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Return to the Workplace
A risk management framework for decision makers

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EXECUTIVE SUMMARY

In many duty stations local pandemic conditions are resolving and consideration is being given to return to the workplace and the resumption of on-site work. This guidance focuses on key COVID-19 related medical and occupational safety and health concerns of the UN Medical Directors (UNMD). It is directed at senior decision makers in each location to aid in the development of local return to the workplace policy. Note that It contains no detail on non-COVID-19 health risks and operational, reputational, or financial risks all of which must be included in the overall return to workplace plan but are for each duty station and/or organization to determine.

The UN Medical Directors offer the following advice:

- ***To the extent possible, each return to the workplace plan should follow local/national workplace guidance.***
- ***Decision makers in each location or entity should take a risk-based approach to return to the workplace that affords reasonable safety to personnel in line with each organization's duty of care.***
- ***COVID-19 vaccination status is a significant driver of risk and therefore should be a key consideration in establishing a sound return to work process.***
- ***COVID-19 vaccination is strongly encouraged but should NOT be made mandatory for personnel.***
- ***Whilst vaccination status is sensitive information, it is not medical-in-confidence[1], and the workplace may ask personnel to voluntarily disclose their vaccination status in order to improve workplace safety.***
- ***The return to the workplace plan must include a mechanism to address requests to delay or amend return.***

SECTION ONE: RETURN TO THE WORKPLACE PLANNING

[1] Note the vaccination *status* – i.e. vaccinated or not vaccinated - is considered sensitive personal information and this status may be requested from the staff member themselves. The vaccination record or vaccination certificate if stored in the medical record is considered medical information and if requested from a medical service is subject to all the normal confidentiality requirements of information in the medical record.

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The UN Medical Directors recommend a risk-based approach to addressing COVID-19 as a hazard in the workplace. Although a complete occupational safety and health (OSH) risk assessment is beyond the scope of this guidance, there are 4 overarching areas to be considered:

1. **Establish the local (community) context for return to workplace:** i.e. "What is happening here?"
   Local guidance sits at the forefront of any plan and should be the first consideration. Although many UN system organizations and workplaces have privileges that allow them to work outside of local rules, we remain community members, and hence local rules form the start point for any action. The approach to access, vaccination, occupancy levels, mask use, distancing, and contact tracing should wherever possible align between community and the workplace, given that:
   - If the workplace is more restrictive than local rules, this will increase the likelihood of personnel not following workplace rules.
   - If the workplace is more permissive than local rules, there may be reputational risk for the organization within the local community.

2. **Establish the operational context**. i.e. "Why do we need to return to the workplace?"
   The balance between safe return to the office and operational needs should be clearly defined by senior management based on organizational mandates and in coordination with managers in the field. This is essential for any subsequent risk-benefit analysis. Where appropriate, different parts of onsite work may be prioritized for earlier return.

3. **Consider organizational culture.** i.e. "How will this plan sit with personnel and managers?"
   Whilst organizational culture should not drive the return to the workplace plan, it should be considered once the overall plan and its components are finalized to guide the speed of return, the amount of flexibility offered, and the overall personnel communication plan.

4. **Undertake a workplace risk assessment**. i.e. "What is the risk to personnel and where does it come from?"
   Once the community, operational and organizational 'context' has been established, an actual risk assessment can take place. This risk assessment defines where and how personnel or others may be exposed to the hazard of COVID-19 in the workplace[2]. This will then drive a set of key risk mitigation measures that form the detail - the rules - for the return to the workplace plan. The resulting guidance should preferably be location focused and agreed by all UN entities locally, not specific to one organization**.**

   The key considerations in undertaking a basic workplace risk assessment are provided in Section Two. Given the vaccination of personnel is such an important component of this risk assessment, the key considerations around vaccination are provided in Section Three.

SECTION TWO: BASIC WORKPLACE RISK ASSESSMENT

The risk assessment should preferably be conducted by a local occupational safety and health (OSH) committee, with representation from management, staff unions, medical/counselling, health and safety, facilities management,

[2] A comprehensive risk assessment will also need to identify and mitigate non COVID-19 health hazards

security, human resources, and any other group with technical input. Recognizing that many duty stations do not have access to occupational safety and health professionals, the following brief overview of a suggested approach is provided as general guidance

The risk assessment should document each of the following areas:

1. What is the exposure to COVID-19 in the community? This should be done based on data, and requires consideration of a range of key metrics. For example:
   - Absolute case numbers, or cases /100 000 population, or weekly/daily incidence of cases/100 000 population;
   - Test positivity rate;
   - Actual number of hospitalizations, or hospitalization rate/100 0000 population

   Other metrics are also available and should be selected for direct relevance to the duty station. Each of these metrics should if possible, have a threshold assigned to them above or below which a particular action (such as relaxing of a rule) can take place. No specific figures can be given as these are so dependent on local conditions. Advice should be sought from local experts as to values that represent reasonable safety. Alternately, general advice is available from WHO: Considerations for implementing and adjusting public health and social measures in the context of COVID-19 (who.int)

2. What is the exposure to COVID-19 in the workplace? This should include:
   - Potential for exposures on the way to and from work, particularly for those locations where public transport forms a major part of commuting.; and
   - Exposures for different types of personnel or tasks, for example security officer, cleaner, driver, administrative worker etc. Wherever possible these should be specific to ensure different categories of personnel have an accurate representation of risks and the mitigation measures that are important to them.

3. What is the individual susceptibility of an employee if exposed? This requires:
   - A mechanism, such as a reasonable accommodation process, to allow exceptions for those who are at higher risk if exposed, such as those over 60 or who have comorbidities;
   - Consideration of those who are vaccinated (or have proven recovery from COVID-19) and hence have lower risk.

