

COVID-19 SURVEILLANCE FREQUENTLY ASKED QUESTIONS

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1. General context

1.1. WHAT IS THE ROLE OF SCIENSANO DURING THE COVID-19 EPIDEMIC?

Question added 07/04/2020 | Last updated 07/04/2020

The World Health Organization (WHO) and the European Union (EU) require each Member State to have a structure capable of dealing with any health crisis. To this end, Belgium has set up a strong structure with 3 components:

1. Risk Assessment Group (RAG)
2. Risk Management Group (RMG)
3. National Focal Point (NFP)

Sciensano (the Belgian institute for health) coordinates the RAG which is in charge of assessing risks to public health in a national and international context. The RAG analyses any signal that may have an impact on health. The RAG is composed of permanent members who are public health experts, supported by specific experts who are invited according to the type of signal such as an infectious disease, an environmental problem, etc. The RAG proposes prevention and control measures to the RMG, which is composed of the health authorities and decides on the measures to be applied. The NFP, including amongst others the Federal Service for Public Health, ensures the implementation of measures in consultation with the various entities. The NFP acts as a relay for communication with European and international institutions. More information on the role of Sciensano in the context of emergency and response can be found on [our website](#).

At the request of the health authorities, Sciensano also coordinates the development of the procedures to be implemented by general practitioners, hospitals, patients and laboratories in the context of the COVID-19 epidemic. It is the Risk Management Group that validates the content of the procedures and then they become operational. These procedures can be found on our website ([in Dutch](#) • [in French](#) • [in German](#)).

Finally, Sciensano has a legally determined surveillance task in the context of public health as laid down by the federal law of 25 February 2018 ([in Dutch](#) • [in French](#)). As part of this task, Sciensano has put a surveillance system in place to monitor the COVID-19 epidemic in Belgium and to report on the data that are collected.

1.2. WHICH DATA DOES SCIENSANO COLLECT FOR THE COVID-19 SURVEILLANCE?

Question added 07/04/2020 | Last updated 07/04/2020

In order to get comprehensive information to monitor the COVID-19 epidemic, Sciensano brings together data streams from different sources. Sciensano collects data on lab-confirmed COVID-19 cases ([see section 3](#)), hospitalized COVID-19 patients ([see section 4](#)) and COVID-19 deaths ([see section 5](#)).

1.3. HOW DOES SCIENSANO ENSURE DATA QUALITY IN TIMES OF A HEALTH CRISIS?

Question added 07/04/2020 | Last updated 07/04/2020

In times of a health crisis, Sciensano continuously monitors the situation in the field and sets up relevant data collection procedures. The data collected need to be checked and consolidated in order to get them reliable. Also, data import by the data providers can't always be done immediately, so it can take a while before a dataset is complete and "stable".

1.4. IS THERE A GENERAL RULE WHEN INTERPRETING THE COVID-19 DATA?

Question added 07/04/2020 | Last updated 07/04/2020

We take a kind of data "snapshot" every day. In such a context, it is important to be careful when interpreting absolute numbers (see also the delay in reporting as referred to in [question 1.3](#)). There is a tendency to focus on these numbers in terms of "risk" whilst in order to monitor the evolution of the COVID-19 epidemic, it is necessary to follow trends instead of absolute numbers.

During the [daily press conference of the Home Affairs crisis centre](#), the intergovernmental COVID-19 spokesmen communicates a number of clear key figures on the COVID-19 epidemic and discusses the important trends of that moment.

1.5. WHERE CAN I FIND THE DATA COLLECTED BY SCIENSANO?

Question added 07/04/2020 | Last updated 07/04/2020

The risk managing authorities receive daily an epidemiological report. That way they can base their actions and decisions on accurate and up-to-date information.

Based on these reports, the intergovernmental COVID-19 spokesmen discuss the epidemiological situation during the [daily press conference of the Home Affairs crisis centre](#) at 11AM CET.

The epidemiological report ([in Dutch](#) • [in French](#)) is also publicly available on our website. Every Thursday you can consult on the same webpage a more extended 'weekly' report ([in Dutch](#) • [in French](#)), with extra graphs, trends and interpretations.

You can also stay up to date with the latest figures via :

- [raw data](#) and the [corresponding codebook](#)
- [dynamic graphs](#)

1.6. WHAT KIND OF DATA IS AVAILABLE IN THE COVID-19 OPEN DATA PORTAL?

Question added 07/04/2020 | Last updated 07/04/2020

You can [consult specific datasets via our website](#) (free of charge). These are updated daily at 12PM CET.

