

Securitising public health emergencies: a qualitative examination of the origins of military intervention in Sierra Leone's Ebola Epidemic

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ABSTRACT

Introduction The 2013–2016 West Africa Ebola Epidemic remains the largest recorded Ebola outbreak. In response to the escalating number of cases in Sierra Leone in the summer and early autumn of 2014, the British Armed Forces and Republic of Sierra Leone Armed Forces intervened in support of the outbreak response. Among other contributions, the militaries established and subsequently helped to lead a national network of bespoke (and inherently militarised) coordination centres, from which almost all formal Ebola response operations were organised. Their contributions were therefore central to the outbreak response. However, the decision and process by which these actors first intervened is not well documented.

Methods In order to examine the historical origin of the militaries' intervention, 110 semistructured qualitative interviews with key stakeholders at the international, national and subnational level were conducted and analysed.

Results Military support to Sierra Leone's Ebola response was found to result from the advocacy and careful planning of a small number of individuals operating in Freetown, alongside closed-door negotiations occurring at the highest level of government in the UK.

Conclusions This has important implications for understanding elite decision-making related to the militarisation of aid and the wider securitisation agenda.

INTRODUCTION

The 2013–2016 West Africa Ebola Epidemic was and remains the largest outbreak of Ebola in recorded history.¹ For several months following the initial case of Ebola, the outbreak was mostly limited to rural areas.² However, in the summer of 2014, the crisis escalated, and the WHO declared a Public Health Emergency of International Concern.³ On 2 September 2014, the then International President of Médecins Sans Frontières (MSF) released a statement that was uncharacteristic for the international non-governmental organisation ((I)NGO), arguing that it would take military mobilisation to bring the

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Médecins Sans Frontières' infamous call for military support in West Africa's Ebola epidemic is widely known, but the specific planning and mechanism through which military intervention was activated is neither widely documented nor understood.

WHAT THIS STUDY ADDS

⇒ This study reveals and examines the behind-closed-door planning of a small number of individuals that were integral to the decision to intervene militarily, providing crucial insights into planning, prioritisation and overall decision-making by elite stakeholders during public health emergencies of international concern.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Research into similar events should ensure the documentation of these elite perspectives and influence (which may not be alluded in the public domain as in this case)—meanwhile, practice and policy should consider this kind of elite power when navigating the localisation agenda.

situation under control (anticipating that militaries would have biohazard capabilities and a high risk tolerance not found in the civilian sector).⁴

In Sierra Leone, the British Armed Forces deployed shortly thereafter alongside the Republic of Sierra Leone Armed Forces (RSLAF).^{5 6} Military support included the establishment of the National and District Ebola Response Centres (the NERC and DERCs, respectively) in late 2014, and the performance of various command and control functions within these centres.^{2 6–9} Military contributions to Sierra Leone's Ebola response were therefore a core component of the overall response. The implications of this are very significant, especially considering the ways the case was used to argue for the



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Interview respondents						
Primary grouping	American Government (USG)	UK Government (HMG)	Sierra Leonean Government (GoSL)	(I)NGO	United Nations (UN)	Paramount Chief (PC)
Count	N = 8	N = 23	N = 43	N = 15	N = 15	N = 6
Secondary grouping	Military (M)	Civilian (C)	<i>Respondents may be either civilians (defined here as non-military), or, military</i>		Defining unique identifiers Primary grouping + secondary grouping + level + count* (*within primary grouping)	
Level	Chiefdom (C)	District (D)	National (N)	International (I)	<i>Respondents may exist at one of four defined levels</i>	

Figure 1 Interview respondents. (I)NGO, international non-governmental organisation.

circumstantial future role of militaries in public health emergency response^{5 10 11}; the central role they did in many contexts during the COVID-19 crisis^{12 13}; and the import this has for a world preparing for a WHO-led Pandemics Treaty in 2024.¹⁴

However, despite its importance, little research has been published detailing how the mobilisation came about—that is, how it was advocated for and planned, and by whom. Accordingly, this study asks: what processes led to the decision to intervene militarily, according to the Ebola response workers (ERWs) who participated in these discussions and decision-making activities.

