



## **CORRIGENDA, 18 April 2023**

### **Considerations for implementing and adjusting public health and social measures in the context of COVID-19**

**(WHO/2019-nCoV/Adjusting\_PH\_measures/2023.1)**

#### **Page 11, Table 2, column 2, lines 46–49**

*Delete:*

- Health service infrastructure, bed capacity, and patient flow to be assessed for anticipated limitations and contingency measures to continue essential operations in the event of an unanticipated surge, including care of patients in isolation (see [Infection prevention and control in health-care facilities in the event of a surge or resurgence in cases of COVID-19 \(26\)](#))

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#### **Page 19, lines 2–9**

*Delete:* Additional indicators that can provide further evidence to help classify the transmissibility are listed in Annex 1 Table 2. These indicators may not be readily available at the lowest administrative level of operations, however. They are therefore considered secondary to the primary five indicators listed in Annex 1 Table 1. Furthermore, they may not directly reflect transmission or force of infection of SARS-CoV-2 or may be more difficult to interpret and compare than those listed in Annex 1, Table 2. Novel indicators with relatively little history of use, such as search engine or social media activity for COVID-19, syndromic surveillance for non-specific indicators such as number of patients placed in droplet isolation, environmental correlates such as air temperature and complex modelling approaches to estimating transmission are not included here.

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**Page 22, Annex 1, Table 5, column 3, lines 2–14**

*Delete:* May be influenced by hospitalization policy (e.g., if all cases are isolated in hospital), which does not indicate true saturation of hospital capacity. A significantly low hospital occupancy rate may also indicate barriers to access to hospital care, requiring investigation into the causes and remedial actions to be taken. In situations of intense transmission, low hospital utilization may indicate large numbers of community deaths, which would potentially not be captured in facility-based mortality reports. It should be noted that high occupancy will not always lead to unavailability of additional beds, since many health systems are able to surge by adding beds if close to

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**Page 22, Annex 1, Table 5, column 3, lines 15–25**

*Delete:* In some health systems, ICU beds are opportunistically filled with moderately ill ward patients, but high occupancy will not always lead to unavailability of additional beds because these patients can be moved back to the wards if necessary. May not be useful in countries with very few ICU beds (in these situations, can be substituted with proportion of occupied hospital beds with oxygen capacity). High occupancy will not always lead to an unavailability of additional beds, as many health systems are able to surge by adding beds if

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**Page 32, reference 32, lines 44–46**

*Delete:* 32. Guillen M, \* IBR, Cabrera EB, Acebes X, Rolda', 1 CB, et al. Acute respiratory infection rates in primary care anticipate ICU bed occupancy during COVID-19 waves. PLoS One [Internet]. 2022;1–10. Available from: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0267428>

*Insert:* 32. Guillen M, Bardes Robles I, Bordera Cabrera E, Acebes Roldán X, Bolancé C et al. Acute respiratory infection rates in primary care anticipate ICU bed occupancy during COVID-19 waves. PLoS One [Internet]. 2022;1–10. Available from: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0267428>

These corrections have been incorporated into the electronic file.