Regional Coordination for the Management of COVID-19 and other infectious diseases on Aircrafts

Background:
On March 11, the Director-General (DG) of the World Health Organization (WHO) declared the outbreak of a novel coronavirus, COVID-19 Public Health Emergency of International Concern (PHEIC), as a pandemic, due to its rapid spreads across the world. The virus has rapidly spread from China to over 100 countries. The International Health Regulations’ Emergency Committee is not recommending trade or travel restrictions at this time. The US CDC has issued travel advisories in countries where there is demonstrated sustained transmission¹.

To date, imported cases have been reported in several Caribbean countries, the rapidly evolving situation now requires a shift in mindset in all countries from preparedness to readiness and rapid response. CARPHA has upgraded the risk of disease transmission to the Caribbean Region to Very High. The revised risk level is based on international risk assessment guidelines, since multiple countries outside the epicentre of the outbreak have reported secondary cases from imported cases, including an increasing number of countries reporting sustained community transmission and sustained transmission of disease in countries with direct flights into the Caribbean Region.

The Caribbean Public Health Agency (CARPHA)² is leading the regional health response to COVID-19, in keeping with its Intergovernmental Agreement (IGA) mandate from CARICOM and recommendations from COHSOD-Health working group on regional coordination for management. As such, CARPHA activated its Incident Management Team-Emergency Response (IMT-ER) on January 21, and convened the Regional Coordinating mechanism for Health Security (RCM-HS), The RCM-HS is actively working with Heads of Government and regional partners on a collective approach to the COVID-19 response. Countries are strongly urged to strengthen their health sector response to respond to possible importation of cases and subsequent local transmission.

Air travel: The spread of the coronavirus and travel are invariably related. The interconnectedness of the globe is now facilitated by ease of travel from one end to the other by aircraft. The travel industry is vulnerable to public health emergencies and in the context of the COVID-19 outbreak, the impact on travel is well noted. The disease has created international anxiety because of its novelty, ease of transmission combined with extensive media coverage. People without symptoms or those incubating illnesses can easily move from one part of the globe to another before developing symptoms and demonstrating signs of disease. The importance of the role of aircraft travel in the movement of infected people from one place to the other cannot be underestimated.

² http://carpha.org/Who-We-Are/About
Travel health notices and restrictions: Since the beginning of February, according to the International Air Transport Association (IATA), more than 50 countries or territories have imposed travel restrictions to China and other countries with sustained transmission to contain the coronavirus spread. The CDC escalated its travel alerts health warning regarding travel to China, Iran, Italy, and South Korea. This means that:

- Travelers should avoid all nonessential travel to these countries (this does not include Hong Kong, Macau, or the island of Taiwan)
- Older adults and people with chronic medical conditions may be at increased risk for severe disease.

Many Caribbean nations have issued travel advisories (either non-essential travel/denied entry to persons who have travelled to countries with local/community transmission in the preceding 14 /21/28 days. Countries decisions are based on assessment of the risk level and their capacity to manage confirmed COVID-19 cases

Proposed Coordination for Management of PHEIC COVID-19 on aircrafts to Member States

International Health Regulations (IHR)
As provided by the International Health Regulations (2005) (IHR), countries should ensure that they:

- Activate public health emergency contingency plans at Points of entry (POE), to respond to public health events.
- Implement measures to identify and detect suspected cases on arrival
- Implement procedures and ensure means are in place for communicating information on ill travellers between conveyances and points of entry, and between points of entry and national health authorities
- Ensure procedures are in place to facilitate safe transportation of symptomatic travellers to hospitals or designated facilities for clinical assessment and that treatment is organized.

1. Activate public health emergency contingency plan at points of entry
Under the IHR (2005), public health authorities at international ports, airports and ground crossings are required to establish effective contingency plans and arrangements for responding to events that may constitute a PHEIC and to communicate these measures with their National IHR Focal Point. The current spread of coronavirus disease (COVID-19) across several borders, has prompted the need for Health Authorities to activate their contingency plans for the detection and management of suspected cases at points of entry (POE), including airports.
2. Measures to identify and manage suspected cases of COVID-19 at points of entry
CARPHA has developed guidance for the management of suspected cases of COVID-19 at ports of entry in Member States\(^3\) that can be used to guide public health actions. This includes algorithms for the identification\(^4\) and management\(^5\) of suspected cases.

