

CORRIGENDA 15 March 2022

Public health surveillance for COVID-19: Interim guidance, 14 February 2022 (WHO/2019-nCoV/SurveillanceGuidance/2022.1)

Page 1, line 30

Delete:

- age and gender of cases and deaths, (probable and confirmed)

Insert:

- age and sex of cases and deaths, (probable and confirmed)

Page 5, lines 16–18

Delete:

- Underlying noncommunicable diseases (NCDs): diabetes, hypertension, cardiac disease, chronic lung disease, cerebrovascular disease, dementia, mental disorders, chronic kidney disease, immunosuppression, HIV [98], obesity and cancer have been associated with higher mortality.

Insert:

- Underlying noncommunicable diseases (NCDs): diabetes, hypertension, cardiac disease, chronic lung disease, cerebrovascular disease, dementia, mental disorders, chronic kidney disease, immunosuppression, HIV, obesity and cancer have been associated with higher mortality.

Page 5, lines 44–45

Delete:

A SARS-CoV-2 variant that meets the definition of a VOI (see below) and, through a comparative assessment, has been demonstrated to be associated with one or more of the following changes at a degree of global public health significance:

Insert:

A SARS-CoV-2 variant that meets the definition of a VOI (see above) and, through a comparative assessment, has been demonstrated to be associated with one or more of the following changes at a degree of global public health significance:

Page 8, Table 1, column 2 (Variables), line 3

Delete:

Gender

Insert:

Sex

Page 11, lines 23–24

Delete:

- Individuals meeting the suspected case definition for SARS-CoV-2 infection should be tested, regardless of vaccination status or disease history (1).

Insert:

- Individuals meeting the suspected case definition for SARS-CoV-2 infection should be tested, regardless of vaccination status or disease history.

Page 12, Table 3, Column 2, lines 10–12

Delete:

Test a subset of the cases using Ag-RDT or NAAT. Consider all other symptomatic individuals as probable cases and isolate, as per WHO guidance (1).

Insert:

Test a subset of the cases using Ag-RDT or NAAT. Consider all other symptomatic individuals as probable cases and isolate, as per WHO guidance.

Page 12, Table 3, Column 2, lines 13–15

Delete:

Test a subset of the cases using Ag-RDT or NAAT. Consider all other symptomatic individuals as probable cases and isolate, as per WHO guidance (1).

Insert:

Test a subset of the cases using Ag-RDT or NAAT. Consider all other symptomatic individuals as probable cases and isolate, as per WHO guidance.

Page 12, Table 3, Column 2, lines 17–19

Delete:

Quarantine as per WHO guidance with testing, where possible, to shorten quarantine. If contacts become symptomatic, assume COVID-19 and isolate, as per WHO guidance (19).

Insert:

Quarantine as per WHO guidance with testing, where possible, to shorten quarantine. If contacts become symptomatic, assume COVID-19 and isolate, as per WHO guidance.

Page 12, line 27

Delete:

Table 5: Community case definitions

Insert:

Table 4: Community case definitions

Page 13, line 10

Delete:

- Age, sex/gender and place of residence

Insert:

- Age, sex and place of residence

Page 13, lines 29–34*Delete:*

Within the existing surveillance systems, the patients selected for additional testing for SARS-CoV-2 should preferably be representative of the population and include all ages and genders. If possible, continue to collect samples from both ILI and SARI sentinel sites to represent both mild and severe illness. It is recognized that, based on the local situation, resources, and epidemiology, countries may wish to prioritize sampling among inpatients (SARI or pneumonia cases) to understand SARS-CoV-2 circulation in patients with more severe disease. Further guidance on sampling for testing in sentinel sites can be found in [Global Epidemiological Surveillance Standards for Influenza³²](#).

Insert:

Within the existing surveillance systems, the patients selected for additional testing for SARS-CoV-2 should preferably be representative of the population and include all ages and sex. If possible, continue to collect samples from both ILI and SARI sentinel sites to represent both mild and severe illness. It is recognized that, based on the local situation, resources, and epidemiology, countries may wish to prioritize sampling among inpatients (SARI or pneumonia cases) to understand SARS-CoV-2 circulation in patients with more severe disease. Further guidance on sampling for testing in sentinel sites can be found in [Global Epidemiological Surveillance Standards for Influenza³²](#).

Page 15. Lines 31–37*Delete:*

Initial seroprevalence of a novel coronavirus in the population is assumed to be negligible. Therefore, surveillance of antibody seropositivity in a population, when analysed in combination with vaccination data, can allow inferences to be made about the cumulative incidence of infection in the population. Serological surveillance can be used to assess population-level exposure to SARS-CoV-2 and help estimate the burden of infections and deaths that could be under-reported by weak surveillance systems, as well as identifying the contribution of asymptomatic infections. Gender and age disaggregation of serosurveillance data should be compared with that of the disease surveillance system, to determine the ascertainment potential and quality of the surveillance system.

Insert:

Initial seroprevalence of a novel coronavirus in the population is assumed to be negligible. Therefore, surveillance of antibody seropositivity in a population, when analysed in combination with vaccination data, can allow inferences to be made about the cumulative incidence of infection in the population. Serological surveillance can be used to assess population-level exposure to SARS-CoV-2 and help estimate the burden of infections and deaths that could be under-reported by weak surveillance systems, as well as identifying the contribution of asymptomatic infections. Age and sex disaggregation of serosurveillance data should be compared with that of the disease surveillance system, to determine the ascertainment potential and quality of the surveillance system.

Page 15, lines 51–52*Delete:*

- assess Knowledge Attitudes and Practices (KAP) to COVID-19 vaccination and Public Health Social Measures (PHSM) in the population by sex and age.

Insert:

- assess Knowledge Attitudes and Practices (KAP) to COVID-19 vaccination and Public Health and Social Measures (PHSM) in the population by sex and age.

Page 17, lines 20–22

Delete:

Counts are based on [WHO case definitions](#)⁴⁹ unless otherwise stated (see [Country, territory, or area-specific updates and errata](#)⁵⁰). All data represent date of reporting rather than date of symptom onset. All data are subject to continuous verification and may change based upon retrospective updates to accurately reflect trends, changes in country case definitions or reporting practices.

Insert:

Counts are based on [WHO case definitions](#)¹⁹ unless otherwise stated. All data represent date of reporting rather than date of symptom onset. All data are subject to continuous verification and may change based upon retrospective updates to accurately reflect trends, changes in country case definitions or reporting practices.

Page 19, Table, column 2 (Detailed surveillance data), lines 2–3

Delete:

Detailed disaggregation of Covid-19 cases and deaths: age, gender, Health Workers, etc.

Insert:

Detailed disaggregation of Covid-19 cases and deaths: sex, gender, Health Workers, etc.

Page 20, Table, Column 3, Lines 7–9

Delete:

1) at least one weekly aggregate surveillance reporting submission providing cases or deaths of health worker cases

Insert:

1) at least one weekly aggregate surveillance reporting submission providing cases or deaths of health worker

Page 20, Line 25

Delete:

Table 1: Variables for aggregate reporting of vaccination deployment

Insert:

Table 5: Variables for aggregate reporting of vaccination deployment

These corrections have been incorporated into the electronic file.