



FEDERATION OF INDIAN PILOTS

FIP/DGCA/26-17

Date: 31 Aug 2026

To,

Mr Ram Mohan Naidu,
Minister of Civil Aviation,
MOCA, Rajiv Gandhi Bhavan,
New Delhi-110003.

**POLICY RECOMMENDATION FOR REVISION OF CAR SECTION 5
SERIES 'F' PART V AND PHASED IMPLEMENTATION OF
PSYCHOACTIVE SUBSTANCE TESTING TECH UNDER DGCA
CONSIDERING UNODC AND ICAO DOC 9654**

Dear Sir,

Greetings from FIP.

1. Reference is made to our previous letter FIP/DGCA/26-13 dated 17 Aug 2026.
2. Attached please find the following documents:
 - a) **UNODC** (United Nations Office On Drugs & Crime),
 - b) **ICAO Doc 9654** specifically dealing with drug/psychoactive-substance testing in aviation.
 - c) **SOTOXATM Oral Fluid Mobile Test System** of Abbot Labs brochure,
 - d) Australian CASA Amendment of instrument **CASA 125/09** — Drug and alcohol testing by CASA under **Subpart 99.C of CASR 1998** regulation.
 - e) **SOP for SOTOXATM Oral Fluid Mobile Test System** of Abbot.
3. The **Federation of Indian Pilots (FIP)** respectfully submits this policy recommendation for consideration by DGCA regarding the phased implementation of oral-fluid (swab) and random testing of psychoactive substance using rapid testing systems such as the Abbott Oral Fluid Testing Platform, similar to the system currently utilised by the Civil Aviation Safety Authority (CASA), Australia under its Drug and Alcohol Management Plan (DAMP) framework. The UNODC and ICAO Doc 9654 needs to be taken into consideration while revising the said CAR.



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NEED FOR ENHANCED TESTING CAPABILITY

4. Indian Civil Aviation is experiencing unprecedented growth in fleet size, Pilot strength, Cabin Crew numbers, Ground Handling personnel, Maintenance Engineers and other safety-sensitive Aviation Professionals. In this environment, effective psychoactive substance surveillance is essential to maintain public confidence and ensure the highest standards of aviation safety.

5. The existing urine-based testing framework prescribed under **DGCA CAR Section 5, Series F, Part V** has provided a robust foundation for regulatory oversight. However, increasing the coverage and frequency of testing presents practical challenges relating to infrastructure, logistics, crew availability and laboratory accessibility.

6. FIP believes that oral-fluid testing can significantly strengthen the existing framework by providing a rapid, reliable and operationally efficient complementary testing methodology.

INTERNATIONAL BEST PRACTICES

7. Several leading aviation regulators have successfully adopted oral-fluid testing alongside conventional urine testing, including:

- a) Civil Aviation Safety Authority (**CASA**), Australia;
- b) United States Department of Transportation (**DOT**);
- c) Federal Aviation Administration (**FAA**);
- d) General Civil Aviation Authority (**GCAA**), UAE.

8. These authorities have demonstrated that oral-fluid testing can be integrated into a highly regulated Aviation Safety environment while maintaining scientific reliability, chain-of-custody requirements, confirmatory laboratory testing and independent medical review.

APPLICABILITY:

9. Provisions of this Civil Aviation Requirements should be applicable to aircraft operators engaged in commercial operations (**Airlines, NSOPs & General Aviation**) for **Pilots, Cabin Crew, FD's and AME's**, Maintenance & Repair Organizations, Flying Training Organizations and Air Navigation Service Providers (ATCO's).

UNODC (UNITED NATIONS OFFICE ON DRUGS & CRIME)

10. The **United Nations Office on Drugs and Crime (UNODC)** is the United Nations' principal body dealing with **illicit drugs, organized crime, corruption and related security and health issues**. Established in **1997**, UNODC supports



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Member States through research, technical assistance, international standards and evidence-based prevention and treatment programmes.

11. Of particular relevance to Aviation and other **safety-sensitive occupations**, UNODC promotes a comprehensive approach to substance-use prevention. Its guidance recognizes **drug and alcohol testing as one component of a broader workplace programme**, alongside education, prevention, counselling, treatment and rehabilitation.

