



## Regular Research Article

# How epidemics affect marginalized communities in war-torn countries: Ebola, securitization, and public opinion about the security forces in Liberia

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## ARTICLE INFO

## Keywords:

Securitization  
Pandemics  
Post-conflict  
Marginalized communities  
Health

## ABSTRACT

Epidemics that overwhelm health and national institutions tend to disproportionately affect individuals from marginalized communities. The securitization of epidemics further exacerbates feelings of alienation and victimization by security forces among those in such communities. Focusing on this population, our study explores how experiences with securitization during the 2014 Ebola Virus epidemic in Liberia affected perceptions of the security forces. We leverage two, unique surveys conducted before and after the Ebola Virus Disease epidemic in two of Monrovia's informal communities with histories of internally displaced persons and ex-combatants in Monrovia, Liberia—West Point and Peace Island. Our analysis allows us to assess differences in public opinion before and after the Ebola Virus Disease. We find that perceptions of police discrimination and disrespect increased in both communities and that demand for police services declined in both communities. With respect to the Armed Forces, direct contact with soldiers enhanced feelings of safety, but only among those who did not witness them engaging in abuse. Our findings suggest that securitization of epidemics could exacerbate trust in the state, thereby weakening its legitimacy.

## 1. Introduction

The 2020 Covid-19 pandemic brought global attention to the use of security forces in health crises (Stott, West and Harrison, 2020). This was not the first time that governments have responded with force in order to impose quarantines, lockdowns, and other measures to contain diseases (Cook, 2010, Kamradt-Scott and McInnes, 2012). Epidemics that spread in urban settings and overwhelm health and national institutions are likely to be hard to contain (Piot, Muyembe, & Edwards, 2014). They also tend to disproportionately affect individuals from marginalized communities such as ethnic minority groups (Abramowitz et al., 2015, Tsai et al., 2020), who already suffer from systemic health disparities (Hutchins et al., 2009, Quinn et al., 2011).

Epidemics such as the 2014 Ebola crisis are often most severe in countries with political instability, where weak institutions and health systems undermined by conflict struggle to cope (Benton and Dionne, 2015; Bausch and Schwarz, 2014; Kruk et al., 2010). In post-conflict countries with low levels of trust and weak governmental institutions, negative perceptions can erode efforts to build more inclusive and stable institutions (Carter et al., 2007, Kahn, 2005, Lazarev et al., 2014,

Rodriguez-Oreggia et al., 2013, Sedik and Xu, 2020). Moreover, a militarized responses to crises in such contexts can exacerbate feelings of hostility and mistrust in marginalized communities for two reasons. First, they can amplify prior perceptions of discriminatory practices before the epidemic. Second, securitization can increase the potential for security forces' abuse. We argue that people's exposure to securitization in epidemics, which we define as the witnessing or experiencing the state's use of police or military-based measures to contain the spread of communicable disease, exacerbates feelings of alienation and victimization by security forces among those in marginalized communities. At the same time we also assess whether exposure to securitization could make people feel more positive toward the state and security forces, if they perceive securitization as a signal of state strength and capacity to 'do something'.

We use the 2014 Ebola Virus Disease epidemic in Liberia as a case study to explore how a health crisis affected marginalized communities. The Ebola Virus Disease epidemic that first started in 2013 in Guinea can be seen as a health crisis once it emerged in Liberia, where the future scale of epidemic could not be anticipated. The epidemic had a major disruptive impact on the life of Liberians (Bausch and Schwarz, 2014). A

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combination of factors created the perfect storm in a country with low trust in authorities, high level of belief in traditional practices, and a ravaged and fragile health system (Piot et al., 2014)). In response to the epidemic, the government dispatched militarized police units. It also deployed its military for the first time since the end of the civil war in 2003. The heavy-handed response by the state became front page news all around the world.<sup>1</sup> Our goal is to understand how people experienced this heavy-handed response and whether it affected their trust in security institutions within marginalized communities.