METHODS

Research team and reflexivity

Lead author (STB, man) conducted this research as a PhD candidate (awarded 2022) under the supervision of coauthors and professors SM and DB.

Data collection

The questions were addressed through qualitative data design including 110 private in-person interviews conducted by STB in 2017–2018 as a part of a larger research project. A wide array of civilian and military ERWs at different levels were identified and included (figure 1). No people refused to participate or dropped out of the study. A standard snowballing method was used. Data collection continued until saturation.

The study sought to obtain the perspectives of outbreak stakeholders in multiple locations. For chiefdom and district-level perspectives, Kambia and Port Loko districts were selected due to the prior involvement of STB in these areas and the access and trust this facilitated. For national-level perspectives, Western Area Urban District—comprising the Sierra Leonean capital—was selected. International-level perspectives were documented in various locations—eg, London, for British governmental (HMG) respondents; Atlanta, for US Centers for Disease Control and Prevention respondents; and Geneva, for WHO respondents. This article primarily relies on data

collected from national-level and international-level respondents, as these are the levels at which the decision to intervene militarily was discussed and taken.

Interviews were recorded and in-depth and typically lasted between 45 and 75 min. While following some core themes of interest (a guide was used, online supplemental file 1), they were open and flexible, to allow that emerging themes were captured. Interviews were transcribed verbatim (which were not returned to participants for comment or correction). A unique identifier was assigned to each respondent, according to the respondents’ grouping, civilian status, geographic level and count (see figure 1). The lead author (STB) conducted all interviews, allowing for ongoing analysis and subsequent filling of gaps. Notes were taken during all interviews, and memos written immediately thereafter. This process aided researcher reflexivity and sought to reduce researcher bias. No repeat interviews were carried out.

Analysis

Data were analysed using deductive and inductive approaches. A consolidated coding frame was derived after each author (STB, SM and DB) conducted coding of a subset of interviews, identified emerging themes and discussed the differences. The coding frame was examined against key domains of Shiffman and Smith’s framework on factors affecting political prioritisation (2007) relevant to this study, and further refined.¹⁵ The frame was then applied in coding the entire dataset in NVivo by STB. During the coding process, the frame was frequently re-examined, with codes modified or amended to reflect new directions. Thematic relationships were then charted and interpreted for patterns and variations that were deemed relevant to the questions asked in this study.

Patient and public involvement

Respondents were first involved in the research during the development of the interview topic guide. As open-ended and conversational interviews, the exploration

of themes in this study were informed by respondents' priorities, experiences and preferences. Respondents also contributed to recruitment through the use of snowballing methods. Respondents were also asked to assess the time required to participate in the research. Respondents were not asked to provide feedback on the findings as relevant to the development of this manuscript.

RESULTS

Drawing primarily on national and international perspectives of the key stakeholders found to be involved, the political processes leading to the decision to intervene militarily are now explored.

Various respondents present in Sierra Leone during the summer and early autumn of 2014 recollect this period as a particularly distressing one. An HMG civilian respondent recalled,

You know, in the early days, we had nothing. We didn't have (Ebola) treatment centres (ETCs), we didn't have ambulances, and we didn't have testing (HMG-C-N-12).

A notable gap—one that was to be instrumental to the decision to intervene in the militarily—was the need to collect the growing number of infectious corpses decomposing in public spaces. This issue affected the contemporaneous epicentre of Kenema, where an (I)NGO respondent remembered how 'there were bodies on the street all the time' (NGO-C-N-14); and also Freetown, where a Government of Sierra Leone (GoSL) civilian respondent remembered how "people... [kept] dead bodies under their beds" (GoSL-C-N-24). In short, the system of dead body management that was in place at the time was inadequate in the face of the escalating crisis: an HMG civilian respondent noted that, 'bodies weren't being collected for a week or 10 days. They were actually kind of dissolving in the heat' (HMG-C-I-5).