12. The **United Nations Office on Drugs and Crime (UNODC)** supports a comprehensive approach to workplace drug-use prevention and testing. Drug testing can be undertaken using different biological specimens, depending on the purpose, detection window and reliability required.

- a) **Urine Testing:** The most commonly used workplace drug-testing method. It can detect drug metabolites for a relatively longer period after use and is generally suitable for **screening and compliance programmes**.
- b) **Oral-Fluid (Saliva) Testing:** Detects drugs present in oral fluid and generally has a **shorter detection window**, making it particularly useful for identifying **more recent drug use**. It is relatively non-invasive and can facilitate supervised or on-site collection.
- c) **Blood Testing:** Provides a relatively short detection window and can be useful for determining the **presence of drugs in the body around the time of testing**. However, it is invasive and less practical for routine workplace testing.
- d) **Hair Testing:** Can provide a **much longer historical detection window**, potentially covering weeks or months depending on hair length. It may be useful for identifying patterns of repeated or historical exposure, but is less suitable for determining very recent use.
- e) **Sweat Testing:** Uses specialised collection patches to detect substances over an extended period. It is less commonly used for routine workplace testing.

ICAO DOC 9654 DRUG/PSYCHOACTIVE-SUBSTANCE TESTING IN AVIATION

13. ICAO Doc 9654-AN/945 – **Manual on Prevention of Problematic Use of Substances in the Aviation Workplace** is ICAO's principal guidance document addressing the prevention, identification and management of problematic use of **alcohol and psychoactive substances** in aviation. ICAO states that it is intended to assist States in developing national strategies and Airlines/employers in implementing workplace programmes.



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14. The document covers five major areas:

- a) **Education and awareness** of aviation personnel.
- b) **Identification** of problematic substance use.
- c) **Treatment and rehabilitation** of affected personnel.
- d) **Employment consequences** of problematic substance use.
- e) **Biochemical testing programmes.**

Types of testing referred to by ICAO

15. ICAO guidance recognises that biochemical testing can be used at different stages, including:

- a) **Pre-employment testing**
- b) **Random testing**
- c) **Testing based on reasonable suspicion**
- d) **Post-accident/incident testing**
- e) **Testing at intervals**
- f) **Follow-up testing** after an identified problem or return to duty.

16. Importantly, ICAO does **not view drug testing in isolation**. The framework combines testing with **education, prevention, identification, medical assessment, treatment, rehabilitation and controlled return to safety-critical duties**.

17. There is also an important **ICAO Assembly Resolution A33-12 (2001)**, “**Harmonization of drug and alcohol testing programmes.**” It directed the ICAO Council to improve guidance and work toward consistency among States' drug and alcohol prevention/testing programmes for safety-sensitive aviation personnel.

18. **ICAO Annex 1, Chapter 6** is also important. It establishes that licence holders must not exercise licence privileges while **under the influence of a psychoactive substance** that could impair safe performance, and must not engage in **problematic use of substances**. ICAO recommends identification and removal from safety-critical functions, with return to duty considered following appropriate treatment/cessation and assessment.



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19. Application to Aviation

For safety-sensitive personnel such as pilots, a combination of testing methods may provide a more comprehensive safety framework. For example, urine testing can provide a broader historical detection window, while oral-fluid testing can complement it by identifying more recent drug use.

20. Importantly, screening tests should be followed by appropriate confirmatory laboratory testing before a result is treated as a confirmed positive. Testing should also be accompanied by **Pilot Education and Sensitisation** regarding prescription/OTC medicines containing psychoactive substances, medical evaluation, confidentiality, counselling and rehabilitation mechanisms.

21. RELEVANCE TO FIP/DGCA:

UNODC principles can therefore support a balanced aviation psychoactive-substance policy combining **effective testing and deterrence with pilot sensitization, confidentiality, medical assessment, treatment and rehabilitation**, rather than relying on testing alone.

22. **ABBOTT ORAL FLUID TESTING TECHNOLOGY** 22. The Abbott oral-fluid testing system provides rapid detection of psychoactive substances through a non-invasive swab collection process. The literature of the instrument with a printer is enclosed.

