

4 ALBERT EMBANKMENT  
LONDON SE1 7SR  
Telephone: +44 (0)20 7735 7611 Fax: +44 (0)20 7587 3210

Circular Letter No.4204/Add.32  
25 September 2020

To: All IMO Member States  
United Nations and specialized agencies  
Intergovernmental organizations  
Non-governmental organizations in consultative status with IMO

Subject: **Coronavirus (COVID-19) – ICAO Harmonized guidance on facilitating passenger flights, including repatriation flights, using public health corridors during the COVID-19 pandemic**

The International Civil Aviation Organization (ICAO) has issued State Letter AN 5/28-20/97 on 23 September 2020<sup>1</sup> containing the attached guidance which provides a framework for harmonizing public health measures implemented by States in order to facilitate passenger and repatriation flights using Public Health Corridors (PHC) during the COVID-19 pandemic. The guidance was developed in the context of the global COVID-19 situation in mid-September 2020 and will be reviewed and updated as necessary with the evolution of the pandemic by the ICAO Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA).

The guidance applies to operations supporting passenger flights, including repatriation flights and seafarer changeover flights, defined in the guidance as flights organized by shipowners<sup>2</sup> to facilitate crew changes and repatriation of seafarers.<sup>3</sup>

The Secretary-General would like to highlight in particular:

- .1 section 5.3, on *Seafarer changeover flights*, where reference is made to the importance of seafarers; facts on the crew change crisis; and the importance of advanced bilateral communication, coordination, and planning between shipowners, aviation stakeholders and the relevant responsible authorities in arranging seafarer changeover flights; and

<sup>1</sup> <https://www.icao.int/covid/Pages/default.aspx>

<sup>2</sup> The term "shipowner" includes "ship operator", "ship manager", "fishing vessel owner", "fishing vessel operator" and "fishing vessel manager".

<sup>3</sup> The term "seafarer" includes "marine personnel", "fishers" and "offshore energy sector personnel". As of August 2020, it is estimated that more than 250,000 seafarers require immediate repatriation, with many more serving on extended crew contracts who are overdue to return home. A similar number of seafarers urgently need to join ships to replace them. On any given day, nearly one million seafarers are working on some 60,000 large cargo vessels worldwide.

- .2 section 5.4, on *Ensuring rapid authorization for flights*, where States are requested to grant rapid authorizations for the entry, departure and transit of aircraft, including for seafarer changeover flights.

The Secretary-General is confident that this contribution by the United Nations will have a positive impact and alleviate the ongoing crew change crisis. Member States are strongly encouraged to bring the contents of this Circular Letter to the attention of the competent authorities, at both national and local levels, as well as all other parties concerned, in particular airports.

\*\*\*

## ANNEX

ATTACHMENT B to State letter AN 5/28-20/97

### FACILITATING PASSENGER FLIGHTS, INCLUDING REPATRIATION FLIGHTS, USING PUBLIC HEALTH CORRIDORS DURING THE COVID-19 PANDEMIC

*Presented by the Collaborative Arrangement for the Prevention and Management  
of Public Health Events in Civil Aviation (CAPSCA)*

#### Introduction

The COVID-19 pandemic continues to evolve, with States in different stages of local transmission and thus different levels of risk in terms of virus transmission across borders. Some States are experiencing intense transmission, others have been able to reduce transmission due to the strict implementation of public health restrictions, while some are experiencing resurgences due to lifting of restrictions. The situation is further complicated by the lack of a vaccine, limitations in COVID-19 testing, limited treatment options, and limited human and economic resources to manage the pandemic.

The current variance in the number of COVID-19 cases in different States has resulted in the implementation of different border control measures regarding COVID-19 requirements, which often change at short notice. This situation has a significant impact on the availability of air travel, causing disruptions in the delivery of goods and services as well as passenger flights. Those impacted often include key personnel in the aviation and maritime industries and citizens that have travelled or worked abroad needing to return to their home countries.

The continuation of air transport is critical to support the delivery of goods and services. It could be facilitated by the implementation of public health measures proportionate to the risk, provided that appropriate risk assessments have been conducted by Civil Aviation Authorities (CAAs) in collaboration with Public Health Authorities (PHAs), and in accordance with ICAO and the World Health Organization (WHO) recommendations.

The CAPSCA PHC (<https://www.icao.int/safety/CAPSCA/Pages/Coronavirus.aspx>) has been developed specifically for the aviation industry, taking into account scientific information, risk management and safety management principles. Although the risk of contracting COVID-19 during air travel or importing or exporting the SARS-Co-V2 virus through air travel cannot be completely eliminated, the risk can be reduced by implementing a multi-layered strategy of public health measures.