In response, a small group of Freetown-based individuals began convening informally to discuss what feasible interventions might mitigate this growing morbid issue (HMG-C-N-12; HMG-M-N-5; NGO-C-N-10; NGO-C-N-7; HMG-C-I-9; HMG-M-N-9). An HMG civilian respondent involved in these discussions recalled,

We just had to do something... and the first thing we decided we had to do was just go around picking up bodies that been sitting on streets for six or seven days (HMG-C-N-12).

The small group—which was comprised of fewer than 10 individuals—included (I)NGO staff; HMG civilians; and also RSLAF and British Armed Forces personnel associated with the country's long-term military officer training programme, the International Security Advisory Team (ISAT, discussed later).

The inclusion of military personnel may have been atypical, but 'at the time', recalled an involved (I)NGO respondent,

...all the NGOs... were swamped... and any other organisation in the world that was interested in stepping up to the

party left. The military were the last people I could think of (NGO-C-N-10).

That is, many (I)NGOs had evacuated their staff from Sierra Leone as the crisis had escalated, and those that remained were overwhelmed.¹⁶⁻¹⁸

However, RSLAF was a historically empowered institution supported by the British Armed Forces (through ISAT), and had more than 10 000 personnel present in the country.¹⁹ As the country was not at war, it was thought the institution could conceivably mobilise their spare capacity, which was not easily found among (I)NGOs at the time. Therefore, as a civil-military team, the small group designed a new system for dead body management that also assigned a coordinating role to military personnel. Recalled an involved British Armed Forces respondent, RSLAF personnel were

...trained to be able to manage the... call centre, so they would be able to task the ambulances... to say 'go to X, pick up body X, take it to the cemetery'... And to make sure that... those ambulances took the bodies there, (and) there was somewhere to put them... That was very much the first thing before the DERC in Western Area (Urban District) or any other DERC came into being (HMG-M-N-5).

In doing so, the small group instigated a process that would eventually underpin the transition away from the civilian-led Ebola Operations Centre (EOC) under the Ministry of Health and Sanitation (MoHS) and WHO, to a new military-led outbreak response architecture (ie, the NERC and DERCs).

This is because the new system for dead body management soon incorporated other Ebola response functions which were peripheral but nevertheless integral to the overall system (NGO-C-N-7), despite these functions falling within the EOC's mandate. According to an involved British Armed Forces respondent, the system was

...modelled on what was the greatest need at the time. That's why the burials were the first thing, because the first problem to solve was making sure that we didn't have civil unrest. The second problem was trying to find the sick people, (to) interview them (so as to evaluate whether they met case definition), and then (to) move them somewhere else (for treatment if they did). And then, as we got quicker at moving them, then we had to very quickly build the quarantine and food and security (systems)... Those were the first... building blocks (HMG-M-N-5).

To this respondent, social mobilisation and community engagement were "not going to take a body off the street, [were] not going to prevent civil unrest, [and were] not going to save anybody's life" (HMG-M-N-5), at least not in an immediate sense. The *modus operandi* of the forthcoming command centres was beginning to take shape. This, a bespoke arrangement, was not modelled per se on military functions, but rather, as largely designed and heavily influenced by military minds drawing on

their skills in command and control (HMG-M-N-5; NGO-C-N-7).

The increasing co-option of other Ebola response roles and responsibilities into the new dead body management system was purposeful: members of the small group recalled the overall goal (one they did not initially declare) of continuing to build out the system until an entirely new coordination architecture incorporating all Ebola response functions was realised. ‘So, it started with burials’, recollected an involved (I)NGO respondent (NGO-C-N-7), who continued:

But we’d been planning it... (and) plotting and scheming for two weeks, mapping and planning, getting all the resources in place, working it out with RSLAF..., looking for somewhere where we could base the command centre... What nobody knew is that our coup was not just going to be on burials... It was about proving the C2 [i.e., command and control] concept, and then taking it all over. Nobody knew that. We were essentially trying to launch a coup against the (MoHS)... So, we started developing a model. I remember sitting in ISAT and drawing on whiteboards, things like roles and responsibilities, where we would put different organisations... (We) drew out all the process maps and then (we) got them printed onto big pieces of paper and it was like, okay. This is how it all works. We made sense of the chaos (NGO-C-N-7).

