. A donor of erythrocytes for the purposes of immunization shall meet all the general health criteria for donors (see sections 4.3 and 4.4). In addition, the donor shall not have had a blood transfusion at any time.

The volume of erythrocytes drawn from a donor should not exceed 450–500 ml of whole blood in any eight-week period.

At each donation the donor shall be found to be negative for syphilis, HBsAg, anti-HIV, antibody to hepatitis B core antigen (anti-HBc), anti-HCV and antibodies to human T-cell lymphotropic viruses (anti-HTLV). The serum level of aminotransferases should be within normal limits as established by the national control authority.

Erythrocyte phenotyping shall be done for ABO as well as for C, D, E, c, e, Kell and Fy^a. Phenotyping for other specificities is often desirable and is recommended especially for Jk^a, Jk^b, Fy^b, S and s.

Ideally erythrocytes obtained for immunization purposes should be frozen for at least 12 months before use and the donor should be recalled and retested for anti-HIV, anti-HCV, anti-HBc, HBsAg and anti-HTLV before the stored cells are used for immunization.

Where suitable facilities for freezing erythrocytes are not available, national control authorities may authorize the use of cells from a single donor to immunize no more than three persons (preferably who have not previously had a blood transfusion) in an initial 12-month period, during which monthly determinations of anti-HIV, anti-HCV, anti-HBc, HBsAg and serum alanine aminotransferase should be made in both the donor and the recipients. If, after 12 months, the initial three recipients show no clinical or laboratory evidence of hepatitis, HIV infection or other blood-transmissible diseases, the donor may be considered acceptable for providing erythrocytes for immunization. As small a number of donors of erythrocytes should be used as possible.

Collection and storage of erythrocytes. Erythrocytes shall be collected under aseptic conditions into sterile, pyrogen-free containers in an appropriate proportion of an approved anticoagulant. They may then be dispensed in aliquots under aseptic conditions into single-dose, sterile, pyrogen-free containers for storage. The microbiological safety of the dispensing environment shall be validated.

Erythrocytes should be stored frozen for at least 12 months to permit retesting of donors for disease markers. The method selected should have been validated such that there is 70% cell recovery *in vivo*. Erythrocytes should be washed after storage to remove the cryoprotective agent.

Adequate sterility data to support the requested shelf-life for stored erythrocytes should be submitted by the manufacturer to the national control authority. A test for bacterial and fungal contamination should be made on all blood dispensed in aliquots in an open system (*9*). The test should also be performed on at least one single-dose vial from each lot of whole blood that has been stored unfrozen for more than seven days. The test should be made on the eighth day after collection and again on the expiry date. Cultures for the sterility test should be maintained for at least 14 days, with subculturing on day 3, 4 or 5.

Erythrocyte recipients. The following additional testing of erythrocyte recipients is necessary:

- The recipient should be phenotyped for ABO, Rh, Kell and Duffy antigens before immunization. Kell-negative and/or Fy(a–) persons should not receive Kell-positive or Fy(a+) cells except for the specific purpose of producing anti-Kell or anti-Fy^a. Only ABO-compatible erythrocytes may be transfused. Matching of Jk^a, Jk^b, Fy^b, S and s phenotypes is also desirable.
- Screening for unexpected antibodies by methods that demonstrate coating and haemolytic antibodies should include the antiglobulin method or a procedure of equivalent sensitivity.

Prospective erythrocyte recipients in whom antibody screening tests demonstrate the presence of erythrocyte antibodies (other than those deliberately stimulated through immunization by the plasmapheresis centre) should be asked whether they have ever been pregnant or had a

transfusion, a tissue graft or an injection of erythrocytes for any reason. This history should form part of the permanent record and should identify the cause of immunization as clearly as possible. Recipients should be notified in writing of any specific antibodies developed after injection of erythrocytes. The national control authority should be notified annually in writing of unexpected antibodies induced by immunization, and the immunized donor should carry a card specifying the antibodies.

Immunization schedules. Erythrocytes used for immunization purposes shall not be administered as part of any plasmapheresis procedure. Such immunization may be performed on the same day as plasmapheresis, but only after it and as a separate procedure.

To minimize the risk of infection to the donor, the immunization schedule should involve as few doses of erythrocytes as possible.

