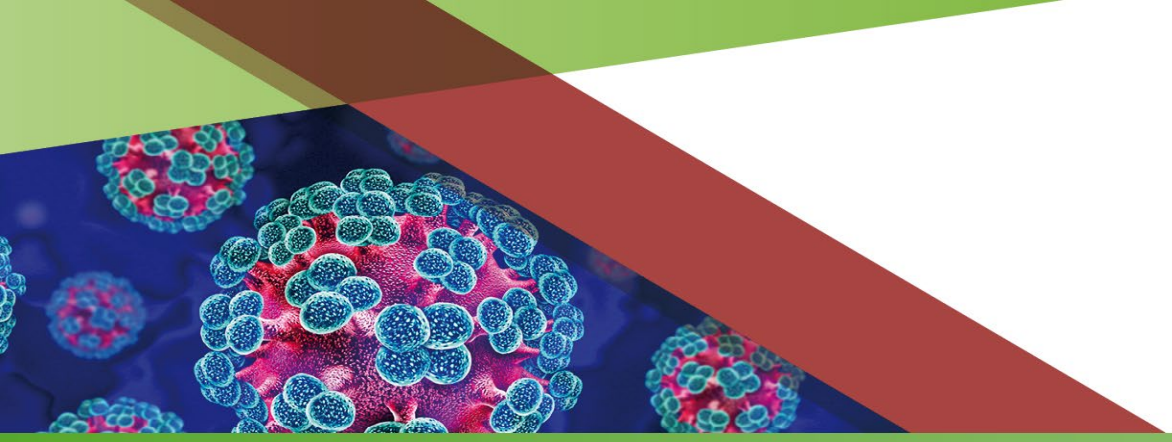

ASSESSMENT

Rapid scientific advice on the management of contacts following sporadic imported Andes orthohantavirus (ANDV) cases in the European Union/European Economic Area (EU/EEA)

11 September 2026

Key messages

- Contacts of sporadic imported Andes orthohantavirus (ANDV) cases should be classified according to the nature and intensity of their exposure in order to determine the appropriate level of monitoring and follow-up.
- Contacts who have had a higher level of exposure should self-monitor for symptoms for 42 days after the last exposure to a confirmed or probable ANDV case and the relevant public health authority should actively follow up with them.
- Contacts who have had a lower level of exposure should self-monitor for symptoms for 42 days after the last exposure to confirmed or probable ANDV cases, without active follow-up.
- If any contact (regardless of exposure level) develops symptoms compatible with ANDV infection, they should self-isolate and immediately notify the relevant public health authority.
- Routine laboratory testing of asymptomatic contacts is not recommended. A decision to undertake laboratory testing should be guided by the presence of symptoms compatible with ANDV infection.

ECDC rapid scientific advice disclosure statement: ECDC issues rapid scientific advice to meet an emerging or urgent public health need, or to quickly reply to external requests. To accommodate the accelerated timeline, the process and methods used for the development of rapid scientific advice may be different to those used for standard assessments and recommendations. Potential limitations are described.

Background

On 26 August 2026, the European Commission's Directorate-General for Health and Food Safety (DG SANTE) submitted a request to ECDC for rapid scientific advice on the management of contacts following sporadic imported Andes orthohantavirus (ANDV) infections, including recommendations on contact classification, monitoring, laboratory testing and appropriate public health measures. The request followed discussions among European Union/European Economic Area (EU/EEA) public health authorities regarding the management of contacts associated with a recent imported case of ANDV infection and the need for a harmonised approach across countries.

The request was made in the context of public health responses to ANDV events involving EU/EEA countries. In May 2026, a cluster of hantavirus pulmonary syndrome (HPS) cases caused by ANDV was identified on the cruise ship MV Hondius. Person-to-person transmission was suspected, and extensive international contact tracing and follow-up activities were implemented. The European Centre for Disease Prevention and Control (ECDC) and the World Health Organization (WHO) issued guidance on contact management, infection prevention and control, and laboratory testing [1-5]. The outbreak resulted in 12 confirmed cases, including three deaths, and one probable case. A total of 237 contacts from 15 countries were identified and monitored for up to 42 days. No secondary cases were detected among monitored contacts, and the outbreak was declared over at the end of June 2026.

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In early August 2026, France reported an imported case of ANDV infection in a traveller returning from Argentina. The case was subsequently managed in Spain, and contact tracing activities undertaken by the French and Spanish authorities identified numerous contacts, including household members, healthcare workers and fellow travellers. Public health measures differed between countries, in particular regarding the use of quarantine for asymptomatic contacts.

