Kenya Medical Association

NATIONAL EXECUTIVE

KMA CENTRE, CHYULU ROAD, P.O. BOX 48502 – 00100 GPO, NAIROBI-KENYA

Mobile: 0722-275695

Email: nec@kma.co.ke Website: www.kma.co.ke

11th June 2026

KMA MEMBERS AND HEALTHCARE WORKERS CIRCULAR

Ebola Virus Disease (Bundibugyo Strain) – Clinical and Preparedness Advisory

1. Situation Overview

The Kenya Ministry of Health, through the Director General for Health, Dr Patrick Amoth, has issued guidance on the current Ebola Virus Disease (EVD) outbreak in the Democratic Republic of Congo (DRC) and Uganda. The KMA endorses and reinforces this guidance in full.

As of 10 June 2026, the DRC has reported 598 confirmed cases and 115 confirmed deaths, with 297 individuals currently hospitalised in isolation. Ituri Province remains the epicentre with 563 confirmed cases. Uganda has reported 19 confirmed cases and 2 deaths. The outbreak is escalating rapidly; confirmed DRC cases have increased nearly six-fold since late May.

The current confirmed Case Fatality Rate (CFR) is approximately 17% in DRC and 7% in Uganda, lower than the historical 25-50% range for Bundibugyo; this likely reflects improved case ascertainment rather than a milder strain and must not be interpreted as reduced severity.

On 17 May 2026, the WHO declared this a Public Health Emergency of International Concern (PHEIC). Kenya has confirmed **no cases.** The Bundibugyo strain has no approved vaccine and no definitive treatment.

2. Why Kenya Is at Risk

Kenya is the primary transport and trade corridor for several landlocked neighbours, including Uganda, DRC, Rwanda, Burundi, South Sudan, and Ethiopia. High volumes of traders, truck drivers, migrant workers, and cross-border communities move daily through Busia, Malaba, Suam, Namanga, and JKIA; much of this movement is informal and continuous.

Border screening is active, and a mobile laboratory has been deployed to Busia to reduce specimen turnaround time. These measures are important but do not eliminate the risk of an undetected imported case. Clinical vigilance at the facility level remains the most important line of defence.

3. Recognising a Suspect Case - High Index of Suspicion

Health care workers must maintain a HIGH INDEX OF SUSPICION. A DETAILED HISTORY IS MANDATORY for every febrile patient. Travel history is a core clinical requirement. Ask every patient about:

- Travel to DRC, Uganda, or South Sudan within the past 21 days
- Contact with a person who has recently travelled from these areas, or with a confirmed or suspected case.

- Sexual contact with a known EVD survivor

Clinical features warranting immediate isolation:

- Acute onset of fever with severe headache, myalgia, or fatigue
- Vomiting, diarrhoea, or abdominal pain
- Unexplained haemorrhage or bruising

Do not wait for travel history confirmation or laboratory results before initiating isolation. Patients may not volunteer history, may be unaware of a contact's travel, or may be too ill to give a coherent account. ISOLATE FIRST. Investigate and initiate supportive management after.

4. Facility Readiness - Prepare Now, Not at Case Presentation

The time to prepare is now. Facilities caught unprepared at the moment of first presentation risk being amplification sites. Notably, many isolation facilities activated during COVID-19 were makeshift and have since been decommissioned or repurposed. Do not assume your facility has a functional isolation area without verifying this today.

***Every facility must immediately*:**

- Identify and designate a physical isolation room with a closing door, separate from general patient flow, with its own waste disposal point
- Ensure PPE is available and accessible at the point of care, NOT in a locked store
- Ensure all clinical staff have been trained on EVD recognition, PPE donning and doffing, and the notification pathway
- Establish clear internal protocols for screening, referral, specimen collection, and healthcare worker exposure management

5. Transmission and Proper Use of PPE

Ebola is transmitted by direct contact with the bodily fluids of an infected person. Fluids implicated include blood, saliva, vomit, diarrhoea, urine, sweat, semen, and vaginal secretions. Direct contact with contaminated fluid on mucous membranes is sufficient for transmission; no breach of intact skin is required. Ebola is NOT airborne under natural conditions.

N95 or FFP2 respirators are required despite the non-airborne primary transmission route because of certain clinical procedures that generate procedural droplets from infected bodily fluids. These include vomiting & diarrhoea management, intubation, suctioning, and bronchoscopy. Combined with a 50% historical CFR and the precautionary principle, this justifies respiratory protection equivalent to aerosol precautions.

Mandatory PPE for any suspect case: double gloves, a gown, a waterproof apron, an N95 or FFP2 respirator, a face shield or goggles, and boot covers. Don before entering the patient area. Doff in the correct sequence under direct supervision, as doffing carries the highest self-contamination risk and must never be done alone. Any unprotected exposure must be reported immediately to the facility IPC officer and public health authorities; do not wait for laboratory confirmation.

6. Diagnostic Investigations

Collect all samples under full PPE. Handle as Category A infectious substances. Coordinate with the receiving laboratory before dispatching any specimen.

