What Clinicians Should Know about Ebola Bundibugyo Virus

Clinician Outreach and Communication Activity (COCA) Call

Thursday, May 28, 2026

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Today's Presenters

- **Peggy Honein, PhD, MPH**
  Deputy Incident Manager
  2026 Ebola Response
  Centers for Disease Control and Prevention

- **Mary Choi, MD, MPH**
  Medical Officer
  Division of High-consequence Pathogens and Pathology
  National Center for Emerging and Zoonotic Infectious Diseases
  Centers for Disease Control and Prevention

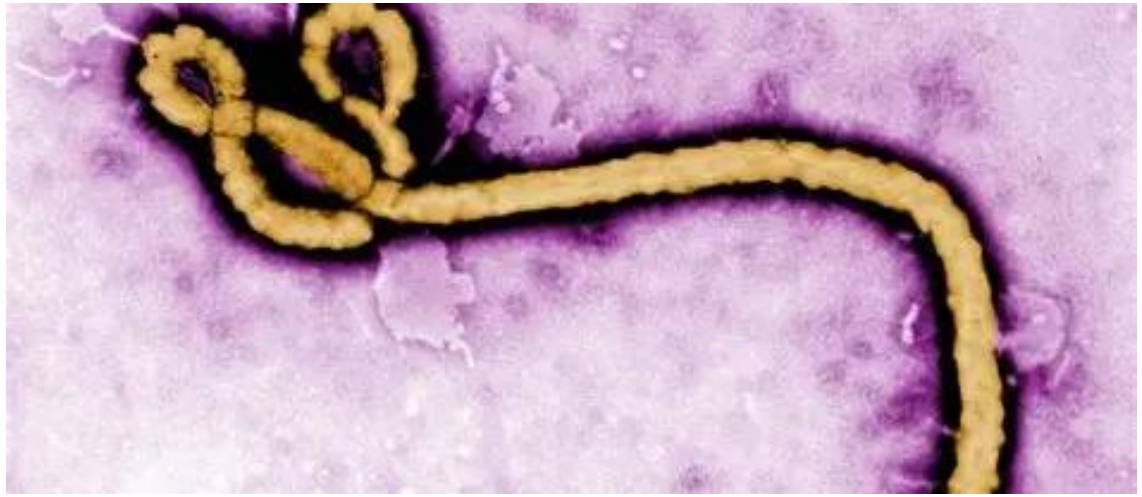
- **Chris Hsu, MD, PhD**
  Deputy Lead, Domestic Readiness Task Force
  2026 Ebola Response
  Centers for Disease Control and Prevention

- **Melissa Schaefer, MD**
  Medical Officer
  Domestic Healthcare Infection Prevention and Control Team
  2026 Ebola Response
  Centers for Disease Control and Prevention

- **Amy Schuh, PhD, MPH**
  Diagnostics Lead
  Division of High-consequence Pathogens and Pathology
  National Center for Emerging and Zoonotic Infectious Diseases
  Centers for Disease Control and Prevention

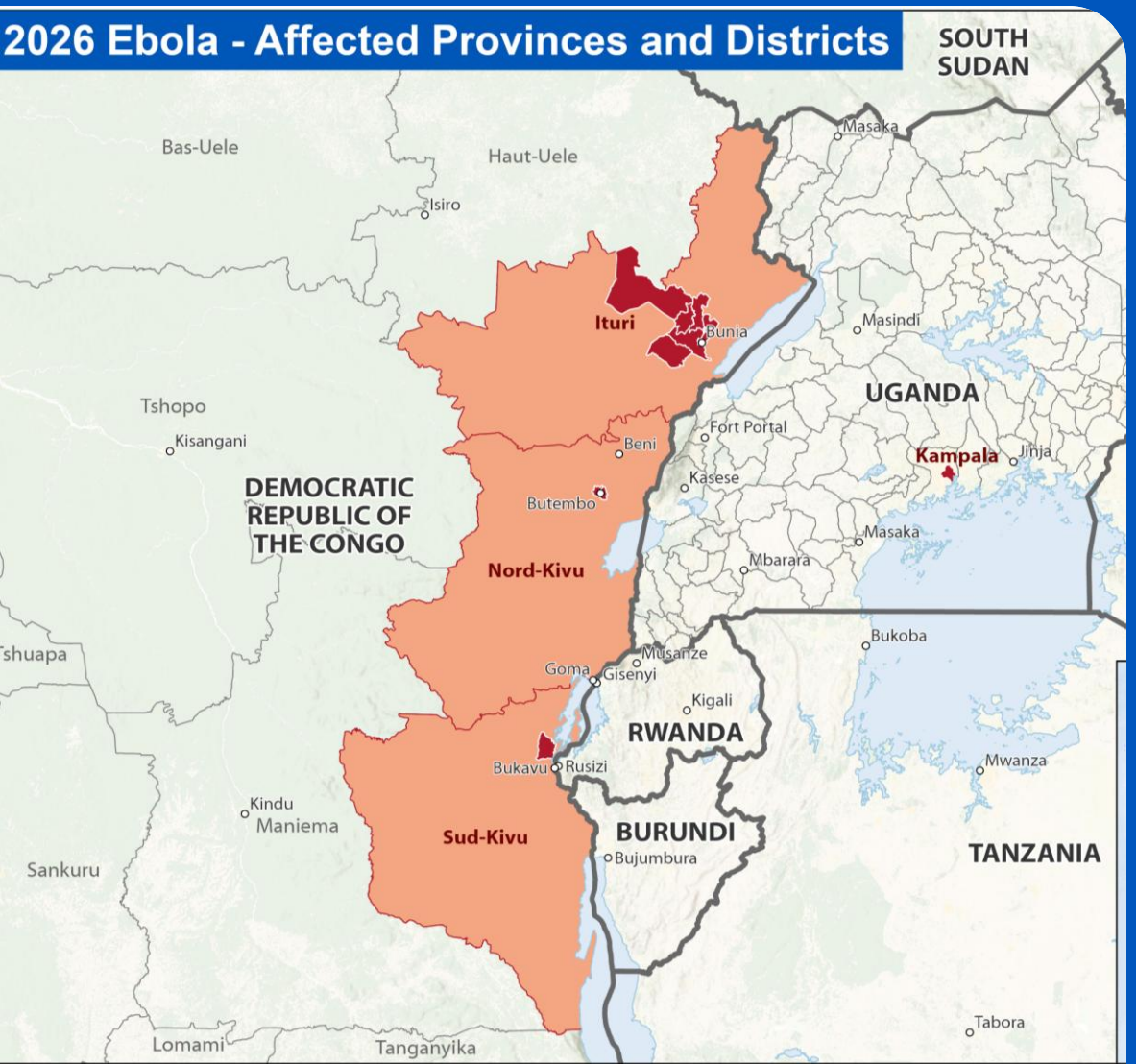
CDC COCA Call: May 28, 2026

What Clinicians Should Know about Bundibugyo Virus



Agenda

- Outbreak overview: Peggy Honein, PhD, MPH
- Basics of Bundibugyo virus disease (BVD): Mary Choi, MD, MPH
- For U.S. settings
  - Recommendations for clinicians: Christopher Hsu, MD, PhD
  - Infection prevention and control: Melissa Schaefer, MD
  - Laboratory diagnostics: Amy Schuh, PhD, MPH
- Q&As
- CDC resources

