This document is scheduled to be published in the Federal Register on 2026-11-25 and available online at https://www.federalregister.gov/d/2026-23990, and on https://govinfo.gov

: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR part 71

RIN 0920-AA88

Control of Communicable Diseases; Foreign Quarantine

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notification; extension of interim final rule – expiration date.

SUMMARY: The Centers for Disease Control and Prevention (CDC), in the Department of Health and Human Services (HHS), is extending the expiration date of the interim final rule published on May 27, 2026. This interim final rule removes an exemption for lawful permanent residents from application of regulations implementing section 362 of the Public Health Service (PHS) Act, which authorizes the Secretary, acting through the CDC Director or other delegate, to suspend the introduction of persons from designated countries or places, if required, in the interest of public health.

DATES:

Effective date: This Federal Register document is effective upon publication.

Expiration date: Unless extended further, the amendment to 42 CFR 71.40(f) made by the interim final rule will cease to be in effect on the earlier of (1) six months from the publication of this Federal Register document, or (2) when the HHS Secretary determines there is no longer a need for the interim final rule. The Secretary will publish a document in the Federal Register announcing the expiration date.

FOR FURTHER INFORMATION CONTACT: Division of Global Migration Health, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, MS H16-4, Atlanta, GA 30329. Telephone: 1-800-232-4636.

SUPPLEMENTARY INFORMATION:

I. Background

On May 27, 2026, the Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), issued an interim final rule (91 FR 31362), effective May 22, 2026, amending the regulations that implement section 362 of the Public Health Service (PHS) Act, 42 U.S.C. 265,[1] as amended, as part of its response to the 2026 Ebola Disease Outbreak in the Democratic Republic of the Congo (DRC), Uganda, and South Sudan.

Pursuant to a delegation of the Secretary's authority, the CDC Director has promulgated regulations under section 362 at 42 CFR 71.40 that permit the suspension of the right to introduce persons and property into the United States when required in the interest of public health based on serious danger of introduction of a communicable disease into the United States. The regulations exempt certain categories of persons from application of the regulation, including U.S. citizens and U.S. nationals. This interim final rule removed the exemption to the suspension of introduction into the United States for lawful permanent residents (LPRs) (42 CFR 71.40(f)).

The interim final rule also provided that unless extended after consideration of submitted comments, it would cease to be in effect on the earlier of (1) six months from the publication of the interim final rule, or (2) when the HHS Secretary determines there is no longer a need for this interim final rule. This document extends the expiration of the interim final rule based on the continuing critical public health need presented by the 2026 Ebola disease outbreak and CDC's ongoing response. The original scheduled expiration date is November 27, 2026. Any order

[1] Section 362 provides that if the Secretary "determines that by reason of the existence of any communicable disease in a foreign country there is serious danger of the introduction of such disease into the United States, and that this danger is so increased by the introduction of persons or property from such country that a suspension of the right to introduce such persons and property is required in the interest of the public health," he has the authority, in accordance with regulations approved by the President, "to prohibit, in whole or in part, the introduction of persons and property from such countries or places as he shall designate in order to avert such danger, and for such period of time as he may deem necessary for such purpose." PHS Act 362, 42 U.S.C. 265.

issued under § 71.40 remains subject to its own duration, exceptions, and reassessment requirements.

II. Rationale for Extension of Interim Final Rule

The confirmed ongoing outbreak of Ebola virus disease caused by the Bundibugyo virus in the DRC continues to present serious public health concern. Uganda has reported containment of its outbreak but remains at risk of further importations from the DRC. The outbreak remains centered in eastern DRC's Ituri Province, although cases have been identified in North Kivu, South Kivu, Haut-Uélé, Bas-Uélé, Nord-Ubangi, Sud-Ubangi, and Tshopo provinces of the DRC. This geographic expansion is concerning, particularly given that response efforts have thus far proven insufficient for outbreak containment. As of November 6, 2026, the DRC reports 10,879 confirmed cases and 5,302 deaths in 67 health zones across eight provinces.

Contact tracing is currently at 84%, well below the operational threshold of 95% identified for outbreak control. Recent assessments indicate that the true magnitude of the outbreak may be much greater than reported surveillance data suggest. Surveillance challenges persist in the most heavily affected areas, with conflict and insecurity, weak health infrastructure, and relatively porous borders in the region complicating containment efforts. Although contact tracing efforts are underway, they remain insufficient because the expected number of contacts has not yet been identified and the daily follow-up necessary to rapidly detect symptomatic individuals and ensure their prompt isolation has not been achieved.

