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29 September 2020

COVID19(20)158

**TO: LABOUR AFFAIRS COMMITTEE
 ALL MEMBERS & ASSOCIATE MEMBERS
 BI WEEKLY MEMBERS MEETING PARTICIPANTS
 INTERNATIONAL ASSOCIATION GROUP PARTICIPANTS**

COVID-19 UPDATE AS OF 28 SEPTEMBER 2020 (NO CIRCULAR NEXT WEEK)

Action Required: *Members are invited to note:*

- *Information below provided by WHO for 28 September 2020 and general epidemiological information regarding Covid 19 issued by WHO in the last few days in report below.*
- *ICAO Circular :- Facilitating passenger flights, including repatriation flights, using public health corridors during the Covid -19 pandemic. Mentions seafarers in the document. At Annex A*

A recording can be found of the UN General Assembly Side Event with the various UN agencies last week for those who missed it

https://us02web.zoom.us/rec/play/utmVA8Kd79mDXJ_5GbvI4lg30hWtqw0KDD5jnCISza2IFW-gjAYRUJaQ7wNR70owjFVt4q0WLyWY61vE.AzBzJjvL02cZW1se

- Message re crew changes from Antonio Guterres , UN Secretary General <https://news.un.org/en/story/2020/09/1073432>
- Flight and crew change availability information below kindly provided by Intermanager.

235 countries have reported 33 034598 confirmed cases of COVID-19 (7.14%) 2,358,923 additional cases were confirmed since last Sunday an increase compared to the previous week. There has also been an increase in fatalities over the last week with 41,925 additional deaths in the last eight days. However, many countries still cannot report all cases due to insufficient testing equipment so numbers are considerably higher. 9 Countries now declare themselves COVID-19 free the same as last week.

SITUATION IN NUMBERS BY WHO REGION

Region	Cases	Deaths
Global	33034598	996342
Africa	1,175,812	25,529
Americas	16,360,122	549,807

Eastern Mediterranean	2,357,703	60,756
Europe	5,725,150	235,139
South-East Asia	6,810,494	111,898
Western Pacific	604,576	12,667

To get specific information about a country please visit the WHO-Covid-19 dashboard. [Link.](#)

TOP 12 COUNTRIES WITH CASES AS AT 28 September 2020 (Greatest first)

	This Week	Last Week	Status
1	United States of America	United States of America	The Same
2	India	India	The Same
3	Brazil	Brazil	The Same
4	Russia	Russia	The Same
5	Colombia	Peru	Changed
6	Peru	Colombia	Changed
7	Mexico	Mexico	The Same
8	Spain	South Africa	Changed
9	Argentina	Spain	Changed
10	South Africa	Argentina	Changed
11	France	Chile	Changed
12	Chile	France	Changed

TOP 12 COUNTRIES

	WITH INCREASED CASES YESTERDAY	WITH HIGH FATALITIES YESTERDAY
1	India	India
2	United States of America	Brazil
3	Brazil	Argentina
4	Argentina	USA
5	Russia	Iran
6	Colombia	South Africa
7	Iraq	Mexico
8	France	Colombia
9	United Kingdom	Indonesia
10	Mexico	France
11	Iran	Turkey
12	Indonesia	Iraq

FLIGHT & CREW CHANGE AVAILABILITY INFORMATION PROVIDED BY INTERMANAGER.

China

SAS starts regular flights to China from 29.09.2020 With weekly flights from Copenhagen to Shanghai

Sri Lanka

The Isolation center established by us is now in operation. The 14 day quarantine requirement has been removed and the government is actually encouraging early repatriation as soon as PCR results are available (usually available within 24-30 hrs) thus deemed safe to embark. Please see revised rates we could offer.

<u>Activity</u>	<u>Details</u>	<u>Rate Basis</u>	<u>USD</u>
1 Arrival Procedure	Arrival permissions, Meet and Greet. Immigration clearance	Per Pax	100
2 Transport to Isolation Centre	Disinfection, Special Bus + Driver isolation	Per Pax (min 10)	30
3 Supply of PPE	PPE Kit (Masks and sanitizer)	Per Pax	30
3 Isolation Centre	Food & Bev, lodging, housekeeping health watch,	Per Pax Per Day	135
4 PCR Testing	1 Test - On arrival	Per Test	100
5 Transportation to Port/Airport	Disinfection/Special Bus + Driver	Per pax (min 10 pax)	30

In case of crew flying from Indian airports to Sri Lanka, government has published names of PCR test centers and Isolation centers recommended by the Indian health authorities. Apart from above, the process remains the same. You may find the whole process at <https://www.colombologistics.com/> crew changes. We will be happy to clarify any matters if you have any. Channa Karunatilake, Colombo Logistics World (Pvt) Ltd, 63/1 Ward Place, Colombo 07 Sri Lanka +94-11-2662050 (ext 302) +94 77 2348763 (mob)

EGYPT

We have pleasure to attend the crew change for all the nationalities at all the Egyptian ports without any delay for the ships even during the procedure of Coronavirus. For your information, please note the following:-

all the on/off signers must hold an approved COVID test (max 72 hours prior to sampling date) to be allowed to enter the Egyptian territory.

Regarding the off signers especially in the Suez canal zone, we will arrange with the authorities to send the quarantine doctor to take their samples at Port Said/Suez outer

anchorage areas, then take the result the following day, and if it is approved we will arrange the repatriation at P.Said/Suez while the vessel is exiting the S.Canal. our last operation was at Hamrawien port (it's 60 KM from Safaga port), we managed to do the crew change smoothly of all the 20 on-signers / 20 off-signers despite the fact that there are no local authorities there to handle that.

We accommodated on-signers at Cairo until all arrived from different countries then transported them to Hamrawien port (about 8 hours by bus) and similarly for the off-signers until they boarded their flights.

