World Health Organization
Kenya

WEEKLY SITUATION REPORT

Emergency Preparedness and Response

Week 46 · 9 – 15 November 2026



Cabinet Secretary for Health Hon. Aden Duale receives Ebola equipment and supplies from WHO Regional Director for Africa Prof. Mohamed Yakub Janabi, Afya House, Nairobi, 9 November 2026
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KEY FACTS

Ebola disease caused by Bundibugyo virus (BVD)

Outbreak declared 6 October 2026 · 42-day countdown: day 5 of 42 on 16 November · Data as of 15 November 2026

9
Confirmed cases
0 new since 19 October

7
Recovered
Last patient discharged 11 November

2
Deaths
CFR 22.2%

135
Contacts listed
All 118 in Kenya discharged

779
Samples tested
9 positive (1.16%)

800,345
Travellers screened
At 28 points of entry, cumulative

11,376
Confirmed cases, DRC
5,568 deaths (CFR 48.9%)

118
Contacts discharged from Quarantine

Current Health Emergencies in Kenya, 2026

Kenya confirmed the first imported case of Ebola (Bundibugyo) Virus Disease in Nairobi on 6th October 2026; nine confirmed cases and two deaths have been reported as of 15 November 2026, with no new case since 19 October; all seven surviving patients have recovered, and the 42-day countdown to the end of the outbreak began on 12 November. Kenya is also responding to mpox in 39 counties, measles active in five counties and one cVDPV2 case in Garissa County.

Event	Total Cases	New Cases	Confirmed cases	Deaths	New Deaths	Case Fatality Rate	Counties	Start of reporting period	WHO Grade
Ebola (BVD) Go →	**9**	**0**	**9**	**2**	**0**	**22.2%**	**1**	**6th October 2026**	**Grade 3**
No new confirmed case since 19 October; the cumulative total remains nine: the index case and eight of his contacts (four health workers and four family members). All seven surviving patients have recovered; the last was discharged on 11 November. All 118 contacts in Kenya have completed 21-day follow-up. The 42-day countdown began on 12 November 2026.									
Mpox Go →	**1,354**	**0**	**1,354**	**21**	**0**	**1.6%**	**39**	**31 July 2024**	**Protracted 2**
No new confirmed case or death in the past week. 405 cases from 24 counties in 2026; 3 cases remain active.									
Measles Go →	**585**	**19**	**140**	**3**	**0**	**0.5%**	**5**	**Nov 2025**	**Ungraded**
19 new cases in the past week, all in Moyale, Marsabit, among refugees in temporary protection sites. Active in five sub-counties: Moyale, Dadaab (Garissa), Bura, Embakasi North and Likoni (Mombasa).									
Polio 2 (cVDPV2) Go →	**1**	**0**	**1**	**0**	**0**	**0.0%**	**1**	**August 2026**	**Grade 2**
No new case since August. One case remains confirmed in Dadaab Sub-County, Garissa County, classified orphan with no confirmed person-to-person transmission.									

Response

1. Ebola (Bundibugyo) Virus Disease Kenya

Confirmed new cases	Cumulative confirmed cases	Recovered	Confirmed deaths	Contacts listed	In quarantine	Discharged from follow-up	In treatment units	Counties
0	**9**	**7**	**2**	**135**	**0**	**118**	**0**	**1**

**Ministry of Health, Kenya. Note: data as of 15 November 2026; new cases are since the Week 46 report (11 November 2026).*

As of 15 November 2026, Kenya has recorded **nine confirmed cases of Ebola (Bundibugyo) Virus Disease and two deaths (CFR 22.2%)**. No new confirmed case has been reported since 19 October 2026. **All seven surviving patients have recovered; the last was discharged from the treatment Centre on 11 November 2026**, and no patient remains in care. The 42-day countdown began on 12 November 2026 and is on day 5 of 42 as of 16 November; if no new case is recorded, Kenya will declare the outbreak over on or about 23 December 2026.

The second to ninth cases were close contacts of the index case who were in quarantine when they developed symptoms and subsequently tested positive: four health workers who cared for the index case and four close family members.

Case 3, a 65-year-old woman and close family contact of the index case, died on 23 October 2026; a safe and dignified burial was conducted on 24 October 2026.

History of the Index case

On 6 October 2026, the Ministry of Health of Kenya notified WHO of the country's first laboratory-confirmed imported case of Bundibugyo virus disease (BVD). The case was a 40-year-old Kenyan male who had travelled from the Democratic Republic of Congo, through Uganda, before arriving at Jomo Kenyatta International Airport (JKIA), Nairobi, on 3 October 2026. He presented care at a hospital on the day of arrival with signs and symptoms of intense fatigue, fever, chills, weakness, muscle pain, and painful swallowing. He was admitted to isolation, and samples tested at the National Virology Reference Laboratory and Kenya Medical Research Institute confirmed Bundibugyo virus infection. The patient died on 5 October and received a safe and dignified burial on 6 October 2026.