During the meeting of the General Working Group of the Health Security Committee on 12 August 2026, Member States discussed the public health response to this event. Some countries raised concerns about the balance between the relatively low and uncertain risk of person-to-person transmission from sporadic imported cases and the burden associated with measures such as prolonged quarantine of asymptomatic contacts. In response, ECDC was requested to provide scientific advice to support a proportionate and evidence-informed approach to contact management in the EU/EEA.

This rapid scientific advice reviews the available evidence on ANDV transmissibility and existing approaches to contact management, and provides recommendations for the identification, classification, monitoring and testing of contacts following sporadic imported cases of ANDV infection in the EU/EEA.

Methods

A rapid review of the available evidence was undertaken to inform this advice. Three sources of information were used.

Firstly, a rapid review of the scientific literature was conducted to identify recent evidence on Andes orthohantavirus (ANDV) transmissibility and contact management. Searches of PubMed, Embase, Scopus and selected grey literature sources were performed between 14 and 17 August 2026 using predefined search terms (Annex 1). After removal of duplicates, 222 records were screened. Titles and abstracts of potentially relevant publications were reviewed, and full texts were assessed for information on person-to-person transmission, exposure settings, contact classification, monitoring approaches and public health measures.

Secondly, relevant guidance and recommendations previously developed by ECDC and WHO during the 2026 MV Hondius outbreak were reviewed. This included guidance on contact management, infection prevention and control measures, and laboratory testing of contacts potentially exposed to ANDV.

Thirdly, a targeted review of official guidance documents from Argentina, Chile and the Pan American Health Organization (PAHO) was undertaken to identify approaches used in ANDV-endemic settings for contact identification, monitoring, follow-up and laboratory testing. Information extracted from these documents was compared and used to provide operational context for the recommendations presented in this advice.

The findings from these evidence sources were reviewed by ECDC experts in food-, water- and vector-borne diseases, emergency preparedness and response and infection prevention and control sections. Recommendations were developed through expert assessment of the available evidence, taking into account scientific uncertainty, operational feasibility and the principle of proportionality in public health response.

This advice reflects the evidence available at the time of publication and may be revised as additional evidence becomes available.

Limitations

The evidence informing this advice is limited to, and derives primarily from, retrospective outbreak investigations, household studies, observational reports and expert guidance. Exposure definitions, contact classification approaches and follow-up practices vary across settings and countries, which limits direct comparison of findings and the certainty of conclusions.

Most evidence on ANDV transmission and contact management originates from outbreaks and epidemiological investigations conducted in Argentina and Chile. The applicability of these findings to sporadic imported cases occurring in non-endemic settings may be influenced by differences in healthcare systems, public health practices, social behaviour and exposure contexts.

The period of infectiousness for ANDV infection is not fully characterised, and the relationship between viraemia, laboratory test positivity and infectiousness remains incompletely understood. Evidence regarding transmission from asymptomatic or mildly symptomatic individuals is lacking.

The proposed exposure levels and operational examples (including exposure duration thresholds and transmission proximity criteria) described in this advice are intended to support public health decision-making and have not been formally validated for ANDV infection. Consequently, this advice emphasises documented exposure characteristics, proportionality of public health measures and individual risk assessment, while recognising that national authorities may choose to apply a precautionary approach where information is incomplete.

This advice reflects the evidence available at the time of publication and may be revised as additional evidence becomes available.

ECDC rapid advice

1. Case definition

Suspected case: a person with acute illness compatible with ANDV infection and either a plausible exposure in an ANDV-endemic area during the previous 42 days or an epidemiological link to a probable or confirmed ANDV case. Compatible illness includes fever, myalgia, chills, headache, marked fatigue, gastrointestinal symptoms or respiratory symptoms.

Probable case: a person meeting the clinical criteria for a suspected case, evaluated by a healthcare professional, with a known epidemiological link to a probable or confirmed case, and for whom laboratory confirmation is not possible or remains unavailable.

Confirmed case: a suspected or probable case with laboratory-confirmed ANDV infection, interpreted in the context of symptom onset and laboratory testing recommendations. Species-level confirmation should be sought where technically possible.

Non-case: a suspected or probable case with negative laboratory results for ANDV. (Non-cases should be retested and reclassified as appropriate until symptoms resolve).

2. Contact identification

Definition of a contact

A person who was exposed to a confirmed or probable case of ANDV infection during the period when the case was considered potentially infectious. Contact identification should document the exposure type and whether personal protective equipment (PPE) was used and it should be revised if the case or exposure timeline changes.