Currently, we have an operation (11 on/11off signers Myanmar crew) we already handled the operation smoothly as usual but we are facing & handling some difficulties because Myanmar airport is closed and we are coordinating now with the Myanmar embassy for repatriation of the off-signers which is expected to be done on 1 week of October we are accommodating them in hotel at port said and coordinating now with the immigration for this long stay.

For your easy reference please find hereunder our tariff for crew change in Suez canal:-

#) Crew change

	cost per person in the same group	
1 CREW GROUP \$250		\$ 250.00
2 CREW GROUP \$340		\$ 170.00
3 CREW GROUP \$360		\$ 120.00
4 CREW GROUP \$440		\$ 110.00
5 CREW GROUP \$475		\$ 95.00
6 CREW GROUP \$510		\$ 85.00
7 CREW GROUP \$525		\$ 75.00
8-10 CREW GROUP		\$ 70.00

- Provided the group of crew members come on the same flight
- above mentioned tariffs include, meeting at the airport, visa, transportation and formalities.

we can arrange hotel accommodation for on/off signers (for any period) accommodation cost = \$ 80.00 (single) The meal will be \$ 20.00 per person/meal (if any)

Re: COVID test

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Please note that the COVID test cost will be \$ 190.00 /person + \$100.00 for transportation to send the sample to Cairo and return to Port-Said/Suez of the result. Please send the following:-

- crew details for on/off signers
- flight details for on/off signers
- copy of passports valid for at least 3 months
- signed/stamped crew list on arrival and departure
- E-Tickets for the off-signers

We need 48 hours prior notice to crew arrival to get all the needed permissions ready timely.

Madrid Æ Panama & Panama to Manila

Please contact Gordon Rennie gordon@eyonzy.com

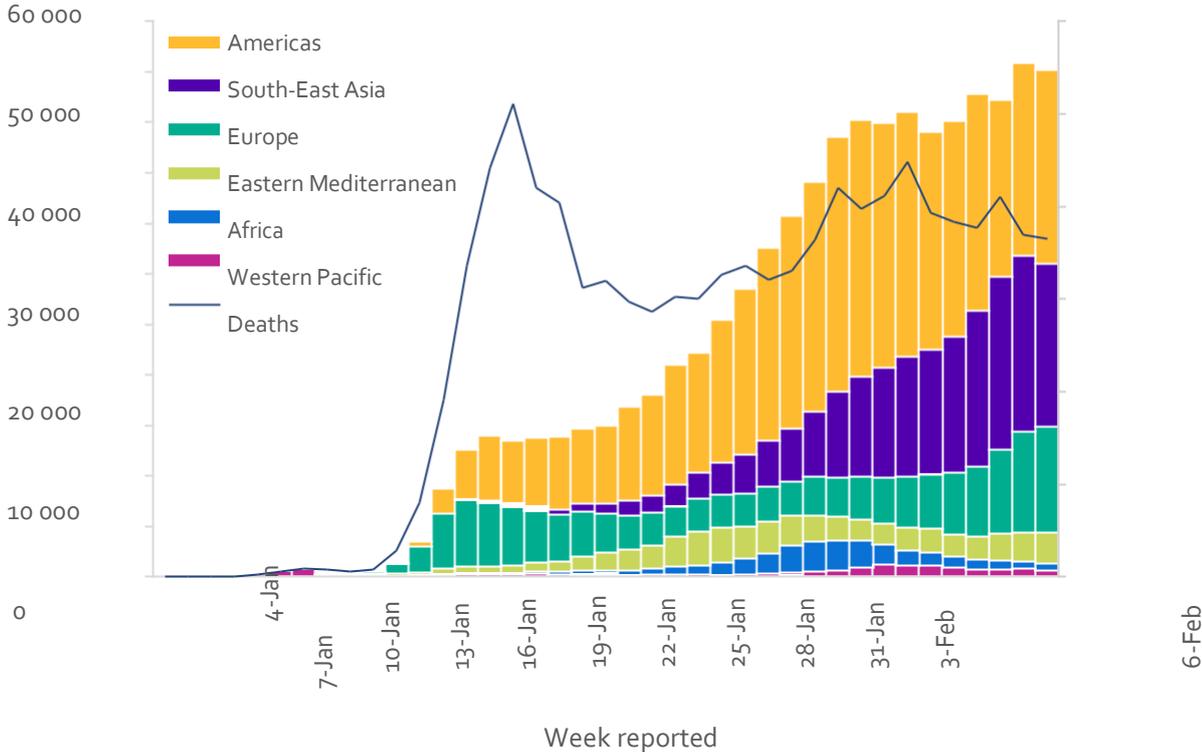
General Information

Coronavirus disease (COVID-19)

