Australian Centre for Disease Control

Ebola Disease

CDNA National Guidelines for Public Health Units

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Enquiries

Enquiries regarding any other use of this publication should be addressed to the Communication and Public Information Section, Strategy and Engagement Branch, Australian Centre for Disease Control, GPO Box 798, Canberra ACT 2601, or via e-mail to CDCComms@cdc.gov.au.

Using these guidelines

These guidelines for public health units (PHUs) outline Australia's agreed national approach for the routine public health management of Ebola disease. They consider available evidence at the time of publication to develop pragmatic guidance, including where evidence is still evolving or where jurisdictional approaches differ. Jurisdictions may implement policies that differ from these national standards based on local factors.

Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources, including, but not limited to, jurisdictional public health guidelines and advice from a public health specialist or other health professional. Clinical judgment and discretion may be required to interpret and apply these guidelines. PHUs should refer to and follow jurisdictional guidance regarding disease management where appropriate. These guidelines are not intended to provide public health guidance or advice to other (non-PHU) audiences.

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Scope

These guidelines have been developed to inform responses to Ebola disease, but would also be applicable to responding to a notification of Marburg haemorrhagic fever.

These guidelines are **not** applicable for Lassa fever, or for vector-borne viral haemorrhagic fevers such as Crimean Congo haemorrhagic fever or Rift Valley fever.

Definitions

Ebola disease refers to the disease caused by infection of any orthoebolavirus which can cause disease in humans. Previously this was referred to as Ebola virus disease. However, in 2023 a review of the nomenclature of *Filoviridae* resulted in changing the term "Zaire virus" to "Ebola virus" in recognition of Zaire being an outdated term. Ebola virus disease now refers specifically to disease caused by Ebola virus (*Orthoebolavirus zairense*).

The term "**public health unit**" in this guideline is a general term referring to any government branch or unit which is responsible for receiving notifications of nationally notifiable communicable diseases and performing the relevant public health response actions.

Revision history

Version	Publication date	Revised by	Comments
3.0	15 June 2026	Australian CDC and CDNA	*Moved to new template and formatting; terminology changed to Ebola disease to reflect updated scientific nomenclature and disease name; background information and references updated; surveillance objectives updated; links to existing guidance updated and highlighted, repetitious information removed from the SoNG; case investigation form updated and provided as separate document; information provided in all other appendices integrated into body of SoNG and retired.*
2.2	24 December 2018	Health	*Endorsed by CDNA*
2.1	24 May 2018	Health	*Revised to align with IPCEAG infection prevention guidelines and Biosecurity Act; included mention of*

Version	Publication date	Revised by	Comments
			vaccination and post Ebola syndrome and infection prevention recommendations for Ebola survivors; updated mentions of the West Africa outbreak; and added sexual contact to the contact definition / recording forms
2.0	26 June 2015	EVD SoNG working group	*New Appendix (Appendix 13) on cleaning in residential settings, revised factsheets, new section on border and monitoring measures during an outbreak with widespread and intense transmission.* *Endorsed by CDNA, noted by AHPPC*
1.4	6 November 2014	EVD SoNG working group	*Revised case definition. Endorsed by CDNA*
1.3	24 October 2014	EVD SoNG working group	*Endorsed by CDNA and AHPPC*
1.2	3 October 2014	EVD SoNG working group	*Endorsed by CDNA and AHPPC*
1.1	26 September 2014	EVD SoNG working group	*Revision for CDNA endorsement*
1.0	15 August 2014	N/A	*Interim version endorsed by CDNA*

Contents

Public health approach

Priority

Priority Classification	Timeframe to initiation of public health response	Timeframe for data entry into state or territory notifiable diseases database
Urgent	Immediately	Within 1 working day

Suspected, probable, or confirmed cases of Ebola disease must be urgently notified to the National Incident Centre and the National Focal Point (via Health.Ops@health.gov.au). Public health units should notify their Chief Health Officer and Chief Human Biosecurity Officer. CDNA representatives should notify the CDNA Chair and secretariat.

Public health importance

Ebola disease was first recognised in 1976 with simultaneous outbreaks occurring in Sudan and the Democratic Republic of Congo. Ebola disease outbreaks in humans have occurred periodically in a number of countries in Africa, with the most notable outbreak occurring between 2014 and 2016 across West Africa with over 28 600 cases and 11 300 deaths.(1)

Ebola disease has a high case fatality rate, which has been observed to be as high as 90% in some outbreaks.(2) Ebola disease also has potential for large outbreaks that are difficult to control in resource-poor settings. Ebola disease outbreaks are public health emergencies, with effective control requiring the cooperation of all agencies, sectors and communities in-country, and effective use of international aid and support as needed.

