GM 6-10



# CIVIL AVIATION AUTHORITY OF BANGLADESH

# FLIGHT AND CABIN CREW TRAINING ON MANAGEMENT OF PUBLIC HEALTH EMERGENCY ON BOARD AIRCRAFT

PART-2

Version 2.0 01 Aug 2018

CAAB HQ, Kurmitola, Dhaka 1229

Bangladesh

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#### **RECORD OF AMENDMENTS**

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## FOREWORD

This Guidance Material (GM 6-10) on "Flight and Cabin Crew Training on Management of Public Health Emergency on board aircraft" provides guidelines for developing and implementing training programme for flight and cabin crew of air operators to evaluate and management of a suspected case of communicable disease on board aircraft. All air operators are required by regulations to impart subject training for both flight and cabin crew.

To mitigate the sufferings of the travellers, the crew members must handle communicable diseases during Public Health Emergency of International Concern (PHEIC) in a most efficient way. To comply with ICAO requirements for protocol questions on public health emergencies and as per the conclusion of 8<sup>th</sup> CAPSCA Asia Pacific and 6<sup>th</sup> CAPSCA Global Coordination Meeting held in Bangkok, Thailand, it is an obligation for Civil Aviation Authorities to ensure regulation and oversight aircraft operators training of flight and cabin crew in Public Health Emergency (PHE) management on board aircraft. With this view Civil Aviation Authority of Bangladesh amended and updated this Guidance material as version 2.0, part-2 of "Flight and Cabin Crew Training on public health emergency management on board aircraft in the line with WHO guide to hygiene and sanitation in aviation", ICAO, IATA and ACI guidelines for management of communicable diseases in flight. This is a guidance material for both the cockpit and cabin crew which will help them to properly handle the suspected cases of communicable diseases through air travel; and ensure the availability, continuity and sustainability of critical air transport services.

In pursuance of the powers conferred upon the Chairman, Civil Aviation Authority of Bangladesh vide rule 214 of CAR 84, the Chairman is pleased to approve this new version of "flight and cabin crew training on public health emergency management on board aircraft".

This supersedes version 1.0 dated 14 May 2017 of Air Operator Guidance (AOG 6-10) and shall take effect from 01 Aug 2018, the date of approval of the Chairman.

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Air Vice Marshal M Naim Hassan, BBP, OSP, afwc, psc

Chairman

Civil Aviation Authority of Bangladesh

Date: 🔨 Aug 2018

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# CHAPTER 1

# CAPSCA (Collaborative Arrangement for the Prevention and Management of Public Health events in Civil Aviation)

#### 1.1 Introduction

CAPSCA is an International Civil Aviation Organization (ICAO) global programme to improve preparedness planning and response to public health events that affect the aviation sector such as an influenza pandemic, a nuclear power plant accident etc. In October 2010 the ICAO Assembly adopted a resolution that urges States to join CAPSCA. Public Health events are often multi sectoral and often International in nature, and therefore be managed at several different levels (national, regional and global). Initially when the capsca was established in 2006, it was named as-

**CAPSCA** -Cooperative arrangement for the prevention of spread of communicable diseases through air travel.

Later on in 2010, ICAO renamed CAPSCA as follows-

**CAPSCA** – Collaborative arrangement for the prevention and management of public health events in civil aviation

#### 1.2 Aim of CAPSCA

The aim of establishing CAPSCA project is to foster development of communication links and collaborative partnership between public health and aviation sector. Its aim is to address all types of public health events and not only the communicable diseases.

#### 1.3 Objectives of CAPSCA

- It provides Public health protection for general public, air travelers and aviation personnel.
- Assist states to establish national aviation pandemic preparedness plan and Adherence to Article 14 of Chicago Convention, 1944.
- Compliance with health related ICAO SARPS(Annexes 6, 9, 11, and 14) and procedures of air navigation services / air traffic Management (PANS ATM, Doc 4444).
- Compliance with International Health Regulations (2005).
- Implementation of ICAO, WHO, ACI and IATA guidelines.

To develop Cooperation amongst civil aviation authorities, public health authorities, airports, air traffic services and airlines.

- To make regional cooperation amongst states by sharing expertise and resources.
- Development of core capacities at the airports and advice states and territories accordingly.
- CAPSCA conducts assistance visit to states and designated international airports to improve their preparedness for the prevention of public health threats.
- It also organizes regional meetings / training events / seminer & workshop.

#### **1.4. Background of CAPSCA establishment:**

CAPSCA came into being after the occurrence of some epidemic and pandemic communicable diseases which seriously affected the human as well as the birds and the poultry.

#### **1.5 CAPSCA Regional Project:** At present CAPSCA is having 5 regional projects:



#### **1.6 CAPSCA** Partner Organization:

ICAO	- International Civil Aviation Organization
UNCFIA	- United Nations Central Fund for Influenza action.
IOM	- International Organization for Migration
OIM	- Offshore International Management
ACI	- Airports Council International.
IATA	-International Air Transport Association.
CDC	- Communicable Disease Control and Prevention
UNWTO	- United Nations World Tourism Organization.

WFP - World Food Program

#### 1.7 ICAO CAPSCA Global Organisation



#### 1.8 CAPSCA ASIA/PACIFIC Regional Organisation



#### **1.9 CAPSCA Asia Pacific Member States**

CAPSCA Asia	Pacific Membe	rship 😻
Afghanistan	Malaysia	Singapore
Brunei Darussalam	Myanmar	Solomon Islands
China	Mongolia	Sri Lanka
Hong Kong, China	Nepal	Thailand
India	New Zealand	+ Tonga
Indonesia	Papua New Guinea	★ Viet Nam
Macao, China	Philippines	Bangladesh
Lao PDR	Pakistan	

#### **1.10 WHY CAPSCA was formed by ICAO?**

- CAPSCA was formed with the aim to reduce rapid dissemination of communicable diseases through air travel.
- Public health emergencies pose a substantial economic impact to a country which needs interference.
- To mitigate human sufferings emergency preparedness was essential
- Article 14 of Chicago convention states the prevention of spread of communicable diseases by air transport.
- ICAO established CAPSCA in 2006 to assist states with the major challenges of multi sectoral collaboration.

# CHAPTER 2 Communicable Disease Outbreak

Communicable disease persists to be one of the topmost public health precedence both nationally and internationally. In the recent past many dreadful communicable diseases outbreak occurred in the world, many of which also had an effect on Bangladesh. Bangladesh due to its climatic change and prevalence of mosquitoes and flies has an impact of communicable disease on human health. The communicable diseases outbreak that came into being since 2003 have been discussed below in brief:

#### 2.1 Severe Acute Respiratory Syndrome (SARS)

- 2.1.1 In 2003 the severe acute respiratory syndrome (SARS) affected Hong Kong. It is a Zoonotic origin virus carried by palm civets.
- 2.1.2 In this outbreak 775 death occurred out of 8273 cases
- 2.1.3 Within weeks, the disease spreads from Hong Kong to 37 other countries in early 2003.
- 2.1.4 Signs /Symptoms of SARS: The patient develops Temperature-100°C or more, Flu like symptoms, X-ray chest shows –Atypical pneumonia. There is respiratory distress, myalgia, sore throat, lethargy etc.
- 2.1.5 No vaccine is available. Treatment is only supportive.

