

Mass protests erupt in Kenya against US offshore Ebola quarantine camp

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On Monday, hundreds of youths and residents marched through the streets of Nanyuki, Kenya, located approximately 120 miles north of the country's capital, Nairobi, blocking access roads and rallying at the heavily guarded gates of the Laikipia Air Base to protest the planned construction of a US Ebola quarantine facility. Demonstrators carried placards denouncing the use of Kenya as a dumping ground for American citizens exposed to the deadly virus and accused their own government of trading away public safety to serve the geopolitical interests of Washington.

This outrage was fueled by observations of unusual military and aviation activity, which correspondent Larry Madowo recently highlighted in reports regarding planes landing at the site. Translating the desperate sentiments of people on the ground from a recent *Citizen Digital* report, local resident Nick Karari stated, "We have started seeing planes going that way, and it is like that quarantine area has already been built. We are very angry because Ebola has no cure, no medicine, and it is our government that has decided to do these things."

Joseph Muriira, another Nanyuki resident, told *Citizen Digital*, "We have heard the quarantine was signed and is already here and already even patients have started to arrive. We ask everyone in Nanyuki and Laikipia, on Monday, without fearing anyone, we will come out early in the morning because we will have protests to say we do not want this quarantine because it has already destroyed our businesses, it has already started making some people close their hotels." Demonstrating the resistance of the population, Mary Githambo declared, "We will all come out, and the youth should not be intimidated or afraid because all these things affect us. And I tell you that death by a bullet is better than Ebola."

These demonstrations coincide with a major legal and political flashpoint. On Friday, the Kenyan High Court issued a conservatory order temporarily halting the establishment of any Ebola quarantine, isolation or treatment facility linked to the United States plan. The ruling came pending an urgent petition from the Katiba Institute and other civil society groups, which warned that the opaque bilateral arrangement violates constitutional safeguards and leaves the country vulnerable. Furthermore, the national doctors' union, Kenya Medical Practitioners, issued a 48-hour strike notice, warning that the fragile Kenyan health system is entirely unprepared for a highly infectious filovirus. Professional associations stressed that the American facility is designed primarily to protect United States citizens, with absolutely no provisions for Kenyans in the event of an outbreak or a containment breach.

These protests represent a popular rejection of Washington's brutal attempt to externalize its epidemic risk onto a country with zero

recorded Ebola cases, even as a rapidly growing outbreak rages across the neighboring Democratic Republic of Congo (DRC). This maneuver exposes the imperialist character of the current global health architecture, posing a central question: "Why is the United States government building a high-risk isolation facility in Kenya exclusively for its own citizens instead of mobilizing maximum global resources to fight the epidemic at its source in eastern Congo?"

The excuse offered by the Trump administration on the unprecedented decision to send American citizens exposed to the Ebola virus while abroad to a new facility in Kenya, rather than returning them to advanced biocontainment units in the United States, is simply untenable.

White House officials presented this maneuver as a logistical necessity, claiming the facility will enable Americans to receive lifesaving care quickly, avoiding more than 12 hours of medevac flight time to American hospitals. This planned 50-bed field hospital at the Laikipia Air Base, coordinated by the Department of Defense, the State Department and the Department of Health and Human Services, is explicitly framed by US officials as an exclusive hub for deployed Americans. Yet, it is completely devoid of any provisions to serve as a regional public health facility for the local population.

This policy of offshoring risk is championed by Secretary of State Marco Rubio, who touted the Kenya center as proof of the administration protecting "our people" while ostensibly supporting response operations in the region. Rubio categorically declared during a Cabinet meeting that the administration will not allow anyone infected with Ebola to enter the United States. This nationalist rhetoric connects directly to broader measures to quarantine the outbreak rather than providing the critical surge support needed for in-country health systems. Washington is seeking to ensure that Ebola only kills people in DRC, Uganda and South Sudan, which are to be effectively isolated from any contact with the US.

The scientific and medical community has forcefully condemned this strategy. Dr. Ronald G. Nahass, president of the Infectious Diseases Society of America, issued a prescient warning regarding the dangers of this approach: "Building and staffing a new unit in Kenya during an active outbreak for Americans exposed to Ebola is deeply concerning. It raises serious questions about resources, timing and the level of care Americans sent there will receive."

Lawrence Gostin, director of the WHO Collaborating Center on National and Global Health Law, characterized the plan as reckless, unethical, and possibly unlawful. Dr. Tom Inglesby, director of the Johns Hopkins Center for Health Security, expressed surprise at the refusal to repatriate personnel, noting a strong ethical commitment to providing them with the best possible care at home. Dr. Craig

Spencer, a Brown University public health expert who survived Ebola in 2014, described leaving Americans in Africa as a dramatic abdication of what the nation owes its own citizens.

