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7 Public health response: Non-pharmaceutical interventions in the Pandemic Alert Period (WHO Phases 3, 4 and 5)

7.1 Introduction

This chapter outlines the rationale for implementing non-pharmaceutical public health interventions against a novel influenza virus in the Pandemic alert period, and some of the difficulties posed by planning these interventions in advance of knowing the characteristics of novel influenza strains, such as infectivity, clinical severity etc. Chapter 8 deals with the use of non-pharmaceutical interventions during the Pandemic Period.

The purpose of this guidance is to promote a consistent approach to population based measures which might be taken at WHO Pandemic Phases 4 and 5, such as school closures, and also measures aimed at individuals in the community to reduce their risk of infection. Some of these measures are appropriate to implement now, at Phase 3, for seasonal influenza.

The non-pharmaceutical public health interventions recommended by the World Health Organisation are reviewed, and recommendations are made on the interventions that are appropriate to implement in Ireland, in the Pandemic Alert Period (Phases 3 (current situation), 4 and 5).^(1;2)

Implementation of these recommendations, if adopted, will not only apply within the health services, but also across other government departments and services. It is recognised that there is a need for flexibility as to which public health interventions are appropriate to implement. This will be dependent on the severity of the novel viruses encountered.

7.2 Aim of non-pharmaceutical interventions

The principal aim of non-pharmaceutical public health interventions during the Pandemic Alert Period is to limit transmission, illness and deaths, and to slow or stop the spread of infection with novel viruses, if possible.

One constraint with their use is the fact that it is unclear how long the world will remain in each of the WHO Phases, and how rapidly progression will occur from one phase to the next. At Phase 4 and 5, there will be evidence of human-to-human transmission, with increasing adaptation to humans, but as yet the novel virus will not be fully transmissible. Many of the interventions may have their greatest potential role during these phases, rather than during the pandemic (Phase 6) when human-to-human transmission is highly efficient.

During Phases 4 and 5, it's important to note that interventions may not be undertaken in isolation, and that strategies may be adopted of using several pharmaceutical and non pharmaceutical public health interventions in combination.

7.3 WHO recommendations for non-pharmaceutical public health interventions

The WHO undertook a broad ranging consultation exercise in 2004 on the public health interventions that could be used during an influenza pandemic.⁽²⁾

The aims of these interventions are:

- To prevent further human-to-human cases caused by a virus that has not yet established efficient human-to-human transmission
- To slow pandemic spread and thus gain time for strengthening preparedness measures, including the augmentation of vaccine supplies
- To reduce the impact of the first wave of a pandemic

The consultation group agreed that once efficient and sustained human-to-human transmission was established, there would be no possibility of averting a pandemic or appreciably slowing its spread. Also at some point, efforts to prevent international spread through travel related measures would also

become ineffective. In addition, as mortality and morbidity increase during the pandemic, contact tracing and quarantine of contacts would not be effective or feasible.

From this consultation process, the WHO identified and categorised non-pharmaceutical public health interventions as follows:

1. Public health information, communications
2. Measures to reduce the risk that cases transmit infection
3. Measures to reduce the risk that contacts (of cases) transmit infection
4. Measures to increase social distance e.g. school closures
5. Measures to decrease interval between symptom onset and patient isolation
6. Disinfection measures
7. Measures for persons entering or exiting an infected area within the country
8. Measures at borders for persons entering or exiting a country
9. Measures at borders for international travellers coming from or going to affected areas
10. Entry screening
11. Exit screening
12. Measures for travellers on board international conveyances from affected areas

The use of non-pharmaceutical interventions categorised as above has been considered where appropriate for each Pandemic Alert Phase (3, 4 and 5).

The first seven interventions apply to persons living or travelling within an affected country, and the next two relate to travel advice. The remainder apply at international level.

7.3.1 Public health information, communications

The Expert Group advises that the WHO approach as outlined in the WHO Outbreak communications guidelines, 2005, be taken to all risk

communication activities in relation to influenza in the Pandemic Alert Period 9.⁽³⁾ This guidance contains a short list of best practice for outbreak communication as follows:

Trust

The overriding goal for outbreak communication is to communicate with the public in ways that build, maintain or restore trust. This is true in every type of system.

