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**HEALTH SECURITY - ROLE OF THE SECURITY SECTOR
IN COMBATING THE 2014 EBOLA OUTBREAK IN
SIERRA LEONE**

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CONTENTS

ACKNOWLEDGEMENT	2
ABSTRACT	4
LIST OF TABLES	5
LIST OF FIGURES	5
LIST OF ACRONYMS AND ABBREVIATIONS	6
CHAPTER ONE	7
INTRODUCTION	7
1.0 BACKGROUND AND STATEMENT OF THE RESEARCH PROBLEM	7
1.1 OBJECTIVES OF THE STUDY	
1.2 SIGNIFICANCE OF THE STUDY	
1.3 SCOPE	
1.4 RESEARCH METHODOLOGY	
1.4.1 DATA COLLECTION METHODS	
1.4.2 LIMITATIONS OF THE RESEARCH	
1.5 CONCLUSION	
CHAPTER TWO	
LITERATURE REVIEW	
2.0 INTRODUCTION	
2.1 AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE 2014 EBOLA OUTBREAK AND THE EFFECTIVENESS OF THE POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING EBOLA	
2.2 EFFECTS OF THE POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING THE EBOLA EPIDEMIC IN SIERRA LEONE	
2.2.1 THE IMPACT OF CIVIL-MILITARY RELATIONS IN RESPONSE TO SUCH OUTBREAK AND THE FUTURE LESSONS	
2.3 CONCLUSION	

CHAPTER THREE.....

AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE 2014 EBOLA OUTBREAK.....

3.0 INTRODUCTION.....

3.1 AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE EBOLA OUTBREAK.....

3.2 THE EMERGENCE OF EBOLA AND CONSPIRACY THEORIES IN SIERRA LEONE.....

3.3 EARLY NATIONAL EBOLA RESPONSE STRUCTURE.....

3.4 TRANSITION TO A NEW RESPONSE ARCHITECTURE.....

3.5 CONCLUSION.....

CHAPTER FOUR.....

AN ASSESSMENT OF THE ROLE, AND EFFECTIVENESS OF POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING THE EBOLA OUTBREAK.....

4.0 INTRODUCTION.....

4.1 EFFECTS OF POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN RESPONSE TO THE 2014 EBOLA OUTBREAK.....

4.2 THE IMPACT OF CIVIL-MILITARY RELATIONS IN RESPONDING TO THE EBOLA OUTBREAK.....

4.3 CHALLENGES.....

4.4 CONCLUSION.....

CHAPTER FIVE.....

SUMMARY OF FINDINGS.....

5.0 INTRODUCTION.....

5.1 KEY FINDINGS.....

5.2 CONCLUSION.....

CHAPTER SIX.....

6.0 SUMMARY AND CONCLUSION.....

BIBLIOGRAPHY.....

ACRONYMS AND ABBREVIATIONS

AGI	Africa Governance Initiative
CCC	Community care Centre
CDC	US Centres for Disease Control and Prevention
DERC	District Ebola Response Centre
DFID	Department for International Development
DHMT	District Health Management Team
DRC	Democratic Republic of the Congo
EOC	Ebola Operations Centre
ETU	Emergency Treatment Unit
EU	European Union
ISAT	International Security Advisory Team
JIATF	Joint Inter-Agency Taskforce
MSF	Medecins sans Frontiers
NERC	National Ebola Response Centre
NGO	Non-Governmental Organisation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PPE	Personal Protective equipment
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
UNMEER	United Nations Mission for Ebola Emergency Response
US	United States
WHO	World Health Organization

LIST OF TABLES

Table 2.1 Previous Ebola outbreaks/infections in humans (Adapted from CDC)

Table 2.2 Basic Country statistics from the three main affected countries. (Adapted from the World Bank data 2014, unless otherwise stated).....

LIST OF FIGURES

Figure 2.1 Geographical distribution of new and total confirmed cases in Guinea, Liberia, and Sierra Leone. (Adapted from WHO).....

Figure 3.3 National Ebola Response Centre Organogram 2015.....30

ABSTRACT

This study assessed the role of the security sector in combating the 2014 Ebola outbreak in Sierra Leone. In achieving the overall goal of the study, the assessment broadly

covered the following: examined the national response structure before the outbreak; the emergence of Ebola and conspiracy theories in Sierra Leone, ascertained the early national Ebola response structure; the transition and composition to a new response architecture; assessed the effectiveness of policies and strategies by the security sector in combating Ebola; ascertained whether the effects of policies and strategies implored by the security sector in response to the outbreak; evaluated the impact of civil-military relations in combating the outbreak; and in the end examined the overall challenges in terms of the security sector's roles, and policies and strategies implored in responding to the outbreak. These areas broadly correspond to some of the objectives in response to the security sector's roles.

Based on findings from assessing the areas stated above, the study has argued that the role played by the security sector in combating the 2014 Ebola outbreak have been largely effective. But while the role of the security sector has been largely positive, but this is not without many other factors - notably without the engagement of communities which underscored the effectiveness of the policies and strategies implored in response to the outbreak. Over the period under consideration the intervention of the security sector helped to curb the scourge with the support of international civilian and military actors. As such, "the deployment of international military forces and the imposition of coercive control measures by the government of Sierra Leone, clearly showcase a securitized response" (Dubois, M. et al, 2015). It also brings to the fore the lack of political will by the government, and a challenge to the security architecture in response to the outbreak. This was visibly seen in the capacity response of the SLP and that of the RSLAF. Such

security interventions also highlighted the linkages between formal and informal structures as a hybrid response; which inadvertently blurred the lines between health and humanitarian response.

Though the evidence is mixed, such achievements by the security sector clearly shows that they can also undertake non-traditional roles in response to public health emergencies such as Ebola. However, the findings from the study relate to Sierra Leone alone and therefore cannot be generalized for all other developing countries. Finally, the findings from the study do and will imply that there is a causal relationship between inadequate healthcare systems and the role played by the security sector in combating the 2014 Ebola outbreak in Sierra Leone. However, this researcher recommends that further empirical research is needed to complement as to what constitutes the call and intervention of the security sector prior to the next public health emergency such as Ebola.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND AND STATEMENT OF THE RESEARCH PROBLEM

Health Security is not a new coinage but rather a global phenomenon that needs a global solution. Because infectious diseases like Zika, Ebola, MERS-CoV, SARS, H1N1 influenza and other epidemics such as HIV/Aids, Cholera, STIs etc have long been threatening humans due to its far-reaching effects across geopolitical boundaries, risk of state failure, and the threat to international peace and security. In addition, the Global Health Security Agenda, which focuses on the strengthening of International Health Regulations enacted by the World Health Organization in 2005, have not curb the re-emergence of such public health emergencies especially in many developing countries; rather it has exposed the vulnerability and low preparedness of these countries in responding to such outbreaks.

Exactly 19 years after the first Ebola outbreak in the Democratic Republic of Congo, what has happened in compliance to the 2005 International Health Regulations by national, regional and international government in response to public health emergencies such as Ebola? According to the Center for Disease Control(CDC, 2014), “out of the thirty-four outbreaks that had taken place up to 2014 in the world, six outbreaks had each killed more than 100 people, although seventeen other outbreaks had killed fewer than ten people or none at all(CDC, 2014; WHO, 2014). To this, one could argue that lack of global leadership, inadequate health care systems mostly in developing countries, microbial drug resistance, evolving trend of the Ebola virus, and other attendant problems have largely contributed to the periodic outbreak of the Ebola Virus Disease. In West Africa, the 2014 Ebola outbreak in Guinea, Liberia and Sierra Leone was described by the WHO

Director-General Margaret Chan as “the most severe acute public health emergency in modern times” (WHO 2014a). Likewise other Ebola affected countries, “Sierra Leone has been most affected in terms of caseload with over 3,500 lives claimed”(CDC 2014a).

Sierra Leone, with an estimated population of 7 million people (Sierra Leone Census Report, 2015), had its first reported case of Ebola on 25th May 2014 in Kailahun District of Eastern Sierra Leone. The first Ebola case in the capital city, Freetown, was reported on 11th July 2014 (Gbla, 2018). Notably, many of the nurses or doctors had either left the country for greener pastures or reached retirement age. As such, those who left behind had sacrificed their opportunities to further their expertise. In total, “the country had only a little over a hundred doctors working clinically in the public sector, and even if you included doctors working in the private sector, this was approximately just one doctor per 45,000 people”(Mankad et al (2015). Therefore, coupled with other attendant social problems of the Ebola epidemic in the country this under-resourced and poorly managed status of the national health response system did not only exacerbate the widespread and momentous spread of the virus but helped largely; in the involvement of the security sector as a last resort to ameliorate the situation at hand. The imminent questions now are: how effective are national response structures in combating public health emergencies such as Ebola in Sierra Leone? Or is the implementation of policies and strategies by the security sector result of combating the Ebola outbreak? Or is there any link between inadequate healthcare systems and security sector involvement in response to the Ebola outbreak in Sierra Leone?

1.1 OBJECTIVES

The objective of this study is to ascertain what role did the security sector played in combating the 2014 Ebola outbreak in Sierra Leone? Therefore, this study will seek to critically assess the role of the security sector services and institutions, discuss the roles played as well as their implications in combating the 2014 Ebola virus outbreak in Sierra Leone. To achieve this, the objectives of this research will look into the following:

1. To examine the national response structure before the 2014 Ebola epidemic outbreak?
2. To assess the effectiveness of the policies and strategies by the security sector in combating the Ebola outbreak.
3. What was the impact of civil-military relations in responding to such outbreaks
4. Which lessons be therefore being drawn with regard to improving preparedness, strengthen response processes; and enhance resilience in the future.

1.2 SIGNIFICANCE OF STUDY

The basic argument is that the use of military and or the role played by security sector institutions in public health emergencies such as Ebola contravenes not only global health governance but also creates an environment of fear and sometimes abuse of human rights of the affected populace when such crisis occur. However, on the question of the effectiveness to curb such national security threat, there is significant confusion in the existing literature. Richard Horton and Pamela Das (2015) posit that ‘to invoke the idea of security risks giving permission to more authoritarian-minded governments to use health crises as justification for sometimes extreme curbs on liberty or the political, economic, and social rights of citizens’ in their study. Their finding supports results from

earlier studies by (Huang 2014; Elbe (2006); Baringer and Heitkamp, 2011), whose findings showed no evidence of any direct negative impact of public health emergencies at a higher scale like the 2014 Ebola outbreak. See also (Waal (2014), Groves (2005) and Palomba (2008)).

However, Haenlin and Godwin, (2015) from their empirical findings on analysis of data for the security sector's role that have reached decision point, suggest that the policies and strategies employed during the emergency response had an effect on curbing this scourge. Specifically, apart from their descriptive analysis that shows the pre-existing structure of the national health response system they also highlighted this epidemic as a test of the Sierra Leonean security sector reform programme (see Walsh and Johnson, 2018; Haenlein and Godwin, 2015). Walsh and Johnson further highlighted that with the advent of the outbreak "the level of mistrust by the population, early mistakes in community engagement, under-resourcing of the response meant the critical moment when Ebola could have been contained was missed"(Walsh and Johnson, 2018) which led to the involvement of the security sector to salvage the situation. Many independent studies have been carried out on different aspects of (de)securitization of public health emergencies. What is often seen in the literature is that either focusing on explaining the civil-military relations in responding to public health emergencies or the 'militarization' process of which the outbreak was handled in terms of allegations of human rights abuses perpetrated by these military forces on civilians.

Therefore, the research question of this study asks 'what is the role played by the security sector in combating the 2014 Ebola outbreak in Sierra Leone'. Another pertinent research question in such a study could be in 'what ways did the British security sector reform programme prepare the security forces for roles in emergencies like Ebola'. Unlike many Ebola affected countries, little is known about a systematic assessment of the role played by the security sector in combating Ebola in Sierra Leone, and to the best of my knowledge no such independent study has been carried out on the country; it therefore becomes a country worthy of conducting a study on. Thus, the significance of this study is to establish the role played by the security sector in combating the Ebola epidemic. Moreover, the study is particularly important since Sierra Leone is a peacekeeping contributing country to regional and international bodies; it therefore becomes imperative to provide an independent assessment on a country level to ascertain the importance and professionalism of the security sector's (especially the SLP and RSLAF) role as a permanent feature in response to public health emergencies.

In addition, the study is not only significant in that it will add value to and complement the work of others in the existing literature on the role of the security sector in public health emergencies, but after completing this study we will be able to appreciate the results from the research objectives by combining each with what have been discovered in the literature. Finally, findings from the study will also contribute to the overall debate with regard to whether the involvement of security sector could be a best practice in response to public health emergencies such as combating Ebola. At this juncture, it is worthy of note to point out that the study does not necessarily claim that the involvement of the

security sector is the only option as causal relationship between public health emergencies and roles played by the security sector. Hence, this will require further empirical research to determine this relationship. Findings from the study will serve as reasonable assumptions about the impact of integrating this sector has had so far in combating the 2014 Ebola outbreak in Sierra Leone.

1.3 SCOPE

In realizing the study's objectives, the analysis will focus on data collected on the roles played by the security sector and other ministries, agencies and departments in response to the public health emergency in Sierra Leone from 2012 to 2019. The choice of the period selected is to cover the years in leading to Sierra Leone's first emergency response in 2014 and the years leading to the end of Ebola in 2016.

1.4 RESEARCH METHODOLOGY

Given the research question - 'what role did the security sector played in combating the 2014 Ebola outbreak in Sierra Leone' and the specific research objectives stated in section 1.1, a valuable aspect of the study relates to objectives 1 and 2: evaluating existing literature on the effectiveness of policies and strategies in combating Ebola in Sierra Leone. A qualitative data analysis collected highlights the role-played by the security sector, which form the basis for achieving the remainder of the research objectives. Attaining the objectives stated here, both secondary and primary data will be required in this regard, but the later will constitute less than 10% of the entire study mainly because of limited time available to collect and analyse raw data. Against this backdrop,

the study is therefore qualitative in nature. Being concerned with the collection (entirely from secondary sources) and analysis of data on the role of the security sector in combating Ebola in Sierra Leone.