The guidance in Appendix A of this document could serve as a framework for harmonizing public health measures implemented by States in order to facilitate passenger and repatriation flights, in accordance with ICAO Standards and Recommended Practices (SARPs), the CART report, applicable modules contained in the CART “Take-off” guidance document (airports, aircraft, crew and cargo) and the WHO and other public health recommendations.

-----

B-2

## Appendix A

### CAPSCA Harmonized Guidance on Facilitating Passenger flights, Including Repatriation flights, Using Public Health Corridors During the COVID-19 pandemic

#### 1. Applicability

This guidance applies to operations supporting passenger flights, specifically:

- 1.1 Repatriation flights, as defined in *Note 1* below;
- 1.2 Seafarer changeover flights, as defined in *Note 2* below;
- 1.3 Flights requiring cabin crew on-board;
- 1.4 Flights carrying passengers on-board.

*Note 1. State Letter (SL) EC 6/3 – 20/55 published on 15 April 2020 refers to “repatriation flights” as flights, which are organized by States for the sole purpose of repatriating their nationals and other eligible persons from other States, with no embarkation or disembarkation of other passengers for “remuneration or hire”.*

*Note 2. For the purpose of this document **Seafarer changeover flights** is defined as flights organized by shipowners<sup>1</sup> to facilitate crew changes and repatriation of seafarers<sup>2</sup>.*

*Note 3. **Relief flights**, as defined in Annex 9 — Facilitation (flights operated for humanitarian purposes which carry relief personnel and relief supplies such as food, clothing, shelter, medical and other items during or after an emergency and/or disaster and/or are used to evacuate persons from a place where their life or health is threatened by such emergency and/or disaster to a safe haven in the same State or another State willing to receive such persons) are excluded from this document.*

*Note 4. Emergency medical flights transporting ill or injured patients for either initial treatment or a higher level of care (**Medical Evacuation flights**) and flights returning patients to their home country following recovery or stabilisation of their condition (**Medical Repatriation flights**) are excluded from this document.*

*Note 5. Guidance material pertaining to the **Repatriation of human remains** was published in an Electronic Bulletin (EB 2020/27) on 6 May 2020 and is therefore excluded from this document.*

#### 2. Applying a multilayer strategy to implement Public Health Corridors (PHC)

2.1 COVID-19 transmission occurs mainly through respiratory droplets when an infected person breathes, talks, coughs, sneezes or sings. It may also spread through touching the face after hand shaking or touching contaminated surfaces (fomite transmission) or through small aerosol particles in crowded and poorly ventilated closed spaces (airborne transmission). Further studies are needed to determine the role and extent of fomite and airborne transmission in aviation. Prevention and early detection of persons with

---

<sup>1</sup> The term “shipowner” includes “ship operator”, “ship manager”, “fishing vessel owner”, “fishing vessel operator”, and “fishing vessel manager”.

<sup>2</sup> The term “seafarer” includes “marine personnel”, “fishers” and “offshore energy sector personnel”. As of August 2020, it is estimated that more than 250,000 seafarers require immediate repatriation, with many more serving on extended crew contracts who are overdue to return home. A similar number of seafarers urgently need to join ships to replace them. On any given day, nearly one million seafarers are working on some 60,000 large cargo vessels worldwide.

B-3

COVID-19 infection, including those without symptoms, are essential steps to limit the spread of COVID-19.

2.2 Globally, States are implementing border restrictions to mitigate the risk of importation or exportation of COVID-19. These restrictions often vary as decisions are informed by national COVID-19 epidemiological status and transmission patterns, public health capacities, availability of tests and other resources, and any other factors considered relevant by the State e.g. level of risk acceptable to the State.

2.3 The epidemiological situation of COVID-19 in each State is available on line from the WHO and other public health authorities. WHO identifies four transmission scenarios for COVID-19, i.e. no cases, sporadic cases, clusters and community transmission (States experiencing larger outbreaks of local transmission). The transmission scenario would need to be considered when deciding on implementing public health corridors between States, as the difference in transmission between States could be a risk factor for importation of COVID-19 into the State of arrival.

2.4 The adverse effects of COVID-19 on travel and other sectors could be mitigated by harmonised implementation of public health measures and the mutual recognition of these measures by States.

