

COOPERATIVE ARRANGEMENT FOR PREVENTING THE SPREAD OF COMMUNICABLE DISEASES THROUGH AIR TRAVEL (CAPSCA)

2nd Meeting of the Regional Aviation Medicine Team 12 September 2008

Conclusions

The Regional Aviation Medicine Team (RAMT) is the technical arm of CAPSCA. The second RAMT was hosted by the ICAO Regional Office, Bangkok, Thailand on 12 September 2008.

There were 41 participants from Australia, Brunei Darussalam, China, Hong Kong – China, Macao – China, Japan, Malaysia, Nepal, New Zealand, Philippines, Singapore, South Africa, Thailand, United Kingdom and United States of America. There was an observer from Canada.

The following Airlines were represented: AirAsia, Bangkok Airways, Cathay Pacific, Malaysian Airlines and Thai Airways International.

The following International Organizations were also represented: Airports Council International (ACI), US Centers for Disease Control and Prevention (CDC), European Civil Aviation Conference (ECAC), International Air Transport Association (IATA), UN System Influenza Coordination (UNSIC), the World Health Organization (WHO) and ICAO.

The RAMT was provided with presentations from CDC, WHO, IATA and the Civil Aviation Safety Authority of Australia, for which it expressed its appreciation.

The RAMT came to the following conclusions:

1. A number of screening methods are available for the health screening of passengers for infectious disease of public health concern. There is currently no single screening measure that provides the requisite sensitivity and specificity and a combination of measures may be required depending upon the prevailing situation.
2. The act of screening is intended to narrow down the number of passengers that may require secondary and possibly tertiary screening. Screening should not, as far as possible, prevent the flow of passengers and cargo through an airport.
3. States should be cognizant of the fact that the quarantine of large numbers of airline passengers is unlikely to be justified, is not practical and may be difficult to implement. After the acute phase, it is also not likely to prevent, in any significant way, the spread of a pandemic by aviation.
4. It is recognized that it may not be possible for States to completely prevent the spread of an evolving pandemic. However, with the appropriate measures, it may be possible to delay and mitigate the effects of such an emerging pandemic. The production of the relevant vaccine remains the best chance to mitigate the high morbidity and mortality usually associated with a pandemic.
5. The use of prophylactic anti-virals by flight and cabin crew is not routinely recommended. Should an airline wish to advocate the use of anti-virals by its flight and cabin crew, due consideration should be given to the side effects of these, including the cognitive and

behavioural side effects that have been reported. There will also be a limited stock of anti-virals and a State's prioritization of the use of such a limited stock of anti-virals would be another consideration.

6. Vaccination against seasonal influenza of airline crew and other front line staff in the aviation sector is strongly recommended.
7. The aviation sector within a State should work in concert with national State authorities to implement the WHO International Health Regulations (IHRs) and ICAO Annex 9, as soon as possible, if this has not already been done. In particular, the transport sector's coordination with the public health sector is vital.
(Secretariat note – Changes to ICAO Annexes 11 (Air Traffic Services) concerning notification of public health authorities of a suspected case on board an inbound aircraft, and Annex 14 (Aerodromes) concerning the inclusion of public health emergencies in an airport emergency plan are currently under development by ICAO.)
8. The IHR implementation at airports will serve to contain known public health risks, detect relevant health events and ensure the appropriate response to public health emergencies.
9. States are encouraged to subscribe to and when required, implement the WHO Rapid Containment Plan for dealing with the initial emergence of a cluster of human cases affected by a novel influenza virus. Although the Rapid Containment Plan may not prevent the spread of disease, it should slow the spread of the virus, enabling time for vaccine development.
10. States should, as part of their Pandemic Preparedness plan, develop business continuity models and put in place a clear risk communication coordination strategy. This should prevail at the local, national and international levels. The plan should allow for flexibility in line with the prevailing situation.
11. With reference to Risk Communication, the traveller should be part of the process.
12. There is no evidence to support the cleaning and/or disinfecting of baggage including items arriving from areas where avian influenza has been reported. This would include the checked-in bags of a suspect case of communicable disease on board a flight.
13. Hand carried cabin baggage and personal belongings of a case of suspected communicable disease on board a flight should follow the passenger, and be placed in a biohazard bag, if deemed necessary.
14. Based upon the available evidence, it was accepted that, upon the identification of a case of a suspected communicable disease on board an aircraft in flight, the passengers seated in the same row and two rows in front and behind, in addition to any other close contact, should be designated as "contact" cases for the purpose of contact tracing and appropriate public health measures on arrival and/or the presentation of health information.
15. The use of remote stands at airports for aircraft arriving with case/s of suspect infectious disease on board in flight, is not recommended. Such aircraft should be parked at stands which would have all the relevant facilities, enable continued ventilation of the aircraft, allow easy accessibility to public health personnel to assess any suspect case(s) and permit efficient clearance of the passengers.

16. There is no evidence to indicate that the use of disinfectant mats at airports, for arriving passengers to step on, is relevant for events relating to transmission of human disease.
17. The IHRs (Annex 1B) clarifies the core capacity requirements pertaining to transport facilities needed to manage public health emergencies. This applies to the designation of ambulances for the transport of cases of infectious disease from a flight.
18. Further research is encouraged to improve the evidence base concerning public health issues related to air transport.