In addition, the overall objective of the study will be to capture and go beyond the various perspectives about the causal mechanisms that drive and enhance the security sector in responding to public health emergencies such as the 2014 Ebola outbreak in Sierra Leone. Specifically, the study will aim to provide a detailed and in-depth explanatory account of the underlying mechanisms that are associated with civil-military response in developing countries. Therefore, following Van de Ven who differentiate between “what are the antecedents or consequences of the issue?” (2007: 145) and Bennett & Elman, who differentiate between “causes of effects and effects of causes” (2006: 458) respective, the proposed research adopts a process-oriented model by examining the ‘causes of effects’. See also Brady (2003: 3) and Goertz & Mahoney (2006: 229). These ‘causes of effects’ are the mechanisms that actually make things happen or an event to happen. Thus, the study will seek to provide an explanatory account of the underlying causal mechanisms that drive and enhance security sector institutions in combating Ebola in developing countries. In light of the above, the study will adopt an intensive research design situated in a real life context (Lewis, 2003: 52). The remainder of this section will include the following: data collection methods and framework to analysis the data; limitations of the research, organization of thesis and the conclusion.

1.4.1 DATA COLLECTION METHODS

In as much as the study is qualitative in nature, both primary and secondary data are adopted in terms of data collection and analysis. As mentioned earlier the latter will constitute most of the data collection, with the former comprising less than 10%. The secondary data collection involves a review of theoretical literature and empirical research work from published sources such as books, technical and academic articles, UN development reports, international bulletins, international manuals, handbooks and online databases on global health security, and publications and national account. Worth noting is that most of the authors are field workers or former employees (of international and non-governmental organizations) who took part in the response (which may indicate potential biases), while others are independent experts, academic researchers and civil society activists. In addition, data on the role of the security sector in Sierra Leone are collected from the national response plans, policy papers and security reports mainly from ONS and MoHS. Furthermore, the author has carried out the literature search by searching through the University e-library and other online libraries for journals, blogs, articles and conference papers and data base from the websites of various institutions such as the WHO and governments institutions. The researcher also used search engines such as Google Scholar, and Jstor extensively.

As stated earlier, these methods and sources have been selected based on the research question and purposes of the research. Case study in particular have been selected to provide the most plausible explanation to answer the research question, to be able to gain an in-depth understanding of the phenomenon under study. The researcher have shown in the literature review that the study is theory-driven. This is important, to systematically

assess the role-played by the security sector in combating the 2014 Ebola outbreak. Moreover, in terms of integrating civil-military relations, policies and strategies adopted, and lessons learnt.

1.4.2 LIMITATION OF THE RESEARCH

A major limitation to the study is inconsistencies in the secondary data collected from both published and unpublished sources, mainly because the Ebola epidemic caught the authorities 'pants-down' and ill-prepared to respond. Hence, the initial response by government policy makers was mostly off the top of their head or merely verbatim with no concrete plans or policies. As those lives claimed by the Ebola virus cannot be independently verified given the time constraint and other undisclosed reasons. Therefore, the researcher cannot guarantee the authenticity of the figures. In addition, there are missing figures from the data presented for the initial period of the Ebola outbreak, which may distort the accuracy of the result. Moreover, results from the study cannot be generalized (Yin, 1994), cited in Chetty (1996) they provide only a real-life based-experiences and perceptions of the various authors (diplomats, INGO and NGO workers, academics) on the 2014 Ebola outbreak in Sierra Leone.

1.4 ORGANIZATION OF THESIS

This study will be organized as follows: Chapter 1 will be the introductory section. This section outlines the problem statement and an overview of the entire purpose of study including its significance and organization of thesis. The Literature Review will be in Chapter 2. This section will examine the various scholarly work or research on this study, with emphasis on the case study. Chapter 3 gives an overview of the pre-existing structure of the national

public health response systems for this study. In this section, we will highlight the initial national response architecture coupled with, the command and control systems in response to public health emergencies in the country. Chapter 4 examines the effectiveness of policies and strategies (during and after response) provided by the security sector to combat the Ebola outbreak, and the various levels of response mechanisms This section will showcase the relevance of these policies and strategies as a civil-military partnership to curb the Ebola virus. In addition, it will highlight the attitude of government in dealing with the crisis as a mere health emergency left in the hands of health practitioners instead of a national security threat. Chapter 5 presents the nexus between Civil-Military relations and its impact in response to the Ebola outbreak. Specifically, it will highlight the challenges and successes in working together in terms of policy and strategy implementation at both national and international levels and Chapter 6 concludes, with the nexus between health security and the sustainable development goals, and recommendations. To this end, this section will lay bare the importance of the security sector in response to the 2014 Ebola outbreak, which could serve as a permanent feature for other public health emergencies in the country. In the same vein, it will highlight key recommendations from the lessons learnt for future response to epidemics such as Ebola outbreaks and in dealing with the challenges from a country perspective.

1.5 CONCLUSION

This chapter has given readers with a brief background on the role of the security sector in combating the 2014 Ebola outbreak in Sierra Leone, including the various shades of opinion in the literature on securitizing public health emergencies in general. The motivation of the study is deliberated and justified and the overall research question and

individual objectives are identified. The remainder of the study includes: chapter two - literature review; chapter three - gives a background of the pre-existing structure of the national public health response systems (background to the case study); chapter four – the effectiveness of policies and strategies; chapter five – summary of findings, and chapter six - conclusions.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

Health Security is an integral tool for national development. Over the years, infectious diseases have proven to be a constantly evolving present threat to global health security. However, health security is not understood in the narrow military sense related to bioterrorism or the state-centred approach of WTO but linked to human, gender and environmental security, a "HUGE" security (Oswald, 2011). Starting in the mid-1990s, the possibility of terrorism with biological and chemical weapons has evolved into the number one security threat for military planners and decision-makers in many countries, most notably the United States (Kelle, 2007). To this end, the sources of security threats have also changed over the years in respect of questions been raised “of what? of whom? and from whom and for what? security” (Baldwin, 1997; see also Elbe, 2007).

In short, infectious diseases like SARS, H5N1 influenza, Ebola, and Zika etc have been securitized (de Waal, A. 2017; Kelle, 2007; Elbe, 2007; and Oswald, 2011). This is amplified and led by western countries, delegated to the World Health Organization. This delegated power to WHO serves the interests of the western countries to curb or prevent epidemics beyond their borders and at the same time displaying the WHO at the international stage, as a public health global governance outfit. To this, I may argue that the securitization of infectious diseases is a pro-western value and or interest and at the same time giving the advantage to the WHO to exert its influence towards the prevention of diseases. Davies (2008, p.313) further posits, “Western states have been able to ensure that progress made in disease surveillance and response mechanisms primarily

suit their national interest”. Primarily, this correlation between health and security was based on emerging and re-emerging infectious diseases that require a global approach. For instance, HIV/Aids found in many developing countries (sub-Saharan Africa) has a borderless effect if not prevented.

The Ebola virus have significant epidemic potential, as shown by the 2013–2016 West African outbreak. Caused by the Zaire strain, this outbreak was unprecedented in scale, being larger than all other outbreaks combined, with 28,646 reported cases (confirmed, probable and suspected) and 11,323 reported deaths (WHO, 2016). This Ebola outbreak was the first to lead to a major global public health threat and the first in which the virus spread across multiple international boundaries (Coltart, C.E.M. et al, 2017). However, previous outbreaks have only occurred in Central and Eastern Africa, no human sporadic cases or outbreaks had previously been reported in West Africa (Coltart, CEM et al, 2017a; see also CDC, 2016; and WHO, 2016a). The first documented outbreak of Ebola occurred in 1976 in northern Zaire (now the Democratic Republic of Congo). It occurred in and around a mission hospital in Yambuku, adjacent to the Ebola River after which the virus was named. In total, 318 cases were identified with a case fatality of 88% (WHO, 1978).

Table 1. Previous Ebola outbreaks/infections in humans (Adapted from CDC)

Year	Countries	No. Outbreaks	No. Cases	No. deaths	Viral Strain
1970 – 1979	Zaire, 1976a	2	319	281	Zaire

	Sudan, 1976b	2	318	173	<i>Sudan</i>
	United Kingdom, 1976	1	1	0	<i>Sudan</i>
1980 – 1989	Philippines, 1989– 1990	1	3c	0	<i>Reston</i>
1990 – 1999	USA, 1990	1	4c	0	<i>Reston</i>
	Gabon, 1994	3	149	97	<i>Zaire</i>
	Côte d'Ivoire, 1994d	1	1	0	<i>Tai Forest</i>
	DRC, 1995	1	315	250	<i>Zaire</i>
	Gabon/South Africa, 1996e	1	2	1	<i>Zaire</i>
	Russia, 1996	1	1	1	<i>Zaire</i>
2000 – 2009	Uganda, 2000 – 2001	2	574	261	<i>Sudan/Bundi bugyo</i>
	Gabon, 2001 – 2002	1	65	53	<i>Zaire</i>
	Republic of Congo, 2001– 2002	3	235	200	<i>Zaire</i>
	Sudanb , 2004	1	17	7	<i>Sudan</i>
	Russia, 2004	1	1	1	<i>Zaire</i>
	DRC, 2007	2	296	202	<i>Zaire</i>
	Philippines, 2008	1	6c	0	<i>Reston</i>
2010 – 2013	Uganda, 2011 – 2013	3	18	8	<i>Sudan</i>
	DRC, 2012	1	36	13	<i>Bundibugyo</i>

a. Now Democratic Republic of Congo (DRC).

b. Now South Sudan.

c. Asymptomatic infection.

d. Patient was hospitalized in Basel, Switzerland for medical treatment.

e. Index case infected in Gabon, admitted to hospital in South Africa for treatment and subsequently infected a nurse.

In Sierra Leone, the 2014 Ebola outbreak was a clear indication of the securitization discourse in dealing with such epidemics at the national level. According to WHO's estimate a total of 3,956 deaths out of 14,124 cases, 28% of the affected population was reported (WHO, 2018). With a weak, fragmented and under-resourced national health

system the epidemic was out of control; and with calls from global leaders “to curb the epidemic it is imperative that States immediately deploy civilian and military assets with expertise in biohazard containment...without this deployment, we will never get the epidemic under control” (Liu, 2014; cited in The Canadian Press, Branswell, H. 2014). See also (Walsh and Johnson, 2018). Therefore, it is believed that “the security sector was an effective agent in handling these health and emergency situations, and an important component in regional responses. On a national level, the security sector was part of the disaster response preparedness structure. Constructive collaboration with the health sector was crucial to facilitate effective and efficient responses to health crises and emergencies (Sandy, J. et al, 2017).

In this chapter, it will be argued that the role played by the security sector in combating the 2014 Ebola outbreak in Sierra Leone may not primarily be the only vehicle to such response - other factors such as the management and use of hybridized response (including international partners, traditional chiefs, volunteers, secret societies, etc), and the implementation of effective policies and strategies, and civil-military relations in a post-conflict environment also have equal stakes.

The paper further asks what role did the security sector played in combating the Ebola outbreak? To answer this, most notable was “the management of dead bodies. Serving personnel provided protection for burial teams from attack. They also managed the deployment of these teams in urban towns, thus providing crucial role in most surge operations that are geared towards the collection of corpses from major streets. This is

the mark of a mature and capable force, working within the boundaries of a national policy of police primacy”(Heanlein and Godwin, 2015a). Secondly, “it provided an opportunity for a litmus test of the security sector. The performance of the country's security forces at the height of the crisis suggests the existence and effectiveness of sound national security architecture that is responsible to public health emergencies” (Haenlein and Godwin, 2015b).

Therefore, the research brings in a fresh perspective in critically assessing the security sector's role focusing on the experiences, and engagement of communities who also served as responders; whilst we seek to understand the manner in which the response was organized and coordinated. Moreover, this outbreak further widened the security discourse on (a) the role of the security sector in the context of response to Ebola and (b) civil-military relations in a post-conflict environment. The lack of critical mass of empirical data on the systematic assessment of the role played by the security sector further highlights the importance of this research. To this end, the remainder of this section has been divided into two broad categories as follows: status of the national response structure before the 2014 outbreak and the effectiveness of the policies and strategies by the security sector in combating Ebola, and the impact of civil-military relations in response to such outbreak and the future lessons.

2.2 AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE 2014 EBOLA OUTBREAK AND THE EFFECTIVENESS OF THE POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING EBOLA

Before the Ebola outbreak, the health budget was simply not enough, with the government spending only \$13 per person on health each year (a minimum of \$86 is

recommended to provide a minimum package of care. (High-Level Panel on the Global Response to Health Crises, 2016 Statistics from 2012 cited in Walsh and Johnson, 2018. p.33). Tracing this link is however outside the scope of this study which may require further empirical analysis. However, the role played by the security sector in combating the 2014 Ebola outbreak will be viewed here in terms of the effectiveness of policies and strategies as a response strategy for public health emergency in focus. It is believed that “the security sector was an effective agent in handling these health and emergency situations, and an important component in regional responses. On a national level, the security sector was part and parcel of the disaster response preparedness structure. Constructive collaboration with the health sector was crucial to facilitate effective and efficient responses to health crises and emergencies(Sandy, J. et al, 2017a).

