MINISTRY OF HEALTH

REGULATORY IMPACT STATEMENT

FOR

THE PUBLIC HEALTH (EBOLA DISEASE) RULES, 2026

2026

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This Regulatory Impact Statement has been prepared by the Ministry of Health pursuant to Sections 6 and 7 of the Statutory Instruments Act, Cap. 2A, in respect of the Public Health (Ebola Disease) Rules, 2026, made by the Cabinet Secretary for Health in exercise of the powers conferred by Section 36 of the Public Health Act, Cap. 242.

DEFINITIONS

TERM	DEFINITION
Act	means the Public Health Act, Cap. 242.
Cabinet Secretary	means the Cabinet Secretary responsible for matters relating to health.
Confirmed case	means a person, whether living or deceased, in whom infection with a virus that causes Ebola disease has been confirmed by an appropriate laboratory diagnostic test.
Contact	means a person reasonably considered, following an assessment of the circumstances of exposure, to have been exposed to infection with a virus that causes Ebola disease through contact with a person who has, or is suspected to have, Ebola disease or with the body of such a person; contact with the blood or other body fluids of such a person; or contact with an infected or contaminated animal, material, article or surface.
Contact tracing	means the identification, listing, assessment and follow-up of contacts for the purposes of detecting illness and preventing the transmission of Ebola disease.
Decontamination	means the application of appropriate cleaning, disinfection or other infection prevention and control procedures to remove or inactivate a virus that causes Ebola disease on premises, conveyances, equipment, articles or other contaminated surfaces.
Ebola disease	means disease in humans caused by a virus belonging to the genus *Orthoebolavirus*, including Ebola virus, Sudan virus, Bundibugyo virus and Taï Forest virus.
Point of entry	means an airport, seaport, inland port or land border crossing through which persons, conveyances or goods enter or leave Kenya and includes the facilities and areas providing services in connection with that entry or departure.

TERM	DEFINITION
Quarantine	means the restriction of activities or separation from other persons of an asymptomatic contact, under medical supervision and in accordance with the Act and the Rules, for the purpose of preventing the possible transmission of Ebola disease.
Rules	means the Public Health (Ebola Disease) Rules, 2026 that are the subject of this Statement.
Screening	means a preliminary assessment to identify a person who may require further clinical assessment, testing or other public health measures in relation to Ebola disease, including obtaining information on symptoms, travel history and possible exposure, reviewing a health declaration, and observing signs of illness or measuring body temperature.
Suspected case	means a person, whether living or deceased, in respect of whom a medical officer of health or medical practitioner has reasonable grounds to suspect Ebola disease, having regard to clinical signs and symptoms, the circumstances of death or relevant epidemiological information.

ABBREVIATIONS

ABBREVIATION	MEANING
IGAD	Intergovernmental Authority on Development
IHR	International Health Regulations (2005)
IMS	Incident Management System
KEMRI	Kenya Medical Research Institute
KNPHI	Kenya National Public Health Institute
NPHEOC	National Public Health Emergency Operations Centre
PHEIC	Public Health Emergency of International Concern
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
RIS	Regulatory Impact Statement
RRT	Rapid Response Team
UHC	Universal Health Coverage
USG	United States Government
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The core mandate of the Ministry of Health is to protect and promote the health of the people of Kenya. Under the Public Health Act, Cap. 242, the Cabinet Secretary for Health holds the power to prevent and suppress infectious and formidable epidemic diseases, in collaboration with county governments.

A Bundibugyo virus disease outbreak was declared in the Democratic Republic of Congo and the Republic of Uganda on 15 May 2026. The World Health Organization declared this outbreak a Public Health Emergency of International Concern (PHEIC) on 17 May 2026, while the Africa Centres for Disease Control and Prevention (Africa CDC) declared it a Public Health Emergency of Continental Security (PHECS) on 18 May 2026. As of 1 October 2026, the Democratic Republic of Congo had reported 8,442 confirmed cases and 4,080 confirmed deaths, a case fatality rate of 48 percent, and the outbreak there remains active. Uganda reported 20 confirmed cases and 2 deaths and declared the end of its outbreak on 28 July 2026.

Kenya has now confirmed its first case of Bundibugyo virus disease on 6 October 2026 in Nairobi County, of a Kenyan who had travelled from the Democratic Republic of Congo and unfortunately succumbed while undergoing treatment. Before this, the national Incident Management System had investigated 262 alerts and tested 266 samples, all negative, as of 4 October 2026.

The Government, through the Ministry of Health and the Kenya National Public Health Institute (KNPHI), has taken the following measures:

a) activation of a national Incident Management System on 20 May 2026, with national and county Public Health Emergency Operations Centres on alert;
b) inauguration of the National EVD Preparedness and Response Taskforce on 20 July 2026;
c) screening of travellers at 15 Points of Entry, with 652,584 travellers screened in total and 3,813 in the 24 hours to 4 October 2026;
d) designation of five laboratories for EVD testing, with sample turnaround time improved to between 6 to 12 hours;

e) designation of six treatment facilities and three screening and holding sites;
f) training of a surge team of 343 personnel and sensitization of 4,971 national and county health workers; and
g) a national risk assessment that identified 25 high-risk counties.

These measures rest on the Kenya Ebola Preparedness, Readiness and Response Plan, 2026 and on administrative directives. The Public Health (Ebola Disease) Rules, 2026 (hereinafter "the Rules") give specific, enforceable effect to these measures under section 36 of the Act.

1.2 PURPOSE OF THE REGULATORY IMPACT STATEMENT

The Regulatory Impact Statement process assesses regulatory proposals and allows members of the public to comment on proposed rules before they are finalised. Public input of this kind provides valuable information and perspectives and improves the overall quality of the Rules. Under the Statutory Instruments Act, Cap. 2A, a regulation-making authority must ensure that statutory instruments are well-targeted, effective and appropriate, and that they impose the lowest possible burden.