2.5 States are encouraged to implement a multilayer strategy to mitigate the transmission of COVID-19 through air travel, taking into account the feasibility of the implementation of these mitigation measures in their particular circumstances. Risk assessments should include an aviation-specific component to determine the most appropriate public health mitigation measures and the prioritization of these measures in the aviation sector.

2.6 The CART Take-off document supports the implementation of a multilayer strategy of public health measures applicable to airports, aircraft, crew and cargo and provides a framework (COVID-19 Response and Recovery Implementation Centre (CRRIC) for sharing of information between States.

2.7 In order to facilitate mutual recognition of public health measures States are strongly encouraged to ensure collaboration between CAAs (CAPSCA focal points) and PHAs (International Health Regulations Focal points) when conducting risk assessments to determine border restrictions, and to actively share these risk assessments with other States when discussing options for establishing Public Health Corridors (travel bubbles) between States. In this respect member States are urged to establish and make use of National Facilitation Committees in line with Annex 9 Standard 8.19 (SL EC 6/3 – 20/46).

2.8 The CAPSCA PHC activities assist States with implementation of the CART recommendations by providing assistance with guidelines, risk assessments, training and tools to facilitate mutual recognition by States and to support multilateral agreements in opening public health corridors between States.

2.9 States are further encouraged to share updated information regarding border restrictions and public health measures through the CRRIC, Air Information Circulars (AICs) and NOTAMS.

### 3. Components of a multilayer strategy in aviation

There has been a limited number of studies regarding the transmission of COVID-19 in airports and on-board aircraft. Further studies are needed to assess the evidence, but the reports published to date indicate low transmission on-board aircraft. The small number of incidents may be the result of lessons learned from previous outbreaks (preparedness plans supported by CAPSCA), aircraft design and airflow patterns within the aircraft, the efficiency of aircraft HEPA filters and existing processes and procedures minimising face to face contact.

B-4

The measures discussed below include essential measures that need to be considered when implementing a multilayer strategy. It is important to recognise that none of these measures would be sufficient to mitigate COVID-19 transmission if implemented separately. They have to be implemented as part of a multi-layer strategy. It should further be noted that the risk of COVID-19 transmission cannot be completely eliminated; and that States would need to determine an acceptable level of risk when resuming passenger flights.

### 3.1 General Hygiene

Passengers, crew and employees should be required to observe the following measures at all times unless otherwise advised by airport staff or aircrew members:

3.1.1 Hand hygiene by washing their hands with soap and water or, where this is not available, using alcohol-based hand-sanitising solution.

3.1.2 Respiratory etiquette by covering the mouth and nose with a paper towel cover or a flexed elbow when sneezing or coughing, even when wearing a face mask.

3.1.3 Limiting direct contact (touch) with any surfaces at the airport and in the aircraft to only when absolutely necessary.

### 3.2 Physical distancing

3.2.1 Preventing close contact with infected people is the most effective measure to prevent COVID-19 transmission. However, the application of physical distancing of at least one meter as recommended by the WHO is not always possible within the confined space of an aircraft cabin or a departure lounge.

3.2.2 Although physical distancing should be implemented at airports and on-board whenever possible, the implementation of other combined measures such as the wearing of suitable face coverings or masks for source control, seat assignment processes, orderly boarding procedures and limiting unnecessary movement of passengers and cabin crew on board could reduce transmission if the target of at least one meter physical distancing cannot be achieved.

### 3.3 Use of face coverings or masks

3.3.1 The wearing of suitable face coverings or masks for source control (preventing the wearer of the mask from transmitting the virus to others) is recommended within airports and aircraft.

3.3.2 For passengers it is recommended that the face covering/ mask be greater than a single layer, is well fitted snugly over the nose and under the chin and doesn't have exhalation valves. It is recommended to wear the face covering during all phases of flight (can be removed for meals) and should be donned during the use of the bathroom.

3.3.3 One exception to the use of masks is that children aged up to five years should not wear masks for source control, although some States could recommend a different and lower age cut-off for mask use. Passengers with mental or physical disabilities could be exempted from wearing masks and it is recommended that passengers with medical exemptions seek a written medical opinion prior to flight and have it available for the airlines and cabin crew.

3.3.4 For crew, minimal face coverings is recommended as above, unless the national public health authority or airline require the use of medical or other masks. Cabin crew may remove face coverings for

B-5

meals. Flight crew can be exempt from wearing masks on the flight deck, unless they develop symptoms suggestive of COVID-19. However, masks should be used whenever they leave the flight deck.