Prior to August 27, 2026, Uganda reported 20 confirmed cases of Ebola disease and two confirmed deaths, as well as one probable case and one probable death. The last confirmed case was reported on June 21, 2026. Of the confirmed cases, 15 were imported cases and 5 were secondary cases linked to imported cases from the DRC. All cases in Uganda have been epidemiologically linked to the ongoing outbreak in the DRC, with cross-border importations having occurred, resulting in secondary transmission among family members and caregivers.

Ugandan authorities have activated emergency response systems, expanded surveillance, and strengthened screening at borders and health facilities.

Uganda has significant prior experience managing Ebola disease outbreaks, including the Sudan virus strain outbreak in 2025, which improved preparedness and response capacity. On July 28, 2026, the Republic of Uganda Ministry of Health declared the outbreak over. No further transmission of the virus within Uganda has been detected and the most recent imported case was discharged from a treatment center on July 16, 2026, following two negative tests results. Although the country has achieved successful containment of the outbreak, continued overland travel from the DRC poses an ongoing risk of cross-border transmission, particularly among healthcare workers and in western Ugandan districts that serve as points of entry for travelers seeking medical care.

Travel-associated cases in Kenya and Nigeria have demonstrated the continued risk of regional and international spread from the ongoing outbreak in DRC. On October 6, 2026, the Kenya Ministry of Health announced the country's first BVD case and death in an individual who had traveled from DRC to Uganda, flown from Kampala to Nairobi on October 2, and was hospitalized before dying on October 5, 2026. On October 20, 2026, Nigeria reported an Ebola case in a traveler arriving from Uganda who developed symptoms on October 7 and tested positive on October 20, 2026. The patient was later medically evacuated to Switzerland; the source of infection remains under investigation. To date, South Sudan has not reported any confirmed Ebola disease cases in the current outbreak. However, it is considered at high risk because of its shared border with the DRC and cross-border connections to affected areas, limited healthcare infrastructure and public health surveillance capacity, and cross-border population movement. Regional and international agencies, including The World Health Organization (WHO) and Africa CDC, are supporting preparedness measures, surveillance, and coordination among the three countries to prevent wider spread. Despite these efforts and in contrast to Uganda, there continues to be a risk that the outbreak in the DRC could spread to

South Sudan through cross-border travel by infected individuals during the virus's incubation period, when they have been exposed but are not yet showing symptoms.

Travelers moving between affected countries and major international transit hubs could unknowingly carry the Bundibugyo virus before becoming ill. Such travelers may spread the outbreak beyond the affected countries and ultimately reach the United States. DRC, Uganda and South Sudan are connected to the global aviation network through a series of regional and international transit hubs that provide pathways into the United States. Travelers departing from outbreak-affected regions frequently transit through densely populated metropolitan airports such as Addis Ababa Bole International Airport (ADD), Jomo Kenyatta International Airport (NBO) in Nairobi, Brussels Airport (BRU), Hamad International Airport (DOH) in Doha, Dubai International Airport (DXB), and Istanbul Airport (IST), all of which maintain extensive passenger connectivity to major U.S. gateway airports including John F. Kennedy International Airport (JFK), Washington Dulles International Airport (IAD), Hartsfield-Jackson Atlanta International Airport (ATL), Chicago O'Hare International Airport (ORD), and Los Angeles International Airport (LAX). These international transportation corridors support continuous movement of travelers between Central and East Africa and major U.S. metropolitan centers, increasing the likelihood that covered aliens exposed to Ebola disease could enter the United States before symptoms become apparent. Complex multi-leg itineraries and the rapid pace of international travel create substantial challenges for identifying potentially infected travelers before arrival.

A traveler infected in an outbreak-affected region of the DRC and Uganda may transit through multiple countries and major international airports before developing fever or other clinical signs of disease. The risk of Bundibugyo virus disease introduction into the United States is heightened by the virus's incubation period, which can extend up to 21 days, allowing infected persons to travel internationally while asymptomatic and therefore unlikely to be detected through routine symptom-based screening measures.