Table 1: *Clinical and travel timeline of the confirmed imported index case (step numbers match Figure 1)*

DRC						
1 26–30 Aug	**2** 1–9 Sep	**3** 10–14 Sep	**4** 15–16 Sep	**5** 17–19 Sep	**6** 20 Sep	**7** 1 Oct
Stayed in Buta	Aketi Health Zone (work)	Aketi to Likati with brother (road)	Malaise; treated at home	Admitted, Tongo Etandi HC, Bondo	Flew to Kisangani; sought care there to 1 Oct	Flew Kisangani to Beni

DRC	UGANDA		KENYA			
8 1 Oct	**9** 1 Oct	**10** 3 Oct	**11** 3 Oct	**12** 3 Oct	**13** 5 Oct	**14** 6 Oct
Road to Kasindi–Mpondwe border	Road, Mpondwe to Kampala	Road, Kampala to Entebbe	Flew Entebbe to JKIA (arrived ~13:10)	Private car to The Nairobi Hospital; isolated	Died ~23:30 after supportive care	Safe and dignified burial

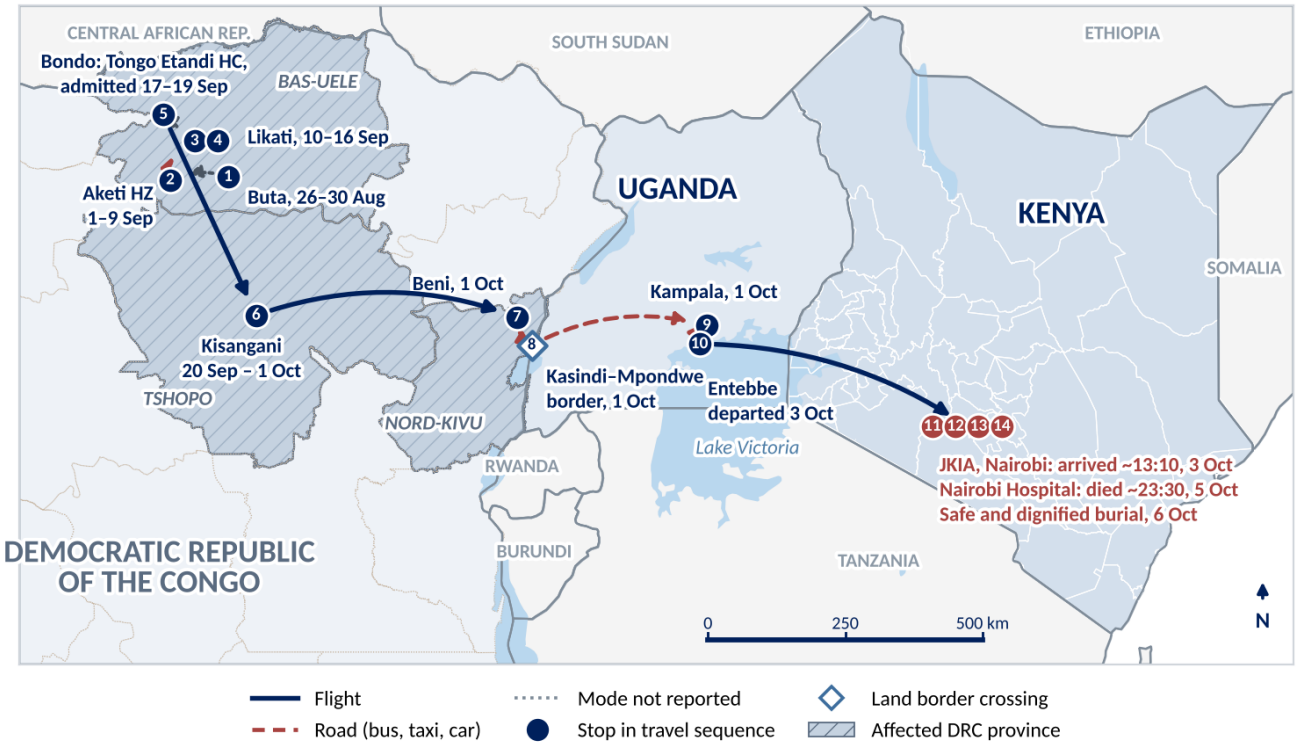


Figure 1: *Travel route of the confirmed BVD index case prior to death in Kenya, 26 August – 6 October 2026*

- **Clinical presentation:** fever, chills, intense fatigue, weakness, muscle pain, painful swallowing and bleeding at injection sites.
- **Laboratory confirmation:** positive for Bundibugyo virus at both the National Public Health Laboratory and KEMRI.
- **Genomic sequencing:** the virus is closely related to strains circulating in the DRC, confirming the PCR result and importation.

Transmission Chain and Contact Follow-up as of 15 November 2026

All confirmed cases are linked to the index case; no case has been confirmed outside his listed contacts.