Exposure window

The primary exposure window should begin from the onset of the earliest symptom compatible with ANDV infection. In instances of poorly-defined prodromal illness, public health authorities may apply a precautionary extension of 48 hours before the earliest identified symptom. This is an operational precaution and should not be interpreted as evidence of pre- or asymptomatic transmission.

Day 0 for follow-up will be considered as the day of the last exposure.

3. Exposure assessment and management of contacts

Contacts should be classified according to the nature and intensity of their exposure in order to determine the appropriate level of follow-up (Table 1, Figure 1). Regardless of exposure level, all contacts should receive information on symptom recognition, recommended preventive measures, and the actions to be taken if symptoms occur. The main difference between follow-up at higher and lower exposure levels is the monitoring approach during the 42-day follow-up period, where we recommend self-monitoring with active follow-up for contacts having had a higher level of exposure level and self-monitoring without active follow-up for those having had a lower level of exposure. For the purposes of this advice document, 'active follow-up' refers to a public health authority being in regular contact, preferably by telephone, throughout the follow-up period.

Table 1. Contact exposure levels and associated monitoring and follow-up activities

Exposure level	Exposure definition	Monitoring and follow-up
Higher	Known exposure to respiratory secretions, saliva, blood, or other bodily fluids from a confirmed or probable case of ANDV; including: • direct physical contact (e.g. care giving, intimate contact, sharing a bed, etc.); • close proximity[1] that would result in exposure to respiratory particles, such as face-to-face interactions; • unprotected exposure in healthcare settings, particularly during patient care, as well as laboratory exposure.	• Self-monitoring for symptoms for 42 days. • Active follow-up by a public health authority for 42 days. If symptoms develop: - self-isolation; - immediate notification to a public health authority; - the relevant public health authority will consider laboratory testing and advice on the best ways to obtain clinical care; - clinical management, depending on the severity of symptoms.
Lower	Possible exposure to respiratory secretions, saliva, blood, or other bodily fluids from a confirmed or probable case of ANDV infection; where the interaction was limited or appropriate protective measures were taken, including: • shared environments where exposure was limited by distance, duration, or other mitigating factors; • transport-related exposure without prolonged close interaction; • healthcare providers and other staff using appropriate PPE throughout exposure.	• Self-monitoring for symptoms for 42 days. If symptoms develop: - Self-isolation - Immediate notification to a public health authority. - The relevant public health authority will consider laboratory testing and advice on the best ways to obtain clinical care. - Clinical management according to severity of symptoms.

Recommended preventive measures

Contacts should take preventive measures to reduce the risk of exposing others to respiratory secretions, saliva, blood or other bodily fluids, including the following:

- ensure regular hand hygiene, using soap and water or an alcohol-based hand rub. Avoid sharing eating utensils, drinking containers, toothbrushes or other personal items that may be contaminated with saliva;
- cover the mouth and nose when coughing or sneezing and dispose of tissues appropriately;
- avoid intimate contact with others;
- ensure good ventilation during prolonged indoor interactions.

Laboratory testing

Laboratory testing should be guided by the presence of symptoms, rather than exposure level. Routine testing of asymptomatic contacts is not recommended. Contacts who develop symptoms compatible with ANDV infection during the 42-day follow-up period should be tested as soon as possible, and managed according to the results of laboratory investigations and clinical assessment.

Laboratory testing of symptomatic contacts

If symptoms compatible with ANDV infection develop during the follow-up period:

- Perform RT-PCR testing as soon as possible (whole blood (EDTA) is the preferred specimen; serum or plasma (EDTA) may also be used).
- Use a validated in-house assay or follow the recommendations of the European Union Reference Laboratory for Public Health on Emerging, Rodent-borne and Zoonotic Viral Pathogens (EURL-PH-ERZV).
- Consider that the testing of bodily fluid samples other than blood generally has a lower diagnostic value [6].
- Consider serological testing – with Immunoglobin M (IgM) prioritised over Immunoglobin G (IgG) – to complement Reverse Transcription-Polymerase Chain Reaction (RT-PCR) testing [7].

[1] As a general rule, the risk of transmission is relative to proximity and length of exposure. There is no scientific evidence on the specific physical conditions necessary for ANDV transmission to occur. One definition of close proximity exposure could be over 15 minutes within one metre. This would include exposure in certain enclosed or shared spaces, such as shared cabin on a ship, aircraft seating proximity, an office space, etc. The risk of pathogens being transmitted through the air is elevated in enclosed spaces, particularly with limited air recirculation.