3.3.5 Passengers at high risk e.g. older people, immune compromised patients and people with chronic diseases should wear a medical mask. Due to supply chain disruptions, there might be limited supplies of medical masks, which might be prioritized by States for use by healthcare workers, suspected COVID-19 cases and individuals considered to be at high risk for COVID-19. PHA resources should be consulted to determine the type of mask which would be considered suitable for wearing at airports and on board aircraft.

3.3.6 Masks need to be worn properly to provide sufficient protection for other passengers. In case of long duration flights masks should be replaced during the journey if it is no longer functional e.g. as soon as it becomes damp.

3.3.7 The use of respirators (FFP2/3, N95/99) is not recommended for passengers as they have been designed for professional use in different occupational settings. Their use on board is not appropriate. Some models of respirators have exhalation valves that could allow the release of unfiltered exhaled air into the cabin that may contribute to COVID-19 transmission.

3.3.8 If airport security personnel need to identify a person wearing a mask for the purpose of confirming their identity, the face cover or mask should only be removed if physical distancing or other adequate mitigation measures are in place.

#### 3.4 Temperature screening at exit or entry points

3.4.1 Temperature screening could provide a false sense of security as there is limited evidence that it is an effective screening tool. It will not detect asymptomatic or pre-symptomatic people with COVID-19 or individuals who have used temperature lowering medication. Temperature monitoring on board long-haul flights may be of limited value.

3.4.2 If temperature screening does form part of a multilayer strategy, non-contact thermometers certified for use by PHAs should preferably be used e.g. thermal cameras capable of scanning the temperature of multiple passengers rapidly and unobtrusively.

3.4.3 Any individual with a high temperature as defined by the applicable PHA, will need to undergo further secondary assessment by public health officers.

#### 3.5 Passenger Self Declaration Form

3.5.1 Some States require the completion of passenger health self-declaration forms, proof of a negative PCR test taken within a prescribed period, and/or the submission of medical certificates prior to departure. It is recommended that passenger health self-declaration forms be used for all passengers.

3.5.2 ICAO, with the assistance of CAPSCA, has designed a Public Health COVID-19 Passenger Self-Declaration Form (Annex C) to promote the use of a consistent format to facilitate the exchange of health-related information between passengers and PHAs, in line with applicable data privacy protection rules (SL EC 6/3 - 20/90).

3.5.3 States are strongly encouraged to use this form when requiring passengers to declare their health status. The form is currently in paper format, but States are encouraged to use electronic options (e.g. mobile applications and QR codes), or as part of their web portals, to enable sending of data in advance to States.

B-6

### 3.6 COVID-19 diagnostic testing

3.6.1 ICAO does not recommend routine COVID-19 testing as a pre-condition for air travel at the time of publication of this guidance.

3.6.2 However, some States are conducting COVID-19 testing as part of their border management policies and require evidence of a negative COVID-19 test either prior to check-in, prior to boarding or upon arrival.

3.6.3 Such testing could potentially be useful to diagnose active COVID-19 infection and might mitigate the risk of importation into the arrival State; or could be used to decrease the quarantine period required by arrival States, provided that:

- a) accredited tests are conducted in accordance with the parameters and procedures prescribed by the relevant national PHA;
- b) testing is conducted within a specified timeframe prior to departure or on or shortly after arrival;
- c) sufficient testing capacity is available within the State;
- d) it does not prevent passengers from travelling due to the departure State's inability to conduct testing prior to departure (if pre-departure testing is a requirement for travel);
- e) passengers are informed in advance of such testing requirements; and
- f) there is follow up with the passenger upon arrival.

3.6.4 The RT-PCR COVID-19 test is currently the only test recommended by the WHO to diagnose an active COVID-19 infection. However, it is important to recognize that a RT-PCR COVID-19 test result could be false negative, meaning that although the RT-PCR COVID-19 test result is negative, the individual was infected with COVID-19 at the time of the test.

3.6.5 If RT-PCR COVID-19 testing is required prior to departure it would be preferable to conduct the test within the three days (72 hours) immediately prior to the flight, although it could be accepted up to four days (96 hours) before the flight taking into account delays in obtaining RT-PCR COVID-19 test appointments or the results of RT-PCR COVID-19 tests. States that require testing should clearly define and communicate the acceptable timeframes relating to testing.

3.6.6 Any testing being conducted in States prior to departure would necessitate that there are facilities available to conduct testing, results are available prior to the flight, that the passenger should not fly if the test is positive and that a procedure is in place should a test result not be available at the time of the flight.