The following datasets are published as open data:

- confirmed cases by date, age, sex and province
- confirmed cases by date and municipality
- cumulative number of confirmed cases by municipality
- hospitalizations by date and provinces
- mortality by date, age, sex, and province
- total number of tests performed by date

1.7. FOR WHICH PURPOSES ARE THE SURVEILLANCE DATA USED?

Question added 07/04/2020 | Last updated 07/04/2020

The authorities and the Risk Management Group use these data to manage this health crisis. Additionally, mathematical modelers use these data to predict the future course of the epidemic taking into account the measures taken. We also share our data with the [European Centre for Disease Control \(ECDC\)](#) and the [World Health Organization \(WHO\)](#) so that they can draw an accurate picture of the international situation.

2. Epidemiological terminology

2.1. WHAT IS THE DIFFERENCE BETWEEN INCIDENCE, PREVALENCE AND OTHER BASIC EPIDEMIOLOGICAL CONCEPTS?

Question added 07/04/2020 | Last updated 07/04/2020

In our reports, we use different epidemiological measures to characterize the current COVID-19 pandemic and its evolution. We use these terms in a vulgarized way to be understandable by the general public. Hence, our definitions may differ from the classical textbook definitions of these measures. Overall, we report 5 distinct measures:

- Number of new cases: the number of new confirmed cases, hospitalizations, or deaths reported (daily update).
- Incidence: the number of new cases, hospitalizations, or deaths reported during a certain period (for example: last 24 hours), relative to the population size.
- Cumulative number of cases: the total number of confirmed cases, hospitalizations, or deaths reported since the beginning of the outbreak or a specific starting point.
- Cumulative incidence: the total number of confirmed cases, hospitalizations, or deaths reported since the beginning of the outbreak or a specific starting point, relative to the population.
- Prevalence: the number of cases present at a given moment. It corresponds to taking a snapshot of the situation at a specific moment in time. For instance, we report the prevalence of occupied hospital beds, i.e., the total number of hospital beds occupied by COVID-19 patients at a given moment.

3. Data on lab-confirmed COVID-19 cases

3.1. HOW DO WE COLLECT DATA ON LAB-CONFIRMED COVID-19 CASES?

Question added 07/04/2020 | Last updated 27/05/2020

According to the COVID-19 case definition and the recommendations for testing ([Dutch](#) • [French](#) • [German](#)), persons are diagnosed on the basis of a laboratory test carried out by the laboratory of the National Reference Centre (KU Leuven) or by a peripheral clinical laboratory, by the national testing platform, or by the network of university laboratories. The diagnostics include molecular techniques as well as rapid antigen tests. Patients with a positive laboratory result are confirmed cases.

Data collection includes the number of tests performed, positive and negative results, as well as basic demographic data (age, gender, postcode) collected via application forms sent to Sciensano by the different laboratories performing COVID-19 diagnostics.

Data collection also includes data on confirmed cases collected by the regional infectious disease control teams. In some cases, this information is provided more quickly than that provided by the laboratories, thus completing the dataset.

Since the 9th of April 2020, the national testing platform has been operational. This platform carries out tests for nursing homes, other residential collectivities and triage centers.

The data on lab-confirmed COVID-19 cases are summarized in the [daily and weekly reports](#) ([Dutch](#) • [French](#)), and are available through the [open data portal](#).

3.2. PERSONS WITH ONLY A POSITIVE SEROLOGICAL TEST ARE NOT INCLUDED IN THE FIGURES OF CONFIRMED CASES, AS A SEROLOGICAL TEST EXAMINES THE PRESENCE OF ANTIBODIES AND DOES NOT INDICATE AN ACUTE INFECTION.WHY IS IT HARD TO COMPARE CASE NUMBERS FROM DIFFERENT COUNTRIES?

Question added 07/04/2020 | Last updated 27/05/2020

Each country has its own testing strategy to determine who should be tested for COVID-19. This strategy evolves and can be adapted to the epidemiological evolution and available resources.

In Belgium, for example, from 11 March 2020, only hospitalized persons with acute respiratory complaints, even if they are mild, as well as health personnel and symptomatic people (up to 5 people) were tested in residential communities such as nursing homes.

In addition, since 10 April 2020, the staff and residents of residential care centres have been systematically tested as part of a specific screening strategy targeting nursing homes only.

On 22 April 2020, the testing strategy was extended and since that date, anyone requiring hospitalisation, including day hospitalisation (first time), can be tested. On top of that, any person entering a residential community for the first time (e.g. nursing homes, homes for disabled, youth centres, prisons, etc.) or any resident of that residential community with compatible symptoms can also be tested.

