

Viral Hemorrhagic Fevers

Investigative Guidelines

June 2026

SITUATIONAL UPDATE

On May 17, 2026, the World Health Organization declared an epidemic of Ebola disease caused by the Bundibugyo virus in the Democratic Republic of the Congo and Uganda a public health emergency of international concern due to the size of the outbreak, lack of clarity regarding its scope, and potential for international spread to border countries. This [CDC Health Advisory](#) summarizes CDC recommendations for U.S. health departments, clinical laboratories, and healthcare workers about potential Ebola disease case identification, testing, and biosafety considerations in clinical laboratories. The risk of spread to Oregon and the United States is considered very low at this time. On May 18, 2026, CDC and DHS implemented enhanced travel screening, entry restrictions, and public health measures to prevent Ebola virus disease from entering the United States.

Effective May 21, all individuals who have been in the DRC, Uganda, or South Sudan within 21 days of arrival in the United States must arrive through specific ports of entry for enhanced public health entry screening. CDC has implemented returning traveler notifications. All individuals returning to Oregon will undergo risk assessment and any individuals with risk for Ebola disease will be actively monitored for new symptoms by the local public health authority for 21 days after leaving affected countries. Regional health care systems will be immediately alerted to any individuals with risk for Ebola disease returning to their area.

1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance

1. To identify the source of infection for viral hemorrhagic fever (VHF) cases.
2. To identify VHF cases as early as possible to prevent transmission.
3. To identify cases and clusters of human illness that may be associated with a bioterrorist event.

Viral Hemorrhagic Fevers

1.2 Laboratory and Physician Reporting Requirements

1. Laboratories and physicians are required to report any known or suspected case of VHF immediately to the local health department (LHD) as an, “uncommon illness of public health significance.”
2. If this is not possible, such cases should be reported to the Oregon Acute and Communicable Disease Prevention (ACDP) section at 971-673-1111.
3. Laboratories must report any potential exposure to an agent that could cause VHF to the Oregon ACDP section at 971-673-1111.

1.3 Local Health Department Reporting and Follow-Up Responsibilities

1. Report all confirmed or suspect cases of VHF immediately to ACDP.
2. Consult with ACDP about strategies for enhanced surveillance, contact investigation, and exposure monitoring.
3. Work with local providers and facilities to ensure compliance with infection prevention and control recommendations for patients with suspected or confirmed VHF.
4. Provide education to and monitoring of VHF persons under monitoring (PUMs).
5. Complete the reporting forms, surveillance, and follow-up forms, and otherwise document investigation, outreach, active surveillance, and completeness of containment efforts.
6. Consult with ACDP prior to closing case and contact investigation activities for each suspected or confirmed VHF case.

1.4 OPHD Responsibilities

1. Provide consultation to LHD public health, Tribal, and private sector health professionals concerning:
 - Isolation of suspect and confirmed cases;
 - Diagnostic evaluation;
 - Required reporting and surveillance activities;
 - Contact identification and follow-up;
 - Inter-jurisdictional tracking of cases and contacts who move out of county or state jurisdiction;
 - Development and maintenance of adequate tools to coordinate case and contact surveillance, and assure adequacy of response activities;
 - Provision of surge capacity if a VHF outbreak investigation overwhelms resources of LHD.
2. Facilitate expert consultation with infectious disease specialists and CDC as needed.
3. Coordinate specimen collection with the relevant LHD or Tribal jurisdiction and Oregon State Public Health Laboratory (OSPHL), to assure confirmation of suspected VHF cases, and early identification of disease in symptomatic contacts and others.

Viral Hemorrhagic Fevers

4. Evaluate the likelihood of an intentional release:

- Some VHF are classified as “Category A” bioterrorism agents
- If effectively disseminated, these viruses could pose a serious public health threat

2. THE DISEASE AND ITS EPIDEMIOLOGY

2.1 Etiologic Agent

VHFs are a group of zoonotic diseases which can cause a hemorrhagic syndrome in humans. Most VHFs are caused by viruses from four families. All are RNA viruses:

- **Filoviruses:** Filoviruses include Ebola virus (EBOV), Marburg virus (MARV), Sudan virus (SUDV), Bundibugyo virus (BDBV), Taï Forest virus (TAFV), and Ravn virus (RAVN).
- **Bunyavirales order:** Viruses in the Bunyavirales order include primarily arenaviruses (Lassa fever virus, Junín virus, Chapare virus, Lujo virus, Machupo virus, Sabia virus, and Guanarito virus) as well as hantaviruses, Crimean-Congo Hemorrhagic Fever (HF) virus (a nairovirus), and Rift Valley Fever virus (a phenuvirus).
- **Flaviviruses:** Flaviviruses include Yellow Fever virus, Dengue virus, Alkhurma HF virus, Kyasanur Forest Disease virus, and Omsk HF virus.
- **Paramyxoviruses:** Paramyxoviruses include Hendra and Nipah viruses. (1)