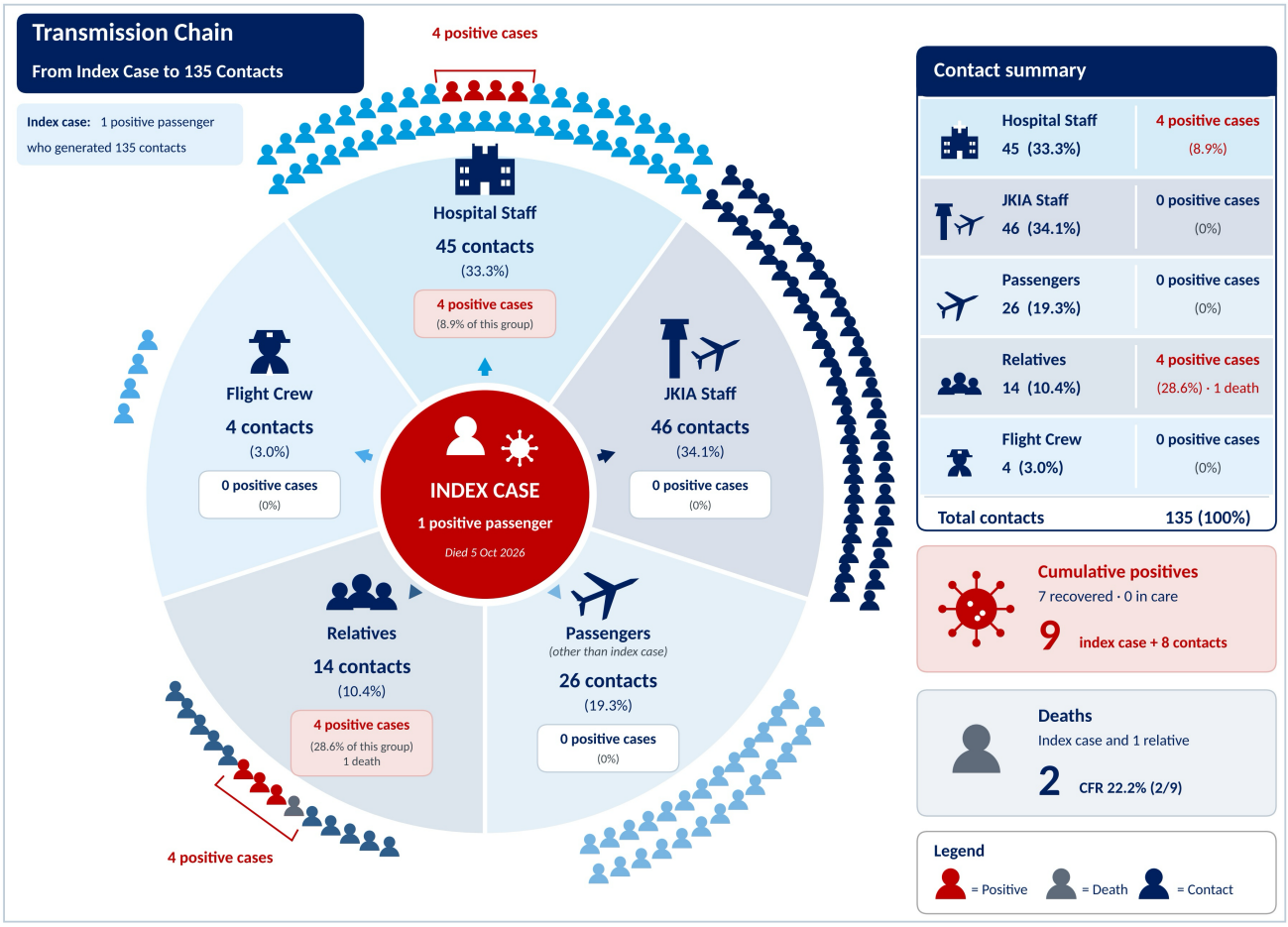


Figure 2: *Transmission chain, Kenya, as of 15 November 2026*

The contact list stands at 135, including 45 hospital staff. As of 15 November 2026, **all 118 contacts in Kenya have been discharged** after completing the mandatory 21-day follow-up, and none remains in quarantine; no new contact was listed in the last 24 hours. The other 17 contacts are the eight who became confirmed cases and nine passengers who travelled outside Kenya, followed up with the countries concerned under the IHR (2005).

Public Health Response Actions

- **Coordination:** coordination meetings continue at strategic (taskforce), operational (IMS) and tactical (field) levels, with regular technical pillar meetings. Regular media briefings keep the public informed. An Incident Management Support Team (IMST) orientation meeting was held with all partners supporting the response. In-kind contributions of about US$650,000 have been mobilized from WHO (US$116,000: VHF kits, PPE and surge support) and the Government of India (US$534,000: PPE).
- **Points of entry:** screening continues at 28 PoEs. In the 24 hours to 15 November, 3,505 travellers were screened, 71 of them from the DRC; 800,345 have been screened to date. Renovation of holding units at the Malaba and Busia one-stop border posts is under way.
- **Surveillance:** in the 24 hours to 15 November, the BVD call centre received 82 calls, 43 of them BVD-related. A total of 594 alerts had been investigated as of 15 November 2026.
- **Case management:** 211 beds are available for isolation and care of BVD patients. All seven surviving patients have recovered; the last was discharged on 11 November 2026, and no patient remains in care. Patients received remdesivir and MBP134 (monoclonal antibodies).

- **Training and surge capacity:** 343 trained public health emergency responders are on standby, and a surge capacity plan has been developed. Africa CDC has deployed 10 AVoHC surge staff to support response pillars. 7,319 health workers have been trained in person and through the ECHO platform, including 142 staff trained in case management and IPC at The Nairobi Hospital and Kenyatta National Hospital. With WHO support, county teams from five high-risk counties have been trained in filovirus surveillance, and training for five more counties is under way.
- **Logistics:** partners including the United States Government, the Government of India and WHO have donated PPE, IPC and laboratory commodities. WHO donated 12 portable PCR machines and a 28-bed Ebola Treatment Unit. UNICEF donated more than 43,126 IPC and WASH supplies; Africa CDC provided laboratory support (US$16,795) and equipment for the Public Health Emergency Operations Centre (about US$350,000); IOM donated IPC supplies (US$13,428); and the Government of Rwanda supplied 500 vials of remdesivir for Kenyatta National Hospital. CORE Group (CGPP) supplied PoEs with 64 tablets, 110 thermoguns, 440 batteries and 26 banners, and Kenya Red Cross provided IEC materials. Supplies funded by the U.S. Department of State have been distributed through MEDS to 28 high and very-high-risk counties, five PoEs, four Level 6 hospitals, one private hospital and the Kenya Defence Forces.
- **Laboratory:** a dedicated laboratory at the Kenyatta National Hospital Infectious Disease Unit runs routine tests for Ebola patients, avoiding contamination or overloading of the main laboratory. 779 samples tested, 9 positive (positivity 1.16%): the index case, four family members and four hospital staff. A laboratory sample referral system is in place in all counties. Turnaround, including second-laboratory confirmation, is 6–12 hours.

