BCG vaccination provides protection against COVID 19: A Systematic review and meta-analysis

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Systematic Review

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Abstract

Context: Lower morbidity and mortality in few geographic locations on the globe suffering with SARS-CoV-2 has been associated with the existing or previously followed long standing BCG vaccination policy amongst infants. But does that hold true that today after years of BCG vaccination few adults have better prognosis or is it just confounding due to differential disease burden, population density, testing facilities or improper reporting. The purpose was to evaluate and correlate this effect systematically.

Evidence acquisition: Detailed electronic search for randomised controlled trials and observational studies in PubMed, Cochrane database and clinicaltrials.gov for eligible studies was performed. We performed a meta-analysis to provide pooled estimate of correlation of mortality with BCG vaccination policy from 4 studies.

Results: 114 number of studies were yielded on search strategy and 28 observational studies were finally included for analysis. From our results we can say that BCG vaccination causes a decrease in COVID-19 incidence and mortality. But these results must be interpreted cautiously as lot of confounding factors were present in included studies, which can affect the outcome.

Conclusion: The evidence of BCG vaccination for protection against COVID-19 can't be ruled out as evidence from many studies support the hypothesis but the evidence of well conducted RCTs and observational studies can strengthen the evidence.

Introduction

COVID 2019 pandemic that began in December 2019 from a localized city, Wuhan in China has spread worldwide to become a global threat and is still showing dubious patterns in terms of its spread and severity of infectivity. A successful vaccine for it in the near future is also not certain. It has become a dynamic situation with many answers yet to be found. Whether any existing vaccine can provide an innate or trained immunity was a matter of concern.

BCG vaccination in wide use among infants and neonates for prevention against tuberculous meningitis and disseminated tuberculosis since 1921 is known to offer heterologous protection against other diseases especially of respiratory origin.[1] Many non-specific antiviral effects of the BCG vaccination resulted in decreased viral load, thus causing a reduction in respiratory tract infections in children. Nations in the world that do not have universal BCG vaccination policy, like Italy and USA, have had higher COVID 19 mortality than countries with long-standing universal BCG vaccination programs, like South Korea and Japan.[2] Even the countries that withdrew universal BCG vaccination program, due to decrease in the incidence of tuberculosis, have reported increased number of cases and deaths due to COVID-19, compared to the ones that retained BCG as a part of at-birth vaccination policy.[3] This geographical variation triggered anxiousness about the mechanism by which this trained immunity enhances body's innate response. BCG may lead to heterologous immunity with antigen-independent mechanism of B and T cells stimulation. It could also cause long-term activation, programming and memory of natural killer cells. So metabolic and epigenetic changes induced by this live vaccine might cause decreased viral load of SARS-COV-2, thus resulting in decrease severity of COVID-19.

Most scientists speculate that protection offered by BCG vaccination against COVID-19 is due to non-specific effects of BCG vaccine. On the contrary to obvious correlation between SARS-CoV-2 and BCG many believe the variations in epidemiological data is influenced by various factors like burden of disease, differing phases of the pandemic in various countries, testing rates and other demographic differences. So these are prone to confounders and bias and vested political and economic concerns are at stake. Other reason presented by authorities not accepting this correlation are an implausible and questionable theory that how BCG vaccine administered decades back can alleviate severity of COVID in today's elderly. [4]

But conclusion drawn from many observational studies of reduced mortality rates of COVID-19 in countries having universal BCG vaccination policy compared to that of the countries without it cannot be negated completely. A thorough and systematic evaluation of the COVID data available from both set of nations is the aim of this review.

Methods

The “PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses)” statement was used for reporting of systematic review. The study protocol was registered with “PROSPERO (International Prospective Register of Systematic Reviews)” database (CRD42020204466).

Electronic search in PubMed, Cochrane database and clinicaltrials.gov for eligible studies was performed on 17th August, 2020. Bibliography search was done of included articles to find other studies. Language restriction was applied as only studies published in English were included. No publication restriction was applied.