We leverage two, unique cross-sectional surveys conducted before and after the Ebola Virus Disease epidemic in two of Monrovia's most infamous, informal communities, which have strong histories of internally displaced persons and ex-combatants in Monrovia, Liberia—West Point and Peace Island.<sup>2</sup> Both communities were affected by the Ebola Virus Disease and increased security force presence. Importantly, while both communities have police stations, they were not overpoliced (either by the police of the military) prior to the epidemic. The lack of police resources prevented the police to engage in “over-policing,”<sup>3</sup> and the military had never been deployed in any community since the war ended. This enables us to tie the increased securitization in these communities to the Ebola Virus Disease and assess how individual exposure to this securitization affected perceptions. Our analysis allows us to assess differences in public opinion before and after the Ebola Virus Disease. In the 2015 survey conducted immediately after the epidemic ended, we ask questions about interactions with security force personnel during the containment of the pandemic phase. The surveys are further contextualized with four focus groups discussions in the two communities taken place in 2015. Among those who experienced a dispute,<sup>4</sup> we find that perceptions of police discrimination and disrespect increased in both communities and that demand for police services declined in both communities. We also find that interactions with the police among the general population affected perceptions in the two communities. In particular, those who witnessed police abuse experienced decreased feelings of safety in the community. With respect to the Armed Forces, direct contact with soldiers enhanced feelings of safety, but only among those who did not witness them engaging in abuse.

Our study contributes to existing work on health and conflict (Enria, 2019; Ghobarah, Huth & Russett, 2004, Gonzalez-Torres and Esposito, 2016; Hicks and Spagat, 2008, Iqbal, 2010, Morse et al., 2016, Blair et al., 2017), by focusing on the effects of disease outbreaks in post-conflict countries. This research goes beyond the macro-level to focus on how epidemics impact individual opinions. We contribute to this trend by exploring how experiences with securitization in response to epidemics affects individual views in marginalized communities (Abramowitz et al., 2015; Aksoy, Eichengreen, and Saka 2020; Morse et al., 2016; Tsai, Morse & Blair, 2020; Woskie and Fallah, 2019). We show that individual experiences with securitization can change perceptions by members of marginalized communities of the state and security agents.<sup>5</sup>

<sup>1</sup> See for example *New York Times* article from August 20, 2014, entitled “Clashes Erupt as Liberia Sets an Ebola Quarantine.”

<sup>2</sup> These two informal communities were the focus of the Carter Center's Access to Justice Program precisely because of their histories. See: [cartercenter.org/news/pr/liberia-021012.html](http://cartercenter.org/news/pr/liberia-021012.html) (Accessed February 23, 2023). See also Bernstein et al (2013).

<sup>3</sup> See Karim and Gorman (2016).

<sup>4</sup> Out pre and post research design is limited to a sample that includes only those who experienced a dispute due to the limitations from the initial 2012 survey.

<sup>5</sup> While we cannot provide a comparison with individuals in non-marginalized communities, this study provides some proof of concept that pandemics and experiences with security responses could negatively impact perceptions of marginalized populations about the security forces.

## 2. Epidemics and marginalized communities in Post-Conflict countries

*...Because, like other hospitals like ... had the best doctors and equipment before the war. And now, I have not seen these equipment, not only for pregnancy cases but for other cases too. There is nothing there. Also, look how Ebola exposed our health sector. Even though most of them are working but they are not qualified. Most of them have only been practicing nursing for like a short period, so the facilities, equipment and ambulances lacked. Even before Ebola, it was hard.*<sup>6</sup>

The quote highlights the challenges post-conflict countries encounter in battling health crises. Violent armed conflicts like the ones Liberia experienced during the Liberian Civil Wars (1989–1996 and 1999–2003) often lead to the dismantling of the national economy and infrastructure, and the destruction of effective state institutions. The health sector is particularly vulnerable to the impact of armed conflict. Health services are often severely disrupted, or they close because of the security situation, personnel fleeing or getting killed, or equipment and facilities being targeted. Even if health services are open, demand for the use of health facilities can diminish as there are issues with access (McCarthy and Maine, 1992: 23). At the end of the Liberian wars out of the 293 public health facilities only 49 were deemed operational, leaving the shattered health system into a state of health dependency to international health care providers (Abramowitz and Panter-Brick, 2015; Kruk et al., 2010).