Announcing early

Trust is established in the first official announcement of the outbreak. This message's timing, candour and comprehensiveness make it the most important of all communications.

Transparency

Maintaining the public's trust throughout an outbreak requires transparency. This means communication that is candid, easily understood, complete and factually accurate. Transparency allows the public to view the information gathering, risk assessing and decision making processes associated with outbreak control

Talking with the public

Understanding the public is critical to effective communication. It is usually difficult to change pre-existing beliefs unless those beliefs are explicitly addressed. It is nearly impossible to design successful messages that bridge the gap between the expert and the public without knowing what the public thinks

Planning

The decisions and actions of public health officials have more effect on trust and public risk perception than communication. In what you do, and what actions you take, you have a risk communication impact. Risk communication is therefore most effective when it is integrated with risk analysis and risk management. Risk communication should be

integrated into preparedness planning for major events and outbreak response.

7.3.1.1 Information for the public and health professionals on risks and risk avoidance (tailored to target populations)

The Expert Group advises that during the pandemic alert period (from Phase 3 on) information should be available for the public and for health professionals on risks and risk avoidance in the Pandemic Alert Period.

Preparatory material should also be available for the next Phase. This information should be tailored to different target populations and should include general information on the pandemic, its phases, and how to reduce the risk of infection.

7.3.1.2 Advice on universal hygiene behaviour

The Expert Group advises that information on respiratory hygiene should be promoted, including public campaigns and respiratory hygiene in healthcare settings, from Phase 3 on. This includes advising the public to cover the nose and mouth with a tissue when coughing or sneezing, and to dispose of tissues promptly in bins after use. Hand washing using soap and warm water is effective in reducing the risk of respiratory diseases, and should be encouraged. Alternatively alcohol based hand rubs can be used.

7.3.2 *Measures to reduce the risk of cases transmitting infection*

7.3.2.1 Confinement/isolation of cases

Patients with seasonal influenza should be asked to isolate themselves at home, unless hospitalisation is required. Isolation of cases is an important measure to prevent transmission of infection by reducing contact between cases in their most infectious phase and uninfected persons. **For initial cases of influenza due to a novel virus, the Expert Group advises that the patients are assessed and isolated in hospital**

An algorithm for the management of persons with acute febrile respiratory illness who may have avian influenza is available in Supplement 11, Appendix 3)

7.3.2.2 Measures to reduce transmission of infection in healthcare facilities

A universal respiratory hygiene strategy is a series of measures designed to reduce transmission of infection in healthcare facilities. These are outlined in Appendix A. These measures are not specific to influenza, but will also reduce the incidence of other respiratory pathogens. They include the use of facemasks by symptomatic patients when waiting for assessment in waiting rooms. **The Expert Group advises that a universal respiratory hygiene strategy should be adopted now in the Pandemic Alert Period (Phases 3, 4 and 5) in all health care facilities.**

7.3.3 *Measures to reduce the risk that contacts of cases transmit infection*

7.3.3.1 Contact tracing and quarantine

In the pandemic alert period, efficient human-to-human transmission of novel, potentially pandemic strains of influenza may not yet have been established. In this context, there is merit in aggressively tracing contacts and isolating and treating them with antiviral drugs if available in order to prevent wider spread. The potential difficulties with successful contact tracing include the fact that if the novel virus behaves similarly to seasonal influenza, with its short incubation period, being infectious for 24 hours prior to onset of symptoms, and a high rate of asymptomatic illness, this could lead to a limited ability to identify all contacts in the time required.

The Expert Group advises that all cases of influenza due to novel influenza virus occurring during the pandemic alert period should be interviewed in depth and all contacts should be identified and contact traced by the Department of Public Health.

A protocol for the management of contacts identified in the pandemic alert period is available in Supplement 11.

7.3.4 *Measures to increase social distance*

The Expert Group advises the voluntary confinement of symptomatic persons throughout the pandemic alert phases. For initial cases, this

confinement will be in hospital. Mandatory quarantine and curfews are not considered necessary.

7.3.4.1 Closure of educational facilities

The aim of this intervention is to reduce spread in those settings where transmission is occurring, and would only be considered in Phases 4 and 5 if **clusters of cases due novel influenza virus were occurring in Ireland.**

The Expert Group advises that in the Pandemic Alert Period, all schools should have ready access to information on influenza, and how to reduce the risk of infection. This information should also be available in the workplace and other settings where groups of people spend time together and use communal facilities.