2.1 Entry Screening
Entrance screening may only be useful for early detection of symptomatic travellers for further evaluation, if pre-arrival screening has been done to determine travel history and thus prevent exportation of the disease, while minimizing interference with international traffic. There is no global standard for disease screening at airports\(^1\). Where Member States decide to conduct entrance screening, the following are recommended:

- Temperature screening should always be accompanied by dissemination of risk communication messages at points of entry, aimed at raising awareness among travellers about signs and symptoms of the disease, and encouragement of health care seeking behaviour, including when to seek medical care, and report about their travel history.
- Countries implementing temperature screening are encouraged to establish proper mechanisms for data collection and analysis, e.g. numbers of travellers screened and confirmed cases out of screened passengers, and method of screening. In implementing entry screening, countries should consider national policies and capacity.
- Privately operated aircrafts may also pose a risk, particularly in the Caribbean setting where many small islands and atolls can only be accessed by smaller aircrafts and many of these could come directly to these airports from affected areas. Health Security measures at airports in the Caribbean must be extended to small / privately operated aircrafts.

2.2 Detection of Ill Travellers

2.2.1 Initial health assessment:
**Self-reporting:** Individual travellers experiencing signs and symptoms of illness may approach authorities at points of entry (POE) for assistance. Travellers who self-report their illness should be managed following the same procedures as used for those who are screened at the POE.

**Visual observation or via temperature measurement:** Ill travellers exhibiting signs suggestive of COVID-19 disease may be identified by POE personnel visually or via temperature measurement.

2.2.2 Suspected Case
1. Suspected cases and their travel companions need to be advised to move away from others, and they should be escorted to a designated area at the POE for further assessment
2. Local quarantine staff will conduct a health assessment of passengers or crew notified with symptoms, or those identified on arrival.

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\(^4\) Algorithm for Contact Tracing for Suspected 2019-novel coronavirus cases traveling on conveyances. [http://carpha.org/Portals/0/Documents/nCoV_Algorithm-ContactTracing.pdf](http://carpha.org/Portals/0/Documents/nCoV_Algorithm-ContactTracing.pdf)

3. Public Health staff should coordinate transportation to a health facility for evaluation and testing.
4. Inform National Epidemiologist of numbers of suspected cases assessed, including the number of persons meeting case definitions, and recommended for isolation at home or in a health care facility.
5. National Epidemiologist / Medical Officer of Health should provide advice on suspected case management in terms of:
   a. Where travellers require further medical assessment, the facility they should be sent to and
   b. the information that needs to be captured for each person.
6. Local Port Health staff should notify the health facility of the imminent arrival of the suspected case and provide the person with a medical mask for use during transportation to the health facility.

2.1.3 Asymptomatic traveller from location with established community transmission
1. Local Port Health and Quarantine staff may conduct a health assessment of passengers or crew on arrival. The assessment should capture complete travel history in the past 14 days and contact details.
2. Inform National Epidemiologist of numbers of asymptomatic persons assessed, and the number of asymptomatic persons that have high risk exposures and are recommended for quarantine.
3. National Epidemiologist / Medical Officer of Health should provide advice on:
   a. Self-isolation and or referral to a quarantine facility
   b. the information that needs to be captured for each person.
4. National Epidemiologist / Port Health staff should notify the relevant public health staff of the list of travellers recommended for self-isolation or sent to quarantine facilities, to enable monitoring.
The following summary can be used to assist Public Health staff at POE to deal with various scenarios.

<table>
<thead>
<tr>
<th>A. Actions</th>
<th>B. No symptoms</th>
<th>C. Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Citizens, permanent residents, students and long-term residents:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>i. Capture personal and contact details</td>
<td>i. Use WHO Case reporting form⁶</td>
</tr>
<tr>
<td>Isolation</td>
<td>ii. Isolate at home / restrict movement for 14 days</td>
<td>ii. Isolate and manage in health facility</td>
</tr>
<tr>
<td>Testing</td>
<td>iii. Only if symptoms develop</td>
<td>iii. To decide discharge based on clinical assessment and/or do a test on day 14 if there is suspect of viral persistence</td>
</tr>
<tr>
<td>Contact Management</td>
<td>iv. Only if symptoms develop</td>
<td>iv. Identify all close contacts from flights, household, health facility etc. v. Manage asymptomatic contacts as per B. i-B.iv.</td>
</tr>
<tr>
<td>Follow-up</td>
<td>v. Public Health to monitor through household or virtual visits or by telephone to check for symptoms.</td>
<td>vi. Public Health to monitor for symptom resolution and ensure convalescent testing conducted on Day 14-21.</td>
</tr>
<tr>
<td><strong>II. Short term visitors and tourists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td>i. Risk assess as per B.i above</td>
<td>i. Use WHO Case reporting form⁷</td>
</tr>
<tr>
<td>Isolation</td>
<td>ii. Isolate in public health designated temporary accommodation and restrict movement for 14 days</td>
<td>ii. Isolate and manage in health facility</td>
</tr>
<tr>
<td>Testing, contact management and follow-up</td>
<td>iii. As per B.iii-B.v above</td>
<td>iii. As per C.iii-C.v above</td>
</tr>
<tr>
<td>No Travel history to high risk area/ No exposure to case</td>
<td>vii. Provide information</td>
<td>viii. Positive COVID-19: Assess and manage as per C.i-C.vi above. ix. Negative: re-test on Day 7 and follow C.i-C.vi if positive.</td>
</tr>
</tbody>
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⁶ Interim case reporting form for 2019 Novel Coronavirus of confirmed and probable cases

