

Adviesaanvraag

Vraagsteller	Regeringscommissariaat Corona
Datum van adviesaanvraag	30/06/2021
Onderwerp	Herfst/Winter 2021 (onderwijs)
Vraag	

Adviesverstrekking t.a.v. het Overlegcomité

Datum van adviesverstrekking	30/06/2021
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GEMS recommendations for transition of acute crisis management into long term risk management

1. Epidemiological context

1.1. Uncertainties

This advice aims to gauge the epidemiological situation during the fall and winter of 2021 and what the remaining measures should be, with a special focus on schools and other places where large groups of vaccinated and not vaccinated persons may come together in indoor settings (i.e. higher education, workplace, horeca, events,...).

It is important to note that there are many remaining uncertainties regarding the epidemiological evolution over the next months of summer, fall and winter, which is why a fixed and final decision cannot be taken at this moment in time. Thanks to the success of the vaccination campaign, high vaccination coverage rates in the adult and adolescent population may be achieved. This can substantially reduce the risk of epidemic flare-ups with major morbidity, mortality and impact on the health care sector. Nevertheless, there is still uncertainty on the dimensions of the 'residual risk', especially with the planned gradual reduction of NPI's and in presence of VOCs with immune escape properties. Flexibility and caution are still a must to safeguard public health during this pandemic.

Furthermore, the GEMS would like to highlight the importance of the on-site (in school) learning for the development and wellbeing of children and asks not to jeopardise "normal" reopening of schools by radical and large scale relaxations of non-pharmaceutical interventions too quickly this summer.

1.2. International component

The ECDC mentioned in their [threat assessment brief of 23/06/2021](#) that *"the introduction of SARS-CoV-2 variants of concern by international and domestic travel-related cases can play a role in triggering increased community transmission of COVID-19 and its variants, particularly when levels of transmission in the receiving locality are low."* This means that as long as there is continuing high-level circulation in other European countries or around the globe, variants may be selected out and enter Belgium, with possibly eventually a variant of concern with substantial immune escape.

As there will be a lot of travelling during the upcoming weeks, and the rules within the EU have been relaxed, the epidemiological situation and introduction of new variants should be closely monitored. An analysis of [Lemey et al.](#) in *Nature*¹ showcases the threat of viral spread via international travel in detail for 10 European countries for the past epidemic waves. The described pervasive spread of variants in summer 2020 highlights the threat of viral dissemination when restrictions are lifted. These findings call for solid strategies to control the current and future spread of variants which are more transmissible and/or evade immunity. Furthermore, the authors of the study highlight that conditions similar to those demonstrated in their study could provide fertile ground for viral dissemination and resurgence, which may now also involve the spread of variants that evade immune responses triggered by vaccines

¹ Lemey, P., Ruktanonchai, N., Hong, S.L. et al. Untangling introductions and persistence in COVID-19 resurgence in Europe. *Nature* (2021). <https://doi.org/10.1038/s41586-021-03754-2>

and previous infections. They hope that a well-coordinated, unified implementation of European strategies to mitigate the spread of SARS-CoV-2 will reduce the chances of future waves of infection.

However, there is currently no solid system in place to control or contain the international spread of variants of concern. For most of the third countries, data on incidence of cases and prevalence of VOCs are lacking. Actual travel restrictions are limited, and often not strictly enforced or controlled.

As we have observed throughout this pandemic, the threat of introducing new variants via international travel has been and remains a reality, as long as the pandemic situation is not under control globally. Therefore it remains essential to: (1) follow up closely the international situation and (2) keep a set of measures to reduce/slow down the risk of introducing new VOCs.

1.3. Scenarios

EU in general

The above mentioned ECDC-modelling scenarios for the EU/EEA indicate that “any relaxation over the summer months of the stringency of non-pharmaceutical measures that were in place in early June could lead to a fast and significant increase in daily cases in all age groups, with an associated increase in hospitalisations, and deaths, potentially reaching the same levels of the autumn of 2020 if no additional measure are taken.” Furthermore, the report also states that as long as children are not vaccinated, it is expected that the Delta VOC will circulate more extensively in these age groups (as observed in the UK); although this finding could be biased because school outbreaks have been prioritised for investigation and contact tracing in the UK. **The ECDC advises to maintain and strengthen physical distancing and other NPIs, such as wearing masks in indoor and crowded outdoor settings,** including in areas where adolescents and young adults gather, to reduce the risk of clusters and outbreaks of COVID-19.

Belgium

The Belgian epidemiological situation will depend on many different elements, such as the vaccination coverage of the general population, remaining pockets of susceptibles, presence of VOCs, worldwide epidemiological situation, behaviour/remaining NPIs, season and climate and worldwide vaccination status. Provisional modelling results of the SIMID group² projecting the Belgian epidemiological situation under different scenarios show that a new surge in cases is to be expected, the earliest starting in the beginning of August, the latest starting in September, depending on the contact behaviour, vaccination uptake, and transmissibility and severity of the Delta VOC. The height

Figure 5. Estimation of possible changes in daily COVID-19 hospitalisation in the EU/EEA according to four NPI relaxation scenarios

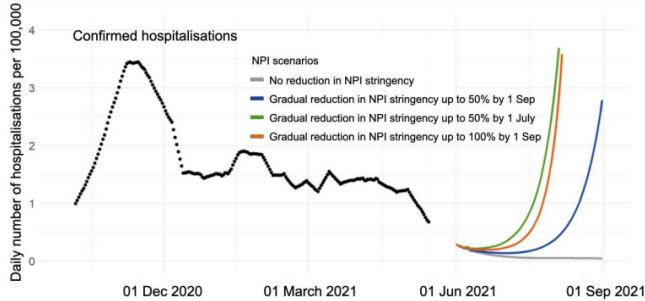
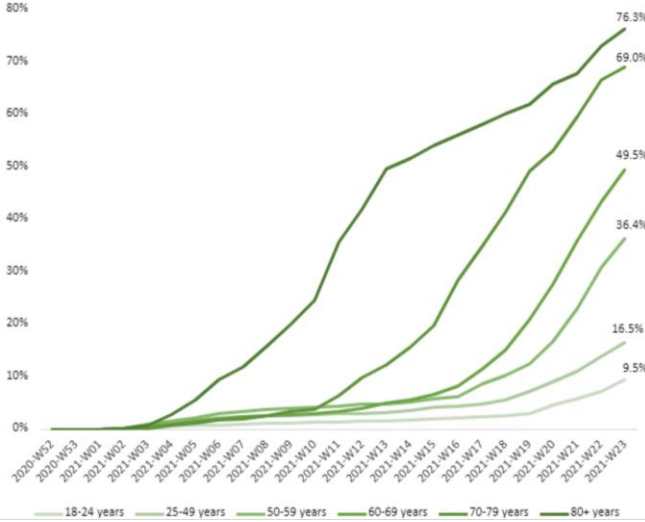


Figure 2. Median cumulative uptake (%) of full vaccination coverage by age group and reporting week* in EU/EEA countries as of 2021-06-13