#### 2.2 Bird Flu, Avian Influenza (H5N1 virus – 2005)

- 2.2.1 The bird flu which is also known as Avian influenza was caused by H5N1 virus in 2005, and was found amongst the migratory birds
- 2.2.2 It first affected China and Vietnam.
- 2.2.3 Then it spreads globally within short time and affected china, kazakhistan, Russia, Middle East, Turkey, Kuwait, Romania, Bangladesh, Myanmar, Pakistan, Vietnam, Thailand and Cambodia.
- 2.2.4 The disease caused death and forced killing about 1.2 million poultry and 140 million birds due to this outbreak.
- 2.2.5 According to WHO, 63 countries reported avian influenza in poultry and out of them 5countries-China,Vietnam Bangladesh, Myanmar and Pakistan reported human infection.
- 2.2.6 Total 341 death out of 578 cases occurred globally till 18 Jan, 2012.
- 2.2.7 First it was identified in China in 1996.
- 2.2.8 The disease is transmitted to the human body from birds / poultry handlers.

#### 2.3 Swine Influenza (H1N1)

- 2.3.1 In the year of 2009 the Swine influenza affected Mexico and United States from pigs. It is similar to seasonal influenza found in humans. It caused worldwide pandemic with more than 18,114 death till 23 Apr 2010 as per WHO reports .
- 2.3.2 As vaccine is available it can save the humans.
- 2.3.3 In Bangladesh the 1<sup>st</sup> case was identified on 18<sup>th</sup> Jun 2009. Since then 1053 cases were identified with 7 confirmed deaths.
- 2.3.4 Risk group is pregnancy and young adults.
- 2.3.5 National Aviation influenza and Human pandemic influenza preparedness plans have been developed in Bangladesh by – Fisheries, Livestock, Environment and forest and MOH& FW

#### 2.4 H7N9 bird flu Virus Infection in China -2013

- 2.4.1 A newer bird flu infection known as H7N9 virus caused a serious illness among the people of China in the year of 2013.
- 2.4.2 But it was confined only in China and there was no history of person to person transmission. So the human is safe.
- 2.4.3 But during outbreak cautions to be taken as genetic change of this virus may cause serious illness to human also.
- 2.4.4 Initially 120 cases were found, out of which 24 died.
- 2.4.5 It was seen that wild water and Shore birds were the hosts of this newer bird flu virus .
- 2.4.6 Of the affected persons most were found to be infected after exposure to birds.

#### 2.5 MERS-CoV infection in Middle-East

- 2.5.1 In 2013 Middle East Respiratory Syndrome (MERS) Corona virus first affected Saudi Arabia then spreads to some other 22 countries like France, Italy, Jordan, Kuwait, Oman, Tunisia, UK, UAE and Qatar.
- 2.5.2 During outbreak only in Saudi Arabia 81 death reported.
- 2.5.3 As per the WHO reports total no of cases were 699 and death were 209.
- 2.5.4 There was an evidence that the transmission of the virus to human occurred from camels in Qatar and from bats in Saudi Arabia. Though the mode of transmission was not definite but droplet infection was assumed.

#### WHO suggested following preventive measures

- Frequent hand washing with soap is suggested. Foam of soap breaks the envelop of the virus and makes it ineffective.
- Cover nose and mouth with tissue paper
- Avoid touching eyes, nose and mouth with unwashed hands
- Avoid close contact with sick people, kissing, sharing cups, eating utensils etc
- Clean and disinfect touched items frequently.

#### 2.6 Ebola Outbreak

In February 2014 Ebola virus also known as Ebola Hemorrhagic fever outbreak occurs in 4 countries (Guinea, Sierra Leon, Liberia and Nigeria) of West Africa. It was emerged as the most severe in recorded history, both in number of cases and fatalities.

#### 2.6.1 Sources of Infection

- 2.6.1.1 Infected monkeys, Fruit Bats, Gorillas and Chimpanzee are the source of this virus. When a person comes in contact with the infected animal he acquires the disease.
- 2.6.1.2 Once a human is infected person to person transmission occurs through body fluids.
- 2.6.1.3 The poor living condition, lack of water and sanitation in most of the parts of West Africa are responsible for this epidemic crisis.
- 2.6.1.4 The cultural habit of West African people is also a reason to be affected by this virus.
- 2.7.1.5 They are habituated to consume equatorial animals in the form of bush meat is also linked to the transmission of this virus to human being.
- 2.6.1.6 They also eat fruit bats by smoked, grilled or making into spicy soup.
- 2.6.1.7 Again those who survive from the disease, the virus remain in semen of the survivors which subsequently transmits to others via sexual intercourse.
- 2.6.1.8 Embalming of an infected dead person, Carcass of gorilla, Chimpanzee, Contaminated medical equipment (like syringes, needles) also spread the disease.
- 2.6.2 Signs / Symptoms of Ebola Virus Disease (EVD)

The patient with Ebola Virus Disease shows the following signs and symptoms:

- 2.6.2.1 H/O contact, fever, diarrhoea & vomiting with or without bleeding
- 2.6.2.2 Influenza like symptoms sore throat, headache, body ache, joint pain .
- 2.6.2.3 Death occurs due to multi organ dysfunction syndrome (MODS) due to fluid redistribution, hypotension, Disseminated Intravascular Coagulation (DIC) etc.

#### 2.6.3 **Prevention of EVD**

The following preventive measures are to be taken during EVD outbreak:

- 2.6.3.1 Not touching patients, their excretions and body fluids, their used utensils.
- 2.6.3.2 Patients are to be isolated and strict barrier nursing to be followed (disposable face mask, gloves, goggles and gown to be used at all time)
- 2.6.3.3 Traditional burial rituals, especially those requiring embalming of bodies, should be discouraged.
- 2.6.3.4 Quarantine of the infected area is to be done
- 2.6.3.5 Risk factors such as contact with fruit bats, non-human primates and bush meat should be avoided.
- 2.6.3.6 Unprotected sexual contact with patient upto 3 months after they have recovered to be avoided
- 2.6.3.7 Wash hands regularly with soap or antiseptics.
- 2.6.3.8 Airlines crew are to be trained to spot the symptoms of Ebola in passengers flying from places where the virus is found. Crew were told to quarantine anyone who looks infected.

#### 2.7 Zika Virus outbreak 2015-2016

Zika virus is an emerging mosquito-borne virus that was first identified in Uganda in 1947 in rhesus monkeys. Subsequently it was identified in humans in Uganda and the United Republic of Tanzania. In the recent past in 2015 the largest outbreaks occur in Brazil and Singapore. The disease now spreads to at least 24 countries of the world.

