

WEEKLY SITUATION REPORT

WEEK 34: 17th TO 23rd August 2026 | KENYA

1 New Events	0 Ongoing Events	3 Outbreaks	0 Humanitarian Crisis
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0 Grade 3	1 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 5 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	1,274	14	1,274	19	1.6%	39	31 July 2024	Protracted 2

Fourteen new confirmed cases have been reported from Nairobi (13) and Kericho (1) in the past week. Total of 325 cases reported from 21 counties in 2026.

Measles	514	0	99	3	0.6%	5	Nov 2025	Ungraded
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No new cases reported in the past week. Outbreak remains active in five sub-counties across five counties. Active in 5 sub-counties across 5 counties (down from 7); Mandera and Tana River no longer active, no new cases in 30+ days.

Circulating Vaccine Derived Polio 2 (cVDPV2)	1	1	1	0	0.0%	1	August 2026	Grade 2
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One case confirmed in Dadaab Sub-County, Garissa County, a 4-year-old girl among recent refugee arrivals from Somalia, genetically linked to an environmental isolate from Beledweyne, Somalia. Classified as ORPHAN, with no confirmed person-to-person transmission identified to date.

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 and has now become the largest BVD outbreak ever recorded and the second-largest Ebola disease outbreak on record. The outbreak spans 6 provinces and 57 health zones, with Bas-Uélé the latest province affected following a confirmed case in Buta health zone. Ituri remains the epicentre, accounting for most cumulative cases and deaths, though transmission has intensified in Nord-Kivu and Haut-Uélé even as it has declined in some established hotspots. WHO declared a PHEIC on 15 May 2026, 96 days since the declaration, 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 23 August 2026, 38 days had elapsed since the last patient's discharge without a new confirmed 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. No secondary transmission has been detected and all five identified flight contacts completed follow-up without developing symptoms.

Country	Cumulative confirmed cases	Recovered	Patients in Isolation	Total confirmed Deaths	CFR (%) Confirmed & Probable)
DRC	5514	1,200	808	2,642	47%
Uganda	21	17	-	3	14.3%
France	1	1	0	0	0.0%

* **Data source:** Date as of 22nd 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.

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 travellers were screened in the last 24 hours. - As of 16th August 2026, a cumulative 420,377 travellers 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		- A total of 4,496 National and County HCWs have been sensitized on EVD, 2,747 via virtual sessions (ECHO platform). - As of 23rd August 2026, a cumulative total of 203 alerts has been investigated, all of which tested negative. 7 alerts were investigated in the past week, reflecting continued active surveillance. - Cascade training has been completed for 19 counties; Migori, Kisumu, Makueni, Mombasa, Nairobi, Laikipia, Isiolo, Meru, Nyeri, Samburu, Busia, Turkana, Trans Nzoia, Bungoma, Nakuru, Kilifi, Kwale, Lamu and Taita-Taveta. - Community-level trainings have been conducted for Community Health Units in Busia, West Pokot, Bungoma and Trans Nzoia, and for refugee camp operators in Kakuma and Kalobeyei, Turkana County.
Case management		41 personnel from KDF, Mombasa, Kwale, Kilifi, Lamu and Taita Taveta counties were trained in Mombasa. 40 personnel from Uasin Gishu, Turkana, Elgeyo Marakwet, KDF, Bungoma and Trans Nzoia were trained in Eldoret.