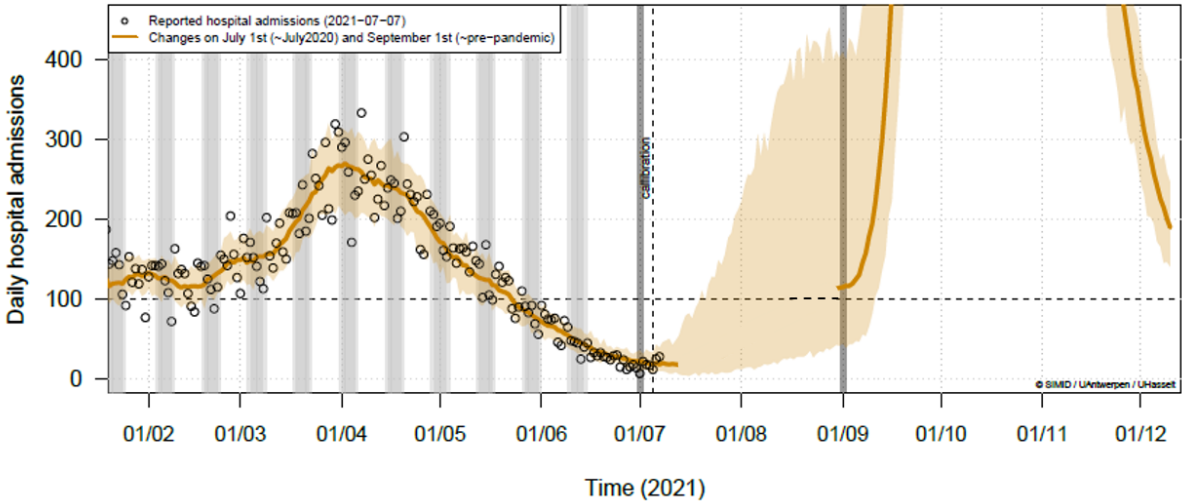


² Assuming a transmission advantage of 40%-60% and a hazard ratio of hospitalisation of 2 for the Delta VOC compared to the Alpha variant.

of the curve can be strongly influenced by the remaining NPI's (measures) as well as the vaccination coverage of children aged 12-18. (Note that the scenarios assume the interval between two AstraZeneca doses is 12 weeks, while the authorities have decided to reduce the time between two doses of AZ to 8 weeks, for those who received their first AZ dose after May 24. However, it is still up to the person to reschedule the initially planned appointment and the impact of altering this assumption for the different modeling scenarios is limited).

There is a large uncertainty mainly pertaining to behavioural changes because of the start of the summer holidays which underlines the necessity for a continuous and careful evaluation of the situation.

A specific scenario that the GEMS would like to bring under the attention is the projection of daily hospital admissions when behaviour on September 1st returns to pre-pandemic behaviour. The figure below assumes a transmissibility increase of 50% for the Delta VOC compared to the Alpha variant and shows very similar results to the ECDC scenarios described above, namely that hospital admissions rise to a very high level. This clearly indicates that returning to pre-pandemic contact behaviour in the first few months is not an option yet.

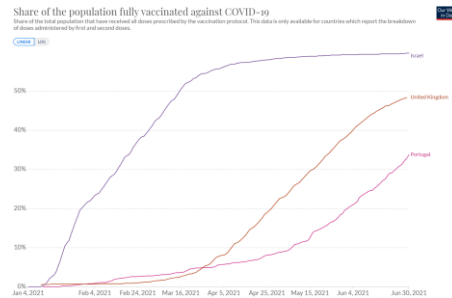
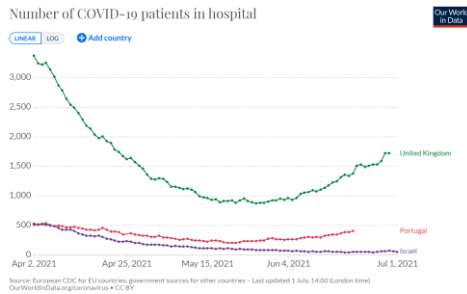


The current situation in different countries shows that even with high vaccination coverage, cases can very rapidly rise due to the Delta-variant (e.g. Israel, Portugal, UK, Cyprus, Spain), with varying results towards hospitalisations. The current hypothesis explaining the difference in these hospitalisations is that full vaccination protects well against the Delta-variant, but a partial vaccination does not protect as well against (severe) symptoms with hospitalisation as a result (see UK vs Israel in the graphs below). The WHO has warned against easing coronavirus restrictions too soon also despite increasing vaccination coverages given that this could lead to spikes in the number of cases and hospitalisations as is also clear from the international situation.

We therefore advise to maintain at least a basic set of NPIs over the next months to come (i.e. reduced n of contacts, wearing masks indoor, promoting outdoor activities, strengthened ventilation,

maintenance of testing, quarantine/isolation,...) and tapering this down only very gradually under guidance of the epidemiological situation.

2. Risk

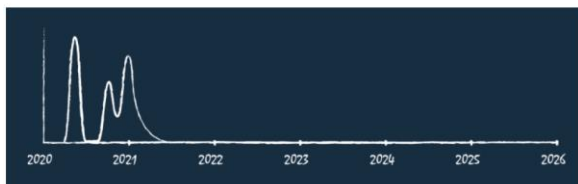


management approach

2.1. Definition of “normality”

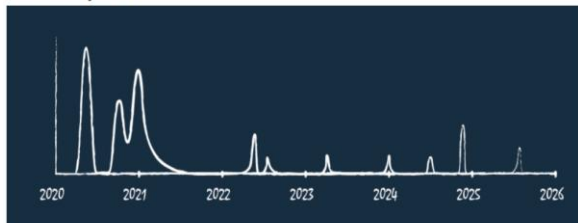
The actual epidemiological situation can be seen as a transition period, between pandemic and ‘returning to normality’. Given the above mentioned ‘remaining risk’ despite high vaccination coverage rates, the question remains what the ‘new normality’ could look like. Several hypothetical scenarios should be considered, depending on the length and width of the actual vaccine-induced immunity. To illustrate these possible scenarios, the Dutch Wetenschappelijke Raad voor het Regeringsbeleid (WRR) and the Koninklijke Nederlandse Akademie van Wetenschappen (KNAW) published an interim [joint study](#) on the broad impact of the corona crisis and its implications for major policy challenges. The interim report concludes that the COVID-19 crisis is not yet over and that there is uncertainty about its further course. This uncertainty has been translated into five possible scenarios (presented below) which are based on four driving forces: immunity, vaccination, mutation and animal reservoirs.

Back to normal



Wereldwijd zijn voldoende mensen immuun door (herhaalde) vaccinatie of doormaken van de infectie; geen immune escape. **Focus on entrenching learnings for future pandemics and targeted revax**

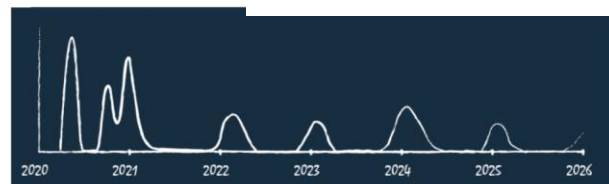
Externally-driven risk



In België / EU onder controle maar in veel andere landen niet, met permanent risico op herintroductie. **Focus on strong EU approach on travel flows; good outbreak management measures to bend the curve. Ongoing high vaccination coverage.**

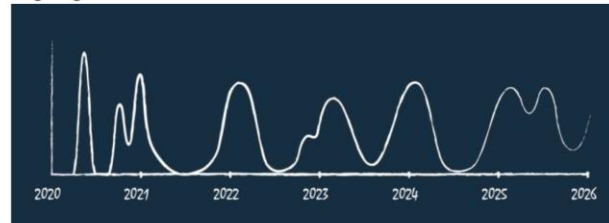
Influenza-type dynamics

and take 'no-regret' actions that noia in any case



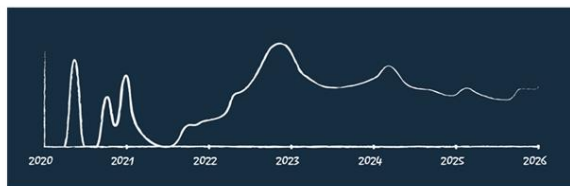
COVID-19 wordt endemisch met jaarlijkse golven in de winter, iedereen >18 is gevaccineerd. Het virus blijft muteren, maar niet op een manier die veel verandert aan ernst. Enkel kwetsbare groepen hebben hoger risico om ernstig ziek te worden. **Focus on effort on (re)vaccinations and protection of vulnerable**

Ongoing



COVID-19 blijft een serieuze bedreiging. Vaccins werken niet voldoende (lang) en er komen steeds nieuwe varianten bij. **Focus on readiness to prepare a bold and short response, with strong signal detection and dynamic understanding of evolution towards constraints.**

Worst case



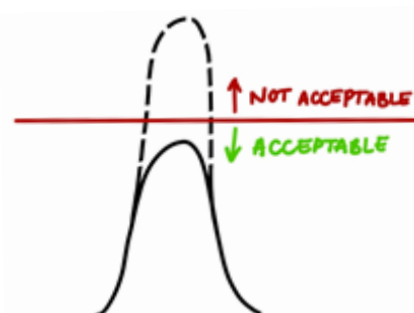
COVID-19 eist jaarlijks meer slachtoffers en blijft wereldwijd circuleren; beperkte immuniteit en effectiviteit vaccins. Het is onzeker wanneer de pandemie zal uitdoven, tot die tijd blijven hevige uitbraken plaatsvinden.