Limited capacity in the provision of health care is often exacerbated by weak governmental institutions and low trust among the population. As such, in weak and post-conflict states, responses to epidemics become difficult and services are more arbitrarily distributed. Low administrative capacity leads to failures in coordinating effectively at the central level, which could lead to uneven distribution of services across the state (Sivaramakrishnan, 2011). While weak states already lack service delivery capabilities, outbreaks put additional strain on such governments, sometimes leading to state failures specifically in health sectors (Hendrix, 2010; Rotberg, 2002). For post-conflict states with low administrative capacity epidemics like Ebola hurt any ability to respond to crises spiraling out of control leaving communities and populations with few options and further disillusionment about national institutions as the following quote illustrates.

*Oh, you know... In our country here, one good thing that Ebola did for us was that it exposed our weak health sector. We never had a good health facility in this country. Because of the poor health facility, many people died. Lack of experience killed a lot of people. The nurses became afraid of each other. You were afraid of me and I afraid of you. Even a person had a malaria which was not Ebola related, they would not treat you. So you end up going home.*<sup>7</sup>

Epidemics, alone, may not contribute to mistrust in the government, but rather the government responses to them may affect how citizen's view the state. National crisis can shine a light on the government's ineffectiveness because the institutions are tested (De Soysa and Gizelis, 2013; Gizelis, 2009; Gonzalez-Torres and Esposito, 2016). The incapacity of the government to respond in an effective and efficient manner results in public disapproval of the government (Brancati, 2007, Drury and Olson, 1998; Gonzalez-Torres and Esposito, 2016, Enria, 2019). Diminishing trust in state institutions exacerbates the government's already low capacity and/or it can worsen discriminatory

<sup>6</sup> Focus group with male participants in West Point. The researchers did four focus groups with men and women in each of the communities as well as 20 semi-structured interviews with community leaders and medical personnel. Four more focus groups were conducted with more affluent and/or integrated communities in Monrovia.

<sup>7</sup> Focus group with male participants in Peace Island.

practices against certain populations if they are perceived as unwilling to comply with health regulations.

In most states, those that are hardest hit by outbreaks are often those who are the most marginalized and portrayed in the narrative of threat as dangerous and unruly populations (Enria, 2019; Wagstaff and Lindelow, 2014). Watson (2019, pg. 2) argues that marginalized communities around the world are alike in their “optional or assigned non-compliance with mainstream ideological, political, social and economic standards,” and “this categorization is usually assigned to peripheral dwellers or groups of socially excluded or ignored individuals within a society.” As such people are marginalized based on residence within a community deemed an informal settlement or by virtue of not having attained the level of education deemed normal by governments or policy makers, or any other marker of “normalcy.” Such populations lack proper access to housing, loans, and other services that force them to live in informal settlements. Residents of such neighborhoods are marked by a stigma of place that affects their relationship with the wider city and with large opportunities (Wacquant, 2019). Those who live in informal settlements are the least equipped to handle disease outbreaks (Corburn et al., 2020). Within societies that have experienced a civil war, these settlements include internally displaced peoples and ex-combatants who have not been integrated into the government (AlKhalidi et al., 2020; Raleigh, 2010; Söderström, 2014; Stuber et al., 2008). Thus, those who are most marginalized are least likely to access services, and they experience the effects of outbreaks in compounding ways (Skoufias, 2003).