4. What care is available should someone contract COVID-19 from the workplace? In large part this can be established by assessing:
   - Tracing, testing and tracking capability
   - Hospital bed availability,
   - Quality and effectiveness of hospital care; and if appropriate
   - COVID-19 Medevac availability.

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SECTION THREE:

1. THE ROLE OF VACCINATION IN ASSESSING RISK

In the context of falling local case rates and hence consideration of return to the workplace, the extent of vaccination against COVID-19 is the main indicator of risk. A fully vaccinated person (2 weeks after their final dose) has a low chance of contracting COVID-19, of being affected if they do get it, or of passing it on to others. Knowing the vaccination status of all personnel is therefore key to developing a plan that affords maximum flexibility and operational capability whilst also being safe. Vaccination status does not affect access to the workplace – however it does affect what restrictions apply to each group. In general, those who are unvaccinated will need to continue to mask and distance, whilst those who are vaccinated may not need to in certain situations.

Given the importance of vaccination the UN Medical Directors have adopted two consensus statements:

<u>On mandatory COVID vaccination:</u>

> ***The UN Medical Directors consensus opinion is that as an invasive medical procedure, and as all forms of the COVID-19 vaccine have been approved to date only under Emergency Use Authorization, COVID -19 vaccination is strongly encouraged but should NOT be made mandatory for personnel.***

Where all other risk mitigation options have been exhausted but the risk profile remains unacceptable, it is recommended if an entity is considering making vaccination mandatory to seek professional medical or occupational safety and health, as well as legal and ethics advice before implementation.

<u>On the right of the workplace to ask for vaccination status</u>

> ***The UN Medical Directors consensus opinion is that vaccination status is sensitive information, but not medical-in-confidence[3], and workplace representatives may ask personnel to voluntarily disclose their vaccination status in order to effectively manage exposure risk in the workplace.***

Safety is a line management responsibility, and hence the most effective way for managers to ensure safety is to know if their personnel are vaccinated or not, and to manage their work accordingly. The right to request an employee's vaccination status comes with a number of caveats:

- The request must be sensitively made, and appropriate to the circumstances.
- It must only be for vaccination status – i.e. (1) fully vaccinated, (2) not yet fully vaccinated or (3) not willing to answer – all are valid, and the response is voluntary.
- It must be solely for managing the risk of activities in the workplace.
- It may not be coercive or punitive and may not include any questions as to why someone is not vaccinated, or not willing to provide an answer.

[3] Note the vaccination *status* – i.e. vaccinated or not vaccinated - is considered sensitive personal information and this status may be requested from the staff member themselves. The vaccination record or vaccination certificate if stored in the medical record is considered medical information and if requested from a medical service is subject to all the normal confidentiality requirements of information in the medical record.

As it is for managing safe work, the request about vaccination status can come from anyone with a legitimate responsibility. In most cases this is the manager overseeing work in a particular location, the organizer of a meeting, etc.
An employee who does not disclose their vaccination status is considered unvaccinated and is subject to all the restrictions that apply to the unvaccinated personnel.

2. PRACTICAL MATTERS REGARDING VACCINATION STATUS

Verifying vaccination status
Where vaccination status amends the risk assessment, the workplace must determine to what extent it will confirm vaccination status with its personnel. There are a number of alternatives, the main options include:

- Direct verification: The safest but most intrusive method, the vaccination proof (certificate, electronic application etc.) is provided by the employee each time it is requested.
- One-off verification. Proof is provided once to a manager or central entity (such as a medical service), who reviews, records and confirms to the employee that the proof meets organizational needs. Thereafter the employee only needs to confirm that they have received confirmation from the workplace that their vaccination has been verified.
- Self-declaration - here there is no verification – the employee simply states their vaccination status.

No specific recommendation is made – decision makers will need to determine based on administrative matters, the availability of IT support or medical support, and a range of other factors the extent and best approach to verification.

The impact of vaccination status on occupancy, mask use and distancing
A vaccinated employee has lower risk and hence decision makers may want to consider whether or not introducing workplace guidance, as appropriate, that has different requirements for mask use, distancing or occupancy by the vaccinated is appropriate in recognition of this lower risk. If applicable, the return to the workplace plan must make clear what the changes are for those who are vaccinated, and where these changes apply, including protocols for masking and distancing:

- Outdoors.
- In public spaces such as lobbies, hallways, elevators and bathrooms.
- In kitchens and cafeterias, or when eating/drinking.
- In offices, cubicles and flexible workspaces
- In meeting rooms

Vaccination may also affect occupancy limitations. Whilst original occupancy limits were usually based on everyone present in a space having to distance, relaxation of distancing requirement for the vaccinated may allow decision makers to increase occupancy or commence a return to normal occupancy, as appropriate.

SECTION FOUR: MANAGING REQUESTS TO NOT RETURN TO THE WORKPLACE

Where return is completely voluntary, there is generally no need for exceptions. An employee with a medical issue who believes they are at risk in the workplace need not return. However when the return to workplace plan foresees a gradual but expected return of all or most personnel, there may be a clear gap between the workplace's expectations and the personnel's perspective on whether it is safe for them to do so. In such a case, all workplaces are advised to have a clear process to manage requests for an exception to return. This may be for personal reasons, or for medical reasons. In general, both can be achieved through a standard 'reasonable accommodation' process.

The details of how to establish and manage a reasonable accommodation process are beyond the scope of this guidance and should be directed to Human Resources or Health/Medical units.