#### 2.7.1 Outbreak in Brazil:

- In early 2015, an outbreak of Zika virus, transmitted by Aedes mosquitoes, was identified in northeast Brazil, an area where dengue virus was also circulating. Among 35 infants with microcephaly born during August–October 2015 in eight of Brazil's 26 states, the mothers of all 35 had lived in or visited Zika virus-affected areas during pregnancy.
- On 1 February 2016, the World Health Organization (WHO) declared a Public Health Emergency of International Concern. Based on research to date, there is now scientific consensus that Zika infection is a cause of microcephaly and Guillain-Barre Syndrome (GBS). Zika virus disease is transmitted primarily by the bite of Aedes mosquitoes.
- Prevention and control of Zika virus disease relies on reducing mosquitoes through source reduction (removal and modification of breeding sites) and by reducing contact

between mosquitoes and people. The management of the outbreak is currently focused on reducing the populations of the Aedes mosquito that transmit the virus (referred to as vector control).

#### 2.7.2 Outbreak in Singapore:

Singapore reported total 215 Zika virus infection including 10 Bangladeshi construction workers at the beginning of September 2016.

#### 2.7.3 Prevention

As Aedes mosquito is the carrier of Zika virus, attention is to be given to control mosquitoes for the prevention of Zika virus infection in the following ways:

- Elimination of mosquitoes by disinsection of the aircraft especially the aircraft arriving from Zika virus affected area.
- Reducing contact between mosquitoes and people.
- Elimination of mosquitoes by environmental control and spraying insecticides.
- Removal and modification of breeding sites.
- Wait six months to try for a pregnancy, if the male partner has symptoms of Zika.
- If a woman is pregnant and her male partner is infected, they should use a condom or abstain from sex for the whole pregnancy period.

## 2.8 Yellow Fever (YF)

Yellow fever, caused by the flavivirus, is normally a zoonosis of monkeys. It is transmitted by Aedes mosquitoes living in the tree-tops. Humans are infected within 3-5 days after the bite by infected mosquito.

#### 2.8.1 Signs/Symptoms:

The patient suffers from yellow fever develops- red eyes, headache, fever, vomiting, muscle and joints pain, hepatomegaly and jaundice.

## 2.8.2 Treatment:

There is no anti viral drug against yellow fever. Treatment is supportive. Vaccine is 99% effective.

#### 2.8.3 Yellow Fever Affected Countries :

Table 3-22. Countrie	es with risk of yellow fe	ever virus (YFV) transm	ission <sup>1</sup>
	AFRICA		CENTRAL AND SOUTH AMERICA
Angola Benin Burkina Faso Burundi Cameroon Central African Republic Chad <sup>2</sup> Congo, Republic of the Côte d'Ivoire Democratic Republic of the Congo <sup>2</sup> Equatorial Guinea	Ethiopia <sup>2</sup> Gabon Gambia, The Ghana Guinea Guinea-Bissau Kenya <sup>2</sup> Liberia Mauritania <sup>2</sup> Niger <sup>2</sup> Mali <sup>2</sup>	Nigeria Senegal Sierra Leone South Sudan Sudan <sup>2</sup> Togo Uganda	Argentina <sup>2</sup> Bolivia <sup>2</sup> Brazil <sup>2</sup> Colombia <sup>2</sup> Ecuador <sup>2</sup> French Guiana Guyana Panama <sup>2</sup> Paraguay Peru <sup>2</sup> Suriname Trinidad and Tobago <sup>2</sup> Venezuela <sup>2</sup>
Countries or areas v <sup>2</sup> These countries ar yellow fever transm	where "a risk of YFV tr e not <u>holo</u> endemic (o nission	ansmission is present. nly a portion of the co	untry has risk of

- Recent outbreak occurs in Luanda, Angola in December 2015
- Countries affected with yellow fever are shown in the above Table.

#### 2.8.4 Prevalence of Yellow Fever in South East Asia

- There is no prevalence of yellow fever cases in this region.
- The vector Aedes Aegypti are endemic in SEA.
- Vaccination is recommended to travellers going to areas at risk of YF
- Travellers arriving from regions with risk of YF required to present proof of vaccination.

#### 2.8.5 Policy of Yellow Fever vaccination

- A single full dose vaccine is sufficient to confer lifelong protection against yellow fever
- This policy of lifetime dose of YF vaccine came into force in IHR on 11 July 2016
- All countries must accept this certificate as valid for the life of the person holding it.
- Fractional dosing using 1/5<sup>th</sup> of the full dose gives protection for 12 months. It is valid for international travel only (Not to get YF certificate).
- The vaccine provides effective immunity within 30 days for 99% of persons vaccinated.
- As per WHO guidelines, all countries to ensure YF vaccination of all travellers aged one year and above travelling to/from endemic countries.

## CHAPTER 3

## Management of Communicable Diseases on Board Aircraft

# **3.1** Inbound aircraft carrying a suspected case of a communicable disease which may pose a serious public health risk

- 3.1.1 A number of considerations should be taken into account when an aircraft arrives carrying a suspected case of a communicable disease which may pose a serious public health risk. The considerations are as follows:
- 3.1.2 The pilot in command (PIC) needs to be advised of where to park the aircraft. Such information will normally be communicated to the PIC by air traffic control. This may be on a remote stand, or, depending on the situation, on the apron with or without a passenger boarding bridge attached. Such aircraft should be parked at stands which have all the relevant facilities, enable continued ventilation of the aircraft and allow easy accessibility to public health personnel to assess any suspected case(s) and permit efficient clearance of passengers.
- 3.1.3 Action should be taken to disembark the travellers as soon as possible after the situation has been evaluated and a public health response has been instituted, if needed.
- 3.1.4 Personal protective equipment (PPE) appropriate to the suspected communicable disease, the mode of transmission and the nature of duties being performed by aviation personnel, should be worn. For many communicable diseases, disposable gloves and good hand hygiene (at times in combination with surgical masks) are sufficient. The national public health authority may provide detailed recommendations.
- 3.1.5 A traveller having a communicable respiratory disease should wear a surgical mask unless the traveller is unable to tolerate it.
- 3.1.6 All surfaces that may have been in contact with a sick traveller need to be appropriately treated. Removable materials should be handled with biohazard precautions.
- 3.1.7 A sick traveller should be appropriately escorted from the aircraft to an area for further assessment/treatment. Appropriate infection control measures should be applied. The IHR (2005), Annex 1B outlines the core capacity requirements regarding transport facilities needed to manage public health emergencies, including the designation of ambulances for the transport of cases of infectious disease from a flight.