While discriminatory practices against certain populations might already be in effect in the types of communities mentioned above, disease outbreaks might exacerbate discrimination (Cederman et al., 2013). Although the Liberian Ministry of Health and Social Welfare (MOHSW) had rolled over the new health policy to 80 % of health clinics, variation in information dissemination led to differences in access to services (Woskie and Fallah, 2019). Communities such as West Point and Peace Island, which we are studying here, had very mixed experiences, with limited access to vital medication and forced payments of large sums of money even though services were meant to be free. The quote below is from a focus group discussion with women in West Point, one of the communities in our study, conducted in September 2015. It illustrates the level of isolation and scapegoating members of the West Point community experienced during the Ebola Virus Disease epidemic that hit Liberia in 2014:

*She was in pain and she went to labour. But when we went to the hospital and she gave birth to the baby, the baby was shaking. So I was told to take the baby to JFK and went. I go to the JFK they ask us for our card, so see whether we had taken treatment there before. When they looked at the card, then they said, where are you from and I said it is on the card. So when they saw on the card that we were from West Point, they refused to touch us, because they said that people from West point are those that spread the Ebola Virus Disease. So we took a taxi to go to another hospital. When we arrived there, they said that she and the baby must remain in the car. So that is how the lady came to our card and interviewed us. Later she said that we should carry the young baby inside, but then she said that I had to pay 44 thousand.<sup>8</sup>*

The quote by the woman is highly representative of the types of stories we heard while doing fieldwork during and after the epidemic was over. It demonstrates how the epidemic heightened levels of discrimination that already existed because it allowed people to place blame for the outbreak on groups that are often marginalized. Disease outbreaks enable this “blame narrative” because diseases are transmitted between people. Minority groups often serve as scapegoats. Thus, discrimination is likely to be more intense during epidemics than other types of crises particularly because majority groups blame minority

groups for the spread of the disease.

While marginalized communities do not receive equitable access to services, they may be subject to higher levels of enforcement of regulations (Boehme, Cann and Isom, 2020; Knox and Mummolo, 2020; Perry, 2006; Watson, 2019; Weaver and Prowse, 2020). This means that if epidemics lead to new regulations, marginalized community members may be more likely to be affected from the enforcement of regulations. In short, marginalized communities are less likely to receive access to services, but more likely to experience militarized interventions during epidemics.

### 3. Securitizing epidemics and public opinion

Securitization of an issue occurs when it is cast as an existential threat that calls for extraordinary measures beyond the routines and norms of daily politics (Karyotis et al., 2021; Williams, 2003). According to Buzan et al., (1998, pg. 21) “the special nature of security threats justifies the use of extraordinary measures to handle them.” While there is variation in the types of issues that become securitized, there is a growing global trend of using militarized tools to address health issues (Fidler and Gostin, 2008). Usually, the securitization of epidemics means declaring a national emergency, re-allocating funds to emergency response teams, enforcing quarantines and checkpoints, and engaging the military or other national branch of the armed forces in the enforcement of regulations. All these actions were taken during the 2014/2015 Ebola Virus Disease epidemic in Liberia (and to a lesser extent in Sierra Leone) (Benton and Dionne, 2015). Moreover, the response to the 2014–2015 Ebola Virus Disease outbreak was unlike the response to previous outbreaks of Ebola Virus Disease such as in the DRC (Zaire) in 1995 (Fidler and Gostin, 2008). Importantly, securitization as a response to disease outbreak might be more common in weak, post-conflict countries due to the low administrative capacity and failures in coordinating effectively at the central level. The only option that remains is the use of the strongest sector in society (the security forces) to help enforce quarantines. In these contexts, health epidemics become a “law and order problem” (Sivaramakrishnan, 2011).

Of particular importance to this study is when security force personnel’s authority extends to enforce health regulations. During non-epidemic times, the face of the state is often represented through the police, who are charged with keeping law and order (Karim, 2020). But when the government calls on the police and/or military to enforce regulations beyond the natural scope of work such as for quarantines, masks, or other regulations, the epidemic becomes securitized. For the police, the extension in authority means enforcing a larger set of rules than they would otherwise, usually through the dispatching of militarized units. For the military, securitization means deploying personnel within the country’s borders. Either way, interventions of containment could lead to more civilian interaction with security personnel among marginalized communities. This increase in presence could create the conditions for community members to develop negative perceptions of the security forces.