On 15 May 2020, the testing strategy was extended once again in the context of the deconfinement strategy. From then on, all persons with a possible COVID-19 infection will be tested, as well as persons who had a high-risk contact with a COVID-19 case and who are themselves in professional contact with people who are at risk of developing a serious form of the disease. Since 12 June 2020, all other high-risk contacts of a COVID-19 case are also tested. (links to case definition/testing : [Dutch](#) • [French](#) • [German](#))

The implementation of testing strategies and the overall epidemiological timelines differ between countries. Therefore a direct comparison of case numbers between two countries remains difficult.

3.3. WHY IS THE REPORTED NUMBER OF CONFIRMED CASES ALWAYS LOW FOR THE LAST REPORTED DAY (I.E. 'TODAY')?

Question added 07/04/2020 | Last updated 05/04/202

There are two important reasons for this apparent underestimation:

1. Firstly, in order to produce the daily reports and open data, we take the situation at 4PM. The data for the last day in the time series are therefore always incomplete.
2. Secondly, the reported data for the last 4 days always require progressive consolidation. The data are mainly displayed on the date the sample was taken. The analysis in the laboratory obviously takes time, as do the subsequent reporting and processing of the data. Therefore, the number of positive samples taken 'today' is only integrated in the data in the course of the following days.

Both issues imply that the data reported for the last 2 days will be updated in future iterations of the daily reports and open data. In other words, our database is dynamic and subject to continuous updating and improvement of the already reported data.

3.4. WHY DO THE MAPS WITH NUMBER OF CASES VERSUS THE ONES WITH INCIDENCE/1000 POPULATION LOOK SO DIFFERENT?

Question added 07/04/2020 | Last updated 07/04/2020

The maps with the (absolute) number of cases per municipality make it easy to see where the largest number of cases are. However, these results are also strongly influenced by the population density of the different municipalities. Indeed, it is easier for larger municipalities, with larger numbers of inhabitants, to accumulate a larger number of COVID-19 cases.

To directly compare the burden of disease between different municipalities with different numbers of residents, we therefore also calculate and map the number of new cases in function of the number of residents. We currently calculate incidence rates per 1000 inhabitants. These maps can give an indication of where the "risk" of infection is highest.

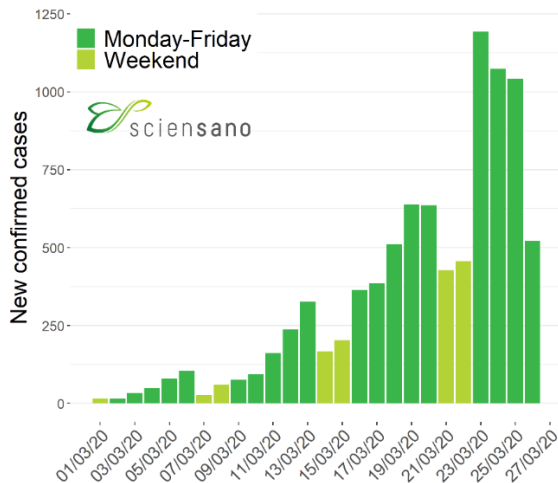
3.5. WHY ARE THERE ALWAYS LESS CASES REPORTED DURING THE WEEKENDS?

Question added 07/04/2020 | Last updated 07/04/2020

For the last weeks we have observed a dip in cases reported over the weekends (see figure in the lighter green). This can be due to several factors:

1. First of all, patients may be reluctant to go to the general practitioner or the hospital during the weekend and rather wait until Monday.
2. Secondly, less staff may be working in the hospitals and in the diagnostic labs on weekends, which may delay the processing of samples and the reporting of results.

We mainly see this effect in the number of reported cases, less so in the number of hospitalizations, and almost not in the number of deaths.



3.6. WHY IS THE NUMBER OF REPORTED CASES 'IN THE LAST 24 HOURS' NOT THE SAME AS SHOWN IN THE GRAPH IN SECTION 2.1 OF THE DAILY REPORT?

Question added 07/04/2020 | Last updated 05/04/202

The reason for this apparent difference is the fact that the number of confirmed cases in 'the last 24 hours' refers to cases *reported* during the last 24h, but not necessarily *diagnosed* during the last 24h. The *reported* cases may have a date of *diagnosis* or a date of sampling in the past, because it requires some time in order to perform the laboratory analysis and to consolidate the data.