Not all scenarios are equally likely, but it is important to be prepared for different possible developments. Scenarios are not about 'predicting', but about sketching plausible futures to broaden strategic thinking.

Each of these scenarios holds a smaller or larger risk for major epidemiological flare-ups. It is important to think about: (1) which level of risk is acceptable for society, (2) how these risks can be reduced to a minimum (e.g. remaining NPIs, travel-measures,...)

2.2. Acceptable burden of disease

The strategy and risk management approach for COVID-19 depends on the burden of disease the country is willing to accept. The overall objective of governing this pandemic is to preserve the nation's public health. Medical risks associated with COVID-19 (morbidity, mortality, strain on all levels of health care sector, delayed care for other pathologies,...) should be balanced with other public health concerns (such as mental health, delayed medical care, social bonds that are essential to overall well-being, and economic harm) and the suspension of people's rights.



During the pre-vaccination waves (waves 1, 2, 3), the non-mitigated exponential character of the covid-epidemic urged the policy makers to give priority to the prevention of the hospital/ICU system being overburdened. As soon as NPIs were somewhat relaxed (e.g. July-October 2020), viral transmission increased again, leading to high rates of hospitalisation and death.

With increasing levels of vaccine-induced immunity but decreasing respect for NPIs, new flare ups may be expected, but hopefully with a lower cases versus hospitalisation/severe disease ratio. Two questions remain then: (1) what is a socially 'acceptable' remaining risk of hospitalisation and mortality and (2) how impactful is the relatively higher burden of 'moderately severe disease' which inevitably continues to occur.

The tolerance limit for question 1 will probably be influenced by the fact whether hospitals are able to function normally, or not. For question 2, one needs to take into account the burden on first line health care services, high levels of absenteeism at work, and the possible impact of 'long covid'. Emerging evidence from case series but also cohort studies suggests that significant numbers of patients may suffer from longstanding (> 6 months) fatigue, cognitive impairment and/or respiratory or neurological symptoms. In depth data on the true epidemiology, pathophysiology and effective management of

these longstanding symptoms after covid-19 are still lacking, as well as comparisons with the long term burden of other infectious diseases (e.g. post-sepsis, post-influenza,...)

2.3. Priorities previously defined by the government

When thinking about what burden of disease is acceptable and defining a risk management approach, one has to take into account what the priorities are. The two main priorities that were defined by the government are (i) no overload of the hospital system and (ii) ensuring continuous education in the best way possible.

The GEMS would like to explicitly express their agreement with these priorities and highlight why schools should remain open at full capacity as long as the epidemiological situation allows it. We highlight below a list of negative effects of school closures:

- Negative impact on learning process;
- Negative impact on neurodevelopmental, social and physical dimensions;
- Documented increased risk of abuse and neglect;
- Long term impact increasing social imbalance and poverty;
- Barriers to implement distance learning (e.g. limits in younger ages where education needs lots of sensorial activities);
- Lack of supervision by parent(s) who is (are) also teleworking, sharing IT material in poorest families, internet limits, lack of motivation, increased school dropout;
- Negative impact on most vulnerable families (e.g. monoparental families), thus increasing social health inequity;
- Burden of mental health issues currently observed in teenagers that might even increase in case of full school closures;
- Potential risk for grand-parents who are looking after their grand-children.

Given the importance of keeping schools open and functional, and given the above described remaining risk for epidemic flare-ups, we think it is important to maintain a certain basic level of NPI's throughout society, including in schools.

With increasing viral transmission, additional measures could be considered to avoid drastic decisions such as school closures. We refer in this context to the recent proposition of the RAG for measures to be taken at schools.

2.4. Alarm levels (defined by RAG)

The GEMS would like to highlight the importance of using thresholds (please refer to advice [GEMS_018 dd. 13/04/2021](#)) and would like to refer to the RAG advice describing different alarm levels with distinct thresholds. Thresholds are a guideline for when measures need to be taken or can be relaxed with the purpose of (i) avoiding large resurgence and (ii) increasing motivation of the population to adhere to the measures. Thresholds increase risk awareness (which is a driver for motivation) as they give an indication of what is perceived as 'high risk' and 'lower risk'. It is important to note that crossing the thresholds does not automatically imply a change of alarm level, but rather is the subject of an assessment by the RAG and subsequent political adoption.

Alarm level	7d incidence hosp	ICU capacity	Doubling time / half life	Positivity rate	Rt infections	Number of contacts GP for COVID	14d incidence infections
Local risk management							
Alarm level 1	<2/100,000 (i.e. <30 nh/d)	<15% (phase 0)	>100 days	0-3%	0-1	<25/100,000	<20/100,000 (<i.e. 165 nc/d)
Alarm level 2	2-4.5/100,000 (i.e. 30-75 nh/d)	15-25% (phase 1A)	20-100 days	0-3%	0-1	25-50/100,000	20-99/100,000 (i.e. 165-800 nc/d)
Provincial and National crisis management							
Alarm level 3	4.5-6/100,000 (i.e. 75-95 nh/d)	25-50% (phase 1B)	15-20 days	3-6%	1-1.5	50-100/100,000	100-299/100,000 (i.e. 800-2400 nc/d)
Alarm level 4	6-9/100,000 (i.e. 95-150 nh/d) AND groei/daling ?	50-60% (phase 2A)	5-15 days	6-10%	>1.5	100-125/100,000	300-399/100,000 (i.e. 2,400-3,200 nc/d)
Alarm level 5	>9/100,000 (i.e. >150 nh/d) AND growth/decline >5% for at least 3d	>60% (phase 2B)	<5 days	>10%	>1.5	>125/100,000 AND growth/decline >2.5% for at least 5 consecutive days	>400/100,000 (i.e. >3,200 nc/d)

2.5. Suggested integrated societal approach

In case the epidemiological situation worsens, measures need to be taken at **all levels of society**. **Measures for schools** advised by both the RAG and the GEMS, linked to the alarm levels defined above, can be found summarised in the table in annex 1. Please also refer to the separate RAG advice on COVID-19 management in the educational system: advice for september 2021 for more elaborate guidelines.

Furthermore, suggested **measures for local risk management** are summarised in a toolbox for local governments. Complementary to this toolbox, the measures proposed by the GEMS in [plan A-B-C \(23/03/2021\)](#) can be used for inspiration. However, it should be noted that plan A-B-C was compiled in a high-stringency situation (i.e. a lot of restrictions in society), with the most impactful measures already in place.

For future use in a situation with only a remaining baseline set of NPIs, we think a contingency plan may be essential to prevent the epidemiological situation from aggravating unwanted scenarios. This plan should probably be based on the basic pillars of NPI-interventions with proven effect to contain the epidemic: reduction in number of contacts (i.e. reduction of capacities), use of masks, keeping sufficient distance, good levels of ventilation, focusing on outdoor activities. The table in annex 1 shows a first and preliminary attempt at defining societal interventions. A more elaborate contingency plan should be worked out.

For additional information on COVID-19 prevention at work, see annex 3 and 4.

