

EMERGENCY PREPAREDNESS AND RESPONSE

WEEKLY SITUATION REPORT

WEEK 32: 2nd TO 9th August 2026 | KENYA

0 New Events	0 Ongoing Events	2 Outbreaks	0 Humanitarian Crisis
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0 Grade 3	0 Grade 2	0 Grade 1	1 Ungraded
0 Protracted 3	1 Protracted 2	0 Protracted 1	

Overview of the Current Health Emergencies in Kenya 2026

Kenya is responding to multiple concurrent public health emergencies, including mpox in 21 counties and measles in 7 counties. The country is also at high-risk of Bundibugyo virus disease importation following the current outbreak in the Democratic Republic of the Congo and Uganda.

Summary of Ongoing Public Health Emergencies in Kenya, August 2026

Event	Total Cases	New Cases	Confirmed cases	Deaths	Case Fatality Rate	Counties	Start of reporting period	WHO Grade
Mpox	1,246	21	1,246	19	1.6%	39	31 July 2024	Protracted 2
Twenty-one new confirmed cases have been reported from Nairobi (19), Nakuru (1) and Machakos (1) in the past week. Total of 297 cases reported from 21 counties in 2026.								
Measles	512	24	97	3	0.6%	4	Nov 2025	Ungraded
Twenty-four new cases with two deaths reported in the past week from Lagdera Subcounty, Garissa County. Outbreak remains active in seven sub-counties across seven counties.								

1. Bundibugyo Virus Disease (BVD) outbreak in the Democratic Republic of Congo and Uganda

The Bundibugyo virus disease (BVD) outbreak in the Democratic Republic of the Congo remains in a phase of intense and expanding transmission, with cumulative deaths crossing the grim milestone of 2,000 only 86 days after the outbreak was officially declared on 15 May 2026. Cumulatively, 4,381 confirmed cases and 2,011 confirmed deaths as of 9 August 2026, corresponding to a case fatality ratio of 45.9% have been reported. Ituri remains the epicentre, accounting for 85.8% of cumulative cases and 80.6% of cumulative deaths.

The epidemic is increasingly characterized by sustained transmission within interconnected geographic clusters alongside continued geographic expansion.²⁶ Uganda has reported no new cases; its last confirmed patient was discharged on 16 July 2026, all identified contacts have completed follow-up, and the country remains on its 42-day countdown before the outbreak can be declared over. However, Uganda remains at high risk of reimportation, given sustained transmission just across the border.

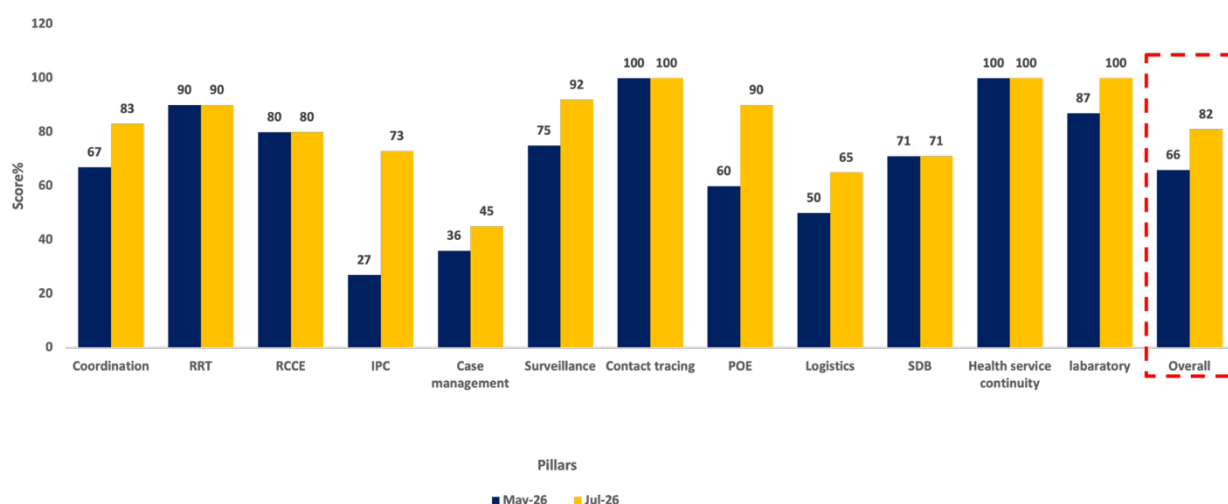
Country	New Confirmed Cases (Last 7 days)	New Confirmed Deaths (Last 7 days)	Confirmed Cases (total)	Confirmed Deaths (total)	Probable Cases	Probable Deaths	Total Cases (Confirmed & Probable)	Total Deaths (Confirmed & Probable)	CFR (%) Confirmed & Probable
Democratic Republic of the Congo	579	304	4 381	2 011	-	-	4 381	2 011	45.9%
Uganda	0	0	20	2	1	1	21	3	14.3%
France	0	0	1	0	0	0	1	0	0.0%