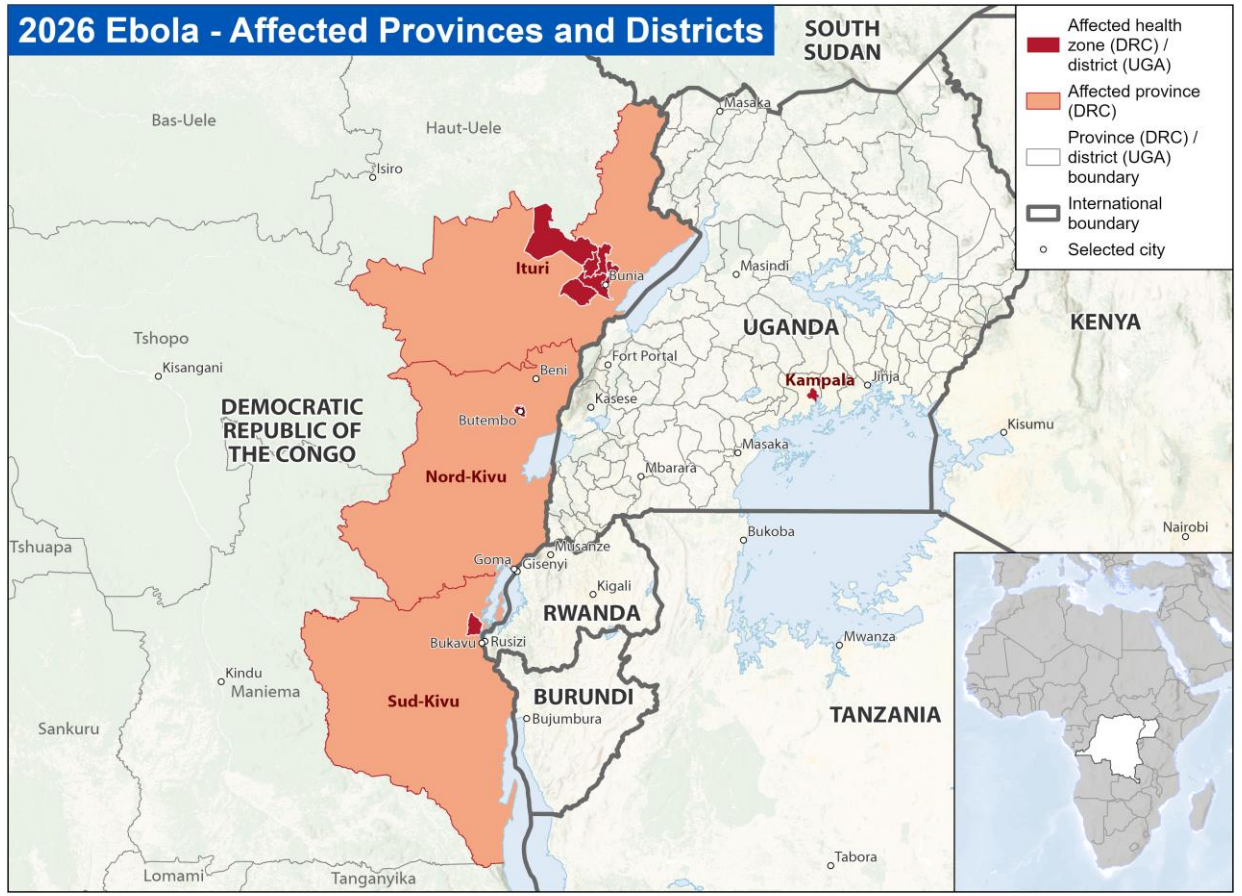


Outbreak overview as of May 28, 2026

Peggy Honein, PhD, MPH
Deputy Incident Manager
CDC 2026 Ebola Response

BVD Outbreak Overview

- As of May 27, the DRC and Uganda Ministries of Health have reported:
  - **DRC**: A total of **1,077 suspected cases, 121 confirmed cases, 246 suspected deaths, and 17 confirmed deaths**.
  - **Uganda**: A total of **7 confirmed cases and 1 confirmed death**.
- This is a rapidly evolving situation, and case counts are subject to change.
- **To date, no Ebola cases associated with this outbreak have been reported in the United States. The risk to the U.S. general public is considered low.**



BVD outbreak background

- In early May, a hospital in northeastern DRC identified a cluster of severe illnesses affecting healthcare workers.
- Classic Ebola disease symptoms like fever, headache, vomiting, severe weakness, abdominal pain, nosebleeds, vomiting blood
- Initial samples tested in DRC appeared negative for Ebola virus, but 8 out of 13 samples later tested positive for Bundibugyo virus and 5 were inconclusive.
- Using genetic characterization, found to be Bundibugyo ("Bun-dee-BOO-joh") virus (*Orthoebolavirus bundibugyoense*), one of the 4 types of orthoebolaviruses that cause Ebola disease in people
    - There have been 2 previous outbreaks of Bundibugyo virus:
      1 in Uganda (2007) and 1 in DRC (2012), with death rates of 25% and 50%, respectively
- In DRC, most cases to date have been in persons aged 20–39 years
    - Two-thirds have been among female patients
- One American patient tested positive for BVD; patient and 6 high-risk American contacts are now in Germany & Czech Republic for care; all in stable condition
- 17th outbreak of Ebola in DRC since 1976
    - Most recent ended December 2025

Work to contain BVD at its source

CDC’s work includes:

- Detecting, monitoring, and containing the outbreak through an evidence-based approach.
- Supporting CDC country offices in DRC and Uganda, assessing needs in-country, and providing support to the Ministries of Health as they respond to the outbreak.
- Offering technical expertise in surveillance, infection prevention control, and laboratory testing and ready to provide assistance with testing, case investigation, contact tracing, incident management, risk communication and community engagement, and border health measures including entry and exit screening of travelers.
- Deploying staff to provide strategic and technical viral hemorrhagic fever response support to the DRC country office.
- Assessing at-risk countries' readiness, identifying critical preparedness gaps, and delivering targeted guidance, tools, and training to strengthen early detection and containment capacity before potential Ebola spread occurs.