2.6. Other initiatives and measures to keep the situation under control

- Aim for maximal vaccination
- Need for internationally coordinated response
- Further continue to structurally improve ventilation
- Discourage international travel

- Careful planning and managing international academic staff and student mobility (see annex 2)

Annex 1. Comprehensive table summarised advice on schools and preliminary suggestions on other societal interventions

Alarm level	RAG suggestions on schools	GEMS suggestions on schools	GEMS suggestions on other societal interventions				
			Higher education	Work	Events	Horeca	Leisure
1	<p>Prevention:</p> <ul style="list-style-type: none"> - Attention for adequate ventilation - Mask wearing not compulsory - Regular hand hygiene and coughing etiquette - Persons who are sick should stay at home - Routine standards of cleanliness of surfaces and high-touch areas should be upheld, but frequent disinfection of surfaces or shared objects is NOT recommended <p>Testing:</p> <ul style="list-style-type: none"> - ≥6 yrs with COVID-19 symptoms --> testing and isolation until result - Routine screening not considered useful in this context. Sentinel surveillance (without isolation/quarantine) could be considered to monitor ongoing transmission. <p>Contact tracing:</p> <ul style="list-style-type: none"> - Quarantine for children with household member who has confirmed COVID-19 - No quarantine for children in the same class in kindergarten and primary school (or group for afterschool activities) because consider as low-risk contacts. Do need testing if any COVID-19 symptoms. If 2 confirmed cases with possible link within the class group within 14 days, entire class goes into Q for min. 7 days. - Pupils in secondary school, need to undergo quarantine and testing if high-risk contact (if identified cumulative face-to-face exposure of >15' at <1,5m, either within the classroom or outside, or had physical contact like hugs or kisses). Exceptions for fully vaccinated persons apply like in the broader society. --- to limit the number of high-risk contacts and facilitate tracing, fixed seating in classes is helpful --- if there are doubts about risk classification of classmates, testing low-risk contacts (as previously advised by the RAG) should be considered. 		<ul style="list-style-type: none"> - 100% capacity - Masks (at least in the beginning) - Norms for ventilation should be reached as much as possible - If >90/80% vacc, can stay longer in green - Bring vaccination to the aula - Offer RAGT (self sampling) - Bring testing facilities to aulas and workplaces 	<ul style="list-style-type: none"> - Norms for ventilation should be reached as much as possible - Follow test strategy (Co-Prev, see annex 4)(incl. RAGT in the workplace) - Bring vaccination to the workplace (especially when vaccination centres disappear) - Dispose of risk assessment for COVID-19 + appropriate preventive measures (existing legislation) - Masks in places where and when people come together (cf. other sectors) - Telework recommended - Reduced capacity in the beginning of September - Keep implementing generic guide: https://werk.belgie.be/nl/nieuws/generiekegids-om-de-verspreiding-van-covid-19-op-het-werk-tegen-te-gaan 	<ul style="list-style-type: none"> - Full capacity only if proper ventilation and masks - Comply with CIRM/CERM for big events and dancings - Green certificate for access to dancings and big events 	<ul style="list-style-type: none"> - Distance of 1.5m between table companies - Mask wearing for employees - Mask wearing for clients when walking through facility, at least at the beginning 	<ul style="list-style-type: none"> - Ventilation - Mask in places when people come together, before and after sport activities

2	<p>Additional to measures in code green:</p> <p>Prevention:</p> <ul style="list-style-type: none"> - Primary schools: All staff wear masks, except in their own classroom with their class. - Secondary schools: All students and staff wear masks, except when distance and adequate ventilation are assured or when working in silence (e.g. during exams or tests) and adequate ventilation is assured. <p>Testing:</p> <ul style="list-style-type: none"> - Secondary schools: Repeated screening of students and staff recommended (1x/week if PCR on saliva used, 2x/week if rapid Ag tests used, cf. previous advices). Screening should be offered to all, but will be most useful in non-vaccinated individuals. <p>Contact tracing:</p> <ul style="list-style-type: none"> - Mask wearing is taken into account when evaluating close contacts 	<p>Extra-muros activities:</p> <ul style="list-style-type: none"> - Fixed groups, limited size of groups <p>Group activities at school:</p> <ul style="list-style-type: none"> - Only limited to classmates <p>Breaks (incl. lunch break):</p> <ul style="list-style-type: none"> - No mixing between groups 	<ul style="list-style-type: none"> - Masks - Restrictions on leisure student life with a lot of contacts - Decreased capacity of occupancy (x%) - If >90/80% vacc, can stay longer in yellow 	<ul style="list-style-type: none"> - Reduced capacity to x% - Extra attention to break rooms (cafeteria etc) - Fixed groups at the workplace (to limit mixing) where possible 			<ul style="list-style-type: none"> - Reduce size and/or number of activities - Fixed groups as much as possible
3	<p>Additional to measures in code yellow:</p> <p>Prevention:</p> <ul style="list-style-type: none"> - No more afterschool activities, except if adequate physical distancing and ventilation - Indoor mixing of groups to be avoided - Primary school students from 5th grade to wear masks when indoor <p>Testing:</p> <ul style="list-style-type: none"> - Repeated screening is NOT considered useful in this circumstances, as incidence is already high and testing will be of limited added value <p>Contact tracing:</p> <ul style="list-style-type: none"> - Primary school: all children of same class are considered high-risk contacts if an index case is detected 	<p>Extra-muros activities:</p> <ul style="list-style-type: none"> - Not allowed <p>Breaks (incl. lunch break):</p> <ul style="list-style-type: none"> - No mixing between groups 	<ul style="list-style-type: none"> - Decreased capacity of occupancy (y%) - No leisure activities or restriction on activities (only seated, max number per table etc.) 		<ul style="list-style-type: none"> - Avoid competitions 		
4	<p>Additional to measures in code orange:</p> <p>Prevention:</p> <ul style="list-style-type: none"> - Secondary school: 50% distance learning 	<ul style="list-style-type: none"> - Still to be defined 	<ul style="list-style-type: none"> - Still to be defined 	<ul style="list-style-type: none"> - Still to be defined 	<ul style="list-style-type: none"> - Still to be defined 	<ul style="list-style-type: none"> - Still to be defined 	<ul style="list-style-type: none"> - Still to be defined
5							

Annex 2. International academic staff and student mobility

Geert Molenberghs, Dirk Ramaekers, Pierre Van Damme, Erika Vlieghe
4 July 2021

Introduction

Over the coming summer months, towards the start of the academic year, as well as while the academic year is ongoing, various types of academic staff and student mobility will take place.

Current legislation

As announced on <https://www.info-coronavirus.be/en/news/occ-0406/>, the following regulation applies to non-residents:

BEGIN QUOTATION

2. *Arrival in Belgium as a non-resident*

- *Arrival from a green or orange zone:*
 - *No obligation to quarantine or test.*
- *Arriving from a red zone:*
 - *Those with a digital corona certificate with full vaccination (+ 2 weeks), a recent negative PCR test or recovery certificate do not need to be quarantined and do not need to be tested.*
 - *The recent test must not be older than 72 hours before arrival in Belgium.*
 - *Those without a digital corona certificate with full vaccination (+ 2 weeks), a recent negative PCR test or recovery certificate, they do need to take a PCR test day 1 or 2 and quarantine until result of the test.*
- *Arrival from outside the European Union:*
 - *Those coming from outside the European Union must be fully vaccinated (+ 2 weeks) with a vaccine recognised by Europe and take a PCR test on the day of arrival and quarantine until the result of the test.. If the test is negative, this person does not need to be quarantined.*
- *Arrival after staying in a very high risk area (“variants of concern”):*
 - *There is a ban on entry for non-Belgians who do not reside in Belgium and who have been in a very high-risk area at any time during the past 14 days. An exception is made for essential travel by transport staff and diplomats. They must undergo a 10-day mandatory quarantine with PCR testing on day 1 and day 7. The quarantine may only be interrupted for the purpose of the essential reason.*

END QUOTATION

Notes:

- (1) The above requires careful qualification, which will be done in what follows.
- (2) In the above, when arriving from a green or orange zone, the obligation to test or quarantine is waived regardless of vaccination status.
- (3) The full vaccination certificate upon vaccination with J&J is given after 4 weeks of vaccination.
- (4) A recovery certificate should not be older than 180 days.
- (5) It is important to ensure that people flying in via airports in neighboring countries follow the rules.

