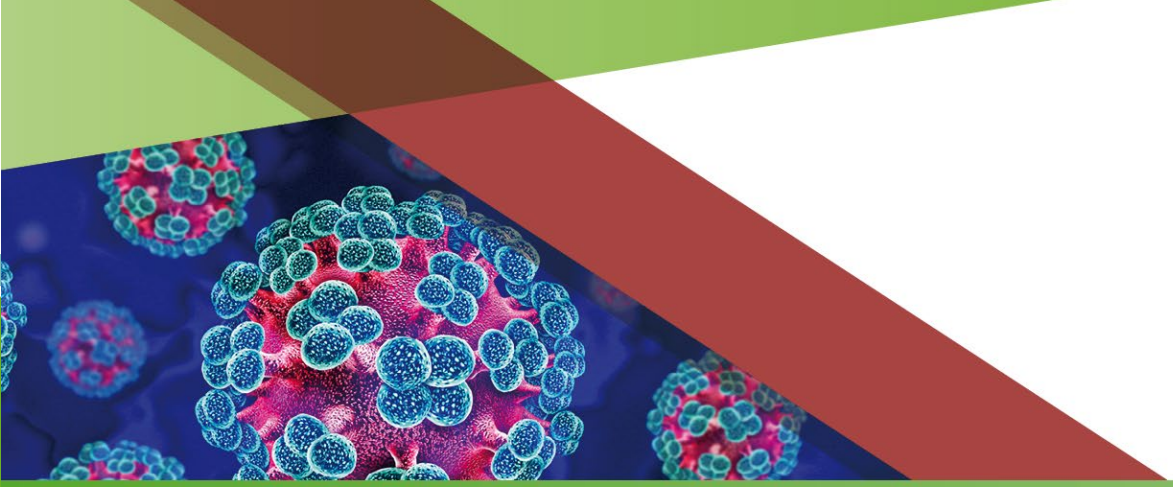

ASSESSMENT

Rapid Scientific Advice on the management of passengers

In the context of the Andes virus outbreak on the cruise ship MV Hondius

9 May 2026

Key messages

As of 9 May 2026, a total of eight cases of Andes virus infection, including three deaths and one critically ill patient, linked to the M/V Hondius cruise ship have been reported.

- ECDC has classified all people on board the ship and for the purpose of disembarkation and repatriation to be high-risk contacts.
- **Monitoring/quarantine** up to six weeks (42 days); Day 0 = 6 May 2026.
  High-risk contacts: self-quarantine, daily symptom monitoring, test if symptomatic.
  Low-risk contacts: passive monitoring; isolate and test if symptoms develop.
- **Flights:** trace contacts for probable/confirmed cases only (same row ±2 rows on long flights).
- **IPC:** masking, one to two metres distancing, PPE for healthcare/cleaning
- Strong **risk communication** and misinformation management.

This document provides advice for public health professionals in the EU/EEA managing individuals potentially exposed to ANDV, including on:

- Defining contact classification criteria based on level of exposure, including close and prolonged contact with symptomatic people;
- The identification, management and monitoring of contacts, including advice on testing;
- Appropriate infection prevention and control (IPC) measures for managing repatriated passengers and crew, suspected and confirmed cases and their contacts in healthcare and community settings; and
- Risk communication, community engagement and the management of misinformation.

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Background

In early May 2026, hantavirus infections were identified among passengers and crew on a cruise ship travelling in the South Atlantic. As of 8 May 2026, a total of eight cases, including three deaths and one critically ill patient, linked to the cruise ship have been reported. Of these, six have been laboratory-confirmed as Andes virus (ANDV) infection. The outbreak occurred on the cruise ship MV Hondius, which departed from Argentina on 1 April 2026 and travelled through the South Atlantic towards Cabo Verde. A total of 149 passengers and crew from 23 nationalities were on board and a further 30 passengers disembarked on 24 April in St. Helena.

Erratum: On 19 May 2026, text in Table 1 was amended for clarity, from 'Aircraft passengers outside the defined seating proximity zone (see Figure 1)' to 'Aircraft passengers on the seats marked with black crosses in Figure 1'.

Suggested citation: European Centre for Disease Prevention and Control. Rapid Scientific Advice on the management of passengers: In the context of the Andes virus outbreak on the cruise ship MV Hondius. Stockholm: ECDC; 2026.