First, security force personnel may replicate their pre-emergency behavior in the communities during the epidemic. If the police, like other government agencies, behave in a discriminatory way as described in the previous section, their behavior is unlikely to change. With more security force personnel present during a crisis, discrimination is more likely. Discrimination might come in the form of enforcing regulations disproportionately on some populations over others. Additionally, regardless of whether there is actual discrimination, prior experiences with discrimination are likely to taint the lens through which some community members view the security forces.

Exposure to securitization is likely to decrease support for the security forces if they are on the receiving end of the enforcement. A larger security presence and increased enforcement may prime marginalized community members about their fears of the government. Indeed, securitization is likely to lead to negative perceptions of the security

<sup>8</sup> 44,000 in Liberian Dollars is the equivalent of 334 in USD.

forces particularly among marginalized communities in post-conflict contexts as they constitute those who have the most to fear from the government resorting to a strong hand to manage the crisis (Sivar-amakrishnan, 2011). Ex-combatants and victims of wartime violence may have more to fear from a strengthened and emboldened security force as heightened security presence means more opportunity for use of force.

Furthermore, if the police and military are engaged in more public interactions than their behavior as they enforce health regulations will affect public opinion. Increased presence almost always correlates with increased use of force (Weaver and Prowse, 2020, Magaloni et al., 2020). This use of force may be tactical. The security forces could use the opportunity to retaliate against socially undesirable populations perceived as unruly or undesirable. At the same time, security forces could also fear these informal communities—Brazilian police, for example, do not often enter favelas out of fear—and instead use excessive force more indiscriminately. Thus, increases in security force personnel is not only intimidating for those who have experienced government abuse in the past, but it could also lead general increases in levels of abuse and violence. Thus, when the security forces use excessive force, the public is likely to be more fearful and resentful of the security forces.

Of course, there is an alternative view. It is possible that securitization of health issues might send a signal to the population that the government is doing something positive about the crisis. Using security forces to contain, engage and support local communities to manage the pandemic reflects efforts to modify the behavior of individuals. For some individuals these interventions create opportunities and a pathway to get out of the pandemic, for others they exacerbate pre-pandemic inequalities (Enria, 2019). There is evidence that increased presence of the security forces during conflict could increase support for the government because it shows that the government is capable. Yet, some studies have shown that securitizing policy issues leads to overall lower state capacity and intensifies fear among locals and potentially reduces public trust (Flores-Macías, 2018). When an issue has been identified as an existential threat, extreme measures become legitimized at the expense of other values (Buzan et al., 1998).

Even if it is possible that more positive opinions might emerge from the intervention policies and interactions with state agents, we expect that for marginalized community members that often are labelled as dangerous or non-compliant, securitization, on the balance, may lead to negative perceptions of the security forces. This means that those who experience securitization in marginalized communities are more likely to develop negative perceptions of the security forces.

*H1: Exposure to the securitization of epidemics will lead to negative perceptions of the security forces.*

#### 4. Case Study: The 2014 Ebola Virus Disease epidemic in Liberia

Liberia has experienced two periods of civil war, first from 1989 to -1996 and then from 1999 to -2003. The estimated death toll was approximately 250,000 deaths, amounting to nearly 10 % of the population. In addition, the conflict generated more than one million displaced, and had a detrimental impact on the country's economy and the capacity of the state (Karim, 2019). The UN Peacekeeping Mission in Liberia (UNMIL) arrived in 2003 to enforce the negotiated peace settlement. With help from the mission, over 100,000 people were disarmed and demobilized through formal programs, many of whom remained in the capital city (Söderström, 2014). In 2018, UNMIL withdrew, meaning that the Liberian National Police and the Armed Forces of Liberia became responsible for their own security.