Data as received by WHO from national authorities, as of 27 September 2020

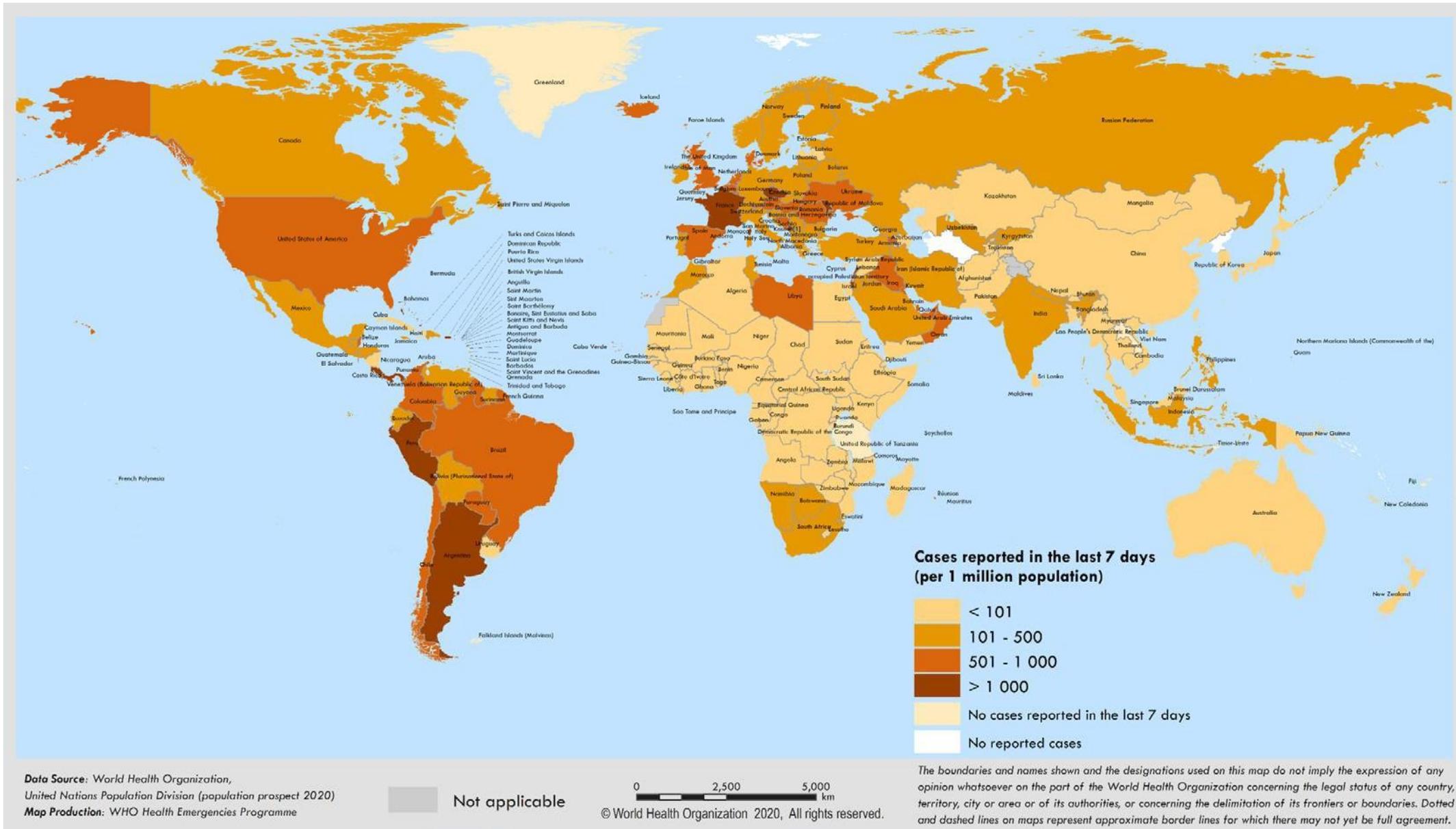
Global epidemiological situation

To date, over 32.7 million COVID-19 cases and 991 000 deaths were reported to WHO between 21. 27 September, more than 2 million new cases and 36 000 new deaths reported, which is similar to numbers reported last week. Cumulative deaths will exceed one million this week.



The Americas Region continues to carry the highest incidence of COVID-19 globally, reporting similar numbers of new cases and deaths as last week. it accounts for 38% of all new cases and 52% of all new deaths reported in the past seven days. The Eastern Mediterranean Region showed the greatest increase (9%) in cases in the past week, while the European Region reported a substantial rise in deaths, with a 9% increase on the previous week. The WHO African, Western Pacific and South-East Asia Regions reported decreases in new cases and deaths over the past week

COVID-19 cases per million population reported in the last seven days by countries, territories and areas, 21 through 27 September 2020**



WHO weekly update

“COVID-19: Nearly 33 million cases and one million deaths in 9 months. As Dr Mike Ryan, Executive Director of WHO’s Health Emergencies Programme said at the press conference on Friday 25 September, “the realities of getting a vaccine out there in the next nine months is a big task for everyone involved. There is a lot that can be done to save lives, both in terms of disease control, existing life-saving measures and the innovations that are coming down the pipe. Are we willing to make the investments now that are needed in the ACT Accelerator, especially in COVAX?+”

“67 higher income economies have joined the COVAX Facility, with another 34 expected to sign, joining 92 low- and middle-income economies eligible for support for procurement of vaccines. However, so far only 1/10 of the \$35 billion needed for scale-up and impact has been received. WHO aims to have two billion doses vaccine available by the end of 2021.

“A new report from Every Woman Every Child, “Protect the Progress: Rise, Refocus, Recover, 2020+” warns the COVID-19 crisis is exacerbating existing inequities, with reported disruptions in essential health interventions disproportionately impacting the most vulnerable women and children.

“WHO has released a video series, Science in 5, in which experts explain the science about specific issues related to COVID-19. So far five episodes have been released on subjects including herd immunity, SARS-CoV2, myths vs science, and reopening schools. The short videos on WHO’s YouTube, Instagram, Facebook, Twitter, and LinkedIn accounts and podcasts.

“Data presented are based on official laboratory-confirmed COVID-19 case and deaths reported to WHO by country/territories/areas, largely based upon WHO case definitions and surveillance guidance. While steps are taken to ensure accuracy and reliability, all data are subject to continuous verification and change, and caution must be taken when interpreting these data as several factors influence the counts presented, with variable underestimation of true case and death incidence, and variable delays to reflecting these data at global level. Case detection, inclusion criteria, testing strategies, reporting practices, and data cut-off and lag times differ between countries/territories/ areas. A small number of countries/territories/areas report combined probable and laboratory-confirmed cases; efforts are underway to identify these for notation in the data table. Differences are to be expected between information products published by WHO, national public health authorities, and other sources.

