EMERGENCY PREPAREDNESS AND RESPONSE WEEKLY SITUATION REPORT

WEEK 33: 9th TO 16th August 2026 | KENYA

0 New Events	0 Ongoing Events	2 Outbreaks	0 Humanitarian Crisis

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 public health emergencies, including mpox in 21 counties as of 2026 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	**1,260**	**14**	**1,260**	**19**	**1.6%**	**39**	**31 July 2024**	**Protracted 2**
Fourteen new confirmed cases have been reported from Nairobi (12), Makueni (1) and Machakos (1) in the past week. Total of 311 cases reported from 21 counties in 2026.								
Measles	**514**	**2**	**99**	**3**	**0.6%**	**4**	**Nov 2025**	**Ungraded**
Two new cases reported in the past week from Kibra subcounty, Nairobi County. Outbreak remains active in five 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 continued to intensify during the reporting period, now confirmed as the second largest and fastest growing Ebola outbreak in history, nine times larger than the 2014–2016 West Africa outbreak at the same point in its timeline. Daily cases are growing at 2.2% (Rt 1.19), with incidence projected to double roughly every 18 days if the trend holds. The outbreak now spans 5 provinces and 55 health zones, with Tshopo Province the latest area affected. WHO declared a PHEIC on 16 May 2026, and Africa CDC declared a Public Health Emergency of Continental Security. Uganda's outbreak has been declared

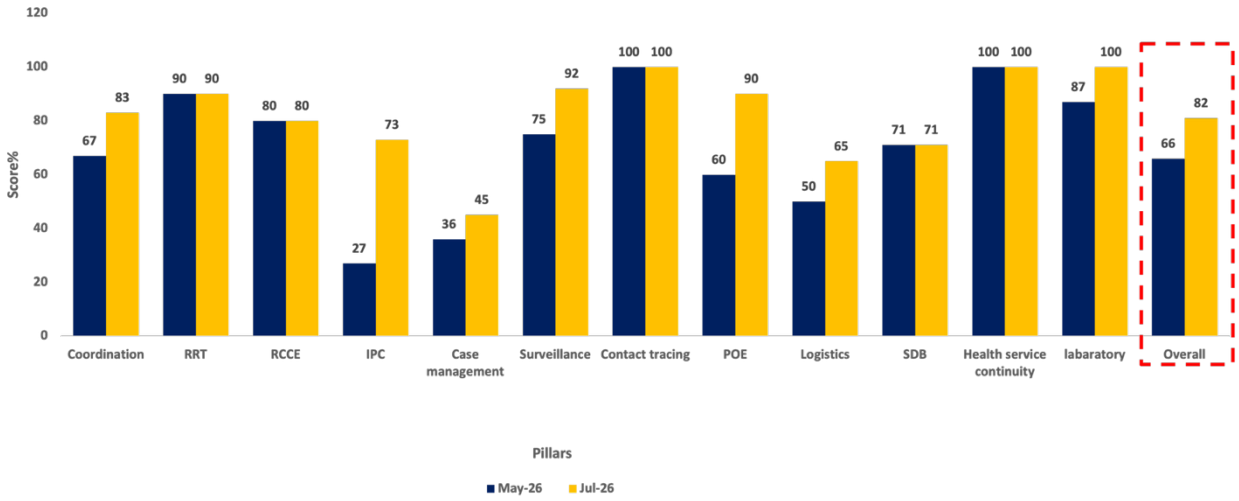
over after 42 days without a case. As of 17 August 2026, the country's last confirmed patient discharge had been followed by 32 days without a new case. Uganda stays at high risk of reimportation given sustained transmission just across the border. France has reported no secondary transmission following the imported case detected on 24 June 2026. The patient recovered and was discharged on 4 July 2026. As of 16 August 2026, 34 days had elapsed since the patient's discharge without an additional confirmed case being reported in France.

Country	Cumulative confirmed cases	Recovered	Patients in Isolation	Total confirmed Deaths	CFR (%) Confirmed &Probable)	Health zones affected
DRC	5 021	1,061	751	2,378	47%	55
Uganda	21	17	-	3	14.3%	0
France	1	1	-	0	0.0%	0

* ***Data source****: Data as 16 th August 2026 | Weekly External Situation Report, 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.