Note: Only confirmed and probable cases are reported.

* **Data source:** Data as 9th August 2026 | Weekly External Situation Report 11, WHO AFRO

Figure 1: Readiness status for BVD outbreak by pillar, Kenya, May 2026

Kenya's overall Ebola preparedness score rose from an estimated 66% in May 2026 to 82% following the July 2026 reassessment, with the largest gains concentrated in infection prevention and control, points of entry, and logistics, the pillars flagged as weakest at baseline. Five pillars, including contact tracing and rapid response teams, remained unchanged.



Kenya Preparedness and Readiness Actions

Risk assessment has identified 13 counties as very high risk, 12 counties as high risk, and the remaining 22 counties as medium risk (Figure 2). WHO and partners continue to support the Ministry of Health in strengthening the response pillars, and preparations are underway for a pillar-based risk assessment in the high-risk counties.

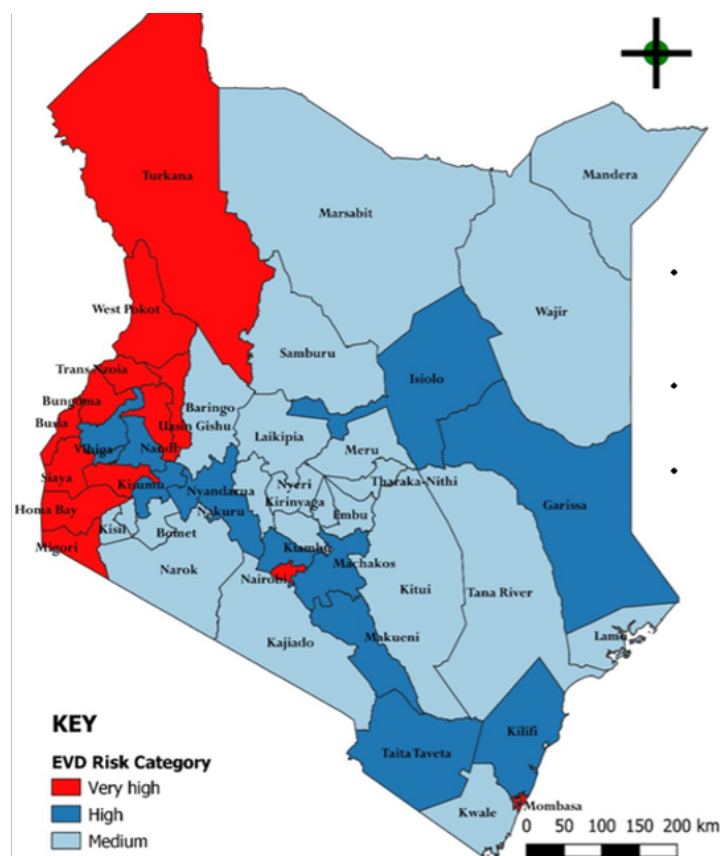


Figure 2: Risk classification status for BVD by county, Kenya, June 2026

Very High Risk: Counties sharing a border with Uganda and South Sudan or serving as international travel hubs, (including Nairobi)
*High Risk: Counties with significant population movement through Points of Entry (PoE), including land borders crossings and airports).**Medium Risk: Counties near high-risk counties with potential spillovers due to cross-county population movement and interaction*