A Regulatory Impact Statement (RIS) provides a detailed and systematic appraisal of the likely effects of a proposed statutory instrument and assesses whether it will achieve its intended objectives. It also sets out how the Rules may limit certain fundamental rights, and why those limits are reasonable and justifiable under Article 24 of the Constitution.

1.3 REGULATION-MAKING AUTHORITY AND LEGAL MANDATE

Section 36 of the Act empowers the Cabinet Secretary for Health to make rules to prevent the spread of formidable epidemic, endemic, or infectious diseases. Rules made under section 36 of the Public Health Act, Cap 241 may provide for, among other matters:

a) the notification of cases and suspected cases of infectious disease;
b) the speedy interment of the dead;
c) the inspection of persons and premises;
d) the provision of medical aid and accommodation;
e) the removal and isolation of persons suffering, or suspected to be suffering, from the disease, and the segregation of their contacts;
f) the inspection and detention of vessels, aircraft, vehicles and persons arriving in Kenya;

g) the disinfection and destruction of articles and premises; and
h) the prevention of the spread of the disease from one part of Kenya to another and from Kenya to other countries.

1.4 REQUIREMENTS OF THE STATUTORY INSTRUMENTS ACT, CAP. 2A

Under sections 6 and 7 of the Statutory Instruments Act, Cap. 2A, where a proposed statutory instrument is likely to impose a significant cost on the community or a part of it, the regulation-making authority must, before making the statutory instrument, prepare a Regulatory Impact Statement.

Under the Act, a Regulatory Impact Statement must contain:

a) a statement of the objectives of the proposed statutory instrument and the reasons for them;
b) a statement explaining the effect of the proposed statutory instrument;
c) a statement of other practicable means of achieving those objectives, including regulatory and non-regulatory options;
d) an assessment of the costs and benefits of the proposed statutory instrument and of any other practicable means of achieving the same objectives;
e) the reasons why the other means are not appropriate;
f) any other matters specified by the applicable guidelines; and
g) a draft copy of the proposed statutory instrument.

Section 5 of the Statutory Instruments Act, Cap. 2A further requires a regulation-making authority to conduct public consultations that draw on the knowledge of persons with relevant expertise, and that give persons likely to be affected by the proposed statutory instrument an opportunity to contribute to the development of the instrument.

CHAPTER 2

OBJECTIVES OF THE PUBLIC HEALTH (EBOLA DISEASE) RULES, 2026

2.1 GENERAL OBJECTIVE

The general objective of the Rules is to prevent and control the transmission of Ebola disease in Kenya through enforceable public health measures proportionate to the public health risk and implemented with respect for human dignity and fundamental rights and freedoms.

2.2 SPECIFIC OBJECTIVES

Rule 3 of the draft Rules sets out the following objects:

a) to facilitate the timely detection, notification and investigation of Ebola disease;
b) to prevent and control its transmission through surveillance, contact tracing and appropriate public health measures;
c) to facilitate safe assessment, referral and care of persons with suspected or confirmed Ebola disease;
d) to protect health workers and other persons involved in the response, and to provide for safe and dignified handling and burial of deceased persons; and
e) to ensure that measures for preventing and controlling Ebola disease are proportionate to the public health risk and implemented with respect for human dignity and fundamental rights and freedoms.

2.3 OBJECTIVES BY PART

The Rules establish a framework for preventing and controlling the importation and spread of Ebola disease through public health measures at points of entry, including screening, medical assessment, isolation, referral and monitoring of contacts, as well as the inspection and decontamination of conveyances and the imposition of obligations on conveyance operators.

They provide for the timely notification of suspected or confirmed cases, prompt investigation, contact tracing, isolation and quarantine in accordance with the law, designation of health facilities, and decontamination of affected premises.

The Rules further prescribe procedures for the safe and dignified handling, transportation, burial and repatriation of the bodies of persons who have died from suspected or confirmed Ebola disease.

In addition, they provide for the declaration of infected areas, public sensitization through media houses, police assistance in enforcing public health measures, offences and penalties for non-compliance, and the review and duration of the Rules.

CHAPTER 3

BACKGROUND AND CONTEXT

3.1 INTERNATIONAL CONTEXT

Ebola disease is a severe and often fatal viral hemorrhagic fever. Human-to-human transmission occurs through direct contact with the blood or body fluids of an infected person, with contaminated materials, and with the bodies of persons who have died of the disease. The incubation period ranges from 2 to 21 days, and healthcare workers, caregivers and burial teams carry the highest risk.

The 2014 to 2016 outbreak in Guinea, Liberia and Sierra Leone caused 11,310 deaths and an estimated total economic and social cost of USD 53.19 billion (Huber et al., 2018). That outbreak showed that weak legal frameworks, unsafe burials, health facility transmission and community mistrust can turn a small number of cases into a national and regional crisis.

The World Health Organization declared the current Bundibugyo virus disease outbreak a Public Health Emergency of International Concern on 17 May 2026. Under the International Health Regulations (2005), this declaration obliges States Parties to apply the temporary recommendations issued, and to maintain capacities to detect, assess, notify and respond to cases, including at points of entry.

No licensed vaccine or therapeutic exists for the Bundibugyo virus, even as candidate vaccines and treatments for other virus species remain under evaluation through WHO trial platforms (the only licensed vaccine and the WHO-recommended monoclonal antibody treatments act against Zaire ebolavirus only). As such, public health measures backed by law become the main line of defence.

3.2 REGIONAL CONTEXT

Table 1 shows the regional situation as of 1 October 2026.

Country	Confirmed cases	Confirmed deaths	Case fatality rate	Recovered	Status
Democratic Republic of Congo	8,442	4,080	48%	2,213	Active
Uganda	20	2	10%	18	Controlled
Kenya	1	1	100%	0	

Table 1: Regional situation of Bundibugyo virus disease (Sources: DRC INSP situation report of 1 October 2026, WHO, and the Ministry of Health)

The outbreak in the Democratic Republic of Congo continues to rise; Kenya shares the Northern Corridor with Uganda and the Democratic Republic of Congo. Trucks move goods daily from the Port of Mombasa through Busia and Malaba into Uganda and onward.