Search strategy was synthesized using the terms SARS-CoV-2, COVID-19 and BCG vaccination. Two authors independently assessed the articles for inclusion and exclusion criteria. All types of studies like RCT as well as observational were included in review. Case reports and case series were not part of review. Any discrepancy in the inclusion were resolved with the help of third author. Two authors independently extracted the data like study patient characteristics, design of study, groups and outcomes. We were unable to perform meta-analysis of all outcomes for included studies as the outcomes were not similar across studies. Many of the studies have studied only correlation and not the number of events with regard to mortality rates. However,
we performed meta-analysis to provide pooled estimate of correlation of mortality with BCG vaccination policy from 4 studies which had given the correlation (r) values.

**Results**

**Evidence from studies**

We did an extensive database search of PubMed, Medline and Cochrane for relevant studies. PRISMA flowchart is shown in Figure 1. A total of 28 studies were included. The studies in which correlation between COVID-19 mortality and morbidity with BCG vaccination was analysed were included.

**Mortality Benefit**: The characteristics and outcome data of studies [2,5-31] is represented in Table 1. Various studies have estimated the mortality and cases in BCG vaccination policy countries in comparison to non BCG vaccination policy. According to Miller et al death per million was significantly less in higher income countries with BCG vaccination policy (BCGVPC) compared to non-BCG vaccination policy countries (non BCGVPC). Covian et al stated that there was statistically significant decrease in mortality (deaths per million) with BCG vaccination in COVID-19 patients. Similarly, Dayal et al showed that countries with past BCG vaccination program had less case fatality rates compared to countries with no BCG vaccination program. Ebina et al exhibited that there was significant decrease in median mortality per million population of COVID-19 in BCGVPC. Gursel et al showed mortality benefit of BCG vaccination in COVID-19 patients. Hegarty et al also showed that death rate from COVID-19 was lower in BCGVPC than non BCGVPC. Hensel et al also showed lower mortality due to COVID-19 with BCGVPC compared to no or past BCGVPC, but did not achieve statistical significance. Analysis done by Goswami et al interpreted that no significant difference occurred in COVID-19 mortality in BCG vaccination countries with less than 95% vaccination coverage versus greater than 95% coverage. But significant difference was observed in European and American countries for COVID-19 mortality. Berg et al found that there was negative correlation i.e. decrease mortality in BCGVPC. Similar negative correlation was shown in Escobar et al and Li et al. Klinger et al elaborated negative correlation between deaths per million in COVID-19 to BCG vaccination policy. The results were similar in study by Macedo et al.

**Number of Cases**: Miller et al evaluated that cases per million was significantly less in higher income countries with BCGVPC compared to Non-BCGVP. Similar results were obtained by Covian et al. According to Goswami et al there was significant difference in incidence of COVID-19 cases in BCGVPC with less than 95% coverage versus greater than 95% coverage. Hegarty et al demonstrated COVID-19 cases in BCGVPC were significantly lower as compared to Non-BCGVPC. Also, Hensel et al stated the similar results regarding COVID-19 cases. Madan et al interpreted that countries having greater BCG coverage had lesser incidence of COVID-19. Also interestingly they compared TB incidence with COVID-19, high TB incidence resulted in lower COVID-19 cases. Samrah et al showed significantly more asymptomatic patients had received BCG vaccine than symptomatic ones. Weng et al exhibited that patients with BCG vaccination were less hospitalised for COVID-19 than no BCG vaccination. Berg et al obtained a negative correlation between COVID-19 cases and BCG vaccinated status which was statistically significant. Similar negative correlation was shown by Li et al. Klinger et al and Macedo et al also demonstrated significant negative correlation between cases per million and BCG vaccination. However, contrary results were also observed. Hamiel et al study findings showed that there was no significant difference in cases of COVID-19 in BCG vaccinated patients and patients who were not BCG vaccinated.

From above results we can say that BCG vaccination causes a decrease in COVID-19 incidence and mortality. But these results must be interpreted very cautiously as there are lot of confounding factors too in various studies, which can affect the outcomes.