As the graph shows the number of cases on the date that their sample was taken or the laboratory *diagnosis* was confirmed, the new cases *reported* in the last 24 hours are therefore spread over multiple days in the graph. This illustrates again why our database is dynamic and subject to continuous updating and improvement of the already reported data.

3.7. ARE SEROLOGICAL RESULTS ALSO INCLUDED IN THE NUMBER OF CONFIRMED COVID-19 PATIENTS?

Question added 23/06/2020 | Last updated 23/06/2020

Persons with only a positive serological test are not included in the figures of confirmed cases, as a serological test examines the presence of antibodies and does not indicate an acute infection. A positive serological test confirms that the person has had a COVID-19 infection. In most cases these are older infections and have already been cured. Therefore, these test results are not included in the reporting of new cases.

4. Data on the tests performed and the positivity ratio

4.1. WHAT IS THE POSITIVITY RATIO AND HOW IS IT CALCULATED?

The positivity ratio describes which proportion of all the performed tests are positive for a certain time period (e.g. per day or per week). Therefore, to calculate it, we divide the total number of positive tests by the total number of tests for a certain time period.

Example: When, in a certain time period, among 100 persons, there are 5 positive tests and everybody got tested only once, the positivity ratio is 5% and there are 5 new cases.

! It is important to bear in mind that the testing strategy has changed a lot since the beginning of March (also see question 3.2). As a result, comparing positivity ratio over time should be done with caution.

4.2. WHY IS THE POSITIVITY RATIO IN THE EPIDEMIOLOGICAL REPORT NOT EQUAL TO THE NUMBER OF DIAGNOSED CASES DIVIDED BY THE TOTAL NUMBER OF TESTS FOR THAT SAME TIME PERIOD?

1. Since March 15 the laboratories are participating in the reporting of PCR tests. It can be noted that the number of positive tests is larger than the number of cases. This is because a positive PCR test is not counted as a new case when there had been a positive test for this person before. Therefore, duplicates have been removed and only the first positive test of a person is taken into account. Depending on the testing strategy, the proportion of people with a previous positive test varies. Stricter application of the testing strategy will result in fewer people being tested, as was the case at the beginning of the epidemic. This reduces the chance of a person testing positive twice and thus the respective share in the total number of tests.

Example: In a given time period, 100 people are tested of which 1 person has already been tested positive at least once. If 5 of those 100 tests are positive, the positivity ratio is 5%. However, there are only 4 new cases because several positive results come from the same person.

2. For the time period until March 15, the number of new cases is higher than the number of positive tests. This is explained by the fact that at the beginning of the epidemic, new cases were notified by the regional health authorities to Sciensano. They used the system of mandatory declaration of infectious diseases that has been in place for years. It was not possible to retrospectively link all of these declarations back to a positive PCR test. These possible cases were counted as confirmed cases. As the PCR test result was not available for these cases, they were not included in the calculations of the positivity rate.

4.3. FOR WHAT REASONS CAN A PERSON BE TESTED SEVERAL TIMES? AND HOW BIG IS THE SHARE OF THESE MULTIPLE TESTS?

There are several situations in which a test is indicated, for example when developing possible COVID-19 symptoms, when returning from an orange or red zone, after a high-risk contact with a confirmed case of COVID-19 or in the context of screening in residential collectivities. On one hand, a person may find himself in several of these situations, on the other hand, he may be tested several times in the same situation.

Preliminary analyses of the data available in Sciensano's database (up to September 17) indicated that 24% of the patients that were tested actually had been tested more than once. Among them, 14% tested positive more than once.

5. Data on hospitalized COVID-19 patients

5.1. HOW DO WE COLLECT DATA ON HOSPITALIZED COVID-19 PATIENTS?

Question added 07/04/2020 | Last updated 07/04/2020

2 separate surveys provide us data about hospitalization:

- All Belgian hospitals with an ICU unit should provide aggregated data on the number of hospitalized and deceased COVID-19 patients through a daily online survey. Since 24 March 2020, this database is the official reference to follow up COVID-19 deaths in hospitals.

You can find this information in the daily report ([Dutch • French](#)) and the [open data portal](#).

- Additionally, all hospitals in Belgium provide case-based data on their hospitalized patients with a confirmed COVID-19 infection through an online survey comprising 2 questionnaires: one on admission information and one on discharge information.

You can find a summary of this information in the weekly report.

5.2. WHY IS THE NUMBER OF HOSPITAL INTAKES BETWEEN 15 MARCH AND DAY X NOT THE SAME AS THE NUMBER OF HOSPITALIZED PATIENTS?