3.3 DOMESTIC CONTEXT

Prior to Kenya confirming its first case, a national risk assessment identified 25 high-risk counties:

- **Very high risk:** Nairobi, Mombasa, Uasin Gishu, Busia, Kisumu, Bungoma, Trans Nzoia, Siaya, West Pokot, Turkana, Homa Bay and Migori.
- **High risk:** Vihiga, Kakamega, Nakuru, Kericho, Nandi, Kiambu, Machakos, Makueni, Kilifi, Taita Taveta, Isiolo, Elgeyo Marakwet and Garissa.

The overall national readiness score rose from 66 percent in May 2026 to 81 percent in July 2026. Infection Prevention and Control readiness rose from 27 to 73 percent, Points of Entry readiness from 60 to 90 percent, and surveillance from 75 to 92 percent. Case management readiness remained low, rising from 36 to 45 percent.

Current isolation capacity stands at 8 beds at Kenyatta National Hospital, 20 ICU-grade beds and 30 surge beds at Moi Teaching and Referral Hospital, and 49 beds at the National Police Service Hospital. An assessment of 27 high-risk counties found that 23 facilities need upgrading to WHO standards.

Under the Fourth Schedule to the Constitution, the national government holds responsibility for health policy and national referral facilities, while county governments deliver county health services. Effective outbreak response requires both levels of government to act under one clear legal framework.

3.4 UNIVERSAL HEALTH COVERAGE

The Constitution guarantees every person the right to the highest attainable standard of health. Achieving Universal Health Coverage (UHC) depends on a resilient health system that can prevent, detect, and respond effectively to public health emergencies. An uncontrolled Ebola outbreak could strain health system capacity, divert essential healthcare resources to outbreak response and disrupt routine health services, thereby undermining progress towards UHC.

The Rules support the realisation of UHC by providing a framework for early detection and containment of Ebola disease, and by requiring health facilities to assess appropriately, provide care and ensure the safe referral of suspected and confirmed cases. These measures aim to limit transmission, protect health workers and the public, and sustain essential health services.

CHAPTER 4

EVALUATION OF THE PROBLEM

4.1 IDENTIFIED CHALLENGES

The Kenya Ebola Preparedness, Readiness and Response Plan, 2026, the national risk assessment and the July 2026 readiness reassessment identify the following challenges:

a) the absence of an Ebola-specific legal framework, since current measures rest on the Plan and on administrative directives that have no force of law;
b) a confirmed case in Kenya, which raises the risk of local transmission through contacts who are not identified, followed up or quarantined;
c) the risk of further importation from the Democratic Republic of Congo, where the outbreak remains active and growing;
d) porous borders, informal crossing points and lake transport that bypass screening at official Points of Entry;
e) low self-reporting by high-risk travellers;
f) limited Ebola treatment, isolation and quarantine capacity, with 23 facilities in high-risk counties requiring upgrading to WHO standards;
g) gaps in human resources and surge capacity, PPE, test kits and IPC commodities;
h) unsafe burial and funeral practices, including washing and handling of bodies, and the transport of bodies across counties and borders;
i) fear, stigma, misinformation and community resistance to isolation, contact tracing and safe burial; and
j) unclear legal duties for conveyance operators, health facilities, heads of institutions and media houses.

4.2 OPPORTUNITIES FOR KENYA

The Rules present the following opportunities for strengthening Kenya's preparedness for and response to Ebola disease:

a) **Early containment of transmission.** Establishing enforceable requirements for case notification, contact tracing, isolation and quarantine will strengthen capacity to detect and contain infections promptly, reducing the risk of further transmission.

b) **Compliance with international obligations.** The Rules provide a legal framework for implementing Kenya's obligations under the International Health Regulations (2005), including measures necessary to prevent, protect against, control and respond to the international spread of disease, consistent with applicable international requirements.

c) **Protection of trade and travel.** Effective and proportionate screening, surveillance and containment measures can reduce the risk of wider transmission and help minimise the likelihood of disruptive travel and trade restrictions, while facilitating the movement of people and goods in accordance with public health requirements.

d) **Mobilisation and effective utilisation of partner support.** The commitments and support provided by development and cooperation partners, including the World Bank, the United States Government and the Intergovernmental Authority on Development (IGAD), present an opportunity to strengthen preparedness and response capacity. A clear legal framework can support coordination, accountability and the effective utilisation of these resources.

e) **Strengthening health system resilience.** Investments in isolation facilities, laboratory capacity, infection prevention and control, trained personnel and emergency surge capacity will strengthen the health system's ability to respond to Ebola and other infectious disease outbreaks.

f) **Enhancement of public trust and community cooperation.** Clear procedures and safeguards for protecting individual rights, human dignity and due process, including appropriate review of public health orders and family participation in burial arrangements, can strengthen public confidence, promote compliance with public health measures and support community engagement.

4.3 CHALLENGES AFFECTING EBOLA PREPAREDNESS AND RESPONSE IN KENYA

Kenya's preparedness for and response to Ebola disease is affected by the following challenges:

a) **Epidemiological risk.** The reported confirmed case in Kenya, alongside the outbreak situation in the neighbouring Democratic Republic of Congo, heightens the risk of further importation and potential local

transmission, necessitating sustained surveillance, rapid detection and effective containment measures.

b) **Geographical and population mobility risks.** Cross-border trade, shared transport corridors, fishing activities, population displacement, refugee movements and international air travel create multiple pathways through which infections may be imported, complicating surveillance and containment efforts.

c) **Health system capacity constraints.** Limitations in case management readiness, isolation capacity, availability of personal protective equipment (PPE) and access to adequately trained personnel may compromise infection prevention and control, increase the risk of healthcare-associated transmission and constrain the management of suspected and confirmed cases.

d) **Socio-cultural and community-related risks.** Unsafe burial practices, stigma, misinformation and limited community awareness may undermine early reporting, timely care-seeking and adherence to public health measures, increasing the risk of transmission.

e) **Occupational exposure risks.** Healthcare workers, laboratory personnel, Port Health officers, ambulance teams, burial teams, Community Health Promoters and transport-sector workers, including truck drivers, face increased exposure in the course of their duties. Inadequate protective equipment, training and adherence to infection prevention and control protocols may heighten these risks.

f) **Operational and logistical constraints.** Gaps in logistics and supply chains, delays in procurement and limitations in human resources may impede timely implementation of response measures. In particular, the reported operation of the public health call centre for only eight hours a day, attributed to insufficient staffing, may constrain timely reporting, information dissemination and access to response services.

