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Externalised Containment: Health Sovereignty, Constitutional Process and Bilateral Biosecurity Arrangements in the Laikipia Ebola Facility Dispute

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ABSTRACT

Bilateral arrangements that place biocontainment infrastructure in one state for the primary benefit of another state's nationals have received little systematic attention in the global health security literature. This narrative and critical review examines the dispute surrounding the United States backed Ebola quarantine and isolation facility at Laikipia Air Base in Kenya, established during the 2026 Bundibugyo virus disease emergency in the Democratic Republic of the Congo and Uganda. Evidence was drawn from peer reviewed literature, World Health Organization and European Centre for Disease Prevention and Control outbreak reporting, Kenyan constitutional litigation, ministerial statements, national preparedness assessments and contemporaneous reporting from established news organisations. The review reconstructs the chronology of the arrangement, analyses the constitutional litigation brought under the public participation and access to information provisions of the Constitution of Kenya, and evaluates the arrangement against established criteria for the ethical justification of liberty limiting public health measures. It then introduces the Externalised Containment Risk Model, an original framework specifying four dimensions along which biosecurity risk transfers between states: locational displacement, beneficiary asymmetry, procedural bypass and capacity externality, with legitimacy erosion identified as the principal downstream outcome pathway. Application of the model to the Laikipia case indicates elevated scores across all four dimensions, a configuration that distinguishes it from earlier civil and military arrangements such as the treatment centre for health workers operated in Conakry during the West African epidemic. National preparedness data published by Kenyan authorities during the same period recorded an overall Ebola readiness score of 66 per cent, with case management identified as the weakest domain. The review concludes that host state negotiating frameworks, mandatory procedural safeguards and enforceable capacity reciprocity conditions are required before comparable arrangements are contemplated elsewhere.

Keywords:
Ebola; global health security; health sovereignty; International Health Regulations; public participation; Kenya

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INTRODUCTION

On 17 May 2026 the World Health Organization determined that Ebola disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda constituted a public health emergency of international concern (WHO, 2026a). Within a fortnight of that determination, the Government of Kenya confirmed that it was partnering with the United States to establish a dedicated isolation and treatment facility at Laikipia Air Base in Nanyuki, a location roughly 200 kilometres north of Nairobi and more than 2,000 kilometres from the outbreak epicentre in Ituri Province. Kenya had recorded no confirmed case of Bundibugyo virus disease at any point during the emergency. The facility, widely reported as comprising fifty beds, was intended primarily for United States nationals exposed to the virus while working in the Democratic Republic of the Congo or Uganda (Madowo et al., 2026).

The arrangement produced an unusual and rapidly escalating sequence of public contestation. A constitutional petition filed by the Katiba Institute secured conservatory orders restraining the establishment or operationalisation of any Ebola related facility linked to a foreign government (Katiba Institute., 2026). Demonstrations in Nanyuki and Nairobi followed, during which two people died of gunshot wounds (Al Jazeera Staff & Reuters, 2026). The Cabinet Secretary for Health was subsequently found in contempt of court for permitting construction to continue, and later announced a cessation of activity at the site (Wangui, 2026). In July 2026 a humanitarian organisation confirmed that seven of its American personnel were being quarantined at the facility, prompting renewed allegations that court orders had been disregarded (Mwangi, 2026).

These events raise a question that the global health security literature has not adequately theorised. Under what conditions may one state site biocontainment infrastructure within the territory of another state, primarily for the benefit of its own nationals, and what procedural and substantive safeguards must attach to such an arrangement? The literature offers rich accounts of the securitisation of health (Wenham, 2019), of military engagement in outbreak response (Allen & Parker, 2024; Michaud et al., 2019) and of asymmetries of power in global health practice (Abimbola & Pai, 2020). It does not offer a framework for assessing arrangements in which containment functions are relocated to a third state that is neither the origin of the risk nor the primary beneficiary of the intervention.

This review pursues three related objectives across the sections that follow. It reconstructs the Laikipia case from publicly available primary and secondary sources, applying a conservative evidentiary standard appropriate to a contested and unresolved dispute. It analyses the case against constitutional, legal and ethical criteria that are already well established in the scholarly literature. It then introduces an original analytical framework, the Externalised Containment Risk Model, intended to support host state decision making where comparable proposals arise in future.

CONCEPTUALISING HEALTH SOVEREIGNTY AND SECURITY

The health and security nexus has dominated health policy discourse for over two decades, yet the concept of global health security has never referred to a unitary object. Wenham (2019) demonstrates that the meaning of health security has shifted according to the pathogen in question, the population considered at risk and the political interests of those deploying the term. She identifies three developments of relevance here: the broadening of what counts as a security threat, the movement of securitisation beyond rhetoric into the direct involvement of the security sector, and the emergence of health security practice as a source of insecurity. Rushton (2011) had earlier posed the foundational distributive question of whose security the global health security agenda serves, noting that the framing tends to privilege the protection of populations in high income states from pathogens circulating elsewhere. McInnes and Roemer-Mahler (2017) propose reframing such threats in the language of risk rather than

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security, partly to escape the exceptionalism that security framing tends to invite. Kamradt-Scott (2016) adds an institutional caution, demonstrating that the attribution of responsibility for failures during the West African epidemic was itself contested and politically consequential.

Military involvement in outbreak response has followed a discernible trajectory. Michaud et al. (2019) document a growing willingness among states to deploy military assets in support of global health objectives, while cautioning that military organisations pursue strategic and operational objectives that can conflict with humanitarian and public health aims. Chretien et al. (2007) had earlier described the surveillance contributions of militaries in low- and middle-income settings. Allen and Parker (2024) offer a more critical assessment, arguing that United Nations Security Council Resolution 2177 legitimised militarised epidemic enforcement in Africa, that claims about its effectiveness are not grounded in robust evidence, and that its principal effect has been to entrench less accountable modes of public authority. Their conclusion that militarisation should be treated as a strategy of last resort is directly pertinent to a containment facility sited on an air force base.