Only four studies have reported correlation values. Pooled correlation revealed significant negative correlation of COVID-19 mortality with BCG vaccination [Random effect Pooled r = -0.48 (95% CI = -0.61 to -0.35)] (Figure 2).

**Discussion**

A number of observational studies have studied the correlation between BCG vaccination and COVID 19 incidence and mortality. Many of them have reported inverse correlation between BCG vaccination program and SARS-C oV2 infections.

Miller et al[2] found that countries with higher income having a current universal BCG program (55 countries) had fewer deaths per million people. Higher income countries without a universal BCG program (5 countries) had greater number of deaths. The number of cases per million inhabitants was 4 times higher in the higher income countries without a universal BCG program. Berg et al[5] in his analysis showed that mandated BCG vaccination is associated with decreased incidence of COVID 19. They controlled for age, gross domestic product per capita, density and size of population, rate of migration, and other cultural factors in their study. Escobar et al found a strong correlation between the BCG index, a measure of the extent of universal BCG vaccination implementation in a country and mortality attributed to COVID 19 in various European countries with similar social background. Sala et al[22] employed multiple regression analysis to control for potential confounders and found that BCG vaccination policy is associated with reduction in both incidence and mortality due to COVID 19. Shet et al[26] used linear regression model to adjust for confounders like GDP per capita and proportion of elderly and assessed the association between BCG vaccination and mortality with COVID 19. Mortality per million population was 5.8 times less in countries with BCG vaccination programs versus countries without any BCG vaccination policies. Dayal et al[7] in their study observed a significant decrease in mean case fatality rate with BCG vaccination. Goswami et al[10] found that in US and European world, countries with greater coverage of population with BCG vaccine resulted in significant decrease in mortality in comparison to countries with population having poor BCG coverage. Hegarty et al[13] found that incidence and mortality in countries with BCG vaccination was much lower than the countries without such a program. Toyoshimo et al, Urashima et al, Ozdemir et al, Sharma et al also found that COVID-19 mortality rate was significantly lower in BCG-vaccinated countries versus no such programs. [21, 24, 28, 29]
There are few studies which were unable to establish a correlation of BCG vaccination with COVID-19. Hensel et al included countries performing more than 2500 COV-2 tests per million population in their analysis and found no significant association between numbers of COVID-19 cases per million population with BCG vaccination. Kirov et al[15] performed linear regression for cofactors and COVID-19 cases and mortality and significant correlation was observed with income level and median age but not with BCG policy. Szegi et al was unable to establish correlation between COVID 19 case fatality rates and the period of introduction of universal BCG vaccination programs.[27] Meena et al adjusted for confounding variables like age, comorbidities like diabetes mellitus, cardiovascular diseases, gross domestic product, hospital beds and number of beds as per population but failed to find significant correlation between BCG vaccination rates and COVID-19 burden.[20] However, there is no control group in the study done by Meena et al. Therefore, the conclusion of no correlation can't be drawn from this study. In the study by Harniel et al, there was no difference in the incidence of COVID 19 among the BCG vaccinated population versus non vaccinated population.[12] In this study the population were different with regard to age group, as BCG vaccinated were born between 1979-81 and unvaccinated were from 1983-85. Whole population data with regard to vaccination was not used. It is like a sub-group study, hence increasing chances of alpha error. In addition, the severity of disease and mortality were not assessed. Wassenaar et al did not find any correlation between countries that had never used the vaccine, had used it previously but stopped some years back, or were currently vaccinating with BCG with COVID 19 case fatality rate.[30] However, authors misinterpreted the results as the countries with past or present BCG vaccination policy revealed less number of cases and death as compared to Non BCGVPC. Authors further stated that countries like India have high attack rates, though less number of deaths as deaths lag behind the number of cases. The study was done in May, 2020. As per current scenario (dated 21st September 2020), India have 5487580 cases and 87,909 deaths. Despite having high number of cases and adequate number of tests per million, case fatality rate in India is 1.60 percent. Similarly, South Africa has case fatality rate of 2.4 percent (Total cases = 661,211 and death = 15,953), which is less as compared to US (CFR = 7,004,768/204,118 = 2.9), where BCG vaccination was never implemented. This is despite the fact that USA is much more advanced on medical and technological front than any of the other two nations.