Travelers utilizing air transit pathways originating in or passing through the DRC, Uganda, and South Sudan include non-U.S. citizens, including regional migrants, foreign contract workers, humanitarian personnel, business travelers, students, refugees, and third-country nationals moving through international aviation hubs in Africa, the Middle East, and Europe. Many travelers entering U.S.-bound itineraries from these pathways may do so under temporary visas, refugee or asylum processing mechanisms, international organizational travel, or multi-country itineraries that complicate identification of their recent travel history. As a result, public health screening and border security systems face heightened operational complexity in identifying travelers with recent exposure histories linked to Ebola-affected regions, particularly when travelers transit through multiple jurisdictions prior to arrival at major U.S. metropolitan airports.

CDC has issued a series of Travel Health Notices (THNs) for the region; the THNs for the affected provinces have escalated over time. A Level 4 THN (avoid all travel) is currently in place for Ituri and North Kivu Provinces. A Level 3 THN (reconsider nonessential travel) is currently in place for Haut-Uélé and Tshopo Provinces of the DRC. The rest of the DRC and all of Uganda remain under a Level 2 THN (practice enhanced precautions). A Level 1 THN (practice usual precautions) is currently in place for Kenya. Modifications to the THNs reflect the geographic distribution of reported cases and do not indicate a reduced level of concern regarding the outbreak, which continues to expand in affected areas and poses a risk of further transmission and geographic spread.

CDC modeling demonstrates that early identification of cases, contact tracing, isolation and treatment of symptomatic individuals, community engagement, and safe burial practices are critical to reducing transmission and mitigating outbreak growth. CDC has concluded that the current outbreak is already the largest known outbreak of Bundibugyo virus disease and that large-scale, sustained public health measures are necessary to prevent further international spread of the disease and to reduce the risk of introduction of infected persons into the United States. In

recognition of the severity of the epidemiological situation in the DRC and indicative of the gravity of public health concern, CDC designated response to the outbreak as a Level 1, the highest level within the agency's Graduated Response Framework.

Restricting entry of covered aliens into the United States is intended to reduce the volume of higher-risk international arrivals requiring public health monitoring and follow-up by the public health departments of jurisdiction in the United States. By limiting the number of potentially exposed travelers entering through major U.S. ports of entry, federal, state, and local public health authorities can concentrate finite surveillance, screening, contact tracing, quarantine management, and medical monitoring resources on returning U.S. citizens and U.S. nationals.

Additional measures have similarly been put in place by CDC and federal partners to help focus U.S. Government resources domestically. This layered approach has reduced operational strain on airport screening systems, CDC port health stations, public health laboratories, and healthcare facilities responsible for evaluating suspected Bundibugyo virus disease cases. It also has improved the ability of authorities to conduct detailed exposure assessments, ensure compliance with monitoring requirements during the 21-day incubation period, rapidly identify symptomatic travelers, and allocate specialized isolation and treatment capacity more effectively. In the context of a rapidly evolving Bundibugyo virus disease outbreak with significant cross-border mobility, prioritizing surveillance efforts toward a smaller and more traceable traveler population has strengthened the overall effectiveness of U.S. disease containment and border health security operations. To date, no cases of Ebola disease have been confirmed in the United States because of this outbreak.

III. Statutory Authority

The primary legal authority supporting this extension of the interim final rule is section 362 of the PHS Act, which is codified at 42 U.S.C. 265. Under section 362, the Secretary—if he were to determine that the existence of a communicable disease in a foreign country creates a

serious danger of the introduction of such disease into the United States, and that this danger is increased by the introduction of persons or property from such country such that suspension of the right to introduction of persons or property is necessary to protect the public health—has the authority, in accordance with regulations approved by the President, to prohibit, in whole or in part, the introduction of persons or property from such countries or places as he designates for such period of time as he may deem necessary for such purpose.

In addition to section 362, other sections of the PHS Act are relevant to this rulemaking, including section 311, 42 U.S.C. 243; section 361, 42 U.S.C. 264; section 365, 42 U.S.C. 268; section 367, 42 U.S.C. 270; and section 368, 42 U.S.C. 271. Section 311 authorizes the Secretary to accept State and local assistance in the enforcement of quarantine rules and regulations and to assist States and their political subdivisions in the control of communicable diseases. Section 361 authorizes the Secretary to make and enforce such regulations that in the Secretary's judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States. It also permits the "apprehension, detention, or conditional release of individuals" in order to prevent the "introduction, transmission, or spread" of such communicable diseases as may be specified from time to time in Executive Orders of the President upon the recommendation of the Secretary, in consultation with the Surgeon General. Section 365 provides that it shall be the duty of designated customs officers and of Coast Guard officers to aid in the enforcement of quarantine rules and regulations. Section 367 authorizes the application of certain sections of the PHS Act and promulgated regulations (including penalties and forfeitures for violations of such sections and regulations) to air navigation and aircraft to such extent and upon such conditions as deemed necessary for safeguarding public health. Section 368 provides that any person who violates regulations implementing sections 361 or 362 will be subjected to a fine or imprisonment for not more than one year, or both. Under section 368, HHS/CDC may refer violators to the U.S. Department of Justice for criminal