Stockholm, 9 May 2026

Hantaviruses are a group of zoonotic viruses transmitted to humans primarily through contact with contaminated rodent excreta, usually by inhalation. Andes virus is of particular concern because very limited human-to-human transmission has been reported, primarily after close and prolonged contact with symptomatic individuals. The incubation period ranges from one to six weeks. Infection can initially present with fever, respiratory and gastrointestinal symptoms and can progress rapidly to severe disease or death.

Given the very limited but documented potential for human-to-human transmission associated with ANDV, a precautionary approach to contact identification, listing, tracing and follow-up is recommended.

Each country can adapt their response to the local epidemiological situation, the latest available science, and available resources.

Methods

The information provided in this report is based on:

- Data reported to ECDC through the Early Warning and Response System (EWRS) and the European surveillance portal for infectious diseases (EpiPulse) and communication with EU/EEA Member States and partners;
- Available epidemiological information related to the outbreak, including reports from national authorities;
- Evidence from peer-reviewed publications on hantavirus infection, including ANDV transmission, clinical presentation and infection prevention control and measures; and
- Consultation with experts from the World Health Organization (WHO) Regional Office for Europe and WHO Headquarters, and the EU Reference Laboratory for Public Health on Emerging, Rodent-borne, and Zoonotic Viral Pathogens (EURL-PH-ERZV).

Limitations

A complete epidemiological, microbiological and environmental investigation is still ongoing, with limited information currently available on the travel history of cases, risk exposures prior to boarding the ship, contacts among passengers and crew on board. Environmental sampling and extensive search for rodent reservoirs on the ship will be undertaken in Spain. In addition, there is limited evidence in literature on ANDV for human-to-human transmission.

Acknowledgments

ECDC would like to acknowledge the WHO Regional Office for Europe and WHO Headquarters, and the EU Reference Laboratory for Public Health on Emerging, Rodent-borne, and Zoonotic Viral Pathogens (EURL-PH-ERZV) for the collaboration in developing the advice presented in this document.

ECDC rapid advice

For this event, the following case and contact definitions have been developed in close collaboration with WHO experts.

Case definition

Case

Suspected case: anyone who shared or visited a conveyance where there has been a confirmed or probable ANDV case OR anyone who has been in contact with an MV Hondius passenger or crew member since April 5 **AND** with acute (or history of) fever **AND** one of the following symptoms: muscle aches, chills, headache, gastrointestinal (e.g. nausea, vomiting, diarrhoea, abdominal pain) or respiratory symptoms (e.g. cough, shortness of breath, chest pain, difficulty breathing).

Probable case: a person with signs and symptoms of a suspected case **AND** a known epidemiological link with a confirmed or probable ANDV case.

Confirmed case: a suspected or probable case with laboratory confirmation of ANDV through PCR or serology testing.

Non-case*: a suspected or probable case who tests negative for ANDV by RT-PCR or serology.

** Non-cases who develop symptoms compatible with the suspected case definition after a negative test and within the maximum incubation period after last exposure to a probable or confirmed case potential exposure, should be retested and reclassified as appropriate.*

Contact definition

Contact

A person who was **exposed to a confirmed or probable case** of hantavirus ANDV while the case was infectious through interactions consistent with exposure to respiratory secretions, saliva, blood, or other bodily fluids; including:

- Direct physical contact, including exposure to saliva or other bodily fluids (e.g. care giving, intimate contact, sharing a bed, etc).
- Close proximity exposure, defined as being within one to two metres for more than 15 minutes cumulative (e.g. face to face interactions, shared meals or other social gatherings).
- Exposure in enclosed or shared spaces (e.g. shared cabin on a ship, aircraft seating proximity*, etc)
- Unprotected exposure in healthcare settings, particularly during patient care, as well as laboratory exposure.

Classification and management of contacts

ECDC recommends a risk-based contact tracing approach, where contacts are classified according to their level of exposure with a suspected or confirmed case.

As epidemiological investigations continue on the ship and more information becomes available, the contact classification for passengers may be modified so not all may be considered high-risk for the purpose of defining modalities for self-quarantine in their home countries.