4.4 CONCLUSION

The Ebola threat presents a significant public health concern for Kenya, particularly considering the reported confirmed case and the outbreak witnessed in the neighbouring Democratic Republic of Congo. The absence of a licensed vaccine or specific licensed treatment for Bundibugyo virus disease further underscores the importance of early detection, prevention, effective case management and rapid containment. Although existing preparedness measures have reportedly attained an implementation level of 81 per cent, the extent to which these measures are enforceable remains a critical consideration where

they rely on administrative directives without an adequate binding legal framework.

The Rules seek to address this gap by establishing legally binding obligations, procedures and enforcement mechanisms for the prevention and control of Ebola disease. They provide a basis for coordinated action across points of entry, health facilities and affected communities, while incorporating safeguards for individual rights and human dignity.

CHAPTER 5

POLICY AND LEGAL FRAMEWORK FOR THE RULES

5.1 INTRODUCTION

The proposed Rules will be implemented within the framework of international health obligations, the Constitution of Kenya, national laws governing public health and national health policies on disease prevention and control.

5.2 INTERNATIONAL PROTOCOLS, CONVENTIONS AND AGREEMENTS

Kenya's preparedness for and response to Ebola disease is informed by international and regional instruments governing public health emergencies, infectious disease surveillance, cross-border cooperation, and biosafety and biosecurity. The principal instruments and frameworks relevant to the Rules include:

a) **International Health Regulations (2005).** The International Health Regulations (2005) (IHR) establish a framework for the prevention, detection, assessment, notification and response to public health risks that may have international implications. They require States Parties to maintain core public health capacities, including at designated points of entry, and provide for the implementation of applicable temporary recommendations issued by the World Health Organization following the determination of a Public Health Emergency of International Concern.

b) **Constitution of the World Health Organization and technical guidance.** The World Health Organization's Constitution provides the institutional foundation for international cooperation in public health. On the other hand, WHO technical guidance on Ebola and Marburg virus diseases informs the development of evidence-based measures for case detection, clinical management, infection prevention and control, safe and dignified burial practices, and outbreak containment.

c) **Biological weapons prohibition and biosecurity instruments.** The Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their

Destruction, together with United Nations Security Council Resolution 1540 (2004), provides a broader framework for preventing the misuse of biological agents and strengthening relevant controls. These instruments are relevant to the safe handling, management and security of dangerous biological materials.

d) **East African Community framework.** The Treaty for the Establishment of the East African Community and applicable regional health and cooperation instruments provide a basis for collaboration among Partner States on public health, disease surveillance and cross-border health threats. The Rules strengthen Kenya's capacity to detect and manage imported cases and coordinate public health measures where necessary.

e) **Africa Centres for Disease Control and Prevention framework.** The Africa Centres for Disease Control and Prevention provides a continental framework for coordinating responses to public health threats, strengthening surveillance and supporting cooperation among African Union Member States. The declaration of the outbreak as a Public Health Emergency of Continental Security on 18 May 2026, underscores the importance of coordinated regional preparedness and response.

5.3 CONSTITUTIONAL MANDATE AND PROTECTION OF FUNDAMENTAL RIGHTS

Article 43(1)(a) of the Constitution of Kenya, 2010, guarantees every person the right to the highest attainable standard of health, including the right to healthcare services. Article 21 places an obligation on the State to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights and to take legislative, policy and other measures towards their progressive realisation.

The Fourth Schedule to the Constitution distributes health functions between the national and county governments. The national government is responsible for health policy and national referral health facilities, while county governments are responsible for county health services, including county health facilities and pharmacies, ambulance services, and the promotion of primary healthcare, among other functions.

The prevention and control of Ebola disease therefore require coordinated action across the two levels of government. The proposed Rules provide a regulatory basis for specified public health interventions while operating within the constitutional allocation of functions and the respective statutory mandates of the institutions responsible for implementation.

5.3.1 LIMITATION OF RIGHTS UNDER THE RULES

The implementation of certain measures contemplated by the Rules may limit the exercise of constitutional rights, including freedom of movement, privacy and freedom of religion and belief, and cultural rights. Article 24 of the Constitution permits the limitation of a right or fundamental freedom only to the extent that the limitation is reasonable and justifiable based on human dignity, equality and freedom. Article 24(2) further requires legislation limiting a right to expressly state that the right is being limited and to specify the nature and extent of the limitation. The measures proposed in these Rules shall not extend beyond what is reasonably required to prevent or control transmission and appropriate procedural and substantive safeguards shall be provided.

Table 2 identifies the principal rights potentially affected by the Rules, the corresponding public health measures and the safeguards provided in the draft.

Constitutional right	**Limitation under the Rules**	**Safeguards under the Rules**
Freedom and security of the person (Article 29) and freedom of movement (Article 39)	Isolation of suspected or confirmed cases, quarantine and movement restrictions affecting contacts (Rules 6, 7 and 13); infected area orders (Rule 19); and police assistance in enforcing lawful orders (Rule 21).	Written orders specifying grounds, requirements, duration and review under Rule 7(4); exclusion of arrival from an affected country, by itself, as a ground for quarantine under Rule 7(6); cessation of orders when their grounds no longer exist under Rules 7(5) and 13(6)(c); access to care, food, water and essential assistance under Rule 13(6)(b); access to essential healthcare and supplies in infected areas under Rule 19(2); and return under medical supervision under Rule 21(2).