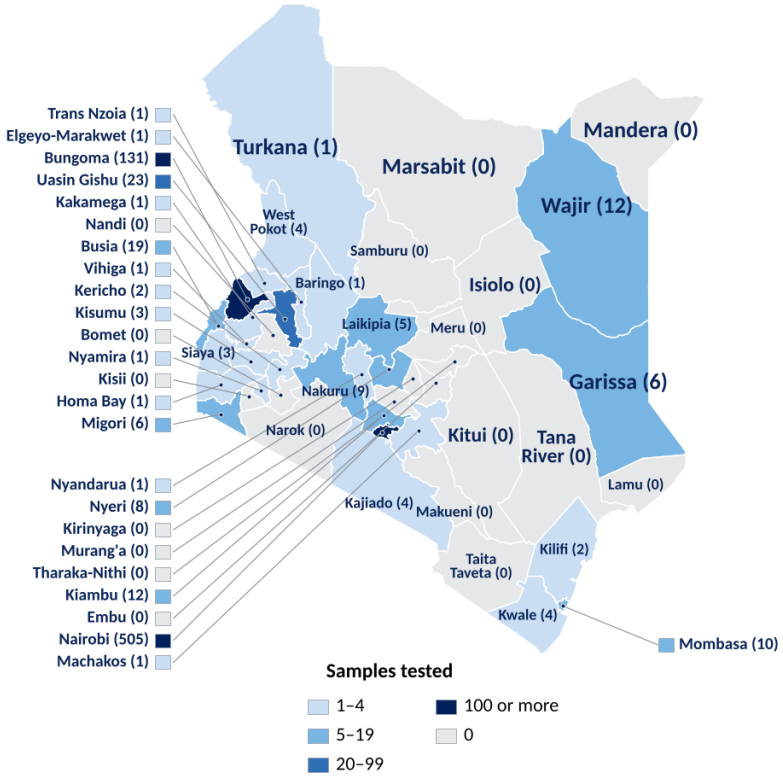


Figure 3: Cumulative samples tested for BVD by county, Kenya, as of 15 November 2026 (29 counties; county counts sum to 778 of 779 samples)

- **Risk communication:** daily social listening and community engagement; media briefings and engagements; press statements; social media campaigns; toll-free hotline 719 (see section 7).

Operational Gaps and Priority Actions

Gap	Priority action
Limited holding, quarantine and isolation capacity	**Expand capacity**, starting with the facilities and PoEs under most pressure
Surge capacity needed to run the expanded treatment centres	**Support treatment units** with point-of-care biochemistry testing (2 Piccolo machines, supplies for at least 100 patients)
Workforce shortages in surveillance, case management and IPC	**Deploy additional trained personnel**; conduct field visits to quarantine units for IPC and clinical management assessments
PoE gaps: PPE, WASH, thermo-scanners, holding space and transport	**Equip priority PoEs** with these items, including transport for suspected cases and specimens
Shortfalls in PPE, laboratory commodities and other supplies	**Quantify, procure and pre-position** supplies for national, county and PoE needs
Sub-optimal inter-pillar collaboration, limiting integration	**Convene a cross-cutting pillar meeting** (IPC, RCCE, surveillance, case management) on community operations; **sensitize community health promoters** in all 27 priority counties

Table 2: *BVD operational gaps and priority actions, Kenya, week 47, 2026*

Preparedness

2. Bundibugyo Virus Disease in the DRC and Uganda; Kenya Readiness

The DRC outbreak remains the largest Bundibugyo outbreak ever recorded: **11,376 confirmed cases and 5,568 deaths (CFR 48.9%)** as of 15 November 2026, with 3,083 recoveries. WHO declared a PHEIC on 15 May 2026, and Africa CDC declared a Public Health Emergency of Continental Security. On 20 October 2026, Nigeria reported one confirmed case in Abuja in a woman with recent travel from Uganda; Uganda reports no active cases. Kenya still stands at high risk of further importation of cases.

DRC Overview

11,376 **Confirmed cases** DRC, cumulative	**5,568** **Confirmed deaths** DRC, cumulative	**48.9%** **Case fatality rate** Confirmed and probable	**3,083** **Recoveries** DRC

Country	Cumulative confirmed cases	New confirmed cases	Cumulative confirmed deaths	Case fatality rate	Recoveries	Outbreak status
DRC	11,376	60	5,568	48.9%	3,083	Active
Kenya	9	0	2	22.2%	7	Active
Nigeria	1	0	0	0.0%	1	Active
Total	**11,386**	**60**	**5,570**	**–**	**3,091**	**–**

**Sources: DRC Institut National de Santé Publique (INSP), 15 November 2026; Nigeria Federal Ministry of Health and Social Welfare, 12 November 2026; Kenya Ministry of Health, 15 November 2026.*

Kenya Preparedness and Readiness

National readiness rose from **66% (May) to 82% (July 2026)**, with the largest gains in IPC, points of entry and logistics. Case management (45%), logistics (65%) and safe and dignified burial (71%) remain below the 80% benchmark.