2. Mpox

New cases* (last 7 days)	Cumulative cases	Deaths	Recovered	Case Contacts	Counties
14	1,274	19	1,220	1,376	39

*Ministry of Health

Fourteen (14) new confirmed cases reported from Nairobi (13) and Kericho (1) in the past week. A total of 325 cases has been reported across 21 counties in 2026. Active cases: 21, with 4 in facility care and 17 in home-based isolation and care. Cumulatively, 1,274 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

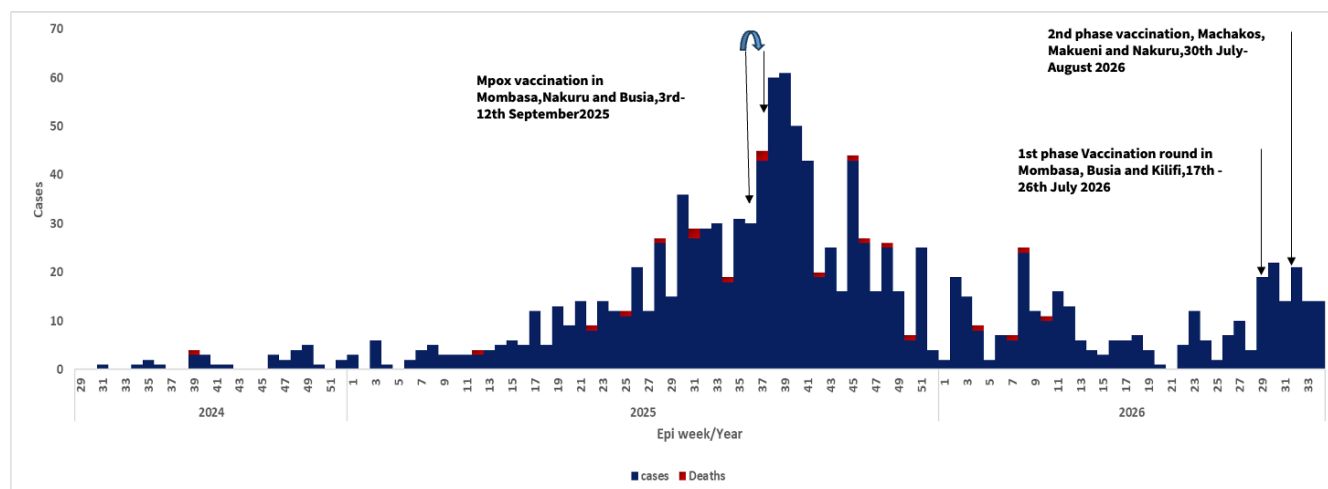


Figure 4: Epi curve of mpox cases in Kenya, July 2024 – August 2026

3. Measles

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

* Source: Ministry of Health of Kenya

- No new cases were reported during the past week. 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). Mandera (Banissa) and Tana River (Galole) have had no new cases in the past 30 days and are no longer classified as active.