Domestic coordination and preparedness

CDC's work includes:

- Supporting preparedness for and communication with U.S. public health departments, clinicians, laboratories, healthcare facilities and the American public.
- Enhanced travel screening, entry restrictions, and public health measures to help prevent Ebola disease from entering the United States amid ongoing outbreaks in East and Central Africa
- Communicating with key audiences:
  - Health Alert Network advisory for clinicians and jurisdictional health departments
  - Travel Health Notice for DRC that recommends avoiding nonessential travel to Ituri, Nord-Kivu, and Sud-Kivu provinces
  - Travel Health Notice for Uganda that recommends practicing enhanced precautions
  - Ebola Disease: Current Situation
- Coordinating an effective public health response focuses on working across the U.S. Government and with other critical partners to respond effectively to the outbreak

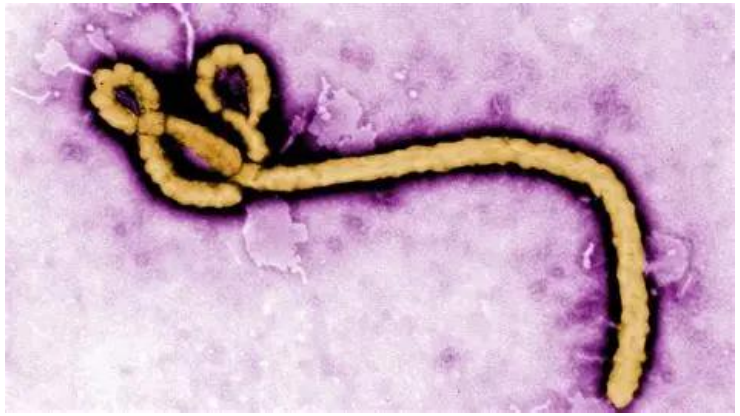
Basics of Bundibugyo virus disease (BVD)

Mary Choi, MD, MPH
Medical Officer
Viral Special Pathogens Branch, CDC

Ebola terminology

- Ebola disease: Umbrella term to describe clinical disease due to infection with any of the 4 viruses within the genus *Orthoebolavirus* that cause disease in humans:
  - Ebola virus (species *Orthoebolavirus zairense*)
  - Sudan virus (species *Orthoebolavirus sudanense*)
  - Bundibugyo virus (species *Orthoebolavirus bundibugyoense*)
  - Taï Forest virus (species *Orthoebolavirus taiense*)

- Illnesses caused by infection with these viruses are clinically indistinguishable
- Bundibugyo virus disease (BVD): Term used to describe clinical disease due to infection with Bundibugyo virus



Ebola disease in humans

- Vast majority of data on Ebola disease in humans come from Ebola virus (*Orthoebolavirus zairense*) cases and are considered applicable to all human-disease-causing orthoebolaviruses.
- Serious, highly transmissible, often rapidly fatal
- Without treatment, Ebola disease has a high mortality rate
- Bats are the likely reservoir

Person-to-person transmission

- In acutely infected persons, the virus can be found in **all body fluids**:
  - Blood
  - Feces/Vomit
  - Urine
  - Tears
  - Saliva
  - Breast milk
  - Amniotic fluid
  - Vaginal secretions
  - Sweat
  - Semen
- Virus transmitted through:
  - Direct contact with the body fluids of a person who is sick with or has died from Ebola disease
  - Contact with contaminated items (clothes, bedding, needles, or medical equipment)
  - Sexual activity with someone who has recovered from Ebola disease (no evidence that virus spreads through vaginal fluids)
- **Ebola is not spread through airborne transmission**

Ebola disease in humans

- Signs and symptoms of Ebola disease include:
  - Headache
  - Fatigue
  - Muscle pain/joint pain
  - Anorexia
  - Sore throat
  - Abdominal pain
  - Rash
  - Diarrhea
  - Vomiting
  - Conjunctivitis
  - Unexplained bleeding/bruising*
- No sign or symptom is pathognomonic for Ebola disease
- Fever is not universally present
- Bleeding/bruising not universally present

* Includes bleeding from the gums, mouth, nose, bloody vomit, bloody stools, bleeding from injection sites, vaginal bleeding outside of a menstrual cycle

INFECTION

Infection occurs after exposure to a person who is sick or has died of Ebola.

NOT CONTAGIOUS

EXPOSURE TO THE VIRUS

INFECTION

Infection occurs after exposure to a person who is sick or has died of Ebola.

INCUBATION PERIOD

- It can last from 2-21 days (usually 4-17 days)
- Person feels well and has no symptoms
- **The person cannot transmit the virus**

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DRY PHASE

Common signs and symptoms are

- Fever
- Fatigue
- Headache
- Joint pain
- Muscle pain
- Back pain
- Sore throat

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EXPOSURE TO THE VIRUS

DAY 0 OF THE DISEASE

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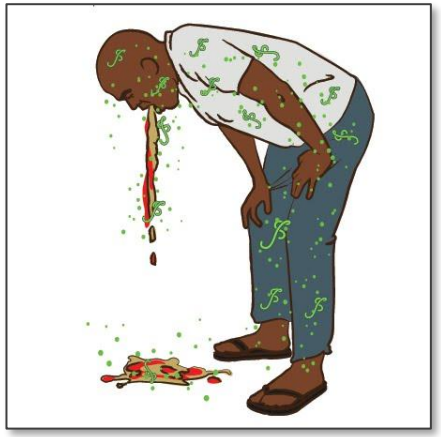
WET PHASE

Common signs and symptoms are

- Diarrhea
- Nausea/vomiting
- Bleeding occurs in some cases
- Hiccups
- Eye redness



NOT CONTAGIOUS

CONTAGIOUS

EVEN MORE CONTAGIOUS

EXPOSURE TO THE VIRUS

DAY 0 OF THE DISEASE

DAY 4 OF THE DISEASE

INFECTION

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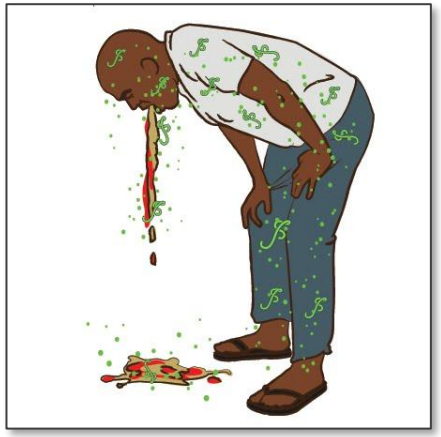


- The patient becomes more contagious as the disease progresses.
- In fatal cases, death occurs on average 7 to 10 days after the onset of symptoms.
- The amount of Ebola virus is highest at the time of death.