Pillar	Capacity	Implementation of priority readiness actions
Points of Entry (PoE)		- Enhanced screening continues at high-risk Points of Entry for travelers arriving from DRC and Uganda. - A total of 4,989 travellers were screened in the last 24 hours. - As of 8th August 2026, a cumulative 370,856 travellers have been screened for Ebola Virus Disease since the outbreak was declared in DRC and Uganda.
Rapid Response Teams		- As of 9th August 2026, a cumulative total of 184 alerts has been investigated, all of which tested negative. 11 alerts were investigated in the past week, reflecting continued active surveillance. - Cascade training still ongoing in Machakos, Homa Bay and West Pokot
Surveillance		WHO, Ministry of Health and the Kenyan National public health institute conducted a two-day Call Centre Refresher Training in Nairobi, equipping 25 frontline call agents to respond to public inquiries on Ebola Virus Disease.

Case management		▪ A cluster training on case management underway in Uasin Gishu ▪ An EVD simulation exercise is planned to take place in Busia Town, organized by the Kenya National Public Health Institute (KNPHI). The exercise will test the implementation and effectiveness of the 72-hour EVD response plan across all response pillars.
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2. Mpox

New cases* (last 7 days)	Cumulative cases	Deaths	Recovered	Case Contacts	Counties
21	1,246	19	1,187	1,376	39

*Ministry of Health

Twenty-one new confirmed cases reported from Nairobi (19), Nakuru (1) and Machakos (1) in the past week. A total of 297 cases has been reported across 21 counties in 2026. There are 40 active cases with four cases are receiving care in facilities while 36 cases are in home-based isolation and care. Cumulatively, 1,246 cases have occurred across 39/47 counties since the onset of the outbreak in July 2024. Of these,

- 69% (456) of the cases are aged 15-44 years
- A total of 19 deaths, 10 (53%) females; 13 (68%) are HIV Positive
- 1,376 contacts listed, 1,141 completed follow-ups; 16 contacts confirmed as cases after developing symptoms
- Nairobi County accounted for the majority of the 2026 cases (44%, 130/297) and is the current hotspot.
- A total of 10,993,216 travellers screened at 26 points of entry since the beginning of the outbreak in July 2024
- Laboratory testing: 3,127 total samples tested, 1,246 positive (positivity rate 40%); thirty-five tests done in the past one week.
- Genomic sequencing: 257 samples sequenced, Sub-clade 1b virus identified in all positive samples