The pooled correlation revealed a significant negative correlation of BCG vaccination with COVID-19 mortality. Pooled data was taken from Escobar et al, Klinger et al, Li et al and Urashima et al. Rest of the studies did not report the r values.

There is moderate quality evidence to conclude that BCG vaccine can prevent COVID-19. One main strength of our review is that we performed a meta-analysis which showed significant protective effect of BCG vaccination. The studies included in our review are all observational studies and many of them have limitations like ignoring the fact that different countries have varying time of onset of the disease and many BCG-using countries have not yet flattened their curve. Another major limitation is that many studies have not adjusted for important confounders, such as testing rates and differences in social and economic development, population size and age structure. Most importantly, unless we have robust evidence from randomised controlled trials (RCT), we cannot conclude that BCG vaccination can prevent COVID-19 or reduce mortality associated with COVID-19. But it is difficult to prove the current hypothesis with RCTs. Therefore, the evidence of well conducted observational studies can strengthen the evidence. Though, it cannot be concluded that BCG vaccination provides protection against COVID-19 or reduces the mortality, but the evidence from many studies do support the hypothesis.

**Conflicts of Interest:** None

**References**


**Table**

<p>| Table 1: Studies evaluating the effect of BCG vaccination in COVID-19 included in systematic review |</p>
<table>
<thead>
<tr>
<th>Author &amp; Year (Study design)</th>
<th>Institution/ Country of study conduct</th>
<th>Study Interventions Control</th>
<th>Study population characteristics</th>
<th>Study outcomes</th>
<th>Strengths &amp; Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaron Miller et al 2020 [2] (Observational)</td>
<td>NYIT College of Osteopathic Medicine, New York Institute of Technology, Old Westbury, New York, USA</td>
<td>Countries with BCG vaccination policy vs without BCG vaccination policy</td>
<td>COVID-19 patients; Middle high- and high-income countries = BCG policy (n=55 countries); Middle high- and high-income countries = No BCG policy (n=5 countries).</td>
<td>Deaths per million in Middle high- and high-income countries with BCG vs no BCG policy: 0.78 ± 0.40 vs 8.39 ± 7.33 (Mean ± SEM); (p=8.64e-04, Wilcoxon rank sum test); Cases per million Inhabitants in Middle high- and high-income countries with BCG vs no BCG policy: 59.54± 23.29 vs 264.90± 134.88 (Mean ± SEM); (p=0.0664, Wilcoxon rank sum test).</td>
<td>Limitations: Under reporting in low income countries, More RCT required with BCG for COVID-19.</td>
</tr>
<tr>
<td>Berg et al 2020 [5] (Observational)</td>
<td>Johns Hopkins University Center for Systems Science and Engineering.</td>
<td>Countries - BCG Mandated policy vs Non-BCG mandated policy</td>
<td>Two categories of BCG policy countries status 1. Current versus combined (past and none) 2. Past versus none</td>
<td>Growth rate COVID-19 cases: Negative correlation of COVID-19 cases with BCG vaccination: b = −0.039, P &lt; 0.001; No significant correlation in growth rate of case between Past vs none BCG policy: b = −0.009, P = 0.610 Growth rate of Death due to COVID-19: Significant Negative correlation of death rate with BCG vaccination: b = −0.059, P &lt; 0.001 No significant correlation in growth rate of deaths between Past vs none BCG policy: b = −0.007, P = 0.772.</td>
<td>Limitations: Underreporting of cases, Confounding factor cultural dimensions.</td>
</tr>
<tr>
<td>Covian et al 2020 [6] (Observational)</td>