When defining these modalities, consider that the incubation period for ANDV infection is typically around two to four weeks, particularly in cases with well-defined and short exposure periods. However, exposure histories may not be clearly defined, and individuals may have had contact with multiple potential sources. Available evidence therefore suggests a wider possible range of seven to 42 days (one to six weeks), so monitoring for a period of up to six weeks allows for the capturing of the full range of possible onset [2,3].

Table 1. Overview of contact classification and proposed management

Risk classification	Definition	Management
High-risk contacts	- All people onboard the cruise ship (at the time of publication of this document), excluding the public health experts who joined the ship in Cabo Verde on 6 May. - Individuals with one or more of the following exposures with a probable or confirmed ANDV case: • People sharing the same room. • Intimate partners or individuals with direct physical contact. • People sharing a bathroom or sleeping space. • Individuals within approximately two metres for prolonged periods (>15 minutes cumulative), in a confined space. • People participating in shared meals, prolonged social interactions, medical care, or caregiving activities. • Healthcare workers with unprotected exposure to a confirmed or suspected case. • Individuals exposed during aerosol-generating medical procedures without appropriate PPE. • Aircraft passengers seated in the same row, and within two rows in all directions from the case in a long flight > 6 hours. • Cabin crew or transport staff with repeated close interactions with a confirmed case or symptomatic person. • People handling contaminated linens, clothing, medical waste, or body fluids without appropriate PPE.	• Self- quarantine for six weeks (use own room, keep at least one to two metres from household members, not use same utensils, open windows for ventilation) – can go out for preservation of mental health and well-being with a fluid-resistant medical/surgical face mask and avoiding mass gatherings. • No use of public transportation or commercial flights for repatriation. • In the transportation means arranged for this purpose, they should wear a fluid-resistant medical/surgical face mask and have one seat free all around them in every direction (see Figure 1). • Daily self-monitoring for fever, myalgia, headache, fatigue, gastrointestinal or respiratory symptoms, up to 42 days (six weeks) from the last exposure. • Monitoring by public health authority in the place of permanence residence for physical health and mental health follow-up, at least every week or preferably more frequently if resources allow. • If symptoms develop, immediate isolation, notification of the local public health authorities and medical evaluation. • Sample and test if meeting the suspected case definition and symptomatic. See 'Testing strategy'.
Low-risk contacts	Individuals without known direct or prolonged close interaction, with a probable or confirmed ANDV case including: • Aircraft passengers on the seats marked with black crosses in Figure 1. • Brief transit or port or casual contacts. • Individuals sharing large open-air spaces without prolonged interaction. • Healthcare providers and other staff using appropriate PPE throughout exposure.	• Passive self- monitoring for fever, myalgia, headache, fatigue, gastrointestinal or respiratory symptoms, up to 42 days (six weeks) from the last exposure. • Share reporting instructions to local public health authorities in case of signs and symptoms. • If symptoms develop, immediate self-isolation, notification of the local public health authorities and medical evaluation. • Sample and test, if meeting the suspected case definition.

Investigating the exposure

For the purposes of contact tracing and monitoring, and based on structured interviews that have been carried out on the remaining passengers and crew on the ship, Day 0 for starting the self-quarantine can be defined as:

- 6 May 2026, when all cases and symptomatic people were medically evacuated and in addition, at the time there were public health professionals on board who verified the adherence to measures such as masking and physical distancing; this is valid provided that no other person develops ANDV infection compatible symptoms in the meantime.
- Date of last close contact with a symptomatic or confirmed ANDV case anywhere else (e.g. flight). As a precautionary measure and out of caution, it is suggested that contacts be identified from two days prior to reported symptom onset of a confirmed or probable case.
- Date of disembarkation, if exposure continued until that point and contact history is uncertain. This is probably true for the passengers that got off in St. Helena.

Exact exposure timing can be uncertain in ship settings like this, justifying conservative dating.

Based on available evidence, and under the precautionary principle, ECDC has classified all people onboard the cruise ship and for the purpose of disembarkation and repatriation to be high-risk contacts [1]. This excludes the public health and infectious disease experts who joined the ship in Cabo Verde on 6 May, given that they boarded when all symptomatic cases had been medically evacuated, they have taken the necessary precautions (physical distancing, IPC measures, appropriate PPE) and were not involved with any excursions in areas with endemic ANDV.