NOT CONTAGIOUS

CONTAGIOUS

EVEN MORE CONTAGIOUS

THE MOST CONTAGIOUS

EXPOSURE TO THE VIRUS

DAY 0 OF THE DISEASE

DAY 4 OF THE DISEASE

DAY 7-10 OF THE DISEASE

Diagnostic testing considerations

- Reverse transcription polymerase chain reaction (RT-PCR) is the diagnostic test of choice for acutely ill persons with suspected Ebola disease

- Symptom onset date is critical to interpreting RT-PCR results in a symptomatic patient
  - A negative RT-PCR test result from a blood specimen collected **less than 72 hours** after symptom onset **does not rule out** Ebola disease

Treatment for Bundibugyo virus

- There is **no FDA-licensed treatment** for Ebola disease caused by Bundibugyo virus

- MBP134
  - Experimental two-antibody cocktail therapy
  - Demonstrated efficacy in preventing mortality in non-human primates due to infection with Sudan virus, Ebola virus, and Bundibugyo virus

- **Supportive care** improves chances of survival when provided early
  - Intravenous (IV) fluids and electrolytes
  - Symptomatic treatment for vomiting, diarrhea

Vaccine against Bundibugyo virus

- There is **no FDA-licensed vaccine** against Bundibugyo virus
- Vaccine candidates undergoing evaluation
- Based on available evidence, ERVEBO® — the FDA-licensed vaccine against Ebola virus (species *Orthoebolavirus zairense*) — **is NOT expected to provide** cross-protection against Bundibugyo virus infection

Recommendations for Clinicians

Christopher Hsu, MD, PhD
Deputy Lead, Domestic Readiness Task Force
CDC 2026 Ebola Response

Recommendations for clinicians: travel history

- Collect travel history for ill patients presenting with a clinical picture suggestive of an infectious etiology
- Ask about risk factors for Ebola disease:

Contact with a symptomatic person with suspect or confirmed Ebola disease or any objects contaminated by their body fluids

Experience a breach in infection prevention and control precautions that result in the potential for contact with body fluids of a patient with suspect or confirmed Ebola disease

Contact with semen from a man who has recovered from Ebola disease

Participated in any of the following activities while in an area with an active Ebola outbreak:

- Contact with someone who was sick or died or any objects contaminated by their body fluids
- Attend or participate in funeral rituals, including preparing bodies for funeral and burial
- Worked in a healthcare facility or laboratory
- Visited a healthcare facility or traditional healer
- Contact with bats or wild animals
- Work or spend time in a mine/cave

Recommendations for clinicians: differential diagnosis

- Include Ebola disease in the differential diagnosis for ill travelers recently arrived from DRC, South Sudan, Uganda
- Malaria is the most common cause of undifferentiated fever after travel to sub-Saharan Africa
- Nearly all signs and symptoms of Ebola disease can also be seen in malaria
- Malaria, especially *P. falciparum*, can progress rapidly, so early diagnosis and treatment are key to survival; malaria testing should not be delayed
- Ask about malaria prophylaxis and adherence
- History of taking malaria prophylaxis does not exclude malaria
- Individuals infected with Ebola can also be concurrently infected with malaria
- Test for malaria in any febrile traveler recently arrived from DRC, Uganda, or South Sudan

Recommendations for clinicians: infection control

- Implement strict infection prevention and control (IPC) measures at the healthcare facility when evaluating symptomatic suspect Ebola disease patients
- IPC measures remain in place until the result of Ebola testing is available
- Strict IPC measures are necessary to prevent potential spread of the virus in the healthcare facility and community

Justification to seek clinical consultation

- Consultation provides a forum where testing can be discussed in order to collectively make a decision in the best interest of the patient
- Testing for Ebola disease necessitates implementation of strict IPC measures, which
  - Might limit the patient's access to routine care
  - Might prolong the duration that patient is under strict precautions
- Decisions to test should be weighed carefully to prioritize health, safety, and well-being

Recommendations for clinicians: notification

- If you are concerned your patient might have Ebola disease, first contact your state, tribal, local or territorial health department and follow jurisdictional protocols for patient assessment
- Identify points of contact and contact information for your health department, including on-call information, before it is needed
- Visit https://libraries.cste.org/after-hours-contact to find contact information for state and large jurisdictional health departments, or call the CDC Emergency Operations Center 24/7 at **770-488-7100**
- Please note that due to high call volume to the CDC Emergency Operations Center, callers will be referred to their jurisdictional health department, except for clinicians who have been unable to reach their health department
- If a clinician has been unable to reach their jurisdictional health department, they can be connected directly to CDC's Ebola Clinical Consult Team

Recommendations for clinicians: notification

- Connect with subject matter experts (SMEs) in viral hemorrhagic fevers from CDC's Ebola Clinical Consult Team and other SMEs as needed
- Discuss the patient's travel history, epidemiologic risk factors, clinical course, diagnostic tests performed, infection control measures in place
- Make a risk assessment based on the information provided and the discussion
- Make a collective decision as to whether watchful waiting or diagnostic testing is recommended
- Work with the hospital/state health department to arrange for shipment and testing of the specimen if decision is to proceed with diagnostic testing

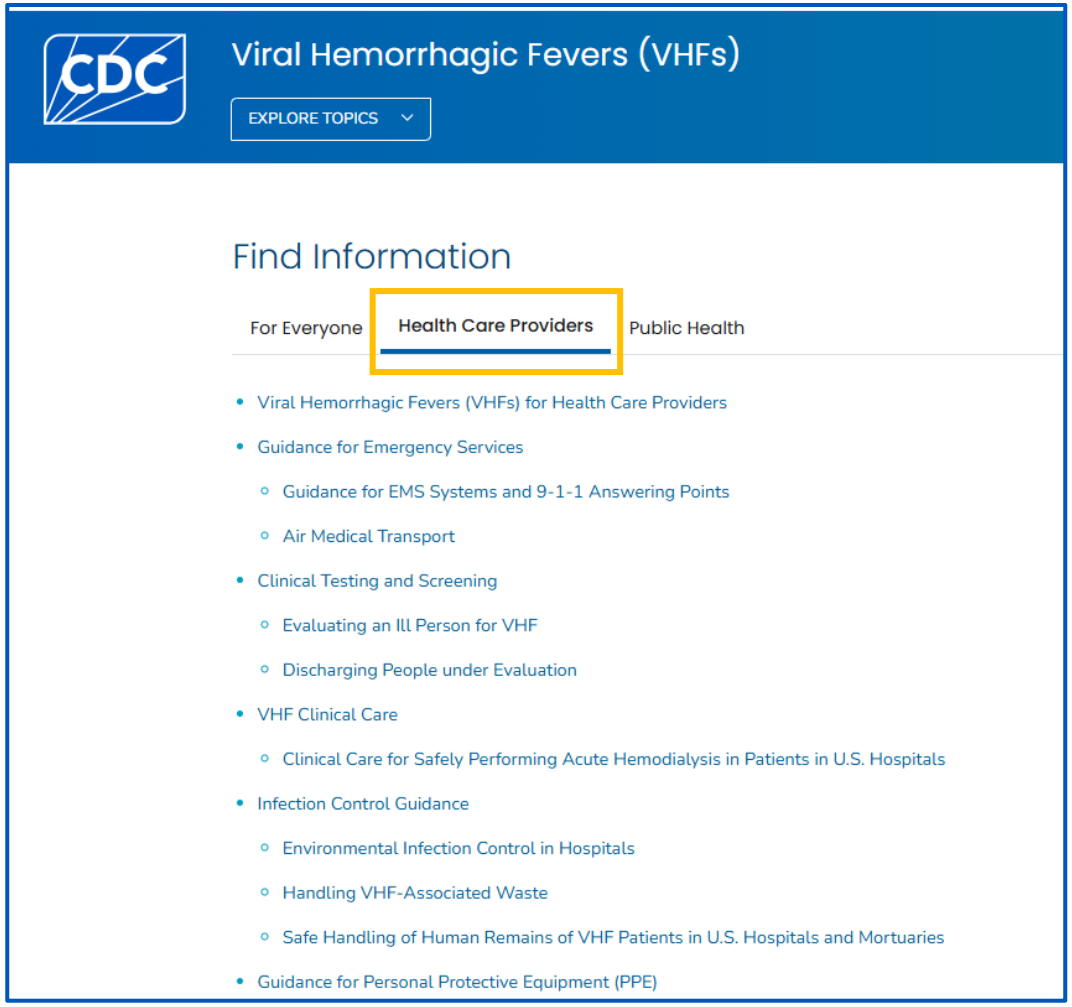
Benefits of clinical consultation for the clinician and jurisdiction