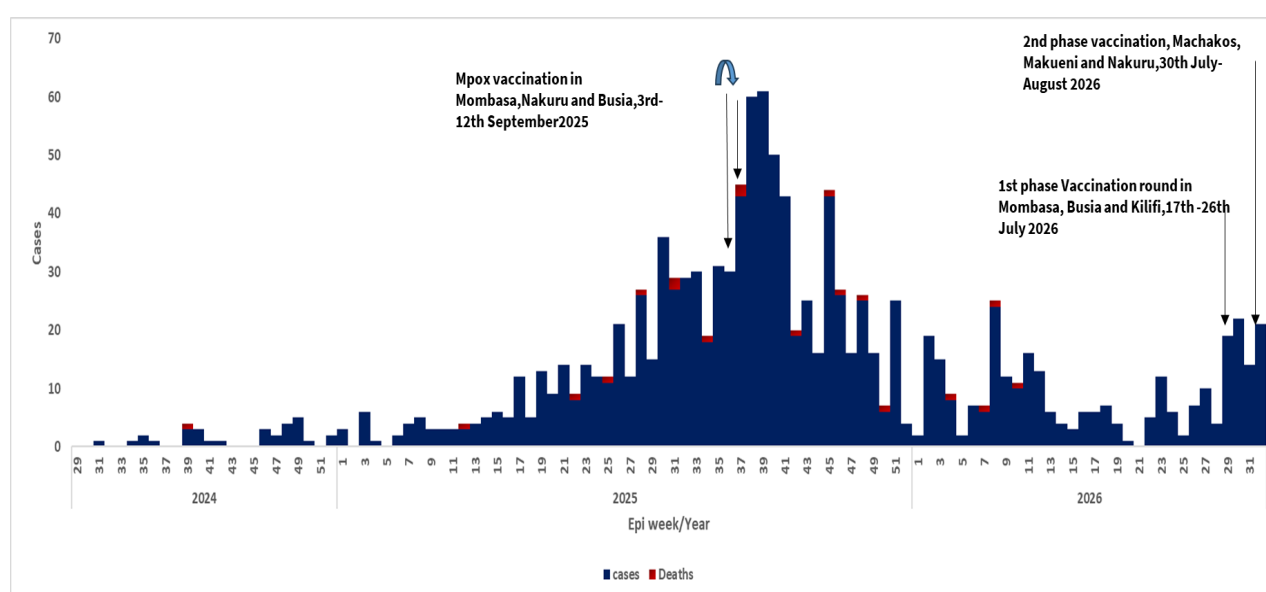


Figure 3: Epi curve of mpox cases in Kenya, July 2024 – August 2026

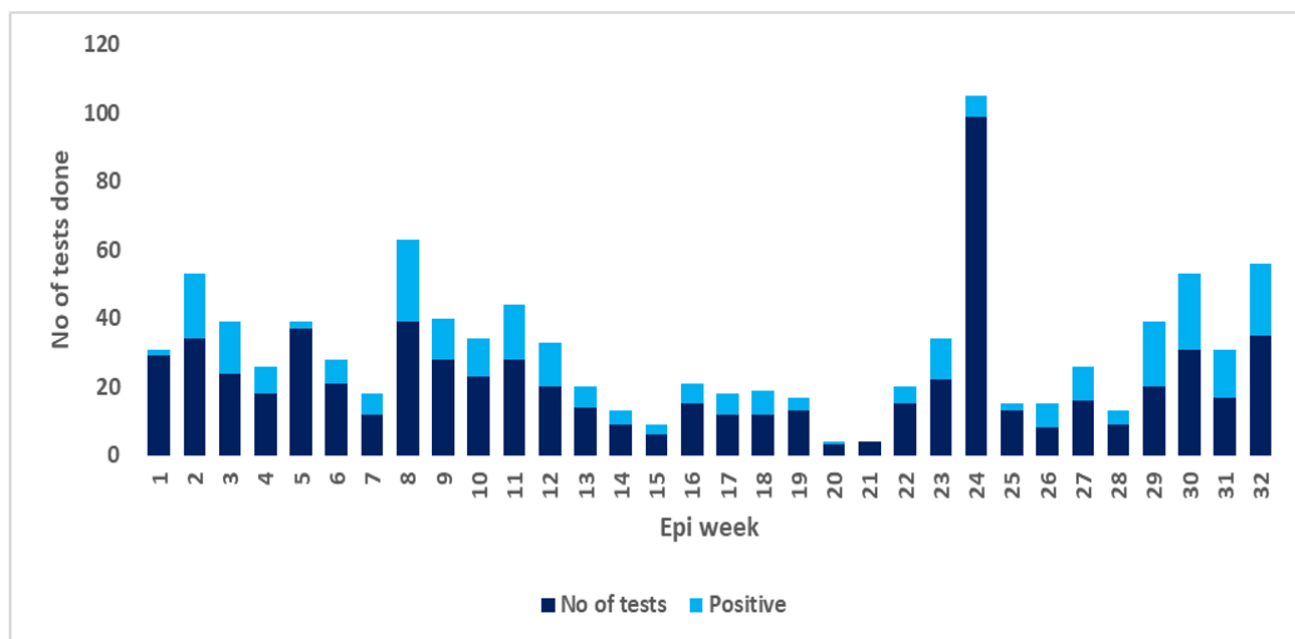


Figure 4: Trends in Laboratory testing of mpox, Kenya, January – August 2026

- Surveillance is still active in all affected and high-risk counties
- Most of the samples tested (2 out of 99 samples) in week 24 are from Nairobi County. Most samples tested from Nairobi County were collected from healthcare workers who had been identified as contacts of confirmed cases managed at Kenyatta University Teaching, Referral and Research Hospital (KUTRRH).
- Enhanced surveillance activities conducted during the vaccination campaign led to an increase in the number of suspected cases identified and tested.