In Australia, Ebola disease is a Listed Human Disease under the national *Biosecurity Act 2015*. In the Australian context, the risk of importation and onward transmission of Ebola disease is lower due to differences in cultural practices, resourcing and health infrastructure. However, to maintain that level of low risk all suspected, probable, or confirmed cases should be urgently investigated and managed appropriately.

Public health response aims

The primary aim of the public health response is to ensure the prompt identification, isolation and treatment of suspected, probable, and confirmed cases of Ebola disease to prevent the exposure of other people, and identify and manage contacts of people with Ebola disease.

Priority populations

People are most at risk of infection with Ebola disease-causing viruses when they have direct contact with the blood and other bodily fluids of people with Ebola disease. People who may have an increased risk of this type of exposure include:

- Healthcare workers who provide care for people with Ebola disease
- People in community who provide care for people with Ebola disease
- People who are required to handle the bodies of people who have died from Ebola disease
- Laboratory workers processing clinical specimens of people with Ebola disease(3, 4)

People may also be at increased risk of infection if they are in regular contact, have eaten, or handle living or deceased animals in areas where viruses that cause disease are endemic, such as people working with wildlife (particularly nonhuman primates in Central Africa and West Africa), and people working in bat-inhabited locations.(3)

Surveillance aims

1. Rapidly identify suspected, probable and confirmed cases of Ebola disease to enable timely public health response
2. To meet the obligations for detection and reporting under the *National Biosecurity Act 2015* and relevant international legislation including the International Health Regulations

Disease summary

Infectious agent

Pathogen

Ebola disease is caused by infection with an orthoebolavirus, which belong to the family *Filoviridae*. *Filoviridae* also contains Marburg virus. Of note, the genera and species names for *Filoviridae* were updated in 2023.(5)

Six species of *Orthoebolavirus* have been identified which include:

- Ebola virus (*Orthoebolavirus zairense*, previously "Zaire virus")(5)
- Sudan virus (Orthoebolavirus sudanense)
- Bundibugyo virus (Orthoebolavirus bundibugyoense)
- Taï Forest virus (Orthoebolavirus taiense)
- Reston virus (Orthoebolavirus restonense)
- Bombali virus (Orthoebolavirus bombaliense)

Ebola virus, Sudan virus, and Bundibugyo virus have been associated with large outbreaks in humans. A single non-fatal human case of Taï Forest virus infection has been recorded.

Reston virus causes asymptomatic infections in humans, and Bombali virus has only been described in bats.

Reservoir

Forest dwelling fruit bats are believed to be the reservoir for orthoebolaviruses. Nonhuman primates are likely incidental hosts, but not primary reservoirs for orthoebolaviruses.

Mode of transmission

Zoonotic transmission of orthoebolaviruses most often occurs when people are handling deceased infected wild mammals, in particular with exposure to blood and bodily fluids. Subsequent human to human transmission occurs via direct contact through mucous membranes or broken skin with blood, urine, vomit, diarrhoea,

semen, other secretions, or organs of infected people. Orthoebolaviruses do not readily spread through air, water, or food.

Incubation period

Usually 8-10 days (range 2 to 21 days).

Infectious period

People with Ebola disease are infectious from the onset of their symptoms. Infectivity is low at the onset of symptoms, and is highest at the point of death and after death. Infectivity increases as symptoms worsen – for example, a person with profuse vomiting and diarrhoea is more infectious than a person with fever only.