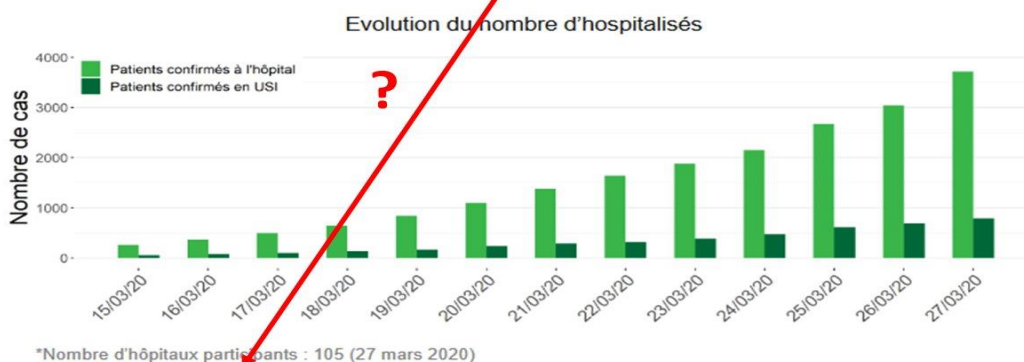
Question added 07/04/2020 | Last updated 07/04/2020

We will use the daily report of 28/03 to answer this question. The report can be downloaded in [Dutch](#) or [French](#).

Au cours des dernières 24 heures, 575 patients avec COVID-19 ont été hospitalisés et 205 personnes ont quitté l'hôpital. Entre le 15 et le 27 mars, 3913 patients avec COVID-19 sont entrés à l'hôpital et 1063 personnes ont quitté l'hôpital.

Plus d'informations : <https://www.info-coronavirus.be/fr/>

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Le 27 mars, 3717 lits d'hôpital dont 789 lits en unité de soins intensifs étaient occupés par des patients confirmés COVID-19.

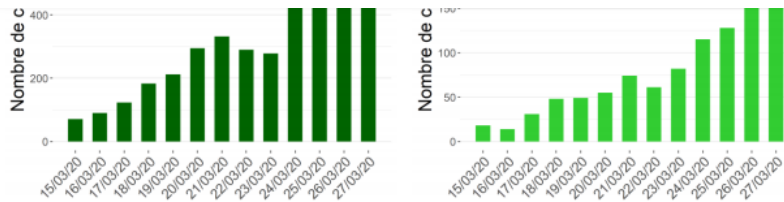
The first number (3913) represents the cumulative incidence of hospital intakes between 15 March and day X (the sum of all new intakes within this period). We use 15 March as a starting point because this is the date from which the majority of hospitals (with ICU) participate on a daily basis.

The second number (3717) represents the total number of hospital beds currently occupied by COVID-19 patients. It is called a prevalence ([see question 2.1](#)). It is a snapshot at a specific moment, hence the observation of a static situation: the number of beds that are occupied at that specific moment. This indicator therefore does not contain any notion of movement, intakes, discharges and so on.

5.3. WHY IS THE DIFFERENCE BETWEEN THE NUMBER OF HOSPITALIZED PATIENTS BETWEEN 2 CONSECUTIVE DAYS NOT THE SAME AS THE DIFFERENCE BETWEEN NEW INTAKES AND DISCHARGES TODAY?

Question added 07/04/2020 | Last updated 07/04/2020

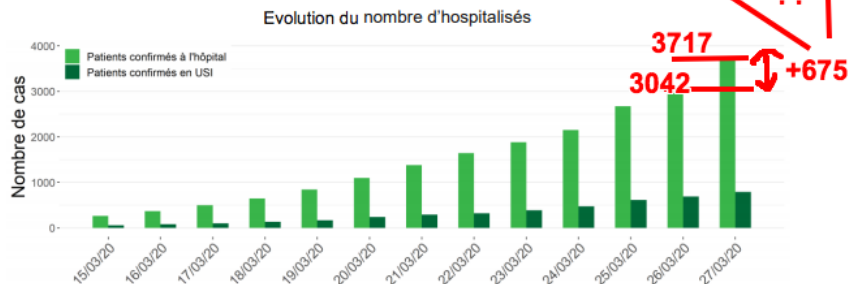
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Plus d'informations : <https://www.info-coronavirus.be/fr/>

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*Nombre d'hôpitaux participants : 105 (27 mars 2020)

Le 27 mars, 3717 lits d'hôpital dont 789 lits en unité de soins intensifs étaient occupés par des patients confirmés COVID-19.