Response Activities

- A second vaccination campaign, utilizing the **20,000** vaccine doses available in-country, was implemented in two phases from 17 July 2026 through 8 August 2026.
- Phases One and Two of the vaccination campaign were successfully completed. Phase One was conducted in Busia, Mombasa, and Kilifi counties from 17–26 July 2026, while Phase Two was conducted in Machakos, Makueni, and Nakuru counties from 30 July–8 August 2026.

Target Population and achievements of the 2nd phase Mpox Campaign in three counties, 30 July–8 August 2026

County	Subcounty	Vaccines Allocated	Target Pop	Total vaccinated	Coverage (%)
NAKURU	Naivasha (Mai Mahiu)	1100	1045	1099	105.2
	Rongai (Salgaa)	1270	1207	1270	105.2

	Nakuru Total	2370	2252	2369	105.2
Machakos	Mavoko	1300	1235	1300	105.3
	Machakos Total	1300	1235	1300	105.3
Makueni	Kibwezi East	780	741	780	105.3
	Kibwezi Wesst	780	741	780	105.3
	Kilome	780	741	780	105.3
	Makueni Total	2340	2223	2340	105.3
Total		6,010	5,710	6,009	105.2

3. Measles

New cases	Cumulative cases	Deaths	Case Contacts	Counties
24	512	3	0	6

* Source: Ministry of Health of Kenya

- Twenty-four new cases and two deaths were reported during the past week.
- Of the new cases, 23 cases and one death were reported from Lagdera Sub-County, Garissa County.
- The other one death was a late-reported death from Dadaab Sub-County.
- Since the onset of the outbreak in November 2025, a total of 512 cases including 97 laboratory-confirmed cases and three deaths have been reported.
- The outbreak remains active in seven sub-counties across seven counties, namely Mandera (Banissa), Kilifi (Kaloleni), Tana River (Galole), Nairobi (Kibra), Kiambu (Thika), Mombasa (Likoni), and Garissa (Lagdera), as 30 days has not elapsed since the last suspected/confirmed case, in line with Kenya IDSR guidelines.