The objective of these meetings was therefore to fundamentally redesign the architecture of the Ebola response and put it under military leadership despite the MoHS’ and WHO’s mandate.

Accordingly, the involved (I)NGO respondent recalled how the MoHS and WHO ‘didn’t know anything about it... [the] incognito meetings’ (NGO-C-N-7). However, the small group’s meetings were known to Sierra Leonean senior leadership, as diplomatic negotiations were ongoing among the small group, the British High Commission and then-president Ernest Bai Koroma. Recalled the (I)NGO respondent:

Everyone was creating momentum for the change that needed to happen... Essentially, (the small group) put a pitch together to go to the government... [and HMG’s in-country Ebola lead] led this pitch (to the Sierra Leonean President) on behalf of the (small group) and got... a gentleman’s agreement between all parties (to put the new system in place) (NGO-C-N-7).

The ‘gentleman’s agreement’ was only initially related to the system for dead body management (NGO-C-N-7), but once the civil-military system was effectively collecting and burying corpses, president Koroma was brought to visit, and the small group

...had a broader message (for him) as well. We said... ‘If it works for burials, why don’t we bring every single (Ebola response) function into this room?’ (NGO-C-N-7).

The small group’s advocacy during this visit was apparently effective, especially including the possibility of military leadership within and over the proposed architecture.

Crucially, a large contingent of RSLAF personnel was also suddenly available due to Ebola-related cancellations of their deployments to UN and African Union peacekeeping missions (GoSL-C-N-27); and, as noted by a British Armed Forces respondent, by this point in the outbreak,

...you’ve gone through the Ministry of Health or national health service, you’ve gone through the police, you’ve gone through the first responders (who were there at the time), you’ve gone through calling up extra service, you’ve gone through everything, (and the crisis was still escalating)... Somebody has got to help, and there aren’t that many somebodies (HMG-M-N-5).

While the military may have been perceived as an institution of last resort (at least in the absence of a concerted intervention by the international community), they were nevertheless at hand.

This was evident to president Koroma during this visit. Recalled the involved (I)NGO respondent:

In that moment, (President Koroma) saw the value. He recognised that the only people who were capable of moving at the kinds of speeds to cover the number of districts that were required, to give him the required result, was not only this model, but this model as staffed by RSLAF (NGO-C-N-7).

An involved British Armed Forces respondent also recalled this moment, and how president Koroma

...was keen to have (RSLAF) be seen to be doing it, because the last thing he wanted was for (the response) to look like it’s a British show (and)... with the odd token Sierra Leonean, that certainly ... (would not be) the case (HMG-M-N-9).

President Koroma, in other words, was convinced to replace the EOC with new civil-military architecture with centres at the national and district levels, but felt it was important that these centres be primarily led by Sierra Leoneans.

On this basis, as recalled by an involved (I)NGO respondent,

...that’s what we did... (We) continued to build the processes and the systems in the command centre until we built a series of SOPs (standard operating procedures), and that is what was sent out to all the districts. So, everyone (in the country) essentially ran this model that we had written... [and with one exception, the command centre heads] were all RSLAF or UK military (NGO-C-N-7).

Importantly, this proposed model included the support and close cooperation of the British Armed Forces, more so than the small number that were associated with ISAT.