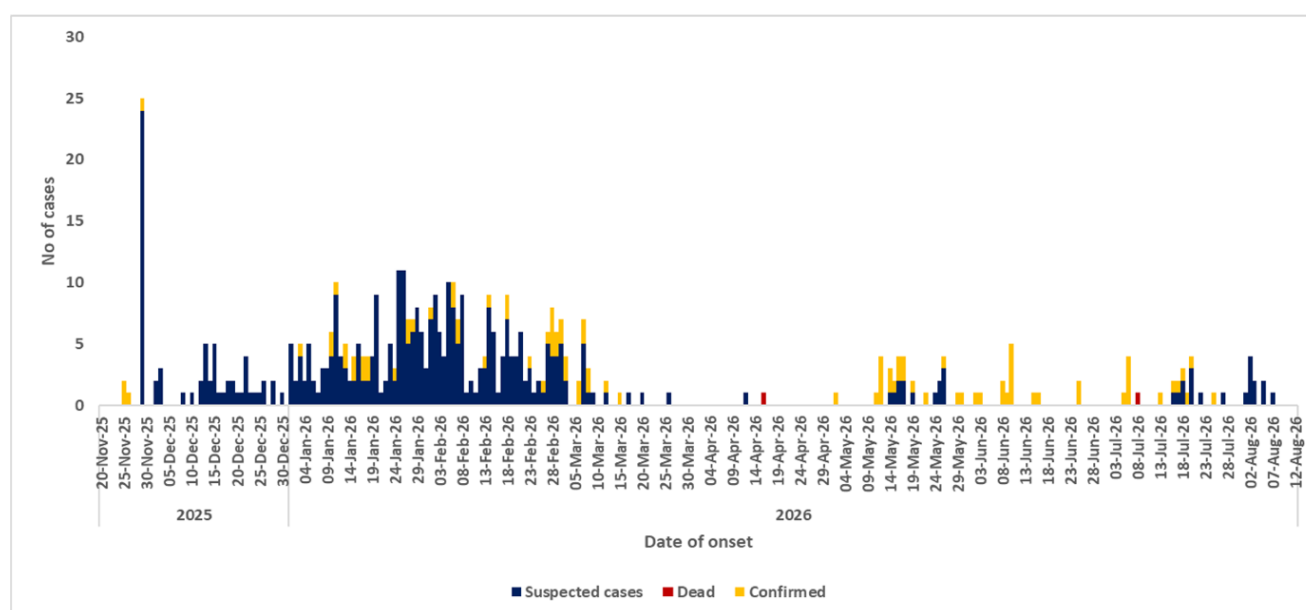


Figure 4: Epi Curve of Measles Cases, Kenya Nov 2025 - August 2026

4. Circulating Vaccine Derived Polio Virus2 (cVDPV2) in Dadaab, Ifo2 refugee camp, Garissa County

New cases	Cumulative cases	Deaths	Case Contacts	Counties
1	1	0	0	1

One case of circulating vaccine-derived poliovirus type 2 (cVDPV2) has been confirmed in Dadaab Sub-County, Ifo 2 refugee camp, a new-arrival refugee from Somalia. The index case, detailed in the table below, was a zero-dose child from a household of recent arrivals with no prior vaccination history. The isolate was confirmed as circulating vaccine-derived poliovirus type 2 (cVDPV2), showing 37 nucleotide differences from Sabin 2 in the VP1 region, and was genetically linked to an environmental cVDPV2 isolate from Beledweyne, Somalia, with 16 nucleotide differences, placing it within the SOM-BAY-1 Beledweyne emergence group; as of 18 August 2026, the case was classified as an ORPHAN, with no confirmed link to person-to-person transmission beyond the environmental linkage.

Index Case Details	
Age/sex	48 months (4 years); Female
Origin residence	Howlwadag Village, Bay Region, Baidoa District, Somalia
Initial residence on arrival	Block E-9, Dagahaley Refugee Camp (9 days, rented house)
Current residence	Block Q-1, Ifo 2 Refugee Camp (West), Dadaab Sub-County
Date of arrival in Kenya	7 July 2026 (new arrival)
Household size	10 members (mother, father, and 8 children including index case, aged 2–16 years); all new arrivals from Somalia
Vaccination status on arrival	Zero dose (per new-arrival screening form)
Date seen at health facility	10 July 2026
Date of sample collection	10 July 2026
Date sample sent to laboratory	23 July 2026
Date results received	18 August 2026
Laboratory result	Confirmed cVDPV2)

Public Health Interventions Undertaken

- Integrated services including measles vaccination, Vitamin A supplementation, and deworming were provided to all eligible children upon arrival (MSF).
- Household WASH and immunization status were assessed following the case investigation.
- Health education was provided on the importance of vaccination and completing the recommended immunization schedule.
- Follow-up is planned to ensure partially immunized siblings complete their vaccination schedule.
- A multi-partner team comprising WHO, MOH, Core Group, Kenya Red Cross, MSF and other partners is conducting an in-depth investigation of the case.

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.