3.6.7 States requiring pre-departure testing are thus reminded to consider the logistical challenges of obtaining a test in the departure State, and are encouraged to communicate testing requirements to relevant stakeholders and passengers timeously or consider other options such as providing testing upon arrival should testing be required by the State.

3.6.8 RT-PCR COVID-19 testing might not be practically feasible at either the departure or arrival airport, due to physical distancing and other constraints. States should consider alternative locations for conducting RT-PCR COVID-19 tests.

B-7

3.6.9 Testing requirements for crews should be no more than that required for passengers. States are encouraged to consider that crew present a different risk profile than the passengers and that more flexibility and relaxation of testing requirements and/or quarantine could be considered (including exemptions), in accordance with PHA recommendations.

3.6.10 WHO does not recommend the use of antigen rapid diagnostic tests (Ag-RDTs) in settings or populations with low expected prevalence of disease such as screening at airport. At the time of publication ICAO, in accordance with WHO recommendations, does not recommend the use of Ag-RDTs as a condition for travel, although it has been implemented in some States.

3.6.11 Some studies have been published indicating acceptable results with Ag-RDTs which could potentially be considered for use as an alternative when RT-PCR COVID-19 tests are not available or where time delays in RT-PCR COVID-19 poses significant barriers to air travel. It should be noted that very few Ag-RDTs have undergone stringent regulatory review and that a limited number of tests has been approved for use in States. (<https://www.who.int/publications/i/item/antigen-detection-in-the-diagnosis-of-sars-cov-2-infection-using-rapid-immunoassays>)

3.6.12 In cases where States are considering the use of Ag-RDTs or have already implemented rapid testing, it is essential that decisions are based on scientific evidence, that it is considered as part of a comprehensive risk-based strategy, that the use of such tests has been validated by the national PHA for its intended use and that it has been communicated to all stakeholders. Further discussions regarding the possible use of these tests in the aviation context is currently taking place within CAPSCA in consultation with WHO.

### 3.7 COVID-19 antibody testing

3.7.1 ICAO does not support conducting antibody testing in the aviation environment. Antibody tests cannot be used to diagnose active COVID-19 infection; they indicate whether a person previously had an infection and developed antibodies against the SARS-CoV2 virus.

3.7.2 It is presently uncertain whether or for how long antibodies can provide immunity against COVID-19, thus removing the practical use of these tests in aviation.

3.7.3 In accordance with WHO recommendations ICAO does not support the use of "Immunity Passports".

### 3.8 Cleaning and disinfection

3.8.1 CART guidance needs to be considered in terms of cleaning and disinfection.

3.8.2 Guidance should be provided by airlines regarding the permitted amounts of alcohol-based sanitisers carried on board, including that carried by passengers, in view of their flammability. Hand sanitation and PPE needs to be available for crew use (including flight deck) in adequate amounts.

3.8.3 The use of ultra-violet cleaning methods and its efficacy against COVID-19 is under consideration and has not yet been approved by the WHO as a recommended method. There are now multiple studies underway to understand the effect of UV-C light on SARS-CoV-2 and whether it could be used effectively in airports or on board aircraft.

B-8

**3.9 Managing passengers with suspected COVID-19 infection**

3.9.1 States should manage suspected cases at the airport in accordance with the National Aviation Plan for Public Health Emergencies (ICAO Annex 9), facilities required for implementation of public health measures (ICAO Annex 9), the aerodrome emergency plan (ICAO *Annex 14 — Aerodromes*), the airport public health contingency plan and any other relevant International Health Regulations (IHR) requirements.

3.9.2 In the absence of such plans any symptomatic passengers should be referred to the PHA at the airport for further assessment and management.

3.9.3 An aircraft shall be equipped with accessible and adequate medical supplies. Universal precaution kits should be carried on aircraft that are required to operate with at least one cabin crew member (ICAO, *Annex 6 — Operation of Aircraft*).

3.9.4 Aircraft operators should follow the procedures for reporting a suspected COVID-19 case on-board in accordance with the Procedures for Air Navigation Services (Air Traffic Management - PANS-ATM, Doc 4444), and by completing the Aircraft General Declaration (ICAO Annex 9, Appendix 1).

3.9.5 Any passengers or crew who develop symptoms should, as far as possible, be isolated from others and provided with a medical mask. It is recommended that the symptomatic passenger not be moved, but that the other passengers be moved away; specifically those in the same row, two rows in front and two rows behind the symptomatic passenger.

