Kenyan court blocks US offshore Ebola camp as epidemic accelerates across central Africa

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The High Court in Nairobi on Friday froze a Trump administration plan to open a 50-bed offshore Ebola camp at a Kenyan air base, on the very day it was to begin operating. The order halts the starkest expression yet of an imperialist response to the deepening Ebola epidemic in central Africa, built on border control rather than the mobilization of medical resources.

Judge Patricia Nyaundi barred the Kenyan government from "establishing, operationalizing, facilitating, approving or permitting" any Ebola quarantine, isolation, or treatment facility under any arrangement with the United States or a foreign government, and from admitting anyone exposed to or infected with the virus, pending a hearing set for June 2. The facility at Laikipia Air Base, about 125 miles north of Nairobi, was built by the US military and was to be staffed by US Public Health Service officers. Washington claimed it had secured Kenya's written approval, even as President William Ruto's government refused to defend the deal publicly.

The camp would institutionalize a policy of keeping exposed US citizens out of the country entirely, unprecedented in the history of American Ebola responses. Washington has already invoked the public health statute Title 42 to bar travelers and green-card holders arriving from the Democratic Republic of the Congo (DRC), Uganda, and South Sudan, and it sent an infected American doctor to Germany for treatment rather than returning him to the US.

Public health experts have denounced the scheme as dangerous and irrational. Lawrence Gostin, director of the World Health Organization (WHO) Collaborating Center on National and Global Health Law, called it "reckless, unethical & possibly unlawful." The administration's own Centers for Disease Control and Prevention opposed the plan, with its acting director Jay Bhattacharya reported to have advised against it.

The United States built a network of bio-containment units decades ago precisely to treat such patients. Its refusal to use them, former US Agency for International Development (USAID) official Jeremy Konyndyk noted, reflects a determination "to block anyone with Ebola from setting foot in the United States under any circumstances."

The petitions brought by the Katiba Institute and the Law Society of Kenya halted the plan, but the working class can place no confidence in the courts or the government that struck the deal. The decisive pressure came from below. The doctors' union issued a 48-hour strike threat when news broke of the plan to create the Ebola camp, denouncing the bid to make Kenya a "dumping ground," but the bureaucracy acted only because it feared an independent movement of the rank and file.

The Ruto government is widely despised, having bloodily suppressed the 2024 Gen Z uprising against the International Monetary Fund-dictated Finance Bill and killed scores more in renewed protests last year. Knowing the secret Ebola deal would inflame this opposition, the union apparatus moved to preempt it, placing itself at the head of the anger in order to contain it.

The camp was conceived to wall off a catastrophe that is rapidly worsening. More than 1,200 suspected and confirmed cases and roughly 250 deaths had been reported as of May 27, according to the Africa Centres for Disease Control and Prevention (Africa CDC), a doubling in a single week from 551 cases and 136 deaths.

The pace of new cases and deaths already eclipses every prior Ebola epidemic. At roughly three weeks into the 2018-2020 Kivu epidemic, only about 111

cases had been recorded; at the same point in the 2014-2016 West African epidemic, the worst on record, about 270. The present outbreak is already the third largest in history, and the International Rescue Committee has warned it could become the deadliest.

DRC authorities revised their tally downward on May 28, to 906 suspected cases, after removing non-cases and reclassifying others, and Health Minister Roger Kamba urged the press to "put into perspective the alarmist cries," undoubtedly under pressure from the central government leadership.

But the WHO's emergency response director for Africa, Marie Roseline Belizaire, reported that responders had traced barely a third of the more than 2,500 identified contacts, owing to insecurity and mass displacement. "When you cannot trace the contacts," she said, "it means you cannot stop the transmission chain." The apparent decline reflects the collapse of surveillance, not the containment of the disease.

The strain now circulating compounds the danger. The Bundibugyo virus is genetically more than 30 percent divergent from the Zaire and Sudan species of Ebola, and the vaccines and antivirals developed over the past decade, which target the Zaire species, are not expected to work against it. A WHO expert panel on May 28 prioritized the monoclonal antibodies MBP134 and Maftivimab and the antiviral remdesivir for clinical trials. But MBP134, shown effective against Bundibugyo in animal studies, is owned outright by the US government, which has stockpiled it rather than release it for Congolese and Ugandan patients.

WHO Director-General Tedros Adhanom Ghebreyesus arrived in Kinshasa on Thursday and traveled toward the outbreak's epicenter in Ituri province, saying the outbreak "can be stopped." He appealed directly to the armed groups fighting in eastern DRC to declare a ceasefire, saying that "no cause, no conflict, no grievance is worth condemning innocent people to death from a preventable disease."

Jean Kaseya, director-general of the Africa CDC, said a vaccine and treatment for Bundibugyo were expected by the end of 2026, but warned that international funding pledges had collapsed from nearly $500 million to about $290 million in the past four days. "We cannot afford to stop this outbreak without resources," he said, condemning Western travel restrictions as "not acceptable."

The funding collapse is the immediate expression of a deeper assault. Over the past 15 months the Trump administration has cut 90 percent of the funding of the US Agency for International Development (USAID), terminated the STOP Spillover program built to detect hemorrhagic fevers in this very region, and withdrawn from the WHO. Britain has announced it will cut its foreign aid budget by 40 percent from 2027.

Against this dismantling of global disease surveillance, Washington's professions of concern stand exposed as nothing but cynical lies. The State Department now advertises an additional $80 million in bilateral aid and $300 million through United Nations pooled funds, alongside the $13.5 million pledged to Kenya. But pledges announced are not resources delivered, and these sums are dwarfed by the structural cuts that produced the catastrophe, including a $423 million reduction in US health funding to Kenya over five years under a deal signed in December.