To strengthen cross-border public health response within the EU/EEA, ECDC encourages Member States to systematically report contacts who are being followed up through EpiPulse Events using the structured reporting listing. This information is critical to support coordinated contact tracing, risk assessment, and timely detection of secondary cases.

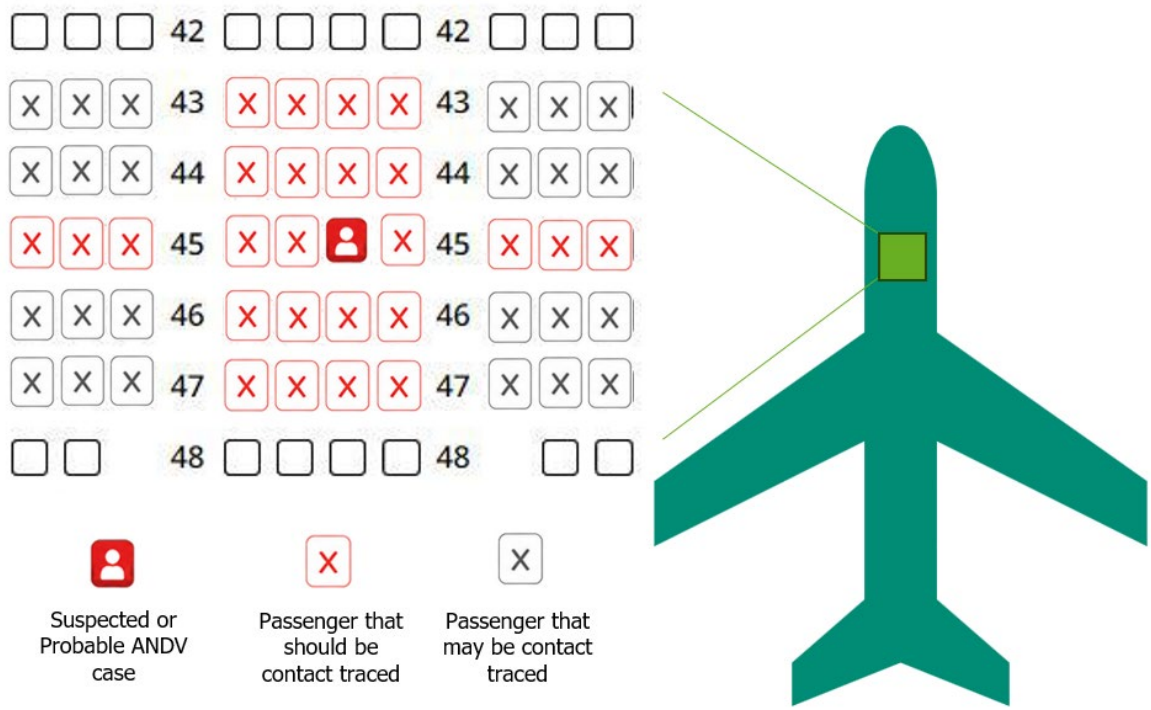
Contact tracing in flights

Contact tracing of probable or confirmed cases in flights should be carried out. As a precautionary measure and out of caution, it is suggested that contacts be identified from two days prior to reported symptom onset of a confirmed or probable case. Contact tracing of flights taken by asymptomatic high-risk contacts is not needed, as they are not considered infectious.

Longer flights should be considered (more than six hours) and contact tracing should be limited to:

- Passengers sitting in the same row, two seating sections directly in front, and two seating sections behind the index case (see Figure 1). For passengers seated in side sections by the windows (black crosses in Figure 1), their potential exposure should be assessed on a case-by-case basis; and
- Crew serving the particular section of the airplane or having close contact of the case, as described in Table 1.

Figure 1. Proposed contact tracing guidance on aircrafts



Testing strategy

Polymerase Chain Reaction (PCR) detects viraemia mainly during early symptomatic disease. Serology (IgM) typically becomes positive after symptom onset. Testing during the incubation period is frequently negative and may give false reassurance [4,5].

Prioritise testing for symptomatic individuals, particularly those with symptoms compatible with hantavirus cardiopulmonary syndrome (HPS).

For contacts under monitoring, there is no evidence-based recommendation for testing frequency for asymptomatic people:

- Performing routine serial testing while asymptomatic can be considered but will have limited operational value (e.g. early transfer to hospital) and mainly addresses research purposes. If done for research purposes, then a joint protocol should be used.
- Test immediately at symptom onset (PCR ± serology).