This apparent discrepancy has many reasons, and the relative importance of each specific reason will vary from day to day. Important to note is that incidence (new intakes) and prevalence (occupied beds) are queried separately; we thus do not (and cannot) mathematically derive one from the other:

- A difference in prevalence is not only the result of new intakes and discharges, but also of new hospital deaths.
- Approx. 99% of hospitals report each day, but the subset of reporting hospitals may vary from day to day; even one (large) hospital reporting or not can already give noticeable differences.
- New 'confirmed' hospitalized patients might not always be reported as 'new intakes' if the patient was already hospitalized as a 'suspected' patient. They would however be counted in the prevalence. We are working with the hospitals to increase consistency in reporting.

5.4. WHAT EXACTLY IS MEANT BY THE TOTAL NUMBER OF HOSPITAL ADMISSIONS?

Question added 17/06/2020 | Last updated 17/06/2020

We will use the daily report of 17/06 to answer this question.

1. Kerncijfers voor België

Aantal gerapporteerde patiënten	In de laatste 24 uur	In totaal
Bevestigde COVID-19 gevallen*	89	60 244
Sterfgevallen**	13	9 675
<i>In ziekenhuizen</i>	3	4 706
<i>Bevestigde gevallen</i>	3 (100%)	4 478 (95%)
<i>Mogelijke gevallen</i>	0 (0%)	228 (5%)
<i>In woonzorgcentra</i>	10	4 845
<i>Bevestigde gevallen</i>	9 (90%)	1 284 (27%)
<i>Mogelijke gevallen</i>	1 (10%)	3 561 (73%)
Opnames in het ziekenhuis	24	17 663***
Ontslagen uit het ziekenhuis	57	16 684***

Between 15/03 (the date after which more than 99% of hospitals participate in data collection) and 16/06, 17,663 COVID-19 symptomatic patients confirmed by the lab were admitted to the hospital. When interpreting this figure, it is important to consider the following information:

- It concerns only the lab-confirmed patients who were hospitalized because of COVID-19. Patients who were hospitalized because of another cause but tested positive in a screening context are registered separately since 30/04 and are not included in this figure. Our weekly report shows the number of new admissions due to a different pathology.
- It only concerns the new patients for whom a lab confirmation was available at the time of reporting. Patients for whom no lab confirmation was (yet) available at the time of reporting were reported as new hospitalizations under the category 'CT confirmed or possible cases' in the survey.

In order to estimate the total number of COVID-19 patients hospitalized by the lab confirmed between 15/03 and 16/06, the sum of

- The number of discharges of lab-confirmed patients between 15/03 and 16/06 = 16 684
- The number of laboratory confirmed patient deaths between 15/03 and 16/06 = 4 163 (4 478 confirmed deaths minus the COVID-19 deaths confirmed by a CT of the thorax without laboratory confirmation).
- The number of lab-confirmed COVID-19 patients present in the hospital on 16/06 = 371

5.6. WHAT ARE THE COMORBIDITIES OF HOSPITALIZED PATIENTS?

Question added 07/04/2020 | Last updated 18/09/2020

You can find an extended report about hospitalization, including the comorbidities in our thematic report on our website ([in Dutch](#) • [in French](#)).

6. Data on COVID-19 deaths

6.1. HOW DO WE COLLECT DATA ON COVID-19 DEATHS?

Question added 07/04/2020 | Last updated 01/05/2020

Sciensano collects and combines data on all deaths due to possible or confirmed COVID-19 through several sources:

- daily reporting from the hospitals to Sciensano ([see question 4.1](#)).
- daily reporting from nursing homes to the regional authorities.
- mandatory declaration for general practitioners to the regional authorities.

6.2. HOW ARE DEATHS REPORTED IN BELGIUM IN COMPARISON TO OTHER COUNTRIES?

Question added 07/04/2020 | Last updated 07/07/2020

Each country has its own reporting strategy of COVID-19 deaths, linked to its ability to implement out-of-hospital data flows.

In Belgium, deaths **in hospitals** are reported by hospitals through the "hospital surge capacity survey". Deaths for which the COVID-19 infection has been confirmed by a laboratory test or on the basis of a CT scan of the thorax with suggestive clinical presentation of COVID-19 are reported as "deaths of confirmed case". Deaths from patients who were not tested for COVID-19 but who met the clinical criteria for COVID-19 as determined by a clinician, are reported as "deaths of possible cases" (links to case definition/testing : [Dutch](#) • [French](#) • [German](#)).