23. Key advantages include:

- a) Collection can be performed directly at the workplace or airport.
- b) No requirement for dedicated washroom facilities.
- c) Direct observation reduces opportunities for specimen substitution.
- d) Faster testing process it takes approx. 20 minutes.
- e) Minimal disruption to operational duties.
- f) Improved capability for random and targeted testing.
- g) Suitable for remote airports and outstations.

The system is currently used internationally and has demonstrated practical applicability in aviation environments.



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COST CONSIDERATIONS

24. FIP recognises that implementation of a new testing methodology carries financial implications. Current indicative costs are:

- Abbott Testing Machine: approximately ₹11-12 lakhs per unit.
- Oral-fluid test cartridge: approximately ₹1,400 per test.

25. However, industry experience indicates that costs can be substantially reduced through:

- a) Bulk procurement;
- b) Centralised DGCA-approved procurement programmes;
- c) Multi-airline participation;
- d) Long-term supply agreements.

With increased testing volumes, the cost of machines and per test may reduce to approximately ₹ 10-11 lakhs per machine and ₹700-₹800 per test, making the programme economically viable over time.

PRACTICAL CHALLENGES FACED BY INDIAN AIRLINES

26. While supporting enhanced testing, **FIP recognises several operational constraints** presently faced by **Operators**.

a) Limited Standby Crew Availability

Many airlines continue to operate with constrained standby crew resources. Removing flight crew members from duty for lengthy testing procedures may result in:

- i. Increased reporting time;
- ii. Flight delays;
- iii. Operational disruptions;
- iv. Increased crew utilisation pressures;
- v. Additional rostering challenges.

The shorter collection and processing time associated with oral-fluid testing can substantially mitigate these concerns.

b) Limited Laboratory Infrastructure

At present, only a small number of laboratories in Delhi and Mumbai possess the capability to undertake specialised psychoactive substance testing and confirmation.



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Many metro airports and regional stations currently lack:

- i. Local testing facilities;
- ii. Rapid specimen transport arrangements;
- iii. Approved confirmation laboratories.

Accordingly, nationwide implementation should be aligned with the gradual expansion of laboratory capability and accreditation.

c) Financial Burden on Operators

A sudden increase in mandatory testing percentages, combined with new equipment procurement requirements, may create financial challenges for Airlines, particularly smaller operators, NSOP/GA, helicopter operators and regional carriers. An Airline with 5000 pilots could have a financial impact of approx. ₹ 2.0-2.5 crores annually for carrying out 100% urine testing of pilots only. However, 100% of swab testing would cost approx. ₹ 15 crores for 500 departures @ ₹ 800 per test on an annual basis.

A phased implementation strategy would allow operators to budget appropriately while ensuring that safety objectives are progressively achieved.

RECOMMENDED PHASED IMPLEMENTATION POLICY

27. FIP recommends a structured four-phase approach.

28. PHASE I – PILOT EVALUATION PROGRAMME (6–12 MONTHS)

DGCA may identify selected operators and airports for controlled evaluation.

Objectives:

- a) Validate operational performance;
- b) Assess reliability under Indian conditions;
- c) Evaluate chain-of-custody procedures;
- d) Assess staff acceptance;
- e) Evaluate cost-benefit outcomes.
- f) Testing to include Pilots, Cabin Crew, FD's, AME's etc.

29. PHASE II – MAJOR METRO IMPLEMENTATION

Implementation at:

- a) Delhi;



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- b) Mumbai;
- c) Bengaluru;
- d) Hyderabad;
- e) Chennai;
- f) Kolkata;
- g) Pune;
- h) Ahmedabad.

Testing may initially focus on:

- Random testing;
- Reasonable suspicion testing;
- Post-occurrence testing;
- Targeted testing programmes.

Random testing annually @ 25% OR more of Urine testing would continue simultaneously.

30. PHASE III – EXPANSION TO TIER-II AIRPORTS

Following successful validation, implementation may be extended to:

- a) Regional airports;
- b) NSOP/GA operators;
- c) Helicopter operators;
- d) Ground handling agencies;
- e) Maintenance organisations.

Additional laboratories may be approved during this stage.