Recommended samples are ethylenediaminetetraacetic acid (EDTA) blood/buffy coat which has been shown to have highest probability for virus detection [4]. Other samples like respiratory samples or urine may be tested according to symptoms shown.

IPC guidance

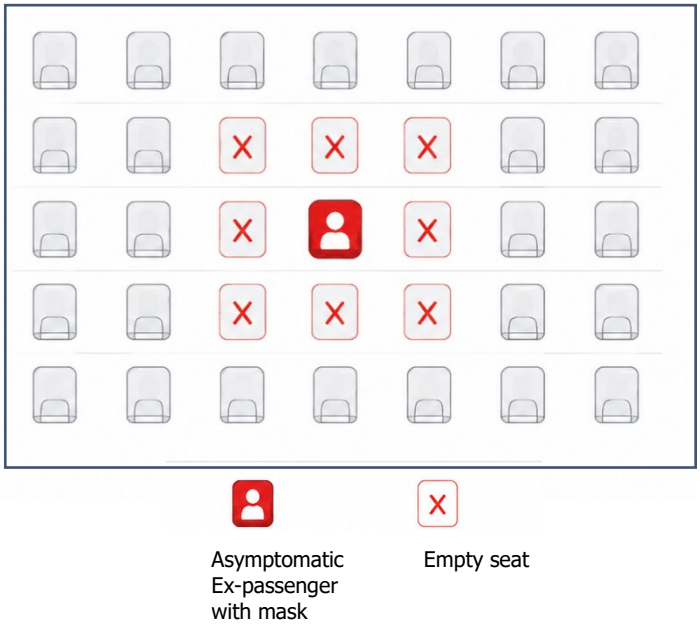
Reception and transport of asymptomatic passengers and crew

Non-medical reception and transportation personnel, defined as individuals in contact with asymptomatic passengers and crew from disembarkation until transfer to evacuation transport, and the asymptomatic passengers and crew should wear face or respiratory protection. At a minimum, this should be a fluid-resistant medical/surgical mask (Type IIR) or, alternatively, a respirator (e.g., FFP2).

Physical distancing of approximately one to one to two metres should be maintained where feasible and eye protection for personnel can be added when distancing cannot reach at least one metre. Measures should also be implemented to minimise crowding and increase ventilation, particularly in reception areas.

For the repatriation conveyances (flights, buses etc) at least one seat should remain free in all directions around the masked ex-passenger or crew member. See Figure 2.

Figure 2. Proposed seating in repatriation conveyances for passengers and crew members



In the event one of the asymptomatic passengers develops HPS-compatible symptoms during the repatriation flight, and depending on the type of aircraft used:

- If they are wearing a fluid-resistant medical/surgical mask, they should be instructed to wear an FFP2 respirator;
- They should be moved to an empty section of the plane until landing.

Strict adherence to hand hygiene practices is essential. Personnel should clean their hands frequently using either soap and water or an alcohol-based hand rub, particularly after contact with passengers, handling documents, or touching shared surfaces.

Respiratory etiquette should be maintained at all times, including covering the mouth and nose when coughing or sneezing, disposing of tissues immediately, and performing hand hygiene afterwards.

Reception and transport personnel should remain vigilant for passengers and crew members presenting symptoms such as cough, fever, gastrointestinal complaints, or other flu-like signs.

Finally, a registry for all reception personnel should be kept and they should be instructed to monitor their own health status. If symptoms compatible with HPS develop, they should stop work immediately, self-isolate, and seek medical advice.

Healthcare interactions

Personnel conducting medical interactions such as care to symptomatic individuals, medical examination of asymptomatic contacts from the ship or sampling for biological tests should use of a transmission-based personal protective equipment (PPE), including respirator (e.g. FFP2), gloves, gown and eye protection. These precautions should

be implemented at all times, regardless of settings, with particular emphasis on strict adherence to hand hygiene before, during, and after patient care.

Patients should wear face or respiratory protection. At a minimum, this should be a fluid-resistant medical/surgical mask (Type IIR) or, alternatively, a respirator (e.g., FFP2). The transport of patients should be limited to essential purposes only.