Deaths **outside the hospital** (nursing homes and others) are reported by the regional authorities and refer to confirmed and possible COVID-19 cases. At the beginning of the epidemic, the vast majority of people who died outside the hospital setting were possible COVID-19 cases.

In Sciensano's daily reports ([in Dutch](#) • [in French](#)), you can find a table that compares the total number of deaths in different European countries. A limitation of this comparison is that the COVID-19 deaths registration in Belgium is quite broad (as it includes confirmed as well as possible cases, and hospitalized as well as extra-hospitalized cases) but other countries can have narrower registration criteria ([link to description of COVID-19 death surveillance among European countries, ECDC](#)). Another interesting point of view is the comparison of the excess in all-cause mortality by week in the different European countries made by [EuroMOMO](#).

6.3. ARE DEATHS IN NURSING HOMES ALSO INCLUDED IN THE COVID-19 DEATH STATISTICS?

Question added 07/04/2020 | Last updated 26/08/2020

Yes, since the surveillance of deaths of confirmed COVID-19 cases in hospital does not reflect the true magnitude of COVID-19 mortality in our population, our goal is to have mortality statistics that are as complete as possible and, therefore, to include COVID-19 deaths occurring in hospital and elsewhere (e.g. in nursing homes, other residential communities, or at home), as well as confirmed and possible COVID-19 deaths.

Nursing home residents dying in nursing homes or in hospitals are reported by the regional authorities.

The daily epidemiological reports publish the deaths by place of death. Deaths of nursing home residents that occur in nursing homes are published on a daily basis, while deaths of nursing home residents that occur in hospitals are included in the hospital mortality figures (without making distinction by place of residence).

All deaths of nursing home residents (i.e. deaths occurring in the nursing home or in the hospital) have been published in the weekly epidemiological report since 6 June.

Deaths of nursing home residents are recorded as individual deaths in Wallonia and Brussels. Until the 2nd of June the Flemish regional authority provided aggregated information on these deaths to Sciensano. A retrospective survey was carried out by the Flemish agency for health (Agentschap Zorg en Gezondheid - VAZG) to retrieve individual data (age, gender and date of death) for the deaths that occurred between March 18 and June 2. Individual data could be obtained for a majority of cases. On August 26, these individual data were integrated in the database and an update of the analyses was published in the report: COVID-19 mortality – Update of the database – August 26 2020 ([NL/FR](#))

Deaths are classified according to the date of the death. The deaths in nursing homes are notified by the regional authorities; these are reported with 2 days delay in the dataset of COVID-19 deaths by Sciensano.

6.4. ARE DEATHS OUTSIDE HOSPITALS AND NURSING HOMES ALSO INCLUDED IN THE COVID-19 DEATH STATISTICS?

Question added 07/04/2020 | Last updated 01/05/2020

Yes, deaths that take place at home and in all other settings are reported by the physician to the regional authorities and subsequently transmitted to Sciensano and included in the COVID-19 statistics, as far as the reporting is complete.

6.5. DO THE DATA ON COVID-19 DEATHS INCLUDE CONFIRMED CASES AND POSSIBLE CASES?

Question added 07/04/2020 | Last updated 27/05/2020

Yes, data on COVID-19 deaths include both cases confirmed by a laboratory test or CT scanner of the thorax and possible cases. Potential cases include patients who did not receive a diagnostic test for COVID-19 but met the clinical criteria for COVID-19 as assessed by the physician (links to case definition/testing : [Dutch](#) • [French](#) • [German](#)).

Mortality statistics are sought to be as complete as possible. Because the surveillance of hospital deaths does not reflect the true extent of COVID-19-related deaths in a population, we also include COVID-19 deaths that occurred outside the hospital (e.g. in nursing homes).

As regards out-of-hospital deaths, only deaths from confirmed COVID-19 cases were reported before the 30th of March 2020. Before the start of the specific screening strategy aimed at nursing homes, the vast majority of out-of-hospital deaths were reported as potential COVID-19 cases. This extension with the possible COVID-19 cases has also been done retroactively for all deaths reported before the 30th of March 2020.