2.2 Description of Illness

The signs and symptoms of VHFs may vary, and classically include the abrupt onset of high fever with additional non-specific symptoms such as myalgia, fatigue, and gastrointestinal symptoms. Unexplained bleeding or bruising may occur several days into the infection. Clinicians should consult the [CDC Guide for Clinicians Evaluating an Ill Person for VHF or Other High-Consequence Disease](#) for additional information.

Mortality rates for VHFs vary and may approach 90% in low-resource settings.(2)

2.3 Reservoirs

Filoviruses can cause severe illness in people and nonhuman primates. The Egyptian fruit bat is the reservoir for Marburg virus. The reservoir for EBOV is unknown but is believed to be a bat. Viruses in the Bunyavirales order are spread by rodents or insects, such as mosquitos, ticks, or sand flies. Flaviviruses are spread primarily by mosquitoes and ticks.(1)

2.4 Sources and Routes of Transmission

Depending on the virus, initial human cases in VHF outbreaks typically involve exposure to affected reservoir rodents or their droppings (arenaviruses), reservoir bats or infected bushmeat (EBOV, Marburg virus), infected livestock (Rift Valley Fever virus, Crimean-Congo HF virus), ticks (Alkhurma HF virus, Omsk HF virus, Crimean-Congo HF virus) or mosquitoes (Yellow Fever virus, Dengue virus). Some

Viral Hemorrhagic Fevers

VHF infections including filoviruses spread readily from person to person through contact with an infected person's body fluids.(1) Percutaneous exposure to contaminated body fluids carries a high risk of exposure. Airborne transmission has not been documented.(3)

2.5 Incubation Period

The incubation period varies by virus and ranges from 2 to 32 days.(1)

2.6 Period of Communicability or Infectious Period

In general, the risk for person-to-person transmission increases as symptoms progress. VHF infection has not been reported in persons whose contact with an infected patient occurred only during the incubation period (i.e., prior to symptom onset).(4)

2.7 Epidemiology

VHFs are distributed globally. Clusters and outbreaks occur following spillover from animal reservoirs to humans.(2)

2.8 Treatment

Supportive therapy is the mainstay of VHF treatment. Virus-specific therapies are limited and may be supported by limited clinical data.(2)

3. CASE DEFINITIONS, DIAGNOSIS AND LABORATORY SERVICES

3.1 Confirmed Case Definition

Acute onset of fever $>38^{\circ}\text{C}/100.4^{\circ}\text{F}$, **AND** one or more of the following clinical findings:

- Severe headache, muscle pain, red maculopapular rash on the trunk with fine desquamation 3-4 days after rash onset, vomiting, diarrhea, abdominal pain, bleeding not related to injury, or thrombocytopenia

N.B. For arenaviruses, the following are also qualifying signs and symptoms: pharyngitis, retrosternal chest pain, and proteinuria

AND one or more of the following laboratory findings:

- Detection of VHF viral antigens by enzyme-linked immunosorbent assay (ELISA)
- VHF viral isolation in cell culture for blood or tissues
- Detection of VHF-specific genetic sequence by reverse transcription-polymerase chain reaction (RT-PCR) from blood or tissues
- Detection of VHF viral antigens in tissues by immunohistochemistry(5)

3.2 Suspect Case Definition

Meets clinical criteria listed above, **AND** has one or more of the following epidemiologic exposures in the three weeks before symptom onset:

Viral Hemorrhagic Fevers

- Contact with blood or other body fluids of a patient with VHF
- Residence in—or travel to—a VHF-endemic area or an area with active transmission
- Work in a laboratory that handles VHF specimens
- Work in a laboratory that handles bats, rodents, or primates from an enzootic area or an area with active transmission
- Sexual exposure to semen from a confirmed acute or recovered case of VHF(5)

3.3 Diagnostic Testing

For information on diagnostic testing, see [CDC Guidance on Performing Routine Diagnostic Testing for Patients with Suspected VHFs or Other High-Consequence Disease](#).