This section therefore asks is there any link between the status of the national response structure in responding to the 2014 Ebola outbreak. From a general view of existing literature there is evidence so far to support that an under-resourced and poorly managed, coupled with limited political will negatively affected the response process during the initial period of the Ebola outbreak. This strategic failure is in part according to Walsh and Johnson (2018b) “with the advent of the outbreak, one of the gaps was that there were too many meetings and not enough action taken right from the president’s office to the Ministry officials; as compared to the 2012 cholera outbreak. This to a large extent was premised on various factors such as the general dysfunction of the response, a lack of transparency about what was going on and the Ministry's insistence on painting the outbreak in a positive light”. It was crystal clear that the WHO gave a lot of funding to the

Sierra Leone government for health but most of this said aid has been allocated to combat HIV infection, malaria and tuberculosis, with much of the residual going to maternal and child health services. Therefore, relatively little external aid was left to support overall development of health systems (Kieny et al, 2014, p. 850); which largely exacerbated the Ebola outbreak.

Sierra Leone, with a population of about 7 million people (Sierra Leone Census Report, 2015), had its first reported case of Ebola on 25th May 2014 in Kailahun District of Eastern Sierra Leone. The first Ebola case in the capital city, Freetown, was reported on 11th July 2014 (Gbla, 2018). Notably, many of the nurses or doctors had either left the country for greener pastures or reached retirement age. As such, those who left behind had sacrificed their opportunities to further their expertise. In total, the country had only a little over a hundred doctors working clinically in the public sector, and even if you included doctors working in the private sector, this was approximately just one doctor per 45,000 people. (Mankad et al (2015). Therefore, coupled with other attendant social problems of the Ebola epidemic in the country this under-resourced and poorly managed status of the national health response system did not only exacerbate the widespread and momentous spread of the virus but helped largely; in the involvement of the security sector as a last resort to ameliorate the situation at hand. Among these were: a slow response due to the initial denial of the existence of the disease by majority of the citizens, especially amongst rural residents; reluctance to discontinue certain cultural practices such as relating to care for the sick and burial preparations; and the initial lack of proactive actions to isolate cases of infection and to recognize the epidemic as a security risk (Haenlein and Godwin 2015c).

Hence, the Ebola epidemic was declared by the government a national emergency in July 2014. However, as the crisis continued to spread throughout the region, the UN Security Council in September 2014 declared Ebola a threat to international peace and security (UN 2014). This moment saw the securitization of the Ebola response (Enria, 2017 cited in Gbla, O. 2018, p.3).

Similarly, some commentators believed that HIV/Aids in 2000 and Ebola in 2013; both been viruses have brought the UN Security Council together for the first time to discuss a public health emergency. And that the Ebola outbreak was “the subject of an unusual resolution that was passed unanimously at the United Nations on 18 September, 2014(Garissi, D.2013). See also (Burci, L.G. and Quirin, J. 2014). According to WHO’s Director-General, Margaret Chan, she described the Ebola epidemic in West Africa as the “most severe acute public health emergency in modern times”. The disaster, she said, represents a ‘crisis for international peace and security’ and threatens the ‘very survival of societies and governments in already very poor countries’ (Bruce, N.C.2014) See also (Wilkinson, A. 2014). To this end, Garissi further posits that the “Ebola and ISIS are serious global challenges that mask deeper, more complex problems. They are, in essence, opportunistic infections taking advantage of weakened, vulnerable systems”(Garissi, D. 2013). To this end, one could posits it brings the equation of the Ebola virus as a threat to international peace and security, hence it needs a security approach.

Therefore, the concept of Global Health Security (GHS) see also (Oswald, 2011; Palomba, 2014; Rushton, 2011; Davies, 2008; and Elbe, 2010) which “reinscribes the geopolitical divide between North and South with confirmed outbreaks, and by logical extension international public health emergencies being primarily located in the global south”(Weir, 2014). This system (global health security) serves as a “protectionist” (Weir, 2014a) for the northern hemisphere and at the same time revises the subject of governance. On the contrary, “at the national level, infectious diseases threaten multiple aspects of a state’s functioning viability, whether by weakening popular confidence in a government’s ability to protect its citizens, undermining social order or disrupting economic activity”(Haenlein and Godwin, 2015). See also (Brower, J and Chalk, P 2003; Peterson, S. 2003; and Dionne, K.Y 2014). To this, I may argue that the securitization of infectious diseases is a pro-western value and or interest and at the same time giving the leverage to the WHO to exert its influence towards the prevention of diseases. To this end, “western states have been able to ensure that progress made in disease surveillance and response mechanisms primarily suit their national interest”(Davies 2008, p.313).

2.1.1 EFFECTS OF THE POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING THE EBOLA EPIDEMIC IN SIERRA LEONE

Many studies (Horton and Das, 2015; Elbe, 2010, Rushton, 2011; de Waal, 2014; and Palomba, 2008) have shown that securitizing health does not lead to the efficiency and effectiveness of the use of security sector to combat public health emergencies but rather it must have amongst other things the right political backing, policies and institutional mechanisms both at the international and national levels that are needed to ensure that public health emergencies such as Ebola are adequately managed and serve their

intended purpose. The securitisation (ie, depiction of health as a threat to a nation's security) of health has distilled health issues of international concern largely down to highly virulent infectious diseases and bioterrorist threats (Stevenson and Moran, 2014), though largely adopted by many developing countries, applied at varying degrees within a different context. As in the case of Indonesia, "H5N1 can thus serve as a pertinent case study for tracing how the effects of securitization unfold specifically in the field of global health"(Elbe, 2010).

On the contrary, Haenlein and Godwin (2015d) posits that at "the national level, infectious diseases threaten multiple aspects of a state's functioning viability, whether by weakening popular confidence in a government's ability to protect its citizens, undermining social order or disrupting economic activity". Therefore, it is worthy of note that this was not just a health crisis but the failure of the political will to timely declare this outbreak as a public health emergency. "Here we enjoy the benefit of hindsight: few could have predicted the severity of the outbreak based on the much lower death tolls seen previously" (CDC, 2014b) in the country and in neighbouring countries. The delay nonetheless reflects a lack of government experience in handling such contingencies: whereas security forces elsewhere are regularly used at times of national crisis (Brian Jones, Head of ISAT, referenced in Haenlein and Godwin, 2015f) due to their unique ability to meet the demands posed by extraordinary events, Sierra Leone lacked the processes to coordinate immediately such a response. But in a case study of Indonesia, a securitized response to infectious disease management can also have anticipated consequences in terms of further complicating international health cooperation (Elbe, 2010a). Because it

was observed by the Indonesian government that pharmaceutical companies in the West were developing and producing lucrative new vaccines through their effort of sharing the H5N1 virus samples with WHO. In this regard, “the Indonesian government took the controversial decision in December 2006 to cease sharing its H5N1 virus samples with the international community” (Elbe, 2010b).

On the domestic front, the securitization of Ebola has also triggered dynamics that have persuaded policymakers worldwide to formulate a range of preparedness plans and policy actions aimed at strengthening disease surveillance and response capacities and speeding up work on an anti-Ebola vaccines and medicines (Huang, 2014). To this end, the Sierra Leone government noted that the fight against the Ebola pandemic was complicated by the uncontrolled movement of people who were either Ebola suspects or had proved positive and the complicity of people to change the identities of Ebola suspects or positives. Therefore, under the provision of Military Aid to Other Government Departments (MAGD; a provision enacted in the NaSCIA, 2002, ONS, Government of Sierra Leone) to contain the unpredictable manner in which the Ebola disease was spreading in the country; it was agreed that a change of strategy was necessary to reduce the footprint of the Ebola disease which was becoming erratic (ONS Inter-Ministerial Meeting Report, 23rd July, 2014). In line with this, various strategies and policies were implemented such as the isolation and quarantining of suspects of Ebola, contact tracing, restriction at epicenters, checkpoints manning, education, and security coordination.

The paper further asks in relation to combating the Ebola epidemic by the security sector what has been the effect of policies and strategies in particular. As an overall response mechanism is there any direct link between the implementation of effective policies and in combating the Ebola epidemic in relation to the security sector's role, what is the level and impact of securitizing the Ebola in relation to these agencies? In this regard, Denny (2015) argues that "in discharging most of these functions, the forces relied on their training and discipline and were highly commended for professionalism. This was, indeed, a deviation from previous popular perceptions of these forces as corrupt, unprofessional, and human rights abusers, with a large degree of civilian distrust". As mentioned earlier Haenlein and Godwin (2015g) from their descriptive analysis reveal an upward trend of confidence building between and among the security sector and the general populace during the Ebola. Thus, building on the words of Gbla (2018b) "for the security forces, the Ebola outbreak presented a significant challenge. The RSLAF and SLP were called on to fulfil a range of traditional and non-traditional public safety functions". Nonetheless, these forces adapted to such challenge with the required capacity in combating the ebola epidemic based on the strict rule of command and control mechanisms.

2.1.2 THE IMPACT OF CIVIL-MILITARY RELATIONS IN RESPONSE TO SUCH OUTBREAK AND THE FUTURE LESSONS.

Many literature often examines civil-military relations from various perspectives. For the purpose of this study we will look at two broad categories. Firstly, domestic civil-military relations, whilst the second deals with the civil-military relations which emerged during the Cold War. For the former, "the issues under investigation revolve around topics such as civilian oversight and control of the military, the risk of conflict between parties leading to unintended outcomes (i.e. military coups), and the importance of democratic

governance and accountability” (Huntington, S. 1957). In retrospect, Bland (1999); see also (Schiff, R. 2009; Bessner, D and Lorber, E. 2012; Coletta, D. (2013)) argued that “the focus is on the balance of power and bargaining between three groups of actors - the general population, civilian government, and military - with various theories emphasising different individual, institutional, or sociological factors to explain whether the armed forces are behaving as intended”. For the latter category, it “emphasizes the importance of particular norms such as the ‘responsibility to protect’, gender ‘mainstreaming’, etc. Here the principal concern is changing military practices and roles in international stability and reconstruction operations”(Jenny, 2001). See also (Rietjens S and Bollen M (eds) 2008; Ankersen C (ed) 2008; Rietjens S, Soeter J and van Fenema, P (2013). Thus, within this literature, the former is more apt in terms of civil-military relations in response to the 2014 Ebola outbreak.

Consequently, the role of military personnel in health-related activities (and corresponding concepts such as ‘health as bridge for peace’) has remained especially controversial (Kamradt-Scott, A. et al (2015). To this, one may agree looking at the initial response of the military. Initially, the military had no clearly defined response mechanism on health-related humanitarian crises neither were they regarded as an appropriate institution to undertake such task meant for health practitioners. Secondly, the outbreak was a novelty in this part of the African region with little or no expertise on the part of the military which according to Kamradt - Scott et al (2015a) “blurred the lines between a public health emergency and humanitarian crisis”. Other findings within this growing literature suggested that, inside the military, opinions also remain divided over the appropriateness

of military-operations-other-than-war (MOOTWs), with some voices arguing that such activities are not 'core business' and should be discarded (especially in light of fiscal tightening (Bernard, K. (2013).

However, the scope of this study does not focus on the military per se rather the security sector as an umbrella body. Against this backdrop, the paper seeks to inform that civil-military relations in this context means the health practitioners, international and domestic civilian actors, security sector and "as well as hybrid structures like the provincial, district and chiefdom security committees and crisis response structures such as the District Ebola Response Committees (DERCs) and Community Care Centres (CCCs), collaborated to tackle the disease"(Gbla, 2018c).

Therefore, the paper further asks what was the impact of such collaboration vis -a-vis civil-military in terms of its process, level and trend of response in combating Ebola? In this regard, a recent finding by Kamradt-Scott, A et al (2015a) posits that it "proved necessary and helped the affected countries to contain the virus sooner, ultimately saving lives". However, in a report published by (Cooper, H. 2014) in the New York Times newspaper argued that the "Ebola crisis was initially framed as a health emergency instead of a humanitarian crisis"; thereby engraving these 'blurry lines' (Kamradt-Scott, A. et al 2015b) into an ad hoc arrangement to establish crisis institutions like the United Nations Mission for Ebola Emergency Response (UNMEER). In the same vein, amidst the under-resourced and poorly robust health system, Kamradt-Scott, A et al (2015c)

cautioned that “civil-military cooperation in health-related humanitarian crises should remain context-specific”(Kamradt-Scott A. et al 2015).

2.3 CONCLUSION

This chapter has discussed the existing literature on the concept of global health security, and linking it with the basis of this research; role of the security sector in combating the Ebola outbreak in particular. Even though there are mixed evidence on the effects of security sector’s role, it will be quite unreasonable to claim that the role of the security sector have not in somehow had any positive effects on combating the Ebola scourge - at least in terms of their professionalism and discipline in dealing with a crisis of unprecedented nature than ever before; also one that is considered a novelty within the West African region. In the absence of any convincing empirical evidence on whether the role played by the security sector correlated to combating the Ebola epidemic, theoretical literature and available data from various authors clearly indicate that the professionalism with which the sector demonstrated itself is characterized by “upholding the rule of law with strong respect for human rights while been very sympathetic to the suffering and grief of the population in a debilitating circumstance”(Haenlein and Godwin, 2015).

Worth noting, from the review is that, there is a lack of critical mass of empirical data on the systematic assessment of the security sector’s role during this crisis. Thus, the importance of this research is timely. Even though, civil-military relations served a timely manner to combat the crisis, studies(Kamradt-Scott, A. et al, 2015) have proved that “civil-military cooperation in health-related humanitarian crises should remain context-specific” rather than a ‘one-size-fits all scenario. Secondly, the role played by the security sector

have had positive effects on the outbreak, it may not have been the only reason for such development - other factors such as the implementation of strategic policies and security measures at institutional levels (notably the manning of checkpoints, quarantine, surveillance and contact tracing etc) for eradicating the transmission of the virus are key components in the fight against the scourge. This, to a large extent are key overall benefits in combating Ebola.