African Region

The region continues its decreasing trend for the seventh week, reporting a 7% decrease in new cases and 14% less new deaths. During the past week, 33 of the 49 affected countries reported either a decrease in deaths or no deaths. South Africa continues to report the highest new cases and new deaths followed by Ethiopia, Uganda, Algeria and Mozambique. South Africa also has

the highest number of cumulative cases and deaths per one million population in the Region, followed by Cabo Verde which has reported increasing numbers of cases and deaths over the past month. Cases in Mozambique have consistently increased over the last four weeks stretching health system capacity. Over half of the new cases and total cases are in Maputo. Its overall case rate remains relatively low: 248 cases per million population and two deaths per million population.

Americas Region

The Americas region remains the most affected WHO Region, accounting for 50% of all reported cases and 55% of deaths. It reported similar numbers of new cases and deaths this past week as compared to the previous week and accounts for 38% of new cases and 52% of new deaths. The United States of America, Brazil, Argentina and Colombia continue to report the highest number of new cases in the past week. Mexico reported the sixth highest number of new cases and third highest number of new deaths.

Eastern Mediterranean Region

Over the past month, new cases and deaths reported in the region have consistently increased, by 9% and 3% respectively. The highest numbers of new cases were reported by Iraq, Iran and Morocco. Somalia, Jordan, United Arab Emirates and Tunisia reported the greatest relative increase in cases compared to last week. While Iraq reported the highest number of new deaths, Bahrain and Jordan reported the greatest increase in deaths compared to last week.

European Region

While new cases and deaths reported in the region continued to increase in the past seven days, the rate slowed, with only a 5% increase in new cases and 9% increase in new deaths reported (compared to 11% and 27% increase, respectively, last week). France, the Russian Federation, Spain and the United Kingdom continue to report the highest new cases. Turkey reported the third highest deaths in last seven days after Russia and Spain. In France, the highest 7-day incidence was observed in the Île-de-France, Hauts-de-France and Provence-Alpes-Côte d'Azur, including Marseille, which has emerged as the epicenter of the second wave in recent weeks. While hospitalized cases have doubled in the past 10 days, numbers remain a magnitude smaller than observed earlier this year and hospital stays tend to be shorter. Nonetheless, test positivity rates have continued to trend upwards (reaching 7.4% on 27 September), and 58/101 departments are now classified in the red zone indicating very high levels of infection.

In the United Kingdom, there has been an increase in people testing positive for COVID-19 in all age groups, with Greater Glasgow and Clyde, the North West and the North East reporting the highest incidence last week. Wales has reported the highest rates of infection to date (727.7 per 100 000 population), followed by England (664), Northern Ireland (566.6) and Scotland (504.7).

South-East Asia Region

South-East Asia is the second most affected region, accounting for 21% and 11% of cumulative cases and deaths, respectively. While it had been reporting increasing cases and deaths since March, last week, a 7% decrease in new cases and a 3% decrease in new deaths were observed. The countries reporting the highest number of new cases continue to be India, Indonesia and Bangladesh, while Myanmar reported the highest increase in cases (92% increase) and deaths (80% increase) compared to last week.

Western Pacific Region

Overall, the region continues to show the lowest cumulative cases, accounting for just 2% of global cases and 1% of all deaths. The Philippines and Japan account for the most new cases and new deaths in the Region. All countries in the region except Malaysia, Papua New Guinea, and Guam reported decreases in new cases, compared to the last week. Only Malaysia reported an increase in new deaths. Incidence of COVID-19 in Papua New Guinea remains low. An 8-fold case increase was reported in August (396) compared to July (52). 73 cases reported so far in September is lower but there may be other undetected cases since the testing and overall health care capacity in the country are limited.

DEATH TOLL EXCEEDS 1 MILLION CASES

The world has recorded more than one million deaths due to the coronavirus. World Health Organization spokeswoman Margaret Harris told a UN briefing today that it was "a very sad milestone". "So many people have lost so many people and haven't had the chance to say goodbye. Many people who died, died alone... It's a terribly difficult and lonely death," she said. But she added that there is still hope.

UN Secretary General António Guterres has called that number "mind-numbing", and has stressed the need for all nations to work together against the virus. "Responsible leadership matters, science matters, cooperation matters and misinformation kills," he said in a statement. "As we remember so many lives lost, let us never forget that our future rests on solidarity -- as people united and as united nations." However, a World Health Organization spokeswoman said there was some good news - this virus was "suppressible" But the number is likely to be much higher as testing rates in many countries remain low, with virus-related deaths not being recorded We are seeing just over 5,000 recorded coronavirus deaths a day around the world at the moment. If that pace continues, we would expect the daily count to pass two million in just over six months. Of course, that's a big if. The tragedy is that the true death toll could pass two million far sooner than that. Back in June, BBC analysis of death records in 27 countries found another 130,000 deaths that didn't feature in the daily headline figure. That gap is surely even wider now.

In the UK, for example, the daily figure of 42,000 counts any death that happens within 28 days of a positive test. It rises to 57,000 if you include people whose death was believed to be caused by the coronavirus or who died more than 28 days after their test. It's even higher if you include people who couldn't get treated for other conditions because of the pandemic. These numbers are, sadly, likely to keep rising for some time.

COVID-19 FAST DIAGNOSTIC TEST FOR LOW & MIDDLE-INCOME COUNTRIES

A test that can diagnose Covid-19 in minutes will dramatically expand the capacity to detect cases in low- and middle-income countries, the World Health Organization (WHO) has said. The \$5 (£3.80) test could transform tracking of Covid-19 in less wealthy countries, which have shortages of healthcare workers and laboratories. A deal with manufacturers will provide 120 million tests over six months. The WHO's head called it a major milestone.

WORLD BANK WARNS PANDEMIC TO PUSH MILLIONS INTO POVERTY

For 20 years, poverty has dramatically dropped throughout most of east Asia. But now, the US-based World Bank has warned that the coronavirus pandemic could keep or push up to 38 million people in the region into poverty. Without rapid government action the triple shock of the virus, lockdown measures and the global recession could cause harm for years to come.