Therefore, the deployment of additional British Armed Forces personnel was needed (also for the build of ETCs among other proposed contributions), which required the approval of then-British prime minister (PM) David Cameron. Accordingly—in parallel to the small group’s advocacy in Freetown—discussions on HMG’s prospective Ebola response role were occurring within the

Cabinet Office Briefing Rooms (COBR). According to an HMG civilian respondent who was a participant in these discussions:

I think people underestimate how much of a trigger was the fact that the British government was then going have to decide, okay, do we close borders down? Do we isolate Sierra Leone? And do we keep people away? Or do we engage in responding to this emergency? And if so, what is that engagement going to look like?... The UK took the strategic decision... quite early that, essentially, the UK border in public health terms was in Sierra Leone as far as Ebola was concerned... That justifies quite a lot of intervention and quite a lot of resources being put into it... Basically, (it was understood that) the UK would need to take a strategic decision to underwrite the international response... There had to be a sort of all-weather guarantee that the platform would work (HMG-C-I-9).

Data thus indicates a growing perception within the Cabinet Office that the UK was at risk, partly because of the significant presence of Sierra Leonean diaspora living in London; and the possibility of British ERWs contracting the virus in Sierra Leone and returning to the UK for medical treatment (as first occurred in August 2014).²⁰ Summed up by a British Armed Forces respondent, it was increasingly felt within the Cabinet Office that ‘the risk of people coming from there to here was higher than getting involved over there’ (HMG-M-N-5), and therefore, that a significant intervention by HMG was required (though its exact form was not yet decided).

Then, towards the end of August, MSF’s International president met with then-US president Barack Obama, and the following day, the British PM. In these private meetings, recalled an HMG civilian respondent, ‘[MSF] said that they wanted the military logistics and command system to be put in place to try and help with this work’ (HMG-C-I-4). Another HMG civilian respondent recalled how MSF also informed the PM

...that they were going to go public... on both... BBC Breakfast News and on (the) radio... (with their request) for (British) military support to the crisis in Sierra Leone (HMG-C-I-11).

On 2 September 2014, they did so.⁴

This advocacy by MSF—to key decision-makers privately, as well as publicly to an American and British audience that was increasingly alarmed by the escalating crisis—was critical in shifting the ongoing COBR discussions where it was being decided how HMG should intervene. An HMG civilian respondent recalled how, suddenly, and

...very much directly from... the PM... was a direction... to (HMG) departments to say, basically, ‘get with the program... this is a genuine threat to the UK. All departments are hereby directed to... work together to deliver a solution as best we can at this moment in time’... (Civil servants) went from going into [a] meeting looking at perhaps a 50-bed hospital or (ETC for Sierra Leone), but... came out with the direction from the PM that he wanted to see 600 beds. And so, obviously, that had the result of a massive

ramping up in scale and capacity that was being allocated to this particular response (HMG-C-I-11).

This was a sudden and significant scale-up of HMG’s proposed intervention, and—in accordance with MSF’s advocacy and the small group’s discussions in Freetown—it was felt among key decision-makers in the Cabinet Office that ‘the only way [for HMG] to do that was with the [British] military’ (HMG-C-I-9). Meanwhile, on 18 September, the UN passed Resolution 2177 describing the outbreak as ‘a threat to international peace and security’.²¹

Taken together (and as found to be compatible with Shiffman and Smith’s list of factors affecting political prioritisation),¹⁵ both RSLAF’s and the British Armed Forces’ intervention in Sierra Leone’s Ebola response was all but assured, as actors were aligned and mobilised; ideas were internally and externally framed in convincing ways; the political context was ripe; and the issue characteristics were perceived to be urgent and to have credible indicators. Accordingly, as written in documents not in the public domain obtained under a freedom of information request from the UK Ministry of Defence, the UK was to become—the framework nation for (the) international response to (Ebola) in Sierra Leone,²² with a significant component of this support coming from the British Armed Forces in support of RSLAF (table 1). This strategy built on the long-standing relationship between HMG and GoSL (HMG-C-N-13).

DISCUSSION

This article provides a uniquely detailed analysis of the dynamics, social relations and contingencies that underly the political process leading up to military intervention in Sierra Leone’s Ebola epidemic.