<td>Millennium Institute on Immunology and Immunotherapy, Santiago, Chile</td>
<td>Countries with BCG vaccination policy vs without BCG vaccination policy</td>
<td>Countries with BCG vaccination policy (n=22) vs countries without BCG policy (n=16).</td>
<td>Cases per million inhabitants: Significant difference between BCG and Non-BCG. Deaths per million inhabitants: Significant difference between BCG and Non-BCG.</td>
<td>Limitations: Amount of testing, social distancing measures, demographic distribution of country.</td>
</tr>
<tr>
<td>Dayal et al 2020 [7] (Observational)</td>
<td>Postgraduate Institute of Medical Education and Research, Chandigarh, India.</td>
<td>No BCG policy countries vs Past BCG policy countries.</td>
<td>Two categories: High COVID-19 burden countries (high case fatality rates) (n=12) vs Countries with BCG revaccinations (n=12).</td>
<td>Case fatality rate: Between two groups: 5.2% vs 0.6%, p value &lt;0.0001.</td>
<td>Limitations: Not representing true CFR, oversimplification of interpretation.</td>
</tr>
<tr>
<td>Ebina et al 2020 [8] (Observational)</td>
<td>National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, USA</td>
<td>BCG vaccinated countries vs Past BCG vaccination countries vs No BCG vaccination countries.</td>
<td>Two categories in terms of BCG vaccination: Currently Recommended Countries (CRC) (n=27) and Currently Not Recommended Countries (CNRC) (n=23).</td>
<td>Median (IQR) mortality /1M population: CRC vs CNRC: 2.1 (0.7–8.0) vs 42.6 (13.1–139.3), Mann-Whitney P &lt; 0.001. Median (IQR) mortality: Never Recommended Countries &gt; Previously Recommended Countries: 46.5 (56.6–260.5) &gt; 2.1 (0.7–8.0).</td>
<td>Limitations: Selection bias in the study participants.</td>
</tr>
<tr>
<td>Escobar et al 2020 [9]</td>
<td>Virginia Polytechnic</td>
<td>BCG vaccination</td>
<td>Potentially confounding</td>
<td>BCG index and COVID-19 mortality: Negative</td>
<td>Strengths: Confounding factors were adjusted in</td>
</tr>
<tr>
<td>Institute and University of Blacksburg, VA</td>
<td>policy vs Past or Non-BCG vaccination policy in socially similar European countries (n=22) and America (US versus Latin America)</td>
<td>factors (e.g., stage of the COVID-19 epidemic, development, rurality, population density, and age structure were adjusted.</td>
<td>correlation: $r^2 = 0.49$, $P &lt; 0.00001$. BCG index and COVID-19 mortality in socially similar European countries: First month of pandemic: $r^2 = 0.88; P = 8 \times 10^{-7}$. Means a 10% increase in BCG index was directly proportional to 10.4% reduction in COVID-19 deaths.</td>
<td><strong>Limitations</strong>: Sampling biases, More RCT needed.</td>
<td></td>
</tr>
<tr>
<td>Goswami et al 2020 [10] (Observational)</td>
<td>All India Institute of Medical Sciences, New Delhi, India</td>
<td>BCG vaccination &lt;95% Coverage countries vs BCG vaccination &gt;95% Coverage countries. From 166 countries: COVID-19 cases: 412637; COVID-19 deaths: 18559. COVID-19 incidence: No difference in European and American countries having &gt;95% BCG coverage ($p=0.28$). COVID-19 mortality less in European and American countries having &gt;95% BCG coverage ($p=0.017$). COVID-19 incidence less in African and Asia and Australasian countries with &gt;95% coverage ($p&lt;0.0008$). COVID-19 mortality: No difference in African and Asia and Australasian countries ($p=0.068$).</td>
<td><strong>Limitations</strong>: Screening of other parasitic diseases, underreporting of cases, Socioeconomics factor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gursel et al 2020 [11] (Observational)</td>
<td>Middle East Technical University, Ankara, Turkey</td>