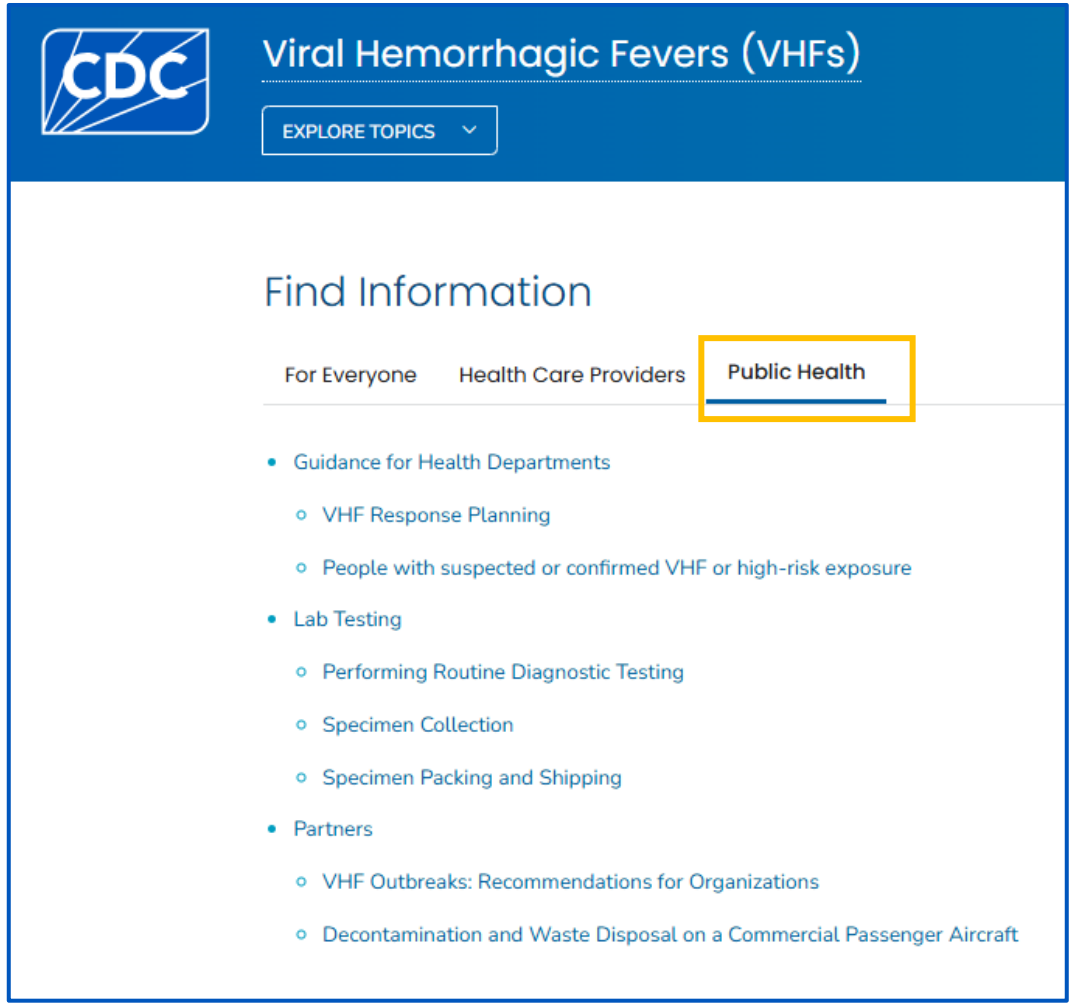
- Provide context to your patient's epidemiologic risk factors
- Decision to test for Ebola is primarily driven by assessing epidemiologic risk factors
- CDC has in-country resources that might be able to provide context for your patient's travel and activities
- Opportunity to ask facility-specific questions
- Facilitate communication with clinic and health department for presumptive testing through the Laboratory Response Network (LRN) and/or confirmatory testing at CDC

U.S. infection prevention and control

Melissa Schaefer, MD
Medical Officer, Domestic Healthcare Infection Prevention and Control Team
CDC 2026 Ebola Response