People who recover from Ebola disease may remain infectious for as long as the virus persists in their blood and secretions. In immune privilege sites, including the eyes, central nervous system and testes, orthoebolavirus may persist for several months.(3) Evidence suggests orthoebolavirus may persist in semen for approximately 12 months, and may present risk of sexual transmission during this period. (6-10)

Clinical condition

Clinical features

Sudden onset of fever, myalgia, headache and fatigue, which progresses in most cases to pharyngitis, vomiting and diarrhoea, and development of a maculopapular rash.(3) Illness may progress to multi-organ failure (often involving the liver and kidneys), central nervous system involvement (confusion, delirium), and profuse internal and external bleeding.(3, 11, 12)

Complications and outcomes

The case fatality rate (CFR) for Ebola disease varies between orthoebolaviruses, with estimated CFRs of approximately 67% for Ebola virus, 49% for Sudan virus, and 33% for Bundibugyo virus.(13) Case fatality rates are also impacted by the geographic context and availability of resources and intensive healthcare infrastructure,(13) with CFRs of up to 90% observed during some outbreaks.(2)

Most people who recover from the acute illness of Ebola disease experience ongoing symptoms. These most often include joint pain, myalgia, fatigue and headaches.(14, 15) Ocular problems including uveitis and visual loss, late onset meningoencephalitis, memory loss and mental health disorders have also been reported.(14, 16, 17)

Case classification

Surveillance case definition

Probable and confirmed cases of Ebola disease are captured by the CDNA surveillance case definition for viral haemorrhagic fevers. See CDNA Surveillance case definition - Viral haemorrhagic fever (not elsewhere classified).

Suspected cases of Ebola disease are not notifiable and not captured in the surveillance case definition. For the purposes of this guideline, suspected cases refer to people with symptoms consistent with Ebola disease AND one of the following epidemiological risk factors:

- Direct skin or mucous membrane contact with blood or bodily fluids of a person with suspected, probable or confirmed Ebola disease without wearing adequate PPE (includes needlestick injury)
- Direct contact with a person (alive or deceased) with suspected, probable or confirmed Ebola disease without wearing adequate PPE or breach of PPE (including brief contact, e.g. shaking hands)
- Was within 1m of a person with suspected, probable or confirmed Ebola disease without wearing adequate PPE or breach of PPE (includes household or household-like contact, attendance at funerals or other gatherings, and presence in waiting or triage areas at healthcare facilities where persons with Ebola disease are reviewed or treated)
- Exposure to susceptible animals in a country where Ebola disease is endemic, e.g. visiting caves or mines, handling sick or dead animals, or consumption of susceptible animals

Laboratory case definition

For more detailed information about the laboratory testing and diagnosis of Ebola disease and other viral haemorrhagic fevers, see the Public Health Laboratory Network (PHLN) case definition: PHLN Laboratory case definition – Viral haemorrhagic fever.

Testing

Requests for testing for Ebola disease should be endorsed by the relevant Chief Health Officer or delegate for the public health unit investigating a suspected case. Treating clinicians should contact their local public health unit to discuss patients presenting with relevant symptoms and potential exposures, to assess whether the patient should be managed as a suspected case and tested. Following assessment, public health units may also consider testing individuals who do not meet the suspected case definition, but have symptoms consistent with Ebola disease and have returned in the previous 21 days from an area where an outbreak of Ebola disease is occurring.

Note: All people who are tested for Ebola disease must be isolated pending test results, and the appropriate infection prevention and control measures should be followed (as for suspected, probable and confirmed cases) until a negative test is returned.

Requesting clinicians should make direct contact with their local medical microbiologist to arrange receipt of specimens and obtain advice on specimen collection, safe packaging and transport. Public health and pathology advice must be obtained before any kind of pathology collection occurs for a person with suspected Ebola disease.

Diagnostic testing for Ebola disease in Australia is restricted to laboratories equipped with high-containment facilities, trained personnel, and the capability to accurately assess and effectively manage biosafety and pathogen security risks.

The National High Security Quarantine Laboratory (NHSQL), hosted by the Victorian Infectious Diseases Reference Laboratory (VIDRL) in Melbourne, is Australia's designated national reference laboratory for quarantinable viral haemorrhagic fevers. VIDRL provides diagnostic capability and confirmatory testing for urgent requests 24 hours a day, 7 days a week – they can be contacted via the Royal Melbourne Hospital

switchboard. Where a jurisdictional public health reference laboratory is able to perform preliminary testing, any positive results must be confirmed at the NHSQL.

Nucleic acid amplification using polymerase chain reaction (PCR) is the primary diagnostic methodology, and the essential specimens to be submitted for virus detection are determined in consultation with the medical microbiologist. These may include:

- Whole blood (EDTA tube) and serum
- Oral fluid/swabs, urine, semen or ocular samples **only if blood collection is not possible**
- If post-mortem specimens are available, serum, liver, lung, spleen and kidney tissues are desirable(18)

People who collect blood or other specimens from people with suspected, probable or confirmed Ebola disease must use the same infection prevention and control precautions as those recommended during patient care. See Case management for details.