The Expert Group advises that closure of schools, universities and educational institutions could be considered during Phases 4 and 5 of the Pandemic Alert Period, but only if clusters of cases due to novel influenza virus were occurring in Ireland at that time, if transmission was occurring in these settings, and if the case fatality ratio was high. All schools and day care institutions should have a plan for how they could close in an emergency. This plan should have input and involvement of teachers, parents and carers.

If a decision were taken to close a school, then ideally, criteria for reopening the school should as far as is possible be agreed in advance.

7.3.4.2 Population-wide measures to reduce mixing of adults

The Expert Group advises that population-wide measures to reduce mixing of adults (close workplaces, initiate leave of absence for non essential workers, discourage mass gatherings) should be considered in Phase 5 of the pandemic alert period, if Ireland was experiencing clusters of cases at that time and the case fatality ratio was high.

7.3.5 *Measures to decrease the interval between symptom onset and patient isolation*

7.3.5.1 Public campaign to encourage prompt self-diagnosis

The Expert Group advises that the public should be informed of the symptoms of influenza, how to recognise if they might have it, and advised of practical issues such as the value of having a thermometer at home, in the pandemic alert period .

7.3.5.2 Public advice and medical help lines

The Expert Group advises that at Phase 4 and 5, a national medical helpline should be established to deal with individual queries or concerns, and to direct those with symptoms to the appropriate location for care and treatment.

7.3.6 *Disinfection measures*

The Expert Group advises that disinfection measures which are effective in preventing the transmission of influenza should be promoted during the Pandemic Alert Period (Phases 3, 4 and 5)

Information on respiratory hygiene should be promoted, including public campaigns and respiratory hygiene in healthcare settings, from Phase 3 on. Hand washing using soap and warm water is effective in reducing the risk of respiratory diseases, and should be encouraged. Alternatively alcohol based hand rubs can be used.

Influenza viruses survive in the environment, and can pass from surfaces to the hands and cause infection. They can survive on tissues also, and cause infection. Tissues should be disposed of after use. Potentially contaminated surfaces should be cleaned using household disinfectants.

Widespread environmental decontamination or air decontamination is not recommended. Further guidance on infection control and disinfection can be found in the infection control supplement (Supplement 10).

7.3.7 Measures for persons entering or exiting an affected area in Ireland during Phases 4 and 5

The Expert Group advises that in the event of clusters of cases due to novel virus influenza (e.g. A/H5N1 infection of poultry) occurring in Ireland (Phases 4 and 5), persons should avoid contact with high-risk environments (such as infected poultry farms, live poultry markets) in areas affected.

The Expert Group advises that during WHO Phases 4 and 5 of the pandemic alert period, if outbreaks of influenza due to a novel virus are occurring at the time, non-essential travel to affected areas within Ireland should be deferred

It is anticipated that during pandemic Phases 4 and 5 most persons will voluntarily restrict travel to and from affected areas. Enforcement of travel restrictions is considered impractical, as is the imposition of a cordon sanitaire around affected areas. For public health purposes, disinfection of clothing, shoes or other objects of persons exiting an affected area is not recommended.

7.3.8 Measures at the international level

7.3.8.1 Travel Advice

The Expert Group advises that from pandemic alert Phase 3 on, advice and information on avoiding contact with high-risk environments should be available for travellers travelling to areas where outbreaks of novel influenza are occurring (e.g. the current international outbreak of A/H5N1 see Appendix B).

The Expert Group advises that from Phase 4 on, travellers should be advised to defer non-essential international travel to affected areas.

7.3.9 Measures at borders for international travellers coming from or going to affected areas

The Expert Group advises the following measures from Phase 4 onwards at borders for international travellers coming from or going to affected areas

- 1. Health Alert Notices should be provided to all travellers**
- 2. Travellers to and from affected areas should be advised to self-report if they have illness.**
- 3. Exit screening for at-risk travellers – identified via health questionnaires or declaration notices - should be implemented**
- 4. All intending travellers who are ill should be recommended to postpone travel**

Entry screening such as screening for symptoms (visual detection of symptoms), health screening questionnaires, thermal screening, and medical examination should not be necessary. There is a lack of proven health benefit with these measures. However, if there is evidence that exit screening at the point of embarkation does not meet the standards expected, it may be considered, following consultation with WHO and EU colleagues.