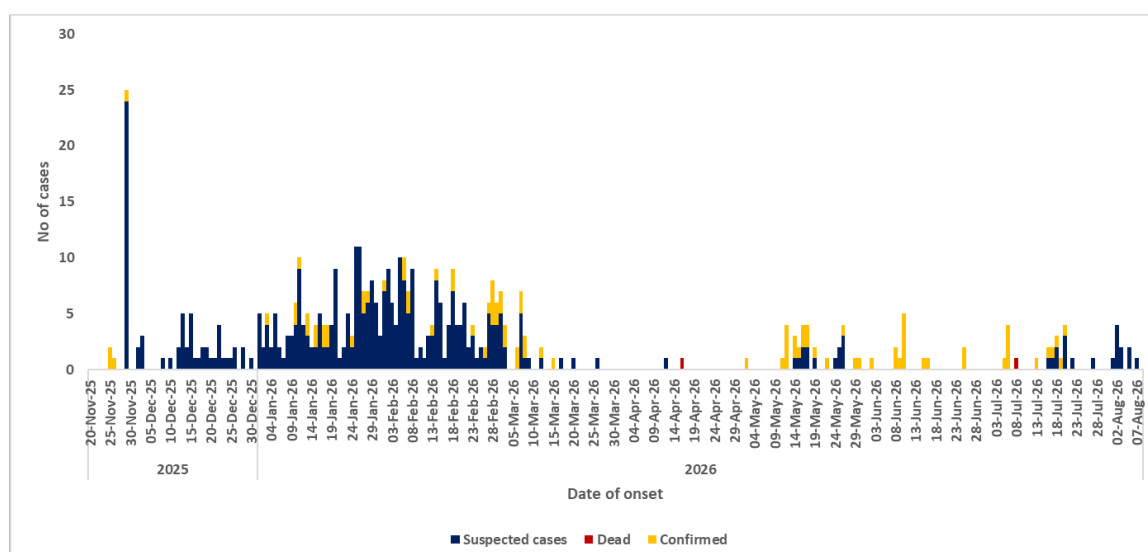


Figure 7: Epi Curve of Measles Cases, Kenya Nov 2025 - August 2026

Public health interventions

- A field investigation was conducted at the patient's residence by the Sub-County Rapid Response Teams (RRTs) to review the deaths, assess vaccination status, and ascertain other factors associated with the deaths.
- Active case search and contact tracing were conducted within the affected households and the surrounding community.
- Key findings from the preliminary report include.
 - A total of 13 suspected measles cases were identified
 - Only 3 (23.1%) had documentation of measles vaccination
 - Five (5) (38.5%) were reported unvaccinated
 - And 5 (38.5%) had an unknown vaccination status
 - Overall, 76.9% of the suspected cases were either unvaccinated or had an unknown vaccination status.
 - Family interviews revealed that many of the affected individuals had spent their early childhood in remote nomadic settlements where routine immunization services were either inaccessible or inconsistently available. These findings suggest significant immunity gaps within the community that may have facilitated local transmission of measles.
 - Review of the 2026 routine immunization performance for Lagdera sub county showed, MRI Coverage for the first dose of Measles-Rubella vaccine (MR1) was 83%, while coverage for the second dose (MR2) was only 68%. In addition, Fully Immunized Child (FIC) coverage stood at 79%. These coverage levels are substantially below the ≥95% threshold recommended for measles elimination and indicate immunity gaps within the population that may have facilitated sustained measles transmission.
- A line list of suspected measles cases was developed and is being updated.
- Samples were collected from suspected cases and referred to the KEMRI Laboratory in Nairobi for laboratory confirmation.
- The County Health Team, in collaboration with the Kenya Red Cross, is conducting integrated mobile outreach services in the affected area, targeting children who have missed any routine antigen and those due for measles vaccination.

5. Integrated Disease Surveillance (IDSR) Overview

** Source: Weekly IDSR reports, KHIS*

Kenya has implemented the third edition of the Integrated Disease Surveillance and Response (IDSR) strategy, which supports the routine surveillance and weekly reporting of 46 priority diseases, conditions, and public health events. These priorities are classified into four categories: epidemic-prone diseases, diseases targeted for elimination or eradication, diseases of public health importance, and public health events of international concern