3.4 Services Available at Oregon State Public Health Laboratory

OSPHL offers Zaire Ebola virus testing by PCR and can facilitate testing for other VHFs through CDC. Contact the ACDP Epi on-call for testing approval. Once testing is approved, OSPHL staff (503-693-4100) will provide specific guidance on specimen collection, handling, and transport. CDC offers guidance on [VHF Specimen Collection](#) and [VHF Clinical Specimen Packaging and Shipping](#).

4. ROUTINE CASE INVESTIGATION

If a suspect or confirmed case of VHF is reported, or there is potential exposure to an agent that could cause VHF, call the ACDP epidemiologist immediately, day or night, at 971-673-1111.

Case investigation of VHFs in Oregon residents will involve close collaboration between ACDP epidemiologists, LHD staff, and the CDC. Not all VHFs are communicable; in the absence of laboratory confirmation that the pathogen is non-communicable, assume communicability and proceed with case and contact investigation as outlined below.(1) Unless absolutely necessary, cases should be investigated remotely (i.e., by phone) due to the potential morbidity and mortality associated with VHF infections.

4.1 Identify the Source of Infection

The case investigation should aim to identify the source of VHF infection. In most cases, the source will be obvious (e.g., an infection prevention breach while caring for an ill patient). In sporadic cases, the source may not be obvious, and identifying risk factors during the incubation period prior to infection, such as contact with wild animals or visiting a cave, will be critical. The [VHF case report form](#) will guide the case investigation and should be completed and uploaded to Orpheus as a document.

4.2 Identify and Quarantine Close Contacts

The case investigation should aim to identify all persons with high-risk exposures to a VHF. These close contacts should be quarantined for the duration of the incubation period of the VHF following their last exposure. They should be actively monitored daily during this period and restricted from traveling by commercial transport.(6)

A close contact is any person who has been exposed to a suspect or confirmed case in one or more of the following ways:

- Physical contact with a person who has a confirmed or suspected VHF, without the use of recommended personal protective equipment (PPE)
- Providing health care to a patient with a confirmed or suspected VHF without use of recommended PPE or experiencing a breach in infection control precautions that results in the potential for percutaneous, mucous membrane, or skin contact with the blood or other body fluids of a patient with a VHF while working in a VHF treatment unit or associated facility (e.g., laboratory) or while taking care of a patient with a VHF;
- Physical contact (without using recommended PPE) with a body of a person who died of confirmed or suspected VHF, or any dead body in an area with a declared VHF outbreak, or experiencing a breach in infection control precautions while handling such a dead body
- Living in the same household as a person with confirmed or suspected VHF while that person was symptomatic(6)
- Has touched the blood or body fluids of a case during their illness
- Has touched the clothes or linens of a case
- A baby who has been breastfed by a case(7)

5. CONTROLLING FURTHER SPREAD

5.1 Protective Actions and Personal Protective Equipment

Protective actions include avoiding non-essential travel to areas with known outbreaks of VHF and avoiding high-risk exposures when traveling to areas with known outbreaks.

Viral Hemorrhagic Fevers

CDC guidance regarding infection prevention and control including personal protective equipment (PPE) in healthcare facilities includes:

- [Infection Prevention and Control Recommendations for Patients in U.S. Hospitals who are Suspected or Confirmed to have Selected Viral Hemorrhagic Fevers](#)
- [Guidance for Personal Protective Equipment](#)
- [PPE: Clinically Stable Patients Suspected to have VHF](#)
- [PPE: Confirmed Patients and Clinically Unstable Patients Suspected to have VHF](#)
- [Considerations for Discharging People under Evaluation for Selected VHFs](#)
- [VHF Clinical Care for Safely Performing Acute Hemodialysis in Patients in U.S. Hospitals](#)
- [Interim Guidance for Environmental Infection Control in Hospitals](#)
- [Handling VHF-Associated Waste](#)
- [Safe Handling of Human Remains of VHF Patients in U.S. Hospitals and Mortuaries](#)

CDC guidance regarding infection prevention and control including PPE for emergency services includes:

- [Interim Guidance for Emergency Services](#)
- [Interim Guidance for EMS Systems and 9-1-1 Answering Points](#)
- [Interim Guidance for Air Medical Transport](#)

The duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities. Factors which should be considered include the presence of symptoms, the time since symptom resolution, and available laboratory information.(8)

5.2 Isolation of VHF Cases

People with suspected or confirmed VHF should remain in isolation until they have been determined not to have VHF (if suspected) or to be no longer infectious (if confirmed).(6)

5.3 Returning Traveler Screening and Activation of Person Under Monitoring Approach

CDC has implemented enhanced screening for travelers returning from active outbreak areas several times in the past. Recently, this has involved the rerouting of commercial flights to specific airports in the U.S. followed by screening by CDC officials upon arrival. This enhanced screening may be augmented through follow-up text notifications regarding symptom monitoring through the isolation period.