Therefore, the analytical framework that sets out the basis for the research as stated in objectives (ii) and (iii) has been carried out in this review chapter. It has explored the status of the national health response structure, and level of response before the outbreak. The exploration also covered the effectiveness of policies and strategies by the security sector to curb the outbreak.

Implying that there is a causal relationship between the status of the national health response structure (inadequate) and other attendant problems that led to the involvement of the security sector in our case study, the presentation (Chapter 3), civil-military relations and the effects of policies and strategies (Chapter 4) and findings (Chapter 5) from both secondary and primary data will showcase a reasonable conclusion on the role played by the security sector in combating the 2014 Ebola outbreak.

CHAPTER THREE

AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE 2014 EBOLA OUTBREAK

3.0 INTRODUCTION

In this chapter an overview of the national health response structure in terms of public health emergency during the 2014 Ebola outbreak in Sierra Leone will be discussed. Mainly an overview of Sierra Leone's early response structure, their function and demise; the focus here will be on the early response mechanism by the Ministry of Health and Sanitation, analysis of such dubious start in terms of staff capacity, awareness raising/sensitization, and social spending on health care will be covered. Furthermore, data and trend analysis of the response structure will be presented, with an outline of the composition of such response towards a public health emergency in terms of local and national response levels to determine how the Ebola virus spread quickly as a result of but not limited to an under-resourced health care system and limited political will. In the end, a brief overview of the transition to a new response structure will then be presented. Highlighting their functions, challenges and evolution and the role of other international, domestic, civilian and military actors.

3.1 AN EXAMINATION OF THE NATIONAL RESPONSE STRUCTURE BEFORE THE EBOLA OUTBREAK

According to the Health Access Index - 'Countdown to 2015 Countries' it shows that, before Ebola struck, Sierra Leone and Liberia were not even in the bottom 20 countries (Health Access Index, 2015, cited in Peter Piot, 2015). In fact, 28 countries came below Liberia in the Index which shows that many more countries are just as vulnerable to epidemics.(Peter Piot, 2015a, p.viii). For instance, Nigeria; that were able to quickly stopped the transmission of the disease in the country.

In Sierra Leone, before the Ebola outbreak, the health budget was simply not enough, with the government spending only \$13 per person on health each year (a minimum of \$86 is recommended to provide a minimum package of care. (High-Level Panel on the Global Response to Health Crises, 2016 Statistics from 2012). Many of the nurses or doctors had either left the country for greener pastures or reached retirement age. As such, those who left behind had sacrificed their opportunities to further their expertise. In total, the country had only a little over a hundred doctors working clinically in the public sector, and even if you included doctors working in the private sector, this was approximately just one doctor per 45,000 people. (Mankad et al (2015). This compared to about one per 350 people in the UK (The World Bank,n.d cited in Walsh and Johnson, 2018b; see also Peter Piot, 2015b) In the same vein, “it was clear that the WHO gave a lot of funding to the Sierra Leone government for health but “most of this said aid has been allocated to combat HIV infection, malaria and tuberculosis, with much of the residual going to maternal and child health services. Therefore, relatively little external aid was left to support overall development of health systems” (Kieny et al, 2014, p.850 cited in Walsh and Johnson, 2018); which to a large extent exacerbated the Ebola outbreak.

In linking the spread of Ebola to that of health services, Peter Piot (2015c) posits “one specific factor that contributed to Ebola getting out of control was inadequate health services”.This, clearly shows the grotesque picture of the under-resourced health care system which did not only help to exacerbate the spread of the virus but also deepen the

chaos and confusion in terms of coordinating an effective response. Similarly, the Free HealthCare Initiative (FHCI) which was introduced in 2010 by the government to address high rates of maternal and child mortality by removing user fees from public maternal and child health services (GoSL, 2009) was met with a huge demand for services showed the inadequacy of healthcare systems. The FHCI supply of services was not improved at the same rate (including the supply of health workers), this meant many people's need for services were unmet, and the demand for services has been gradually dropping since then (McPake et al, 2013, cited in Peter Piot, 2015, p.5) Research has shown that many people preferred to take their children to traditional healers even after FHCI was introduced(Diaz T. et al, 2013).

Moreover, "Sierra Leone only had a quarter of technical and professional staff needed to run the country" (The World Bank, 2012, p.1). Thus, these and other attendant issues such as the weak, under-resourced, and fragmented health care, coupled with the post-cholera outbreak in 2012 left the MoHS 'licking its wounds', the emergence of the Ebola was the "straw that breaks the camel's back" in exposing such a weak national health care response structure.

3.2 THE EMERGENCE OF EBOLA AND CONSPIRACY THEORIES IN SIERRA LEONE

Sierra Leone's first Ebola confirmed case was reported on 25th May, 2014 of a forty-two year-old woman named Mamie Lebbie, mother of two who had tested positive in the south-eastern town of Kailahun District (Walsh and Johnson, 2018d). See also (Gire S.k et al, 2014; and Coltart C.E,M et al, 2017). Two months after the MSF had called the

outbreak in Guinea and Liberia ‘unprecedented’. As a dubious start, a three day Twitter battle followed during which the official WHO spokesperson in Geneva warned MSF not to “overblow” or “exaggerate” the situation.(Sack et al, 2014).To this end, one may regard this as a lukewarm approach taken by not only the government but the international health organization such as the WHO responsible for such epidemics. At least, this could have spared the lives of the many Ebola victims within these three countries. Bedevilled by other socio-economic and political factors within the WHO regional offices; and “anxious not to scare away airlines or mining companies, they promoted “positive communication” about the outbreak and downplayed its seriousness” (Sack et al, 2014a) within these countries. However, one may argue that the Ebola outbreak creates a socio-economic stigma that poses a huge international disadvantage in terms of tourism and the closure of borders for passengers from Ebola affected countries. To this end, “this left us with a weak and politicised WHO Regional Office to support a poorly equipped WHO country office in dealing with this unprecedented outbreak” (Walsh and Johnson, 2018e).

The Ebola outbreak was recorded at infecting an estimated 28,616 people and causing an estimated 11,310 deaths across Guinea, Sierra Leone and Liberia, the three worst-affected countries (WHO, 2015a; WHO, 2016a). “Sierra Leone which experienced the highest number of cases, with 14,124 infections, including 3,956 deaths, reported to WHO, and where the operational architecture of the Ebola response went through three main iterations over a 22-month period” (Ross, E. 2017). Previously, there have been Ebola outbreaks in other parts of the African region. Out of the thirty-four outbreaks that had taken place up to 2014, six outbreaks had each killed more than 100 people, although

seventeen other outbreaks had killed fewer than ten people or none at all.(CDC Report(n.d), cited in Walsh and Johnson, 2018).

As the Ebola spreads across the country, people had so many conflicting messages or rumor mongering from the messages aired by the Ministry of Health. Hence, they prefer to rather die in their communities than to find treatment elsewhere. Thus, the populace were “angry, frustrated, scared of this disease that was killing them and of these recommendations that clashed with their belief systems, they felt misunderstood and abandoned by the whole world” (Niang, 2015).

Widespread distrust of health services and a corresponding lack of care-seeking at the few facilities that were available were important aspects of the spread of Ebola (Wurie, H.2014), with some infected people staying in their communities because they were unable to access treatment or mistrusted the health services. This put others at risk of onward transmission(Kucharski, A.J and Piot, P.2014; 19(36). See also (Walsh and Johnson, 2018; Haenlein and Godwin, 2015).

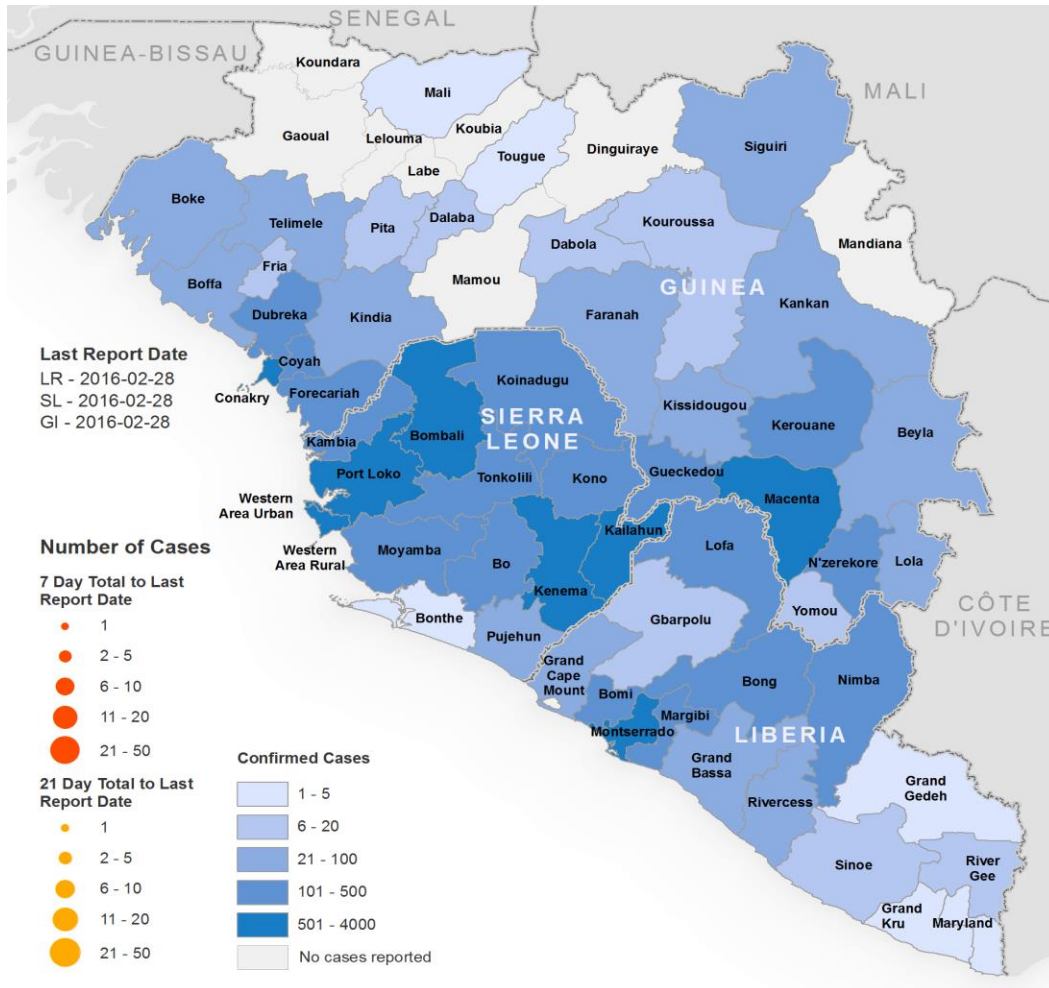


Figure 2: Geographical distribution of new and total confirmed cases in Guinea, Liberia, and Sierra Leone. (Adapted from WHO).

Moreover, conspiracy theories abounded. These rumours played part as the scourge ravages on. People had misconceptions about foreigners coming to assist them with this ‘new killer’ virus. And that it was “a US plot to kill Africans through bio-terror, others claimed it was a foreign plot to steal the blood of Sierra Leoneans and harvest their organs” (Walsh and Johnson, 2018e), See also (The Guardian, 2014; Thurtle, 2014) depopulation of the opposition stronghold for census purposes, and government using this epidemic to request for more funding etc. This impeded both treatment and efforts at

communication, the latter aimed specifically at addressing particular ceremonial practices around sickness and burial (Haenlein and Godwin, 2015). Some claimed it was a curse placed on a particular family during a female secret society initiation rites, whilst others believed that a local businessman who was admitted at the Kenema hospital (one of the epicenters) lost his bag full of money which they believed was stolen by the nurses; hence they have been cursed. However, building on the words of Walsh and Johnson, (2018f), “while these rumours might sound irrational, they usually had a linkage to facts. For instance, the national government did have a long history of marginalizing people within this border region. And the US Army’s Medical Research Institute of Infectious Diseases had been one of the partners in the Kenema Lassa fever Centre for several years, involved in research activities which could involve blood samples”.

Table 2. Basic Country statistics from the three main affected countries. (Adapted from the World Bank data 2014, unless otherwise stated)

Country Statistics	Guinea	Liberia	Sierra Leone
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capital city	Conakry	Monrovia	Freetown
population	12.3 million	4.4 million	6.3 million
gross domestic product per capita (US\$)	539.6	457.9	792.6
rural population (% of total)	63.3	50.7	60.4
physicians per 1000 people (as of 2010)	0.1	0.014	0.022
total number of reported Ebola cases† (WHO 2013 – 2016)	3811	10 678	14 124
total number of Ebola deaths (WHO 2013 – 2016)	2543	4810	3956

*confirmed, probable, and suspected cases reported by WHO

According to Walsh and Johnson (2018) “with the advent of the outbreak, one of the gaps was that there were too many meetings and not enough action taken right from the president’s office to the Ministry officials; as compared to the 2012 cholera outbreak. This to a large extent was premised on various factors such as “the general dysfunction of the response, a lack of transparency about what was going on and the Ministry's insistence on painting the outbreak in a positive light”.(Walsh and Johnson, 2018).See also (Ross, E. 2017). It was also noted that during the initial outbreak, there were no clear institutional mandates or policies regarding the cooperation between security and medical personnel. This created a weak and ineffective synergy as was amply demonstrated in the response architecture. For instance, “the capacity of correctional centres to prevent or control outbreaks of Ebola and other infectious diseases was highly inadequate, and the accommodation of new inmates and thus new risks of infection was a serious challenge”(Sandy, J. et al 2017).The nature of response by both national and international actors was based on the evolving trend of the Ebola virus as well; “from a health emergency to that of a security threat”(Gbla, 2018).