3.9.6 A designated aircraft parking position for PHE management should be identified at each airport and provided with adequate facilities.

3.9.7 Aircraft operators should follow the procedures for aircraft parking and further assessment by PHA personnel prior to allowing passengers to disembark.

**3.10 Managing flights from high risk areas**

3.10.1 If entry screening is utilized, States should, if practicable, prioritise entry screening or other measures for crew and passengers arriving on direct flights from high-risk areas as identified by the PHA.

3.10.2 Crew screening should be performed in dedicated checkpoints and separately from passengers (as an additional preventive health measure), where possible.

3.10.3 In addition, airports should have dedicated areas where passengers with symptoms can undergo secondary health assessments by PHA personnel.

3.10.4 Where possible, flight baggage should be allocated to carousels in a manner that facilitates physical distancing between passengers, with dedicated baggage carousels to be used for flights from high risk areas.

**3.11 Contact tracing, isolation or quarantine**

3.11.1 Aircraft operators should assist PHAs with contact tracing by distributing the Public Health Passenger Locator Form (PLF) (Appendix, ICAO Annex 9) to passengers in accordance with ICAO, WHO and national PHA requirements. States are encouraged to use electronic options or their web portals to enable completion and submission of the PLF on-line.

B-9

3.11.2 States implementing isolation or quarantine of crew or passengers upon arrival, should determine the appropriate measures (isolation or quarantine) and the minimum effective duration (based on a risk assessment or mitigation measures such as COVID-19 testing, passenger health status, etc.) in accordance with national PHA regulatory practices and WHO guidance on isolation and quarantine of contacts in the context of COVID-19.

#### **4. Communication and information sharing**

All stakeholders, including national CAAs, PHAs, aircraft operators and airports are strongly encouraged to establish effective communication channels to inform ICAO (through the CRRIC web site and PHC tools), crew (through AIC, NOTAMS and other means) and passengers (through the web site, or other relevant communication means e.g. flight briefings), as far as possible on a real-time basis, of:

4.1 State departure and arrival requirements relating to entry and exit screening, required health declarations or medical certificates, COVID-19 testing (if required), isolation procedures and quarantine procedures (where required);

4.2 Public health measures being applied at airports and by aircraft operators in terms of physical distancing, the wearing of masks, disinfection processes, etc.; and

4.3 The need to self-monitor for the potential onset of symptoms upon arrival for 14 days, and to report to PHAs at the destination any symptoms of COVID-19 as soon as becoming aware of them.

#### **5. Specific recommendations for repatriation and seafarer changeover flights**

##### **5.1 CAPSCA survey results**

5.1.1 CAPSA received 67 responses from States following a mini-survey on their practices regarding repatriation flights, with 93 per cent of respondents confirming that their States offer repatriation flights. In general respondents interpreted repatriation flights as evacuation flights to bring home national citizens stranded abroad, which in some cases also include permanent residents of other nationalities.

5.1.2 The majority of repatriations is done by means of scheduled commercial airline flights; with alternatives being use of non-scheduled charter flights specifically for repatriation purposes or use of State-owned airlines or military aircraft.

5.1.3 Costs for repatriation flights are paid either by the State or the passenger, in some cases funded by the State initially but then recuperated from the passenger.

##### **5.2 State arranged repatriation flights**

Where repatriation flights are organized by States for the sole purpose of repatriating their nationals and other eligible persons from other States, the following factors need to be considered:

5.2.1 Flights, with no embarkation or disembarkation of other passengers for “remuneration or hire”, could be designated as “repatriation flights” to ensure that necessary authorizations for the entry, departure and transit of aircraft carrying out such “repatriation flights” are granted expeditiously (SL EC 6/3 – 20/55);

B-10

5.2.2 For “repatriation flights” carried out on a commercial basis, States are encouraged to review their authorization procedures with a view to granting speedy approval to such “repatriation flights,” in line with the relevant provisions relating to international non-scheduled flights found in Section F of Chapter 2 to Annex 9 to the Chicago Convention (SL EC 6/3 – 20/55);

5.2.3 Advanced bilateral communication, coordination, and planning between the relevant State authorities and aviation stakeholders are essential prior to departure as it can facilitate flight clearances, etc.;

5.2.4 States are encouraged to establish in advance the health status of the repatriates and the urgency for repatriation, if possible, to determine the need for carrying qualified healthcare personnel on board;

