Update to requirements for reporting COVID-19 surveillance data under the International Health Regulations (IHR 2005)

Addendum to Public health surveillance for COVID-19 interim guidance

25 August 2023

In the context of the integration of COVID-19 monitoring into broader respiratory disease surveillance core capacities, WHO has determined that it is no longer necessary for Member States to report daily counts of cases and deaths publicly or to WHO at the global level, as previously required. Instead, in order to maintain visibility on the global epidemiology of key morbidity and mortality indicators of the ongoing COVID-19 pandemic, WHO requests that countries bolster efforts to strengthen the reporting of weekly aggregate indicators of COVID-19 morbidity and mortality, as well as variant surveillance data, with the modifications described below. Importantly, individual WHO Regional Offices may have additional reporting requirements that are not reflected here.

Weekly aggregated reporting to WHO at the global level

The aim of ongoing global weekly aggregate reporting is to obtain further information on global COVID-19 trends for enhanced analysis, alongside other respiratory pathogen surveillance data sources, to allow for comprehensive situational awareness of the burden of infectious respiratory diseases. WHO recommends aggregating on the date of reporting to the health system. The following data set should be considered as the core list of surveillance indicators to be included in routine weekly reporting to WHO at the global level:

- number of confirmed cases
- number of confirmed deaths
- disaggregation of deaths by age
- number of new admissions to hospital for COVID-19 treatment (confirmed)
- number of new admissions to ICU for COVID-19 treatment (confirmed)
- number of persons tested (NAAT or Ag-RDT)

Note: while it has been deemed impractical to request all Member States to report age-disaggregated data on hospitalizations and ICU admissions to WHO, those with the ability to collect these data are strongly encouraged to report these data publicly, as they are very useful to identifying any changes in the impact of evolving SARS-CoV-2 variants.

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1 Surveillance should incorporate information from an appropriate mix of representative sentinel populations, event-based surveillance, human wastewater surveillance, sero-surveillance, and surveillance of selected animal populations known to be at risk of SARS-CoV-2. States Parties should leverage the Global Influenza Surveillance and Response System (GISRS) and support the establishment of the WHO Global Coronavirus Laboratory Network (CoViNet). Statement on the fifteenth meeting of the IHR (2005) Emergency Committee on the COVID-19 pandemic (who.int) (June 08).

2 Where not possible to report only admissions due to COVID-19, rather than all new admissions with positive SARS-CoV-2 tests, the latter may be substituted.

3 Used for calculating test positivity rate (TPR).
The following data are thus **no longer requested**:
- number of probable cases, admissions, and deaths
- number of cases and deaths amongst health and care workers
- number of persons tested specifically by NAAT
- disaggregation of cases by age group and/or sex
- disaggregation of deaths by sex

The deadline for Member State submission of weekly data for each epidemiologic week is **Thursday** of the following week. Member States are requested to **submit weekly data** even when **no new cases were reported** during the week (**zero reporting**).

Listed core surveillance indicators and indicated submission date concern the global surveillance; additional requirements may vary by region. Countries should continue reporting through existing Regional Platforms via their respective WHO Regional Offices, including through RespiMART (FluID and FluNet) where relevant. Alternatively, weekly aggregated reporting data can continue to be reported via Excel using the form “**Global Surveillance of COVID-19: WHO process for reporting aggregated data-V3**”. A data dictionary is included.

In addition, countries are encouraged to enhance integrated surveillance (especially those that have received the multiplex influenza and SARS-CoV-2 reagent kits from GISRS) and to monitor the relative co-circulation of influenza and SARS-CoV-2 viruses, and report weekly to RespiMART (FluNet and FluID) or regional platforms collecting epidemiological and laboratory information together with influenza data. The current interim guidance on integration of SARS-CoV-2 and influenza sentinel surveillance can be found [here](#).

**Country metadata**
Member States are requested to provide additional surveillance metadata to WHO to facilitate interpretation of submitted surveillance data:
- definition of epidemiologic period/week in used in country (e.g. “Monday to Sunday”)
- case definitions used by the country, and the date these definitions came into effect
- surveillance/detection/testing strategy or strategies in place in the country, and the date these strategies came into effect (articulating the surveillance strategy is particularly important where surveillance does not seek to capture all cases, such as when it is limited to sentinel sites)

Changes in definitions or criteria have an impact on case ascertainment and, consequently, on multiple epidemiologic parameters, such as the epidemic curve and calculation of the case fatality ratio. Metadata should be submitted using the dedicated mailbox for COVID-19 surveillance (covidsurveillance@who.int) or through respective WHO Regional Offices.

Countries are also encouraged to monitor the quality of COVID-19 surveillance by monitoring such performance indicators as timeliness, completeness and representativeness of surveillance data.

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4 These data may be continued if removing them from reporting would create an additional burden.
Genomic surveillance and reporting of sequences

Genomic sequencing capacities globally have expanded substantially during the COVID-19 pandemic and countries should maintain these investments and continue to strengthen genomic surveillance for SARS-CoV-2 and other pathogens with epidemic and pandemic potential.

The use of SARS-CoV-2 testing is prioritizing at risk groups and individuals with moderate or severe symptoms. Samples and metadata obtained by testing these COVID-19 confirmed cases should be prioritized for genomic sequencing and real-time sharing on public platforms. In addition, sequencing of samples collected through integrated sentinel surveillance for acute respiratory infections (ARI, ILI and SARI) provides a sustainable and representative way to monitor virus evolution and genetic diversity. This remains critical information for WHO Technical Advisory Groups to assess the risk posed by emerging SARS-CoV-2 variants as well as their impact on available countermeasures.

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