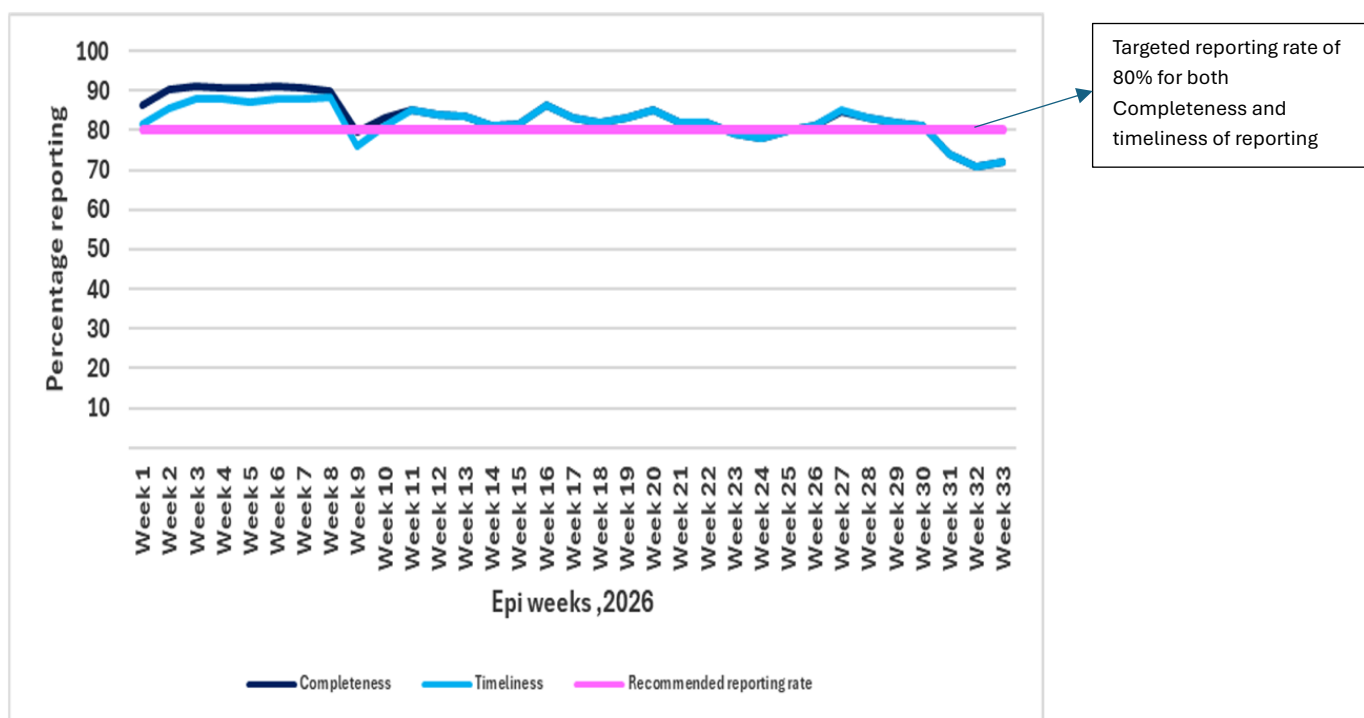


Figure 5: Overview of key indicators of IDSR, Kenya from Epi week 1-33, 2026

- 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

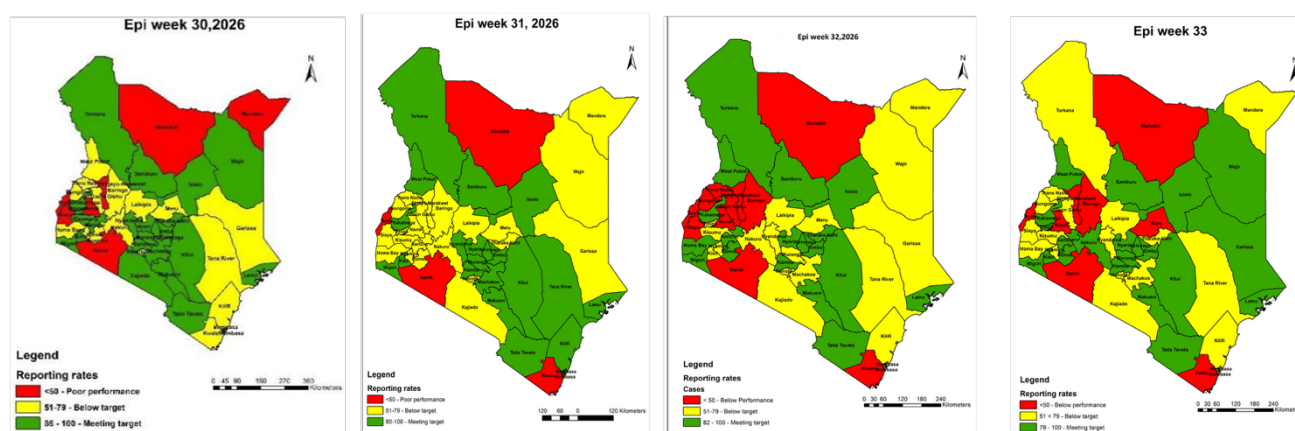


Figure 5: Completeness of IDSR reporting Epi week 30-33,2026

- 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 Issues	Online Sentiment/ Discussion	RCCE & Infodemic Management Recommendation
Ebola / BVD	▪ Hoax/propaganda claims; users question whether Ebola is real or media-driven. ▪ Vaccine mistrust: suspicion that disease and vaccines are linked to outside interests. ▪ Resource/mineral conspiracy narratives connect Ebola response with alleged looting. ▪ Border anxiety: fear that regional spread means Kenya may soon be affected.	Maintain predictable updates separating regional outbreak facts from Kenya's status. Use "risk vs reality"; explain testing, screening and vaccine purpose; use trusted Kenyan/African technical voices.
Dengue fever	▪ Foreign-experimentation/"lab rat" narratives have resurfaced around dengue. ▪ Discussion links mosquito interventions to Bill Gates/foreign actors. ▪ Political/resource-allocation claims question why Garissa and Wajir are prioritized.	Pre-bunk with a county-specific explainer on cause, symptoms, mosquito transmission, prevention and care. Publish transparent case and response information; avoid amplifying conspiracy actors.
Kirinyaga foodborne illness	▪ Concern and information-seeking after the burial-related illness event. ▪ Risk of speculation around poisoned food, contaminated water or cholera.	Use one consistent county update: affected numbers, clinical status and investigation status. Do not label as cholera until confirmed; share hydration, hygiene and care-seeking advice.