<td>BCG vaccination policy countries vs No BCG vaccination policy countries. Countries with at least 1000 COVID-19 cases were included. COVID-19 Cases/million: Countries with BCG vs No BCG programme: $P&lt;0.0001$. Deaths/million: Countries with BCG vs No BCG programme: $P&lt;0.0001$. Deaths/million: Countries (n=5) ceased BCG 2 decades back vs Countries (n=8) ceased BCG 3-4 decades back: P=0.0109.</td>
<td><strong>Strengths</strong>: Large samples, similar age groups, limited confounders. <strong>Limitations</strong>: Immigrants vaccine status more minority age groups (4.9% and 4.6% of the older and younger).</td>
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<td></td>
</tr>
<tr>
<td>Hamiel et al 2020 [12] (Observational)</td>
<td>Tel Aviv University, Tel Aviv, Israel.</td>
<td>BCG patients (n=297340) vs Non-BCG patients (n=301600). Previously vaccinated patient’s vs Non vaccinated; No. of tests done: BCG vs Non-BCG: n=3064 vs n=2869; Men Tested (%): BCG vs Non-BCG: n=1509 (49.2) vs n=1458 (50.8) ($p=0.29$).</td>
<td>Positive test results: No. (%): BCG vs Non-BCG: 361 (11.7) vs 299 (10.4) ($p=0.09$); Men positive (%): BCG vs Non-BCG: 181 (50) vs 152 (51) ($p=0.87$).</td>
<td><strong>Limitations</strong>: Limited testing and reporting.</td>
<td></td>
</tr>
<tr>
<td>Hegarty et al 2020 [13] (Observational)</td>
<td>USA</td>
<td>BCG vaccination policy countries vs No BCG vaccination policy countries. Total= 178 countries; BCG programme: n=131; No BCG programme: n=21; Unknown status: n=26. COVID-19 Incidence: BCG vs No BCG: 38.4/million vs 358.4/million; Death rate: BCG vs No BCG: 4.28/million vs 40/million; Case fatality rate (CFR): BCG vs No BCG: 0.13% vs 0.33%.</td>
<td>COVID-19; Cases/1M inhabitants: BCG policy vs No or Past BCG policy: significantly Less with BCG policy. Percent mortality: BCG policy vs No or Past BCG policy: significantly Less with BCG policy. High CoV-2 testing countries: BCG policy (n=21) vs No BCG policy (n=6) vs Past BCG policy</td>
<td><strong>Limitations</strong>: Faulty case reporting, lack of reporting, socioeconomic barriers, other comorbidities, adherence to vaccination.</td>
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**Strengths**: Large samples, similar age groups, limited confounders. **Limitations**: Immigrants vaccine status more minority age groups (4.9% and 4.6% of the older and younger).
<table>
<thead>
<tr>
<th>Study</th>
<th>Institution</th>
<th>Setting</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirov 2020 [15]</td>
<td>Bristol-Meyers Squibb, USA</td>
<td>BCG vaccination policy countries versus no BCG vaccination.</td>
<td>Pearson correlation: Median age and infection rates: R=0.774; BCG policy and the infection rates: R=0.521; ( p = 0.17 ); Start date of BCG vaccination and infection rates: R=0.21.</td>
<td><strong>Strengths:</strong> All important confounding factors included. <strong>Limitations:</strong> Other confounders such as B.P., public policies and time from first infection not included; Need more RCTs.</td>
</tr>
<tr>
<td>Klinger et al 2020 [16]</td>
<td>The Hebrew University of Jerusalem, Israel</td>
<td>BCG vaccination policy countries versus no BCG vaccination.</td>
<td><strong>Strength:</strong> Included confounders such as population size, Gross Domestic Product (GDP), lifespan, median age. <strong>Limitations:</strong> Different countries with variable demographic parameters mask protective effect of BCG, results driven by small no. of influential countries.</td>
<td></td>
</tr>
<tr>
<td>Li et al 2020 [17]</td>
<td>University of Oxford</td>
<td>BCG vaccination policy countries versus no BCG vaccination.</td>