31. PHASE IV – NATIONAL HYBRID MODEL

A permanent risk-based framework may then be established whereby:

- a) Oral-fluid testing is used for rapid random screening;
- b) Urine testing remains available where longer detection windows are required;
- c) All non-negative findings undergo confirmatory laboratory testing;



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- d) Independent medical review remains mandatory before any final regulatory action.

PROPOSED TESTING COVERAGE

32. FIP continues to support an increase in random testing coverage beyond the present 10% annual requirement. However, **any increase should be aligned with practical implementation capability.**

Suggested progression:

- a) Current Minimum: 10%
- b) Phase I: Increase to 15%
- c) Phase II: Increase to 20%
- d) Phase III: Increase to 25%
- e) Phase IV: Target minimum 25% annual coverage

This approach balances safety enhancement with operational realities.

REGULATORY SAFEGUARDS

33. The following safeguards should remain mandatory:

- a) Screening result shall not constitute proof of impairment.
- b) Every non-negative result must undergo laboratory confirmation.
- c) Independent medical review shall be mandatory.
- d) Aviation personnel must have access to appeal and review mechanisms.
- e) Chain-of-custody requirements must be maintained.
- f) Confidentiality and data protection requirements must be enforced.
- g) Pilot awareness and education programmes should accompany increased testing.

34. PILOT SENSITIZATION AND AWARENESS REGARDING MEDICINES, PSYCHOACTIVE SUBSTANCES AND ALCOHOL

An effective psychoactive-substance prevention programme should not rely exclusively on testing. **Education and sensitization of pilots are equally important preventive measures.**

35. FIP recommends that DGCA, in association with **AIRLINES AND PILOT ORGANISATIONS**, establish a structured **Pilot Psychoactive-Substance and Medication Awareness Programme.**



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36. The objective should be to ensure that every pilot understands that certain

prescription medicines, over-the-counter (OTC) medicines, herbal preparations, supplements and other commonly available products may contain substances that can affect alertness, performance or produce a finding in a drug or alcohol test.

37. Medicines That May Affect Flight Safety

Pilots should be specifically sensitized regarding medicines that may:

- a) Cause drowsiness or sedation;
- b) Impair judgement or reaction time;
- c) Reduce alertness;
- d) Affect coordination;
- e) Produce residual effects after sleep;
- f) Interact adversely with alcohol;
- g) Contain prohibited or controlled substances; or
- h) Result in a positive or non-negative drug test.

38. **Particular attention should be given to:**

a. **Cough and Cold Preparations**

Some preparations may contain alcohol, sedating antihistamines or other active ingredients that may affect fitness for duty.

b. **Antihistamines and Anti-Allergy Medicines**

Certain first-generation antihistamines may cause significant sedation and impaired alertness.

c. **Sleep and Anxiety Medicines**

Sedative or hypnotic medicines may produce residual impairment even when taken many hours before reporting for duty.



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d. Strong Pain-relieving Medicines

Certain analgesics may contain opioid or opioid-like substances and require appropriate medical assessment.

e. Prescription Psychiatric or Neurological Medicines

Some medicines may affect alertness or may require specific aviation-medical consideration.

f. Herbal and Traditional Medicines

Pilots should not assume that a product is automatically safe for flight merely because it is described as “natural”, “herbal” or “Ayurvedic”.

g. Supplements and Performance Products

Products obtained through unregulated channels may contain undeclared pharmacologically active ingredients.

h. Alcohol-containing Medicines and Preparations

Pilots should be made aware that some medicinal preparations may contain alcohol and that their use must be considered in the context of applicable DGCA alcohol restrictions and fitness-for-duty requirements.

39. “Check Before You Take” Principle

FIP recommends introducing a simple principle throughout the Indian pilot community:

40. “CHECK BEFORE YOU TAKE.”

A pilot should not commence any new prescription, OTC medicine, supplement or herbal preparation without determining:

- a) What are the active ingredients?
- b) Does the product contain alcohol?
- c) Does it contain a controlled/prohibited substance?
- d) Can it cause drowsiness or impaired performance?
- e) What is its residual effect?