Symptomatic individuals should be accommodated in single rooms. Where single rooms are not available, separation between patients should be ensured, for example through the use of physical barriers. Cohorting of patients with the same confirmed infectious pathogen may be considered. Doors to patient rooms do not need to remain closed.

For procedures that may generate aerosols, consideration should be given to the use of a FFP3 respirator and, where feasible, the patient should be managed in a negative pressure room.

During healthcare interactions, attention should be given to open windows, allow natural air to circulate or ensure ventilation without air recirculation. Environmental cleaning and disinfection of patient care areas should be performed in accordance with the routine cleaning procedures and products specified in the facility's guidance for isolation settings.

Healthcare workers involved in the care of such patients should undergo vigilant monitoring for symptoms.

Environmental cleaning and disinfection of ship

Cleaning, disinfection, and waste handling aboard the ship risk aerosolising dried biological material – including bodily fluids and secretions – deposited on surfaces, fabrics, and in enclosed cabin spaces. Airborne precautions are therefore mandatory for all cleaning personnel. Cleaning and disinfection procedures should ensure adequate 'wet time' and avoid dry sweeping. Further information can be found in the WHO's Guide to Ship Sanitization [6].

Disinfection should follow normal cleaning using a disinfectant effective against viruses, or 0.1% sodium hypochlorite. Surfaces should be rinsed with clean water after 10 minutes contact time for chlorine. For surfaces that could be damaged by sodium hypochlorite, 70% concentration of ethanol with 10 minutes contact time is needed for decontamination, after cleaning with a neutral detergent.

Risk communication, community engagement, misinformation management

As the outbreak is unfolding, information needs from different audiences evolve and volumes of rumours and misinformation increase. In this section, ECDC outlines recommendations regarding risk communication, community engagement and the management of misinformation.

Risk communication

As outlined in the ECDC Threat Assessment Brief, risk communication should be tailored to the different audiences, addressing information needs in people's own language. As passengers disembark the ship and are repatriated to various countries, communication with the passengers, inhabitants of the Canary Islands and the population of the countries of repatriation need to stay informed.

Passengers and crew members
Clear guidance on disembarkation procedures needs to be given, in writing or other formats accessible to the passengers and crew members. This includes IPC guidance during the repatriation, as well as explanations of how to monitor for symptoms and who to call in case symptoms develop during and after travelling. Passengers should also be briefed that this outbreak continues to be monitored closely by media and that misinformation continues to spread – which could result in stigmatising views towards them. Make sure that passengers and crew members have easy access to those involved in the outbreak response, and potentially psychosocial assistance, to help them navigate this.

General population
Countries that will receive passengers from the ship should provide regular updates about the epidemiological situation to the general population, in their own language and without medical jargon. It should clearly state what is known, what is unknown and the level of risk to the general population, noting that the assessed level of risk may be different from the perceived level of risk.

Managing misinformation

Rumours and misinformation tend to accompany infectious disease outbreaks – thus far, various narratives have been circulating about the ANDV outbreak. It is important to keep monitoring these narratives through social media listening, but also through dialogue with communities (e.g. those living close to the port or airport in Tenerife). Understanding public perceptions and concerns helps to target risk communication and to better address concerns.

Scientific evidence around addressing misinformation, shows that belief in misinformation is influenced by multiple factors, such as prior knowledge and experience with a topic, trust in the sources and worldviews [7]. Dispelling (or

debunking as it is commonly called) a myth therefore requires a better understanding of the target audience, their general belief system and their trusted sources of information. Debunking can be effective if done with empathy, showing an understanding for someone's beliefs and clear explanations of why the misinformation is false and why the correct information is true [8]. Importantly, it should ideally be delivered by a credible and trusted source [9]. To facilitate the acceptance of the correct information, the debunking message should be narratively coherent [8]. Another method is to forewarn people that they may be exposed to misinformation (prebunking), which has been shown to increase resistance to believing the misinformation [8].

Community engagement

The potential unrest among the population on the Canary Islands highlights the need for enhanced community engagement. Going beyond outreach to the population, community engagement can be deepened through further collaborations, starting with basic consultations, to involving the target population through for instance gathering feedback on risk communication materials. Further community engagement could be developed from there, from collaborating in the outbreak response, to even shared leadership of the response [10]. While inhabitants of the Canary Islands are considered at low risk for ANDV, they need at the very least to be consulted and involved so that their fears and worries are addressed.

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