5.2.5 If the State PHA has determined that there is a need to carry qualified healthcare personnel on-board to render support to high risk passengers; airlines should ensure that the aircraft is equipped with sufficient qualified healthcare personnel, medical equipment and medical supplies (as determined by the PHA) to respond to potential in-flight emergencies;

5.2.6 In cases where qualified healthcare personnel are not deemed to be necessary on board, the airline should ensure that the flight is staffed with appropriately trained cabin crew members familiar with procedures for managing suspected COVID-19 cases on board;

5.2.7 Aircraft must be equipped, at all times, with accessible and adequate medical supplies for the number of passengers on board (ICAO Annex 6); and

5.2.8 The travel of passengers showing symptoms suggestive of COVID-19 should be delayed; they should be referred to the local PHA for further evaluation and treatment, with travel being rearranged when they are declared “fit to fly” by the PHA.

### 5.3 Seafarer changeover flights

5.3.1 The world relies on seafarers to transport more than 80 per cent of trade by volume, including vital food and medical goods, energy and raw materials, as well as manufactured goods across the globe. Travel restrictions have resulted in many seafarers being stranded on ships, or unable to join ships.

5.3.2 The shipping industry identified the need for approximately 300,000 seafarers a month to access international flights to enable ships’ crew changeover. This is in accordance with the International Labour Organization’s Maritime Labour Convention (MLC, 2006) providing for seafarers repatriation at the end of their contracts.

5.3.3 Cancellation of seafarer changeover flights and border restrictions hampering routine crew changes, despite the endorsement of a Framework for ensuring safe ship crew changes<sup>3</sup>, have created an urgent need for facilitating seafarer changeover flights.

5.3.4 Advanced bilateral communication, coordination, and planning between shipowners, aviation stakeholders and the relevant responsible authorities is essential in arranging seafarer changeover flights.

---

<sup>3</sup> Recommended framework of protocols for ensuring safe ship crew changes and travel during the coronavirus (COVID-19) pandemic, issued by IMO Circular Letter No.4204/Add.14 of 5 May 2020 ([http://www.imo.org/en/MediaCentre/HofTopics/Documents/COVID%20CL%204204%20adds/Circular%20Letter%20No.4204-Add.14%20-%20Coronavirus%20\(Covid-19\)%20-%20Recommended%20Framework%20Of%20Protocols.pdf](http://www.imo.org/en/MediaCentre/HofTopics/Documents/COVID%20CL%204204%20adds/Circular%20Letter%20No.4204-Add.14%20-%20Coronavirus%20(Covid-19)%20-%20Recommended%20Framework%20Of%20Protocols.pdf))

B-11

**5.4 Ensuring rapid authorizations for flights**

States are requested to grant rapid authorizations for the entry, departure and transit of aircraft of the following flights (in no specific order):

- a) Repatriation flights as defined in SL EC 6/3 – 20/55;
- b) Cargo transport flights carrying essential medical equipment and supplies; and
- c) Seafarer changeover flights.

**6. Operational guidance for cabin crew on passenger flights**

CART guidance needs to be implemented in terms of cabin crew recommendations during travel and layover. In view of updated information, the following is recommended:

6.1 Crew should not report for duty if they have any symptoms suggestive of COVID-19. Upon reporting for duty, crew members are required to complete the revised Crew COVID-19 Status Card (Appendix D);

6.2 Safety demonstrations should highlight to passengers that face masks should be removed before donning emergency oxygen masks, should they be needed. Note that this could be achieved by an additional announcement after screening of the safety video;

6.3 Passengers should be informed to limit movement and touching of surfaces, to the extent practicable during the flight, to reduce exposure to other passengers; and

6.4 Passengers should be informed that closing the lavatory lid before flushing is an effective method to mitigate the spreading of potentially infectious particles.

-----

B-12

**Appendix B**

**Organizations that contributed to the development of the guidance**

**Global CAPSCA Partners**

1. International Air Transport Association (IATA)
2. Airports Council International (ACI)
3. International Federation of Air Line Pilots' Associations (IFALPA)
4. International Coordinating Council of Aerospace Industries Associations (ICCAIA)
5. International Business Aviation Council (IBAC)
6. International Organization for Migration (IOM)
7. International Maritime Organization (IMO)
8. International Transport Workers' Federation (ITF)
9. Global Express Association (Cargo representative)
10. The International Air Cargo Association (TIACA)