Running alongside this literature is a growing body of work on health sovereignty. Okereke (2026) argues that sovereignty in health should not be read as a retreat into isolation but as a claim to agency, encompassing authority over priority setting, budgetary control and accountability mechanisms, together with the institutional capability to act on those choices. This formulation aligns closely with the direction of contemporary continental policy. The New Public Health Order articulated by Africa Centres for Disease Control and Prevention was subsequently extended into an Africa Health Security and Sovereignty Agenda organised around the principle that countries lead, regions coordinate and the global level supports (Edwin, 2025). The decolonisation literature supplies the normative underpinning for these claims, with Abimbola and Pai (2020) framing the objective as the removal of supremacy from all spaces of global health practice, and Büyüm et al. (2020), Lawrence and Hirsch (2020) and Oti and Ncayiyana (2021) examining how partnership arrangements reproduce asymmetric authority.

The International Health Regulations provide the governing legal framework for global health security, imposing obligations on states parties to develop and maintain core capacities and to collaborate in their strengthening (Gostin & Katz, 2016). The Regulations do not, however, address the siting of containment infrastructure by one state within the territory of another. Hanrieder and Kreuder-Sonnen (2014) observe that emergency governance in global health frequently proceeds through exceptional decision making that escapes ordinary accountability structures, a pattern the present case illustrates. Ooms et al. (2017) note the persistent tension between health security investment and broader health system development, a tension that surfaces when scarce national resources are drawn towards a single high-profile facility.

A useful analytical parallel exists in the migration governance literature. Nicolosi (2024) develops a taxonomy of externalisation practices, defined as measures through which states shift functions ordinarily performed within their own territory so that those functions occur, wholly or partly, outside it. He observes that such practices are employed to move the burden of management away from the receiving state and onto other actors or territories, frequently on the assumption that human rights obligations apply only territorially. The structural similarity to the arrangement examined here is close, although the transferred function is biocontainment rather than asylum processing. This review adopts the term externalised containment to describe the phenomenon while developing an assessment framework specific to the biosecurity context.

METHODS AND EVIDENCE BASE

This paper is a narrative and critical review incorporating documentary case analysis. It does not employ systematic review methodology, and no claim is made that the literature search was exhaustive. The design was selected because the

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object of analysis is a single unfolding policy episode for which no peer reviewed empirical literature yet exists, and because the analytical contribution lies in conceptual synthesis rather than in evidence aggregation.

Four distinct streams of evidence were assembled for the purposes of this review. The first comprised peer reviewed scholarship on global health security, health sovereignty, militarisation of outbreak response, public health ethics and externalisation in international law, identified through targeted searching of major journal platforms and citation tracing from key articles. The second comprised institutional epidemiological reporting, principally World Health Organization Disease Outbreak News and situation reports, European Centre for Disease Prevention and Control outbreak assessments and Africa Centres for Disease Control and Prevention policy documents. The third comprised Kenyan governance materials, including the Constitution of Kenya, published statements of the Ministry of Health, national preparedness assessment figures released by Kenyan authorities and public documentation of the constitutional petition. The fourth comprised contemporaneous reporting from established international and Kenyan news organisations, used exclusively for the reconstruction of the chronology of events.

A deliberately conservative evidentiary rule was applied throughout the reconstruction of events. A factual assertion about the arrangement was admitted only where it was documented in a primary source or corroborated by at least two independent reporting organisations. Assertions that remained contested at the time of writing are identified as contested rather than resolved, and no attempt is made to adjudicate between the accounts of the parties. Material from advocacy publications and from outlets without established editorial standards was excluded. Because the underlying evidence is documentary and descriptive rather than inferential, associative language is used throughout, and no causal claims are advanced regarding the relationship between the arrangement and any observed outcome.

The framework presented later in this paper was developed inductively from the case material and then refined through comparison with three reference arrangements drawn from the published literature. It is offered as a conceptual instrument for structuring deliberation rather than as a validated measurement tool, and empirical validation across a larger set of cases remains an outstanding task.

THE 2026 BUNDIBUGYO VIRUS EMERGENCY

The World Health Organization received an alert on 5 May 2026 concerning an illness of high mortality in Mongbwalu Health Zone, Ituri Province, in the Democratic Republic of the Congo, including reports of four health workers who died within four days. Laboratory testing at the Institut National de la Recherche Biomédicale in Kinshasa confirmed Bundibugyo virus disease on 15 May 2026, and the Ministry of Public Health, Hygiene and Social Welfare declared the seventeenth Ebola outbreak in the country on the same date. Uganda declared a concurrent outbreak on the same date following its own laboratory confirmations. The Director General of the World Health Organization determined on 17 May 2026 that the event constituted a public health emergency of international concern, and an Emergency Committee convened two days later issued temporary recommendations to states parties (WHO, 2026b, 2026b).

Two features of this event distinguish it from recent filovirus emergencies in the region. The first of these is the causative viral species involved in the event. Bundibugyo virus has been responsible for only two previous recorded outbreaks, in Bundibugyo District in Uganda during 2007 and 2008 and in Isiro in the Democratic Republic of the Congo during 2012, and case fatality in those events ranged between 30 and 50 per cent. Critically, there is no licensed vaccine and no approved specific therapeutic agent for this species, so that the countermeasure architecture assembled for Zaire ebolavirus is not directly transferable (Nicolosi, 2024). The second distinguishing feature is the length of the interval

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preceding detection. A gap of approximately four weeks separated symptom onset in the presumed index case from laboratory confirmation, indicating substantial undetected transmission before the response commenced (WHO, 2026b, 2026c).