For primary immunization two injections of erythrocytes, each of about 1–2 ml and given three months apart, elicit antibody formation within three months of the second injection in approximately 50% of volunteers; the result is not improved by injecting larger amounts or giving more frequent injections.

It is advantageous to choose as donors of anti-D (anti-Rh_o) volunteers who are already immunized, since useful levels of anti-D are then usually attained within a few weeks of reimmunization. In some people, the level of antibody reaches its maximum within the first three weeks and will not increase after further immunization. In others, antibody levels may continue to rise for more than 12 months when injections of 0.5–1 ml of erythrocytes are given at intervals of five to eight weeks. About 70% of immunized volunteers eventually produce antibody levels well above 100 IU/ml. Once attained, such levels can be maintained by injections of 0.1–0.5 ml of erythrocytes at intervals of two to nine months, as required. If injections of erythrocytes are discontinued, antibody levels usually fall appreciably within 6–12 months.

The baseline antibody titre of every recipient of erythrocytes should be established, and the antibody response, including both type and titre, should be monitored monthly.

Erythrocytes to be used for immunization purposes should be selected, for each recipient, by a licensed physician.

Risks to recipients. Recipients of erythrocytes for immunization purposes may run the risk of:

- viral hepatitis (B and C) and HIV infection;
- other infectious diseases;
- HLA immunization;
- the production of unwanted erythrocyte antibodies that may complicate any future blood transfusion;
- a febrile reaction if the antigen dose is too great;

– the production of antibodies that may interfere with future organ transplantation if it is needed.

Record-keeping. Records of erythrocyte donors and of the recipients of their erythrocytes should be maintained and cross-referenced.

5. Collection of blood and plasma

A number of precautions must be taken in the collection of blood and plasma, as described in the following sections.

5.1 *Blood collection and apheresis procedures*

The skin of the donor at the site of venepuncture shall be prepared by a method that has been shown to give reasonable assurance that the blood collected will be sterile. Blood shall be collected into a container by means of an aseptic method. The equipment for collecting the sterile blood may be closed or vented provided that the vent is designed to protect the blood against microbial contamination.

With apheresis procedures, care shall be taken to ensure that the maximum volume of erythrocytes is returned to the donor by intravenous infusion. If the red cells cannot be returned to the donor, no further collection should be made until the donor has been re-evaluated. Several checks shall be made to ensure that donors receive their own erythrocytes, including identification of the containers of erythrocytes by donors before re-infusion. Haemolytic transfusion reactions are avoidable, since they are caused by the accidental infusion of incompatible erythrocytes. Personnel involved in reinfusion procedures should be adequately trained to prevent them. The signs and symptoms are hypotension, shortness of breath, stomach and/or flank pain, apprehension, cyanosis and haemoglobinuria.

If a haemolytic transfusion reaction occurs, the infusion of cells to all donors at the centre concerned should be discontinued until the identity of all containers of erythrocytes has been checked. Automated plasmapheresis is preferred to manual plasmapheresis in some institutions because of its greater safety.

5.1.1 *Summary of minimum general requirements for apheresis*

Equipment. This must be electrically safe and non-destructive for blood elements; disposable tubing must be used wherever there is blood contact. In addition, equipment must be accessible to detailed inspection and servicing and its decommissioning should not significantly interrupt the programme. It should also be provided with suitable automatic alarms.

Procedure. This must be non-destructive for blood elements and aseptic; there must be adequate safeguards against air embolism.

Disposables. These must be pyrogen-free, sterile and biocompatible (e.g. there must be no activation of enzyme systems).

5.1.2 *Adverse reactions*

Provision must be made to prevent and treat any adverse reactions in donors. As with any medical procedure involving the treatment of individuals, adverse reactions may occur with blood collection and plasmapheresis. Almost all such reactions are mild and transient, but an occasional serious reaction may occur. The possibility of adverse reactions, though remote, should be anticipated and adequate provision should be made to ensure that care is available to donors. Initial and continuing training in emergency care is mandatory for personnel. If any serious adverse reaction occurs, a physician should be called.

5.1.3 *Types of adverse reaction*

Vasovagal syncope. This is most likely to occur with new donors. The signs and symptoms are hypotension, bradycardia, syncope, sweating and (rarely) convulsions.

Local infection, inflammation and haematoma at the phlebotomy site. Reactions of this type are best prevented by adequate preparation of the venepuncture site and by training phlebotomists in proper methods of initiating blood flow. The symptoms are localized pain and redness and swelling at the phlebotomy site.