⁷ Interim case reporting form for 2019 Novel Coronavirus of confirmed and probable cases
2.2 Facilities

- Identify a structure/facility near the POE where ill travellers can be referred to wait for an interview/assessment. The facility should be sufficiently spacious to allow for at least 1 metre of spatial separation among the ill travellers who are waiting.
- Ideally, this structure/facility should have the capacity to also isolate ill travellers who, after interview/assessment, are suspected of having COVID-19 disease, while they wait for transport to a healthcare facility.
- Make arrangements with local healthcare facilities so travellers who are suspected of having COVID-19 infection can be promptly referred.
- An additional long-term quarantine facility should be located away from the POE in case there is a need to accommodate a large number of contacts, as well as suspected and confirmed cases.

2.3 Staffing

- Staff working in assessment facilities at POE must be trained to conduct interviews, maintain security, and provide transportation to medical facilities for travellers who are being referred for further evaluation or treatment.
- Staff should also be trained in:
  - infection prevention and control measures including adequate hand hygiene techniques,
  - maintaining 1 - 2 m or 3 – 6 feet of distance from travellers at all times during the interview process, and
  - educating patients, their family and travel companions and addressing their concerns.
  - the importance of source control (that is, providing medical masks to travellers with respiratory symptoms before and during the interview process).
  - how to instruct ill travellers about the use of respiratory hygiene (that is, coughing or sneezing into tissues or a bent elbow) and the need for ill travellers to wear a mask and perform frequent hand hygiene, especially after coughing or sneezing, or touching or disposing of their mask.

2.4 Equipment

Identify needs for and procure and ensure a sustained supply of the following equipment and materials needed to conduct interviews.

- Hand hygiene: adequate supplies of an alcohol-based hand rub or soap and water
- Respiratory hygiene: adequate supplies of medical masks that can be used by ill travellers with respiratory symptoms and paper tissues.
- Waste bins with liners and lids available for disposing of medical masks and tissues; and subsequent waste disposal in accordance with infectious waste regulations.8
- Cleaning supplies, including household cleaner and disinfectant are available and the area cleaned three times a day with regular household soap or detergent first and then, after rinsing, regular household disinfectant containing 0.5% sodium hypochlorite (that is, equivalent to 5000 ppm or 1 part to 9 parts water) should be applied.
- Adequate amounts of Personal Protective Equipment (PPE) for cleaning staff to use.
- Ensure that there are chairs or beds, or both, in the isolation areas.

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8 The local sanitary authority should adopt measures to ensure that the waste is disposed of securely at a sanitary landfill and not at an unmonitored open dump.
• Guidelines available in the interview area about how to clean and disinfect frequently touched surfaces and bathrooms.

• Plans and standard operating procedures in place for the referral of exposed travellers, including travel companions of symptomatic travellers with suspected COVID-19 infection, to healthcare facilities for further assessment and treatment.

3 Plans and standard operating procedures to facilitate safe transportation of symptomatic travellers to hospitals or designated facilities for clinical assessment

Transportation of ill travellers suspected of having COVID-19 infection to healthcare facilities for evaluation, diagnosis and medical care should be carried out rapidly to ensure early clinical care is provided and to avoid crowding suspected cases at the POE. Preparations should include:

• identifying healthcare facilities that can provide evaluation for, diagnosis of and medical care for people with COVID-19 infection;
• ensuring that access to safe transport by ambulance is available, if needed.
• ensuring that infection prevention and control precautions are in place, hand hygiene resources and PPE are available, and staff at the healthcare facility and those providing transport are trained in the correct use of PPE.
• establishing a process to inform the receiving healthcare facility about suspected cases prior to their transfer.
• addressing security issues that may arise during the transfer, if applicable.
• ensuring systematic recording of all personnel involved in screening and transporting travellers with suspected COVID-19 infection.