A key overview about travel regulations, frequently updated, can be found on [Sciensano's website](#):

It should be interpreted alongside the MB/AB of 23.06.2021.

Implications of the rules: When is incoming student mobility allowed?

The rules that apply are described in the overview at the Sciensano website **and** the fact that incoming student travel is allowed from outside of EU/Schengen/third countries, based on the exception described in the MB/AB (Bijlage/Annexe 2/10). This is regardless of vaccination status, but entry procedures are different.

The one exception is for students coming from “High risk VOC countries”. There is a ban in this case. The list of countries is updated on a bi-weekly basis. The intention is to avoid as much as possible the introduction of VOCs that have no or weak circulation in Belgium.

<https://www.info-coronavirus.be/en/countries-with-high-risk/>

An overview (the category ‘Belgian residents’ is left out because not relevant for the purpose of this document).

	Recovery/vaccination certificate	Residents EU/Schengen	Other nationalities
Coming from EU/Schengen/third: green/orange	Yes/no	No T, no Q	
Coming from EU/Schengen/third: red	Yes	No T, no Q	
	No	PCR max 72 h before arrival; – Test D1 and quarantine until result	
Coming from outside of EU/Schengen/third	Yes	PCR at arrival (Q until result)	
	No	Mandatory Q upon arrival, PCR at arrival and Day 7 (Q terminated at 2 nd negative test). [<i>This is where an exception applies for ‘other nationalities’, because student travel is considered essential in this case.</i>]	
Zones with very high VOC risk	Yes/no	No travel allowed. [<i>For this category, student mobility is not in the list of exceptions for this case.</i>]	

(Note: the third countries in the EU/Schengen categories refer, for example, to mini-states that also receive a color code.)

Conferences and academic/business meetings

In non-pandemic times, academic staff tends to take part in conferences, workshops, and other scientific meetings. The same holds for expert meetings (e.g., monitoring committees for clinical trials, consensus meetings, etc.). Virtually all of this has been suspended since the onset of the pandemic. There is a wish to resume such activities in the near future.

However, for the time being, and likely throughout the Summer and Autumn seasons 2021, as well as Winter 2021-2022, this is considered high risk and should be discouraged.

The rationale is as follows:

- Conferences and expert meetings bring together people, with unknown viral or vaccination status, from a variety of countries, often from different continents. In the current climate of very high viral circulation in at least some parts of the world, including circulation of known and potential emergence of novel variants of concern, this is classified as high risk.
- The risk is exacerbated by the fact that such meetings involve close interactions for longer periods of time.
- A very large fraction of such meetings can easily take place via online tools. Considerable expertise has been developed and routine built in this regard. While it cannot be the intention to replace face-to-face meetings by online alternatives for extended periods of time, in the coming 2021-2022 season such a substitution will be a workable alternative.

Exceptions, for EU/EEA countries that are not on the VOC list, for fully vaccinated staff:

- Meetings that cannot possibly be replaced by online activities, such as short courses and other training sessions that involve practical sessions for which there is no online alternative.
- Meetings at a regional scale, with delegates from a well circumscribed set of countries, all of which in a favorable epidemiological situation (low circulation, low VOC circulation, high vaccination rates).

The above should also apply to students coming in for summer courses.

Outgoing student and staff mobility (ERASMUS, other exchange programs, study leaves, sabbaticals,...)

For the Flemish region, a survey has been done by the VLIR secretariat, to obtain an estimate of the magnitude of outgoing student mobility. It refers to students from both universities (VLIR) and colleges (VLOHRA).

Week of departure	Total departees	Total EEA+CH+UK	TOTAL Rest of World
28/6-4/7	12	9	3
5/7-11/7	0	0	0
12/7-18/7	1	0	0
19/7-25/7	1	0	1
26/7-1/8	28	14	13

2/8-8/8	12	3	9
9/8-15/8	93	33	40
16/8-22/8	106	69	24
23/8-29/8	119	94	14
30/8-5/9	596	403	59
6/9-12/9	201	153	20
13/9-19/9	373	268	92
20/9-26/9	164	126	29
27/9-3/10	244	192	50
4/10-10/10	89	79	9
11/10-17/10	39	28	11
18/10-24/10	11	7	4
TOTAL	2089	534	100

Student mobility should be discouraged towards countries with very high circulation and/or large high risk of VOC.

For other countries, it is important that outgoing students, to a maximal extent, should be fully vaccinated before departure.

It is to be avoided that they would depart with a partial vaccination. This is especially important for mobility towards countries that do not work with the European DGC. The landscape of bilateral agreements between EU and third countries is in full evolution and should be closely monitored.

Action point: *The majority of these students and staff members will be fully vaccinated by the end of August or sooner. These students should be encouraged to subscribe on the Q-Vax list of their vaccination centre. To the extent possible (policy permitting once the minus 30 is being invited for vaccination), organize specific vaccination for such outgoing student and staff mobility - for those people wishing to be vaccinated and not already vaccinated.*

Incoming students and staff

For international students and staff that come in, attention is needed. Particular attention goes out to international study programs. In several programs, the majority of students comes from outside Belgium (EEA and beyond). Even though there are restrictions, as specified above, there will be a considerable group of students coming in.

The HEIs should take up responsibility to ensure that testing and quarantine requirements are satisfied.

For incoming non-vaccinated people, there are important additional vaccination issues:

- Incoming students may wish to be vaccinated, but may not have been offered a vaccine in their country of origin.
- Incoming students may have received partial vaccination in their country of origin, prior to traveling to Belgium. Given that the majority will be here for longer periods of time (semester,

year, multiple years), it is important to offer them completion of their vaccination or, if needed, to restart immunization with an EMA approved vaccine.

- A complicating factor will arise when a partial vaccination were done with a non-EMA approved vaccine, or with a vaccine that is (temporarily) unavailable in Belgium. This will be solved by restarting or completing immunization with an EMA approved vaccine.

Action points:

- *Uniform procedures should be put in place, ensuring to the extent possible that students/personnel in similar situations receive similar guidance, and vaccination. Foreign students that have not been vaccinated yet and stay in Belgium for more than 3 months, will be offered full vaccination starting from September onwards. The HEI will ensure that they are registered (e.g., BIS number) to allow registration in VaccinNet.*
- *There should be dedicated points of contact (e.g., one in each of the higher education systems in the country) to resolve ad hoc issues. The solutions offered should be made part of a FAQ, to ensure a uniform approach.*

Annex 3. Involvement of work in control of the pandemic and safe exit: role of committee for prevention and protection at work supported by services for Prevention and Protection at work

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Introduction

Occupational risk to SARS-CoV-2 depends on several factors including the type of industry and occupation and whether there is frequent or extended close contact with people infected (usually defined within two meters) with SARS-CoV-2. The workplace is an important place of possible infection, it is often (up to 25%) reported in the contact centre database as one of the collectivities visited by the index case.

By taking appropriate measures in the workplace, you can contain the spread of the virus through the workplace. Therefore, taking preventive measures, monitoring and adjusting is one of the most important measures a government can take in the exit strategy of the second wave and also to avoid a third wave. The committees and services for prevention and protection at work have a crucial role to play here, in order to work out the necessary safety and organizational measures at company level.

This does not require additional legislation, but the implementation of it. Consequently, the government should make full use of those existing structures and empower companies to implement them together with the committees and services for prevention and protection at work. This way you involve people and give them the opportunity to help bring the pandemic under control. This requires public health and occupational health and safety authorities to work together at both the local and national level to prevent the spread of COVID-19 in the workplace and in the general population.