prosecution; HHS/CDC does not have independent authority under section 368 to impose criminal fines or imprison violators.

IV. Response to Comments Submitted Concerning the Interim Final Rule

CDC received eight comments in response to the May 27, 2026, interim final rule. Six comments were within the scope of the rulemaking and two were outside the scope. Most commenters raised concerns regarding the removal of the exemption for LPRs under 42 CFR 71.40(f), generally arguing that CDC should rely on individualized, risk-based assessments rather than restrictions applied uniformly to LPRs as a population. One commenter expressed support for the rule's overall public health framework and offered recommendations regarding its implementation. The two comments deemed outside the scope of the rulemaking addressed the geographic scope of a related order and offered a proposal for quarantine facilities along the U.S. border for diseases unrelated to the current Ebola outbreak. The discussion below summarizes and responds to comments that were within the scope of the rulemaking.

Comment: Several commenters objected to removal of the exemption previously extended to LPRs in 42 CFR 71.40(f), such that LPRs may now be subject to the same suspension of entry as other non-citizens under § 71.40. Commenters stated that LPRs should be treated similarly to U.S. citizens and U.S. nationals rather than other non-citizens in a situation such as this.

Response: CDC appreciates these comments and recognizes the significant interests of LPRs who reside in the United States. CDC does not dispute that many LPRs have deep and longstanding ties to the United States comparable to those of U.S. citizens and U.S. nationals. However, the relevant consideration under section 362 of the PHS Act is not the strength of an individual's ties to the United States, but the risk of introducing a quarantinable communicable disease based on recent exposure. That risk does not vary based on immigration status. CDC's prior regulatory framework did not exempt LPRs because LPRs presented a lower risk of exposure or transmission than other travelers with the same travel history. Given the severity of

Ebola disease, the absence of an approved vaccine or therapeutic for the current outbreak strain, and the resource and logistical constraints associated with case-by-case review, CDC has determined that applying a uniform, presence-based standard regardless of immigration status is the most administrable and protective approach. CDC addresses the resource and hardship considerations raised by these comments in greater detail below. CDC is therefore making no changes in response to this comment.

Comment: One commenter expressed support for a public health framework that protects the United States from communicable disease risk while preserving operational clarity, evidentiary discipline, interagency coordination, and public trust. The commenter suggested that CDC could achieve this by conducting on-going situational assessments, evidence-based interventions, collaborative interagency development and enforcement of risk-based quarantine policies, credible public communication, and after-action review.

Response: CDC appreciates this comment and agrees that these principles are essential to an effective response which is reflected in CDC's current approach. CDC continuously monitors the current epidemiological evidence for this outbreak and uses this information to inform the continued need for this rule and the scope of any orders issued under it. CDC has and continues to develop and implement these measures in consultation with partner agencies and organizations, including the Department of State, Department of Homeland Security, Customs and Border Protection, and the Department of Transportation. CDC has also provided public comment opportunities on this rule and related orders to maintain transparency concerning the rationale, and periodically reviews orders issued under this rule, including after significant developments in the outbreak, to assess continued necessity and effectiveness. CDC is making no changes to the rule in response to this comment.

Comment: Three commenters disagreed with CDC's representations of the potential impacts on LPRs due to the interim final rule. The same commenter expressed concern about the potential impacts on the legal status of LPRs when subject to extended absence from the United

States. Other commenters believe that the rule's assertion that LPRs may have stronger ties to foreign countries than U.S. citizens is speculative and not supported by epidemiologic evidence. One commenter stated that many LPRs have families, jobs, and long-term homes in the United States, and denying their reentry could impose significant hardships without demonstrating a corresponding public health benefit.