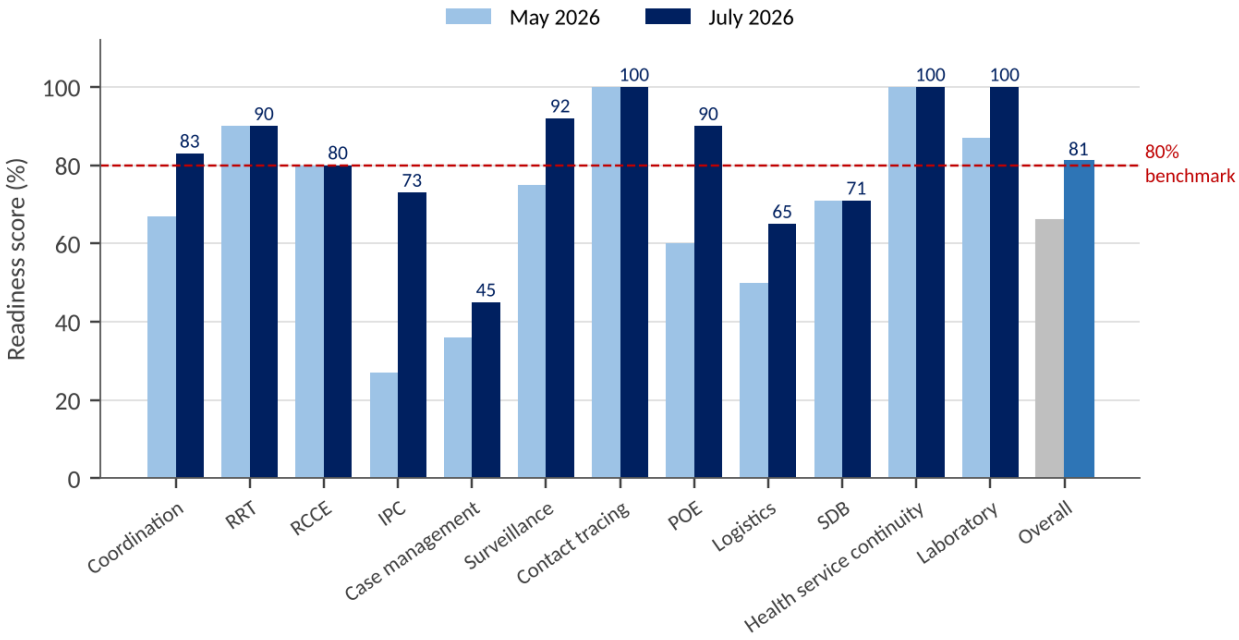


Figure 4: Readiness for BVD by pillar, Kenya, May and July 2026

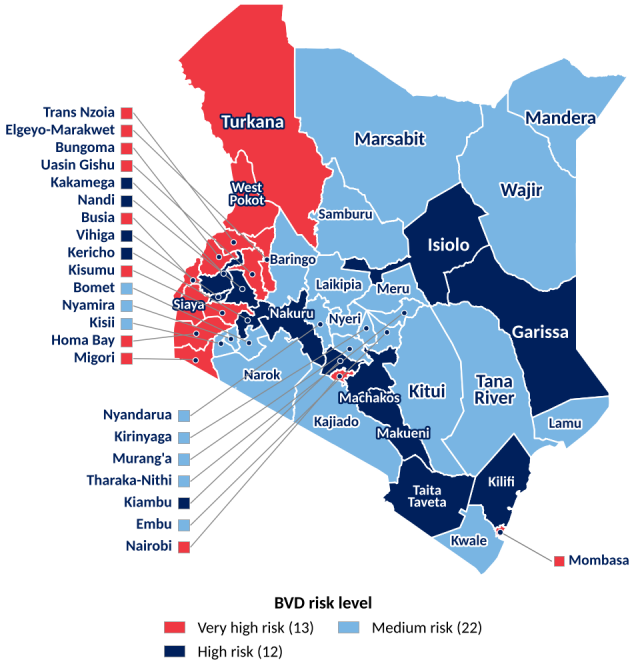


Figure 5: BVD risk classification by county, Kenya, June 2026

13 very high-risk counties: border Uganda or South Sudan, or are international travel hubs (including Nairobi).

12 high-risk counties: heavy population movement through land borders and airports.

22 medium-risk counties: neighbour high-risk counties, with possible spillover.

Training: all very high-risk counties except Homa Bay are trained, and 8 of 12 (67%) high-risk counties. More training is needed to cover both groups.

Other Responses

3. Mpox

New cases	Cumulative cases	New deaths	Total deaths	Recovered	Case contacts	Counties

0	1,354	0	21	1,330	1,376	39

**Ministry of Health, Kenya. Data as of 15 November 2026.*

No new confirmed case was reported in the past week; the 2026 total remains 405 cases in 24 counties. There are 3 active cases (1 in facility care, 2 in home-based care). Since July 2024, 1,354 cases have been reported from 39 of 47 counties (83%). No new death was reported; deaths remain at 21 (CFR 1.6%).

- **Contacts:** 1,376 listed; 1,141 (83%) completed follow-up; 16 became confirmed cases.
- **Hotspot:** Nairobi County accounts for 54% (219/405) of 2026 cases.
- **Laboratory:** 3,296 samples tested (1,354 positive, 1,942 negative, none pending), none in the past week; 257 sequenced, all sub-clade Ib.
- **Points of entry:** 12,259,613 travelers screened at 26 PoEs since July 2024.