Orthoebolavirus is classified as a Security Sensitive Biological Agent (SSBA) under Australia's SSBA Regulatory Scheme. Samples obtained which are suspected or confirmed to be orthoebolavirus must be handled in accordance with the requirements under the *National Health Security Act 2007, National Health Security Regulations 2018,* and the SSBA Standards for handling, storage, transport and disposal.

PHLN has prepared several guidance documents which detail the procedures for collecting, packaging, transporting, testing, handling and disposing of samples from people with suspected viral haemorrhagic fever:

- PHLN Laboratory case definition - Viral haemorrhagic fever
- Part A: Guidelines for laboratories that are not associated with a designated isolation hospital
- Part B: Guidelines for laboratories that are associated with a designated hospital

For further information about testing at the NHSQL, see the NHSQL Guideline for management of quarantinable viral haemorrhagic fevers.

Case management

Response procedure

Public health responses are required for **suspected**, **probable** and **confirmed** cases of Ebola disease. Public health units should:

- commence case investigation immediately after receiving notification
- notify the Chief Health Officer, Chief Human Biosecurity Officer, National Incident Centre, and CDNA representative as soon as possible (and other briefings as required locally)
- perform contact tracing and determine management of contacts
- monitor for further cases

Public health units may provide advice on required infection prevention and control measures, including appropriate facility for assessment and management based on assessed risk.

Clinical management of the person is the responsibility of the treating clinician or clinical team.

Case investigation

Investigation is required for all **suspected**, **probable**, and **confirmed** cases of Ebola disease. Case investigation should include the following actions:

- Confirm results of available pathology testing, or arrange testing for suspected cases if required (see Testing)
- Contact the treating clinician to:
    - Determine if the person or their care giver has been informed of the diagnosis
    - Determine what treatment has been given to-date and the setting in which it occurred
    - Discuss appropriate infection prevention and control measures, including the most appropriate facility for assessment and treatment
    - Determine who is best placed to conduct an interview with the person or their care giver (or other appropriate person) – it is important to minimise the number of people who have contact with a person with suspected,

probable or confirmed Ebola disease wherever possible. Public health unit staff should **not** conduct face to face interviews.

- Interview the person, their care giver or other appropriate person to:
  - Confirm the onset date and symptoms of the illness
  - Assess possible exposures and determine the likely source of infection (see Exposure investigation)
  - Identify potential contacts
  - Provide information about Ebola disease and advice about exclusions and restrictions following recovery (if appropriate to do so)
- Follow-up identified contacts – see Contact management

Exposure investigation

Use this case investigation form to assist in the exposure investigation.

Public health unit staff should **not** conduct face to face interviews. Use alternative methods such as telephone, or explore if clinical staff already providing care can collect information.

Exposure investigation should investigate if the person had:

- been travelling in an area with active Ebola disease outbreak
- contact with a person with Ebola disease, and whether they were a confirmed, probable, or suspected case (if known)
- The nature of their contact with the person
- visited a healthcare facility or hospital in an area with an active outbreak of Ebola disease during their exposure period
- attended a funeral or burial of a person with known or suspected Ebola disease
- contact (including consumption) with bats, primates, or other animals in an area with known zoonotic Ebola disease transmission

Treatment

The clinical management of Ebola disease is the responsibility of the treating clinician. Treatment is primarily supportive and focussed on preventing complications. People with Ebola disease should be managed in a designated quarantine hospital.

Two neutralising monoclonal antibody therapies, mAb114 (ansuvimab, Ebanga™) and REGN-EB3 (atoltivimab/maftivimab/odesivimab, Inmazeb™), have been found to reduce mortality from infections with Ebola virus and are recommended for use during outbreaks by the World Health Organization (WHO).(19, 20) They are not currently recommended for outbreaks caused by Sudan virus, Bundibugyo virus, or Taï Forest virus.(19) They are not currently approved by the Therapeutic Goods Administration for use in Australia. Other therapies, such as monoclonal antibody MBP134, are still undergoing trials to determine their effectiveness.

Infection prevention and control

Public health units and health services should refer to local guidelines where available. The Infection prevention and control principles and recommendation for Ebola virus disease(21) guideline may also be referred to for detailed instructions for managing people with Ebola disease in Australian healthcare settings, including the appropriate choice and use of PPE.