- 3.1.8 Before disembarkation, sick travellers and crew on the same aircraft hould be segregated from other travellers until traveller seating details, contact details and destination have been obtained and they have been advised by public health authority staff of any necessary precautionary measures.
- 3.1.9 Procedures need to be in place for obtaining baggage, customs and security clearance of a sick traveller, and other travellers. There is currently no evidence to support the cleaning and/or disinfection of baggage belonging to a suspected case or his/her contacts.
- 3.1.10 Consideration should be given to the comfort of all passengers, particularly if placed in isolation, or detained on board the aircraft. Provision should be made for food, water and other essentials.
- 3.1.11 A procedure for transporting a sick traveller to hospital needs to be in place.

# **3.2** General guidelines for cabin crew when facing a suspected case of Communicable disease on board:

- 3.2.1 Civil Aviation Authority of Bangladesh will ensure that the crew members of air operators have enough knowledge to evaluate a traveller who is suffering from a suspected case of communicable disease on board, based on the presence of fever (temperature 38° C /100°F or greater) associated with one or more of the following signs or symptoms:
  - Appearing obviously unwell
  - Persistent coughing
  - Impaired breathing
  - Persistent diarrhea
  - Persistent vomiting
  - Skin rash
  - Bruising or bleeding without previous injury
  - Confusion of recent onset
- 3.2.2 CAAB will check that the air operator's cabin safety manual contains "General Declaration Form", (As per Appendix 1 of ICAO Annex 9) dully filled up by the cabin crew/Pilot-in-command and is submitted to the Public Health Authority of Director General of Health Services when there is a suspected case of communicable disease on board.

**Note 1**: If food poisoning from in-flight catering is suspected, proceed as per companyestablished protocol and ICAO procedure mentioned in para 3.3.15 below.

**Note 2:** If temperature of the affected person is normal but several travellers have similar symptoms, think of other possible public health issues such as chemical exposure.

**3.3** Procedures of management of a suspected case of communicable disease on board by the cabin crew:

CAAB will ensure that air operator's Operation Manual or Cabin safety Manual contains the procedures to evaluate a traveller who is suffering from a suspected case of communicable disease as mentioned in para 3.2 above and crew members take following steps for management of such case(s) on board

- 3.3.1 If medical support from the ground is available, contact that ground support immediately and/or page for medical assistance on board (as per company policy).
- 3.3.2 If medical ground support and/or on board health professional is available, crew should follow their medical advice accordingly.
- 3.3.3 If no medical support is available, relocate the ill traveller to a more isolated area but only if two rows can be cleared immediately in front of a solid bulkhead. If the ill traveller is relocated, do not reuse the vacated seat and make sure that the cleaning crew at destination is advised to clean and disinfect both locations.
- 3.3.4 Designate one cabin crew member to look after the ill traveller, preferably the crew member that has already been dealing with this traveller. More than one cabin crew member may be necessary if more care is required.
- 3.3.5 When possible, designate a specific lavatory for the exclusive use of the ill traveler. If not possible, clean and disinfect the commonly touched surfaces of the lavatories (Faucet, door handles, waste bin cover, counter top) after each use by the ill traveller.
- 3.3.6 If the ill traveller is coughing, ask him/her to follow respiratory etiquette:
- 3.3.7 Provide tissues and advice to use the tissues to cover the mouth and nose when speaking, sneezing or coughing.
- 3.3.8 Advise the ill traveller to practice proper hand hygiene\*. If the hands become visibly soiled, they must be washed with soap and water.
- 3.3.9 Provide an airsickness bag to be used for the safe disposal of the tissues.
- 3.3.10 If a face mask is available, the ill traveller should be asked to wear it. As soon as it becomes damp/humid, it should be replaced by a new one. These masks should not be

reused and must be disposed safely after use. After touching the used mask (e.g., for disposal), proper hand hygiene must be practiced immediately.

- 3.3.11 If the ill traveller cannot tolerate a mask or refuses it, the designated cabin crew member(s) or any person in close contact (less than 1 metre) with the ill person should wear a mask. The airline should ensure that their cabin crewmembers have adequate training in its use to ensure they do not increase the risk (for example by more frequent hand-face contact or by mask adjustment, or by repeatedly putting it on and off.)
- 3.3.12 If there is a risk of direct contact with body fluids, the designated cabin crew member should wear disposable gloves. Gloves are not intended to replace proper hand hygiene and hands should be washed with soap and water. An alcohol-based hand rub can be used if the hands are not visibly soiled. Store soiled items (used tissues, face masks, oxygen mask and tubing, linen, pillows, blankets, seat pocket items, etc.) in a biohazard bag if one is available. If not, use a sealed plastic bag and label it "biohazard".
- 3.3.13 Any similar symptoms.
- 3.3.14 Ensure hand carried cabin baggage follows the ill traveller.
- 3.3.15 As soon as possible, advise the captain of the situation because he/she is required by the International Civil Aviation Organization regulations (ICAO Annex 9, Chapter 8, and paragraph 8.15) and the World Health Organization International Health Regulations (WHO IHR 2005, Article 28(4)) to report the suspected case(s) to air traffic control. Also remind the captain to advise the destination station that cleaning and disinfection will be required.
- 3.3.16 Ask all travellers seated in the same row, 2 rows in front and 2 rows behind the sick traveller to complete a passenger locator card. Cards are to be made available in the aircraft or in the airport by the public health authority when there is declaration of public health emergency of international concern (PHEIC) by WHO.
- 3.3.17 It is advisable of washing one's hands with soap and water for at least 15 seconds.
   Touching the face with hands should be avoided. Hands should be washed frequently.
   (*Ref: IATA General Guidelines for cabin crew on suspected communicable disease,* Oct 2011)

# **3.4** Notification of suspected communicable diseases or other Public Health risk, on board aircraft

- 3.4.1 CAAB will ensure that the air operators have established the procedures for the pilot in- command of an aircraft shall, upon identifying a suspected case(s) of communicable disease, on board the aircraft, promptly notify the ATC with the following information :
  - aircraft identification;
  - departure aerodrome;
  - destination aerodrome;
  - estimated time of arrival;
  - number of persons on board;
  - number of suspected case(s) on board; and
  - nature of the public health risk, if known.
- 3.4.2 The ATS unit, upon receipt of information from a pilot regarding suspected case(s) of communicable disease, on board the aircraft, shall forward a message as soon as possible to the destination/departure ATS unit as well as to the public health authority (PHA)/airport authority/aircraft operator and the aerodrome authority
- 3.4.3 Civil Aviation Authority of Bangladesh shall also confirm that the air operators have included the above procedures in their operations manual

# 3.5 Responsibilities of ATS Unit on receipt of information of Public Health Emergency on board aircraft from the Pilot-in-command:

3.5.1 Upon receipt of the above information from the Pilot-in-command, the relevant ATS Unit shall inform the concerned public health authority (PHA), aircraft operator and all relevant agencies according to the procedures established in International Health Regulations (2005), Article 28.4 and ICAO PANS-ATM, Doc 4444, chapter 16.6.
Note 1: AFTN (urgency message), telephone, facsimile or other means of transmission may be used.