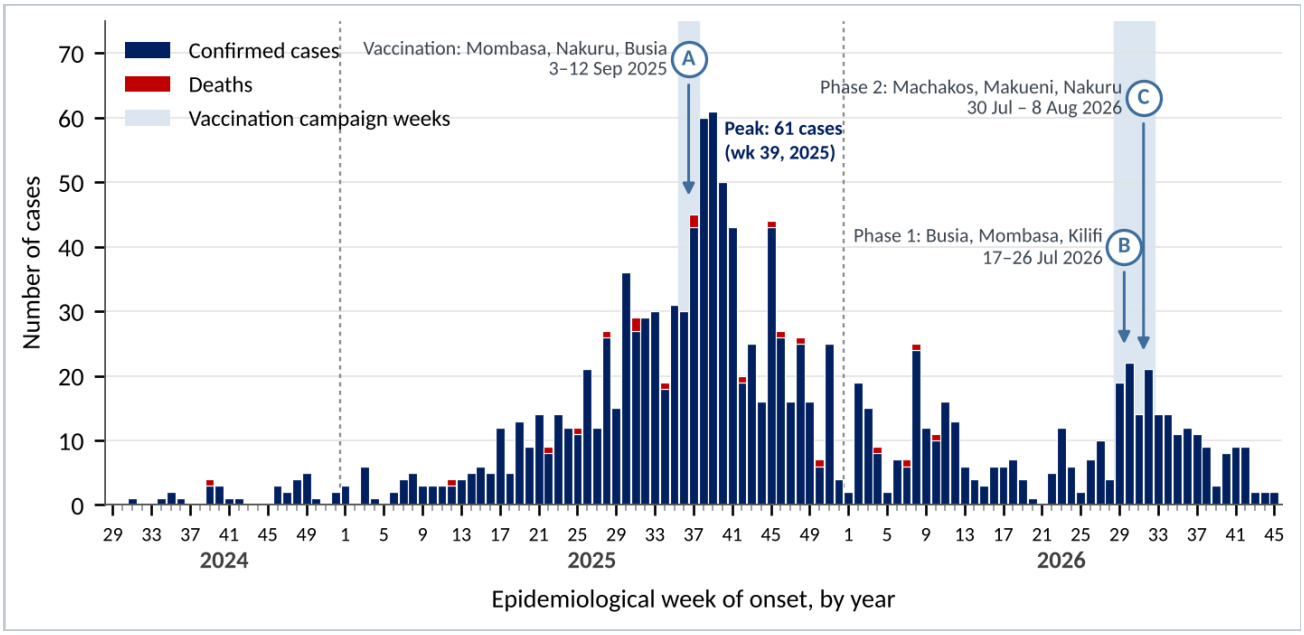


***Figure 6:** Confirmed mpox cases and deaths by week, Kenya, July 2024 – November 2026 (A–C: vaccination campaigns)*

Public Health Interventions

- Second vaccination campaign (20,000 doses) completed: phase 1 in Busia, Mombasa and Kilifi, 17–26 July 2026 (13,948 vaccinated, 105.2% of target); phase 2 in Machakos, Makueni and Nakuru, 30 July – 8 August 2026 (6,009 vaccinated, 105.2%).
- Clinical care and isolation continue in facilities and through home-based care; PoE surveillance and screening are ongoing.
- Transition of the response to the routine health system is under review, in line with continental IMST guidance.

4. Measles

New cases	Cumulative cases	New deaths	Deaths	Case contacts	Counties
19	585	0	3	0	5

**Source: Ministry of Health, Kenya. Data as of 15 November 2026.*

- 19 new cases were reported in the past week, all from Moyale, Marsabit, among Ethiopian refugees in temporary protection sites. No new death.
- Ten counties affected since January 2026; transmission is active in five sub-counties in five counties: Moyale (Marsabit), Dadaab (Garissa), Bura (Tana River), Embakasi North (Nairobi) and Likoni (Mombasa).
- 585 cases to date (140 laboratory-confirmed, 445 suspected) and 3 deaths (CFR 0.5%).
- 52% of cases with known age (295 of 567) are aged ≥10 years; 55% (320) are male.
- Moyale cluster: 38 cases with onset from 15 October to 12 November 2026, mostly among refugees in temporary protection sites (TPS). 23 cases (60.5%) had received no measles vaccine dose. Of 9 specimens tested, 8 were measles IgM-positive and 1 indeterminate; the other cases are epidemiologically linked.
- In Moyale, children aged 0–5 years are most affected (23 cases; median age 4 years) and 21 cases (55%) are male. Qilta and Arosa TPS in Butiye Ward account for 30 cases (79%), followed by Al-Huda TPS, Township Ward (5), OMC TPS, Golbo Ward (2) and Manyatta TPS, Heilu Manyatta Ward (1).

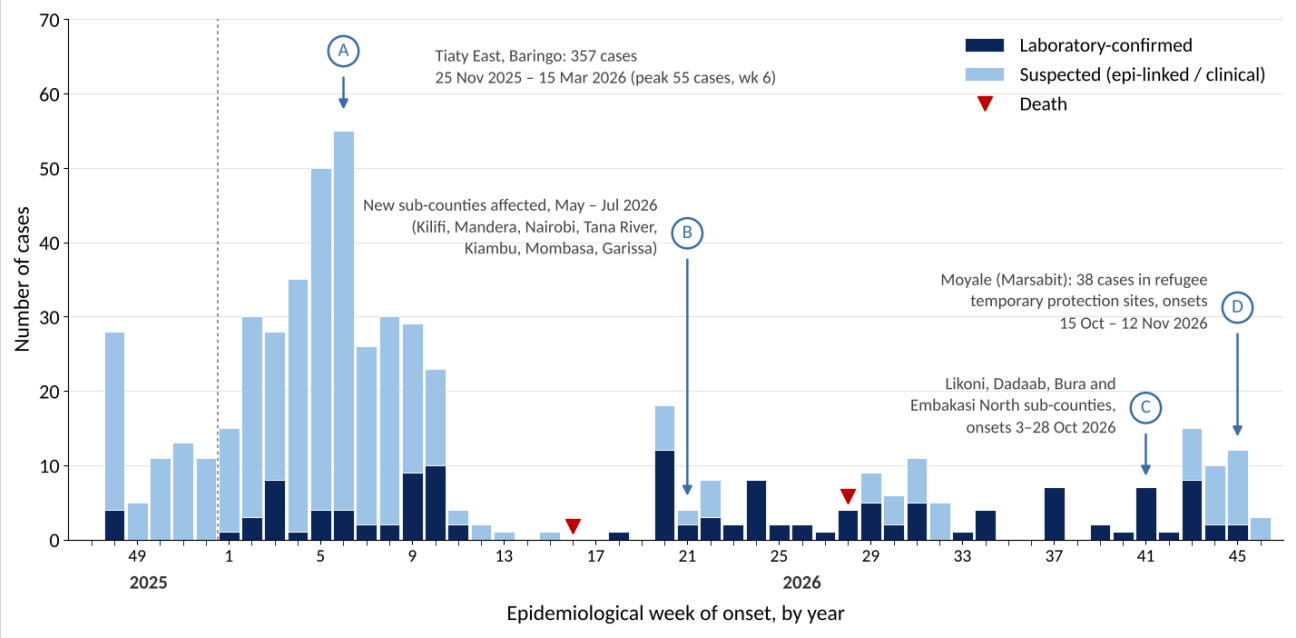


Figure 7: Measles cases by week of onset, Kenya, November 2025 – November 2026 (cases with onset date, n = 541; D: Moyale cluster)