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- f) Is there an aviation-medical restriction applicable to the medicine?
- g) How long should the pilot remain unfit for flight after taking it?
- h) Does the medicine require consultation with an Aviation Medical Examiner (AME)?

This should become part of the normal professional safety culture of every pilot.

41. **Airline Responsibility**

Air operators should establish an easily accessible **Medication and Substance Advisory System** for pilots. **Each operator** should provide Pilots/CC/FD/AME with:

- a) A list of commonly encountered restricted medicines;
- b) Guidance on OTC medicines;
- c) access to an appropriately qualified aviation medical professional;
- d) A confidential mechanism for medication-related questions;
- e) Guidance concerning alcohol-containing preparations;
- f) Information on prohibited/restricted substances;
- g) Procedures for declaring medication use where required; and
- h) Instructions on obtaining medical clearance where necessary.

42. The objective should be **early consultation rather than inadvertent violation**. A pilot should be encouraged to ask:

“Is this medicine safe and permissible for me to take before operating an aircraft?”

Rather than discover the problem through a drug test.

43. **Mandatory Initial and Recurrent Sensitization**

FIP recommends that DGCA consider requiring **initial and recurrent sensitization programmes** for pilots.

I) **Initial training**

All newly licensed or newly employed pilots should receive a module covering:

- a) DGCA psychoactive-substance regulations;



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- b) Drug and alcohol testing procedures;
- c) Commonly encountered medicines;
- d) Prohibited substances;
- e) Legitimate prescription medication;
- f) OTC medicines;
- g) Alcohol-containing preparations;
- h) Residual effects and impairment;
- i) Consequences of non-compliance;
- j) Testing procedures;
- k) Rights and responsibilities; and
- l) Medical consultation procedures.

II) **Recurrent Training**

A refresher programme should be conducted periodically, preferably **at least annually**, and should include updates on:

- New medicines;
- New testing methodologies;
- Changes in DGCA regulations;
- Emerging psychoactive substances;
- Medication-related incidents;
- Lessons learned from anonymised testing data; and
- Changes in aviation-medical guidance.

44. **Sensitization Should Accompany Increased Testing**

This is particularly important if DGCA increases random testing from the present 10% level. A stronger testing regime should be accompanied by an equally strong **awareness and prevention programme**.

45. The philosophy should be:

Educate → Prevent → Test → Confirm → Medically Review → Take Appropriate Action

rather than:



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Test → Detect → Punish

The former creates a stronger safety culture.

46. Confidential Medical Consultation

Pilots should have access to confidential professional advice before taking a medication that could potentially affect their ability to safely perform flight duties.

47. The system should encourage pilots to disclose medication use to an appropriate aviation medical professional without creating a fear that seeking medical advice itself will automatically result in punitive action. This is important because a pilot who is uncertain about a medication should feel able to **seek advice before taking it**, rather than conceal its use. At the same time, where a medication or substance genuinely affects fitness for duty, the overriding principle must remain **flight safety**.

ACTION BY DGCA ON DECLARING POSITIVE IN THE TEST

48. For a policy proposal to **DGCA**, the **FIP** would suggest the following principle:

“A confirmed positive psychoactive-substance test should result in immediate removal from safety-sensitive duties, but the ultimate penalty should be determined after confirmatory testing, Medical Review Officer assessment and consideration of the circumstances, rather than automatic cancellation of the pilot’s licence.” The policy should distinguish between:

- a) **Use outside duty without impairment**
- b) **Presence of a substance/metabolite**
- c) **Actual impairment while on duty**
- d) **Deliberate use before/during duty**
- e) **Refusal or manipulation of testing**
- f) **First occurrence versus repeated/relapse cases**
- g) **Legitimate therapeutic medication versus prohibited substance use**

49. This is important because **a laboratory-positive result does not by itself establish that a pilot was impaired while operating an aircraft**. A robust policy should therefore protect flight safety while also ensuring medical due process and avoiding disproportionate punishment.