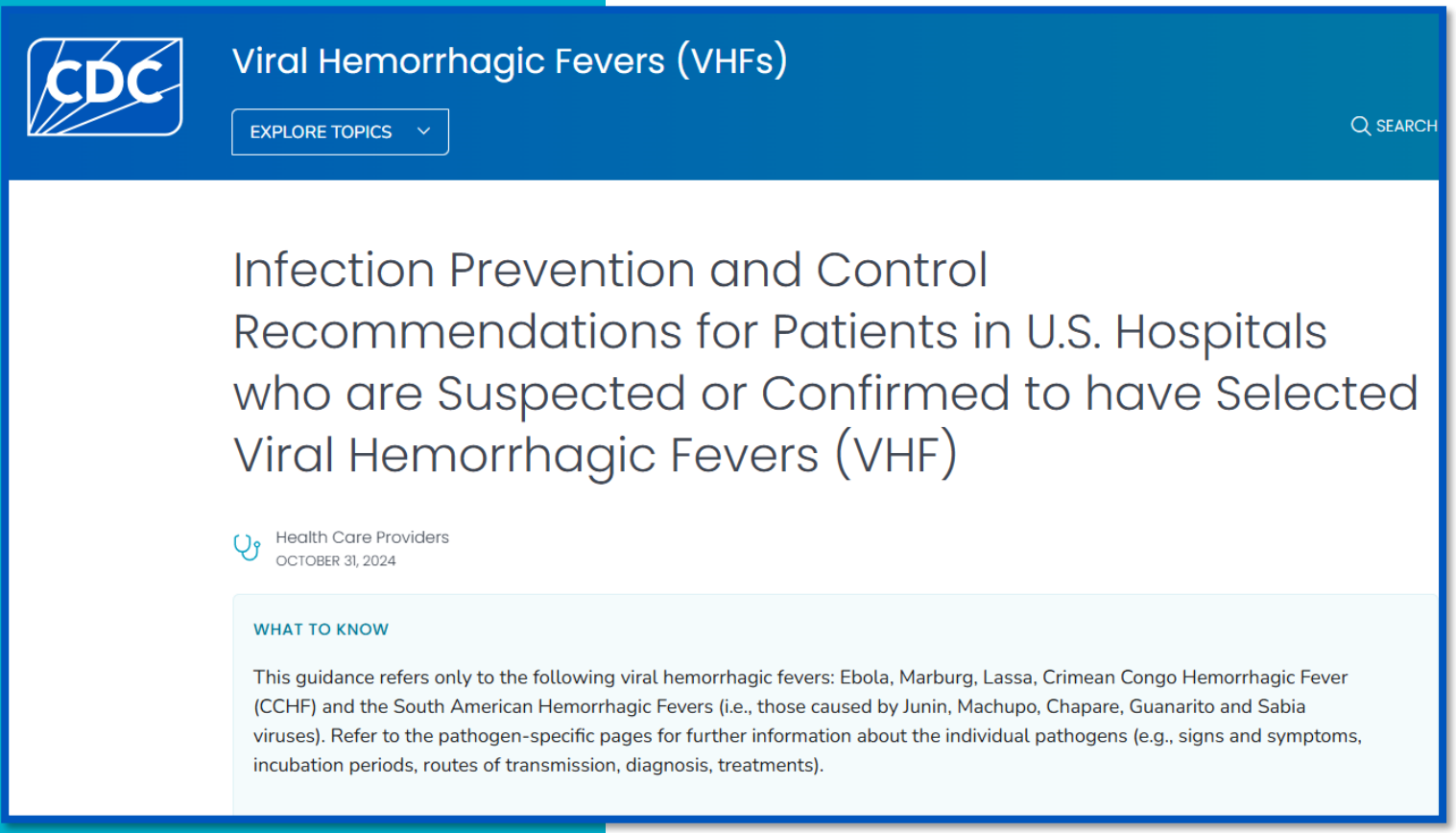
CDC Main VHF Resource Directory





HTTPS://WWW.CDC.GOV/VIRAL-HEMORRHAGIC-FEVERS/SITE.HTML#HCP

IPC Guidance for VHFs



https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html

- Similar to guidance developed during the 2014-2016 Ebola response
- Now framed as VHF guidance and extended to Marburg, Lassa, and several other specified viruses
  - Approved by HICPAC and posted to Fed Register before finalizing
- For healthcare personnel (HCP) including EMS any healthcare setting, though focus is hospitals
- Main index re-organized and includes groupings for Health Care Providers and Public Health audiences

Identify, Isolate, Inform

- Minimize potential exposures in healthcare settings
  - Healthcare facilities should have a process to identify potentially infectious persons at initial points of encounter
  - https://www.cdc.gov/infection-control/hcp/core-practices/index.html
- VHFs are rarely encountered in the U.S. and early symptoms are similar to other febrile illnesses https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/diagnosis-testing/index.html
- Standard screening process can help identify persons potentially infected with VHFs or other high consequence pathogens
  - For example, Joint Commission (Standard IC.07.01.01, EP1) requires hospitals to have procedures for screening at the points of entry to the hospital for **respiratory symptoms, fever, rash and travel history**
    - Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics.
  - Helps guide when additional precautions and further consultation are needed

HTTPS://WWW.CDC.GOV/VIRAL-HEMORRHAGIC-FEVERS/HCP/DIAGNOSIS-TESTING/INDEX.HTML

Identify, **Isolate,** Inform

- Isolate when potential VHF is suspected based on clinical presentation and travel history or other epidemiologic risk factor
- Recommended patient placement consists of
  - Single patient room with the door closed
  - Private bathroom or covered bedside commode
  - Adequate space for putting on and taking off PPE

https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/diagnosis-testing/index.html

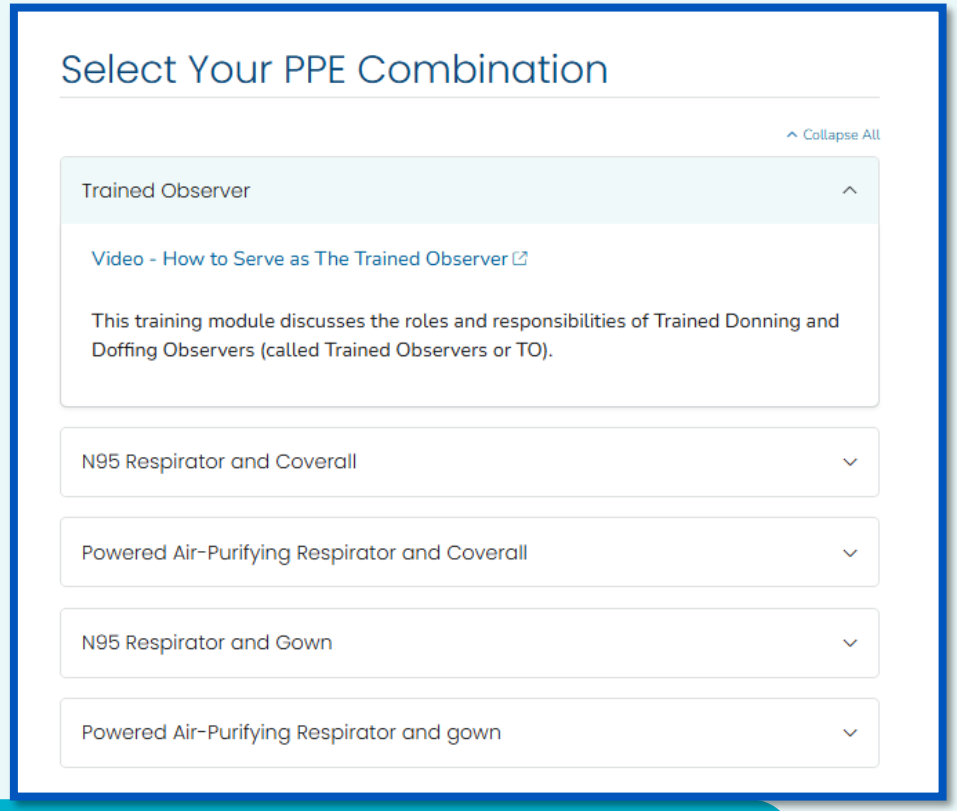
Identify, Isolate, **Inform**

- Notify facility's IPC Program and other key personnel
- Immediate public health consultation
  - CSTE 'Epi On Call' for healthcare providers to contact their health department https://libraries.cste.org/after-hours-contact/
  - CDC Emergency Operations Center 24/7 **770-488-7100** and request on-call Viral Special Pathogens epidemiologist
- Recent Health Alert Network summary includes CDC contact info and other helpful links https://www.cdc.gov/han/php/notices/han00530.html