When enhanced screening is activated, CDC typically notifies OPHD of returning travelers to Oregon and recommends activation of a person under monitoring (PUM) approach, in which individuals who meet a specific risk threshold are asked to self-monitor or are actively monitored by public health through one incubation period

Viral Hemorrhagic Fevers

following their departure. It is important to note that returning traveler screening is typically implemented at the country-level, while VHF outbreaks may be limited to a specific 'area of concern' within the country.

While every outbreak is unique, the general approach to returning traveler screening and activation of a persons under monitoring approach is as follows:

1. OPHD immediately attempts to contact all returning travelers for an initial VHF Risk Assessment (see below). All information obtained during the risk assessment is documented in the Orpheus VHF Persons Under Monitoring record and the PUM is categorized as no risk, low risk, or high risk for VHF disease.
2. PUMs with no risk for VHF disease are asked to self-monitor through one incubation period following their departure. They are provided with a formal VHF Risk Assessment letter to carry with them should they need to seek care and are asked to call the OHA 24/7 Epidemiologist On-call at 971-673-1111 if they develop symptoms so that their risk assessment can be shared with the health care facility.
3. PUMs with any risk for VHF disease will be actively monitored by the LHD or Tribal jurisdiction. OPHD will work with the local authority and relevant health care systems to develop a care plan for these individuals should they develop symptoms.

VHF Risk Assessment

Exposure potential	High-risk exposures
Having contact with someone who was sick or died, or any objects contaminated by their body fluids	Contact with a symptomatic person with a suspected or confirmed VHF, or any objects contaminated by their body fluids, without the use of recommended PPE
Working in a healthcare facility or laboratory	Experienced a breach in infection prevention and control precautions that result in the potential for contact with body fluids of a patient with a suspected or confirmed VHF
Visiting a healthcare facility or traditional healer	Attending/participating in funeral rituals, including preparing bodies for funeral or burial
Having contact with bats or wild animals (including raw meat)	
Working or spending time in a mine/cave	

5.4 Public Health Orders

Quarantine or isolation may be voluntary or under public health orders. State, tribal, local and territorial authorities have primary jurisdiction for isolation and other public

Viral Hemorrhagic Fevers

health orders within their borders. Federal public health authority primarily extends to international arrivals at ports of entry and to preventing interstate spread of communicable diseases. Federal public health orders may be issued to enforce isolation, quarantine, or conditional release. The list of [quarantinable communicable diseases](#) for which federal public health orders are authorized is defined by Executive Order and includes viral hemorrhagic fevers.(6)

6. MANAGING SPECIAL SITUATIONS

We anticipate outbreak- and pathogen-specific recommendations from the CDC and these will be disseminated to public health and clinical partners through a variety of mechanisms including the Health Alert Network.

7. REFERENCES

1. CDC. About Viral Hemorrhagic Fevers. April 15, 2024.
2. Belhadi D, El Baied M, Mulier G, Malvy D, Mentré F, Laouénan C. The number of cases, mortality and treatments of viral hemorrhagic fevers: A systematic review. PLOS Neglected Tropical Diseases. 2022;16(10):e0010889.
3. Siegel JD, Rhinehart E, Jackson M, Chiarello L, Committee HCICPA. 2007 guideline for isolation precautions: preventing transmission of infectious agents in health care settings. American journal of infection control. 2007;35(10):S65.
4. Control CfD, Prevention. Update: management of patients with suspected viral hemorrhagic fever--United States. MMWR Morbidity and mortality weekly report. 1995;44(25):475-9.
5. CDC. Viral Hemorrhagic Fever (VHF) 2022 Case Definition. August 30, 2021.
6. CDC. Public Health Management of People with Suspected or Confirmed VHF or High-Risk Exposures. May 15, 2024.
7. Greiner A, Angelo K. CDC methods for implementing and managing contact tracing for Ebola virus disease in less-affected countries. 2014.
8. Siegel JD, Rhinehart E, Jackson M, Chiarello L. 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings. Last update: September 2024. 2024.

8. UPDATE LOG

2026. Banner added regarding Ebola outbreak in DRC, Uganda; expansion of section 5.3. (Sutton)
2024. Original document. (Sutton, Moffett)