Allergic and anaphylactoid reactions. These may occur during the introduction of saline into the donor while red cells are being processed, or during reinfusion of red cells. The signs and symptoms are urticaria, burning in the throat, tightness of the chest, wheezing, pain in the abdomen and hypotension.

Systemic infection. Care should be taken at all stages of plasmapheresis to avoid the transmission of infectious organisms to the donor.

5.2 *Containers*

The original blood container or a satellite attached in an integral manner shall be the final container for whole blood and red cells, with the exception of modified red cells, for which the storage period after processing should be as short as possible and certainly not longer than 24 h. Containers shall be uncoloured and translucent and the labelling shall be placed in such a position as to allow visual inspection of the contents. They shall be sterilized and hermetically sealed by means of suitable closures so that contamination of the contents is prevented. The container material shall not interact adversely with the contents under the prescribed conditions of storage and use.

The specifications for containers should be approved by the national control authority (*10, 11*).

If sterile docking devices are not available, closed blood-collection and processing systems should be used to prepare blood components.

5.3 *Anticoagulants*

The anticoagulant solution shall be sterile, pyrogen-free and of a composition such as to ensure that the whole blood and separate blood components are of satisfactory safety and efficacy.

> Commonly used anticoagulant solutions are acid–citrate–glucose, citrate–phosphate–glucose and citrate–phosphate–glucose–adenine; the amount of adenine used varies in different countries. Solutions of adenine, glucose and mannitol used for red cell preservation may be added after removal of the plasma.
>
> For plasmapheresis, sodium citrate as a 40 g/l solution is widely used as an anticoagulant.

5.4 *Pilot samples*

Pilot samples are blood samples provided with each unit of whole blood or of red blood cells. They shall be collected at the time of donation by the person who collects the whole blood. The containers for pilot samples shall be marked at the collection site before the samples are collected, and the marking used must be such that the sample can be identified with the corresponding unit of whole blood. Pilot samples must be collected by a technique that does not compromise the sterility of the blood product.

> Pilot samples should be attached to the final container in a manner such that it will later be clear whether they have been removed and reattached.

5.5 *Identification of samples*

Each container of blood, blood components and pilot and laboratory samples shall be identified by a unique number or symbol so that it can be traced back to the donor and from the donor to the recipient. The identity of each donor shall be established both when donor fitness is determined and at the time of blood collection.

When blood-derived materials are transferred to a fractionation plant, the following details shall be provided by the supplier:

- name and address of collecting centre,
- type of material,
- donor identification,
- date of collection,
- results of mandatory tests,
- conditions of storage,
- other details required by the fractionator,
- name and signature of responsible person,
- date.

Part B. Requirements for single-donor and small-pool products

6. General considerations

These requirements for single-donor and small-pool products cover the methods used to prepare products directly from units of whole blood or of components collected by apheresis, starting with the testing of the units and proceeding to the separation of the various cell and plasma protein components. Among the products that may be prepared in small pools (12 donors or fewer) are cryoprecipitated factor VIII and platelets. In addition to tests on the units of whole blood that provide information on the safety, efficacy and labelling of the components, specific tests are included, where applicable, to ensure the quality of various components.

It is important to note that single-donor and small-pool products have certain specialized uses other than therapeutic application to correct deficits in patients. Although not dealt with further in these Requirements, these uses include the stimulation of plasma donors with red blood cells in order to raise antibody levels for the preparation of anti-D (anti-Rh_o) immunoglobulin (*12*) and special blood-grouping reagents. It is of the utmost importance that the donors of cells and plasma for such purposes be carefully studied both initially and on a continuing basis to minimize the likelihood of the transmission of infectious diseases to recipients. The use of red cells, stored frozen, that have been demonstrated to be free from infectious agents by retesting the donor 12 months after the initial collection reduces the risk of such transmission to volunteers for immunization.

Plasma donors may also be immunized with viral or bacterial antigens for the preparation of specific immunoglobulin products. All donor immunization procedures must be planned and carried out under the supervision of a physician who is familiar with the antigens being used and especially with the reactions or complications that may occur. Donors being immunized shall have been fully informed of all known hazards and shall have given their written informed consent to the procedures.

Donor immunization practices are considered in more detail in Part A, section 4.7.

Minimum general requirements for apheresis are summarized in Part A, section 5.1.1.