About prevention and protection at work

The employer is responsible for health and safety at work and all employers must set up an internal occupational health service with one or more health and safety experts. A health and safety committee should be set up in all workplaces with at least 50 employees. This committee should work closely with the Services for Prevention and Protection at Work' (SPPW).

Services for Prevention and Protection at work are services entrusted with essentially preventive functions and can be either set up by the employer (internal SPPW) or sourced out to external SPPW. Only about 100 (large) companies have an internal SPPW, all other employers have an external SPPW (215.000 companies and 3.600.000 employees). They are responsible for advising the employer, the workers and their representatives on the requirements for establishing and maintaining a safe and healthy work environment which will facilitate optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers. Currently there are 10 External SPPW represented by Co-Prev, which is the umbrella organization to further detail and work out the action points presented here.

SPPW activities include a broad list of preventive actions such as: workplace surveys, provision of information, counselling, health examinations, risk assessment, maintenance of first-aid skills, etc. Consequently, external SPPW employ specialists from different fields: 900 prevention advisers-occupational physicians, 45 ergonomics prevention advisers, 170 prevention advisors-engineers, 135

prevention advisers-psychologists and 50 prevention advisers occupational hygiene. The responsibilities, tasks and activities are described in the Belgian occupational health and safety legislation (Codex on the Wellbeing at Work, including among others, the protection of the health of workers at work, psycho-social stress, ergonomics, hygiene at work, safety at work, ...).

Prevention during corona crisis: role of services for prevention and protection at work

During the corona crisis, Services for Prevention and Protection at Work (SPPW) have been and are playing an important role in the prevention of transmission of SARS-CoV-2 at work through testing, contact tracing, vaccination of personnel, etc. in different occupational settings (Hospitals, long-term care facilities, schools, enterprises,...). In addition they have assessed workplaces on the implementation of measures and provide advice on how to improve them. Some SPPW have also assessed the quality of mouth masks, provided advice on ventilation and provided training on workers and prevention advisors.

Another important aspect is the prevention and follow up of mental health problems both on collective and individual level. SPPW supported employers, managers and employees affiliated with them as much as possible through a permanence (by phone or mail) staffed by nurses, occupational physicians and psychosocial aspects prevention advisors (PAPA). Finally, they have provided advice on ergonomic aspects of teleworking.

Since the activities of SPPW are strictly legally prescribed during this crisis specific Royal Decrees have been negotiated among social partners and the minister of Work to allow them to carry out these additional tasks instead of carrying out other activities (e.g. periodic health follow up). For an overview we refer to: <https://werk.belgie.be/nl/themas/coronavirus>

Additional actions that taken by SPPW

Workplace preparedness should be applied to all workplaces and should address risk both during a high-risk epidemic period and during the prolonged post-lockdown periods. Disease preparedness for COVID-19 depends on the way of transmission, the prevalence of disease, and the degree of immunity in a population. Virus transmission patterns are ultimately determined by how people adhere to the hygiene recommendations.

- Involve and address committees and services for prevention and protection at work

Stimulate prevention at work through the involvement of existing prevention structures at the enterprise (committees for prevention and protection at work), stimulate social dialogue and involve actively SPPW. They can be key especially for the many SMEs in our country (not having committees for prevention and protection at work). Prevention-advisors can develop tools for risk analysis and also develop specific protocols for safe working. Communicate with these structures and have them involved, e.g. in the development of protocols, which will facilitate the later implementation in the field.

- Provision of risk assessments and preventive measures

It is essential that employers and companies develop and dispose of an Infectious Disease Risk analysis and prevention strategy that parallels the sector protocols and government's pandemic planning. The Codex on the Wellbeing at Work requires the involvement of the prevention advisor - occupational physician in a risk analysis concerning the employees' risks of exposure to biological agents (like a virus). The employer also has to involve the Health and Safety Committee of the enterprise as to the measures taken. This is an ongoing process which needs to be adapted to changing circumstances. Collective measures always take priority over individual measures.

SPPW provides advice on this specific risk analysis. SPPW have developed model (self)assessments with accompanying text. Finally, SPPW provides advice and has developed assessment tools and online trainings around telework for employees and employers: How to start telework? How can supervisors coach their employees remotely? Workplace setup,....

- **Development, validation and implementation of sector protocols and adopt at company level**

SPPW can revise and provide technical and expert advice on these protocols. SPPW can play a key role in the implementation of these protocols. Hence, SPPW during workplace visits can support employers with the correct implementation and also help them with the translation of these general guidelines into concrete measures at the workplace. During the exit strategy it is to be expected that a certain sequence of reopening of professions will be followed. SPPW could then assess and support a random sample (or upon indication) of enterprises before and during the first weeks of re-opening of the sector. They can provide online training to employers and workers.

- **Control measures**

Committees for prevention and protection at work supported by the SPPW should develop and implement control measures at the workplace such as:

a) Engineering controls that reduce employee exposure to work-related hazards, such as increasing ventilation rates in the work environment, CO₂ measurements and/or installing physical barriers.

b) Administrative controls that change work policies, such as minimizing contact among workers, clients, and customers by replacing face-to-face meetings with virtual meetings, or implementing rotation of days of work in a team/workplace.

Promoting Safe work practices are part of administrative controls and include measures such as encouraging thorough hand washing. Implementing basic Infection Prevention Measures is a key component of pandemic planning and preparation. Face masks should be provided to employees and customers, and regular training on how to use PPE should be done. Policies and practices should be established to increase the physical distance among employees, including flexible worksites (e.g., telework) and flexible work hours. While the correct use of PPE can help prevent some exposures, it should not substitute other prevention strategies. Appropriate training, education, and informational materials should be provided: informed workers who feel safe at work are more likely to adhere to recommended best practices.

- **Telework**

Telework at home is a general rule for all companies, organizations and services for every workplace where this is possible. Where it is not possible to introduce telework, a corona health and safety risk assessment should be carried out by the employer after which appropriate preventive measures should be implemented in order to guarantee safe working. It is important to mention that social partners launched explicitly a call to maximally implement telework and facilitate the implementation (https://werk.belgie.be/sites/default/files/content/documents/Welzijn%20op%20het%20werk/Adviezen%20Hoge%20Raad/OproepSocialePartnersHRPBW_telethuiswerk_def.pdf). Moreover, social partners in the National Labour Council have developed a framework for telework in the context of this COVID-19 pandemic. The resulting CLA no.149 concerning recommended or compulsory telework because of the coronas crisis has just been published (26 January 2021) on the NAR website. It is an ad hoc CLA that is applicable during this COVID-19 crisis (for the year 2021).

- **Enforcement on quarantine and isolation**

Quarantine measures and isolation measures need to be correctly followed. One needs to be aware that quarantine certificates issued by call centers or general practitioners for high risk contacts are not always delivered to the employer by the employee. Hence, the employee sometimes fears temporary unemployment, is afraid of the employer's reaction,...

In contrast, occupational physicians who certify quarantine for high risk contacts in a company as a result of contact with an index patient of the company, also send a copy of the certificate to the employer to guarantee that quarantine or telework is implemented. These measures and follow-up of the quarantine is very important to limit the transmission at work during the quarantine period. Hence, high risk contacts are tested in the majority of cases (80% underwent testing in the first week), and when positive they in turn become index patients, which is the case in about 1 in 4 workers. A sickness certificate issued by the GP sometimes causes the same problem. Consequently, one should develop a follow-up procedure to guarantee that quarantine certificates reach the employer, so that the employer can enforce quarantine or telework.