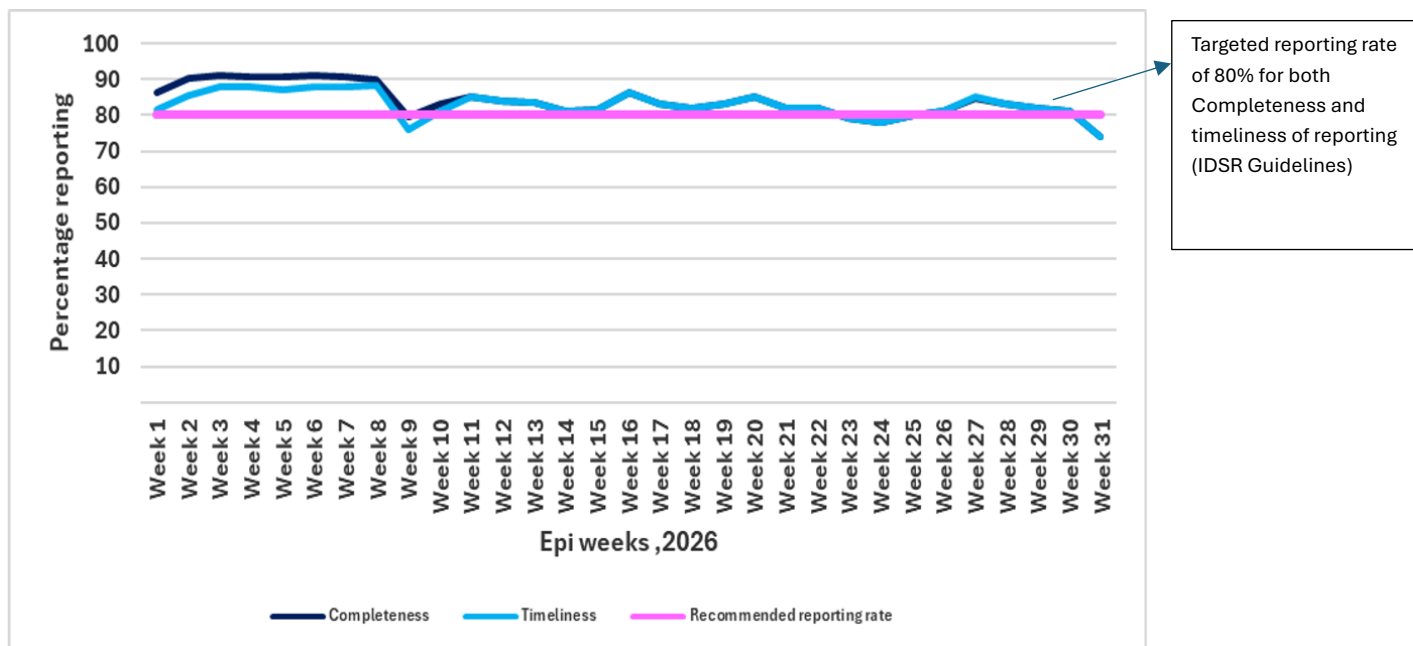


Figure 8: Overview of key indicators of IDSR, Kenya from Epi week 1-31,2026

- The average overall completeness of reporting from Epidemiological Week 1 to 31 was 84%.
- The average overall timeliness of reporting during the same period was 83%.
- Notably, Epi Week 9 recorded the lowest timeliness at 76%.

6. Completeness of IDSR reporting Epi 28-31,202

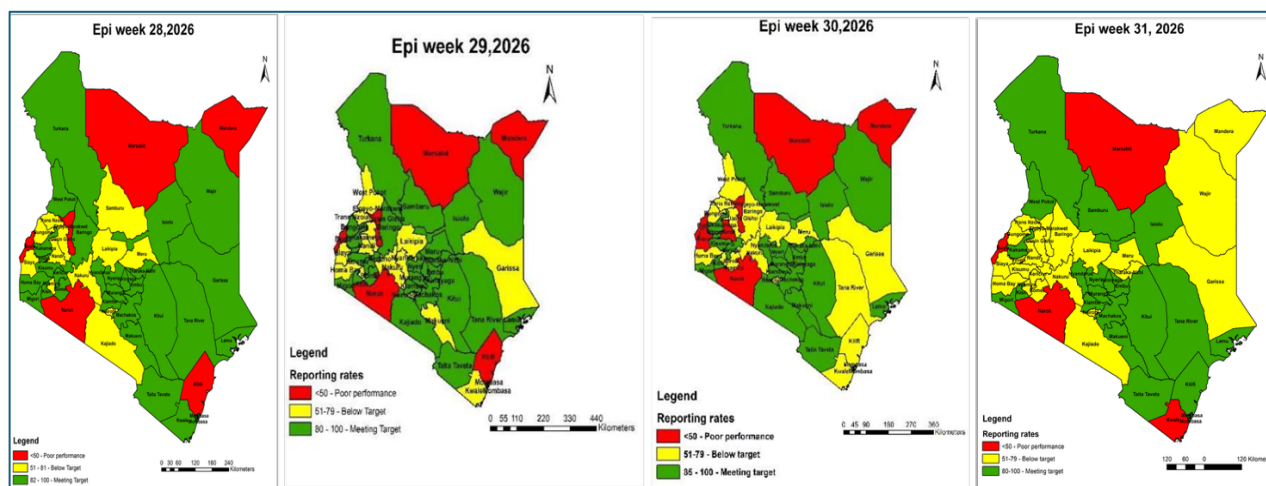


Figure 9: Completeness of IDSR reporting Epi 27-30,2026

- Targeted reporting rate of 80% for both Completeness and timeliness of reporting (IDSR Guidelines).
- Notably several counties are below the recommended reporting rate (counties with yellow).
- Marsabit and Narok Counties has consistently reported below 50%.

IDSR Interventions

- A dedicated focal person for integrated disease surveillance has been assigned by the Kenya National Public Health Institute (KNPHI) to follow up with counties with low reporting rates.
- The designated focal person will ensure regular monitoring and follow-up of low-performing counties, with timely identification of reporting gaps and coordination of corrective actions to improve reporting rates.
- WHO is supporting the KNPHI team to identify the challenges contributing to low reporting and develop strategies to strengthen reporting performance in the affected counties.