Right of a citizen to enter Kenya (Article 39(3))	Referral for refusal of entry in circumstances involving refusal to undergo lawful screening under Rule 5(5)(a).	Rule 5(6) excludes Kenyan citizens from refusal of entry on this ground.
Freedom and security of the person, including bodily integrity (Article 29)	Medical examination and specimen collection under Rules 6(4), 12(2)(c) and 16(2).	Examination and specimen collection by qualified personnel, with informed consent except where otherwise lawfully authorised, under Rules 6(4) and 12(5).
Right to privacy (Article 31)	Collection of health declarations and passenger or crew records, and access to information for disease investigations under Rule 5, Rule 8(b) and Rule 12.	Limitation of information collected to what is reasonably required and secure provision of records under Rule 8(b), alongside applicable requirements of the Data Protection Act, 2019.
Freedom of religion and belief (Article 32) and cultural rights (Article 44)	Restrictions on washing, embalming, undressing or redressing the bodies of persons who have died from suspected or confirmed Ebola disease, and requirements for handling by trained personnel under Rule 16(3) and (4).	Consultation with next of kin, family participation and observance of religious or cultural practices, where compatible with public health requirements, under Rule 17(2); identification of the grave and communication of its location to the next of kin under Rule 17(4); and removal of restrictions where Ebola disease is excluded under Rule 16(6).
Right to property (Article 40)	Decontamination and restrictions on the use of, or destruction of, conveyances, premises	Written directions specifying grounds and conditions for restoration under Rules 9(2) and 15(3); destruction only where decontamination is

	and articles under Rules 9 and 15.	insufficient under Rule 15(5); and prompt lifting of restrictions when no longer necessary under Rules 9(3) and 15(4).

Table 2: Constitutional Rights Potentially Limited by the Rules and Corresponding Safeguards (Source: Constitution of Kenya, 2010, and the draft Rules)

5.4 LEGAL FRAMEWORK GOVERNING PUBLIC HEALTH AND DISEASE CONTROL

(i) Public Health Act, Cap. 242

The Public Health Act, Cap. 242, is a principal statutory instrument governing the prevention and suppression of infectious diseases in Kenya. Section 36 provides the rule-making basis identified for the proposed measures, including provisions relating to notification, isolation, inspection, disinfection, the disposal of the dead and the control of conveyances, as well as the application of relevant measures to specified areas by order.

The proposed Rules seek to operationalize the applicable statutory powers in the specific context of Ebola disease by establishing procedures and obligations for screening at points of entry, notification and investigation of suspected cases, isolation and quarantine, contact tracing, decontamination, safe management of bodies and enforcement of public health measures.

(ii) Health Act, Cap 241

The Health Act, Cap 241, provides the framework for the organization and delivery of health services and the protection and promotion of public health. The Rules should be interpreted and implemented consistently with the Health Act, the Public Health Act and other applicable legislation, without displacing statutory functions or creating powers beyond those conferred by law.

Other Applicable Legislation

The implementation of the Rules will require coordination with other laws governing immigration, law enforcement, registration of deaths, data protection,

broadcasting, occupational safety, environmental management and the making of subsidiary legislation. The principal laws include:

a) Data Protection Act, 2019, Cap. 411C.
b) Occupational Safety and Health Act, 2007, Cap. 236A.
c) Environmental Management and Co-ordination Act, 1999, Cap. 387.
d) Kenya Citizenship and Immigration Act, 2011, Cap. 172.
e) National Police Service Act, 2011, Cap. 84.
f) Births and Deaths Registration Act, Cap. 149.
g) Statutory Instruments Act, Cap. 2A.

5.5 NATIONAL LAWS AND POLICY FRAMEWORK

The Rules are informed by national policies, preparedness plans, technical guidelines and operational protocols designed to strengthen disease surveillance, emergency response, health system resilience and universal access to essential health services.

The principal policy and technical instruments include the Kenya Health Policy; the Kenya Ebola Preparedness, Readiness and Response Plan, 2026; the national Integrated Disease Surveillance and Response guidelines; national infection prevention and control standard operating procedures; Ebola virus disease pocket guidelines; Ebola virus disease specimen management guidelines; the Universal Health Coverage policy framework; and the *One Health* approach.

These instruments provide policy direction and technical guidance on surveillance, case identification, notification, specimen collection and transportation, laboratory diagnosis, clinical management, infection prevention and control, contact tracing, risk communication and community engagement.

5.6 INSTITUTIONAL FRAMEWORK

Effective implementation of the Rules will be through collaboration by National and County government institutions.

5.7 CONCLUSION

Kenya's constitutional, policy and legal framework provide a firm foundation for the Rules. The Rules give specific, enforceable effect to section 36 of the Act, contain safeguards for each limitation of rights, and align Kenya's domestic regime with the International Health Regulations (2005).

CHAPTER 6

PUBLIC PARTICIPATION AND STAKEHOLDER ENGAGEMENT

6.1 LEGAL REQUIREMENTS RELATING TO PUBLIC PARTICIPATION AND CONSULTATION

Participation of the people, inclusivity, transparency and accountability are national values and principles of governance under Article 10 of the Constitution. They bind the State whenever it makes or implements law or public policy. This requirement rests on the sovereignty principle under Article 1. Article 174(c) of the Constitution enhances the participation of the people in the exercise of State power and in decisions affecting them. Article 232(1)(d) requires the involvement of the people in the process of policymaking.

The Statutory Instruments Act, Cap. 2A requires a regulation-making authority to undertake public consultation before making a statutory instrument.

6.2 STAKEHOLDERS CONSULTED

Due to the urgency of the Rules, the Ministry consulted the following key stakeholders in their development:

(i) Ministry of Health SAGAs and MDAs including the National Public Health Institute, the National Public Health Emergency Operations Centre, Port Health Services, the National Public Health Laboratory Services and the Kenya Medical Research Institute;
(ii) the Office of the Attorney-General and Department of Justice;
(iii) the Council of Governors; and
(iv) The Law Reform Commission

During implementation of the Rules, the Ministry will:

a) engage all 47 counties to ensure fully operational county Public Health Emergency Operations Centres;
b) build the capacity of healthcare workers on the requirements of the Rules, including notification, isolation, infection prevention and control, and safe and dignified burial; and

c) build the capacity of the public to understand and comply with the Rules.