3.3.EARLY NATIONAL EBOLA RESPONSE STRUCTURE

The early response structure was based on two folds: The National Ebola Task Force, established in March 2014, and the Ebola Operations Centre, established in July, 2014. In late March 2014, the National Ebola Task Force which was established by the Ministry of Health and Sanitation (MoHS) was the earliest response coordination mechanism when the disease emerged in Guinea, but before the first case was detected in Sierra Leone (Republic of Sierra Leone, 2014). The strategy included awareness raising, contact tracing and surveillance in the border communities which was solely directed and implemented by the MoHS. This was ineffective, uncoordinated and lacked leadership as the epidemic continued to spread creating more fear among the populace and mistrust of the health ministry. This initial response was led and chaired by the Minister of Health and Sanitation, wherein the task force convened daily and the early meetings attracted about 80 people, including the Chief Medical Officer (CMO) and other senior MoHS staff, representatives from other government departments, four UN agencies (WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Food Programme (WFP)); donors and NGOs (Ross, E. 2017b).

In essence, the MoHS used the task force to organize the national communication strategy in response to the Ebola epidemic around four technical 'pillars' such as surveillance, case management, social mobilization and logistics (Republic of Sierra Leone. 2014a). With its long standing history of responding to epidemics across the world, WHO supported the MoHS with a handful of international organizations such as MSF, the IFRC, Save the Children, World Vision and the King's Sierra Leone Partnership (Ross, E. 2017) as the national capacity was weak; and at the same time most of the international

institutions had either fled or working on development rather than responding to a health crisis. According to the WHO, the number of cases in Kailahun peaked at more than 80 a week in June 2014, then reduced to 10 new infections in the second week of August (WHO, 2014a cited in Ross, E. 2017, p.6). A total of 645 people were known to have contracted the disease in Kailahun, and although the outbreak was quelled there before the international community arrived en masse, it had meanwhile spread to the nearby district of Kenema(Ross, E. 2017), where the hospital became another epicenter.

According to Walsh and Johnson (2018), 'safe burials' were part of the procedures to stop the transmission of the Ebola virus, wherein trained burial teams used the PPE and special equipment like chlorine and body bags. However, this was seen by the community as "something demeaning and associated with garbage - the plastic (of the bodybag) was seen to be similar to that of a garbage bag and...caused relatives to think their loved ones were "being thrown away like rubbish"(Johnson et al, 2015, p.8 cited in Walsh and Johnson, 2018, p.86). To this end, it became hard for the response to be effective as both national and international workers were plagued with the traditional burial practices. For instance, in the village of Conakry-D, close to the Freetown International Airport, over 20 family members died in one household. These corpses were buried at night, and unpatriotically, they family members planted potato leaves stems to disguise their unlawful act.

As the outbreak intensified, it was crystal clear that these response mechanisms were not properly working. Thus, the MoHS established an Ebola Operations Centre (EOC) on 11

July to serve as the response command-and-control centre (donor's unpublished slide presentation, 2015 cited in Ross, E. 2017). Unlike the National Task Force the EOC established nine pillars as part of a review to strengthen the communications strategy in response to the Ebola. Each of these pillars was co-chaired either by a UN agency or the ICRC. These coordination structures were replicated at the district level through district task forces led by the MoHS that met daily (Ross, et al 2017). According to Enria (2017), "giving the leadership of coordinating the Ebola response to the MoHS triggered diverse arguments". One such argument is that the ONS was most appropriate for such a role (Gbla, 2018) looking at their role during the 2012 cholera outbreak. Moreover, the ONS had a small unit known as the Disaster Management Department which has been very active in dealing with previous emergencies across the country. This was possible due to the localized security committee structures "linked with traditional chiefs" (Ross et al 2017) known as the PROSECs, DISECs and CHISECs for early warning early response mechanisms.

Lessons learnt from the early response mechanism created room for a co-lead approach of the EOC, thus MoHS and WHO as co-chair. "The (now six) technical pillars were led by an MoHS director and co-chaired either by a UN agency or by the IFRC, which co-chaired the new burials pillar. International NGOs gave important support to operations on the ground. The coordination structure was replicated at the district level, through district task forces, led by the MoHS, that met daily" (Olu et al., 2016). On 29 August, at a meeting with CDC's director in Freetown, President Koroma, after consulting with representatives of the UN, WHO, the UK Department for International Development

(DFID) and other donors, decided to review the structure of the EOC (Thomas, 2014 cited in Ross, E. 2017, p.8). With a reformed EOC, sacking of the Minister of Health and the replacement of the WHO Country Director, response mechanisms to the epidemic still looked gloomy and shady. Despite these restructuring measures, the EOC continued to lack the capacity to manage the response (Enria, 2017). One of the problems was that “its coordinator did not have a mandate to hold the various ministries to account, and there needed to be a change in structure in order to enable someone to hold such executive authority. By August, the disease had spread to all but two of Sierra Leone’s 14 districts” (National Ebola Response Centre, 2015). Another challenge was the issue of resources not forthcoming from the Ministry of Health at the earlier set of the response. This could be explained in two factors - trust and corruption. These problems greatly affected the response particularly in Kailahun District who had the lion’s share of WHO and MSF expertise. It was reported on 26th June “the government had allocated US\$1.8 million to the Ebola response”(Sierra Leone Ministry of Health and Sanitation Report, 2014b). Walsh and Johnson, (2018) further posits “the dysfunction in the Ministry at that time was such that people feared that if they signed off on expenditure, other colleagues would steal the money and they would be held responsible.(Walsh and Johnson, 2018). Hence in the midst of all these, “the level of mistrust by the population, early mistakes in community engagement, and under -resourcing of the response meant the critical moment when Ebola could have been contained was missed” (Walsh and Johnson, 2018).

This initial response was fraught with many challenges ranging from the lack of coordination with other sectors to that of specific guidelines on the dress code, especially with the PPE that was worn; which made it difficult for many health professionals and NGOs. “Each organisation had a duty of care not to put their staff at unnecessary risk....it was widely thought that at the time that there was an 80% chance of dying if infected, and it wasn’t at all clear what treatment we would be able to access”(Walsh and Johnson, 2018)

Similarly, Sandy, J et al (2017) noted that, “in the absence of clear frameworks of roles and responsibilities during the initial outbreak, cooperation between security and medical personnel was weak...more security sector involvement was needed for crowd management and the protection of quarantined homes and treatment centres” (Sandy, J. et al, 2017). Without much ado, the “government declared a public health state of emergency on 30th July 2014 and established a Special Task Force on Ebola under his chairmanship to aid the work of the EOC”(Government of Sierra Leone Press Release, 17 October 2014) that brought the security sector into the fight as the Ebola scourge ravages the population.

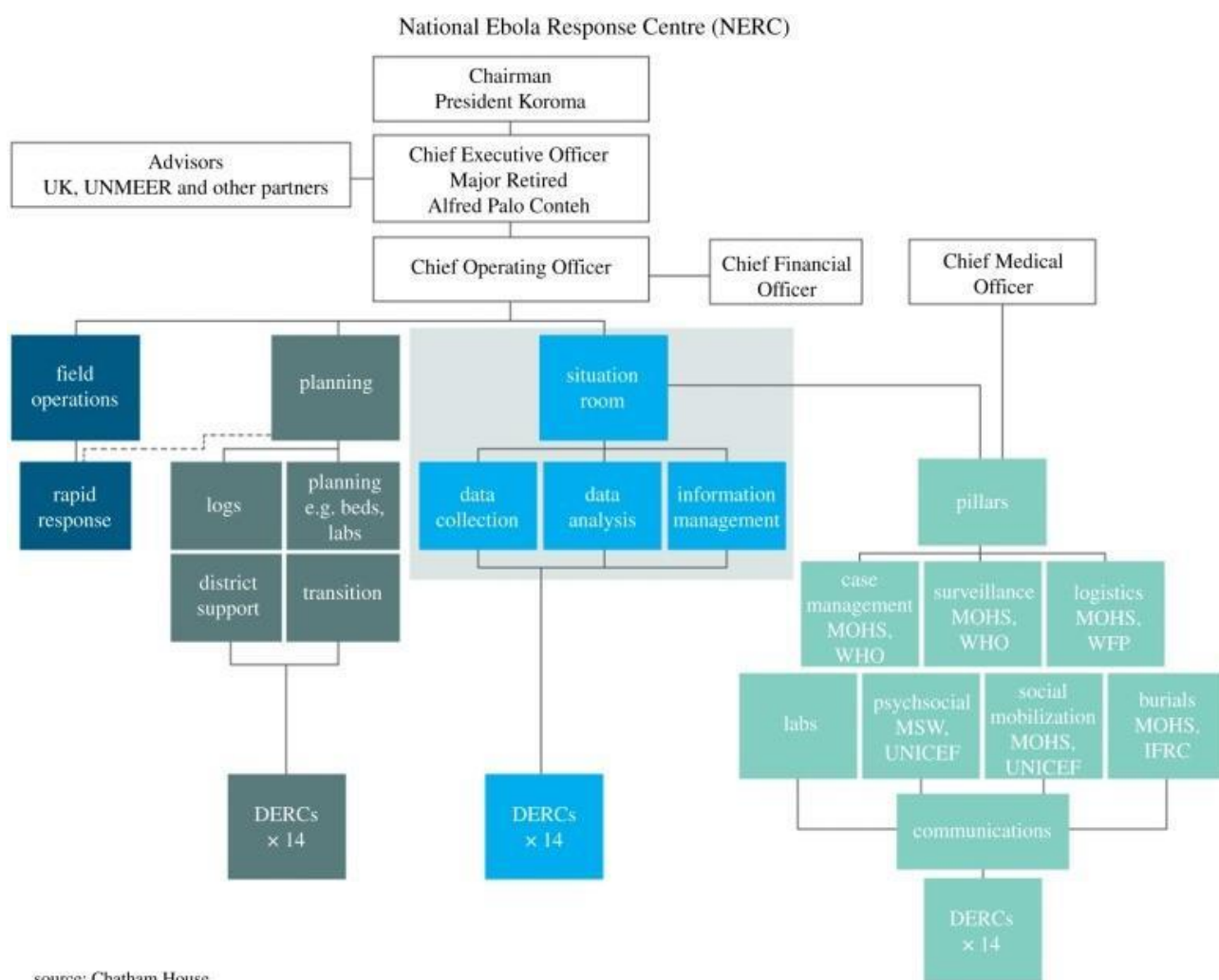
3.3 TRANSITION TO A NEW RESPONSE ARCHITECTURE

Five months into the outbreak, faced with a rapidly deepening humanitarian crisis and realizing that the existing systems were not working, Sierra Leone overhauled its response management structure and put in place the architecture that became a cornerstone of its strategy: a National Ebola Response Centre (NERC) that coordinated at the national level; and District Ebola Response Centres (DERCs) that served as

command-and-control hubs in each of the 14 districts(Sandy, J, et al 2017). See also (Ross, et al 2017; Gbla, 2018; Haenlien and Godwin, 2015) in October, 2014. This was pitched as a forum, with a robust command and control structure, to effectively eradicate Ebola (GoSL Press Release 2014). The NERC's governing authority was overseen by the President as Chairman with former Minister of Defence, Rtd Major Alfred Paolo Conteh, as Chief Executive Officer(GoSL Press Release, 2014). It included staff from national and international, civilian and military personnel and the UNMEER, British and civilian personnel were embedded in the NERC command and control architecture(Gbla, 2018).

This strategic foresight was applauded by many as the outbreak has not only escalated but it has moved from a health to that of a humanitarian crisis(Ross, E et al, 2017), which also served as a national security threat to the state. On the other hand, others claimed it was a strategic mistake as taking the “leadership away from the MOHS meant an opportunity was missed to build that capacity for the future. It might have been a good trade-off if the result was rapid containment at a time when the priority was keeping up with burials and scaling up treatment capacity, but not when the response turned out to be protracted and the primary need shifted to case finding and contact tracing – i.e. a key health ministry domain”(Ross, E. et al 2017). However, the MoHS was equally represented in all district level response committees in-charge of technical and health related measures.

One of NERC’s main drivers in responding and stemming down the scourge was the setting up of the National Situation Room. “Its core function was to collect and analyse real-time data and inform decision-making. MOHS and RSLAF staff assigned to it were paired with an embedded international responder – usually from WHO, CDC or the British military. The staff included an adviser from the Tony Blair Africa Governance Initiative (AGI); and the police and ONS were also represented, as were UNMEER and OCHA”(Ross, E. et al 2017). This structure was also widened and replicated at the provincial and district levels of the response known as the DERCs.



source: Chatham House

Figure 2: National Ebola Response Centre Organogram 2015

The NERC's structure went beyond the responsibilities of the MoHS and ONS. Which operated as a command and control centre developing the national response strategy, overseeing the national response work, including the various pillars established by the EOC and regularly briefing the President on progress (Dubois et al, 2015). In addition, NERC's technical pillar heads were also crucial in setting policies and coordinating pillar activities at the district level (Gbla, 2018). These decentralized structures served a crucial role in information sharing within a bottom-top approach for an effective response. With the NERC control and command centre, Sierra Leone confronted the Ebola epidemic with the sense of a military operation (AGI, 2015 cited in Gbla, 2018, p.7). This approach clearly gave way to enforcement of laws and in reducing the daily numbers of infected people; but at the same time "some NGOs and donor representatives opposed it on grounds of limiting access to essential supplies and inciting civil disorder" (Ross, E. et al, 2017).

Unlike the NERC, the DERCS served as the District Emergency Response Centres modelled on "the Western Area Command Centre; which were established in all 14 districts, with UK support staff embedded in the eight districts where the disease was most active"(Ross, E. 2017). This initiative came as a result of the many challenges faced in the Western Area with the backlog of dead bodies piling up in the streets of Freetown. "Thus negatively affecting the operations during the response"(Operation GRITROCK Report, 2015). The success of this initiative was what Ross (2017) calls "a proof of

concept for the efficiencies that command and control could bring, and was a turning point in the response” (Ross, E. 2017). With the sole business of adaptability to its peculiar environment, issues dealing with planning, operations and administration was brought under a central hub within the various districts.