Both the Liberian National Police and the Armed Forces of Liberia were dissolved after the war ended in 2003. The United National Mission in Liberia (UNMIL) was tasked with helping to create a new police force and the United States was tasked with helping to rebuild the Armed Forces of Liberia (AFL). Both processes of rebuilding included the

vetting of police officers and soldiers, ensuring that they did not recruit former combatants. They both underwent heavy training and professionalization.<sup>9</sup> While not perfect,<sup>10</sup> both institutions were rebuilt to ensure that their past histories of abuse during and before the war did not replicate themselves. The public came to develop more trust in both institutions. In 2008/2009, about a third of the population trusted the police and 40 % did not find the police to be corrupt.<sup>11</sup> In 2011/2013, about half of the population trusted the Armed Forces.

Many ex-combatants, IDPs, and other affected by the war did not receive government assistance for integrating back into society. As a result, many of them moved to informal settlements or built their own settlements on abandoned land.<sup>12</sup> There are several areas that became known for such settlements of war affected populations. They predominantly inhabit two areas in Monrovia, Peace Island and West Point. Based on oral histories of seventy-five communities in 2022,<sup>13</sup> West Point and Peace Island continue to stand out in terms of the numbers of war affected population particularly IDPs and ex-combatants. These communities house ex-combatants and IDPs from different factions and ethnic groups. Moreover, these two communities were the focus of the Carter Center's Access to Justice program precisely because of the high numbers of ex-combatants and IDPs in them.<sup>14,15</sup> Other studies have focused on these two communities as well when looking at trust in the police.<sup>16</sup> As such, they represent post-war communities with high levels of marginalized populations. The communities have their own governance structure such as elected chairwoman/men and traditional leaders. Just like with any informal settlement, the Liberian government tolerates their presence.<sup>17</sup> Crackdowns and repression were not common in either of the communities because of the presence of the UN peacekeeping mission. At the same time, however, the communities are perceived to be more insecure than other communities because of crime. Though notably, organized crime is not a common feature of Liberia.<sup>18</sup>

There are some differences between the two communities both historically and in terms of the intensity of securitization (explained below) that we leverage in the analysis below. West Point is an older informal community that was formed from displaced rural Liberians. It became heavily populated with former internally displaced persons and ex-combatants after the first civil war in the 1990s. Peace Island, on the other hand, is a more recent community that was formed by internally displaced persons and ex-combatants in the aftermath of the disarmament, demobilization and reintegration program in 2003.

In 2014, Liberia faced the Ebola Virus Disease epidemic. During the Ebola Virus Disease crisis, Liberia had the highest count and death toll of all the countries that experienced the epidemic, but also the steepest decline in new cases. The epidemic killed 4,809 individuals in Liberia out of a total of 10,675 registered cases (See Fig. 1).

The first Ebola Virus Disease case in Liberia was reported in the Foya district near Guinea in March 2014. The epidemic reached the capital Monrovia by June 2014. According to estimates by the World Health Organization (WHO), there were between 300 and 400 new reported

<sup>9</sup> See Joyce, 2020,2022 and Karim and Gorman, 2016.

<sup>10</sup> See Karim and Gorman, 2016.

<sup>11</sup> Afrobarometer data from 2008/2009 and 2011/2013 rounds in Liberia. There were no trust questions about the Armed Forces in 2008/2009. The descriptive analysis was done using their "analyze online" tool.

<sup>12</sup> Jennings, Kathleen M. "The struggle to satisfy: DDR through the eyes of ex-combatants in Liberia." *International Peacekeeping* 14.2 (2007): 204–218.

<sup>13</sup> See the work of Priscilla Torres.

<sup>14</sup> See: [cartercenter.org/news/pr/liberia-021012.html](https://cartercenter.org/news/pr/liberia-021012.html) (Accessed February 23, 2023). See also Bernstein et al., 2013 See Karim and Gorman, 2016.