Health Summit / SHA	▪ Mixed, skeptical and accountability-focused discussion around health reforms. ▪ Health-worker/patient concerns are being weighed against official reform milestones.	Pair reform claims with measurable service indicators people can verify. Address legitimate complaints directly rather than treating criticism as misinformation.
Mpox / HIV	▪ Low-noise monitoring; no major new misinformation wave identified this period. ▪ Earlier vaccine, stigma and prevention misinformation remains on the watch list.	Maintain low-intensity monitoring and service-oriented messaging. Pre-bunk known myths when campaigns or hotspot updates are announced.
Amboseli elephant deaths	▪ Concern, anger and shock around suspected/probable cyanide or toxic exposure. ▪ Claims blame farmers for deliberately poisoning elephants. ▪ Food-safety fears: concern that contaminated tomatoes/food could affect people. ▪ Distrust/cover-up claims allege authorities are hiding the real cause.	Use “what we know / don’t know yet.” Consistently say findings are preliminary and investigations ongoing. Avoid unverified blame or national food alerts; coordinate One Health messaging.
Cross-cutting priority	▪ Information gaps and uncertainty are creating space for speculation. ▪ Predictable, transparent updates are needed to reduce information voids.	Strengthen rapid social listening, rumor triage and coordinated response. Timestamp figures, publish updates at predictable intervals and link audiences to verified sources.

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

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FOR MORE INFORMATION & FEEDBACK:

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- ✉ ndahendekireg@who.int
 - ✉ afkeninfo@who.int