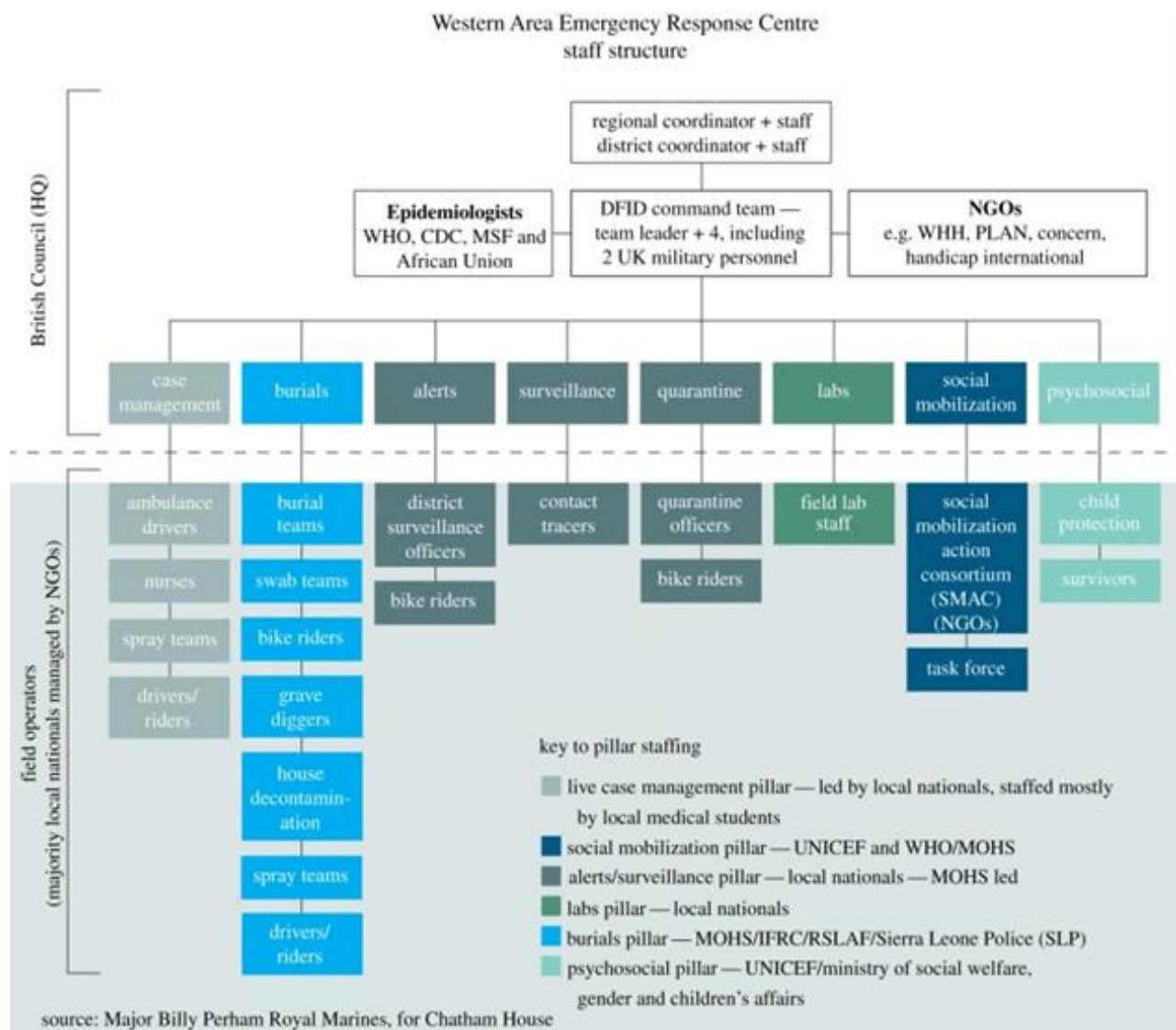


Figure 3 shows the eventual configuration of the Western Area Ebola Response Centre, the DERC for Freetown and its outskirts, from where around 130 people managed more than 1,300 front-line responders.

As a show of political will, the President appointed a District Coordinator (DC) as co-chair with the DMO under a standard structure. “UNMEER had a field crisis manager

embedded in each DERC. In addition, each of the British-supported DERCs initially had a UK military staff member, and, by January 2015, a District Ebola Support Team (DEST) to help run operations. The DEST comprised a mix of usually five or six UK military and civilian personnel. The head of the DEST was a DFID civil servant or contractor, and the chief of staff came from the UK military. The UK deployed 80 people in the DERCs at the peak of the outbreak” (Operation GRITROCK Report, 2015a).

At the operational level, decisions were made by the international partners, the DC interfaces at the local level to bridge the formal and informal structures for an effective response. “The disease control interventions were implemented through the pillars, which (as at the national level) were led by MOHS staff in partnership with a UN agency. At the district level, the pillar leads were in charge of implementing the technical advice and addressing technical questions, and guided strategic priorities, provided the medical response and developed recommendations” (Ross, E. 2017). In addition, the front-line responders were mostly Sierra Leoneans hired by NGOs who were the implementing partners. Most donors like DFID, CARE, USAID or Concern Worldwide regarded these NGOs to be ‘accountable and result-oriented’ in crisis period unlike the Ministry of Health. The WHO and CDC were mainly involved in epidemiology. According to Ross (2017), “the RSLAF staff ran the command-and-control operation for burials. Contrary to what had happened under the early response mechanisms, the traditional authorities – i.e. paramount, section and village chiefs, as well as other community leaders – were not systematically woven into the fabric of the DERCs, and there were reports that as late as February–March 2015 social mobilization activities were attempted without following the

approach of engaging the village chiefs, as would be expected by convention in Sierra Leone”(Ross, E. 2017). However, paramount chiefs participated regularly in DERC meetings, reportedly after fearing marginalization in the new system and successfully petitioning the president’s office to be included (Olu et al., 2016; Richards, 2016: p. 131).

3.4 CONCLUSION

This chapter has examined the national response structure before the Ebola outbreak. In so doing, it explored the inadequate health system as one of the underlying currents in exacerbating the outbreak. And that the initial response mechanism lacked leadership and ineffective leading to serious delays in addressing the crisis. Moreover, it explored the attitude and lukewarm response from the WHO; which was believed to be capable to handle the outbreak initially. Moreover, it showcased the need for a transition to another response structure which became the strategic focus in not only combating the outbreak but gave way to the Sierra Leonean government in using a military approach towards the outbreak.

This transition to a new response architecture included international and domestic civilian actors, security sector, decentralized security structures linked with traditional chieftaincy and the establishment of an ad hoc UN crisis management institution known as UNMEER. Its structure, composition and communication strategy was also explored. In essence, this chapter highlighted the effective collaboration of formal and informal structures as a “hybridized security governance”(Gbla, 2018) approach in response to the Ebola outbreak.

With the view that, WHO downplayed the seriousness of the initial outbreak which exacerbated the outbreak, it is believed that international responses are key in bringing together formal and informal actors in terms of their linkages in responding to future emergency crisis. Largely due to the concerted efforts of these external actors to help curb not only a crisis within the affected countries, but to also prevent such crisis reaching their own borders; vis-a-vis a global approach. As Garrett (2015) posits, “rich nations generally show only marginal interest in outbreaks until the microbes seem to directly threaten their citizens, at which point they hysterically overreact”. In the preceding chapter, the extent to which the SSR programme in 2002 helped build the capacity of the security sector would be examined. i.e. the training and experiences acquired to respond to such an ‘unprecedented’ emergency by the various security apparatus especially the RSLAF and SLP is the subject of analysis in response to the Ebola outbreak.

CHAPTER FOUR

AN ASSESSMENT OF THE ROLE, AND EFFECTIVENESS OF POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN COMBATING THE EBOLA OUTBREAK

4.0 INTRODUCTION

In this chapter, the study will assess the roles, and effectiveness of policies and strategies implored by the security sector in combating the 2014 Ebola outbreak in Sierra Leone. Mainly, the focus will be on the various policies and strategies adopted and implemented at national and local levels in response to the outbreak. The study will explore how these management strategies were organized and coordinated by the security sector; in terms of guidance and direction in the management of checkpoints, quarantine, safe burials, sensitization/awareness raising, contact tracing and surveillance etc within the context of the Ebola response. It will also explore the aspect of the security sector reform provided by the UK government in 2002; in terms of how prepared the sector is, in response to such outbreak, with a civilian oversight in implementing these policies at some levels, and examining the successes and challenges in a post-conflict environment plagued by years of mistrust of the security sector by the general populace. Furthermore, it will also highlight the impact of civil-military relations in response to the outbreak. A relationship that one may consider as a hybridized response at national, regional and international levels.

4.1 EFFECTS OF POLICIES AND STRATEGIES BY THE SECURITY SECTOR IN RESPONSE TO THE 2014 EBOLA OUTBREAK

The Ebola outbreak ushered in many policies by policymakers in a bid to combat the scourge. To this, community engagement proved to be one of the main processes in

stemming down the flow of infected persons. However, prior to the implementation of community engagement plans, the security sector in collaboration with the MoHS had already intervened with key measures. These measures were implemented due to the uncontrolled movement of people who were either Ebola suspects or proved to be positive, denial or ignorance of the disease, and the over defiance by people to medical operatives. This consensus was to change the strategy necessary to reduce the footprint of the Ebola disease which was becoming erratic. Therefore, under the provision of Military Aid to Other Departments (NaSCIA, ONS, 2002), several strategies were constituted with key responsibilities as follows:

- a. Isolation and quarantine of Ebola suspects Ebola - (SLP and RSLAF)
- b. Contact tracing and Surveillance - (SLP and MoHS)
- c. Restriction at epicenters - (SLP and MoHS)
- d. Checkpoints Manning - (RSLAF and SLP)
- e. Education - (MoHS)
- f. Security Coordination (SSG, PROSECs and DISECs (ONS)

These strategies played a key part in combating the scourge which were managed by standard operating procedures in the implementation process by the sector; albeit the many isolated incidents. However, it is worthy to note that other interventions such as lockdowns, curfews, safe burials, door-to-door campaigns, and schools and other public places closed were also a multiplicity of interventions to curb the scourge. “These interventions were part of an improved package in Ebola treatment, where treatment beds and improved community-based infection control were implemented in tandem” (Kucharski, A.J et al 2015). Therefore, the effectiveness of policies and strategies can be

ascertained by the security sector's role in the fight against the Ebola outbreak. Such management of policies and strategies clearly showcased the level of professionalism, training and experiences acquired over the past decade in the process of security sector reform.

The security sector which includes the RSLAF, SLP, Intelligence services, ONS, border guards, and other security actors such as traditional chiefs, civil society, media, youth leaders, secret societies, volunteers etc played critical roles in response to the outbreak. (see Sandy, J, et al, 2017, Gbla, O. 2018, Heanlein and Godwin, 2015). Primary actors - SLP and RSLAF were deployed as preventive measures. For the SLP, the initial deployment of personnel was to maintain law and order at quarantine homes; being the primary actor for internal security. However, it became clearer that there were widespread public disorder due to the massive district quarantines across the country "constituting a security crisis"(Haenlein and Godwin, 2015). Hence, under the Military Aid to Civil Authority (MACA) framework embedded in the National Security and Intelligence Act, (NaSCIA, ONS,2002), the RSLAF was deployed to assist in tackling the menace and giving supportive roles to the SLP. According to Sandy, J et al, (2017) the involvement of the RSLAF was not only timely and beneficial but firstly, "the armed forces command a higher degree of discipline, secondly, military medical doctors were well trained, disciplined and able to cope with crisis situations, thirdly, military doctors displayed more discipline than many civilian health workers in civil hospitals, moreover, collaboration between civil and military coordination centres collaborated closely and exchange information in daily joint briefings, and military personnel served as liaison to regional

actors”(Sandy, J. et al 2017). To this end, one may posit that the experiences of the civil war, especially with the military, in the minds of the general populace was a significant factor for the successful role of the RSLAF during the outbreak.

In terms of their roles, the SLP provided their training facilities as medical outlets for Ebola affected persons. Served as static personnel at quarantine homes and manning of checkpoints, and roving personnel in providing security for health officials (both national and international), and contact tracing and surveillance. In addition, they provided the internal primacy of security across the country in collaboration with other security agencies. Most importantly, “the professional and timely police response to outbreaks of public disorder (Fofana 2014; NBC News 2014; Olu-Mammah 2014; Enca 2014) – of which there were around five every week during September and October 2014 (largely correlating with unrest due to body disposal delays) – did not go unnoticed by the Sierra Leonean people”(Heanlein and Godwin, 2015). During the first three-day lockdown by government, the SLP was very ‘professional in handling’ the crisis which had huge tendencies to plunged the country into chaos but which went peacefully. See (Heanlein and Godwin, 2015). Denny (2015) further posits, “the training and support in handling protests, including the provision of equipment, provided during the post-war SSR programmes, were pivotal to prepare the SLP for the role they played in the Ebola response” (Denny, 2015). However, this is not, “suggesting that there were not worrisome accusations of these forces, including receiving bribes at checkpoints and shooting of unarmed civilians”(Gbla, O. 2018).