7.3.10 Measures for travellers on board international conveyances from affected areas

The Expert Group advises the following measures for travellers on board international conveyances coming from affected areas **from Phase 4 on:**

- 1. Travellers should be asked to self-report flu like illness, and sick travellers should be separated on board, if possible.**
- 2. The public health authorities in the destination and transit countries should be informed that there is an ill person on board so that appropriate contact tracing and control procedures can be initiated.** In addition, appropriate arrangements for medical assessment and treatment of the sick traveller need to be in place.

Interim Guidance for Aircraft Cabin Staff on Management of Suspected Human Cases of Avian Influenza is available in Appendix C.

7.4 Public Health Surge capacity

Non-pharmaceutical public health interventions may be the only tools available to slow spread of an emerging novel virus in advance of sufficient quantities of antivirals and pandemic strain vaccine becoming available.

The Expert Group considers it is crucial that consideration is given to the significant human resource implications of implementing these recommendations and that manpower planning for pandemic influenza also includes planning for a robust public health infrastructure and sufficient surge capacity for public health.

7.5 Reference List

(1) WHO. WHO global influenza preparedness plan. www.who.int . 2005.

Ref Type: Electronic Citation

(2) WHO. WHO consultation on priority public health interventions before and during an influenza pandemic. www.who.int . 2004.

Ref Type: Electronic Citation

(3) WHO Expert Consultation. Outbreak Communication. Best practice for communicating with the public during an outbreak. www.who.int . 2005.

Ref Type: Electronic Citation

Appendices

7.6 Appendix A Universal Respiratory Hygiene

The following are components of a universal respiratory hygiene strategy to be adopted in all health care facilities.

- The posting of visual alerts at the entrances to all healthcare facilities, instructing patients and those who accompany them to:
 - Inform healthcare personnel of symptoms of a respiratory infection when they first register for care
 - Practice respiratory hygiene
 - Advise visitors with respiratory symptoms to defer their visit until symptoms have resolved
- All patients and visitors who have symptoms of an infectious respiratory illness (cough, runny nose, sore throat or sneezing) should be provided with a surgical mask and instructions on their proper use and disposal. They should also be provided with instructions on hand hygiene.
- For those who cannot wear a mask, provide tissues and instructions on when to use them (i.e. when coughing, sneezing, or controlling nasal secretions), where they should be disposed of, and on the importance of hand hygiene after using them
- Waste bins should be readily available for disposal of tissues.
- Provide hand hygiene materials in the waiting room areas and encourage persons with respiratory symptoms to perform hand hygiene i.e. wash hands with soap and water and/or alcohol based hand disinfectants
- Instruct registration, reception and triage staff of their risk of exposure to infections spread by droplets and to consider wearing masks whenever

registering or assessing patients who have respiratory symptoms and are not wearing a mask. Instruct them to remain at least 3 feet from unmasked patients.

- Consider the use of Plexiglas barriers at the point of triage or registration to protect healthcare personnel from contact with respiratory droplets.
- Where possible, designate an area, cubicle or separate room in waiting areas where patients with respiratory symptoms can be segregated (ideally by at least 3 feet) from others without respiratory symptoms.
- Commonly used surfaces such as door handles, handrails, table surfaces etc. should be cleaned twice daily with disinfectant.
- Use droplet precautions to manage patients with respiratory symptoms until it is determined that the cause of the symptoms is not an infectious agent that requires more than standard precautions.

7.7 Appendix B: Advice for travellers going to and returning from travel to areas affected by avian influenza

The World Health Organisation (WHO) has not recommended travel restrictions to countries affected by avian influenza, including countries that have reported cases in humans. If the WHO changes its assessment of the risks of travel to an increased threat level, you will be advised accordingly.

Pre travel

- Always educate yourself and others who may be travelling with you about any disease risks in areas you plan to visit. A full list of countries with outbreaks of highly pathogenic avian influenza in avian species is available on the HPSC website.
- See your doctor before you travel to get any information on travel risks to the area you are going to.
- Include a thermometer and alcohol-based hand rub for hand hygiene in your travel health kit.