<td>Pearson Correlation (sig. 2-tailed): BCG2018: Cases per million: -0.396 (0.000); Deaths per Million: (-0.252 (0.004)); BCG2008: Cases per million: (-0.423 (0.000)); Deaths per Million: (-0.282 (0.001)); BCG1998: Cases per million: (-0.380 (0.000)); Deaths per Million: (-0.260 (0.003)); BCG1988: Cases per million: (-0.183 (0.040)); Deaths per Million: (-0.129 (0.149))</td>
<td><strong>Limitations:</strong> Old age as a confounder.</td>
</tr>
<tr>
<td>Macedo et al 2020 [18]</td>
<td>DCBM Universidade do Algarve, Faro, Portugal</td>
<td>BCG vaccine coverage countries vs Non BCG vaccinated</td>
<td><strong>Strengths:</strong> Included confounders such as population size, Gross Domestic Product (GDP), lifespan, median age. <strong>Limitations:</strong> Different countries with variable demographic parameters mask protective effect of BCG, results driven by small no. of influential countries.</td>
<td></td>
</tr>
<tr>
<td>Madan et al 2020 [19]</td>
<td>All India Institute of Medical Sciences (AIIMS), New Delhi, India</td>
<td>BCG coverage versus COVID-19 (n=174)</td>
<td><strong>Strengths:</strong> All important confounding factors included. <strong>Limitations:</strong> Other confounders such as B.P., public policies and time from first infection not included; Need more RCTs.</td>
<td></td>
</tr>
<tr>
<td>Meena et al 2020 [20]</td>
<td>Department of Pediatrics, All India Institute of Medical Sciences,</td>
<td>Countries with BCG vaccination policy (n=142).</td>
<td><strong>Strengths:</strong> All important confounding factors included. <strong>Limitations:</strong> Other confounders such as B.P., public policies and time from first infection not included; Need more RCTs.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Institution</td>
<td>Country</td>
<td>Group Comparison</td>
<td>Details</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>---------</td>
<td>-----------------</td>
<td>---------</td>
</tr>
<tr>
<td>Ozdemir et al 2020</td>
<td>Institute of Child Health, Istanbul University, Istanbul, Turkey</td>
<td>New Delhi, India</td>
<td>BCG vaccinated (n=138) vs Non BCG vaccinated (n=37)</td>
<td>COVID-19 cases in the Northern Hemisphere (n = 144) and the Southern Hemisphere (n = 31), with respect to BCG vaccination status. Effects of BCG vaccination on COVID-19 in European countries (BCG-vaccinated countries (n = 25), BCG-non-vaccinated countries (n = 26))</td>
</tr>
<tr>
<td>Sala et al 2020</td>
<td>Fujita Health University School of Medicine, Japan</td>
<td></td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Countries with populations of at least one million for which at least 13 days of data since the detection of the first case were available as of April the 26th (142 countries)</td>
</tr>
<tr>
<td>Samrah et al 2020</td>
<td>King Abdullah University Hospital (KAUH), Jordan</td>
<td></td>
<td>BCG vaccine given (n=68).</td>
<td>Hospitalised COVID-19 patients; Females: 44 (54.3%), Mean age (± SD): 39.95 ± 16.39; 84% patients receive BCG.</td>
</tr>
<tr>
<td>Sharma et al 2020</td>
<td>Jawaharlal Nehru University, New Delhi, India</td>
<td></td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Countries with universal BCG vaccination, discontinued vaccination, and countries that never adopted BCG vaccination. Countries with over 1000 reported COVID-19 cases included.</td>
</tr>
<tr>
<td>Sharma AR et al 2020</td>
<td>Post Graduate Institute for Medical Education and Research (PGIMER), Chandigarh, India</td>
<td></td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Countries with universal BCG vaccination and those without</td>
</tr>
</tbody>
</table>
| Shet et al 2020 | Johns Hopkins Bloomberg School of Public Health, Baltimore, USA | | BCG vaccinated vs Non BCG vaccinated | Top 50 countries reporting highest case events were included in the study. BCG using | COVID-19-attributable mortality among BCG-using countries was 5.8 times lower [95% CI 1.8-19.0] than in non BCG-