The epidemic expanded rapidly across multiple provinces in the weeks that followed. Data reported by the Democratic Republic of the Congo on 21 July 2026 recorded 2,473 confirmed cases and 999 associated deaths, with 737 patients hospitalised in isolation and 482 recoveries. Ituri Province remained the most affected, accounting for 2,202 cases and 838 deaths across 28 of its 36 health zones, while North Kivu recorded 247 cases and 146 deaths. Cases had been reported from 47 of 140 health zones across five provinces. Uganda recorded 20 confirmed cases and two deaths, with the last confirmed case reported on 21 June and the countdown to declaring the outbreak over commencing in mid-July (Nicolosi, 2024). The trajectory was steep throughout this period, with 915 confirmed cases and 234 deaths reported across both countries by the middle of June, before those figures more than doubled over the following five weeks (WHO, 2026b).

Exported cases shaped the political context in which the Kenyan arrangement emerged. A United States citizen infected in the Democratic Republic of the Congo was medically evacuated to Germany in May 2026, a case was reported in France in late June, and a second United States citizen working for a humanitarian organisation tested positive in early July and was evacuated to Germany days later (Nicolosi, 2024). Each of these events demonstrated that repatriation to high containment facilities in the sending state remained operationally feasible, a point of considerable analytical significance for the proportionality assessment developed below.

The response has also been shaped by a pronounced deficit of community trust. Treatment facilities in Rwampara and Mongbwalu were attacked and burned, with several suspected patients escaping in one incident, and Zumla et al. (2026) argue that rebuilding trust after such attacks requires sustained engagement rather than technical intensification alone. This pattern is consistent with earlier scholarship documenting that resistance to outbreak control reflects social and political grievance rather than rejection of biomedical knowledge (Fairhead, 2016; Nguyen, 2019). The relevance to the Kenyan case is direct, since public confidence in the legitimacy of outbreak governance is itself an operational asset.

RECONSTRUCTING THE LAIKIPIA ARRANGEMENT

Reporting in late May 2026 indicated that United States officials had secured Kenyan approval for isolation and quarantine units on Kenyan territory, and that a unit of fifty beds would become operational imminently. The stated purpose was to accommodate United States nationals exposed to Bundibugyo virus in the Democratic Republic of the Congo or Uganda for the standard monitoring period of twenty-one days, avoiding the risks associated with lengthy transport back to the United States. The proposal attracted immediate criticism from within the United States public health establishment, with officials at the Centres for Disease Control and Prevention reported to have advised against it (Madowo et al., 2026).

Domestic opposition within Kenya emerged with equal rapidity across several professional constituencies. The principal doctors union and the Law Society of Kenya opposed the arrangement, arguing that it risked importing Ebola into a country with no recorded cases and would place additional strain on an already constrained health system. The Secretary General of the Kenya Medical Practitioners, Pharmacists and Dentists Union characterised the country as a sovereign republic rather than a geopolitical isolation ward, a formulation that captured the sovereignty dimension of the objection with unusual economy (Abuora, 2026).

The Government of Kenya confirmed on 28 May 2026 that it was partnering with the United States to establish a dedicated isolation and treatment centre in Laikipia, framing the initiative as strengthening national surveillance, emergency

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response and treatment capacity. Ministry of Health communications indicated that additional isolation and treatment centres would be established at Kenyatta National Hospital and at the Kenya National Police Hospital. Kenya had by that point tested sixteen suspected samples, all of which returned negative results (Madowo et al., 2026).

Justice Patricia Nyaundi of the Milimani High Court in Nairobi issued urgent conservatory orders on 29 May 2026 following a petition brought by the Katiba Institute against the Attorney General and the Cabinet Secretary for Health, with a health rights organisation joined as an interested party. The orders restrained the establishment, operationalisation, facilitation or approval of any Ebola related quarantine, isolation or treatment facility under arrangements with the United States or any other foreign government, and barred the admission of persons exposed to or infected with the virus pending determination of the petition (Abuora, 2026; Magee, 2026). On 2 June 2026 the court extended those orders and directed the government to disclose the agreements, assessments, approvals and operational protocols relating to the project (Al Jazeera Staff & Reuters, 2026).

Government activity at the site nevertheless appeared to continue after those orders were issued. Reporting indicated that United States personnel associated with the facility arrived at Laikipia Air Base shortly after the initial orders were issued, and satellite imagery published in June showed tents and vehicles at the site (Madowo et al., 2026). Representatives of the petitioning organisation reported being denied access to the site by defence personnel on the basis that no prior communication had been received (Chelangat & Oketch, 2026). Demonstrations in Nanyuki on 1 and 2 June turned violent, and two people died of gunshot wounds according to protest organisers and a security source (Al Jazeera Staff & Reuters, 2026). Protesters in Nairobi carried a mock coffin, a symbolic register that conveyed the depth of public opposition.

On 22 June 2026 the High Court found the Cabinet Secretary for Health in contempt for failing to comply with the interim orders and summoned him to appear in person for mitigation and sentencing. In response to the contempt application, he maintained that activities under the bilateral collaboration had been suspended immediately upon issuance of the conservatory orders, and argued that the orders had halted the bilateral arrangement without preventing Kenya from independently strengthening quarantine and isolation capacity at the base as part of national preparedness (Wangui, 2026). This distinction between bilateral and autonomous activity became central to the subsequent dispute over compliance. The Cabinet Secretary announced a cessation of project activity shortly thereafter (Soucheray, 2026).