The Ministry will use the media, including radio, television, print and social media platforms, to communicate the Rules to the public.

CHAPTER 7

OVERVIEW OF THE RULES

The Cabinet Secretary for Health makes these Rules under section 36 of the Public Health Act (Cap. 242) to detect, notify, investigate and contain Ebola disease across Kenya. While the Rules define Ebola disease broadly, the definition covers all other ebolavirus species, including the Ebola, Sudan, Bundibugyo and Taï Forest viruses. The objects require measures that match the public health risk and respect human dignity and fundamental rights.

7.1 PART II: POINTS OF ENTRY (RULES 5 TO 9)

Port health officers may screen anyone entering or leaving Kenya and require a health declaration. A non-citizen who refuses screening may face referral for refusal of entry, while a citizen cannot be refused entry. Officers must arrange medical assessment, testing, isolation and referral for suspected cases, including persons in transit. Contacts receive daily follow-up for 21 days from last exposure. Any quarantine order must state its grounds, duration and review arrangements. Arrival from an affected country alone does not justify quarantine. Conveyance operators must report suspected cases or deaths on board, share passenger and crew records, and cooperate with transfer and decontamination.

7.2 PART III: NOTIFICATION AND DISEASE CONTROL (RULES 10 TO 15)

Any person who suspects an Ebola case or death must notify a medical officer of health or the nearest health facility at once. Heads of schools, workplaces and institutions carry this duty for people under their care. Practitioners, facilities and laboratories must notify immediately and follow oral reports with a written record. Medical officers of health must investigate, trace contacts and collect specimens. Community health personnel may assist but cannot order compulsory measures. Persons in isolation or quarantine must receive care, food, water and essential assistance. The Cabinet Secretary, with county governments, designates and gazettes isolation and treatment facilities. Officers may order decontamination and restrict use of premises. Destruction of articles applies only where decontamination fails. A person shall be released from

quarantine or isolation only in accordance with the conditions and criteria set out in the approved Ministry protocols.

7.3 PART IV: INTERMENT (RULES 16 TO 18)

Only trained personnel in protective equipment may handle bodies. Bodies go into sealed, labelled body bags and may not be washed, embalmed or redressed. The medical officer of health arranges prompt burial, consults next of kin and allows family participation and cultural or religious observances within infection control limits. Graves must remain identifiable, with records kept. Moving a body out of Kenya requires written approval from the medical officer of health.

7.4 PART V: MISCELLANEOUS (RULES 19 TO 23)

The Cabinet Secretary may declare infected areas by order, with a set duration and access to essential care and supplies. The National Police Service may help enforce isolation and quarantine orders, under medical supervision. Offences include non-compliance, giving false information and helping someone escape isolation or quarantine. The penalty is a fine of up to KES 50,000, imprisonment of up to six months, or both. The Cabinet Secretary for Health must review the Rules at least every three months. The Rules will lapse one year after commencement unless revoked earlier.

CHAPTER 8

THE COST-BENEFIT AND IMPACT ANALYSIS FOR THE RULES

8.1 INTRODUCTION

The implementation of the proposed Ebola Rules is intended to strengthen Kenya's legal and operational capacity to prevent, detect and control the spread of Ebola disease.

Implementing these measures will require financial, human, technical and logistical resources from the national and county governments, health facilities and other relevant institutions. However, effective implementation may also generate substantial public health and socioeconomic benefits by reducing transmission, limiting the scale and duration of outbreaks, protecting healthcare workers, and maintaining continuity of essential health services, trade and travel.

The costs that can be directly attributed to the development of these Rules are compliance costs for conveyance operators, health facilities, families and travellers.

8.2 COST ANALYSIS

The costs of implementing the Rules will depend on the scale of implementation, the number of suspected cases and contacts requiring investigation or monitoring, the volume of cross-border movements, and the capacity of existing health and emergency response systems. The Kenya Ebola Preparedness, Readiness and Response Plan 2026, Section 9 budgets KES 6.358 billion for preparedness and response from May to December 2026. The Rules give legal force to activities identified under the Plan. A single uncontained imported case could cost far more in lives, health spending, trade and tourism.

Table 3 illustrates the costs that can be directly attributed to the operational scale of preparedness that may be required for effective implementation of the Rules.

Cost category	Nature of expenditure	Institutions likely to incur costs
Surveillance and screening	Screening equipment, health declarations, surveillance systems, personnel and referral arrangements at designated points of entry.	Ministry of Health and Ministry of Interior and National Security.
Case investigation and contact tracing	Field investigations, transport, communication, monitoring of contacts and deployment of rapid response teams.	National and county health departments
Isolation, quarantine and clinical care	Designation and operation of isolation facilities, patient transport, clinical supplies, food, water and essential support for affected persons.	National and county governments, designated health facilities.
Laboratory services	Specimen collection, packaging, transportation, diagnostic testing, laboratory consumables and quality assurance.	National laboratory network, KEMRI and other authorised laboratories.
Infection prevention and control	Personal protective equipment, disinfectants, hand hygiene facilities, training and safe handling of infectious waste.	Health facilities, laboratories, emergency response teams and relevant employers.
Safe management of bodies	Trained personnel, protective equipment, safe transportation, burial materials and family liaison services.	National and County health departments.
Public communication and community engagement	Public education, media messaging, interpretation, community outreach, misinformation management and accessible information materials.	Ministry of Health and County governments.
Enforcement and administration	Training of authorised officers, preparation and service of orders, recordkeeping, legal	Ministry of Health, county governments and

	guidance, compliance monitoring and review of decisions.	
Coordination and information management	Incident management, secure data systems, inter-agency coordination, reporting and monitoring of implementation.	National and county governments and Ministry of Interior and National Security.