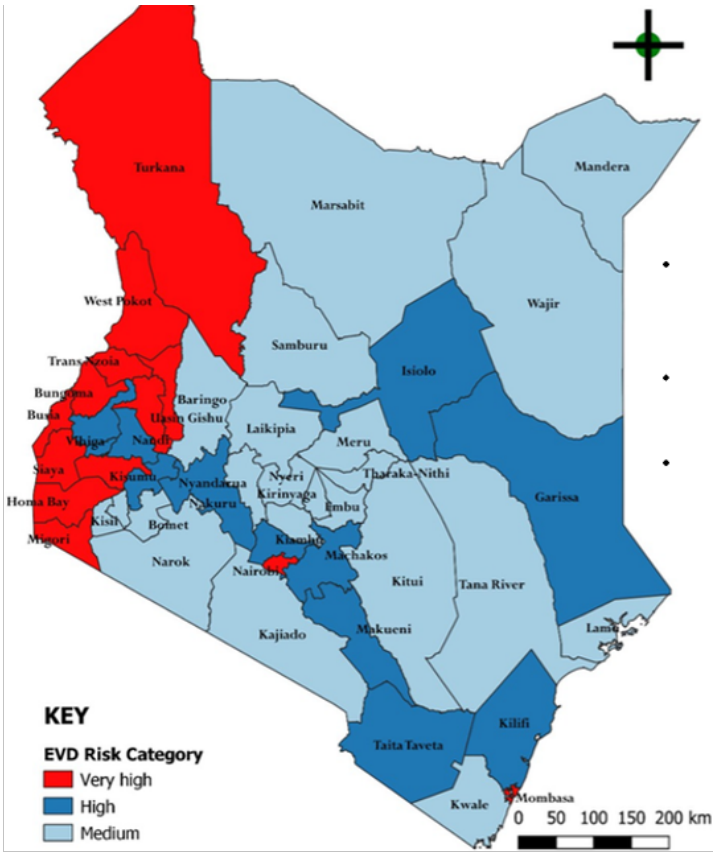


Figure 2: Risk classification status for BVD by county, Kenya, June 2026

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 7,360 travelers were screened in the last 24 hours. ▪ As of 16 August 2026, a cumulative 420,377 travelers have been screened for Ebola Virus Disease since the outbreak was declared in DRC and Uganda. ▪ A POE training on EVD for the POE officers of Busia and Bungoma counties is underway in Busia ▪ A sensitization meeting for key stakeholders at the border point of Busia was conducted at Busia

Rapid Response Teams		▪ Cascade training was done for Migori and Kisumu, Makueni, Mombasa, Nairobi, Laikipia, Isiolo, Meru, Nyeri and Samburu. ▪ As of 16 August2026, a cumulative total of 196 alerts has been investigated, all of which tested negative. ▪ 12 alerts were investigated in the past week, reflecting continued active surveillance.
Case management		▪ An EVD simulation exercise was conducted in Busia Town, organized by the Kenya National Public Health Institute (KNPHI). The exercise tested implementation and effectiveness of the 72-hour EVD response plan across all response pillars.

2. Mpox

New cases* (last 7 days)	Cumulative cases	Deaths	Recovered	Case Contacts	Counties
14	**1,260**	**19**	**1,120**	**1,376**	**39**

*Ministry of Health

Fourteen (14) new confirmed cases reported from Nairobi (12), Makueni (1) and Machakos (1) in the past week. A total of 311 cases have been reported across 21 counties in 2026. Active cases: 21, with 4 in facility care and 17 in home-based isolation and care. Cumulatively, 1,260 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 (46%, 142/311) and is the current hotspot.
- A total of 11,083,017 travellers screened at 26 points of entry since the beginning of the outbreak in July 2024
- Laboratory testing: 3,144 total samples tested, 1,260 positive (positivity rate 39%); seventeen tests done in the past one week.