The matter did not rest with that announcement of cessation. Residents near the base reported continued arrivals of United States military aircraft through June and July, and in mid-July a humanitarian organisation confirmed that seven of its American personnel were being quarantined at the facility. The personnel formed part of a disaster assistance response team of 72 members deployed to the outbreak, of whom 44 were American, and none of the seven had developed symptoms (Jovanovic, 2026). The petitioning organisation characterised the admissions as a disregard of court orders raising constitutional and public safety concerns (Mwangi, 2026). The President of Kenya defended the facility publicly, describing it as consistent with other facilities across the country and as an element of a long-standing health partnership (Al Jazeera Staff & Reuters, 2026). Table 1 summarises the chronology of these events.

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Table 1: Chronology of the Laikipia Ebola facility dispute, May to July 2026

Date	Event
15 May 2026	Bundibugyo virus disease confirmed; outbreaks declared in the Democratic Republic of the Congo and Uganda
17 May 2026	World Health Organization determines a public health emergency of international concern
28 May 2026	Government of Kenya confirms partnership with the United States for an isolation and treatment centre
29 May 2026	High Court issues conservatory orders restraining establishment and operationalisation of any such facility
30 May 2026	Reports that personnel associated with the facility arrive at Laikipia Air Base
1 to 2 June 2026	Demonstrations in Nanyuki and Nairobi; two deaths from gunshot wounds reported
2 June 2026	Court extends conservatory orders and directs disclosure of agreements and protocols
22 June 2026	Cabinet Secretary for Health found in contempt of court and summoned for sentencing
23 June 2026	Cessation of activity at the site announced
2 July 2026	Ministry of Health reports national Ebola preparedness at 66 per cent
18 July 2026	Humanitarian organisation confirms seven American personnel quarantined at the facility

Note. Compiled by the author from publicly available reporting and institutional statements. Dates reflect the date of the reported event rather than the date of publication.

CONSTITUTIONAL LITIGATION AND PROCEDURAL LEGALITY

The Constitution of Kenya (2010) establishes an architecture of participatory governance that the petition invoked directly. Article 1 vests all sovereign power in the people of Kenya, to be exercised directly or through democratically elected representatives. Article 10 identifies participation of the people among the national values and principles of governance binding all state organs, state officers, public officers and all persons whenever any of them applies or interprets the Constitution, enacts or applies law, or makes or implements public policy decisions. Article 35 guarantees access to information held by the state, Article 47 guarantees fair administrative action, and Article 43 recognises the right to the highest attainable standard of health.

Kenyan jurisprudence has progressively raised the threshold for what satisfies the participation requirement, moving beyond formal consultation towards a standard of meaningful engagement in which public views are genuinely considered. The courts have been willing to invalidate legislation and administrative decisions where that threshold was not met. The doctrinal significance of the present dispute lies in the extension of this jurisprudence into an area conventionally treated as executive prerogative, namely the conduct of health diplomacy with a foreign state during an active international emergency.

The petition advanced four principal grounds in support of the relief sought. It contended that the arrangement had been pursued secretly and unilaterally, without public participation or parliamentary oversight. It argued that no publicly available evidence indicated that environmental, biosafety or health impact assessments had been conducted before commitments were made. It asserted that the country lacked the laboratory and clinical infrastructure required to manage highly infectious foreign origin cases safely. It further sought orders compelling the Ministry of Health to table a detailed contingency plan demonstrating national preparedness, surveillance and emergency response arrangements (Katiba Institute, 2026).

The relief granted by the court was correspondingly broad in its scope. The court restrained the establishment, operationalisation, facilitation and approval of any Ebola related quarantine, isolation or treatment facility connected to arrangements with the United States or any other foreign government, prohibited the admission or facilitated entry of exposed or infected persons under the disputed arrangement, and compelled disclosure of the underlying instruments (Abuora, 2026; Al Jazeera Staff & Reuters, 2026). The disclosure order is

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analytically important because it treated the opacity of the arrangement as a justiciable constitutional defect in its own right rather than as a matter of political discretion.

Two features of the litigation merit particular emphasis for the purposes of this analysis. The first is that the constitutional framing succeeded where a purely epidemiological objection would probably have failed. The petitioners did not principally contest the technical merits of quarantine, which are well established, but rather the legality of the process by which a consequential decision affecting public health had been taken. The second feature is the compliance dispute that followed the making of those orders. The distinction drawn by the Cabinet Secretary between suspended bilateral activity and continuing autonomous national capacity building at the same site illustrates how arrangements that lack a published instrument become difficult to supervise, since the scope of the restrained conduct cannot be determined from any document available to the court or the public.

This particular difficulty is by no means unique to the health domain. Nicolosi (2024) documents that judicial challenges to externalisation arrangements in migration governance encounter the same structural obstacle, namely that informal or unpublished instruments obscure the allocation of responsibility between the sending and receiving states. The remedy identified in that literature, which is mandatory publication of the instrument as a precondition of lawful operation, transfers directly to the biosecurity setting and is incorporated into the recommendations advanced below.

ETHICAL ANALYSIS OF THE ARRANGEMENT

Upshur (2003) specifies four principles that must be satisfied before public health authorities may contemplate an autonomy limiting strategy: the harm principle, the proportionality or least restrictive means principle, the reciprocity principle and the transparency principle. These criteria were developed to assess the imposition of quarantine on individuals, and they require adaptation when the subject of assessment is the siting of a quarantine facility within a third state. The adaptation adopted here retains the four principles while treating the host population, rather than the quarantined individual, as an additional bearer of imposed burden.