Recommended actions to be taken in case of positive laboratory results

If laboratory results are positive for acute ANDV infection:

- manage the individual as a confirmed case;
- isolate the case at a clinical facility (as clinical status of a patient with ANDV HPS may deteriorate rapidly [8]);
- provide clinical management as appropriate;
- whole genome sequencing may be considered, if resources allow, to support epidemiological investigations and interpretation of potential transmission chains. Sequencing is not required for case management.

Recommended actions to be taken in case of negative laboratory results

If laboratory results are negative for acute ANDV infection but symptoms persist:

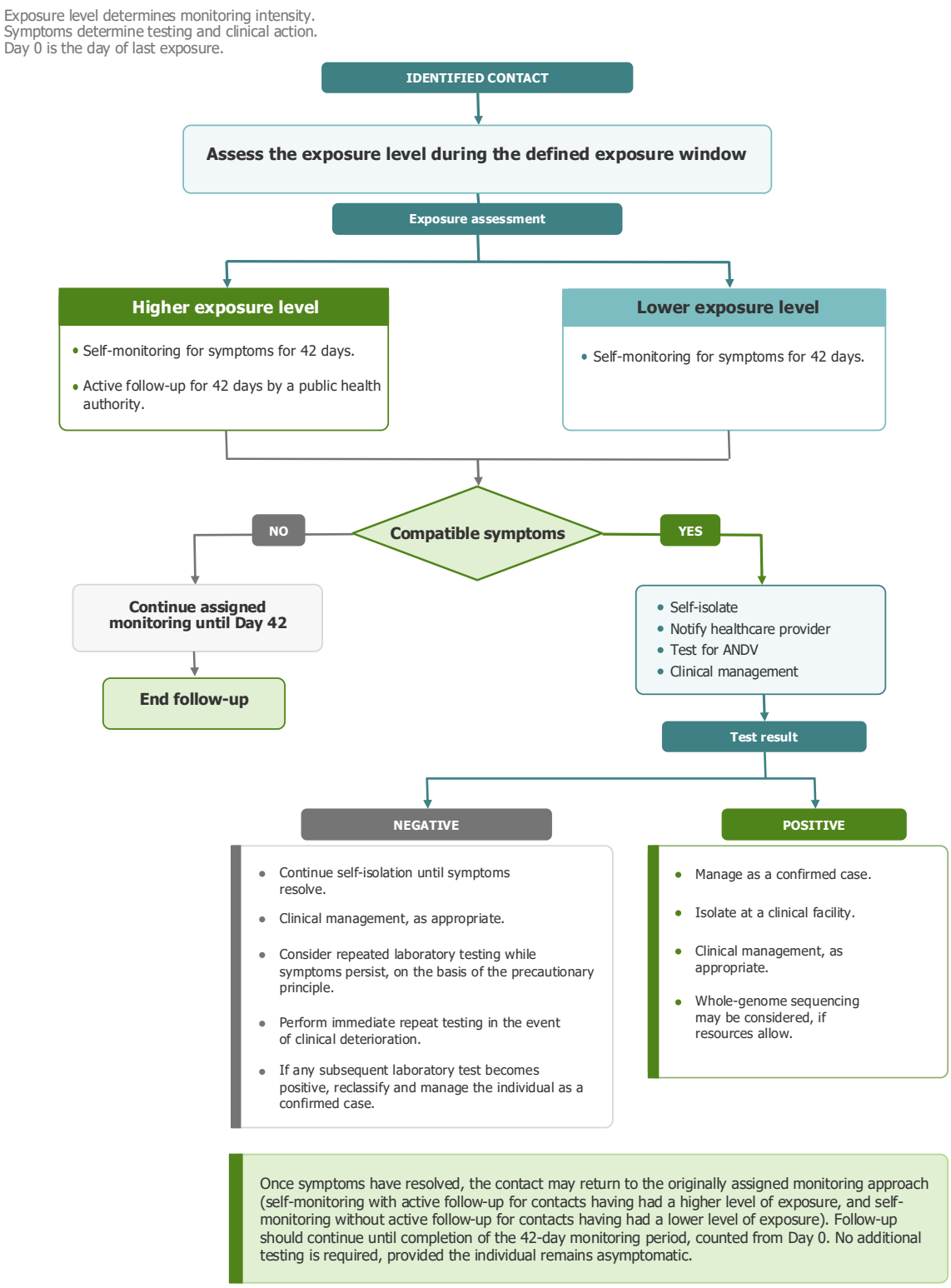
- continue self-isolation until symptoms resolve;
- provide clinical management, as appropriate;
- consider repeated laboratory testing (e.g. two to three times per week) while symptoms persist, on the basis of the precautionary principle;
- perform immediate repeat testing in the event of clinical deterioration;
- if any subsequent laboratory test becomes positive, reclassify and manage the individual as a confirmed case.