#### ATC Notification of Event



Figure 3.1: Notification of Suspected Communicable diseases or other Public Health Risk, on board an aircraft

# **3.6** Responsibilities of PIC in case of Public Health Emergency on board an aircraft during disruption of air traffic services

3.6.1 CAAB will ensure that in the event of disruption or potential disruption of air traffic service (ATS) or related supporting services at Dhaka ACC, if there is any suspected case of communicable disease on board aircraft, the Pilot-in command of the aircraft shall ask for medical assistance for the health and safety of the passengers on board from the adjacent ACC such as Kolkata or Yangon as no service will be available from Dhaka ACC.( Ref: IHR 2005, Article 28.5)

- 3.6.2 The Pilot-in-Command of the aircraft shall notify Kolkata or Yangon ACC, as applicable, about the following information:
  - aircraft identification
  - departure aerodrome
  - destination aerodrome
  - estimated time of arrival
  - number of passengers on board
  - number of suspected case(s) on board; and
  - nature of the public health risk, if any
- 3.6.3 The event shall also be recorded on the Health part of the Aircraft General Declaration.

# 3.7 Responsibilities of ATS Unit of Kolkata/Yangon on receipt of information of Public Health emergency on board aircraft during disruption of ATS Unit in Bangladesh:

3.7.1 Upon receipt of the above information from the Pilot-in-command, the relevant ATS Unit (Kolkata/Yangon) shall inform the concerned public health authority (PHA), aircraft operator and all relevant agencies according to the procedures established in international Health Regulation (2005), Article 28.4, 28.5 and ICAO PANS-ATM, Doc 4444, chapter 16.6. In this regard, Bangladesh shall complete MOU with India and Myanmar to support each other.

(Ref: para 7.10.1 & 8.3.2 of ATS Contingency Plan, Civil Aviation Authority of Bangladesh)

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# **CHAPTER 4**

## Disinsection and disinfection of the aircraft

#### 4.1 Disinsection

Disinsection of the aircraft is to be carried out in such a manner that passengers do not undergo any discomfort or suffer any injury to health and no damage is done to the structure or operating equipment of the aircraft. As far as possible, the aircraft should be disinsected using methods approved by WHO. As Bangladesh is a malaria and other mosquito borne disease prone area, disinsection of the aircraft is to be done as per International Health Regulations (2005) when the aircraft leaves our international airports for an area where these vectors have been eradicated. The same requirement applies to aircraft leaving an airport in an area where the transmission of malaria or other mosquito borne diseases are occurring. Disinsection is also permitted at the airport of arrival if it is not carried out satisfactorily (Ref: WHO Guide to hygiene & sanitation in aviation 2009, para 10.3 and IHR 2005)

#### 4.2 SPECIFIC MEASURES FOR VECTOR-BORNE DISEASES

- 4.2.1. WHO shall publish, on a regular basis, a list of areas where disinsection or other vector control measures are recommended for conveyances arriving from these areas. Determination of such areas shall be made pursuant to the procedures regarding temporary or standing recommendations, as appropriate.
- **4.2.2** Every conveyance leaving a point of entry situated in an area where vector control is recommended should be disinsected and kept free of vectors. When there are methods and materials advised by the Organization for these procedures, these should be employed.

The presence of vectors on board conveyances and the control measures used to eradicate them shall be included:

(a) in the case of aircraft, **in the Health Part of the Aircraft General Declaration**, unless this part of the Declaration is waived by the competent authority at the airport of arrival;

(b) States Parties should accept disinsecting, deratting and other control measures for conveyances applied by other States if methods and materials advised by the Organization (WHO) have been applied.

#### 4.3 Definition of Disinsection:

The procedure whereby health measures are taken to control or kill the insect vectors of human diseases present in baggage, cargo, containers, conveyances, goods and postal parcels.

#### 4.4 Symptoms due to disinsection process:

4.4.1 Reports completed by flight attendants or airline personnel have suggested the possibility of the following symptoms in passengers and crew members as a consequence of pyrethroid application:

a. metallic taste,

b. slight and nonspecific irritation of- eyes, throat, upper respiratory tract and in some cases skin rash,

c. Sometimes severe respiratory symptoms such as Dysponea, cough and even asthma.

d. In other cases headache and allergic reactions were reported.

#### 4.5 Verification:

All empty or partly used cans used for disinsection of the aircrafts must be kept for inspection and removal by the Quarantine Officer boarding the aircraft at the first port of entry into the requesting country, when other quarantine formalities will be undertaken.

#### 4.6 Disinsection of Cargo holds:

Spraying of holds shall be carried out at the last port in the following methods:

- a) manually, after loading of last container and immediately before closing hold doors.
- b) by use of 1 Shot aerosol cans which are suitably located inside the hold and fired with the hold doors being immediately closed.
- c) by the use of automatic hold disinsection apparatus may be carried out at any time after doors are closed .

#### 4.7 Conditions when disinsection is carried out:

- a) Disinsection of the aircraft is done as per country requirement
- b) When an aircraft leaves an area infected with yellow fever or where mosquito vector exist, to an airport where vector has been eradicated.
- c) Again an aircraft leaving an airport in an area where the transmission of malaria or other mosquito borne diseases are occurring.
- d) It is to be done as per IHR (2005) and with insecticides approved by WHO

e) To be carried out in a way so that the passengers do not undergo any discomfort or suffer any injury to health

#### 4.8 Recommended Insecticides:

The Insecticides recommended by WHO include the following chemical insecticides (WHO, 1985).

(i) Natural Pyrethrins (ii) d-Phenothrin (iii) permethrine

#### 4.9 WHO Recommended Methods of disinsection:

- 4.9.1 The World Health Organization and the International Civil Aviation Organization stipulate **two approaches for aircraft disinsection:** 
  - (i) either spray the aircraft cabin, with an aerosolized insecticide, while passengers are on board or
- (ii) treat the aircraft's interior surfaces with a residual insecticide (residual method) while passengers are not on board.

#### 4.9.2 Recommended methods:

Three methods are currently recommended by WHO for aircraft disinsection: This involves, in practice, four techniques-

- (1) Blocks away method (2) Top of descent
- (3) Pre-flight (4) Residual Treatment

#### 4.9.3 Blocks Away Disinsection:

Spraying is carried out by crew members when the passengers are on board, after closure of the cabin door and before the flight takes off. An aerosol containing an insecticide for rapid action is used. The air-conditioning system should be switched off during cabin spraying. The flight deck is sprayed before the pilot boards (when no passengers are on board). The doors of overhead luggage racks should be closed only after spraying has been completed. An aerosol containing 2% D-Phenothrin is currently recommended by WHO and should be applied at a rate of 35 g of formulation per 100 m<sup>3</sup>. Cargo holds should also be disinsected.