Harm Principle

Quarantine of asymptomatic persons following high risk exposure to a filovirus satisfies the harm principle in ordinary circumstances, since Bundibugyo virus transmits from person to person and the consequences of undetected onward transmission are severe. The complication in this case is the location of the harm being averted. The primary harm avoided by quarantining exposed United States nationals in Kenya is the potential introduction of the virus into the United States, whereas the residual risk generated by the arrangement, however small, is borne by a Kenyan population that would otherwise have had no exposure pathway. The harm principle is therefore satisfied in respect of the individuals quarantined but is not straightforwardly satisfied in respect of the host population.

Proportionality and Least Restrictive Means

The proportionality assessment requires that the measure adopted be the least restrictive available means of achieving the public health objective. Three alternative approaches were demonstrably available during the course of the same emergency. Exposed personnel could have been monitored in the country of exposure, an approach adopted for the overwhelming majority of national and international responders. Exposed or infected personnel could have been repatriated directly to high containment facilities in the sending state or in a European partner state, an approach actually used on at least three occasions during this outbreak (ECDC, 2026). Alternatively, isolation capacity could have been established within the outbreak affected states themselves, following the model of the treatment centre for health workers operated by French military medical services in Conakry during the West African epidemic. Against these alternatives, the

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siting of containment infrastructure in a third state with no epidemiological connection to the outbreak is difficult to characterise as the least restrictive option from the standpoint of the host population.

Reciprocity

The reciprocity principle requires that those on whom burdens are imposed receive corresponding support. Applied to the host state, reciprocity would require that the arrangement deliver identifiable and durable additions to national capacity, and that those additions be specified, quantified and enforceable rather than asserted. The Kenyan government advanced precisely this justification, framing the facility as strengthening national monitoring, isolation and emergency response capacity. The difficulty encountered here is evidentiary in nature rather than conceptual. Because no instrument was published, it was not possible for the public, the legislature or the court to determine whether the facility would be staffed by Kenyan personnel or by seconded foreign personnel, whether commodities would be imported or drawn from national stocks, or whether infrastructure and equipment would transfer to Kenyan control at the conclusion of the deployment. Reciprocity that cannot be independently verified cannot discharge the principle in any meaningful sense.

Transparency

The transparency principle failed most comprehensively, and this failure plausibly drove most of the downstream harm. The arrangement became public through reporting rather than through disclosure, its terms were never published, and the site was located on a military installation to which independent verification was denied. Hanrieder and Kreuder-Sonnen (2014) describe how emergency governance in global health licenses exceptional decision making that escapes ordinary accountability structures, and the present case conforms closely to that pattern. The consequence was that a measure defensible on narrow technical grounds became, in public perception, an opaque transaction conducted over the heads of those bearing its risks.

Distributive justice and consent

Two further considerations extend beyond the Upshur framework. The first of these additional considerations concerns distributive justice between populations. The provision of dedicated evacuation and quarantine infrastructure for international responders stands in marked contrast to the position of Congolese and Ugandan health workers, who have historically borne disproportionate mortality in filovirus outbreaks without access to comparable arrangements. This asymmetry has been documented since the West African epidemic and remains a persistent feature of outbreak response (Abimbola & Pai, 2020). The second additional consideration concerns the structure of consent underpinning the arrangement. Individual consent appears to have been present, since transfer to the facility was described as voluntary for persons with high-risk exposure. Collective consent from the host population was absent, and it is precisely this absence that the constitutional litigation identified. An arrangement can therefore be individually consensual and collectively imposed at the same time, and this combination is the ethical signature of externalised containment.

KENYAN PREPAREDNESS AND CAPACITY BASELINE

Assessment of the capacity implications of the arrangement requires a baseline. Kenya underwent its second Joint External Evaluation of International Health Regulations core capacities in September 2024, conducted across nineteen technical areas using the third version of the assessment tool, with scores agreed by consensus between external experts and national counterparts (WHO, 2025). That evaluation recorded commendable progress in several domains alongside identified areas requiring strengthening in emergency preparedness and response.

More directly relevant is the outbreak specific assessment conducted by the Bundibugyo Virus Disease Incident Management System under the Kenya National Public Health Institute. Ministry of Health communications in July 2026 reported

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an overall national Ebola preparedness score of 66 per cent, describing this as encouraging progress while identifying persistent gaps in case management, infection prevention and control, rapid response deployment, health workforce surge capacity and sustainable financing for emergency preparedness (Ministry of Health, 2026). Reporting of the underlying assessment indicated that case management was the weakest domain at 36 per cent, while contact tracing, rapid response teams and laboratory capacity scored substantially higher (Chelangat & Mutai, 2026).

The distributional pattern within these reported figures is analytically important for present purposes. Kenya scored strongly in functions performed before a patient arrives, including surveillance, contact tracing and laboratory diagnosis, and weakly in functions performed after a patient arrives, including clinical management, infection prevention and control, logistics and sustained operations. This is precisely the inverse of the capacity profile that hosting an isolation facility for imported high risk cases would require. The Kenya National Public Health Institute identified twenty-five high risk counties for intensified preparedness activity, and reported that a national referral hospital had prepared an isolation unit of twenty beds expandable to fifty, while a second national referral hospital maintained an eight-bed unit for initial response (Chelangat & Mutai, 2026; Ministry of Health, 2026).

These figures place the proposed facility of fifty beds into meaningful perspective. A dedicated unit of that size, equipped and staffed to the standard implied by its stated purpose, would have represented a substantial proportion of national high containment isolation capacity. Whether it constituted a net addition to that capacity or a diversion from it depends entirely on the source of its personnel, the origin of its consumables and the disposition of its assets at the conclusion of the deployment. None of these matters was publicly documented, and the analysis is therefore necessarily indeterminate. Reported figures for individual assessment sub domains also varied across secondary accounts, and readers should treat the sub domain values as indicative rather than definitive pending publication of the underlying assessment.