Sickness, food insecurity, job losses and school closures could lead to erosion of human capital and earning losses that last a lifetime, the bank said. Of those 38 million, an additional five million who were not previously in poverty would fall into the bracket. They define poverty as anyone living on less than \$5.50 a day. In May, it warned global growth could shrink by 5% and up to 60 million people worldwide could be pushed into extreme poverty living on under \$1.90 a day.

Australia

Port Hedland is a major port in Western Australia (file photo)

Port Hedland is a major port in Western Australia (file photo)

Authorities in Western Australia say a further eight crew members have tested positive from the bulk carrier Patricia Oldendorff . bringing the number of infections to 17 of 21 total crew. Seven remain on board to operate ship while the remaining 10 have been taken to a hotel in nearby Port Hedland for quarantine. Those still on the Patricia Oldendorff reportedly have mild symptoms or none at all. The vessel arrived from Manila last week, and Western Australian authorities said all crew were in good spirits and have been able to speak to their families back in the Philippines. Australia saw a huge spike in cases over the last few months which only now have begun to fall after stringent lockdown measures. The Australian Broadcasting Corporation reports that residents around Port Hedland . a major iron ore export terminal . are becoming increasingly concerned about the situation. Port Hedland Ratepayers Association president Arnold Carter told ABC it was "amazing, shocking and disastrous", while Australian Medical Association local president Andrew Miller said more needed to be done to handle ships. More and more and more of the

ships that turn up in Western Australia are going to have Covid on them, and so we now need to fully understand how we will handle it when it happens in these very vulnerable regional areas,+he told ABC

Czech Republic and Slovakia

The Czech Republic and Slovakia are set to declare states of emergency this week. Most big events will be banned in Slovakia from tomorrow and Czech Health Minister Prymula will present proposals to the cabinet today. Czech infection rates are among the highest in Europe but have fallen in recent days.

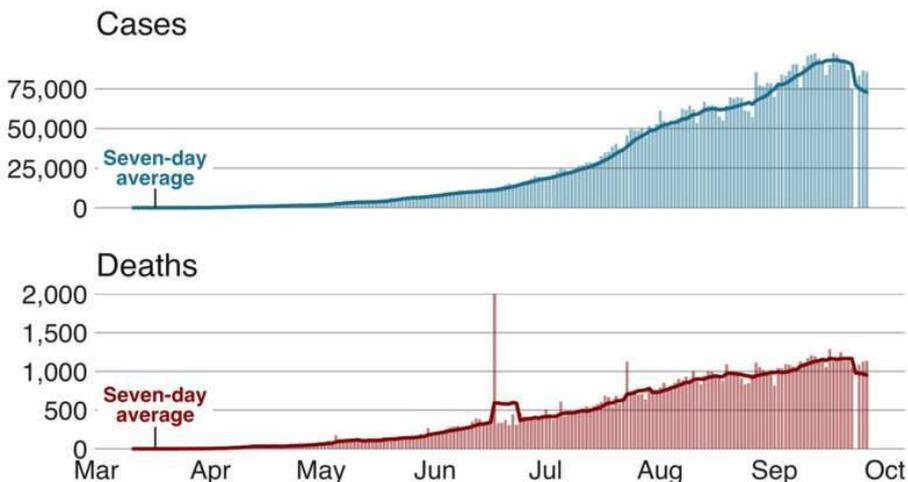
Greece

Mein Schiff 6 was the first cruise ship to enter Greek waters since the pandemic but it's now arrived in Piraeus for a health inspection after 12 crew members tested positive. 922 passengers had to provide negative test certificates before boarding. Greek reports say crew who tested positive have now tested negative.

India

India has now over six million coronavirus confirmed cases, after authorities announced 82,170 more recorded cases. It is second worldwide for cases but there are fears it could soon surpass the US, as new infections are rising faster than anywhere else. Some believe the situation could be even worse than reported. Health experts believe that low testing rates cover up the scale of infections, and there are allegations of authorities undercounting deaths.

Number of daily cases and deaths in India



Deaths on 17 June include historic deaths reclassified with coronavirus as cause

Source: Indian Ministry of Health and Family Welfare, data to 26 Sep



The Gavi Vaccine Alliance has announced further collaboration with the Indian pharmaceutical company Serum Institute. Gavi and the Bill & Melinda Gates Foundation will fund a further 100 million doses of Covid-19 vaccines from Serum, bringing it to a total of 200 million doses for low and middle income countries . with a maximum price of \$3 (£2.33) per dose. Different companies

and countries are striking up vaccine deals around the world. There are concerns that wealthier countries will push out more vulnerable nations, and authorities are trying to make sure any vaccine developed is rolled out globally.

Italy

Fourteen players and staff tested positive at Serie A club Genoa in an outbreak that Italy's top football league will be watching carefully. Genoa played Napoli on Sunday and their next match on Saturday and their next match on Saturday is at risk . but there are fears for other matches too.

Netherlands

The Netherlands introduces new curbs, including working from home where possible, and limits on groups. Prime Minister Mark Rutte once described the Dutch approach to tackling Covid-19 as an "intelligent lockdown" and has been openly sceptical about mask wearing. But as the Netherlands enters its second wave with some of the worst infection rates in Europe he had to tighten the rules. For the first time since the start of the pandemic, people in Amsterdam, The Hague, Eindhoven and Rotterdam are being advised to wear face coverings in shops. Facemasks are being advised in the biggest Dutch cities, and cafes and restaurants must shut early.