Rapid antigen tests (OraQuick Ebola RDT, available in Kenya) have a high specificity and moderate sensitivity; therefore, they are good for ruling in, not ruling out. A negative result does NOT exclude EVD and must not be used to rule out infection in a symptomatic patient with a relevant exposure history.

RT-PCR the confirmatory gold standard, with high sensitivity and high specificity. However, timing matters; viral RNA is detectable from 48-72 hours after symptom onset. A negative result in the first 1-3 days does not exclude EVD; repeat testing after 48 hours is required if clinical suspicion remains high. Kenya CDC multiplex PCR panels can simultaneously test for multiple viral haemorrhagic fever pathogens, which is valuable when the differential is broad.

Serology (ELISA IgM/IgG): limited utility for acute diagnosis. More useful for convalescent confirmation than acute case management.

Routine investigations to guide supportive management: FBC (leucopenia and thrombocytopenia are early features), urea and electrolytes, creatinine, LFTs (AST > ALT pattern), coagulation screen (PT, APTT, fibrinogen, and D-dimer), random blood glucose, malaria RDT, blood cultures, and urinalysis.

Designated Ebola testing laboratories:

- KEMRI Nairobi
- KEMRI Kisumu
- National Public Health Laboratory, Nairobi
- Mobile Laboratory - Busia One-Stop Border Post

7. Clinical Management

There is no approved vaccine or licensed antiviral for Bundibugyo virus disease. Management is entirely supportive. Supportive treatment is significantly more effective when initiated early, before complications such as DIC, renal failure, and haemorrhage are established. Early presentation is the single most modifiable determinant of survival. Initiate supportive care immediately alongside isolation and notification.

- Aggressive fluid and electrolyte replacement
- Nutritional support and hypoglycaemia management
- Antipyretics and pain management. Avoid NSAIDs (platelet dysfunction and GI haemorrhage risk)
- Management of vomiting and diarrhoea
- Empirical broad-spectrum antibiotics, indicated where secondary bacterial infection or sepsis cannot be excluded clinically
- Antimalarials: treat empirically if malaria cannot be excluded pending results, given endemicity and the risk of missing a coexisting treatable condition
- Coagulopathy management: avoid invasive procedures where possible; fresh frozen plasma and platelets only where haemorrhage is life-threatening and in consultation with a haematologist
- Psychological support

The role of the first-contact health care worker is to recognise, isolate, notify, and stabilise. All decisions for a confirmed case must be made in coordination with the national and county Ebola response teams.

8. Post-Ebola Syndrome and Survivor Transmission Risk

Ebola virus persists in immunologically privileged sites after systemic blood clearance. This has direct clinical implications for transmission risk beyond the acute outbreak:

- Eye: viable virus has been detected in aqueous humor months after blood PCR negativity
- CNS: viral RNA detected in CSF months to years post-recovery; survivors may present with neurological sequelae including headache, memory loss, and encephalitis-like features
- Semen and genital secretions: viable virus documented in semen up to 1-2 years post-recovery; sexual transmission from male survivors has been confirmed as the index event in some late flare-ups

All survivors should be enrolled in a structured follow-up programme, counselled on the risk of viral persistence in semen, vaginal secretions, ocular fluid, and CSF, and supported with sequential testing until clearance is confirmed.

9. Reporting and Notification

Any health worker encountering a suspect case must:

- Immediately notify the facility Medical Superintendent or IPC focal person
- Notify the County Public Health Officer
- Contact PHEOC: call 719 or dial *719# (toll-free, 24 hours)
- Arrange specimen dispatch to the designated laboratory network

KMA Position and Recommendations

The KMA calls on all members to discharge their professional obligation to protect themselves, their colleagues, and their patients. Healthcare workers are the first line of detection and response. Our collective vigilance is Kenya's most reliable defence against an imported case becoming a domestic outbreak. The KMA strongly urges all members to follow the advisories issued by the Ministry of Health and the Director General for Health and to treat those advisories as the operational standard for practice during this outbreak.

The KMA further emphasises that **Ebola preparedness is a shared responsibility** requiring action at the facility, county, and national levels:

Health facilities must:

- Ensure adequate PPE, IPC supplies, and functional isolation capacity
- Conduct regular staff training and preparedness drills
- Establish clear screening, reporting, referral, and exposure management protocols
- Provide a safe working environment and psychological support for healthcare workers

County governments must:

- Strengthen county Ebola preparedness and response plans with adequate resourcing
- Ensure PPE, diagnostics, and emergency response resources are available at facility level, particularly in high-risk border counties
- Conduct regular facility preparedness assessments and address identified gaps
- Support surveillance, risk communication, and continuous healthcare worker training

The national government must:

- Provide regular, updated clinical guidelines to support members in maintaining the highest standard of practice
- Sustain and expand the four designated laboratory network and ensure surge capacity planning
- Establish a formal EVD survivor follow-up programme as part of the national response architecture
- Ensure pandemic preparedness investment is sustained beyond the acute outbreak phase and not decommissioned when the immediate threat recedes

Dr Lyndah Kemunto
Secretary General
Kenya Medical Association