Two further constraints reported in the same assessment bear on the feasibility of hosting imported cases. Emergency funds were described as not rapidly accessible at either national or county level, and delays were reported in the importation of health products and technologies. At principal border crossings with Uganda, unstable connectivity was reported to have hampered screening operations (Chelangat & Mutai, 2026). A system exhibiting these characteristics is one in which the marginal cost of absorbing an additional high acuity containment obligation is likely to be substantial.

The opportunity cost of concentrated outbreak response is documented in the empirical literature and should inform assessment of any such obligation. Wagenaar et al. (2018) identify measurable reductions in primary healthcare delivery in Liberia across the period of the West African epidemic, using interrupted time series analysis of routine service data. Sochas et al. (2017) estimate substantial indirect maternal and neonatal mortality attributable to health system disruption in Sierra Leone during the same period. These findings indicate that decisions to concentrate scarce personnel, commodities and financing within a single containment facility carry system wide consequences that are seldom captured in the framing of such proposals.

THE EXTERNALISED CONTAINMENT RISK MODEL

The preceding analysis indicates that existing conceptual tools address adjacent phenomena without capturing this one. Securitisation theory explains why health threats attract exceptional measures but not how those measures are geographically allocated between states. The militarisation literature addresses the deployment of armed forces in outbreak response but not the reverse arrangement in which a host state provides territory and a sending state provides personnel and purpose. The decolonisation literature identifies the asymmetry at issue but does not

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supply an assessment instrument. The Externalised Containment Risk Model is proposed to fill this gap.

Externalised containment is defined here as an arrangement under which a state establishes or operates biocontainment, quarantine or isolation capacity within the territory of another state, primarily for the benefit of its own nationals or personnel, where the host state is neither the origin of the biological risk nor the principal beneficiary of the intervention. The model specifies four dimensions along which such arrangements may be assessed, together with one downstream outcome pathway, summarised in Table 2.

Locational Displacement

This dimension captures the geographic and jurisdictional distance between the origin of the biological risk, the site of containment and the jurisdiction of the beneficiary population. Displacement is low where containment occurs within the outbreak affected jurisdiction or within the beneficiary jurisdiction itself, since in both cases responsibility and risk remain aligned. Displacement is high where a third state with no epidemiological connection to the outbreak hosts the containment function. Elevated displacement is not objectionable in itself, but it severs the ordinary correspondence between the population that generates a risk decision and the population that bears its consequences.

Beneficiary Asymmetry

This dimension captures the divergence between the population bearing residual risk and the population receiving clinical benefit. Relevant indicators include the proportion of the served population holding host state nationality, the existence of an enforceable commitment to admit host nationals on equivalent terms, and the equivalence of clinical standards available within the facility and within the surrounding national health system. Asymmetry is high where the facility serves foreign nationals exclusively or predominantly, and where host nationals in the same locality could not access care of comparable quality for the same condition.

Procedural Bypass

This dimension captures the extent to which the arrangement circumvents the ordinary constitutional and administrative requirements of the host state. Indicators include whether public participation was conducted to the standard required by domestic law, whether legislative approval or ratification was obtained, whether the instrument was published, whether environmental and biosafety assessments were completed and disclosed, and whether the arrangement remained susceptible to effective judicial supervision. Procedural bypass is the dimension most amenable to correction through institutional design, and it is also the dimension most predictive of subsequent conflict.

Capacity Externality

This dimension captures the net effect of the arrangement on the host health system, measured across four components: health workforce, isolation and treatment capacity, commodities including personal protective equipment and diagnostics, and emergency financing. Capacity externality may be positive where the arrangement leaves durable infrastructure, trained personnel and replenished stocks under host control, and negative where it draws scarce national resources towards a facility serving an external population. Determination requires specification of staffing sources, commodity sources and the disposition of assets at termination.

Legitimacy Erosion as Outcome

The model identifies legitimacy erosion as the principal pathway through which externalised containment generates public health harm. The proposed mechanism is understood to operate through three sequential stages. Elevated procedural bypass and beneficiary asymmetry generate a public perception that the host population bears risk for external benefit. That perception is amplified where the containment site is militarised and independent verification is restricted. The resulting loss of institutional trust degrades population compliance with subsequent public health measures, including those unrelated

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to the original arrangement. This mechanism connects the framework to a substantial body of evidence establishing community trust as an operational determinant of outbreak control (Fairhead, 2016; Nguyen, 2019; Zumla et al., 2026).

Table 2: Dimensions of the Externalised Containment Risk Model

Dimension	Core question	Principal indicators
Locational displacement	How far is containment sited from both the risk origin and the beneficiary jurisdiction?	Epidemiological connection of host state to the outbreak; distance from epicentre; availability of in country or sending state alternatives
Beneficiary asymmetry	Who bears residual risk and who receives clinical benefit?	Nationality composition of served population; enforceable open access commitment; equivalence of clinical standards for host nationals
Procedural bypass	Were the host state's own constitutional requirements observed?	Public participation to domestic standard; legislative approval; publication of instrument; biosafety and environmental assessment; access to judicial review
Capacity externality	Does the arrangement add to or draw from host system capacity?	Source of staffing; source of commodities; net change in isolation capacity; access to emergency financing; asset disposition at termination
Legitimacy erosion	What is the effect on public trust in outbreak governance?	Litigation and protest activity; institutional trust indicators; compliance with unrelated public health measures

Note. The first four rows of the table set out the assessment dimensions. The fifth row is the outcome pathway through which elevated scores on the preceding dimensions are proposed to generate public health harm.

