

UK CAA Guidelines for providing JAA Class 1 and 2 and European Class 3 Aeromedical Certificates to HIV Seropositive Applicants

The Joint Aviation Requirements – Flight Crew Licensing 3 (JAR-FCL 3) Amendment 5 does not allow initial JAA Class 1 and 2 certificates to be issued to HIV positive applicants. [European Class 3](#) certificates can be considered for initial Air Traffic Control Officer (ATCO) applicants. For pilots JAR-FCL 3 does permit recertification to JAA Class 1 with an Operational Multi-crew Limitation (OML) and Class 2 with an Operational Safety Pilot Limitation (OSL).

Until the European Aviation Safety Agency (EASA) implementing rules are implemented there may be circumstances in which it can be demonstrated that an individual who is HIV positive but without any symptoms or signs related to seropositivity or anti-viral therapy, is at low risk of disease progression or incapacitating events. The UK CAA in these circumstances may assess pilots for Class 1 and 2 certificates issued as a deviation from JAR provided the associated [ICAO](#) standard (contained in Annex 1 – Personnel Licensing) is met. This may limit the certificate holder to flying UK registered aircraft only. However, once the EASA implementing rules are implemented (in 2012 at the earliest) holders of certificates issued as a deviation may not be eligible for EASA certification.

The UK CAA guidance for assessing HIV positive applicants is as follows:

1. Following an initial diagnosis of HIV seropositivity or on application for an initial certificate

The Pilot or ATCO should be declared temporarily unfit or certificate issue deferred to the Aeromedical Section (AMS). The AMS will require reports from reviews described in (a) to (e) below. The intent of gathering these reports is to assess functional fitness and the prospective incapacitation risk.

a) HIV Specialist Review

An accredited specialist in genito-urinary medicine, who further specialises in HIV medicine, should undertake this review. The report submitted should include a history of infection, current symptoms, stability of condition, history of AIDS defining opportunistic infections or associated illnesses, a list of CD4+ T cell counts and Viral Load measurements, medication with start dates (confirming no ongoing side-effects), results of co-infection testing (which may include Hepatitis B & C, Cytomegalovirus (CMV), Toxoplasma and Tuberculosis), and blood testing for full blood count (FBC), urea and electrolytes (U&Es), liver function tests (LFTs), fasting glucose, lipids.

b) Neurology Review

Assessment should be undertaken to look for neurological sequelae of HIV positivity and therapy by an HIV specialist or consultant neurologist.

c) Neuropsychological Review

The pilot should undertake a baseline neuropsychological assessment. The tests should assess timed psychomotor tasks and memory tasks, which require attention, learning and active monitoring or retrieval of information. These baseline tests may be used as a future comparator (see “Follow-up”).

d) Psychiatry Review (if clinically indicated)

This should be undertaken with a consultant psychiatrist with particular attention paid to psychiatric symptoms and signs related to HIV seropositivity or Anti-Retroviral Therapy (ART).

e) Cardiology Review (if clinically indicated)

Lipodystrophy and a metabolic syndrome may arise as an interaction between HIV disease and/or immune recovery and antiretroviral medication. This may manifest as dyslipidaemia with raised total cholesterol, low HDL cholesterol and raised triglycerides or insulin resistance with hyperglycaemia.

Cardiology review is required in the presence of these or other significant cardiac risk factors e.g. hypertension, smoking, raised lipids, diabetes, age and evidence of left ventricular hypertrophy.

2. Aeromedical Certificatory Assessment

Pilots and ATCOs whose condition is stable, asymptomatic, with an acceptable CD4+ count and viral load (currently data from the CASCADE Collaboration and the EuroSIDA Study Group are used as a guide), with acceptable co-infection serology may be considered for a JAA Class 1 certificate (initial or unrestricted) to be issued as a deviation, or JAA Class 1 with an Operational Multi-crew Limitation (OML). Similarly they may be considered for a JAA Class 2 certificate (initial or unrestricted) to be issued as a deviation or JAA Class 2 with an Operational Safety Pilot Limitation (OSL). For ATCOs a European Class 3 certificate may be issued. Those applicants with a history of an AIDS defining opportunistic infection or associated illness will require more careful consideration.

Medication

As a guide, the following are generally acceptable medications: abacavir, didanosine, emtricitabine, lamivudine, tenofovir, zidovudine, atazanavir, fosamprenavir, lopinavir, ritonavir, nelfinavir, saquinavir, nevirapine and efavirenz.

Other medications will be considered on an individual basis assuming they are appropriately licenced and there is sufficient data on their safety available.

Certificate holders should be declared temporarily unfit whilst initiating, modifying or discontinuing ART and may be reassessed after a period of 2 months, although in some cases it may be at least 6 months before recertification.

Those commencing or modifying efavirenz treatment may need a psychiatric and neurological examination at initial certification or 2 months after commencing the therapy.

Applicants commencing ART can be assessed for certification providing that they have no ongoing side-effects and their FBC, LFTs, lipids and fasting glucose are acceptable.

Any change in therapy requires the certificate holder to be declared temporarily unfit and a report from an HIV specialist usually after 2 months to include recent CD4+ counts and viral loads, and no ongoing effects from either their medication or HIV seropositivity.

3. Follow-up

Regular follow-up is required and will usually include CD4 and VL measurements every 3 months, neurology assessment (by an HIV specialist or neurologist) every 6 months and, if on ART measurement of LFTs, FBC, lipids and fasting glucose, at least every 6 months.

Annual cognitive function assessment should be undertaken, although, for pilots, evidence of having passed a Licence Proficiency Check (LPC) or the report from a medical flight test (MFT) with a Flight Instructor Examiner (FIE) may be considered in lieu of this where the risk of disease progression is acceptably low. Impaired performance will require further neuropsychological assessment to be compared with baseline testing and any deficits will require that the pilot is declared temporarily unfit and referred to the AMS. Neuropsychological assessment may also be required if there are clinical concerns about cognitive impairment.

Further co-infection testing will be required where clinically indicated and those with new positive tests must be deferred to the AMS for further certificatory assessment.

If a certificate holder develops new symptoms and/or falls out with the acceptable limits listed above at any time after certification they should inform the AMS.