Unlike the SLP, the RSALF created a militarised posture. “They were deployed to quarantine communities, prevent individuals from leaving or entering infected communities, and restrict movement across the borders of the countries in the region”(Sandy, J. et al, 2017). This deployment did not only helped greatly to slow down the movement of people but also the transmission of the Ebola virus. Most notably, was the RSLAF’s swift response in the management of ‘safe burials’; a hallmark in rebranding and building the confidence of the civilian populace. As FitzGibbon, (2014) posits “like their SLP counterparts, military personnel have been used to protect burial teams from attack. However, since mid October, the RSLAF has also managed the deployment of these teams in Freetown, eliminating a three-day delay in the collection of bodies – a major source of infection and community unrest – within the space of a week (FitzGibbon, 2014; See also Ross, et al, 2017). To this, Jones in reference to the RSLAF said “the source of their authority with the public is their discipline and their structure”(Brian Jones, Head of ISAT, cited in Haenlein and Godwin, 2015, p. 5). In addition, the RSLAF treatment centres played a major role in improving survival rates, especially when their doctors developed intensive fluid replacement strategies that were later adopted by foreign-run centres where patient survival rates had been low (Haenlein and Godwin, 2015). At the borders and checkpoints, “the RSLAF were tasked with offering protection to the population and health workers alike, providing logistical assistance, and transporting materials and medical supplies”(Sandy, J. et al, 2017). Surveillance activities in tandem with other intelligence agencies was also played by the military to trace and intercept Ebola infected persons in various communities.

Similarly, the national intelligence services primarily helped in contact tracing and surveillance of ebola affected persons across the country. Their involvement was very crucial in information gathering and prompt response at the operational levels. As such, “the intelligence services and informants helped to facilitate the monitoring of Ebola cases. Thus in many instances “it was neighbours who called the authorities to report suspected persons who might have contracted the virus”(Sandy, J. et al, 2017). Aside from food shortages in the quarantine homes, many people feared that their loved ones would die in medical centres, which in turn will place them in quarantine. Ritual and cultural practices was also another reason. Notwithstanding this, there was little effort on information sharing at the sub-regional levels between the three countries; due to linguistic and bureaucratic barriers.

The ONS provided coordinating roles at the provincial, district and chiefdoms through the decentralized structures of PROSECs, DISECs and CHISECs (National Security and Intelligence Act, 2002). This helped greatly in bridging the gap between the primary security forces (RSLAF and SLP) and other major stakeholders at the various levels during the response. See also (Gbla, O. 2018). Information collected from these operational levels were collated and analysed for strategic implementation of government policies towards the response. Moreover, with the Disaster Management Department housed in the ONS, they were able to coordinate with NGOs and INGOs regarding emergency relief items like food and non-food items for the affected victims in the various quarantined homes. In addition, due to the ONS long standing relations with the various communities, the international responders (both civil and military) were able to work

effectively with other agencies through the ONS's weekly sitrep in the security committee meetings.

Other security actors such as traditional authorities, community groups, health volunteers, secret societies, religious leaders, civil society, media and traditional healers also played an important role which one could regard as a "hybridized governance response" (Gbla, O. 2018) to the outbreak. The need for such collaborative engagement was based on the need to support government in bridging the gap of health and security service delivery within an emergency. For instance, there were reports of cross-border engagements with traditional leaders thereby invoking bye-laws within their various communities to curb the outbreak. Secondly, with the outbreak, there were huge socio-cultural challenges which gave way for community engagement strategies and processes. The shaking of hands, caring for the sick, initiation rites and burial ceremonies were identified as causes of the high Ebola transmission rates. A successful change in customary behaviours at the time required the involvement of chiefs, community elders, religious leaders, traditional healers and secret societies (Denny, 2014; see also (Gbla, O. 2018). The media brought out the messages within the communities regarding 'safe hand washing' techniques and emergency response details. With the shortage of food in some quarantine homes, the civil society were able to organise delivery efforts and ensuring 'accountability and transparency' in meeting the affected victims.

In examining the effectiveness of these strategies; isolation and quarantining of Ebola suspects was the mandate of both the SLP and RSLAF. Quarantines took place in high

risk areas to separate and restrict the movement of people who may have been exposed to an infected person. The duration of quarantine was generally the maximum length of the disease's incubation period (2-21 days for Ebola), taking into consideration the individual's suspected time of exposure. Unlike Isolation, they SLP and RSLAF separated and restricted the movement of an already infected individuals. These measures were implemented at the household, village/section or chiefdom levels(Unpublished, Government of Sierra Leone, 2014). However, there were cases of attempted escape from cordon. "This was as a result of food shortages that affected some of the affected quarantined areas and forced people to break quarantine"(Maxmen, A. 2015). Hence, the security forces had to use some minimal force to restrain and returned them inside the cordon. Aside from the ethical concerns, many felt that mass quarantine measures were ineffective for Ebola as patients are not infectious until they become symptomatic(CBC News, 2014 cited in Coltart, C.E.M et al 2017, p.8), and that quarantines "may have been counterproductive by preventing the free movement of necessary medical supplies and personnel"(Drazen, J.M et al, 2014).

Contact tracing and surveillance was a pre-quarantine process in the containment efforts of the responders. This strategy was very critical in enabling the security sector to not only combating the disease but also provided an opportunity for the intelligence forces to include requirements of the global security agenda into their modus operandi. The ability to identify and subsequently interrupt, chains of transmission was crucial and a success in the containment process. Through the support of communities, these forces were able to "give accurate information to those attempting to curb the outbreak"(Greiner, A.L,

2015). However, with the evolving trend of the virus, others claimed that “contact tracing was far from adequate as new cases were also from identified contacts and chains of transmission proved to be stubbornly difficult to intercept”(Dixon, M.G et al. 2015; Olu OO et al. 2016).

Manning of checkpoints proved to be the most challenging during the response due to the allegations of undue restriction of movement of people from place to place. However, these checkpoints were mandated to be operationally independent, professionally managed, corrupt-free with human rights observed. It is estimated that a total of seventy-one (71) checkpoints were established across the country(Unpublished; Government of Sierra Leone, Standard Operating Procedure on Checkpoints Review 2014). The major checkpoints comprised personnel from the SLP, RSLAF and other stakeholders as required, which include - Operations Support Division (OSD), Military Police (MP), Forces Intelligence and Security Unit (FISU), General Duty Investigators, Special Branch/Crime Intelligence Services (CIS), Health personnel, and Immigration. To this, medical screening was a national requirement for all persons going through the checkpoints. Persons with temperature of 38 degrees and above were kept in isolation until they were removed to hospitals/holding centres for further investigation. The medical screening form was to be completed by the senior medical personnel at the checkpoint, run on a twenty-four (24) hour basis.

In addition, education which entailed the ‘Ose-to-Ose’ Ebola sensitization campaign and restriction at epicenters was also effective. For the former, trained teams moved from house to house to disseminate information on the Ebola Virus Disease and enlisted

family/community support and participation in the response. Key objectives of this process was to gather accurate information, acceptance of infected persons, rebuild confidence in the public health system, install neighbourhood watch, and promote sanitation and hygiene (hand washing with soap) at the household level. These measures stemmed the infection rate at the household, community, village, and towns. The latter, which involved the security sector was in strict adherence to the protocols of safeguarding the community, health personnel from the infected persons within the various epicenters. Lastly, security coordination was the heartbeat of the ONS (NaSCIA, ONS, 2002). A civilian-led approach to ensure that early warning early response mechanisms were in place in the implementation of these policies and strategies at the national, district and chiefdom levels.

From a wider perspective, the ebola outbreak was not only ‘unprecedented’ but also challenged the security sector in dealing with an emergency on a larger scale than ever before. This challenge provided the platform for the security sector to undertake a range of “traditional and non-traditional public safety functions”(Gbla, 2018). As posit by Sandy et al, (2017) “constructive collaboration with the health sector was crucial to facilitate effective and efficient responses to health crises and emergencies. This also suggests that preparedness for health crisis responses should be included in SSR activities.”(Sandy, J. et al, 2017).

4.2 THE IMPACT OF CIVIL-MILITARY RELATIONS IN RESPONDING TO THE EBOLA OUTBREAK

With the occurrence of the 2014 Ebola outbreak, it provided a unique opportunity to assess the impact of civil-military relations in terms of the response. Although the initial response was lukewarm and ineffective, “once established it demonstrated unprecedented and impressive levels of international cooperation” (Rio, C. 2015; see also Dubios, M et al, 2015; Gbla, O. 2017). Realizing this, the international support to national actors in the Ebola response clearly reflects the nature and management of response; particularly to the security sector. As such, “civil–military cooperation during the 2014 Ebola outbreak proved necessary and helped the affected countries to contain the virus sooner, ultimately saving lives”(Kamradt-Scott, A. et al, 2015).

Therefore, in assessing such impact the study underscored the relevance of international and domestic civilian actors, and foreign and domestic forces. To this, the various aspects of emergency response capacity, and coordination were examined to ascertain such cooperation and beyond. At the emergency response level, the initial approach by the International civilian actors such as the WHO, UNMEER, MSF, OCHA and other INGOs was relatively ineffective and slow (See Kamradt-Scott, A. et al, 2015; Dubois, M et al 2015; and Ross et al, 2017). In particular, the WHO played a ‘positive communication’ with the Government of Sierra Leone in framing the crisis as ‘health’ rather than a ‘humanitarian’ one; adversely affecting the response. However, MSF stood out as a pivotal player in the response as was displayed by the timely effort of alerting the international community for military deployment; an organization known to be averse to military involvement in health crisis. Additionally, many staff were reluctant to be deployed in a health-risk environment which was considered to be ‘unprecedented’ neither do they

want to be quarantined or restricted back in their countries. See (Ross, et al, 2015; Kamradt-Scott, A. et al, 2015; and Dubois, M. et al 2015). “Concurrent with the Ebola outbreak in West Africa were multiple category 3 (‘L3’) humanitarian emergencies in other locations, including Syria, the Central African Republic, South Sudan, and Iraq, as well as health crises of MERS-CoV, polio and avian influenza H7N9” (WHO, 2015 cited in Kamradt-Scott, A. et al, 2015, p.6). These, largely had adverse implications at the global level in response to the Ebola-affected countries.

In terms of coordination, UNMEER served as the first UN health emergency mission which coordinated the response at the international level. After a slow start, it became “an important player in 2015 with a new proactive leadership”(Ross et al, 2017). UNMEER served as the hub for donors, participation in weekly NERC meetings, payment of salaries for 32 core staff attached to NERC and provided support to address critical Ebola caseload surges with over US\$550,000 from the UN Ebola Response Multi-Partner Trust Fund (Ross et al, 2017; see also Gbla, O. 2018). With such collaborative support, Sierra Leone benefited from these interventions to have about 1046 beds in 19 Ebola Treatment Units and 26 CCCs and 49 isolation units with 998 operational beds (WHO, 2014-2015 cited in Gbla, O, 2018, p.8). Also, capacity building for both civilian actors and domestic forces were enhanced through these UN specialised trainings on the various response strategies. However, it was believed that UNMEER had insufficient staff and was ‘working at arms length’ from Ghana in coordinating such outbreak.

Unlike their civilian counterparts, foreign military forces are mostly disciplined with the available logistical capacity. Such capacity have rendered them infallible in response to many humanitarian crises across the world. Thus, this crisis was not an exception. The African Union, for instance, deployed approximately 720 civilian and military health workers from Nigeria, Ethiopia, the Democratic Republic of Congo, and Kenya to assist affected countries as part of Operation African Union Support to Ebola Outbreak (ASEOWA; African Union Factsheet, 2015). In a direct support to UK, the Canadian military contribution in Sierra Leone comprised of 36 military health workers in total (Kao, R and Praught, J. 2015). Similarly, in the eastern part of Freetown, an ETU centre was managed by the Chinese military.

Most importantly, the deployment of the 750 UK military personnel and “other military assets (such as equipment including some 700 hospital beds), collating and analysing data, and coordinating the work of pillar heads in the DERC were a key milestone to the response. (See also Gbla, 2018; Ross et al, 2017) As such, the UK military showed “a level of professionalism and urgency; thereby creating a positive shift in the response process. Through the JIATF, the UK military integrated a civil-military cooperation; described as a “uniformity of effort”(Walsh and Johnson, 2018). As a direct impact, the deployment of foreign military gave confidence to many international organisations to send in their staff on humanitarian grounds. Secondly, there was a structured command and control responsibility in terms of coordination by these forces. As an indirect impact, the UK military presence provided a level of professionalism by not only the domestic forces but also for most INGOs. This could be attributed to the long years of supporting

the former - RSLAF and SLP. See (Gbla, 2018; Kamradt-Scott A. et al, 2015; Walsh and Johnson, 2018; and Haenlein and Godwin, 2015). Worth noting is that, this was not the kind of foreign military response that MSF hoped for when they called for a 'military' response to curb the outbreak. This is what Walsh and Johnson calls "there was less need for 'alarm-rising' about the crisis at national and international levels - we had most of the resources now and, on the international side, the UK were showing real leadership" (Walsh and Johnson, 2018).

For domestic forces, the use of the security sector to respond in major crises have always been the norm rather than the exception in terms of capacity towards an emergency response. For instance, the 2012 cholera outbreak was a typical crisis wherien the use of the RSLAF was greatly applauded. However, with the 2014 outbreak, they were only involved when the crisis was uncontrollable and became a humanitarian one. "Following the appointment of Rtd. Major Paolo Conteh, the RSLAF assumed a much more prominent role in coordinating the national response though such appointment effectively side-lined the MOHS from further involvement in coordination. The RSLAF was supported by the British armed forces" (Kamradt-Scott, A. et al, 2015). In terms of coordination, the RSLAf and SLP helped massively to enforced quarantines, manning checkpoints, and the management of 'safe burials'. Thus, rebranding the image of these forces due to the SSR training and experiences acquired over the years. Apart from the minor isolated incidents that somehow negatively affected the SLP.

To this end, one could argue that a crisis that is framed as 'health' or 'humanitarian' adversely influences the level and management of response. To this, civil-military relations in response to such an emergency should be context-specific, as it "blurred the lines between a public health emergency and a humanitarian crisis" (Kamradt-Scott, A. et al, 2015).