Personal Protective Equipment for VHFs

- Current PPE Guidance
  - PPE: Confirmed Patients and Clinically Unstable Patients Suspected to have VHF
  - PPE: Clinically Stable Patients Suspected to have VHF
  - PPE FAQs

- CDC collaboration videos (2014) https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/index.html



VHF Exposure Assessment and Monitoring in U.S. Healthcare Settings

- Of particular concern are unprotected healthcare exposures, which can occur when VHF is not yet recognized
- For HCP potentially exposed to VHFs in U.S. healthcare settings, it is urgent to
  - Assess risk and need for clinical management
  - Determine need for work restrictions
  - Monitor and manage those who become symptomatic
- Assessment and monitoring efforts can
  - Be challenging technically and logistically
  - Involve high numbers (>100) of potentially exposed HCP
- Public health support to healthcare occupational health authorities is often needed

Healthcare Exposure Risk Assessment and Monitoring Tool

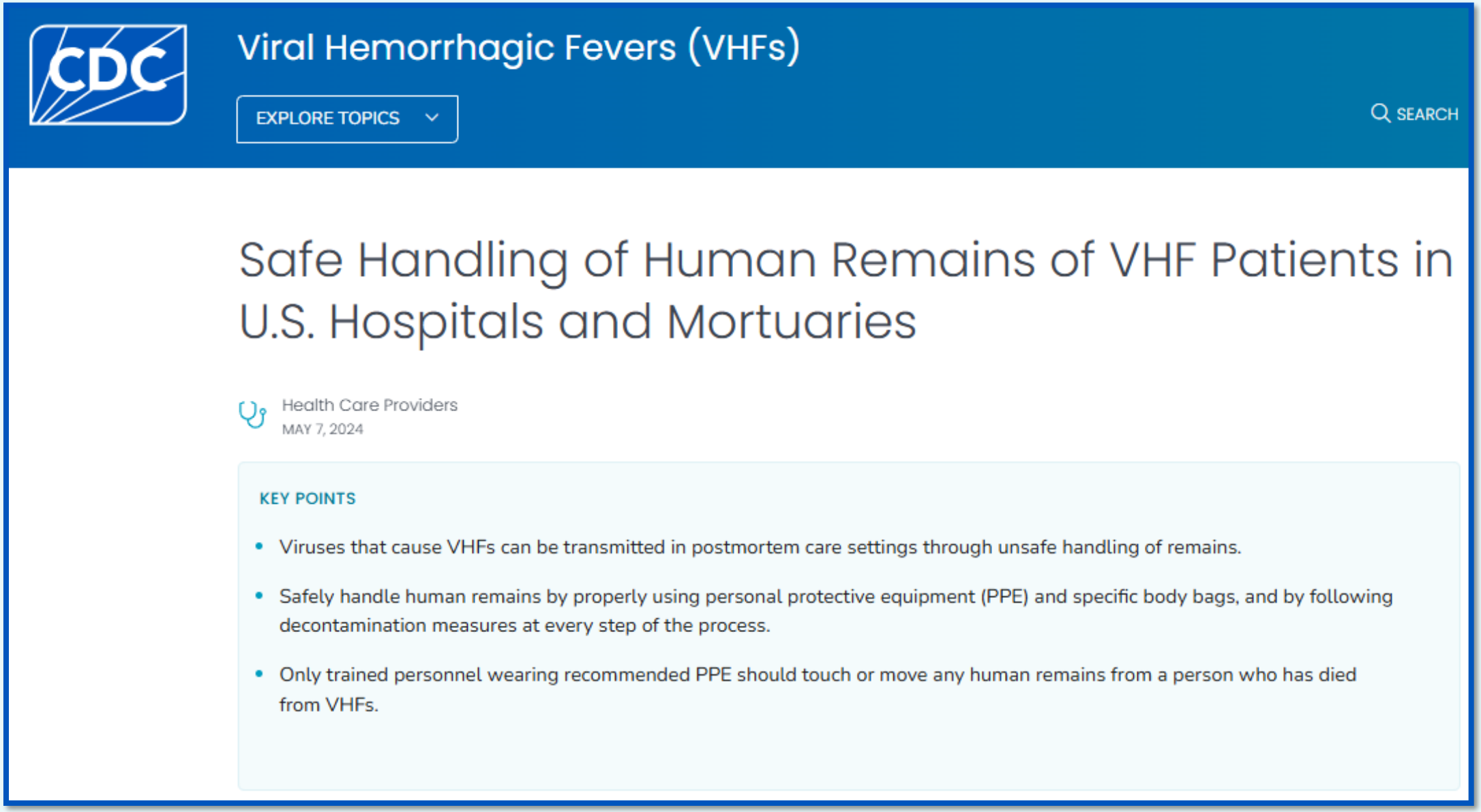
- Some states developed monitoring tools during prior VHF and other responses
- CDC/DHQP worked with several State health departments to adapt an updated REDCap VHF template to support exposure assessment and monitoring of HCP
  - Instructions and template files shared with State Healthcare Associated Infections programs
  - Adapted for 2024 Iowa HHS response to a travel-associated case of Lassa fever https://www.cdc.gov/mmwr/volumes/74/wr/mm7411a3.htm

Environmental Infection Control for VHFs

- Ensure that environmental services or other HCP designated to clean and disinfect areas and equipment are trained, protected and monitored
- See lists of disinfectants appropriate for VHFs at EPA website: https://www.epa.gov/pesticide-registration/disinfectants-emerging-viral-pathogens-evps-list-q
- Avoid contamination of reusable porous surfaces that cannot be made single use
- Discard contaminated linens and other textiles; should coordinate with waste management company

VHF-associated Waste Management

- Healthcare facilities must comply with federal, state and local regulations for handling, storage, treatment and disposal of VHF-associated waste
  - DOT/PHMSA Cat A Solid Waste https://www.phmsa.dot.gov/transporting-infectious-substances/planning-guidance-handling-category-solid-waste
  - Proactively discuss with your waste management company
- Solid waste generated during Ebola patient care is Category A waste and requires a special DOT permit (SP16279) to transport
  - Considerations about holding waste in secure location during VHF rule out period
- CDC guidance states that sanitary sewers may be used for safe disposal of liquid waste but some state or local regulations may require pretreatment
- https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/handling-vhf-associated-waste.html


Viral Hemorrhagic Fevers (VHFs)
EXPLORE TOPICS
SEARCH
Safe Handling of Human Remains of VHF Patients in U.S. Hospitals and Mortuaries
Health Care Providers
MAY 7, 2024
KEY POINTS
Viruses that cause VHFs can be transmitted in postmortem care settings through unsafe handling of remains.
Safely handle human remains by properly using personal protective equipment (PPE) and specific body bags, and by following decontamination measures at every step of the process.
Only trained personnel wearing recommended PPE should touch or move any human remains from a person who has died from VHFs.