Response: CDC addresses the comment regarding the evidentiary basis for applying suspension orders to LPRs above. CDC provides the following responses to the remaining concerns raised by these comments.

CDC acknowledges the concern that extended absence from the United States can carry immigration consequences for LPRs, including potential effects on continuous residence determinations. However, the legal consequences of an individual's physical absence from the United States are governed by the Immigration and Nationality Act and administered by DHS and USCIS, not by CDC's public health authority under section 362 of the PHS Act. This comment is therefore outside the scope of this rule because it relates to immigration determinations outside of the agency's purview. CDC notes that individuals affected by a suspension order retain the ability to raise case-specific circumstances, including exceptions based on humanitarian, law enforcement, or public safety considerations, through the process established for such orders.

CDC does not dispute that LPRs affected by a suspension order may experience significant hardship, including separation from family, employment, and community ties in the United States. CDC does not take this hardship lightly. However, section 362 of the PHS Act authorizes the Secretary, acting through the CDC Director or other delegate, to suspend the introduction of persons when necessary to prevent the introduction, transmission, or spread of a communicable disease posing a serious danger to public health. This standard does not require CDC to demonstrate that the benefit of a given suspension order outweighs the hardship to each individual affected; it requires a determination that a serious danger of disease introduction exists

and that suspension is necessary to address it. CDC also notes that the rule itself does not suspend anyone's entry; it establishes a procedure that CDC may use to issue a subsequent order if and when the relevant public health threshold is met. Any such order may be subject to its own comment process and periodic reassessment as applicable. For these reasons, CDC is making no changes to the rule in response to these comments.

Comment: Commenters suggested that CDC consider using individualized, risk-based criteria rather than applying blanket restrictions to LPRs or any other populations. They suggested considering a variety of factors, including specific locations visited, length of stay, activities, interactions, precautions followed, and reasons for travel. They suggested that CDC distinguish actual exposure risk rather than make broad nationality-based assumptions. Several commenters stated that blocking the return of LPRs who have travelled to impacted countries is not supported by evidence and may actually increase public health risk by encouraging travelers to obscure their travel history and thus avoid public health screening. One commenter also requested that CDC estimate the number of travelers impacted by the rule.

Response: CDC recognizes that individual risk may differ among persons who have been present in a designated country or place where the quarantinable communicable disease outbreak is occurring. However, CDC also considers the public health and other resources required to implement an Order issued under Sections 362 and 365 of the Public Health Service Act and the implementing regulation at 42 CFR 71.40. Based on such considerations, CDC has determined that a generally applicable threshold based on whether an individual was present in a designated country or place during the relevant period is both more protective of public health and more feasible to implement.

CDC does not agree that individualized exposure assessments, testing, symptom screening, or monitoring can presently be feasibly implemented and serve as a substitute for the Orders for all covered persons. Additionally, CDC notes that the exclusion of LPRs helps conserve public health resources by further limiting the overall number of individuals arriving in

the United States from a designated country or place. CDC appreciates commenter concerns around the risk of travelers obscuring their travel history to avoid being subject to a suspension on entry.

CDC acknowledges that any travel restriction can create an incentive for affected individuals to conceal or misrepresent their travel history. CDC does not view this risk as a reason to forgo restrictions altogether but has designed its implementation of the regulation to reduce the likelihood and impact of concealment. Screening and verification draw on multiple independent sources, including passenger manifest and itinerary data, transit records, and CBP's existing entry-screening protocols, rather than traveler self-report alone. CDC will continue to monitor for evidence of concealment or evasion and will adjust screening and verification protocols as needed. CDC is therefore making no changes in response to this comment.

Lastly, although CDC acknowledges that it does not have exact numbers and it is difficult to estimate the number of travelers potentially impacted by this regulation, CDC has determined that this regulation is a necessary part of its outbreak response and that an alternative approach relying on individualized, risk-based assessments is more resource intensive and thus impracticable.

Comment: One commenter objected to the inclusion of LPRs from Uganda due to the absence of Ebola in Uganda.

Response: This comment is outside the scope of the interim final rule. Decisions related to how CDC identifies specific countries and geographic scope covered by a suspension order are made through the accompanying orders issued under this rule's procedures, not through the rule itself, which establishes only the general mechanism for such determinations. CDC is therefore making no changes in response to this comment.

Comment: One commenter requested CDC open larger quarantine facilities along our border to address typhoid, tuberculosis, and cholera outbreaks.