Four propositions follow from the model and are offered as testable claims rather than established findings. The first proposition holds that arrangements scoring high on both locational displacement and beneficiary asymmetry will attract legitimacy contestation irrespective of their technical merits. The second holds that procedural bypass is the strongest single predictor of judicial intervention, since it converts a policy dispute into a constitutional one. The third holds that positive capacity externality can offset beneficiary asymmetry only where the additions are specified, quantified and enforceable in advance. The fourth holds that militarisation of the containment site amplifies legitimacy erosion by removing the possibility of independent verification.

APPLYING THE MODEL COMPARATIVELY

Application of the model to four reference arrangements, summarised in Table 3, clarifies what is distinctive about the Laikipia case. The first comparator is the treatment centre for health workers operated by French military medical services in Conakry between January and July 2015, which provided critical care for national and international responders suspected of infection within the outbreak affected country (Dindart et al., 2016). The second comparator is the direct medical evacuation of infected or exposed personnel to high containment facilities in Germany, France and the United States, a practice used during both the West African epidemic and the present emergency. The third comparator is the offshoring of asylum processing to third states, analysed by Nicolosi (2024) as the paradigmatic externalisation practice. The fourth comparator is the Laikipia arrangement examined throughout this paper.

The comparison isolates the feature that distinguishes the Laikipia arrangement. Direct evacuation to sending state facilities exhibits high beneficiary asymmetry, since the benefit accrues exclusively to nationals of the sending state, but the residual risk returns to that state as well, so the asymmetry raises no question of imposed burden on a third population. The Conakry model exhibits low displacement and low procedural bypass because the facility operated within the outbreak affected state with the consent of its authorities, and it produced positive capacity externality by serving national health workers alongside international personnel. The Laikipia arrangement is distinctive because it combines high displacement with high beneficiary asymmetry

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and high procedural bypass simultaneously. It is this conjunction, rather than any single dimension, that generated the observed pattern of litigation, protest and institutional conflict.

The structural similarity to offshored asylum processing is close enough to be instructive and different enough to require caution. Both practices relocate a function to a jurisdiction whose population has no stake in the outcome, both rely on instruments that are frequently unpublished, and both raise the question of whether obligations follow the function across the border. The material difference is that offshored asylum processing transfers a population that the sending state wishes to exclude, whereas externalised containment transfers a population that the sending state wishes to protect. This distinction does not diminish the burden on the host state, and it may complicate the analysis by lending the arrangement a humanitarian framing that the migration analogue lacks.

Table 3: Comparative application of the Externalised Containment Risk Model

Arrangement	Locational displacement	Beneficiary asymmetry	Procedural bypass	Capacity externality
In country treatment centre for responders, Conakry 2015	Low	Low to moderate	Low	Positive
Direct evacuation to sending state facilities	Low	High	Not applicable	Neutral
Offshored asylum processing in third states	High	High	High	Contested
Laikipia Air Base facility, Kenya 2026	High	High	High	Indeterminate

IMPLICATIONS FOR REGIONAL HEALTH GOVERNANCE

The International Health Regulations establish obligations concerning the development and maintenance of core capacities and concerning collaboration among states parties, and they require implementation with full respect for the dignity, human rights and fundamental freedoms of persons (Gostin & Katz, 2016). They do not address the siting of containment infrastructure by one state within the territory of another. This is a governance gap rather than an ambiguity, and it means that arrangements of the kind examined here are currently constrained only by the domestic law of the host state and by whatever conditions the host government chooses to negotiate.

The gap matters because the incentives on both sides are durable. Sending states have strong reasons to seek containment capacity close to areas of deployment, since transport of high-risk personnel over long distances carries operational and clinical costs. Host states have reasons to accept, including access to infrastructure, equipment and training that domestic budgets could not otherwise finance, and the diplomatic value attaching to partnership. Osborne (2025) observes that financing asymmetries induce recipient governments to reorient policy towards donor priorities even when those priorities diverge from domestic health needs, and the same logic applies to infrastructure offers made during an emergency.

Continental policy direction points in the opposite direction to unregulated externalisation. The Africa Health Security and Sovereignty Agenda advanced by Africa Centres for Disease Control and Prevention is organised around a reduction in dependency on external systems and a principle that countries lead while regions coordinate and the global level supports (Edwin, 2025). An arrangement negotiated bilaterally, concluded without publication and sited on a military installation is difficult to reconcile with that principle, whatever its technical merits. Okereke (2026) frames the underlying claim as one of agency rather than isolation, and agency in this context means the capacity to set terms rather than the capacity to refuse.

The regional dimension of the question is also material to this assessment. The states of the East African Community share extensive land borders,

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dense trade corridors and integrated labour markets, and a containment decision taken by one member has implications for the others. The absence of any regional notification requirement for arrangements of this kind means that neighbouring states may learn of a new containment facility on their borders through media reporting. A regional notification protocol would impose minimal cost and would substantially improve the coherence of preparedness planning across the community.

There is finally a precedent effect that warrants serious consideration by policymakers. If the arrangement examined here is normalised without accompanying safeguards, the conditions under which it may be replicated are undefined. The relevant question for African health authorities is not whether to accept or reject such proposals categorically, since circumstances will vary and some arrangements may be genuinely beneficial. The question is whether a standard framework exists against which any particular proposal can be assessed, negotiated and, where appropriate, declined. No such framework currently exists, and its absence leaves each host government to improvise under emergency conditions and political pressure.

Policy Recommendations for Host States

The following recommendations are directed principally to host governments, and secondarily to regional institutions and to sending states seeking arrangements that will prove durable. They are derived from the dimensions of the framework presented above and from the specific failures identified in the case reviewed.