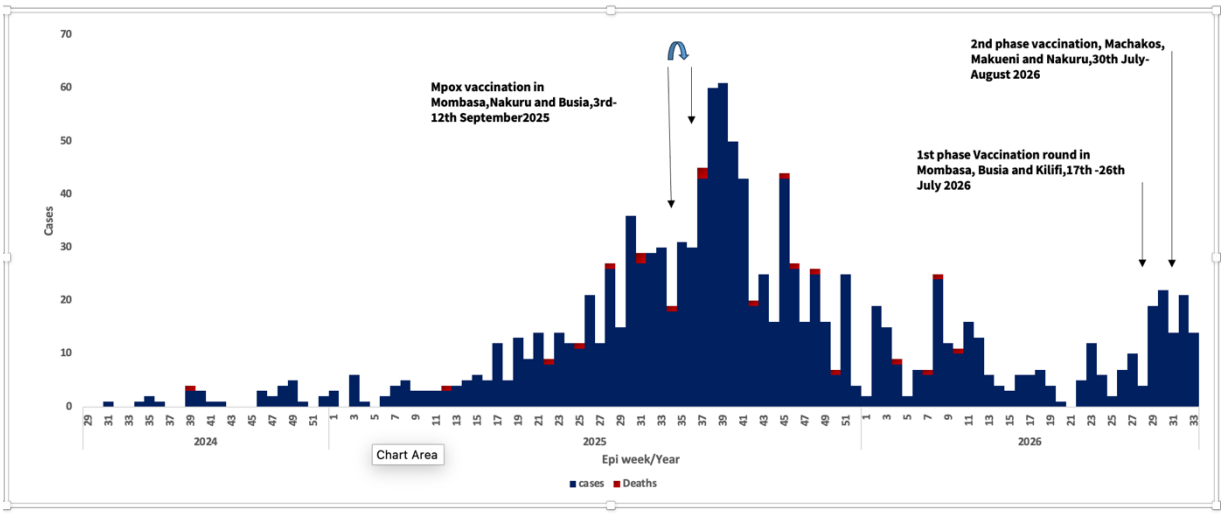


Figure 3: Epi curve of mpox cases in Kenya, July 2024 – August 2026

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 (coverage of 105.2% of the targeted population), while Phase Two was conducted in Machakos, Makueni, and Nakuru counties from 30 July–8 August 2026 (coverage of 105.2% of the targeted population).

3. Measles

New cases	Cumulative cases	Deaths	Case Contacts	Counties
2	514	3	0	6

* *Source: Ministry of Health of Kenya*

- Two (2) new cases were reported during the past week, from Kibra Sub-County, Nairobi County.
- Since onset in November 2025, a total of 514 cases including 99 laboratory-confirmed cases and three deaths have been reported. The outbreak remains active in five sub-counties across five counties: Kilifi (Kaloleni), 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.

