Third CAPSCA-Asia Pacific Regional Aviation Medicine Team Meeting

3-4 September 2009

The third CAPSCA-Asia Pacific Regional Aviation Medicine team meeting held at the ICAO Regional Office, Bangkok, on 3-4 September 2009 was attended by 35 participants from 10 States and 6 International Organizations

Following the opening remarks and introductions, the terms of reference, as established by the CAPSCA-Asia Pacific Steering Committee, were reviewed. This was followed by presentations from the World Health Organization (WHO), Airports Council International (ACI) and International Civil Aviation Organization (ICAO). The meeting considered a number of specific items from the ICAO Guidelines for States, airport and aircraft operators and made adjustments as necessary, to be incorporated into the guidelines. The complete list of recommendations is in Appendix A.

The value of airport screening was considered. The representative from Thailand provided some statistics concerning the value of thermal scanners as follows:

Thermal scanners were in use from 26 April 2009. During the first month 1.6 million passengers were screened and on average three passengers per day were found to have a temperature of more than 38C. Of these, two in a month were confirmed positive for Influenza a (H1N1).

The representative from Malaysia reported that from 27 April to 9 July 2009 1.4 million passengers were screened by thermal scanning and 243 were confirmed positive for Influenza A (H1N1).

It was agreed that additional research concerning the reasons why airport screening had been undertaken by States, and the results of such research, during the current Influenza A (H1N1) pandemic would be valuable.

Business Continuity Planning during a pandemic that results in high absenteeism rates was regarded as an important aspect of preparedness planning and one which the RAMT felt deserved further emphasis. It recommended that further work be undertaken in this area.

The Health Declaration Card (HDC) proposed by the International Air Transport Association (IATA) to assist in standardizing such forms was discussed. It was confirmed that the Public Health Passenger

Locator Card (PLC) was available in six languages and was posted on the websites of WHO, ICAO and IATA. The Health Declaration Card was, for the moment, only available in English, on the website of IATA. There is a link to this site on the ICAO website. The RAMT was of the view that a standardized PLC and HDC, using both sides of one sheet of paper, would be of value. It was recognized that an aircraft arriving with a suspected case of communicable disease on board may not need to have the PLC completed by all travellers on board, whereas the HDC may be required from everyone. A number of technical points were brought up concerning both the PLC and HDC which may improve the content of the forms, which will be further considered.

The proposal to have an annual 'global RAMT' meeting was agreed in principle, commencing in 2010. This could take the form of an enhanced regional RAMT in one of the three CAPSCA regions, but would be expanded to include representatives from the other two CASPCA regions. The venue would change each year so that each region hosted it every three years.

Appendix A – Discussion concerning items from the ICAO preparedness guidelines for States, Airports and Airlines: final agreed text

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. Further research is recommended to determine effectiveness

2. The act of screening is intended to detect passengers that may require secondary and possibly tertiary screening. Screening should not, as far as possible, impede 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 morbidity and mortality usually associated with a pandemic.

5. Consideration of the use of prophylactic antivirals by aircrew should be based on any general recommendation for their use by WHO. Normal precautions concerning the use of medication by aircrew should be taken.

6. Vaccination against seasonal influenza of airline crew and other front line staff in the aviation sector is recommended. Operationally critical staff in the aviation sector should be considered in the State's determination of priority for vaccination against any specific emerging disease of pandemic potential.

7. The aviation sector within a State should work in concert with national State authorities to implement the WHO International Health Regulations (IHRs) and relevant aspects of ICAO Annex 9, as soon as possible, if this has not already been done.

(Secretariat note – Changes to ICAO Procedures for Air Navigation Services – Air Traffic Management, concerning notification of public health authorities of a suspected case on board an inbound aircraft, and to ICAO Annexes 11 (Air Traffic Services), and Annex 14 (Aerodromes) concerning the inclusion of public health emergencies in an airport emergency plan will be implemented in November 2009).

8. Additional consultation between the public health and other sectors, including the aviation sector, to facilitate preparedness and the effective implementation of public health measures, is recommended.

9. 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.

10. States are encouraged to subscribe to and when required, implement the IHR contingency plan, which contains 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 countermeasures to be developed including vaccine production.

11. States should, as part of their pandemic preparedness plan, develop business continuity models and put in place a clear risk communication and coordination strategy. This should prevail at the local, national and international levels. The plan should allow for flexibility in line with the prevailing situation.

12. With reference to preparedness planning, a ‘whole of society’ approach should be adopted, with special emphasis on communication to travellers and the general public.

13. There is no evidence to support the cleaning and/or disinfecting of baggage including items arriving from areas where influenza has been reported. This would include the checked bags of a suspect case of communicable disease on board a flight.

14. Hand carried cabin baggage and personal belongings of a case of suspected communicable disease on board a flight should follow the passenger, and normal hygiene measures adopted.

15. 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.

Note 1: This recommendation may be adjusted depending on specific circumstances e.g. very large or small aircraft.

Note 2: Crew members would not normally considered close contacts of an index case. However, in special circumstances, such as cabin-crew member designated to look after an ill passengers who is subsequently found to have infectious or potentially infectious illness, public health authorities may consider the cabin-crew member(s) to be close contacts [Editorial note – Note 2 was adjusted as shown after the meeting at the request of WHO, to bring it more into line with the WHO Tuberculosis and Air Travel Guidelines]

16. The use of remote stands at airports for aircraft arriving with case/s of suspect infectious disease on board in flight, is not necessary for public health reasons. 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.

17. 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.

18. 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.

19. Further research is encouraged to improve the evidence base concerning public health issues related to air transport e.g. concerning the mechanisms for transmission of disease on board aircraft.

20. In-flight illness

Note 1 A State may request information from an airline relating to the traveller's destination

(so that the passenger can be contacted) and information concerning the traveller's itinerary. The public health authority (or other 'competent authority') will coordinate any necessary contact tracing of those potentially exposed to communicable disease of pandemic potential. Aircraft operators should cooperate with the relevant authority to promptly supply all available information needed to contact passengers who are likely to have been exposed, so that they may provide the contacts with appropriate information and guidance. To facilitate the timely release of such information the State should submit a written request, including a reference to the appropriate legislation under which the request is made.

[Editorial Note – On review of the ICAO Guidelines to States it was found that the information concerning contact tracing was already mentioned in Note 1 to the same paragraph. On discussion with WHO, it was decided to adjust Note 1, as above, rather than add Note 3]