Response: This is outside the scope of this rulemaking and CDC is therefore making no changes in response to this comment.

V. Statement of Good Cause

HHS previously published a statement of "good cause" in connection with the interim final rule (91 FR 31366) on May 27, 2026. After careful consideration, HHS finds that the factors listed in that statement of good cause remain in effect and support a temporary extension of the interim final rule.

Agency rulemaking is governed by the Administrative Procedure Act (APA) (5 U.S.C. 553). Section 553(b) requires that, unless the rule falls within one of the enumerated exemptions, HHS must publish a notice of proposed rulemaking in the Federal Register that provides interested persons an opportunity to submit written data, views, or arguments, prior to finalization of regulatory requirements. 5 U.S.C. 553(b)(B) authorizes a department or agency to dispense with the prior notice and opportunity for public comment requirement when the agency, for "good cause," finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. In addition, because extending the interim final rule represents a critical part of the dialogue between the United States and the Governments of the affected countries, the DRC, Uganda, and South Sudan, as well as potential implementing partners Mexico and Canada, in preventing the spread of Ebola disease caused by Bundibugyo virus, it involves a "foreign affairs function of the United States." 5 U.S.C. 553(a)(1).

As noted above, the United States and the affected countries of the DRC, Uganda, and South Sudan, along with other countries have taken necessary measures to try to contain or slow the transmission or spread of this Ebola disease outbreak. Such public health actions, especially the actions by the Secretary, have been taken to attempt to slow introduction and transmission of the disease into the United States, which benefit the public health, preserve limited public and private resources, particularly in the areas of quarantine and isolation, and give the U.S. public health system additional time to implement further measures to protect and support the public.

Nevertheless, these measures have not completely stopped (and will not completely stop) global travelers, and other people crossing from one country into another country, from spreading Ebola disease caused by the Bundibugyo virus across country boundaries. The interim final rule's expanded discretion to exercise the suspension authority is therefore critical to slowing the introduction of Ebola disease into the United States. Suspending the introduction of persons, including LPRs, from certain countries or places is required in the interest of the public health because it materially reduces the transmission and spread of Ebola disease in the United States and the need for limited resources to implement any necessary public health actions.

Because persons can have Ebola disease and be asymptomatic (although not infectious until symptomatic) at the time of introduction into the United States, and because specialized testing is needed to confirm infection with the disease, it is impracticable to confirm who is infected with Ebola disease and who is not infected with Ebola disease as persons move into the United States. Similarly, Federal quarantines or isolations of all such persons pending test results would be impracticable due to the potential numbers of people involved if this necessary limitation is not imposed, logistical challenges, and CDC resource and personnel constraints.

Given that the outbreak has been declared a public health emergency of international concern, and that quick action is crucial to preventing spread of the disease, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay extending this regulation until a full public notice-and-comment process is completed. Furthermore, extending this interim final rule for an additional six months or until the HHS Secretary determines there is no longer a need for the interim final rule is justified based on the current trajectory of the outbreak and scientific principles of outbreak control. As stated previously, the number of Ebola cases in the affected countries continue to increase rapidly with no indication that this trend line is likely to be reversed in the short term. Declaring an end to the Ebola outbreak also requires that a country undergo 42 consecutive days without a new confirmed case since the country’s last Ebola patient, including any imported cases. The

completion of this 42-day period, equivalent to twice the upper limit of the incubation period for Ebola, is a critical step, as it provides an additional safeguard that no chains of transmission associated with the last imported case have been missed. The 42-day countdown is also the internationally established benchmark for determining that transmission linked to an Ebola outbreak has ended. Based on the increasing trajectory of the outbreak and the internationally recognized standard that countries complete a 42-day period with no new cases until an outbreak may be declared over, HHS believes that a six-month extension of the interim final rule is warranted. Additionally, as noted, the HHS Secretary may choose to end this interim final rule sooner if he determines that a need no longer exists based on scientific or other principles.

Pursuant to 5 U.S.C. 553(b) (B), and for the reasons stated above, HHS therefore concludes that there is good cause to dispense with the opportunity to comment and prior public notice before extending the expiration date of the interim final rule. For the same reasons, HHS has determined, consistent with 5 U.S.C. 553(d), that there is good cause to make this document effective immediately upon filing at the Office of the Federal Register.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026-23990 Filed: 11/24/2026 8:45 am; Publication Date: 11/25/2026]