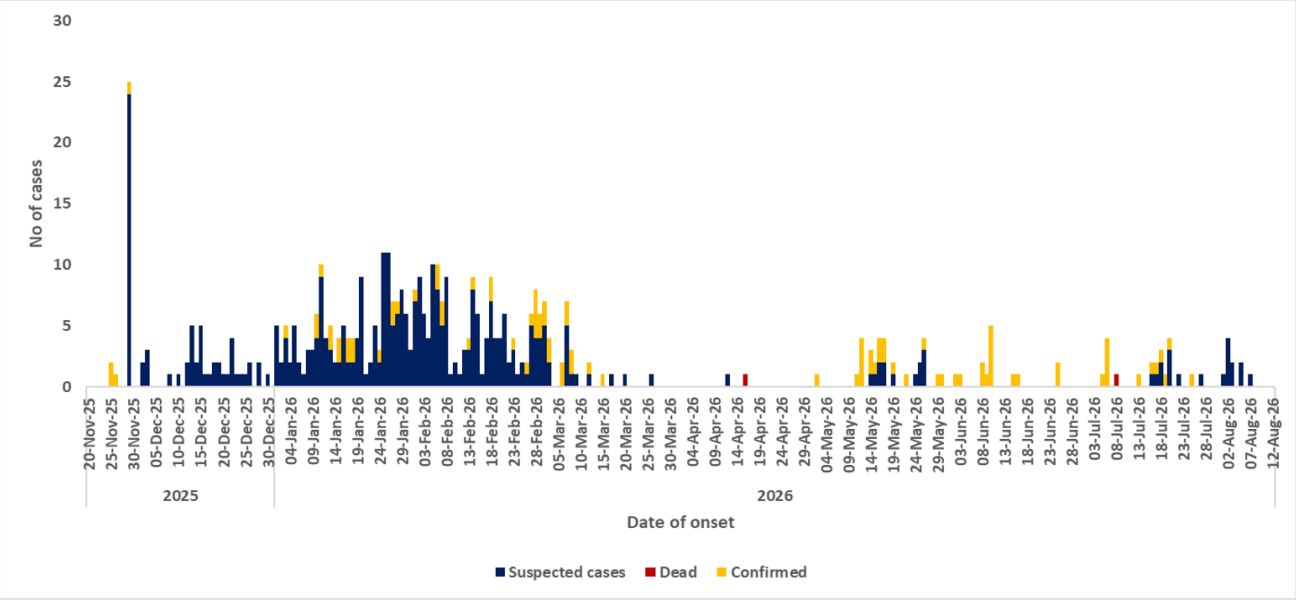


Figure 4: Epi Curve of Measles Cases, Kenya Nov 2025 - August 2026

Public health interventions

- Active Case Search: Health facility and community levels to identify suspected cases promptly.

- Enhanced Surveillance: For timely detection and response currently ongoing in the health facility and community in the affected counties
- Provision of supportive care at health facilities reporting cases