#### **4.9.4** Top of Descent Disinsection:

Top-of-descent spraying is carried out as the aircraft starts its descent to the arrival airport. An aerosol containing 2% D-Phenothrin is currently recommended by WHO for this purpose and is applied with the air recirculation system set at from high to normal flow. The amounts applied are based on a standard spray rate of 35 g of the formulation per 100 m<sup>3</sup>.

#### 4.9.5 **Pre-Flight Disinsection:**

A pre-flight aerosol containing an insecticide with rapid action and limited residual action is applied by ground staff to the flight deck, passenger cabin including toilet areas, open overhead and side-wall lockers, coat lockers and crew rest areas. The spray is applied before the passengers board the aircraft but not more than 1 h before the doors are closed. A 2% permethrine cis:trans (25:75) formulation is currently recommended for this application, at a target dose of 0.7 g a.i./100 m<sup>3</sup>. This requires application at 35 g of formulation per 100 m<sup>3</sup> to various types of aircraft, with a droplet size of 10–15  $\mu$ m. preflight spraying is followed by a further in-flight spray, i.e. top-of-descent as the aircraft starts its descent to the arrival airport.

#### 4.9.6 Residual Treatment:

The internal surfaces of the passenger cabin and cargo hold, excluding food preparation areas, are sprayed with a compression sprayer that has a constant flow valve and flat fan nozzle according to WHO specifications.<sup>1</sup> Permethrine 25:75 (cis:trans) emulsifiable concentrate is currently recommended by WHO at a target dose of 0.2 g/m<sup>2</sup> applied at intervals not exceeding 2 months. The emulsion is applied at 10 ml/m<sup>2</sup> to avoid run off. Residual sprays are applied by professional pest control operators and are intended for long-term residual activity on aircraft interior surfaces. In electrically sensitive areas, it may be necessary to use an aerosol instead of a compression sprayer. After treatment is completed, air-conditioning packs should be run for at least 1 h before the crew and passengers embark to clear the air of the volatile components of the spray. Areas that undergo substantial cleaning between treatments require supplementary 'touch-up' spraying.

The pesticide formulations, including spray cans, should comply with national regulations and international standards as well as with WHO specifications for pesticides. Spray operations should follow international regulations and WHO recommended procedures and comply with quarantine requirements in the country of arrival.

(Ref: Annex 1 of Guidelines for testing the efficacy of insecticides used in aircraft, WHO 2012)

#### 4.10 Disinfection

Disinfection of aircraft is very much important following transport of a suspected case of communicable disease on board an aircraft. WHO, IATA, aircraft manufacturers and ICAO are the main organizations involved in determining a suitable disinfection process at the international level. Should an infectious disease be diagnosed either during the flight or immediately on arrival and before the aircraft departs again, disinfection may be of value.

#### 4.10.1 The Procedures

- The disinfectants most commonly employed are sodium hypochlorite diluted to strength of 100 mg/L and a 5% solution of formalin.
- Sodium hypochlorite is also used when disinfecting aircraft after the carriage of a person infected with a food or waterborne disease.
- Personnel wearing water proof gloves should swab the following areas with the sodium hypochlorite solution, which should remain in contact with these surfaces for 30 minutes before they are rinsed with warm water and dried to remove any residual chlorine:
  - a. All surfaces of the toilet compartment.
  - b. All surfaces and food containers in the galley.
  - c. All meal tables, seat armrests and ashtrays in the cabin.
- The toilet system should be drained and flushed in the normal way but the chemical fluid containing a bactericide should be allowed to stand at least for 2 hours.
- The fabric covers of the seat in which the infected person sat, and those of the seats in row in the front and the row behind should be removed, soaked in the disinfectant solution for 1 hour and, sent for dry cleaning suitably marked.
- The remaining seats and carpets should be vacuum cleaned and the dust incinerated.
- All hard surfaces should be swabbed with formalin solution which, after 30 minutes contact, should then be rinsed away with warm water.
- The personnel engaged in disinfecting work should wear waterproof gloves as well as face masks in addition.

#### 4.11 Disposal of used air sickness containers

Used air-sickness containers should be stored in the toilet compartment. They should not be put down the toilet, and a notice to this effect should be placed in the toilet compartment. They should be removed from the aircraft by the toilet servicing team and disposed of along with the toilet wastes. If any receptacle is used on the aircraft for storage of used sickness containers, it should be thoroughly cleaned, washed and disinfected after each use.

#### 4.12 Precautions against animal transportation in the aircraft

- 4.12.1 Animals, both wild and domestic, tropical fish, birds and different types of domestic pets are transported in a large number by air, regularly and frequently.
- 4.12.2 As domestic pets can transmit a lot many zoonotic diseases, all animal should be transported in the freight holds under most aseptic condition. Before any animal is accepted for transport, it must be ascertained that no discomfort will be caused to passengers or crew from odours, noise or the animal's escape from restrain during voyage.
- 4.12.3 Only healthy animals in a suitable condition should be accepted. Those that are unfit, infirm, diseased or injured, or likely to give birth during the journey should be rejected.
- 4.12.4 All animals should be carried in containers suitable to their species and size.
- 4.12.5 Animals should not be placed near foodstuffs.
- 4.12.6 Animals for laboratory use must be separated from other animals to reduce the risk of cross infection.
- 4.12.7 Different species of animals should not be mixed, and care should be taken not to place in close proximity cages containing animals naturally hostile to each other.
- 4.12.8 To minimize odour during flight, and cages are being handled, solid deodorant sachets should be attached to each container, but out of the animal's reach. They must never be sprayed with disinfectant.
- 4.12.9 The consignor should be given full information about import permit, veterinary health certificate, veterinary examination, quarantine and trans-shipment to the country of destination.
- 4.12.10All airports from which animals are exported, imported or held in transit should be provided with animal holding rooms and to be suitably constructed as per "WHO guide

to hygiene and sanitation in aviation" Under all the conditions Veterinary advice must be readily available in the airports.

# 4.13 WHO recommended the following steps of hand wash to clean soiled hands:

Wash hands when visibly soiled for a duration of 20-30 seconds.

- (1) At first wet your hands with water.
- (2) Then apply a palmful of liquid soap in a cupped hand, covering all surfaces.
- (3) Rub hands palms to palms;
- (4) Rub the back of each hands with fingers interlaced;
- (5) Rub Palms together with fingers interlaced;
- (6) Rub with back of fingers to the opposing palms;
- (7) Rotational rubbing of left thumb clasped in right palm and vice versa;
- (8) Rub the tips of fingers.
- (9) Rub each wrist with different hands, then
- (10) Rinse the hands with water
- (11) Dry thoroughly your hands
- (12) your hands are now safe.