Table 3: Direct implementation costs

8.3 BENEFITS ANALYSIS

The principal benefits of implementing the Rules arise from establishing a clear and enforceable framework for early detection, containment and coordinated response. These benefits include direct public health gains, improved institutional preparedness, and the potential avoidance of substantial economic and social losses associated with an uncontrolled outbreak.

a) **Early detection and containment of transmission:** The Rules establish procedures for notification, investigation, contact tracing, isolation and quarantine, enabling public health authorities to respond promptly to suspected cases and reduce opportunities for further transmission.
b) **Protection of healthcare workers and the public**: Requirements for infection prevention and control, safe specimen handling, decontamination and the management of bodies can reduce exposure risks among healthcare workers, laboratory personnel, emergency responders, families and other members of the public.
c) **Improved coordination and accountability:** Clearly defined obligations and procedures can improve coordination among national and county governments, health facilities, port health authorities, law enforcement agencies and other response partners. This may reduce delays, duplication and uncertainty in the exercise of public health powers.
d) **Continuity of essential health services**: Prompt containment can reduce the likelihood that an outbreak will overwhelm health facilities or divert substantial resources from routine healthcare. The WHO identifies surveillance, clinical preparedness, infection prevention and control, and community engagement as key components of the response to the current Bundibugyo virus disease outbreak.

8.4 ECONOMIC AND FISCAL BENEFITS

Early containment may reduce the need for prolonged emergency operations, additional treatment facilities, large-scale contact tracing and extensive deployment of personnel. The extent of any savings will depend on the outbreak's scale and the response effectiveness.

Effective, evidence-based disease control can help maintain confidence in Kenya's public health safeguards and reduce the risk of unnecessary disruption to transport, trade and tourism. As such, measures should remain consistent with applicable international health recommendations. WHO has cautioned against general travel and trade restrictions that lack a scientific basis because they can damage local economies and impede response operations. Where restrictions are necessary, timely information and appropriate support can help minimise the burden on affected households.

Implementation may also strengthen Kenya's capacity to manage other infectious disease emergencies. Investments in laboratory networks, surveillance systems, emergency coordination, trained personnel, infection prevention and control, and community engagement can support responses to other epidemic-prone diseases.

8.5 IMPACT ANALYSIS

8.5.1 PUBLIC HEALTH IMPACT

The Rules are expected to strengthen the ability of public health authorities to identify suspected cases, investigate potential exposure, implement lawful containment measures and coordinate safe clinical referral. The extent of the impact will depend on the availability of trained personnel, diagnostic capacity, protective equipment, isolation facilities and effective communication with affected communities.

8.5.2 SOCIAL AND HUMAN RIGHTS IMPACT

The Rules may affect individuals through isolation, quarantine, medical examination, specimen collection, movement restrictions, access to personal information and requirements governing the handling and burial of bodies.

These measures may cause anxiety, stigma, loss of income, family separation and interference with religious or cultural practices. Such impacts should be mitigated through clear communication, confidentiality, access to essential services, appropriate family engagement, review of orders and the use of the least restrictive measures consistent with the public health objective.

8.5.3 ECONOMIC AND BUSINESS IMPACT

Businesses operating in the aviation, shipping, road transport, tourism, hospitality, trade and logistics sectors may incur additional operational time and costs to comply with applicable screening, reporting and public health requirements. Temporary restrictions may also disrupt business operations where a conveyance, premises or article is subject to inspection, isolation or decontamination.

However, clear and predictable procedures can improve regulatory certainty by informing operators of their obligations, the circumstances in which measures may be imposed and the conditions for lifting restrictions. Risk-based implementation and coordination with relevant operators can help minimise unnecessary delays and avoid disproportionate economic consequences.

8.5.4 INSTITUTIONAL AND INTERGOVERNMENTAL IMPACT

The Rules will require cooperation between the national and county governments and the agencies responsible for health services, immigration, policing, transport infrastructure, laboratory testing and emergency response. The additional responsibilities may create staffing, budgetary and administrative pressures.

8.6. RISK MITIGATION AND IMPLEMENTATION MEASURES

To maximise the benefits of the Rules while managing their costs and adverse impacts, the following measures should be considered:

a) Adequate and sustainable financing: Prepare an implementation budget that identifies the additional costs attributable to the Rules and assigns responsibility for financing each activity.
b) Risk-based application: Ensure that screening, isolation, quarantine and movement restrictions are based on applicable public health

evidence, lawful authority and individual risk assessments, and are not applied more broadly or for longer than necessary.

c) Capacity building: Provide training for authorised officers, healthcare workers, laboratory personnel and other responders on the Rules, infection prevention and control, documentation, enforcement and the protection of individual rights.

d) Public communication and community engagement: Provide timely, accurate and accessible information to reduce misinformation, stigma and resistance to public health measures. Engage community leaders and affected families, particularly in relation to isolation, quarantine and burial arrangements.

e) Protection of affected persons: Ensure that persons subject to public health measures have access to essential healthcare, food, water, appropriate communication and applicable review procedures. Consideration should be given to vulnerable persons and households facing financial hardship.

f) Inter-agency coordination: Establish clear operational responsibilities, referral arrangements and information-sharing procedures among national and county governments and other relevant agencies.

g) Monitoring and evaluation: Monitor the costs, implementation performance and outcomes of the Rules using indicators such as timeliness of notification, completion of contact tracing, time taken to investigate alerts, compliance with infection prevention and control procedures, and the duration of restrictions imposed.

8.7. CONCLUSION

Implementing the proposed Ebola Rules is expected to entail additional financial, administrative, operational and compliance costs for government institutions, health facilities, businesses and affected individuals. The scale of these costs will depend on the nature of the public health situation.

Overall, the analysis shows that the benefits of the Rules, in terms of lives saved, protection of the public, continuity of trade and travel, and protection of rights, considerably outweigh their compliance and implementation costs.