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

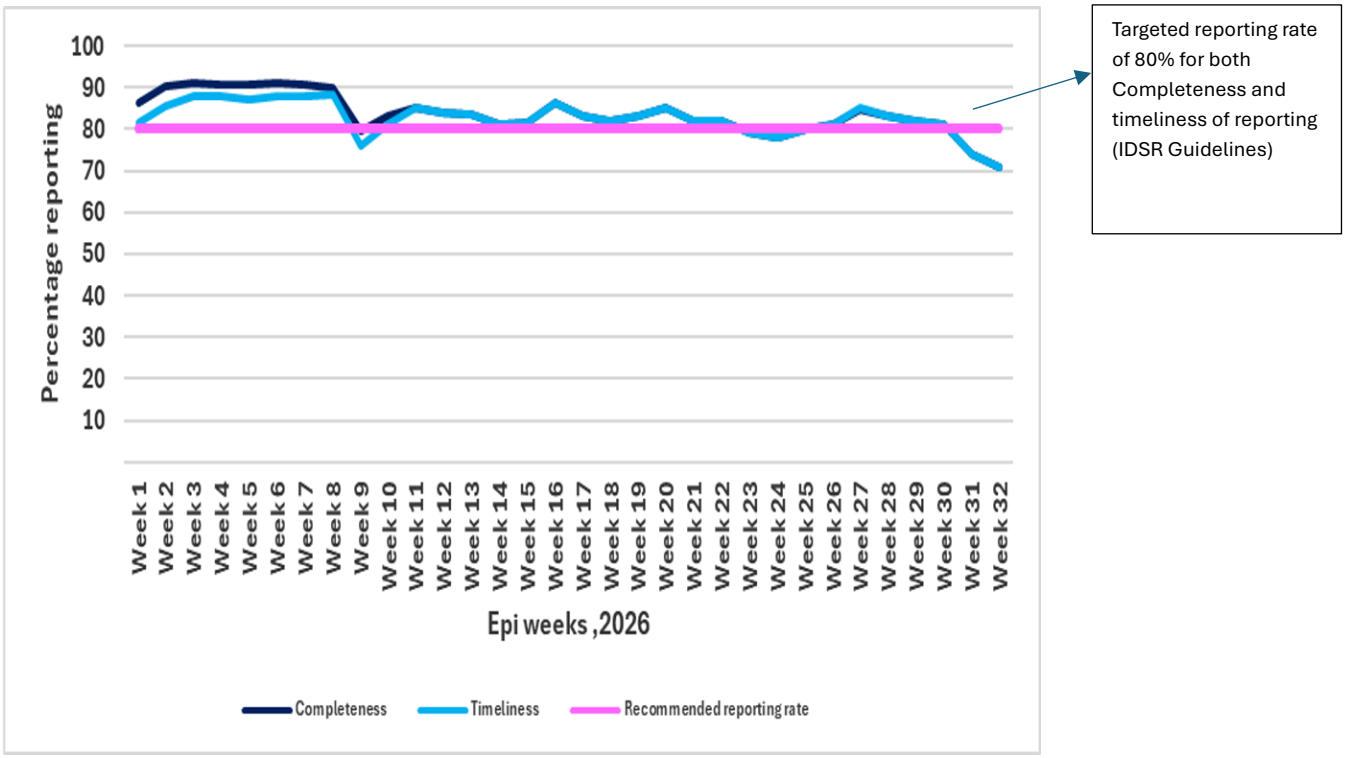


Figure 5: Overview of key indicators of IDSR, Kenya from Epi week 1-32, 2026

- The average overall completeness of reporting from Epidemiological Week 1 to 32 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 29-32,2026

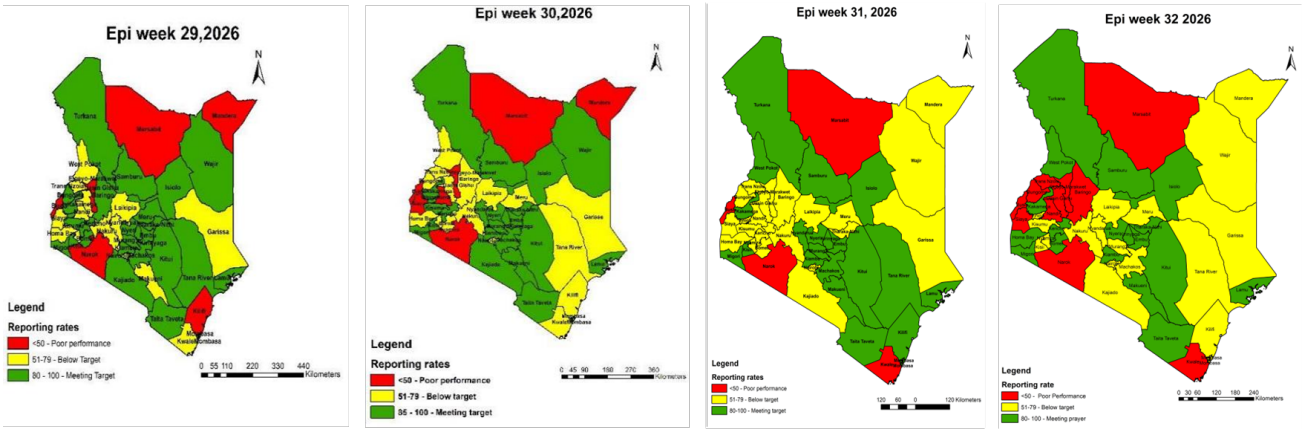


Figure 4: Completeness of IDSR reporting Epi week 29-32,2026

- 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, Narok and Kwale 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.
- The Kenya National Public Health Institute (KNPHI), through the designated focal person, is following up on the assignment of focal persons for the six regions of the country. The regional focal persons will be responsible for following up with the respective counties on all matters related to disease surveillance and reporting.
- 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 weekly social listening report tracks emerging health-related misinformation, public sentiment and online discourse in Kenya to identify information risks early and guide RCCE and infodemic management. This week, monitoring focused mainly on BVD/Ebola and Kenya's border preparedness, with Mpox, cholera and residual malaria-mosquito narratives maintained on watch.