6. Social Listening: Priority Health Issues & Response Actions

- This Social Listening summary provides a snapshot of emerging public conversations, concerns, misinformation and perceptions that may influence health behaviours and public trust. Through monitoring of X, Facebook, TikTok, Instagram and WhatsApp, alongside credible media and official sources, the report identifies priority information risks and provides actionable recommendations to guide RCCE and infodemic management.
- During this reporting period, discussions are being monitored around Bundibugyo Virus Disease (BVD)/Ebola, Ebola response funding and vaccine trials, the invasive malaria mosquito (*Anopheles stephensi*), Mpox, cholera and other emerging health signals.

Health issue	Risk level	What is being discussed online	Suggestion solutions/recommendations for RCCE & infodemic management response
Bundibugyo Virus Disease (BVD) / Ebola regional outbreak	VERY HIGH	▪ Claims that Ebola is a hoax or externally managed scare. ▪ Questions about why international/European media appear to report developments before African audiences. ▪ Resource-theft and diversion narratives linked to DRC minerals. ▪ Large case/death figures driving panic, fatalism and demands for border closure. ▪ Confusion between the severe DRC outbreak and Kenya's status.	▪ Use a consistent "what is confirmed / what is not confirmed" format. ▪ Always state country, source, date and whether figures are cumulative/confirmed. ▪ Clearly separate DRC outbreak severity from Kenya's status. ▪ Explain preparedness and screening without stigmatizing DRC/Uganda-linked travelers. ▪ Use trusted Kenyan/African technical voices and rapidly correct information gaps.

Bundibugyo vaccine trial	HIGH	▪ Moderna Phase 1 trial triggering memories and distrust associated with COVID-19/mRNA vaccines. ▪ Claims of human experimentation, pharmaceutical profit and deliberate disease creation. ▪ Narratives suggesting Africans will be used as test subjects, although the report notes the trial is in Canada among healthy adult volunteers.	▪ Explain Phase 1 in plain language: early safety and immune-response research. ▪ State where the trial is taking place and who is enrolled. ▪ Clarify that a trial does not mean the vaccine is approved or being administered in Kenya. ▪ Prepare FAQs on Bundibugyo, mRNA, trial ethics, safety, participant protection and possible future use.
Invasive malaria mosquito (Anopheles stephensi)	HIGH	▪ A real vector-surveillance concern is being blended with unsupported mosquito-release conspiracies. ▪ Claims that Ebola is a “cover-up” or distraction from an invasive malaria mosquito. ▪ Bill Gates/foreign experimentation narratives and confusion about “anti-malaria mosquitoes.” ▪ Risk that misinformation undermines both Ebola communication and malaria/vector surveillance.	▪ Separate the facts: An. stephensi is a legitimate surveillance concern; deliberate-release claims are unverified. ▪ Develop a simple explainer: what it is, where detected, why it matters, urban malaria risk and household actions. ▪ Pre-bunk mosquito-release narratives before they grow. ▪ Emphasize Kenyan-led surveillance, regulation and technical expertise.
Mpox	MEDIUM	▪ No major new misinformation wave, but residual vaccine concerns remain. ▪ Targeted vaccination of high-exposure groups may trigger stigma, privacy concerns or moralizing narratives. ▪ Low online noise could change quickly if adverse-event rumours or misinformation re-emerge.	▪ Maintain brief, county-specific, low-drama updates. ▪ Explain that vaccination is based on exposure risk—not moral judgement. ▪ Use peer educators, hotspot teams, transport associations and healthcare-worker champions. ▪ Address eligibility, side effects, privacy and consent early.
Cholera & other monitored health signals	WATCH	▪ Cholera currently has low misinformation noise, but water-safety rumours, home-remedy misinformation, sanitation blame and stigma	▪ Continue low-intensity social listening. ▪ Keep ready-to-publish WASH messages on safe water, early rehydration, when to seek care and verified affected locations.

		toward affected locations can escalate quickly. ▪ HIV prevention information risks being crowded out while Ebola dominates public attention.	▪ Maintain routine, low-drama HIV prevention/service reminders across media and community platforms.
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