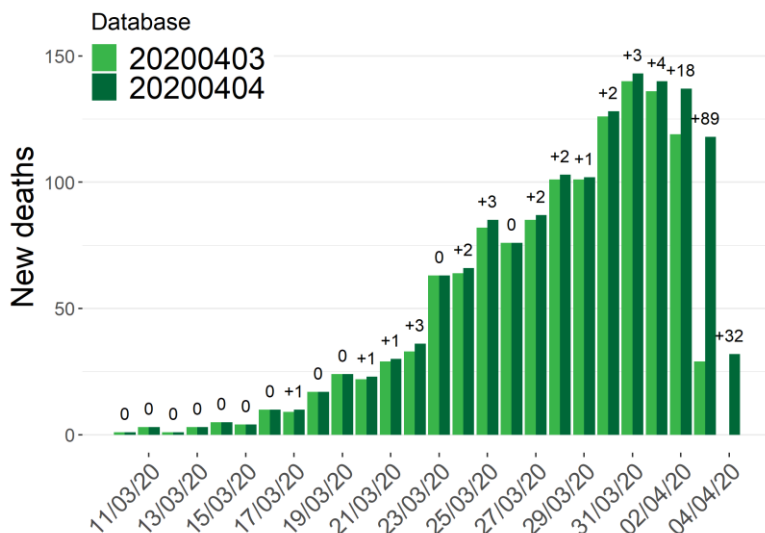
As of 5 May, deaths from possible in-hospital cases are also included in the mortality statistics. This extension also includes retrospectively the deaths of possible hospital cases reported before this date.

6.6. WHY DOES THE NUMBER OF DEATHS REPORTED OVER THE LAST 24 HOURS NOT MATCH THE PREVIOUS DAY'S NUMBER OF DEATHS?

Question added 03/04/2020 | Last updated 01/05/2020

The number of additional deaths reported in the daily report is the number of deaths as *reported* to Sciensano in the last 24h. It therefore does not correspond to the number of new deaths that *occurred* on the previous day alone in the sense that reported deaths may have a date of death in the past. The reason is that there may be a delay of a few days between the death and the moment that the death is notified. Each death is classified according to its date of death. Finally, the data on the number of reported deaths for the last day of the time series are always incomplete, since our data collection for that day is closed in the middle of the day.

For instance, on 5 April 2020, 164 new deaths were reported. This corresponds to the difference between the total number of reported deaths on 5 April 2020 (1447) and on 4 April (1283). The graph below shows how these additional deaths were distributed by date of death.



6.7. WHY CAN THE NUMBER OF DEATHS FOR A SPECIFIC DATE DECREASE?

Question added 22/04/2020 | Last updated 26/08/2020

The mortality database is dynamic. Every day improvements are made following datacheck with regional authorities. It happens that dates of death or dates of birth could incorrectly be encoded in the questionnaires and, after verification with hospitals and nursing homes, these dates are corrected afterwards. More specific information about the deaths in nursing homes in Flanders were added to the database on August 26 (see question 5.3). As a result, there may be a case that is moved to another date of death or a case that is deleted if it is found to be a duplicate.

7. Data from the Influenza Surveillance System

7.1. HOW DO WE COLLECT DATA ON INFLUENZA-LIKE ILLNESSES?

Question added 07/04/2020 | Last updated 03/04/2020

The sentinel network of general practitioners continuously records consultations in general medicine for influenza-like illnesses and acute respiratory infections. The network has around 120 general practitioner offices spread throughout Belgium. It records for each episode age group, vaccination status, outcome and immediate hospitalization. In a subset of these patients, a clinical sample is collected and virologically tested by the National Reference Centre (NRC) for Influenza. From this subgroup, we also record additional clinical data (symptoms, risk factors and comorbidities, vaccination, treatment and severity indicators).

Additionally, six sentinel hospitals participate in this surveillance. Since the 2011-2012 respiratory season, this network has recorded all episodes of hospitalized severe acute respiratory infections (SARI) that occur during the period of high influenza activity. The surveillance starts as soon as the first signs of influenza virus circulation are detected by the NRC for Influenza, and ends at least 3 weeks after the incidence of influenza-like syndromes (collected via the sentinel network of general practitioners) again drops below the epidemic threshold. For each episode, the patient's demographic characteristics, symptoms, risk factors and comorbidities, vaccination status, treatment, severity and clinical outcome are registered during the hospital stay. In addition to this clinical data recording, the hospital collects a nasopharyngeal sample from each patient, which is virologically tested by the NRC for Influenza.

We carry out both surveillances in close collaboration with the NRC for Influenza, which performs microbiological tests on nasopharyngeal samples collected from each patient for the influenza virus and, since March 2020, SARS-CoV-2.

The results of the influenza surveillance can be found on our website.

They are also included in the weekly COVID-19 report [\(in Dutch](#) • [in French](#)) which is also available on our website.