1) Publish the governing instrument in full before any operationalisation occurs. No containment arrangement with a foreign government should become operational before the governing instrument is published in full, including its purpose, duration, admission criteria, staffing arrangements and termination provisions. Publication is the single measure that would have prevented most of the conflict documented in this case.
2) Conduct public participation to the standard required by the domestic constitution. Where a host state constitution requires public participation in the making of policy decisions, that requirement applies to health security arrangements with foreign states, and the affected local community should be specifically engaged rather than consulted only at national level.
3) Establish a legislative approval pathway for arrangements involving foreign governments. Arrangements involving foreign governments and carrying material public health risk should require ratification or approval by the national legislature, providing a forum for scrutiny that emergency executive decision making does not supply.
4) Complete and disclose an independent biosafety and environmental assessment before commitment. Assessment should be conducted by a body independent of the negotiating ministries and published before commitments are made, addressing waste management, transport routes, containment standards and the risk of onward transmission.
5) Include an enforceable non-discrimination clause within the governing instrument itself. Any facility established under such an arrangement should be required to admit host state nationals meeting the same clinical criteria, on equivalent terms and to equivalent clinical standards, with the obligation stated in the instrument rather than asserted in public communications.
6) Specify a capacity reciprocity schedule with quantified and verifiable commitments. The instrument should quantify the additions to host system capacity that the arrangement will deliver, covering personnel trained, equipment supplied, commodities replenished and infrastructure transferred, and should provide for transfer of physical assets to host control at termination.
7) Maintain civilian custody of the facility and guarantee independent monitoring access. Containment facilities should be under

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civilian health authority rather than military command, and independent monitors including the national human rights institution and relevant professional bodies should have guaranteed access.

8) Insert sunset and periodic review clauses into every such arrangement. Arrangements should terminate automatically at the conclusion of the declared emergency unless renewed through the same procedural pathway, preventing emergency infrastructure from becoming a permanent extraterritorial installation.

9) Notify regional institutions before the facility begins any operational activity. Host states should notify Africa Centres for Disease Control and Prevention and the relevant regional economic community before operationalisation, enabling neighbouring states to adjust preparedness planning accordingly.

10) Provide for identifiable community benefit within the immediate host locality. Where a specific community bears the proximate risk, the instrument should provide identifiable benefit to that community, including strengthening of local health facilities and transparent communication conducted in local languages.

Limitations

Several limitations constrain the conclusions that may reasonably be drawn from this review. The case examined remained unresolved at the time of writing, the constitutional petition had not been determined and the governing instrument had not been published, so that material facts remain contested between the parties. Reconstruction of the chronology relied substantially on contemporaneous reporting, which is subject to correction as further information becomes available, and reported figures for individual preparedness sub domains varied across secondary accounts.

The review generated no primary data and conducted no interviews with participants, officials or affected residents, and the perspectives of the Nanyuki community are therefore represented only indirectly through reported statements and observed collective action. The framework advanced here was developed inductively from a single case and refined against three comparators drawn from published literature, which is sufficient for conceptual specification but not for validation. The dimension ratings presented in the comparative table are analytical judgements rather than measurements, and no scoring instrument, weighting scheme or inter-rater reliability testing has been developed.

Because the underlying evidence is documentary and descriptive, all statements concerning relationships between the arrangement and observed outcomes are associative rather than causal. No claim is advanced that the arrangement caused the protests, the litigation or any change in public trust, and alternative explanations grounded in the broader political context of Kenya during this period cannot be excluded on the evidence reviewed.

CONCLUSION

The dispute over the Ebola quarantine facility at Laikipia Air Base is significant beyond its immediate circumstances because it discloses a gap in the architecture of global health security. Existing instruments govern the detection and reporting of events, the declaration of emergencies and the obligations of states parties to build core capacity. They do not govern the circumstances in which one state may site containment infrastructure inside another, for the primary benefit of its own nationals, in a country with no epidemiological connection to the outbreak concerned.

The analysis presented here suggests that the difficulty in this case was not principally epidemiological. Quarantine of persons with high-risk exposure to a filovirus for which no licensed vaccine or specific therapeutic exists is defensible on established public health grounds. The difficulty lay in the process by which the arrangement was made and in the distribution of

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its burdens and benefits. An arrangement negotiated without publication, concluded without public participation, sited on a military installation and directed primarily at the protection of foreign nationals will attract contestation in a constitutional democracy irrespective of its technical merits, and the Kenyan courts treated precisely these procedural defects as justiciable.

The Externalised Containment Risk Model is offered as a means of structuring assessment of such proposals before they are concluded rather than after they are contested. Its four dimensions of locational displacement, beneficiary asymmetry, procedural bypass and capacity externality are intended to make explicit the considerations that were left implicit in this case, and its identification of legitimacy erosion as the principal harm pathway connects the framework to a substantial evidence base establishing community trust as an operational determinant of outbreak control.

Three practical implications follow from the analysis developed in this paper. Host governments require a standing negotiating framework so that proposals arriving during an emergency can be assessed against predetermined criteria rather than improvised under political pressure. Regional institutions require a notification protocol so that containment decisions taken by one member state do not surprise its neighbours. Sending states have an interest in these safeguards as well, since arrangements that collapse into litigation and protest deliver neither the operational capability sought nor the diplomatic benefit anticipated.

The wider point concerns the meaning of health sovereignty in practice. Sovereignty in this domain is not the refusal of cooperation, which would be neither feasible nor desirable during a transboundary emergency. It is the capacity to set the terms on which cooperation occurs, to insist that those terms be published, and to require that arrangements leave the host system stronger than they found it. Whether African health authorities secure that capacity in the arrangements that follow this one is a question of institutional design, and the design work has not yet been done.

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Data availability: All sources analysed in this review are publicly available and are listed in the reference list.

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