4.4 CHALLENGES

From a wider perspective, the role played by the security sector in combating the 2014 Ebola outbreak in terms of its roles, policies and strategies employed, also had some challenges, and criticisms levied in terms of civil-military relations. Firstly, in terms of policies, the outbreak was framed as a "health-related humanitarian crisis" (Kamradt-Scott et al, 2015) which led to the intervention of both foreign and domestic forces. With this, the response; especially the NERC was organised in a militarised fashion. "As briefings were given, orders or instructions relayed with no alternate views requested" showed that the "pendulum had swung too far in that direction" (Walsh and Johnson, 2018). This, largely could be attributed to the fact that, neither the NERC or the UK military had no better experience in epidemiological humanitarian crisis (See Walsh and Johnson, 2018; Ross et al, 2017). Leadership, was also a challenge at NERC. There were parallel meetings been held separately by the MoHS and the NERC officials. Thus, affecting the level and impact of response across the national and local levels. This is what Ross referred to as "people with no health backgrounds were now in-charge of this huge health crisis" (Ross et al, 2017). These tensions over power and control including, of course, control of resources continued and became a major fault line in the response. Lack of

international and national political will to contain the virus at the initial period was a strategic mistake.

In addition, containing the Ebola was a test for post-conflict security sector reform in Sierra Leone. Hence, the effectiveness of policies and strategies implemented did not only helped to curb the outbreak but also exposed the imbalance between key security apparatus like the SLP and RSLAF. “This imbalance in the UK’s approach to security sector reform, encapsulated in the differing levels of support provided to the armed forces and police, has been manifested, in part, in Sierra Leone’s response to the Ebola crisis”(Haenlein and Godwin, 2015). The deployment of forces and military doctors involved in the ETUs were a serious risk to their personal health becoming infected. At the same time, “often military hospitals were neither sufficiently equipped nor sufficiently capacitated”(Sandy, J. et al, 2017). Similarly, detainees at the Sierra Leone Correctional Services were often placed in prison with no precautionary measures in terms of checking inmates for EVD at the initial outbreak. Considering such jam packed capacity of these prisons, a single case would have rendered a multiplicity of factors creating a complex humanitarian crisis. Lack of coordination and effective command and control at the operational level of the SLP showed a grimming picture, that the SLP cannot adequately ‘grip’ the situation; resulting in the use of the military under the Military Aid to Civil Power policy (NaSCIA; ONS, 2002).

Another aspect was the issue of bye-laws. As the Ebola evolved, bye-laws were placed across the various local communities. As such, “a bye-law required the burning of

personal belongings of people died from EVD, but in several instances these bye-laws were not understood...hence the whole building/house was burnt down leaving surviving relatives homeless”(Sandy, J. et al, 2017). Coercive measures such as quarantine were often the source of many riots or chaos within the various townships which lead to some isolated incidents. As such, “Human Rights Watch explained that quarantines did not meet the relevant legal standards and called for coercive measures to be replaced by social mobilisation” (HRW, 2014 cited in Dubois, M. et al, 2015, p.8).

In terms of civil-military relations, it was observed that there were no clear mandate between foreign and domestic forces in terms of coordinating the response. For instance, “the British military worked—in principle—under the direction of a civilian led by the UK’s Department for International Development, but integrated some personnel within the Sierra Leone armed forces. Although some militaries provided clinical care, others refused even to transport biological samples and patients”(Kamradt-Scott, A. et al, 2015). Additionally, late payment of allowances to medical personnel, inadequate provision of food and logistics to quarantine households, welfare of security personnel deployed to quarantined households, slow response to contact tracing and surveillance teams, inadequate number of ETUs and laboratories, traditional burial practices, denial syndrome, corruption, violation of public health emergency regulations, weak quarantine measures, and neglect of the welfare of patients by health workers were critical challenges to the fight against Ebola. At the end, “the call for military intervention and subsequent collaboration has further ‘blurred the lines’ between civilian, military and non-governmental work” (Kamradt-Scott, A. et al, 2015).

4.5 CONCLUSION

This chapter has discussed the roles, effectiveness of policies and strategies implored by the security sector, the impact of civil-military relations, and the general challenges in response to the outbreak. It showcased the roles of the various institutions within the ambit of the security sector; most especially the SLP and RSLAF who were an effective agents in combating the Ebola virus. Notwithstanding their roles, the use of effective policies, and community engagement by these security structures was also an essential element in creating a “hybridized response”(Gbla, O.2018) structure in eradicating the scourge.

Clearly, the deployment of foreign and domestic forces established a securitised response. Thus, ‘taking’ the leadership from the MoHS to that of the military with the appointment of a former military officer. In the same vein, the outbreak also challenged the role of the SLP and RSLAF from the traditional view of security to non-traditional. However, the “security structures showed a considerable capacity to adapt to the changed context”(Gbla, O.2018). This involved the manning of checkpoints, quarantining districts, contact tracing and surveillance, supply of logistics to affected communities; and at the same time exhibiting their professionalism in a complex emergency. Thus, “the RSLAF’s deployment in support of the police is particularly noteworthy, marking the first time it has been used in response to a national crisis since the end of the civil war”(Haenlein and Godwin, 2015).

The Ebola clearly tells us that with all the requisite staff and structures in place by the Government of Sierra Leone; it was more in theory than practice. Because these structures were never brought together at the initial phase of the response to ‘nip it (Ebola) on the bud’ Thus, “it reflects in part a lack of balance in reform efforts over the past fifteen years”(Haenlein and Godwin, 2015).

FINDINGS

SUMMARY OF FINDINGS

5.0 INTRODUCTION

Albeit, the role of the security sector in combating the 2014 Ebola outbreak was not the only measure, while the research does attempt to imply a causal relationship between the inadequate health systems and the security sector's intervention, effectiveness of policies and strategies in combating Ebola in Sierra Leone will only be viewed in terms of: the country combating the outbreak presented in the previous chapters, analysis of the existing national response system before the Ebola, transition to a new response architecture and post-measures plus the impact of civil-military relations and whether the role played by the security sector provided the additional resources as required in response to such outbreak. Additionally, the effectiveness of such policies and strategies implored by the security sector will also be considered in terms of the effects and sustainability for future public health emergencies such as Ebola.

5.1 KEY FINDINGS

The key findings of the study on the role of the security sector in responding to the 2014 Ebola outbreak in Sierra Leone are summarised in the following paragraphs.

First and foremost, the 2014 Ebola outbreak in Sierra Leone came to an end amongst others due to the intervention of the security sector as “an effective agent in handling this health and emergency situation”(Sandy, J. et al, 2017). To this end, the management of ‘safe burials’ was a crucial in the fight as it stemmed down the rate of Ebola transmission among the populace. The implications from above is that while the role played by the

security sector have been effective in Sierra Leone in terms of combating the Ebola outbreak, but not without other factors as pointed out in the previous chapters.

Also, this crisis highlighted the state of the healthcare system in Sierra Leone before the outbreak. Weak, underfunded, understaffed, fragmented and unable to provide the daily needs of the population. As Jim Yong Kim, President of the World Bank Group said “Ebola spread so quickly in part because of weak health systems in Guinea, Liberia and Sierra Leone”(Jim Yong Kim, cited in Walsh and Johnson, 2018, p.5; see also WHO, 2015). Also, findings revealed that “an estimated sum of \$1.2 billion USD was spent by the US government towards Sierra Leone’s response cost”(CDC, 2016, cited in Walsh and Johnson, 2018, p.6). See also Glassman, 2016.

In respect of the role of national government during the outbreak, this study further revealed that “Ebola has shown the country’s national security architecture lacks maturity”(Haenlein and Godwin, 2015) in two ways. Firstly, the ineffective and lukewarm approach by government greatly affected the level and management of the response as a multi stakeholder (international and national). Secondly, it exposed the inadequacy of the operational level of the SLP responsible for primary security as compared to their counterparts - RSLAF. This, largely left the MoHS to coordinate the response rather than the Office of National Security (ONS), in coordinating the response had important implications in handling of the epidemic.

Additionally, the study revealed that international responses to such emergencies like Ebola are largely due to the fact that, their efforts are based to prevent not only crisis within a national boundary, but to also prevent such crisis from reaching their own international boundaries/borders signalling a global response.

As an important resource, community engagement proved to be an effective policy in linking the formal and informal structures who over the years have been “dictated by diverse historical contexts that led to a hybrid security response structure”(Gbla, O.2018). This collaboration helped greatly in adherence to these policies and strategies imposed by the security sector in combating the scourge.

5.2 CONCLUSION

This chapter has provided the analytics from the data collected on the role of the security sector in combating the 2014 Ebola outbreak in Sierra Leone, but only on the basis of research objectives one to four upon which the observations are premised. Consequent upon the results from the analysis it can be argued that the role of the security sector in responding to the outbreak in Sierra Leone have been largely effective in the sense that the management of dead bodies helped stemmed the transmission of the virus during the period. However, while the security sector’s role has been largely positive, but this is not without many other factors - notably the effects of community engagement and the support of international response.

Thus, one could argue that the Ebola epidemic is a wake up to not only the national health system of Sierra Leone and other affected countries but to the WHO as well. As the old adage goes ‘prevention is better than cure’; in a bid to transform the health system of developing countries

who are poor and marginalised. Not doing so is causing unnecessary deaths and suffering every day and also making future infectious disease outbreaks that, in our interconnected world, have the potential to lead to pandemics...more infectious than Ebola”(Piot,P, 2014).

CHAPTER SIX

6.0 SUMMARY AND CONCLUSION

The study was conducted to ascertain the role played by the security sector in combating the 2014 Ebola outbreak in Sierra Leone. The study employed both quantitative and qualitative data, but the former constituted less than 10% of the data presented and

analysis. In order to get a clear picture of the situation the study has extensively used actual data on health security; role played by the security sector in crisis management, with a focus on Sierra Leone. This constituted a desk-based approach with no interview conducted.

Based on the available data presented and analysed, the study has argued that the role played by the security sector in combating the 2014 Ebola outbreak have been largely effective in the sense that some of the policies and strategies adopted and implemented were the cornerstone to curb the scourge. However, while the security sector's role has been largely positive, this is not without many other factors - notably without community engagement and response of the international community. In accomplishing this goal, the presentation and analysis covered the research objectives; most of which broadly correspond to some of the objectives of the security sector's role in response to the outbreak. These findings generally correspond to an examination of the national response structure, their level of response in the initial outbreak and transition to a new response architecture, their level of implementation; assessment of the roles, efficiency and effectiveness of policies and strategies by the security sector in combating the outbreak, their management and composition, effects of such policies and strategies at various levels; impacts of civil-military relations in responding to the outbreak; and their challenges as a whole. In view of this, the study has maintained throughout the findings and also imply that there is a causal relationship between the inadequate health systems and the role played by the security sector to combat the Ebola outbreak in Sierra Leone.

Specifically, the WHO declared the end of Ebola transmission in Sierra Leone for a second time on 17 March, 2016 (WHO, 2016). The role played by the security sector cannot be overemphasized. This is partly due to their role in adopting and implementing strategic policies to curb the outbreak. These strategies included manning of checkpoints, quarantine, contact tracing and surveillance, restriction at epicenters, and security coordination. Albeit, with the few challenges associated with the security sector's role during the response; it is believed that the positive outweighs the negative in a health-humanitarian crisis regarded as 'unprecedented'.

Moreover, this study revealed that community engagement was also an important factor in the role played by the security sector. For instance, the management of 'safe burials' by the security sector, especially the military was a landmark in rebranding the RSLAF. This could not have happened without the collaboration of local traditional leaders like the paramount chiefs, community groups, youth, religious leaders, traditional healers, and secret societies. They were not only part of the "hybridized response" (Gbla, 2018) but helped in shaping the messages and changing the narrative towards a positive behaviour; thereby stopping the transmission of the virus.

International response from the WHO, CDC, MSF, UNMEER, OCHA, ECOWAS, AU, foreign troops from the UK, Canada, China, and Cuba, INGOs, Members of the diplomatic corps, and Foreign Embassies etc were all pivotal. They did not only helped to synergise the linkages between formal and informal structures but also showcased the Ebola

outbreak as “a public health emergency of international concern that had been declared in August 2014” (WHO, 2016). Again, the study revealed that the Ebola outbreak was a test of multilateralism as the world slowly reacts. Also, it exposed the politics and culture of international aid to which Marc Dubois et al (2015) referred to as “the humanitarian system lacks both the capacity and the agility to meet the multiple demands that have been placed upon it...while often being hamstrung by external political forces”(Dubois, M. et al 2015).

Most importantly, the study further revealed the nexus between health security and Sustainable Development Goals. This is not only achievable in the long term but calls for proper reform of health systems in most developing countries. This can only be achieved if we can learn from the Ebola outbreak and many other previous health emergencies in strengthening the health systems in many poor and developing countries. The level of preparedness should not only be in theory but in practice. For instance, at the time of writing, the Sierra Leone government has taken the lead as the first country in Africa to “fully transform its national disease surveillance system from paper-based to web-based electronic platform”(WHO, 2019). This shows a positive reaction to some of the challenges in data reporting during the Ebola outbreak.

However, the results from the study are subject to some limitations in that they cannot be generalised about the security sector’s role in responding to public health emergencies such as Ebola for other developing countries; rather it has to be context specific. There are also inconsistencies in the secondary data collected from both published and

unpublished sources, mainly because the figures cannot be independently verified given the time constraint and other undisclosed reasons. Therefore the researcher cannot guarantee their authenticity. Finally, having maintained that the research findings do suggest that there is a causal relationship between the inadequate health systems and the role of the security sector in combating the 2014 Ebola outbreak in Sierra Leone. However, this researcher recommends that further empirical research is needed to complement as to what constitutes the call and intervention of the security sector prior to the next public health emergency such as Ebola.

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