7. Production and control

7.1 *General requirements*

Single-donor and small-pool products shall comply with any specifications established by the national control authority. Cellular blood components and certain plasma components may deteriorate during separation

or storage. Whatever the method of separation (sedimentation, centrifugation, washing or filtration) used for the preparation of cell components, therefore, it is important that a portion of plasma protein sufficient to ensure optimum cell preservation be left with the cells, except when a cryoprotective substance is added to enable them to be stored for long periods in the frozen state, or additive solutions (for example containing adenine, glucose and mannitol) are used for the same purpose for liquid storage.

> The methods employed for component separation should be checked before they are introduced. The characteristics assessed might include yield of the component, purity, *in vivo* recovery, biological half-life, functional behaviour and sterility.
>
> The nature and number of such checks should be determined by the national control authority.

Immediately before issue for transfusion or for other purposes, blood components shall be inspected visually. They shall not be issued for transfusion if abnormalities of colour are observed or if there is any other indication of microbial contamination or of defects in the container.

Blood components shall be stored and transported at the appropriate temperature. Refrigerator or freezer compartments in which components are stored shall contain only whole blood and blood components. Reagents required for use in testing may be stored in a separate section of the same refrigerator or freezer provided that they have been properly isolated and are in suitable containers.

7.2 *Testing of whole blood and plasma*

7.2.1 *Sterility*

Each donation of whole blood intended for transfusion and each preparation of component cells constitutes a single batch. Single batches shall not be tested for sterility by any method that entails breaching the final container before the blood is transfused.

> The national control authority may require tests for sterility to be carried out at regular intervals on final containers chosen at random and at the end of the storage period. The purpose of such tests is to check on the aseptic technique used for taking and processing the blood and on the conditions of storage.

7.2.2 *Laboratory tests*

Laboratory tests shall be made on laboratory samples taken either at the time of collection or from the pilot samples accompanying the final container, labelled as required in Part A, section 5.

> In some countries, test reagents, in particular those used for blood-grouping and for detecting anti-HIV, anti-HCV and HBsAg, must be approved by the national control authority.

The results of the tests shall be used for ensuring the safety and proper labelling of all components prepared from units of whole blood.

7.2.3 *Tests for infectious agents*

Syphilis. Each donation of whole blood shall, if required by the national control authority, be subjected to a serological test for syphilis. If so tested, only units giving negative results shall be used for transfusion or component preparation.

Viral hepatitis. Each unit of blood or plasma collected shall be tested for HBsAg and anti-HCV by a method approved by the national control authority and only those giving a negative result shall be used (*13*). Units giving a positive result shall be so marked, segregated and disposed of by a method approved by the national control authority, unless designated for the production of a reagent or experimental vaccine in an area designed and segregated for such production.

In some countries plasma pools are also tested.

The label on the container or the record accompanying the container should indicate the geographical source of the blood or plasma as well as whether and how the material has been tested for HBsAg and anti-HCV.

Liver function tests, such as serum transaminase determinations, are used in some countries to detect liver damage that may be associated with hepatitis.

Anti-HIV-1 and anti-HIV-2. Blood for transfusion and for use in the preparation of blood components must be tested by a method approved by the national control authority for antibodies to HIV-1 and HIV-2 and be found negative. However, when other important factors outweigh the benefits of such testing (e.g. in emergencies) formal arrangements, approved in advance by the national control authority, should be in place that enable the prescribing physician to have access to an untested product. In all such cases, retrospective testing of the pilot sample shall be performed.

Other infectious agents. It is important for the national control authority to reassess testing requirements from time to time in the light of current knowledge, the prevalence of infectious agents in different populations and the availability of tests for serological markers of infection. For example, human retroviruses other than HIV have been described (HTLV types 1 and 2) and more may be identified in the future.

7.3 ***Blood-grouping***

Each unit of blood collected shall be classified according to its ABO blood group by testing the red blood cells with anti-A and anti-B sera and by testing the serum or plasma with pooled known group A (or single subtype A_1) cells and known group B cells. The unit shall not be labelled as to ABO group unless the results of the two tests (cell and serum grouping) are in agreement. Where discrepancies are found in the testing or the donor's records, they shall be resolved before the units are labelled.

In countries where polymorphism for the D (Rh_o) antigen is present, each unit of blood shall be classified according to Rh blood type on the basis of