Public Health Response

- Active case search in health facilities and communities.
- Enhanced surveillance in affected counties for early detection and response.
- Supportive care at health facilities reporting cases.
- Moyale: the outbreak has been notified to the Marsabit EOC, and the Health and Nutrition Technical Working Group, chaired by the Sub-County Medical Officer of Health, leads the response. Situation reports and line lists are updated daily, all cases receive vitamin A, samples are shipped to KEMRI for confirmation, and severe cases are referred to Moyale Referral Hospital.

5. Circulating vaccine-derived poliovirus type 2 (cVDPV2)

New cases	Cumulative cases	New deaths	Deaths	Case contacts	Counties
0	1	0	0	0	1

Index case details	
Age / sex	48 months (4 years); female
Origin	Howlwadag Village, Bay Region, Baidoa District, Somalia
Arrival in Kenya / vaccination status	7 July 2026 (new arrival); zero dose
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
Household	10 members (parents and 8 children aged 2–16 years); all new arrivals from Somalia
Seen at facility / sample collected	10 July 2026
Sample sent to laboratory / result	23 July 2026 / 18 August 2026

Table 3: *cVDPV2 index case details, Dadaab, Garissa County*

- The isolate has 37 nucleotide differences from Sabin 2 (VP1) and is genetically linked to an environmental isolate from Beledweyne, Somalia (SOM-BAY-1 emergence group); classified orphan as of 18 August 2026.
- Planning for inactivated poliovirus vaccine (IPV) intensification in the camp and surrounding areas.
- Case investigation completed by WHO, MoH, CORE Group, Kenya Red Cross, MSF and partners; a country response plan covering routine immunization, surveillance and cross-border coordination is being developed.
- All eligible children received measles vaccine, vitamin A and deworming on arrival (MSF); follow-up planned so partially immunized siblings complete their schedule.

Surveillance

6. Integrated Disease Surveillance and Response (IDSR)

Kenya reports weekly on 46 priority diseases, conditions and events under the third edition of IDSR. In weeks 1–45, average **completeness was 82%** and **timeliness 81%** (target 80%). Reporting fell below target in weeks 31–39 and has met the target since week 40; it was **83% in week 45**.

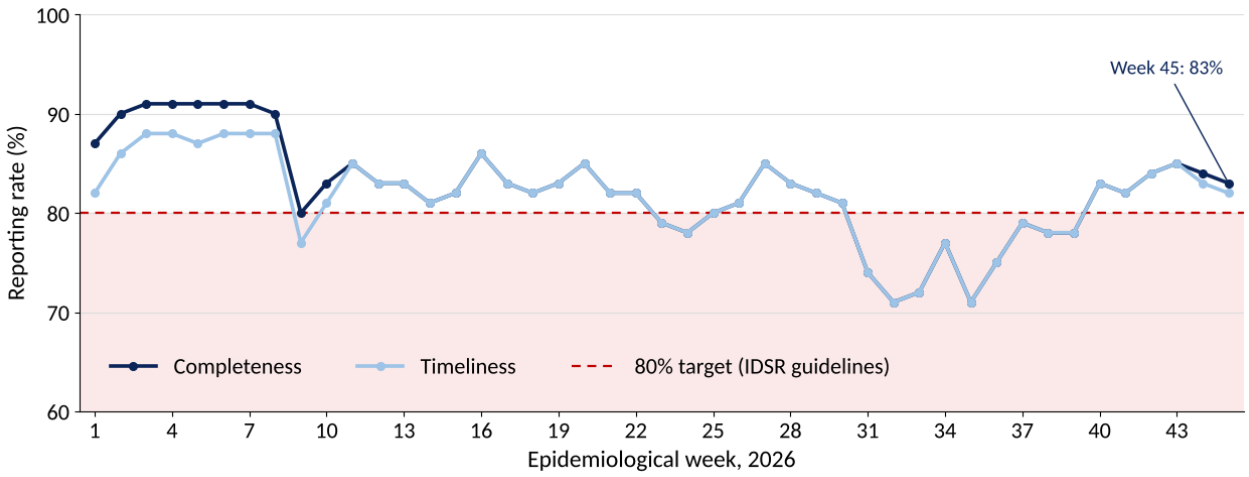


Figure 8: *Completeness and timeliness of IDSR reporting, Kenya, epidemiological weeks 1–45, 2026 (weeks 44–45 read from the MoH chart)*