Restaurants and bars across the country must close by 22:00 local time (20:00 GMT). Fans are banned from attending sports events. Businesses such as hairdressers and dentists must log their clients contact details. People are encouraged to work from home and stay indoors if they have symptoms. This week the Netherlands broke its own daily infection record and expects 5,000 new cases per day by next week. Hospital admissions have risen for the 26th consecutive day and ICU numbers are increasing. Last night, standing alongside the prime minister, Health Minister de Jong said, "We are doing our best, but the virus is doing better."

Singapore

Progress appears to be being made with an increase in the daily number of crew changes to about 300 people per day now possible. Dialogue continues between the various authorities to keep the situation moving forward.

South Africa

A new government gazette regarding information which will impact on crew changes is expected to be issued imminently. Once available ICS will share with the wider membership.

The Philippines

The number of coronavirus cases in the Philippines rose to over 309,000 Tuesday after 2,025 new infections were added to the tally. This pushed the

total caseload to 309,303, of which nearly 17% were active cases or people who are still undergoing

Metro Manila recorded the highest number of new cases with 628. Cavite came in second with 279, followed by Negros Occidental with 218, Laguna with 108 and Bulacan with 102. Eighty-one percent of the new cases occurred in the last two weeks, the Department of Health said. Total recoveries climbed to 259,930 after the DOH reported 290 additional recovered patients.

Meanwhile, 68 more people died from the disease, raising the death toll to 5,448. The DOH said yesterday that there is a seeming downtrend in the number of new infections but it advised the public to continue practicing minimum health standards. Only Lanao del Sur, including Marawi City, will be under a stricter modified enhanced community quarantine beginning October 1.

Metro Manila, the epicenter of the country's outbreak, will remain under general community quarantine until the end of October. Other areas under GCQ include Batangas, Tacloban City, Bacolod City, Iligan City and Iloilo City.

Meanwhile, the rest of the country will be under modified GCQ, the most relaxed form of community quarantine. The government first imposed quarantine measures in mid-March to slow the spread of the disease but thousands of cases are still being reported daily. Over 3.46 million people have been tested. The virus has reached all 81 provinces in the Philippines nearly eight months since local health authorities first detected a case. This, after the northernmost province of Batanes today reported its first confirmed COVID-19 case. The patient is a "locally-stranded individual" who returned on September 22. "Locally-stranded individual" classifies residents of other provinces stuck in Manila or other urban areas due to pandemic lockdowns. The patient is asymptomatic but under strict isolation at Batanes Resort. Close contacts of the first case and other LSIs under quarantine are being monitored. The Department of Health noted that the province's first case has not been officially reported but it is coordinating with appropriate agencies for relevant information. Batanes recording a confirmed case means that all provinces have or have had COVID-19 cases. Early action, strict 'stay-at-home' measures in some provinces helped keep COVID-19 out. Remoteness and early lockdowns helped protect Batanes. Batanes Gov. Cayco advised CNN Philippines in August that the province's location and early implementation of lockdown and other health measures helped keep covid out. Government-led programs have been blamed for spread of the virus elsewhere. Despite implementing the longest lockdown, the Philippines still has the most COVID-19 cases in the region with over 307,000. 252,665 have recovered, while 5,381 have died.

United Kingdom

The UK government reported 4,044 new cases on Monday, the third day in a row the daily total has fallen Covid and measures associated with it are putting the UK's health service under stress, its bosses warn. The number of weekly deaths where coronavirus was on the death certificate has risen to more than 100, official figures for England and Wales show. Some 139 deaths were

registered in the week ending 18 September where "novel coronavirus" was mentioned - accounting for 1.5% of all deaths, the Office for National Statistics said. It is the second consecutive weekly rise in such deaths. The latest figures for each of the UK nations show 57,860 deaths have been registered where Covid-19 was mentioned on the death certificate, including suspected cases.

Young people's job prospects have been hit hardest by the pandemic in the UK, where thousands have been furloughed or made jobless. Many have had to look for other ways of making money.

UK mortgage approvals last month hit the highest levels since 2007, new data suggests, as the market continues to recover from the coronavirus lockdown. The Bank of England says some 84,700 mortgages were approved in August, up from 66,300 in July. The August figure, however, only partially offset weak numbers seen from March to June. In 2020 there have been 418,000 approvals, compared with 524,000 in the same period in 2019.

A UK government minister has been unable to clarify parts of the new coronavirus restrictions within north-east England. People who break a new law against mixing socially in seven places face a maximum £6,400 fine. The tougher measures which come into force on Wednesday amid a spike in Covid-19 cases - will affect about two million people. Skills Minister Gillian Keegan was asked whether the new restrictions apply to outside areas, such as pub and restaurant gardens. I'm sorry I can't clarify that. I don't know the answer to that question but I'm sure they can find out."

Students at Queen's University in Belfast now have to self-isolate at their halls of residence, as UK universities continue to struggle with outbreaks of coronavirus. About 100 students were told to self-isolate after 30 people tested positive for Covid-19. A university spokesperson said "robust protocols" were in place to minimise further spread. Coronavirus cases at about 40 universities mean thousands of students have had to self-isolate in the first few weeks of the new academic year unable to attend lectures or socialise. This includes 1,700 students at Manchester Metropolitan University, where some students were being prevented from leaving by security guards and police.

United States of America

New York was the early epicentre of the pandemic in the US. At one point in April the state had recorded more coronavirus cases than any single country, and it took authorities months to bring infection rates down. On Monday, however, Governor Andrew Cuomo warned that the percentage of Covid-19 tests coming back positive has risen to 1.5% - a worrying trend for the state, where previously the number had hovered around 1%. Health authorities said rates had risen at an alarming rate in some neighbourhoods, particularly in the boroughs of Brooklyn and Queens. Officials are still trying to find a reason for the clusters, Mr Cuomo told reporters yesterday. It is part of a surge in cases throughout the US. Latest figures show the US is reporting around 45,000 cases a day, compared to 40,000 a week ago and 35,000 two weeks ago. New cases have risen for two weeks in a row in 27 US states, according to Reuters.