The intervention of UK and Sierra Leone militaries was found to largely result from the advocacy of a small group of individuals in Freetown, alongside private discussions and public advocacy occurring at the international level. This resulted in the deployment of the British Armed Forces under Operation Gritrock in September 2014 to work alongside RSLAF, and the transfer of Ebola response authority from the MoHS-led and WHO-led EOC to the new NERC and DERC architecture the following month.

The British-established ISAT programme was central to this decision. Initiated towards the end of the Sierra Leone Civil War in 2001, under ISAT, the national military was disbanded and completely rebuilt into a professionalised army.²³ Military-adjacent institutions were simultaneously empowered. Ultimately, ISAT was considered so successful that it ‘is frequently seen as *the example*’ (emphasis in original) of security sector reform.²³ As largely funded by HMG and directed by uniformed members of the British Armed Forces, this transformation not only served to influence and in some ways define RSLAF’s Ebola response capabilities but also to further bolster positive relationships between Britain and the Sierra Leonean public due to the former’s

Table 1 Timeline of initial military intervention in Sierra Leone's Ebola outbreak, according to documents not in the public domain obtained under a freedom of information request

Date	Event
Early September 2014	HMG officials determine the British Armed Forces are best-placed to provide not only the treatment beds that the prime minister has called for, but also to implement the new civil-military coordination architecture being proposed by the small group that president Koroma favours. ⁵
Mid-September 2014	HMG formally announces the Joint Interagency Task Force—a Department for International Development-led civil-military body for coordinating HMG's interventions—with the British Armed Forces component organised under Operation Gritrock. ^{5,44} These HMG structures purposefully mirror and integrate with Government of Sierra Leone's national response.
End of September 2014	The main British Armed Forces contingent arrives in Sierra Leone. ⁵
Mid-October 2014	The National Ebola Response Centre—at the direction of president Koroma and under the leadership of Sierra Leone's Minister of Defence—formally supersedes the EOC's authority (therein completing the small group's goal of removing the Ministry of Health and Sanitation and WHO from leadership of the Ebola response). ^{5,45–47}
November–December 2014	A network of constituent District Ebola Response Centres—which are led by civil-military command teams—are established, thus removing district leadership from the respective district medical officer and district health management team (with the exception of Kono district). ^{5,45–47}
Source: author. HMG, British government.	

sustained presence and support for the government of Sierra Leone. As seen in the data, it ensured the continuous presence of British military personnel in Sierra Leone preceding and at the start of the Ebola epidemic, and significantly bolstered bilateral and military–military relationships between the two countries, which thus had considerable influence on the origin, nature and effect of military support to the Ebola outbreak.

However, unlike the security sector, Sierra Leone's health system was left in disrepair after the Civil War.²⁴ For example, in Sierra Leone's 2013 budget (the most recent comparative data available at the time of writing), the MoHS received approximately one-third of the funding that the national army did, despite the country being at peace and in dire need of a more resilient health service.²⁵ The MoHS was therefore very unprepared for the Ebola epidemic. As examined in this article, many—including MSF, anticipating strong biohazard capabilities and a high risk tolerance—thus perceived the militaries' intervention to be a necessary 'last resort'.⁴ To some scholars, however, this substantial and conspicuous militarisation of a public health emergency is concerning. For example, it could represent the inappropriate 'securitisation' or 'militarisation' of civilian domains that should be led by civilians and guided by the humanitarian principles (unlike in the Sierra Leone case).^{26,27}

Others argue exogenous interventions impede capacity building among public institutions, in that they may limit staff's ability to learn, and funnel funds elsewhere.^{28–30} Both effects decrease resilience to future crises.^{31–33} Relatedly, scholars argue exogenous interventions ignore local actors, which can: exacerbate their marginalisation and existing inequities^{34–36}; mean responses are less adaptive and sensitive to local context(s)^{37–39}; and fail to take advantage of endogenous capacities.^{40–42} This has been

seen in Sierra Leone, where the military was once again heavily involved in responding to the COVID-19 crisis as a 'go to' organisation characterised by some as 'a dramatic reputational shift' and 'part of a pattern of the army's involvement in domestic emergency response efforts'.⁴³

Taken together, the deployment of militaries in Sierra Leone was valuable for the assistance that was provided, but perhaps also detrimental for the ways it may have reinforced the social and political context that limited the resilience of Sierra Leone's public institutions; which resulted in them being overwhelmed by the outbreak of Ebola; which led to the perceived need for military intervention among a small, elite and exclusive group of actors.