Completeness of IDSR Reporting by County, Epi Week Weeks 42–45, 2026

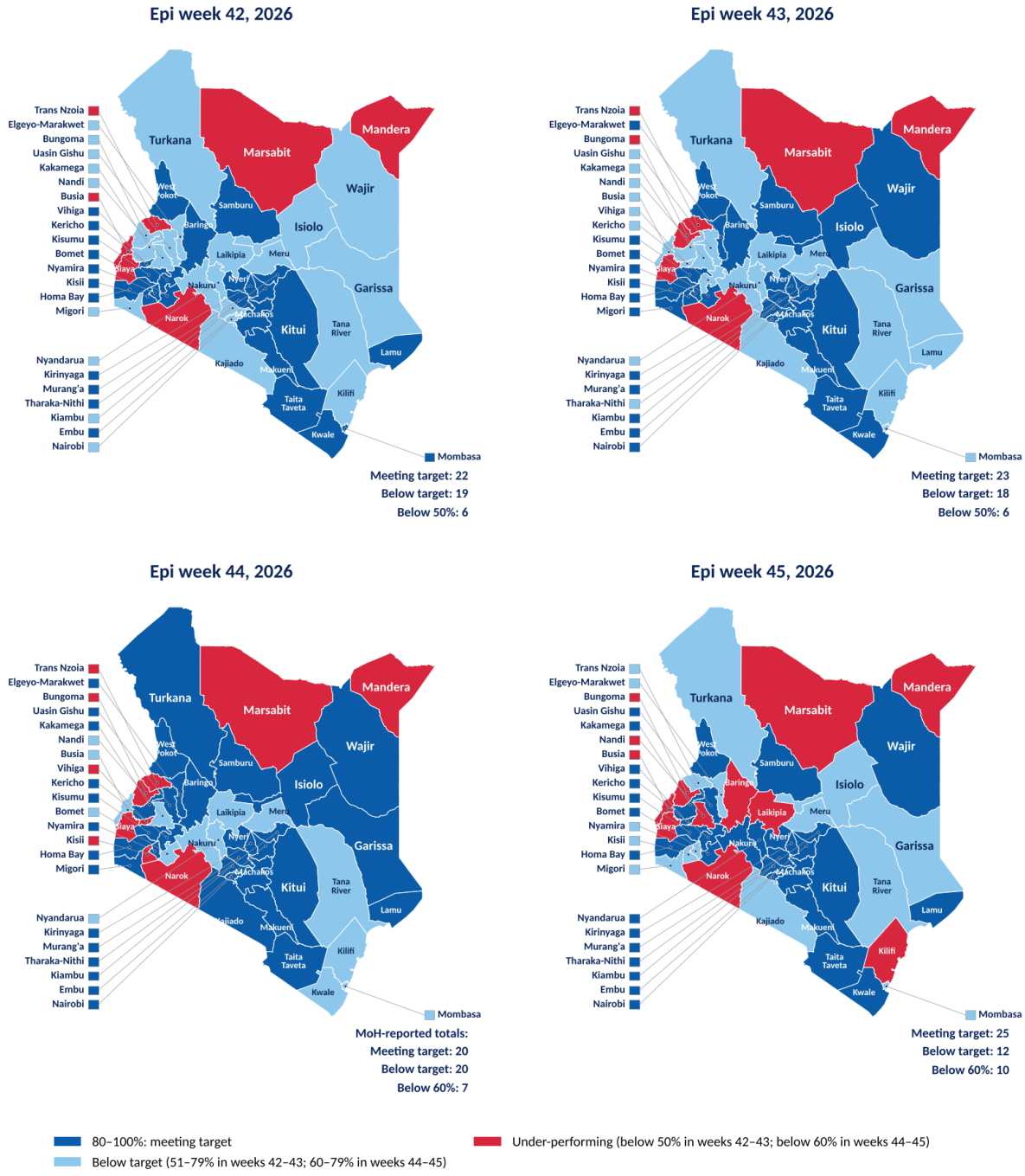


Figure 9: *Completeness of IDSR reporting by county, Epi week weeks 42–45, 2026 (weeks 42–43 as published in earlier reports; weeks 44–45 classified from the MoH county maps, 15 November 2026)*

- In week 45, 25 counties met the 80% target, 11 reported 60–79% and 10 reported below 60%: Baringo, Bungoma, Busia, Kilifi, Laikipia, Mandera, Marsabit, Nandi, Narok and Siaya.
- Marsabit, Mandera and Narok counties have remained in the lowest reporting band every week from week 42 to week 45.

IDSR Interventions

- A dedicated focal person for Integrated Disease Surveillance has been designated by the Kenya National Public Health Institute (KNPHI) to monitor and follow up with low-performing counties, identify reporting gaps in time, and coordinate corrective actions to improve completeness and timeliness.

- The Ministry of Health has planned a national review meeting bringing together all County Surveillance Officers, during which reporting will be a key agenda item.
- 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.

7. Social Listening: Priority Issues and Recommended Responses

Kenya | 13 – 16 November 2026 | Overall infodemic risk: medium

Overall infodemic risk has fallen from high to medium. Ebola discussion is quieter, with no major Kenyan headlines identified, but reduced visibility of MoH updates may create information gaps, weaken trust and allow earlier denial and donor-profiteering narratives to resurface. Continued entry screening also needs clear explanation to prevent anxiety or false reassurance.

Narrative / concern	Risk	Trend	Priority response
Reduced MoH updates and a perceived information vacuum	MEDIUM	↑ Increasing	Publish predictable, dated countdown and surveillance updates, including when there is no material change.
Declining attention and complacency	MEDIUM	↑ Increasing	Maintain proportionate reminders on continued vigilance, early care seeking and the 719 reporting line.
Misunderstanding of entry screening	MEDIUM	↑ Increasing	Explain the limits of screening and how it links to referral, testing and wider surveillance.
Recurring outbreak denial and profiteering claims	MEDIUM	→ Stable	Pre-bunk with the verified timeline and countdown explanation; answer resource-use questions transparently.

Table 4: *Risk matrix from social listening, Kenya, 13 – 16 November 2026 (Kenya National Social Listening report, 16 November 2026). Risk levels and trends are qualitative.*

Priority RCCE Actions

- Maintain scheduled MoH updates on the countdown and surveillance findings.
- Explain that patient recovery and contact release do not constitute formal outbreak closure.
- Reinforce ongoing surveillance, early care seeking and symptom reporting through the toll-free hotline 719.
- Equip media, port-health and community teams with consistent messages.
- Prepare verified holding statements for any suspected or confirmed case report.
- Monitor recurring denial, treatment-trial concerns and accountability questions without amplifying unsupported claims.

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

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