50. A proposed penalty ladder is as follows:

- a) **First confirmed positive → Remove from duty → MRO assessment →
Rehabilitation/education → Negative test → Monitored return**



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- b) **Second positive → Longer suspension → Specialist assessment → Structured rehabilitation → Intensive random testing → Conditional return**
- c) **Third/repeated positive or deliberate on-duty use → Prolonged suspension/cancellation consideration + formal enforcement action**
- d) **Refusal/tampering → Serious regulatory offence → Suspension and enforcement action**

51. This approach is broadly consistent with the more rehabilitation-oriented elements of **EASA and CASA**, while retaining strong sanctions where there is **actual safety risk, deliberate misconduct or repeated non-compliance**.

If this is for the **FIP proposal to**

CONCLUSION & RECOMMENDATIONS BY FIP

52. Indian aviation is entering a period of unprecedented expansion, with fleet sizes expected to double over the coming decade. The effectiveness of the psychoactive-substance testing programme must therefore evolve to meet this growth while maintaining the **highest levels of Aviation Safety**.

53. ICAO Doc 9654 + ICAO Annex 1 + ICAO Assembly Resolution A33-12

Together, they provide a strong international basis for arguing that India's programme should include **adequate frequency of testing, random testing, reasonable-suspicion testing, post-accident/incident testing, follow-up testing, education/sensitisation and rehabilitation**, while maintaining due process and confidentiality.

54. **UNODC framework provides a sound basis for developing a comprehensive and balanced policy on drug and psychoactive-substance use in safety-sensitive occupations such as aviation.** The policy should not rely solely on punitive testing, but should integrate **prevention, education and sensitisation, appropriate drug testing, early identification, medical assessment, counselling, treatment, rehabilitation and follow-up monitoring**.

55. For the Aviation Sector, the policy should provide for **pre-flight, random, pre-employment, reasonable-suspicion, post-incident/accident and follow-up testing**, using appropriate biological specimens and scientifically validated laboratory methods. Particular emphasis should also be placed on **educating pilots about prescription and over-the-counter medicines that may contain or cause impairment from psychoactive substances**.

56. A UNODC-aligned approach would therefore ensure that drug-testing programmes achieve their primary objective—**protecting flight safety—while maintaining**



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fairness, confidentiality, due process and opportunities for rehabilitation.

This approach can serve as a useful foundation for strengthening India's existing **DGCA psychoactive-substance testing policy** and bringing it closer to internationally accepted best practices.

57. FIP submits that oral-fluid testing using internationally accepted technologies such as the Abbott system offers DGCA an opportunity to significantly enhance random testing coverage, improve deterrence, reduce operational disruption and strengthen overall safety oversight. At the same time, we recognise the practical **constraints faced by Operators**, including **limited standby crew availability, inadequate testing infrastructure at several airports and the additional financial burden associated with increased testing.**

58. Accordingly, FIP strongly recommends a **phased and evidence-based implementation** strategy **rather than an immediate nationwide mandate.** Such an approach would allow DGCA, Airlines/NSOPs/GA/MRO/FTO etc and testing agencies to progressively build capability, validate procedures and optimise costs while preserving the integrity of the existing regulatory framework.

59. The ultimate objective should be a modern, scalable and scientifically robust testing programme that combines prevention, education, random testing, confirmatory analysis and medical review to protect Passengers, Crew and the continued Safety reputation of Indian Civil Aviation.

60. FIP remains available to assist DGCA/MOCA in developing the proposed implementation framework and to participate in any technical working group or stakeholder consultation on this matter.

Yours faithfully,

(Capt. CS Randhawa)

President

Federation of Indian Pilots (FIP)

Encls:

1. UNODC (United Nations Office On Drugs & Crime),
2. ICAO Doc 9654 specifically dealing with drug/psychoactive-substance testing in aviation.
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Copy To:

1. Director General, DGCA, Sri Aurobindo Marg, New Delhi – 110003
2. Secretary, Ministry of Civil Aviation, Rajiv Gandhi Bhavan, New Delhi-110003.
3. Chairman, Parliamentary Standing Committee on Transport, Tourism and Culture Rajya Sabha Secretariat, New Delhi.
4. Chairman, Public Accounts Committee, Lok Sabha Secretariat, New Delhi.
5. PMO, Seva Teerth, South Block, New Delhi – 110011.
6. DG, AFMS, A' Block, Room No-403 Africa Avenue, New Delhi-110023