Return to follow-up

Once symptoms have resolved, the contact may return to the originally assigned monitoring approach (self-monitoring with active follow-up for contacts exposed at a higher level, and self-monitoring without active follow-up for contacts exposed at a lower level). Follow-up should continue until completion of the 42-day monitoring period, counted from Day 0. No additional testing is required, provided that the individual remains asymptomatic.

The flowchart in Figure 1 summarises the recommended approach to exposure assessment, monitoring, laboratory testing and management during the 42-day follow-up period.

Figure 1. Recommended approach to the management of contacts following sporadic imported Andes orthohantavirus (ANDV) cases



4. Public health measures to reduce the risk of secondary transmission

4.1 Infection prevention and control

The application of infection prevention and control (IPC) measures should be proportionate to the assessed risk and informed by existing ECDC guidance for patients with suspected or confirmed ANDV infection [1]. Particular attention should be paid to preventing exposure to respiratory secretions, saliva, blood and other bodily fluids during healthcare provision and when caring for a symptomatic case.

Detailed IPC measures for healthcare settings are described in existing ECDC scientific advice [1] and are not repeated here.

4.2 Contact tracing

When undertaking contact tracing for air, rail, bus or maritime travel, consideration should be given to whether exposure occurred while the case was symptomatic or in the prodromal phase, taking into account journey duration, proximity and nature of the interaction, provision of care, movement of the case, and events involving coughing, vomiting, bleeding or secretion exposure. As a precautionary measure, contacts may be identified from up to two days prior to the reported symptom onset for a confirmed or probable case. For flights longer than six hours, the same technique may be used to identify passengers for assessment as that described in ECDC's rapid scientific advice on the management of passengers in the context of the Andes virus outbreak on the cruise ship MV Hondius, dated 9 May 2026 (same-row and two-rows-forward-and-behind zone) [2]. Within this zone, high- or low- exposure level classification should be based on the actual exposure. With a sporadic event, seating proximity should support contact tracing but not automatically define the event as a high-level exposure. Crew members with repeated or prolonged close interactions should be assessed on an individual basis.

4.3 Risk communication

Risk communication activities should support informed decision making by contacts, healthcare professionals and public health authorities. Communications should clearly explain the rationale for contact exposure assessment, the expected duration of follow-up, symptoms that require medical assessment, and the actions to take if symptoms develop.

Communications should emphasise that person-to-person transmission of ANDV has been documented but remains uncommon, and that it has primarily been associated with specific types of close and prolonged exposure. Public health measures should therefore be proportionate to the assessed level of risk.

Contacts should be informed that most monitored contacts do not develop disease, but that early recognition of symptoms and prompt medical evaluation are important to ensure appropriate clinical management and public health follow-up.

References

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Annex 1. Literature search protocol

Searches run 14 August 2026

PubMed (pubmed.ncbi.nlm.nih.gov)

Query	Results
("Orthohantavirus"[Mesh:NoExp] OR "andes hantavirus*"[tw] OR "andes virus*"[tw] OR "Andes orthohantavirus*"[tw] OR ANDV[tiab]) AND (2026/04/30:3000/12/31[edat])	110

Embase (Embase.com)

Query	Results
('andes virus'/exp OR ((andes NEAR/5 (hantavirus* OR orthohantavirus* OR virus*)):ab,ti,kw) OR andv:ab,ti,kw) AND [30-04-2026]/sd	116

Scopus (Scopus.com)

Query	Results
INDEXTERMS (Orthohantavirus*) OR TITLE-ABS-KEY (andes W/5 (hantavirus* OR orthohantavirus* OR virus*)) OR TITLE-ABS (ANDV) AND PUBYEAR > 2025	133

Google Scholar via Publish or Perish

Title words, keywords: andes hantavirus|virus|orthohantavirus; Years: 2026–2026

40 results.

OpenAlex via Publish or Perish

Title words: andes; keywords: hantavirus; years: 2026–2026

118 results.

Searches run 17 August 2026

Keywords: Orthohantavirus, hantavirus, andes virus

Repositories/grey literature search engines	Results
WHO IRIS https://iris.who.int/	1
CDC Stacks https://stacks.cdc.gov/gsearch	3
NICE https://www.nice.org.uk/guidance	0
Guidelines International Network (GIN) https://guidelines.ebmportal.com	0
Grey Matters https://greymatters.cda-amc.ca	0
CORE https://core.ac.uk	0