**Regional and other CAPSCA Partners**

1. European Union Aviation Safety Agency (EASA)
2. European Union (EU)
3. African Union (AU)
4. Aviation Medicine Advisory Service (AMAS)
5. MedAire

**ICAO Medical Provisions Study Group**

1. Civil Aviation Authority of Singapore (CAAS)
2. UK Civil Aviation Authority
3. Transport Canada
4. Federal Aviation Administration (FAA)
5. Civil Aviation Administration of China (CAAC)
6. South African Civil Aviation Authority
7. Civil Aviation Safety Authority (CASA)
8. Aviation Medicine Doctors Association (AMDA) (Russia)
9. Kenya Civil Aviation Authority
10. Egyptian Aviation Academy
11. Nigerian Civil Aviation Authority
12. Jordan Civil Aviation Authority

-----

B-13

Appendix C

PUBLIC HEALTH COVID-19 PASSENGER SELF  
DECLARATION FORM

*Proposal – a health declaration to include on the reverse of the existing PLF.*

PUBLIC HEALTH COVID-19 PASSENGER SELF DECLARATION FORM	
<p><b>Purpose of this form:</b> This form is intended to support public health authorities by allowing arriving passengers to easily provide relevant information pertaining to their health status, particularly with regard to COVID-19. Information needs to be recorded by an adult member of the group or travel group. Notwithstanding completion of this form, a passenger might still be subjected to additional health screening by the Public Health Authority as part of a multi-layer prevention approach. Your information is intended to be held in accordance with applicable national laws and used only for public health purposes.</p>	
<p><b>1) Traveller Information:</b></p> <p>First Name(s): <input type="text"/></p> <p>Last Name(s): <input type="text"/></p> <p>Date of Birth (dd/mm/yyyy): <input type="text"/></p> <p>Travel document No. &amp; issuing country: <input type="text"/> <input type="text"/></p> <p>Country of residence: <input type="text"/></p> <p>Port of Origin: <input type="text"/></p>	
<p>2) During the past 14 days, have you, or a member of your group travelling with you, had close contact (face-to-face contact for more than 15 minutes or direct physical contact) with someone who had symptoms suggestive of COVID-19? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>3) Have you, or any member of your group travelling with you, had any of the following symptoms during the past 14 days:</p> <p>Fever Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath Yes <input type="checkbox"/> No <input type="checkbox"/> Coughing Yes <input type="checkbox"/> No <input type="checkbox"/> Sudden loss of sense of taste or smell Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>4) Have you, or any member of your group travelling with you, had a positive COVID-19 test in the last 3 days? Yes <input type="checkbox"/> No <input type="checkbox"/> Please attach report if available</p>	
<p>5) Please indicate all countries and cities that you and the group travelling with you have visited or transited through in the last 14 days (including airports and ports), providing the dates of the visit. List the most recent country first.</p> <p>_____</p> <p>_____</p>	
<p><i>For more information on penalties related to the provision of false information on this form, please refer to the applicable national legislation and/or local health authorities.</i></p>	
<p>Signature: _____</p> <p>Date: _____</p>	

B-14

Appendix D

Crew COVID-19 Status Card

CREW COVID-19 STATUS CARD	
<b>Purpose of this card:</b> Information to be recorded by crew prior to departure to confirm their COVID-19 health status and to facilitate processing by State's Public Health Authorities.  Notwithstanding completion of this card, a crew member might still be subjected to additional screening by Public Health Authorities as part of a multilayer prevention approach e.g. when recorded temperature is 38 C° (100.4 F°) or greater.	
<b>1. During the past 14 days, have you had close contact (face-to-face contact within 1 meter and for more than 15 minutes or direct physical contact) with someone who had symptoms suggestive of COVID-19?</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>2. Have you had any of the following symptoms during the past 14 days:</b>	
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Coughing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Breathing difficulties	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sudden loss of sense of taste or smell	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. Temperature at duty start:</b>	
Temperature not recorded due to individual not feeling/ appearing feverish <input type="checkbox"/>	
Temperature in degrees C° <input type="checkbox"/> / F° <input type="checkbox"/> : _____	
Date: _____ Time: _____	
Recording method : Forehead <input type="checkbox"/> Ear <input type="checkbox"/> Other <input type="checkbox"/> _____	
<b>4. Have you had a positive COVID-19 test during the past 3 days?</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
Attach report if available	
<b>Crew member Identification:</b>	
Name:	
Airline/ aircraft operator:	
Nationality and Passport No:	
Signature:	
Date:	

Public health corridor (PHC) Form 1

— END —