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# **CHAPTER 5**

# **Requirements – Universal Precaution Kit (UPK)**

- 5.1 No person shall operate an aircraft that requires a cabin crew member unless it is equipped with at least one universal precaution kit.
- 5.2 The universal precaution kit shall be used by the operating cabin crew in managing incidents of ill health associated with a case of suspected communicable disease, or in the case of illness involving contact with body fluids.
- 5.3 Universal precaution kits should be distributed as evenly as practicable throughout the passenger cabins so that they are readily accessible to cabin crew members.

# 5.4 Each aircraft shall carry universal precaution kits in accordance with the following:

- 5.4.1 One universal precaution kit where the aircraft carries less than 250 passengers
- 5.4.2 Two universal precaution kits where the aircraft carries more than 250 Passengers.

**Note:** Additional kits, as determined by CAAB, at times of increased public health risk, such as during the outbreak of a serious communicable disease having pandemic potential.

#### 5.5 The Universal precaution kit container shall:

- 5.5.1 Be constructed to prevent dust and moisture contamination
- 5.5.2 Be constructed of non flammable material
- 5.5.3 For UPK containers, emboss the words"UNIVERSAL PRECAUTION KIT" in red color, in Bangla and English, and a red crescent, prominently and permanently displayed.

# 5.6 Each Universal Precaution Kit shall contain basic instruction for its use and an inventory of contents as follows :

- Dry Antiseptic Powder that convert small liquid spill into a sterile granulated gel
- (2) Germicidal disinfectant for surface cleaning
- (3) 20 Skin wipes
- (4) Face /Eye Mask (multiple pairs)

- (5) Disposable Gloves ( multiple pairs )
- (6) Protective Apron ( As per the number of cabin crew )
- (7) Large absorbent disposable towel
- (8) Pick up Scoop with Scrapper
- (9) Biohazard bag
- (10) Instruction book.

#### 5.7 **CERTIFICATION**

- 5.7.1 The contents and serviceability of the contents for Universal Precaution Kit shall initially, and subsequently at twelve months' interval, be verified and certified by an authorized company medical officer.
- 5.7.2 The Certification shall be affixed to the container exterior and shall contain the serial number, date of certification, expiry date, signature and seal of the authorized person certifying.

# **CHAPTER 6**

### **APPENDIX 1**

#### Colour Coded Disease Outbreak Response System and WHO Pandemic Phases

Code	Status	WHO Pandemic Phases
		description
Alert Green	Isolated external or local cases of	<i>PHASE 1</i> - No animal
	animal-to-human transmission. Threat of	influenza virus circulating
	human-to-human infection remains low. The	among animals has been
(Phases 1-3)	disease, if any, is basically limited to	reported to cause infection in
	animals.	humans.
	Strategy is to step up vigilance and make	PHASE 2 - An animal influenza
	preparations to meet the potential threat.	virus circulating in domesticated
		or wild animals is known to have
		caused infection in humans and
		is therefore considered a specific
		potential pandemic threat.
		PHASE 3 - An animal or
		human-animal influenza
		reassortant virus has caused
		sporadic cases or small clusters of
		disease in people, but has not
		resulted in human-to-human
		transmission sufficient to sustain
		community-level outbreaks.

Alert	Further spread can be prevented	PHASE 4 - Human-to-human
Yellow	through public health measures to	transmission (H2H) of an
(Phase 4)	isolate and quarantine contacts.	animal or human-animal
	Risk of import is elevated. Isolated imported	influenza reassortant virus able
	cases may occur but there is no sustained	to sustain community-level
	transmission	outbreaks has been verified.
	Strategy is to prevent spread. The focus will be	
	to prevent treatment of all cases, and antiviral	
	prophylaxis to contacts including exposed	
	health care workers.	
Alert	Virus becoming increasingly better adapted to	PHASE 5 - The same
Orange	humans but may not vet be fully transmissible.	identified virus has caused
010190	requiring close contact with an index case.	sustained community level
(Phase 5)	1	outbreaks in two or more
	Larger clusters appear in one or two places	countries in one WHO region
	outside the State but a pandemic has not yet	countries in one with region.
	been declared. A cluster of cases may also occur	
	within the State but human-to-human spread	
	remains localized. Public health measures such	
	as isolation and quarantine will be effective to	
	break the chain of transmission. Strategy is	
	to contain spread arising from any local cases	
	and break the chain of transmission, while	
	preserving essential services and resources	

Alert Red	WHO declares that an influenza pandemic	PHASE 6 - In addition
(Phase 6)	has begun. Home State is eventually also	to the criteria defined in
(I hase 0)	affected. Higher risk of acquiring the disease	phase 5, the same virus
	from the community once pandemic spreads	has caused sustained
	to the home State. Strategy is to mitigate the	community level
	impact of the pandemic.	outbreaks in at least one
	All measures taken in Alert Orange will	other country in another
	continue to be applied. Closing of school and	WHO region.
	suspension of selected events to prevent	
	congregation of large groups of people.	
	II'-l and a former discourse of deaths	
Alert Black	High rates of severe disease and deaths.	-
	Emergency measures implemented to bring	
	the situation under control. Healthcare and	
	social support systems are overwhelmed by	
	the pandemic. Economic activities are	
	severely disrupted. Strategy is to ensure that	
	medical & public health measures take	
	precedence over social & economic	
	considerations.	
	Focus is to contain the "damage" and regain	
	control of the situation. Drastic measures like	
	stopping all social events may be implemented	

*Post Peak Period*-Levels of pandemic influenza in most countries with adequate surveillance have dropped below peak levels.

*Possible New* Wave- Level of pandemic influenza activity in most countries with adequate surveillance rising again.

*Post Pandemic*-Levels of influenza activity have returned to the levels seen for seasonal influenza in most countries with adequate surveillance.

#### **Aircraft General Declaration**

(Inward/Outward)

Owner or Operator			Flight No	Date
Nationality and Registration		•	Arrival at	
Departure from			(Place and Co	ountry)
(Place and Country)				
FLIGHT ROUTING				
(Place column always to l	list origin, every en-route s	top and destination	on)	
		_		
Place	Total Number of Crews	Number of Pass	engers	Cargo
		Departure Place	e:	
		Embarking		
		Transit or	n same	
		flight		
		<b>Arrival Place:</b>		
		Disembarking		
		Transit on same	flight	
		Transit on Same	ingitt	

Ref: Regulations 12(1),(2) and 109(1) (2) (3) (4)

#### **Declaration of health**

Name and seat number or function of persons on board with illnesses other than airsickness or the effects of accidents who may be suffering from a communicable disease ( a fever- temperature 38°c/ 100°F or greater- associated with one or more of the following signs or symptoms, e.g. appearing obviously unwell, persistent coughing, impaired breathing, persistent diarrhoea, persistent vomitting, skin rash, bruising, or bleeding without previous injury or confusion of recent onset, increases the likelihood that the person is suffering a communicable disease as well as such cases of illness disemberked during a previous stop.....