CHAPTER 9

CONSIDERATION OF ALTERNATIVES TO THE RULES

9.1 INTRODUCTION

The Statutory Instruments Act, Cap. 2A requires a regulation-making authority to carry out an informed evaluation of regulatory and non-regulatory policy measures, having regard to costs, benefits, distributional effects and administrative requirements. The options considered are:

a) Option One: Doing Nothing;

b) Option Two: Administrative Measures; and

c) Option Three: Implementing the Public Health (Ebola Disease) Rules, 2026.

9.2 THE ALTERNATIVES

9.2.1 OPTION ONE: DOING NOTHING

Doing nothing would mean relying on the general provisions of the Act and on the measures already in place, with no new legal instrument. Inaction is not an option.

The outbreak in the Democratic Republic of Congo continues to escalate, with 8,442 confirmed cases and 4,080 deaths as of 1 October 2026, and new cases reported daily, even as Kenya has now confirmed its first case of Bundibugyo virus disease. Without enforceable rules, a single contact who refuses follow-up, a single unsafe burial or a single unreported case could start local transmission. No licensed vaccine or treatment exists for Bundibugyo virus to fall back on. Doing nothing would also fail Kenya's obligations under the International Health Regulations (2005) during a declared Public Health Emergency of International Concern.

9.2.2 OPTION TWO: ADMINISTRATIVE MEASURES

This non-regulatory option would rely on Ministry circulars, advisories, guidelines, standard operating procedures and public awareness campaigns. However, administrative measures have no force of law and are therefore not enforceable.

A public health officer cannot compel a person to undergo screening, to report a case, to remain in isolation or quarantine, or to allow safe burial on the strength of a circular. No penalty applies for breach. Under Article 24 of the Constitution, a fundamental right may be limited only by law. Administrative measures alone therefore cannot lawfully support isolation, quarantine, restrictions on movement or restrictions on burial, and they may be successfully challenged in court. For a public health concern of this severity, where one breach can cost lives, administrative measures are not the best option. They remain a useful complement to the Rules.

9.2.3 OPTION THREE: IMPLEMENTING THE RULES

Implementing the Rules will give specific, enforceable effect to section 36 of the Act. The Rules set clear duties on travellers, conveyance operators, health facilities, laboratories, heads of institutions, and families. They give medical officers of health and port health officers lawful powers to screen, investigate, isolate, quarantine and decontaminate. They protect rights through written orders, review, informed consent and family participation in burials. They set proportionate penalties, and they are time-bound, with review every three months and expiry after one year.

9.3 CONCLUSION: THE PREFERRED OPTION

Based on the analysis in Table 5 below, Option Three (Implementing the Rules) is the preferred option. Doing nothing is not an option given the escalating cases in neighbouring countries and the confirmed case in Kenya. Administrative measures have no force of law and cannot be enforced. Only the Rules provide an enforceable, rights-based framework to contain Ebola disease in Kenya.

9.4 IMPACT ANALYSIS OF THE OPTIONS

Impact on Sectors	**Option One: Doing Nothing**	**Option Two: Administrative Measures**	**Option Three: Implementing the Rules**
Impact on Public Sector	Officers lack enforceable powers to contain the confirmed case and its contacts. Unclear	Guidance only. Directives without force of law are open to challenge and	Clear, lawful and procedurally fair powers for medical officers of health and port health officers.

Impact on Sectors	**Option One: Doing Nothing**	**Option Two: Administrative Measures**	**Option Three: Implementing the Rules**
	roles between national and county governments.	cannot compel compliance.	Gazetted facilities. Defined roles for both levels of government.
Impact on Private Sector	No clear duties for conveyance operators, private facilities, funeral providers or media houses. Inconsistent practice.	Voluntary compliance only. Uneven practice across facilities and operators.	Clear duties and standards. Level playing field. Lower risk of facility closure or trade disruption.
Economic Impact	High risk of local transmission, with heavy losses to trade, tourism and productivity.	Limited reduction in risk. Economic exposure remains high.	Lowest risk of a large outbreak. Protects trade, tourism and livelihoods. Costs largely funded under the Plan and by partners.
Social Impact	Continued risk from unsafe burials, stigma and facility transmission. Loss of life.	Some gains in awareness. No binding duty to protect health workers or to provide safe burial.	Safe and dignified burials, protection of health workers, care for persons in isolation and quarantine.
Human Rights Impact	The State fails its duty to protect the right to health under Article 43.	Limits on rights without a legal basis, contrary to Article 24.	Limits on rights by law, proportionate and time-bound, with written orders, review and

Impact on Sectors	**Option One: Doing Nothing**	**Option Two: Administrative Measures**	**Option Three: Implementing the Rules**
			consent safeguards. Supports the right to health.
Impact on Environment	No binding standard for decontamination or infectious waste.	Guidance only.	Binding requirements for decontamination, infectious waste and burial sites.
Impact on Existing Legal Frameworks	Powers under section 36 remain unused. IHR obligations during a PHEIC unmet.	Directives may conflict with existing law and be set aside.	Gives effect to section 36 of the Act and aligns with the IHR (2005).

Table 4: Impact Analysis of the Three Options

CHAPTER 10

IMPLEMENTATION OF THE RULES

10.1 COMPLIANCE AND IMPLEMENTATION

It is the duty of the regulation-making authority to assess the adequacy of the institutional and legal framework through which the Rules will take effect, and to design responsive implementation strategies.

The implementation and enforcement of the Rules will be undertaken through the existing institutional framework. At the national level, the Ministry of Health will lead through the Kenya National Public Health Institute. County governments will implement through the County Executive Committee Member responsible for health, county medical officers of health and County Public Health Emergency Operations Centres.

10.2 CONCLUSION

Based on the analysis in this Statement, the Public Health (Ebola Disease) Rules, 2026 are necessary and urgent. The Rules offer health, socio-economic, environmental and legal benefits that outweigh their costs, and they limit rights only as far as Article 24 of the Constitution permits.

10.3 RECOMMENDATION

The Public Health (Ebola Disease) Rules, 2026 be adopted.

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