President Trump has faced strong criticism for his handling of the pandemic. The US has recorded the most deaths and most infections anywhere in the world and is still reporting tens of thousands of new cases a day. On Monday, US President Donald Trump said the federal government would this week start sending out millions of rapid tests to states, and called on governors to place a priority on testing school children . though governors can use them as they choose. Officials said 6.5 million tests will go out this week and a total of 100 million in the weeks to come. Numbers of tests per state are based on population. The US recently agreed to buy 150 million rapid tests from Abbott Laboratories in a \$750 million (£583m) deal.

Trump's announcement comes just weeks before the US presidential election in November. The US president has faced strong criticism for how he has handled the pandemic, and is currently trailing Joe Biden in national polls. The first presidential debate between the candidates is on Tuesday.



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Ref.: AN 5/28-20/97

23 September 2020

Subject: Facilitating passenger flights, including repatriation flights, using public health corridors during the COVID-19 pandemic

Action required: a) note the guidance specifically applicable to facilitating passenger and repatriation flights during the COVID-19 pandemic; and b) complete the online survey on COVID-19 Testing and Quarantine Measures no later than 15 October 2020

Sir/Madam,

1. I have the honour to inform you that the International Civil Aviation Organization (ICAO) has developed a guidance specifically applicable to facilitating passenger and repatriation flights using Public Health Corridors (PHC) during the COVID-19 pandemic.
2. The ongoing COVID-19 pandemic continues to have a significant impact on air transport, causing disruptions in supply chain delivery and hampering the movement of people. The ICAO Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) continues to develop guidance material on the implementation of PHC to facilitate continued flight operations whilst mitigating the spread of COVID-19.
3. The initial CAPSCA PHC guidance applicable to flight crew conducting cargo operations (Electronic Bulletin 2020/30, published in May 2020) was updated and expanded to include maintenance, ferry and delivery flight operations (Electronic Bulletin 2020/36, published in June 2020).
4. For the commencement of operations following extended periods of reduced flying, the need to ensure adequate flight crew training and proficiency checking is of particular importance, since failure to do so could have grave consequences. Equally important is the renewal of medical certification of crew. In some instances crew members are required to undergo aviation medical examinations in States which might be different to their States of residence. Noting that many States do not have direct access to training facilities such as flight simulation training devices, it is essential to consider flight crew as key workers to benefit from PHC initiatives when accessing such facilities or being required to undergo medical

examinations in other States. Flight crew travel facilitation between States for training and medical certification purposes is essential in re-establishing operations as alleviations to medical certification, training and checking requirements expire.

5. This new guidance, focusing on cabin crew and passenger protection, has been compiled on the basis of a recent CAPSCA survey and discussions during CAPSCA and industry coordination meetings in accordance with the ICAO Global Implementation Roadmap (State Letter EC 6/3-20/80 published on 24 July 2020) supporting the implementation of the Council Aviation Recovery Task Force (CART) guidance (<https://www.icao.int/covid/Pages/default.aspx>).

6. As an immediate action to assist in facilitating passenger and repatriation flights, States are requested to take note of this newly issued guidance on the COVID-19 Response and Recovery Platform (<https://www.icao.int/covid/Pages/default.aspx>) and on the recently redesigned CAPSCA website (www.capsca.org).

7. Please note that the guidance has been developed in the context of the global COVID-19 situation in mid-September 2020. As the pandemic evolves, CAPSCA will review and update these guidelines.

8. Some States have implemented COVID-19 testing as part of their border control procedures. ICAO is requesting Member States to provide information about their current COVID-19 testing and quarantine practices. In particular, States are requested to share available data and conclusions in using these tests. The online survey, in English only, is available at the following link: <https://www.surveymonkey.com/r/CAPSCA2>. The survey may also be completed using the attached form. Responses using the attached form should be returned by email to MED@icao.int. States are further requested to share available high-level analytical data on testing results with ICAO by sending it to MED@icao.int, taking into account medical confidentiality considerations.

9. Pursuant to the above, I would be grateful if your Administration would encourage the completion of the online survey in consultation with relevant stakeholders as identified above, as soon as possible, but no later than **15 October 2020**.

Accept, Sir/Madam, the assurances of my highest consideration.

Fang Liu
Secretary General

Enclosures:

- A ô State COVID-19 Testing and Quarantine Measures
- B ô Facilitating Passenger Flights, including Repatriation Flights, Using Public Health Corridors During the COVID-19 Pandemic

STATE COVID-19 TESTING AND QUARANTINE MEASURES

Objective

Under the framework of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) programme, ICAO is requesting Member States to provide information about their current COVID-19 testing and quarantine practices. The responses to this survey will be used to develop guidance material using a risk-based approach to support the recovery of air traffic through the re-opening of borders and by means of implementing Public Health Corridors. States are further requested to share available high-level analytical data on testing results with ICAO by sending it to MED@icao.int, taking into account medical confidentiality considerations.

Questions 1-7 below relate to testing prior to departure

Q1: Does your State currently require mandatory COVID-19 tests prior to flight in the country of departure?

No

No, if the passenger or aircrew member provides a health certificate which shows a clean bill of health Yes

Yes, but with exceptions. Please list

Q2. Is your State considering implementing COVID-19 testing, in the country of departure, as a requirement prior to flight?

No

Yes

Yes, with exceptions. Please list

Q3. What type of COVID-19 test is currently required/accepted? Please indicate if more than one test is required.

PCR lab test

A rapid test

Antibody testing

Specify test being used

N/A

Q4. When is the COVID-19 test required? Please indicate the number of hours/days required for testing prior to departure.

Prior to departure at the airport ó state how many hours prior?

A minimum number of days prior to departure ó indicate how many days?

N/A

Q5. Where is the COVID-19 test to be conducted and how long does it take to obtain the results? Specify the type of facility and average waiting period for results. Please complete all possible options.