People with suspected, probable or confirmed Ebola disease should be placed in a single room (with negative pressure, where available) with private bathroom and an anteroom, with the door closed. Signage that includes a list of required PPE and check-in procedures for healthcare staff and visitors should be displayed.

Healthcare facility staff should be trained in the use of PPE for managing people with Ebola disease. This should include when PPE is required to be used, how to properly don and doff PPE, the disposal or decontamination of used PPE, and the disposal of other contaminated waste. Staff donning and doffing PPE should be observed by another trained staff member in a 'buddy' system in order to prevent and identify PPE breaches.

If the facility allows visitors, staff must be confident in training visitors in PPE use, supervising PPE donning and doffing, and must supervise the visits. Visitors should not be allowed to make direct contact with the person with Ebola disease. A log should be kept of all staff and visitors, including their contact details.

Aerosol generating procedures should be avoided wherever possible. In the event of a PPE breach or other exposure incident, facility protocols must be followed.

In instances where a person with suspected Ebola disease returns a negative test for Ebola disease and an alternative diagnosis has been made, they may be released

from isolation and managed according to their diagnosis. If diagnosis remains uncertain and repeat testing is indicated, the person should remain in isolation.

Convalescence

People who have recovered from Ebola disease do not pose a risk to healthcare staff where care involves contact with intact skin, sweat, tears, saliva, cerumen and conjunctivae. Additionally, people who are recovered and not febrile do not pose a risk through phlebotomy, as they are not viraemic.

However, where care involves contact with spinal fluid, brain tissue, semen, or ocular contents, or where the recovered person is febrile and there is risk of persistent infection, the infection prevention and control measures as for management of a suspected, probable or confirmed case should be used until appropriate testing for orthoebolaviruses is negative.

Exclusions and restrictions

Isolation

People with suspected, probable or confirmed Ebola disease must follow public health directions provided to them. They must remain in isolation in healthcare facilities until they have sufficiently recovered and have been cleared by their treating team (infectious diseases specialist) and local public health unit to be released from isolation. If required, a Human Biosecurity Control Order (*Biosecurity Act 2015*) may be enacted to ensure required activities are completed.

Sexual activity

People who produce semen who have recovered from Ebola disease should be educated about the risks of possible sexual transmission, and advised to use condoms (and safely dispose of them) to avoid exposing sexual partners to semen. Testing of semen should be offered 3 months after onset of symptoms, with two negative PCR tests taken at least one week apart indicative of clearance of virus. People who return a positive test should be offered a test every month until they return a negative test.(18) Infection prevention and control measures as for management of a suspected, probable or confirmed case should be used when

collecting and analysing these tests. Where testing is not performed, people should be advised to continue use of condoms for at least 12 months.

Blood donation

Due to the uncertainty around the exact duration of persistence of virus in some bodily fluids, people who have Ebola disease or have recovered from Ebola disease are currently not permitted to provide blood or other donations at any time (i.e. indefinitely). See Contact management for deferral periods for blood donation for contacts.

Case education

Information should be provided to people with suspected, probable or confirmed Ebola disease and their care givers, families, and other appropriate people about Ebola disease. Resources include:

- Ebola virus disease | Australian Centre for Disease Control
- Ebola virus - transmission (spread), symptoms and treatment | healthdirect
- Ebola disease | WHO (available in multiple languages)

Contact classification

Contact identification

Contact tracing should be conducted as soon as possible for suspected, probable and confirmed cases of Ebola disease, from the onset date of the person's symptoms. Contacts may be identified individually from case interviews, or as part of potentially exposed cohorts (e.g. passengers on a plane, staff and patients at a healthcare facility). See Special situations for advice about contact tracing on aircraft.

Contact definitions

Contact type	Definition
Higher risk exposure	Direct contact with the person with Ebola disease or their bodily fluids, including: • Percutaneous (e.g. needlestick injury) or mucous membrane exposure to blood or bodily fluids of a person with Ebola disease • Direct skin contact exposure to blood or bodily fluids of a person with Ebola disease without appropriate PPE or breach of PPE • Laboratory processing of bodily fluids of a person with suspected, probable or confirmed Ebola disease without appropriate PPE, breach of PPE or standard biosafety precautions • Direct contact with a deceased person without appropriate PPE or breach of PPE • Household or household-like contact with a person with Ebola disease without appropriate PPE or breach of PPE • Unprotected sexual contact with a person with male genitalia who has Ebola disease, or has recovered from Ebola disease in the last 12 months where clearance has not been demonstrated
Lower risk exposure	Close contact in healthcare or community settings (other than household or household-like contact) where close contact is defined as: • Being within approximately 1 metre of a person with Ebola disease, or within the person's room or patient care area for a