Conclusion

The intervention of militaries as seen in Sierra Leone during the Ebola Epidemic is increasingly regarded as a step-change internationally in the militarisation of epidemic response and takes on particular significance as the world prepares for a new Pandemics Treaty in 2024. Such militarisation has many potential benefits including harnessing a capacity for rapid and large-scale deployment which more orthodox forms of health assistance may lack. Such capacities may prove crucial in outbreaks and other emergency responses, especially in contexts where health systems lack resilience and resources.

However, our findings underline significant scepticism regarding militarisation in this way. In the Sierra Leone case, of significant concern is how the political process leading to the militaries' intervention was an exclusive and untransparent process among a small number of elite and usually unelected actors. It also cost the inclusion of and public trust in Sierra Leone's health ministry, putting into question longer-term commitments to sustaining

and strengthening the public sector. Yet, it signalled a change in epidemic response approaches that has global reverberations.

These findings have significant implications. They highlight the need for understanding better the architecture of public health emergency responses and the ways decisions are or are not made using transparent and normative mechanisms. Further, the case begs a number of fundamentally important questions. What is the balance of benefits and harms incurred by militarised responses to public health emergencies? Can harms be mitigated to the extent they become convincingly beneficial? And if so, under what circumstances? Further, what was the nature of the militaries' relationships to (I)NGO and (sub)national actors once activated; what was the diversity of opinion within tary were also involved in the resthese groups; and what implications does this have for balancing the perceived need for exogenous support with community engagement and the localisation agenda? Are there ways to have 'the best of both worlds', that is, that draws on the perceived benefits of militarisation and securitisation without the negative consequences it can have for national sovereignty and local capacity building? These are important questions demanding further examination and elucidation, including across other contexts where, for example, former colonial powers were not involved in the response.

Limitations

This article examines discussions that occurred among a small number of people in primarily private fora. Therefore, by necessity, findings rely on a limited dataset. This presents several limitations, namely: the inability to divulge received information that could only be known to one person, thereby risking a respondents' identification; and the limited ability for the principal investigator (PI) to cross-check some data, or, to fully examine differences in perspectives between groups or levels. Further—and related to the former limitation—some respondents may have been circumspect in their interviews. These limitations were mitigated by the various protections that were taken to ensure participation in this study remained confidential, and statements provided remained anonymous. Respondents—who were made aware of these protections—appeared open and forthcoming in their interviews (eg, no questions were unanswered, and no respondent chose to withdraw consent either during or after the interview). Another limitation is sole focus on the Sierra Leone experience—in Liberia and Guinea (the two main other affected countries), the military were also involved in the response. The examination of these other contexts was beyond the scope of this research project and remains a research gap.

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Contributors STB was primarily responsible for the conception and design of the work, data acquisition, analysis, interpretation and drafting of this article. STB is also responsible for the overall content as guarantor, and accepts full responsibility for the finished work and/or the conduct of the study, had access to

the data, and controlled the decision to publish. SM and DB provided substantive support to conception and design, interpretation and article revision. All authors are accountable for all aspects of the work.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants. Two ethics boards approved this study: the Sierra Leone Ministry of Health and Sanitation Office of the Sierra Leone Ethics and Scientific Review Committee (no reference number; approved on 28 August 2017); and the London School of Hygiene & Tropical Medicine Research Ethics Committee (reference #14424). Participants gave informed consent to participate in the study before taking part.

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