CDC VHF Guidance and Resource Summary of Key Links

- **Patient Placement** https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/index.html
- **PPE** (including training videos link) https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/index.html
- **Environmental infection control** https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/environmental-infection-control-hospitals.html
- **Guidance for Emergency Services** (Ground, Air, 9-1-1) https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/emergency-guidance/index.html
- **Waste management** https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/handling-vhf-associated-waste.html
    - DOT/PHMSA Cat A Solid Waste https://www.phmsa.dot.gov/transporting-infectious-substances/planning-guidance-handling-category-solid-waste
- **Monitoring and management of HCP**
    - Including exposure risk https://www.cdc.gov/viral-hemorrhagic-fevers/php/public-health-strategy/people-with-suspected-or-confirmed-vhf-or-high-risk.html
- **Recommendations for Organizations** Sending U.S.-based Personnel to Areas with VHF Outbreaks https://www.cdc.gov/viral-hemorrhagic-fevers/php/partners/recommendations-for-vhf-outbreaks.html
- **Safe handling of human remains** https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/guidance-for-safe-handling-of-human-remains-of-vhf-patients-in-u-s-hospitals-and-mortuaries.html

Laboratory Testing

Amy Schuh, PhD, MPH

Diagnostics Lead, CDC Viral Special Pathogens Branch

Prior to specimen collection

- All U.S. laboratories handling patient specimens must comply with OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) to reduce the risk of personnel exposure to bloodborne pathogens, including Bundibugyo virus
- Prior to receiving specimens in the laboratory, conduct a site-specific risk assessment to minimize the risk of personnel exposure to sprays, splashes, or aerosols generated during laboratory activities
- Risks should be mitigated by implementing engineering controls, administrative and work practice controls, and use of appropriate PPE
- An appropriate waste management plan must also be established and implemented

https://www.cdc.gov/viral-hemorrhagic-fevers/php/laboratories/specimen-collection.html

Shipping specimens for testing

- Public health authorities will determine whether orthoebolavirus testing will occur at an LRN laboratory, CDC, or both
- All specimens collected from patients with suspected Ebola disease must be shipped Category A as a non-select agent
- Consider applicable shipping requirements (e.g., Category A) before referring specimens for routine diagnostic (non-orthoebolavirus) testing prior to laboratories that may be unaware of the patient's clinical context

https://www.cdc.gov/viral-hemorrhagic-fevers/php/laboratories/specimen-packing.html

Diagnostic orthoebolavirus shipping and testing

- Presumptive testing for orthoebolaviruses, including Bundibugyo virus, is available at select LRN reference laboratories
- Whole blood EDTA specimens submitted to LRN laboratories should be refrigerated (2–8°C) and shipped on cold packs
- Confirmatory testing for orthoebolaviruses is available at CDC
- Whole blood EDTA specimens submitted to CDC for Bundibugyo virus testing must be frozen (<-20°C) and shipped on dry ice (Ebola Hemorrhagic Fever Testing - CLIA CDC-10309)

Guidance for malaria testing

- Microscopic examination of thick and thin blood smears is the gold standard diagnostic test for malaria
- Laboratory staff can safely perform testing by adhering to OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030), including wearing appropriate PPE and manipulating the specimen in a biosafety cabinet
- Standard protocols for preparing and staining thick and thin smears do not sufficiently inactivate orthoebolaviruses

Guidance for Malaria Diagnosis in Patients with Suspected Orthoebolavirus or Orthomarburgvirus Infection in the United States

Guidance for malaria testing

- No modified protocol is currently recommended to inactivate orthoebolavirus in thick smears
- Modified thin smear protocol to inactivate orthoebolaviruses:
  1. Fix thin smears for 15–30 minutes in 100% methanol. Allow to dry.
  2. Prepare 40 ml of working Giemsa stain. Add 2 drops of 5% Triton X-100 and mix. Stain thin smears for 45 minutes.
  3. Measure 40ml of working Giemsa buffer for rinsing. Add 2 drops of 5% Triton X-100. Rinse thin smears for a few seconds with agitation to remove excess stain.
  4. Allow smears to air-dry (do not use a hair dryer or fan) before examination.
- Coverslips with rapid-drying mounting medium may be applied to stained slides

Guidance for Malaria Diagnosis in Patients with Suspected Orthoebolavirus or Orthomarburgvirus Infection in the United States

Resources

Consultation and notification

- CDC clinical consultation: vspb@cdc.gov or 770-488-7100
- 24-hour State Epi-On-Call contact list

Situational awareness

- Ebola Disease: Current Situation
- CDC Travel Health Notices
- Sign up for the Health Alert Network
- Laboratory Outreach Communication System (LOCS)

Clinical recommendations and preparedness

- VHFs for Health Care Providers
- IPC Recommendations for Patients in U.S. Hospitals with Suspected/Confirmed VHFs
- Public Health Guidance for Ebola Disease
- National Emerging Special Pathogens Training & Education Center

Thank you.

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 https://www.cdc.gov/
Follow us on social **@CDCgov**

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the U. S. Centers for Disease Control and Prevention.

To Ask a Question

- Using the MS Teams Platform
  - The ability to ask questions during the live webinar is limited to the first 1,000 attendees who join the webinar.
  - Questions may be submitted after the live session by emailing coca@cdc.gov.
- If you are a patient, please refer your question to your healthcare provider.
- If you are a member of the media and have a question, please contact CDC Media Relations at www.cdc.gov/media. Click “Contact Media Relations” at the bottom of the page and then complete the Request for Comment form.

Today's COCA Call will be Available to View On-Demand

- **When:** In approximately one week
- **What:** Closed-captioned video and transcript
- **Where:** On the COCA Call webpage: What Clinicians Should Know about Ebola Bundibugyo Virus

Additional Resources

- Continue to visit https://www.cdc.gov/coca/hcp/trainings/index.html to get more details about upcoming COCA Calls.

- Subscribe to receive notifications about upcoming COCA calls and other COCA products and services at https://www.cdc.gov/coca/hcp/trainings/index.html.

Thank you for joining us today!

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