4 Guidance for Airlines and crew coming to the Caribbean

The WHO has developed guidance to provide advice on detecting and managing ill travellers with suspected COVID-19 infection who arrive at international airports, ports and ground crossings, including those arriving in conveyances. The majority of passengers arriving and departing from Member States use commercial airlines. Airline and ground staff need to be prepared in the event of a suspected case among travellers and or crew. CARPHA has adapted WHO Interim guidance: Management of ill travellers at points of entry – international airports, ports and ground crossings – in the context of the COVID-19 outbreak and recommendations for Airline Crew published by the US CDC and the European CDC below.

The management of ill travellers at international ports, airports and ground crossings in the context of the current COVID-19 disease outbreak should include the following measures, to be implemented based on the priorities and capacities of each country:

1. detection of ill travellers;
2. interview of ill travellers to determine the possibility of symptoms of and exposure to the virus responsible for COVID-19 disease;
3. reporting cases with suspected COVID-19 infection;
4. isolation, initial case management and referral of those with suspected COVID-19 infection.
4.1 Compliance with Relevant Regulations

Airlines need to be aware of COVID-19 related entry requirements at the destination country. Airlines processing passengers for flights destined for Caribbean Countries must check with immigration officials at arrival destination on any COVID-19-related travel restrictions or requirements as these may change over time. An update on travel related actions and bans for Caribbean countries will be maintained by CARPHA. Procedures should be in place for communicating information on ill travellers between conveyances and points of entry as well as between points of entry and national health authorities. Public health authorities should have clear channels of communication with airlines operators for case management on board aircraft and reporting, should a traveller with respiratory disease symptoms be detected, in accordance with the IATA guidance for cabin crew to manage suspected communicable disease on board an aircraft.

4.2 Reporting ill travellers detected on board aircraft

The health section of the aircraft General Declaration form should be submitted to the POE health authority unless the State Party does not require their submission. If the health section of the aircraft General Declaration form is not required for all passengers arriving by airplane, the country may consider making its submission mandatory for aircraft arriving from areas affected by the COVID-19 outbreak, as defined by the health authority. The State Party shall inform aircraft operators or their agents of these requirements.

5 Disease Surveillance and Data Sharing

1. Staff at POE must update the National Epidemiologist and IHR Focal Point on any suspected cases of COVID-19 as per guidelines.
2. For confirmed cases, the National Epidemiologist should liaise with the airline to identify exposed contacts for follow-up of exposed crew members or passengers, as per local protocols.
3. Local Public Health Authorities should be provided with information to ensure contact tracing can begin immediately. The Algorithm for Contact Tracing for passengers on conveyances is provided for guidance.⁹
4. National and Local health authorities should commence contact tracing as per guidelines.

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⁹ Algorithm for Contact Tracing for Suspected COVID-19 cases on conveyances http://carpha.org/Portals/0/Documents/nCoV_Algorithm-ContactTracing.pdf
6  Infection, Prevention and Control for Point of Entry Staff and Staff transporting suspect COVID-19 cases

Personal protective equipment (PPE) is not necessary when interviewing asymptomatic individuals, when 1 - 2 metres or 3 – 6 feet distance is maintained.

- Close contacts of the affected persons (e.g. passengers, crew members or cleaning staff) should be identified, assessed for their specific level of exposure and asked to do self-monitoring of symptoms for 14 days.
- Local public health authorities should monitor through household or virtual visits or by telephone to check for symptoms.
- Any contacts who develop symptoms will need to have their own contact follow-up done.

Ambulance and transport staff should follow the following recommendations:

- Routinely perform hand hygiene and wear a medical mask and gloves when loading patients into the ambulance.
- If the traveller with suspected COVID-19 infection requires direct care (for example, physical assistance to get into ambulance) then transport staff should add eye protection (for example, goggles) and a long-sleeved gown to their PPE.
- Change their PPE after loading each patient and dispose of appropriately in containers with a lid and in accordance with national regulations for disposal of infectious waste.
- The driver of the ambulance must remain separate from the cases (keeping more than 1 - 2 m or 3 – 6 feet distance). No PPE is required for the driver if distance can be maintained. If drivers must also help load cases into the ambulance, they should follow the PPE recommendations in the previous point.
- Transport staff should frequently clean their hands with an alcohol-based hand rub or soap and water and should ensure that they clean their hands before putting on PPE and after removing it.
- Ambulances and transport vehicles should be cleaned and disinfected, with particular attention paid to the areas in contact with the suspected case. Cleaning should be done with regular household soap or detergent first and then, after rinsing, regular household disinfectant containing 0.5% sodium hypochlorite.