Details of each disinsecting or sanitary treatment (place, date, time, method) during the flight. If no disinsecting has been carried out during the flight, give details of most recent disinsecting.....

Signature.....

Crew member concerned

I declare that all statements and particulars contained in this General Declaration, and in any supplementary forms required to be presented with this General Declaration are complete, exact and true to the best of my knowledge and that all through passengers will continue/have continued in this flight.

Signature Authorised Agent or Pilot –in- Command

Ref: ICAO Annex 9 (Appendix 1)

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## **Certificate of Residual Disinsection**

GOVERNMENT OF.....

#### CERTIFICATE OF RESIDUAL DISINSECTION

Interior surfaces, including cargo space, of this aircraft.....were treated with an approved residual disinsection product on (date).....in accordance with the world health organization recommendations (WHO weekly Epidemiological Record No 7, 1985.p. 47; No 12 1985, p. 90; No 45, 1985, pp. 345-346; and No 44,1987, pp. 335-336) and any amendments thereto.

The treatment must be renewed if cleaning or other operations remove a significant amount of the residual disinsection product and in any case within 8 weeks of the above date.

Expiry date
Signed
Designation
Date

## Public Health Passenger Locator Form (PLF)

<b>PUBLIC HEALTH PASSENGER LOCATOR FORM</b> : To protect your health, public health officers need you to complete this form whenever they suspect a communicable disease on board a flight. Your information will help public health officers to contact you if you were exposed to a communicable disease. It is important to fill out this form completely and accurately. Your information is intended to be held in accordance with applicable laws and used only for public health purposes. – <i>Thank you for helping us to protect your health</i> .
FLIGHT INFORMATION: 1. Airline name 2. Flight No
3. Seat No4. Date of arrival
PERSONAL INFORMATION: 4. Name
Name
City State/province Country ZIP/Posta
l code
1
Country codeE-Mail
Desenant or Travel degument
rassport of flaver document
NumberIssuing country/Organization
<b>CONTACT INFORMATIONS:5.</b> Address and Phone Number where you may be contacted during
vour stavStreet Name and
j • #
Number
Number City
Number.     City.       State/Province.     City.
Number       City         State/Province       Country         ZIP/Postal code       Telephone Number
Number.       City.         State/Province.       Country.         ZIP/Postal code.       Telephone Number.
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name.       Family Name.         Given Name.       b. Telephone Number.
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name
Number.       City.         State/Province.       Country.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name.       Family Name.         Given Name.       b. Telephone Number.         country       code.         Phone         Number.       E-Mail address.
Number
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.       Telephone Number.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name.       Family Name.       Given Name.       b. Telephone Number.         country       code.       Phone Number.       Phone Number.         Number.       E-Mail address.       City.       City.
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.       Telephone Number.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name
Number.       City.         State/Province.       City.         Country.       .ZIP/Postal code.       Telephone Number.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name.
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.         Telephone Number.       Country.         6. Contact information for the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name
Number.       City.         State/Province.       City.         Country.       ZIP/Postal code.         Telephone Number.       States and the person who will best know where you are for the next 31 days, in case of emergency or to provide critical health information to you. Please provide the name of close personal contact or a work contact, This must not be you.         a. Name.       Family Name.         Given Name.       b. Telephone Number.         country       code.         Phone       Phone         Number.       E-Mail address.         c. Address:       Street Name and Number.         City.       City.         State/Province.       ZIP/Postal code.         7. Are you travelling with anyone else.       YES/NO.         if so who? (Name of individual or group)       State/Province.

Ref: ICAO Annex 9 (Appendix 13)

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# Public Health Passenger Locator Form (Modified)

<u>gnt In</u>	
a.	Airline and flight no
D.	Date of arrivalC. Seat No
<u>rsonal</u>	information :
a.	Named. Father's Name
b.	Country (coming from)e. Phone no
c.	Passport No f. E-mail (if any)
ntact l	nformation :
0	Addrass (of Stay in Panaladash)
a.	Address (of Stay in Bangladesii)
e you I	<b>Fravelling with anyone else</b> , if so who? (Name of individual or group)
c you .	

Ref: CAAB Approved on 18 Aug 2014

Γ

# Sample of a Health Alert Notice (HAN)

#### Government of the Peoples Republic of Bangladesh Ministry of Health & Family Welfare <u>Health Alert Notice</u>

- Monitor your temperature and look out for flu-like symptoms (fever >38°C/ 100°F), cough, runny nose, or sore throat). If you are unwell, please see a doctor. Be socially responsible. Stay in and res t. If you need to go out, wear a mask and minimize contact with others.
- 2. If your symptoms are mild, the nearest medical college hospital or your usual health facility would be able to manage you. The Physician and health workers have been especially equipped to assess your condition and treat you. (Details of health facility will be provided by the CAAB CMT and MoH&FW)
- 3. If symptoms are severe (e.g. difficulty in breathing, chest pain, severe vomiting, etc), please call for an ambulance to deliver you to the nearest hospital Emergency department.

# **Health Declaration Form (HDF)**

- Upon activation by the Crisis Management Team, airlines will activate their own respective plans to distribute HDF (A standardized HDF is currently under review by ICAO, WHO and IATA). The contents of HDF will be similar to Health Part of Aircraft General Declaration (Appendix 1 of ICAO Annex 9). The HDF may be distributed together with the Passenger Locator Form (PLF). PLFs are used for contact tracing of the passengers and crew members (if required). A modified version of the PLF has been developed by CAA, Bangladesh for easy understanding and completion.
- 2. Airport Health Officer (AHO) will need to ensure sufficient supply of HDFs and PLFs for distribution to the airlines.
- 3, The completed HDFs and PLFs should be collected at the designated counters (e.g. Health desk/arrival immigration / customs or designated HDF/PLF collection counter.
- 4. If a traveler, based on his/her declaration in the HDF, is suspected of having contracted/ been exposed to a communicable disease (representing a potential PHEIC), s/he shall be immediately referred to the airport health centre. The traveler shall then be examined and if required, be referred to the designated referral hospital using designated ambulance/s.

### References

- (1) Suspected communicable disease: General guidelines for cabin crew, IATA December 2017.
- (2) Guidelines for testing the efficacy of insecticide products used in aircraft (WHO).
- (3) Airport preparedness guidelines for outbreaks of communicable diseases, issued by ACI

and ICAO: Revised April 2009.

- (4) WHO International Health Regulations (2005), 3rd edition, 2016
- (5) Procedures for Air Navigation Services- Air Traffic Management (PANS-ATM, Doc 4444)
- (6) IATA Medical Manual, 11<sup>th</sup> Edition, 2018
- (7) World Health Organization (WHO), Guide to Hygiene and Sanitation in Aviation, third edition, Geneva 2009.
- (8) ICAO: An Aviation Public Health Emergency Preparedness Plan: Cooperative Arrangement for the Prevention of Spread of Communicable disease through air travel (CAPSCA).