Contact type	Definition
	prolonged period of time while not wearing appropriate PPE or breach of PPE • Having brief direct contact (e.g. shaking hands) with a person with Ebola disease while not wearing appropriate PPE
Unlikely exposure	No direct or close contact as for higher and lower risk exposures above, but within the vicinity of a person with Ebola disease

Contact management

All contacts should be provided with information about Ebola disease (see Case education) and the contact details for the public health unit.

Unlikely exposure

- Provide reassurance to contacts and their household members about the very low risk of developing Ebola disease
- Emphasise information in any resources provided about Ebola disease, including:
  - How it is spread, and how to avoid it
  - Where high-risk areas for Ebola disease currently are
  - Symptoms of Ebola disease
  - What to do if symptoms develop

Lower risk exposure and higher risk exposure

- The assessed level of risk should be explained
- Instruct contacts to perform twice daily self-monitoring of temperature for 21 days from their last exposure (provide thermometer and instructions on use)
- Instruct contacts to notify the public health unit if fever or other symptoms develop, including headache, joint pain, myalgia, abdominal pain, lethargy, diarrhoea, vomiting, rash, conjunctivitis, chest pain, dysphagia, or bleeding
- Explain how active monitoring will occur (according to the public health unit's protocols). At least daily active monitoring by the public health unit for 21 days from their last exposure:
  - **Higher risk exposure contacts** must undergo active monitoring
  - **Lower risk exposure contacts** should be assessed on a case by case basis for the need for active monitoring
- Advise not to undertake onward international travel within 21 days after their last exposure.

If a contact develops symptoms within 21 days after their last exposure, they should be isolated and assessed against the criteria for a suspected case.

Exclusions and restrictions

Routine quarantine of asymptomatic contacts is not recommended.

Healthcare workers – Australian settings

Healthcare workers providing care for people with Ebola disease in Australian hospitals and related healthcare services are generally at low risk of infection with Ebola disease. Where a risk of exposure has occurred, for example a PPE breach, the healthcare worker must follow all occupational health and safety instructions and policies for their healthcare facility, and the local public health unit should be notified. Healthcare facility policies may include regular monitoring for fever and other symptoms in the workplace, in addition to required public health monitoring activities. In this context, healthcare workers do not require restriction in work duties if they are asymptomatic. However, if they develop symptoms they should isolate and advise the public health unit and their employer immediately.

Returning aid workers (including healthcare workers)

Returning aid workers must follow instructions from their host organisations, the National Incident Centre, biosecurity officers, and public health units. Due to differences in resourcing and health infrastructure in overseas settings, assessment of exposure risk can be difficult and in general a precautionary approach is taken. Therefore, it is recommended that returning healthcare workers must not work in clinical care in Australia during their 21-day monitoring period – employers may consider temporary re-assignment to non-clinical duties, or non-punitive leave policies.

For more information on the assessment and management of returning aid workers, see Special situations.

Blood donation

Contacts of people with Ebola disease, or people who have had household contact or sexual contact with a person who has recovered from Ebola disease in the past 12 months, should defer blood donation for 8 weeks from the date of their last exposure.

Note: in the context of blood donation, sexual contact includes oral, vaginal, or anal sex **with or without** condoms.

Prophylaxis

There are no available prophylactic treatments for people exposed to Ebola disease in Australia. In Ebola virus disease outbreak settings internationally, ring vaccination of contacts is recommended by the Strategic Advisory Group of Experts on Immunization (see Vaccination).(22)

Testing

Routine laboratory screening for Ebola disease is not recommended for asymptomatic contacts.

Contacts that develop fever within 21 days of the last possible exposure to a person with Ebola disease should be isolated, assessed, and tested if they are classified as a suspected case.

Environmental evaluation and management

Disinfection and environmental treatment is a key component to control Ebola disease. The environmental hygiene and waste management controls required in Australian healthcare settings are described in detail in the Infection prevention and control principles and recommendation for Ebola virus disease guidelines. The handling and examination of deceased people with Ebola disease is also outlined in these guidelines. Healthcare facilities should always follow their local protocols for environmental management of Ebola disease where they are available.