During travel

- Avoid all direct contact with poultry, including touching well-appearing, sick, or dead chickens and ducks. Avoid places such as poultry farms and bird markets where live poultry are raised or kept, and avoid handling surfaces contaminated with poultry faeces or excretions. Large amounts of the virus are known to be excreted in the droppings of infected birds
- One of the most important preventive practices is careful and frequent hand washing. Cleaning your hands often, using either soap and water or waterless alcohol-based hand rubs, removes potentially infectious materials from your skin and helps prevent disease transmission.
- Influenza viruses are destroyed by heat; therefore, as a precaution, all foods from poultry, including eggs and poultry blood, should be thoroughly cooked.
- If you become sick with symptoms such as a fever, difficulty breathing, cough, or any illness that requires prompt medical attention, it is advisable that you defer travel until you are free of symptoms unless your travel is health-related.
- Don't attempt to bring any live poultry or other avian products back to Ireland

Post travel

For 7 days following travel to an affected area:

- If you become ill with fever, difficulty breathing, cough, or any illness during this period, consult your GP

Before you visit your GP, or seek medical attention, tell your GP about your symptoms and recent travel history so that he or she can be aware you have travelled to an area reporting avian influenza.

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7.8 Appendix C - Interim Guidance for Aircraft Cabin Staff on Management of Suspected Human Cases of Avian Influenza

7.8.1 Introduction

This guidance is intended to inform airline crews on the appropriate management of an ill passenger who has recently been in an area affected by avian influenza outbreaks in poultry and other birds.

7.8.2 Background

Avian influenza is an infectious disease of birds caused by type A strains of the influenza virus. The disease, which was first identified in Italy more than 100 years ago, occurs worldwide and mainly affects wild birds.

http://www.who.int/mediacentre/factsheets/avian_influenza/en/index.html

Avian influenza also affects domestic and wild avian species such as chickens, turkeys, ducks, geese, shorebirds, gulls and others. Avian influenza outbreaks associated with highly pathogenic H5N1 have occurred in several countries since 2003.

Information on countries currently affected by avian influenza outbreaks in animals is available on the [World Organisation for Animal Health](#) and the [WHO websites](#). The spread of H5N1 to poultry in new areas is of concern as it increases opportunities for further human cases to occur. However, all evidence to date indicates that the H5N1 virus does not spread easily from birds to infect humans.

Regular updates on the numbers of confirmed cases, and situation updates from the affected countries are available on the [WHO website](#) and also on the HPSC website [countries affected by highly pathogenic avian influenza](#).

Although avian influenza A (H5N1) virus is highly pathogenic in humans, it is not transmitted efficiently from one human to another and human outbreaks have been short-lived. The 2004/2005 human influenza A (H5N1) infections were associated with close contact with infected poultry. These infections were thought to have been directly transmitted from the poultry. In September 2004, the Thai government reported a probable case of human-to-human H5N1 transmission, but this and any other suspected cases of human-to-human transmission so far have been limited to family members. There is currently no evidence of sustained person-to-person

transmission of avian influenza. However it is prudent to consider that individuals who are ill with H5N1 are potentially infectious.

7.8.3 Clinical presentation of avian influenza

The main presenting clinical symptoms during the 2004 avian influenza epidemics in Thailand and Viet Nam were fever, cough, widespread aches, sore throat, runny nose, shortness of breath and diarrhoea. Transmission of H5N1 viruses from infected individuals, if it does happen, could occur through the spread of large respiratory droplets, which usually requires close contact (<1 metre/3 feet) with an infected person or contact with contaminated hands or inanimate objects (e.g., armrests).

An [algorithm](#) outlining guidance for health professionals on the assessment and management of cases of respiratory illness in travellers returning from areas affected by avian influenza is available.

Any respiratory illness is more likely to be caused by the usual circulating respiratory pathogens but evaluation by a health care provider should take place.

7.8.4 Measures to control spread of infectious diseases while travelling

Many infectious diseases can be spread by human hands. Soiled hands are an effective means of delivering infectious material (e.g., saliva or other body fluids that may contain viruses) to the nose or eyes, where they can enter the body. Hand washing is an important way to reduce exposure to common infectious diseases. Cleaning one's hands with soap and water removes potentially infectious material from one's skin. Hands should be cleaned before preparing food, eating or touching one's face, and after handling soiled material (e.g., used tissues, lavatory surfaces), coughing or sneezing, and using the toilet. Waterless alcohol-based hand rubs may be used when soap is not available and hands are not visibly soiled.