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	▪ Outbreak reported in a 6th DRC province, increasing concern about regional spread. ▪ Hoax and minerals narratives: claims Ebola exists only in media or is being used to enable resource theft. ▪ Population-control, poisoning and biological-warfare claims. ▪ Large case/death figures and "deadliest ever" headlines driving panic, fatalism and denial.	▪ Lead with verified DRC/Uganda/Kenya status; always state source, date, place and data category. ▪ Use "confirmed / not confirmed" framing and clearly distinguish preparedness from local transmission. ▪ Use Kenyan/African technical voices to explain case verification and laboratory confirmation. ▪ Publish search-friendly FAQs such as "Is Ebola in Kenya?" and "How does Ebola spread?"
Kenya border preparedness / Northern Corridor	VERY HIGH	▪ Calls to close borders with Uganda and fear around Busia, Malaba and the Northern Corridor. ▪ Confusion between outbreak location, travel routes, porous borders and actual risk. ▪ Fear that Kenya would be unable to cope if Ebola arrives. ▪ Risk of stigma against travellers, truck drivers, Ugandans, Congolese and border communities.	▪ Issue county/PoE-specific updates explaining screening, traveller assessment, RRT readiness and referral pathways. ▪ Use a corridor frame: Where is the outbreak? Uganda status? Kenya status? What is happening at PoEs? ▪ Explain why risk-based screening is preferable to fear-driven stigma. ▪ Integrate anti-stigma messaging into all Ebola preparedness updates.
WHO / foreign-agenda narratives	HIGH	▪ WHO described online as a "business/cabal"; foreign health support framed as control or exploitation. ▪ Claims of population control, deliberate deception and biological warfare. ▪ Sovereignty narratives calling for Africa to reject foreign health systems.	▪ Anchor communication locally: Kenyan clinicians, county teams, KEMRI/NPHI and respected African scientists should lead. ▪ Show locally owned response, accountability and transparent source attribution. ▪ Explain how outbreak data is verified: sampling, laboratory confirmation, contact tracing, case classification and death reporting. ▪ Acknowledge accountability concerns while correcting unsupported claims.

Catastrophic headlines & information-seeking	HIGH	▪ Headlines such as “one victim every 30 minutes,” “300 children die” and “deadliest ever” amplifying fear. ▪ Kenyan Google searches for “Ebola” surged on 11 August, indicating anxiety and active information seeking. ▪ Poorly contextualized figures can trigger panic or reinforce hoax narratives.	▪ Every update should answer where, when/source, what data category, and Kenya’s status. ▪ Work with media/editors to contextualize figures and avoid vague alarmist headlines. ▪ Fill search gaps quickly with short, factual FAQs and explainers on MoH/county websites and social platforms.
Mpox	LOW/ MEDIUM	▪ Little major social attention this week. ▪ Residual risk that targeted vaccination/hotspot outreach is interpreted as moral blame against sex workers, truck drivers or mobile populations. ▪ Privacy and vaccine-hesitancy concerns may re-emerge with new county updates.	▪ Maintain brief, practical, county-specific updates without national-crisis framing. ▪ Reinforce case status, vaccination availability, symptom recognition, privacy and consent. ▪ Use peer educators and hotspot outreach teams to communicate without increasing stigma.
Cholera & other watch signals	LOW/ MEDIUM	▪ No major cholera misinformation wave, but unsafe-water, poisoned-food, sanitation-blame and home-remedy rumours remain possible. ▪ HIV prevention conversation remains low noise. ▪ Residual invasive-malaria-mosquito narrative continues to be used to frame Ebola as a “cover-up.”	▪ Continue low-intensity monitoring and pre-bunking. ▪ Keep cholera/WASH messages ready on safe water, early rehydration and verified affected locations. ▪ Continue quiet HIV service reminders on testing, condoms, PrEP/PEP and adherence. ▪ Maintain simple malaria vector-control explainers to counter mosquito-release rumours.

World Health Organization
Kenya

Thanks to the Ministry of Health, the Kenya National Public Health Institute, our donors, and our partners for your support!

Follow us on: X LinkedIn

For real time updates and key stories

FOR MORE INFORMATION & FEEDBACK:

ndahendekireg@who.int
afkeninfo@who.int