<table>
<thead>
<tr>
<th>Study</th>
<th>Institution</th>
<th>BCG Vaccinated vs Non BCG Vaccinated</th>
<th>Study Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weng et al 2020</td>
<td>Baylor College of Medicine, Houston, Texas, U.S.A</td>
<td>Top 68 countries based on number of cases were included in the study. Countries with and without universal BCG vaccination in place before 1980.</td>
<td>Median crude COVID-19 mortality per 1 million population among countries with economies classified as low-middle-income(5), upper-middle-income(13) and high-income countries(32). Using countries. Interquartile Range (IQR) 0.06, 0.4), 0.65 (IQR 0.2, 2.2) and 5.5 (IQR 1.6, 13.9), respectively. Strengths: used a log-linear regression model after adjusting for confounders.</td>
</tr>
<tr>
<td>Wassenaar et al 2020</td>
<td>Molecular Microbiology and Genomics Consultants, Zutphen, Germany</td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Median crude COVID-19 mortality per 1 million population among countries with economies classified as low-middle-income(5), upper-middle-income(13) and high-income countries(32). Using countries. Interquartile Range (IQR) 0.06, 0.4), 0.65 (IQR 0.2, 2.2) and 5.5 (IQR 1.6, 13.9), respectively. Strengths: used a log-linear regression model after adjusting for confounders.</td>
</tr>
<tr>
<td>Toyoshimo et al 2020</td>
<td>Japanese Foundation for Cancer Research, Tokyo, Japan</td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Median crude COVID-19 mortality per 1 million population among countries with economies classified as low-middle-income(5), upper-middle-income(13) and high-income countries(32). Using countries. Interquartile Range (IQR) 0.06, 0.4), 0.65 (IQR 0.2, 2.2) and 5.5 (IQR 1.6, 13.9), respectively. Strengths: used a log-linear regression model after adjusting for confounders.</td>
</tr>
<tr>
<td>Urashima et al 2020</td>
<td>The Jikei University School of Medicine, Tokyo, Japan</td>
<td>BCG vaccinated vs Non BCG vaccinated</td>
<td>Median crude COVID-19 mortality per 1 million population among countries with economies classified as low-middle-income(5), upper-middle-income(13) and high-income countries(32). Using countries. Interquartile Range (IQR) 0.06, 0.4), 0.65 (IQR 0.2, 2.2) and 5.5 (IQR 1.6, 13.9), respectively. Strengths: used a log-linear regression model after adjusting for confounders.</td>
</tr>
<tr>
<td>Weng et al 2020</td>
<td>Federally qualified health centre in Rhode Island, United States</td>
<td>BCG vaccinated individuals (n=82) vs Non-BCG vaccinated individuals (n=38)</td>
<td>Median crude COVID-19 mortality per 1 million population among countries with economies classified as low-middle-income(5), upper-middle-income(13) and high-income countries(32). Using countries. Interquartile Range (IQR) 0.06, 0.4), 0.65 (IQR 0.2, 2.2) and 5.5 (IQR 1.6, 13.9), respectively. Strengths: used a log-linear regression model after adjusting for confounders.</td>
</tr>
</tbody>
</table>

**Limitations:**
- Confounders not adjusted
- Modified death rate as Death Per Case (i.e. case fatality)/Days (dpc/d) for the endemic of each country
- Study design was ecological
- Multi-linear regression model was used
- Did not account for confounding factors

**Strengths:**
- Investigated SARS-CoV-2 genome mutations, BCG-vaccination status, and HLA genotypes in 28 countries and identified significant associations of some virus genome variants with the fatality rates.
- Investigated BCG vaccine coverage and COVID-19 mortality: Moderately negative association (adjusted R² = 0.1457; rho = −0.29). No correlation with morbidity (adjusted R² = 0.3814).