This improvised response marks a total abandonment of prior Ebola playbooks. As documented in a recent report by *STAT*, “The Abandoned Playbook: Trump’s Shift in Ebola Strategy,” published earlier this year, the Biden administration left hundreds of pages of detailed plans addressing the rapid repatriation of Americans for care in domestic high-containment units. The Trump administration completely discarded these protocols. Maj. Gen. Paul Friedrichs, former head of the White House Office of Pandemic Preparedness and Response Policy, noted that refusing to bring exposed citizens to the United States for care is contrary to any protocol established in the last 40 years.

The epidemic in the DRC is accelerating at a terrifying scale. A recent joint statement by the World Health Organization (WHO) and the DRC government acknowledged that the outbreak is already spreading rapidly across multiple health zones with no licensed vaccine or specific treatment available, despite being formally recognized for only a few weeks. The European Centre for Disease Prevention and Control (ECDC), in its most recent update as of May 28, reported 906 suspected cases with 223 suspected deaths across Ituri, North Kivu and South Kivu provinces, alongside 125 laboratory-confirmed cases including 17 confirmed deaths, with a further nine confirmed cases in Uganda. The true scale of transmission almost certainly exceeds these figures, as health authorities have explicitly warned that surveillance gaps, insecurity and community resistance to testing mean the outbreak is likely considerably larger than reported data reflect.

Providing granular details, the May 31 situation report from the national Centre d’Opérations des Urgences en Santé Publique (COUSP) recorded 282 confirmed cases in the DRC by May 30, with 264 concentrated in Ituri Province alone. According to the COUSP epidemiological graphs, the trajectory of the outbreak shows a rapid, explosive rise in new cases throughout May, with only a slight dip in notifications toward the end of the month, while transmission remains highly active. The demographic data reveals that the working-age population, specifically those between 20 and 49 years old, suffers the highest proportion of infections.

This is the DRC’s 17th Ebola outbreak since 1976, but only the third caused by the Bundibugyo strain. The first, which started in Uganda in 2007, produced 149 total cases. Within two weeks of the current outbreak’s official declaration, confirmed cases alone had nearly doubled that figure, and combined suspected and confirmed cases surpassed 1,000, a threshold reached in prior outbreaks only after months of transmission.

Critically, unlike the Zaire Ebola virus strain that drove the DRC’s worst previous outbreaks and for which ring vaccination protocols were developed, no licensed vaccine or specific treatment exists for Bundibugyo, stripping responders of the tools that contained prior emergencies and exposing the structural abandonment of a population subjected to epidemic after epidemic without durable health infrastructure.

This explosive spread is exacerbated by a chronic humanitarian crisis engineered by decades of imperialist plunder. Ituri is devastated by active armed groups, mass internal displacement, and highly mobile populations moving constantly between the DRC, Uganda and South Sudan. The COUSP situation report exposes catastrophic structural weaknesses in the local response. There is a complete lack

of fully functional, standard Ebola treatment centers in Ituri. Local health workers are forced to rely on ad hoc isolation wards that suffer from severe shortages of essential medicines, basic infection prevention and control materials such as personal protective equipment and chlorine, and a lack of adequate staff training.

Furthermore, responders face massive operational challenges. The COUSP documents weak contact-tracing, profound community resistance to postmortem sampling, the proliferation of rumors promoting traditional treatment recipes and dangerously low alert-reporting from some affected zones. The safe transport of laboratory samples to testing facilities in Bunia, Goma and Kinshasa is constantly hindered by repeated attacks and profound insecurity around health facilities and the construction sites of new treatment centers.

While militant protests erupt in Kenya against the criminal maneuvers of the United States, this outrage must be understood alongside the increasingly hopeless position of the WHO. Stripped of critical resources by imperialist funding cuts, the agency has been reduced to managing an expanding catastrophe with empty rhetoric. This was vividly illustrated by the recent visit to the eastern DRC conducted by WHO Director General Tedros Adhanom Ghebreyesus.

Arriving in Bunia, the capital of Ituri Province, over the weekend, Tedros was accompanied by DRC Health Minister Dr. Samuel Roger Kamba and Communication Minister Patrick Muyaya Katembwe. The visit was organized as a visual spectacle of global solidarity, featuring high-profile press conferences, media tours of health facilities and a ceremonial handover of 135 motorcycles to provide logistical support for the response. However, this diplomatic pageantry stood in jarring contrast to the persistent insecurity and massive medical shortages dictating the deadly reality on the ground.

The underlying despair gripping global health officials was made plain in remarks captured in a *New York Times* video report filed aboard a plane to the region. Pleading for swift international support, Tedros warned, “Of course there are different scenarios, but it’s in our hands. We move fast, we will catch up. If we don’t, it will be a very serious problem. So, it’s time to really move fast.” When pressed by the reporter on whether the world was actually moving fast enough, he bluntly conceded, “It’s starting to understand now, but I still don’t think it’s enough.”



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