- **Vaccination**

SPPW has been involved in the vaccination of workers of long-term care facilities and hospitals. They organize the planning, place the vaccine, register correctly in the medical file and vaccinet, which allows a correct follow-up. SPPW dispose of the necessary structure and strict control process and procedures for vaccination requiring a cold chain and have a large experience with vaccination campaigns e.g. hepatitis A&B and flu, also during pandemics such as the Mexican flu some time ago.

An important asset that studies have shown is that vaccination through SPWW can dramatically increase the vaccination coverage, hence the vaccine is brought to the worker at his/her workplace. Consequently, one could consider organizing vaccination campaigns in big enterprises through SPPW.

SPPW can play an important role to raise employee awareness of the importance of vaccinating many communication tools already exist in this regard. A list of possible actions are available in (<https://www.sciencedirect.com/science/article/pii/S0264410X18305395?via%3Dihub>; <https://www.sciencedirect.com/science/article/pii/S0264410X20301560?via%3Dihub>; [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(87\)90971-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(87)90971-8/fulltext)).

Consequently, booster vaccination and follow-up for workers with a professional risk on covid-19 are best vaccinated through the SPPW. In addition, SPPW are vaccinating against the flu. It is important that for the winter season 2021-2022 that this vaccination program can run normally to guarantee high vaccination coverage in the working population.

- **Communication, information and training**

SPPW plays a key role in the information campaigns to reach out to different working populations. A campaign could be set up with information about how the virus spreads easily at work. Currently instructions are only focused on what one should not do, however it is also important to explain what can and must be done: e.g. how to wear a mask very correctly SPPW can make general advice and guidelines more concrete for the specific setting: e.g. the catering guide mentions 'complete cleaning and disinfection'. SPPW could make that concrete by explaining how this can be done and with which products. Thus, SPPW expertise can make the instructions of guides much more concrete for the employer, workers and especially for the clients of the employers. This can also include training on communication e.g. on how do I tell a visitor as an employee to wear a mask?

In corona times, we cannot forget the non-native workers and specific instruction movies tailored to various sectors could be developed by and spread through SPPW channels such as: cleaning in coronation times, working in agriculture and horticulture in coronation times, working in construction in 'corona' times, working in the hospitality industry in off-peak times.

The External Services for Prevention and Protection at Work send, both during this period and before, specific mailings to their clients (by sector, by target group (e.g. Employers, Managers, Confidential Advisors, ...)) with a preventive offer on themes such as "fear, resilience, how to strengthen your team, telework, ..." This in the form of training courses/webinars, awareness campaigns (flyers and brochures).

- **Contact tracing and testing**

For contact tracing, COVID-19 positive tested employees are reported to the SPWW as from Summer 2020. Of these index cases contact tracing by SPPW is performed of high- and low-risk contact within the company. Subsequently, appropriate measures (including testing) are taken within the company and by high risk contacts to limit spread of the infection (see also higher).

Concerning testing, we refer to the RAG advice and also to the Co-Prev document about the self-test strategies in companies. In that report, the use of rapid antigen and selftests are proposed for screening COVID-19-positive workers and high-risk contacts in corporate clusters and for broader screening purposes. Such tests could provide useful epidemiological information and improve the rapid isolation of positive workers in confirmed clusters. In this context, these tests can also be taken in low risk contacts. It remains important to stress that occupational health physician are responsible for the follow-up of workers and assess biological risks and safe working.

In this context, occupational medicine play a role in source testing. Hence, novel non-invasive tests have come in the market. Rapid antigen testing, self-test and saliva testing (PCR test) are being implemented in screening programs in companies/institutions/schools under the supervision and responsibility of occupational health physicians. This could be important in specific phases of the

pandemic for specific work setting e.g. in order to keep schools open, non-medical contact professions. However, one needs to discuss this and work it out with the sector. To make practical, organizational, financial arrangements. Finally, it is important to reiterate that testing is part of a broader strategy to control the pandemic and does not replace the need to isolate positive cases or to identify and quarantine high-risk contacts.

- **Monitoring and reporting**

To assess the COVID-19 incidence per economic activity in Belgium, we monitor 2-weekly the 14-day incidence of confirmed COVID-19 cases per NACE-BEL code, and is evaluated longitudinally by a Gaussian-Gaussian modelling two-stage approach. Additionally, the number of high-risk contacts in working segments and regions is described for companies affiliated with IDEWE. COVID-19 positive tested employees are reported to IDEWE starting from 22 July 2020. Of these index cases, contact tracing is performed of high and low-risk contact within. Index cases are asked about the work relatedness of their infection. Both analyses are 2-weekly generated and reported through the GEMS and can be found on the GEMS webpage.

- **Mental health**

The COVID-19 pandemic has a serious impact on the psycho-social functioning of the entire population. Major changes at work are imposing themselves (e.g. teleworking, combination of family and work, temporary unemployment, increased stress at work in essential sectors,...) and are contributing to an increased well-being of employees in all sectors. Since employees with psychological difficulties often cannot find help themselves, it is important, on the one hand, to screen for people with difficulties (preventive) and, on the other hand, to quickly find an appropriate solution for people or teams with difficulties (curative, depending on the nature of the problem).

The first priority of the EDPBW is the collective approach, on a preventive level. This prevention can be situated on 3 levels. Primary prevention: outlining a welfare policy within organizations, based on the Dynamic Risk Management System (DRBS), via the methodology of a Risk Inventory and Evaluation (RIE). Some SPPW developed corona barometers at work to gain an insight into the mental health of employees within the work context. Through a short and scientifically designed survey, the employer and supervisors get an idea of the consequences of the corona crisis on the mental health of the employees. Through this analysis SPPW can figure out what their needs are so that the employer can define possible actions. Secondary prevention includes providing procedures in case of psychosocial risks and psychosocial incidents. Finally, tertiary prevention helps and directs workers with psychosocial complaints to the various appropriate channels available outside the organization (so also to specialized help if necessary) . More emphasis by SPPW is currently placed on "mental support" of workers and permanence, triage and referral system is now set up that will be operated by PAPAs.

During, but also before the Corona period, most EDPBWs therefore have a preventive offer (both primary and secondary prevention) in terms of psychosocial assistance, which may include: risk analysis psychosocial aspects specifically Corona-focused or not; coaching of the hierarchical line; supervision of the hierarchical line, but also of the fiduciaries; how to (re)connect with your team, after corona, after the x-th wave ?; how to strengthen the resilience of your team ?

- **Re-integration**

With the rise of long-term sickness absence, it is clear that occupational health physicians play a key role in the re-integration of sick listed people, but also of teleworkers that have not been to the workplace since the start of the crisis. A fast referral by general practitioners to the occupational health physicians during the first 3 months of sickness absence has been shown to be key in successful re-integration and to prevent long-term absence from work. This is certainly important also for the workers dealing with long covid-19 syndrome

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Annex 4. Co-Prev stappenplan zelftesten binnen arbeidsrelatie

18 mei 2021

Finaal voorstel vanuit de sector; goedgekeurd door alle vertegenwoordigers van de EDPB in de Commissie medisch toezicht van 18 mei 2021.

Dit stappenplan gaat **niet** over zelftesten die buiten de arbeidsrelatie uitgevoerd worden. Zelftesten aangekocht door de werkgever op eigen initiatief en ter beschikking gesteld van werknemers om in de privésfeer uit te voeren en waarvan positieve resultaten gemeld moeten worden aan de huisarts, maken geen deel uit van deze nota.

1. Basisvoorwaarden

Het beperken van het risico op Covid-19 besmettingen vereist een bredere preventiestrategie.

- Het toepassen van de algemene preventiemaatregelen blijft van essentieel belang (afstand houden, dragen van mondmasker, ...)
- In het belang van de organisatie én de maatschappij is er een strategie nodig om snel en correct te handelen wanneer er covid19-besmettingen bij het personeel vastgesteld worden. Dit omhelst een plan met betrekking tot testen, contact tracing, quarantaine-maatregelen, ...