7.8.5 In-flight care of suspected case of Avian Influenza

If a passenger travelling from an affected area becomes noticeably ill with a fever and respiratory symptoms, the following action is recommended for cabin crew:

1. The passenger should be, as far as possible, isolated from other passengers and crew (1-2 metres). Designate one cabin crew to look after the sick passenger.

2. The passenger should be asked to wear a protective (surgical) mask to reduce the number of droplets coughed into the air. If a surgical mask is not available, provide tissues and ask the ill patient to cover his/her mouth and nose when coughing and to put the used tissues into a waste bag. If the ill person is unable to wear a mask, the designated crew should wear a surgical mask.
3. The designated crew should wear disposable gloves for direct contact with blood or body fluids of any passenger. Immediately after activities involving contact with body fluids the gloves should be discarded into a wastebasket and hands should be cleaned with liquid soap and water or an alcohol based hand rub. Dispose of soiled materials in a biohazard bag, if one is available. If not use a sealed plastic bag.
4. The captain should radio ahead to the airport of destination so that local Director of Public Health can be alerted to the arrival of a suspect human case of Avian Influenza.

5. On arrival, the ill passenger should be placed in isolation and medically assessed.

7.8.6 *Contacts*

1. All contacts of the ill passenger should have already been identified during the flight. For the purposes of air travel a contact is defined as:
 - Passengers sitting in the same seat row or within at least 3 rows in front or behind the ill passenger
 - All flight attendants on board
 - Anyone having intimate contact, providing care or otherwise having contact with respiratory secretions of the ill passenger
 - Any one on the flight living in the same household as the ill passenger
2. Contacts should provide, to the local Department of Public Health, identification and details of address/contact details valid for 14 days.
3. Contacts should be given information about avian influenza and a public Health contact number. They should be advised to seek immediate medical attention, according to local Public Health protocols, if they develop any symptoms of avian influenza within seven days of the flight. In seeking medical attention they should ensure that all those treating them are aware that they have been in contact with a suspect case of avian influenza

4. Contacts should be allowed to continue to travel.
5. If over time it becomes apparent that the suspect case is a probable case of avian influenza the health authority where the case is being cared for should inform other health authorities in those areas in which contacts reside that active surveillance of each contact (daily temperature check and interview by health care worker) should be undertaken until seven days after the flight.

7.9 Aircraft Cleaning - General Guidelines for Cleaning Crew issued by IATA

The following are general guidelines for Cleaning Crew who has to clean an arriving aircraft with a suspected case of communicable disease. During an outbreak of a specific communicable disease, the World Health Organization (WHO) or member states may modify or add further procedures to these general guidelines. However, these general guidelines would always provide a basic framework of response that would reassure the cleaning crew and help them through any unplanned incident.

1. Wear non-sterile impermeable disposable gloves.
2. Remove and discard gloves if they become soiled or damaged, and after cleaning.
3. Wash hands with soap and water immediately after gloves are removed. An alcohol-based hand sanitizer can be used if the hands are not visibly soiled.
4. Surfaces to be cleaned (affected seat, adjacent seats same row, back of the seats in the row in front),
 - Armrests
 - Seatbacks (the plastic and/or metal part)
 - Tray tables and trays if still in place
 - Light and air controls
 - Adjacent walls and windows
 - Individual video monitor
 - Lavatory(ies) used by the sick traveller: door handle, locking device, toilet seat, faucet, washbasin, adjacent walls and counter.
5. Disinfection of upholstery, carpets, or storage compartments is only indicated when they have been soiled by body fluids. In such cases, disinfect before vacuuming to eliminate the risk of re-aerosolization.
6. Use only cleaning agents and disinfectants that have been approved by aircraft manufacturers.
7. Dispose of soiled material and gloves in a biohazard bag if one is available. If not, use a sealed plastic bag and label it as biohazard.
8. Do not use compressed air. It might re-aerosolize infectious material.

Source:

http://www.iata.org/whatwedo/safety_security/safety/health_safety/aviation_communicable_diseases.htm