Airport/Waiting period until results are available?

Private clinic/Result time?

Public facility/ Result time?

N/A

Q6. Which of the following will be required to take the COVID-19 test?

Aircrew only

Passengers only

Both crew and passengers

N/A

Q7. Please provide any other additional relevant information concerning COVID-19 testing.

Questions 8-23 below relate to testing upon arrival

Q8. Does your State currently require COVID-19 tests upon arrival?

Yes, from all States

Yes, from some States ó please list

Yes, but with some exceptions ó please explain

No, if the passenger or aircrew member provides a health certificate that shows a clean bill of health.

No

Q9. Is your State considering implementing COVID-19 testing as a requirement upon arrival?

Yes, from all States

Yes, from some States, please provide criteria for requirement

No

Q10. What type of COVID-19 test is currently required? Please indicate if more than one test would be required.

PCR lab test

A rapid test

Antibody testing

Self-test

Specify test being used

N/A

Q11. When is the COVID-19 test required?

Immediately upon arrival at the airport?

Upon arrival, but not at the airport? Specify the number of days after arrival.

Both upon arrival and a subsequent test. State the number of days until the subsequent test.

N/A

Q12. Which of the following would be required to take the COVID-19 test? Complete all possible options.

Aircrew
All arriving passengers
Both aircrew and arriving passengers
Only inbound passengers from outside the State
Only inbound passengers from outside the region
Only passengers arriving from high-risk States
Please mention exceptions (e.g. bilateral or multilateral agreements with other States, Public Health Corridor)
N/A

Q13. Where is the COVID-19 testing being conducted? Please select all possible options and provide details.

On-site (at the airport)
At an approved/certified clinic, health centre, laboratory
At a special designated facility
Other?
N/A

Q14. Who performs the COVID-19 testing?

Airline personnel
Airport personnel
Health personnel of an accredited health centre
Other
N/A

Q15. Who assumes the cost for the COVID-19 testing?

Aircrew
Passenger
Airline
State
Specify other

Q16. Do aircrew and passengers need to wait before leaving the airport until COVID-19 testing results are available?

Yes ó if so is there a designated area for those waiting for their results? Specify.
No ó what are the follow-up parameters, if any, in place? Are there any conditions for follow-up?

Q17. If aircrew and/or passengers test positive, where are they isolated?

At the airport
At a testing facility
Permitted to leave to a specified address (i.e. home, hotel).
N/A

Q18. How long does it take for the COVID-19 test results to be available if tested upon arrival?

Q19. Are passengers quarantined upon arrival? If so, please provide details including duration of quarantine.

No

Yes

Only if they have been in contact with a suspected COVID-19 case while on board the aircraft

Only inbound passengers from outside the State Only inbound passengers from outside the region

Only passengers arriving from high-risk States

Only passengers with a positive COVID-19 test result upon arrival

All passengers

N/A

Additional details

Q20. How long is the required quarantine? Provide details.

Q21. Does a negative test result eliminate or shorten the quarantine period?

Yes ó provide details

No

N/A

Q22. Are there procedures in place for contact tracing and further communication with passengers if testing is conducted upon arrival? If yes, provide details.

Q23. What other COVID-19 health measures is your State considering to implement for aircrew and passengers?

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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.

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 ó 20/55 published on 15 April 2020 refers to **õrepatriation 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 õremuneration or hire.*

*Note 2. For the purpose of this document **Seafarer changeover flights** is defined as flights organized by shipowners¹ to facilitate crew changes and repatriation of seafarers².*

*Note 3. **Relief flights**, as defined in Annex 9 ô 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

¹ The term õshipownerõ includes õship operatorõ, õship managerõ, õfishing vessel ownerõ, õfishing vessel operatorõ, and õfishing vessel managerõ.

² The term õseafarerõ includes õmarine personnelõ, õfishersõ and õoffshore energy sector personnelõ. 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.

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 ó 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.

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 does not 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

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.

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.

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.

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.

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 of 20/55);

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 6 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 changes³, 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.

3 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/HotTopics/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/HotTopics/Documents/COVID%20CL%204204%20adds/Circular%20Letter%20No.4204-Add.14%20-%20Coronavirus%20(Covid-19)%20-%20Recommended%20Framework%20Of%20Protocols.pdf))

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 ó 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.

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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

Appendix C

**PUBLIC HEALTH COVID-19 PASSENGER SELF
DECLARATION FORM**

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

PUBLIC HEALTH COVID-19 PASSENGER SELF DECLARATION FORM	
<p>Purpose of this form: 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>1) Traveller Information:</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. & 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: Date:</p>	

Appendix D

Crew COVID-19 Status Card

CREW COVID-19 STATUS CARD									
<p>Purpose of this card: 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.</p> <p>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.</p>									
<p>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?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>									
<p>2. Have you had any of the following symptoms during the past 14 days:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 40px;">Fever</td> <td style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 40px;">Coughing</td> <td style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 40px;">Breathing difficulties</td> <td style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 40px;">Sudden loss of sense of taste or smell</td> <td style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>		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"/>
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"/>								
<p>3. Temperature at duty start:</p> <p style="text-align: right;">Temperature not recorded due to individual not feeling/ appearing feverish <input type="checkbox"/></p> <p>Temperature in degrees C° <input type="checkbox"/> / F° <input type="checkbox"/> : _____</p> <p>Date: _____ Time: _____</p> <p>Recording method : Forehead <input type="checkbox"/> Ear <input type="checkbox"/> Other <input type="checkbox"/> _____</p>									
<p>4. Have you had a positive COVID-19 test during the past 3 days?</p> <p style="text-align: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attach report if available</p>									
<p>Crew member Identification:</p> <p>Name: Airline/ aircraft operator: Nationality and Passport No: Signature: Date:</p>									