Wat de concrete teststrategie betreft, die dus een onderdeel is van die bredere preventiestrategie, zijn volgende zaken van belang:

- De arbeidsarts is de coördinator van de teststrategie.
- Een werknemer kan nooit verplicht worden zich te laten testen. Daarom is het van groot belang om het doel van de tests adequaat toe te lichten
- Werknemers instrueren over correcte afname van de testen en wat te doen met het testresultaat
- Welke test ook gebruikt wordt, degene die de test afneemt geeft de positieve resultaten steeds door aan de arbeidsarts. Hij/zij zal u verder helpen en staan in voor de algemene coördinatie (correcte opvolging van testresultaat, tracing, quarantaineattesten, administratie).
- De resultaten van (zelf)sneltesten kunnen nooit gebruikt worden om de standaard preventiemaatregelen/quarantainemaatregelen niet te moeten naleven.

2. Coördinatie van teststrategie

Dit gebeurt door de arbeidsarts, in nauw overleg met de werkgever en het Comité voor Preventie en Bescherming op het Werk.

De indicatie om preventief repetitief te screenen is een beslissing van de arbeidsarts, op basis van

- profiel van de onderneming en sector en/of
- aard van de activiteiten en werkomstandigheden en/of
- verhoogde incidentie in de regio

De arbeidsarts voert de risicoanalyse uit en stuurt op basis hiervan desgevallend de preventiestrategie bij. Hij/zij bepaalt vervolgens waar zelftesten een plaats kunnen hebben in de teststrategie:

- Doelgroep:
 - werknemers met verhoogd risico op besmetting door de aard van de activiteiten
 - rekening houdend met niet of onvolledig gevaccineerde werknemers
- Soort test: enkel door FAGG goedgekeurde testen kunnen gebruikt worden
- Frequentie van test
- Afname thuis of op het werk
- Duur
-

Testresultaten zijn gezondheidsgegevens die door alle betrokkenen EN op elk moment vertrouwelijk moeten behandeld worden.

Covid-coaches zijn interne personen binnen de onderneming, die in overleg met de arbeidsarts en zijn/haar medewerker, meehelpen om teststrategie uit te rollen. De arbeidsarts coördineert. De coach is het intern aanspreekpunt voor alle Covid-gerelateerde maatregelen en vragen, ook de vragen over de teststrategie.

3. Taken en bevoegdheden van Covid- coach

Algemene principes

- Het is de arbeidsarts die beslist of er nood is aan /een toegevoegde waarde is voor het aanstellen van een Covid coach.
- De werknemer kan zelf vrijwillig beslissen of hij/zij wel of geen beroep doet op de Covid-coach.
- Het instellen van een Covid coach is tijdelijk. Het is een middel om allen samen de verspreiding van het coronavirus in de onderneming te beperken. Het gaat om een tijdelijke toekenning van deze bijkomende taken met name in het kader van de bestrijding van de coronapandemie op het werk. De functie van Covid coach zal worden opgeheven op het moment dat de pandemie afneemt en voldoende onder controle is; net zoals dit geval is voor een aantal bijkomende, specifieke taken die in het KB van 5/1/21 toegewezen worden aan de arbeidsarts om de coronapandemie zo efficiënt mogelijk te kunnen bestrijden op de werkvloer.

Taken van Covid-coaches

- Intern het eerste aanspreekpunt zijn. Bij problemen wordt overlegd met de arbeidsarts/verpleegkundige van de (externe) preventiedienst.
- Opleiden van de werknemers: hoe voer ik een zelftest correct uit.
- Advies rond organisatie en logistiek en meewerken aan de praktische organisatie wanneer werknemers zichzelf testen op het werk.
- Staat in voor het afvalbeheer bij testing op het werk.
- Ontvanger en beheerder van de stock zelfsneltesten in het bedrijf
 - Inventaris zelfsneltesten bijhouden
- Verantwoordelijk voor naleven van de interne procedure rond testing die door de arbeidsarts opgemaakt werd.
- Informeren en sensibiliseren van de werknemers rond testing maar ook rond algemene preventie maatregelen en het blijvend respecteren ervan zelfs bij negatieve testresultaten.
- Alleen op vraag van werknemers hen begeleiden bij het uitvoeren van zelftesten.

Wat doet een Covid-coach énkél op vraag van een collega

- Superviseren van test bij collega
- Testresultaten ontvangen

Wat doet een Covid-coach NIET

- Test uitvoeren bij collega
- Testresultaten verzamelen en bijhouden
- Taken overnemen van de arbeidsarts zoals quarantaineattesten verstrekken, verdere testen voorschrijven
- Enige vorm van druk uitoefenen op collega's om zich te laten testen. Het blijft een vrijwillige test.

Bevoegdheden

- Aanspreekpunt voor de werkgever voor vragen rond zelftesting
- Contactpersoon voor de werknemers voor hun vragen
 - Ik test positief: wat moet ik doen?
 - Het testresultaat is onduidelijk: wat moet ik doen?
 - Het testresultaat is negatief: wat mag ik doen?
- Liaison tussen bedrijf en arbeidsarts (of bedrijfsverpleegkundige)
 - Verzamelt en stelt vragen aan de arbeidsarts
 - Geeft regelmatig feedback aan arbeidsarts: wat loopt goed, wat loopt minder goed
 - Zorgt er voor dat snelle melding van positieve testresultaten aan de arbeidsarts mogelijk is
 - met bewaken van confidentialiteit
 - maximaal direct contact tussen werknemer en arbeidsarts. Beschikbaar stellen aan alle werknemers van contactgegevens van arbeidsarts is belangrijk.

Voorwaarden om Covid- coach te kunnen worden

Het is belangrijk dat de Covid-coach gemakkelijk bereikbaar is, vertrouwen heeft en een breed draagvlak binnen de onderneming heeft.

- Achtergrond
 - Verpleegkundige
 - Bedrijfs hulpverlener
 - Interne Preventieadviseur
 - Vertrouwenspersoon
- Opleiding
 - Er moet een opleidingsmoment vanuit de Externe Diensten georganiseerd worden voor deze coaches om dit stappenplan toe te lichten (met schriftelijk bewijs).
 - Hoe zelftesten gebruiken?
 - Privacy van de werknemers?
 - Testen is vrijwillig

- Testresultaten zijn gezondheidsgegevens en moeten in principe door de werknemer zelf doorgegeven worden aan de arbeidsarts. Testresultaten mogen nooit doorgegeven worden aan de werkgever.
 - Plaats: in bedrijf of thuis
 - Hoe resultaat interpreteren
 - Wat doen met een positief resultaat?
 - Wat doet arbeidsarts na een positief resultaat?
 - Bij nieuwe ontwikkelingen moet de Covid- coach proactief op de hoogte gebracht worden door de Externe Dienst
- Tijdsbesteding
 - De coach moet voldoende tijd krijgen om zijn taken behoorlijk te kunnen vervullen.
- Faciliteiten
 - Bij zelftesting op het werk moet hiervoor een goed verluchte ruimte voorzien worden met stoel en tafel. De ruimte moet de privacy van de werknemers respecteren (naar analogie met een EHBO-lokaal).
 - De nodige middelen voor correct stockeren en bewaren (temperatuur) van testkits
- Onafhankelijkheid
 - De coach werkt zelfstandig en onafhankelijk.
 - Testing op het werk gebeurt niet onder supervisie van de werkgever of HR, wél onder supervisie van de arbeidsarts

Taken Externe Dienst

- Duidelijk contactpunt: centraal telefoonnummer, e-mail
- Opleiding coaches
- Schriftelijke instructies en procedures (weblink)
- Primair aanspreekpunt voor de coaches
- Coördinatie teststrategie
- Contact tracing
- Ontvangen positieve testresultaten. Het melden van positieve testresultaten moet
 - eenvoudig zijn
 - door de werknemer zelf kunnen gebeuren, onafhankelijk van werkgever
 - resulteren in snelle opvolging van deze resultaten door de arbeidsarts