Residences and other non-clinical settings

Orthoebolaviruses are susceptible to environmental stresses and viricides. If a person with Ebola disease has potentially contaminated materials in their home or another non-clinical setting, they can be effectively disinfected. The preferred disinfectant is sodium hypochlorite.

Public health units should consult their local environmental health team, infection prevention and control teams (both public health unit and hospital-based teams, where applicable) and the healthcare facility providing care for the person with Ebola disease, to determine the level of risk of contamination in the setting, the timing of disinfection, and who is best placed to perform cleaning. People conducting environmental disinfection must be appropriately trained in the use of PPE and disposal of waste. Disinfection should be conducted in line with local healthcare facility protocols.

Animal health

If a person with Ebola disease has had contact with animals in Australia, it may be appropriate to consult with the relevant state or territory animal health authority to assess the risk that animals could have become infected.

Population level prevention

In the Australian context, the risk of infection of other people in the community from an imported case of Ebola disease is very low, due to contextual and cultural differences to countries where outbreaks have occurred. The risk of transmission in healthcare settings is significantly reduced by adhering to the recommended infection prevention and control measures.

Travellers should follow all advice provided by the Australian Government, including registering with Smartraveller to stay up to date with travel advice.

Vaccination

There is currently no vaccination for Ebola disease available for routine use in Australia. Routine vaccination at a population level is not recommended in any context.(22) Two types of vaccine against Ebola virus have been developed, licensed and prequalified by the WHO. There is no evidence for their effectiveness against Sudan virus or Bundibugyo virus. The Strategic Advisory Group of Experts on Immunization only recommend their use during outbreaks of Ebola virus disease (or in well-defined target groups where used preventatively), and recommend ring vaccination as the strategy of choice.(22)

Communications

The need for media or other public communications should be considered carefully. Public health units should consult with their Chief Health Officer regarding planned media and communications, to ensure it is coordinated at both a state/territory level and a national level. Public health units may also contact the Australian Centre for Disease Control for assistance with developing and coordinating communications in the event that a suspected, probable or confirmed case is identified in Australia.

Special situations

Suspected, probable or confirmed cases who travelled by aircraft

Contact tracing should be considered for suspected, probable and confirmed cases of Ebola disease if the person was symptomatic during the flight, and the National Incident Centre should be contacted for assistance. Contact tracing should focus on people who may have had direct contact with, or been within 1 metre of the person with Ebola disease. A wider range of contacts may be included depending on the symptoms of the person, however, at a minimum the following people should be identified in contact tracing:

- Passengers or crew with reported direct contact, e.g. co-travellers, crew members providing assistance
- Passengers one seat away in all directions (including across aisles)
- Passengers who have shared a toilet with a suspected case who had vomiting and/or diarrhoea during the flight
- Crew members of the relevant aircraft section, i.e. staff who provided in-flight service
- Cleaning staff for the relevant aircraft section
- If the case is a crew member, all passengers seated within their aircraft section and other crew members

These contacts are at higher risk of exposure and should be managed as higher exposure risk contacts.

People who have had none of the above exposures to the person with Ebola disease, including those who have shared a toilet with the person (where contamination with vomit, blood or diarrhoea is unlikely), are at very low risk of developing Ebola disease. Public health units may choose to contact all passengers and crew and provide information as for unlikely exposure risk contacts as appropriate.

Cleaning and disinfection of aircraft should be performed as per the airline's policies and protocols. The International Air Transport Association (IATA) also publish resources and tools related to managing public health events, including Ebola disease and other communicable diseases, during air transport.

Returning aid workers

Most returning aid workers are at low to very low risk of developing Ebola. People who are infected but not yet showing symptoms do not pose a risk to others.

Aid workers who have worked in healthcare or community settings during an Ebola disease outbreak and their host organisations should adhere to the Guidance for managing departing and returning aid workers. Contact details of returning aid workers should be provided to public health units for follow-up and determination of their contact classification and required management, and monitoring.

Where possible, returning aid workers should travel directly to their final destination in Australia. Further advice about travel can be found in the Guidance for managing departing and returning aid workers.

Outbreaks

Outbreaks in an Australian context are a public health emergency – the National Incident Centre should be alerted if onward transmission occurs. A national incident management team should be stood up in addition to local management teams.

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