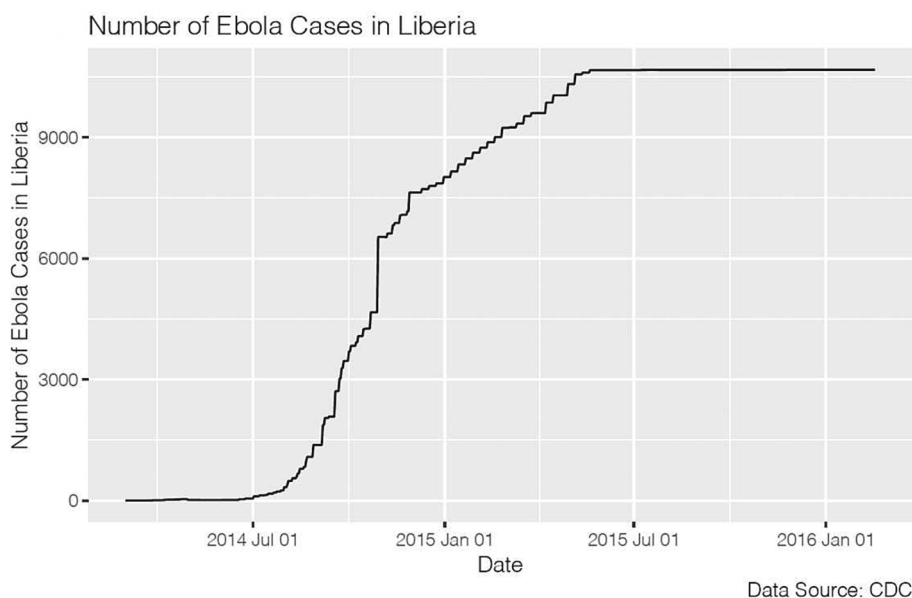
<sup>15</sup> The authors have spent significant time in both communities between 2012 and 2017, which allowed for these observations.

<sup>16</sup> See Karim, 2019.

<sup>17</sup> See for example, Holland, Alisha C. "Forbearance." *American Political Science Review*, 110.2 (2016): 232–246.

<sup>18</sup> See Berens and Karim, 2023.





**Fig. 1.** Number of People Infected with the Ebola Virus Disease in Liberia Over Time. Notes: We plot the daily CDC counts of cases in Ebola over time.

cases every week as the epidemic reached its peak in August and September 2014. Health workers were killed at the outset of the epidemic, and affected patients were largely left without medical care for routine sicknesses and injuries, or were afraid of increased risks of infection at health facilities as medical facilities were overrun by Ebola Virus Disease patients (Streifel, 2015). Armah-Attoh and Okuru (2016) find that the outbreak dramatically affected Liberians' daily lives—more than three-quarters of Liberians went without medicine or medical care at least once during the height of the outbreak. They also find that during the epidemic, 89 % of Liberians could not participate in social and communal events, 86 % could not attend school, and 86 % could not engage in income-generating activities. The loss of family members has caused economic insecurity in many households (Bowles et al., 2016).

Prior experience and perceptions of the government further impacted the way locals perceived state institutions. Research has found that the use of health services during the Ebola Virus Disease was affected by distrust in the government and by exposure to people with the Ebola Virus Disease (Morse et al., 2016; Tsai et al., 2020). Blair et al. (2017) find that in Monrovia, those who expressed low trust in government were much less likely to take precautions against the Ebola Virus Disease in their homes, or to abide by government-mandated social distancing mechanisms designed to contain the spread of the virus. They were also much less likely to support potentially contentious control policies, such as the safe burial of the Ebola Virus Disease-infected bodies. As such, non-compliance was a result of government distrust and not a result of insufficient understanding of how the Ebola Virus Disease was transmitted. Moreover, Fang et al. (2016) found a clear link between the political prominence of an area and its incidence of the Ebola Virus Disease. Their research suggests that the Ebola Virus Disease intersected with prior grievances and disparities. The implication is that informal communities, because they are more likely to distrust the government and have lower political prominence, may have been particularly hard hit by the epidemic and thus more resentful of the government. Amidst the inability of national institutions and international organizations to respond to the crisis, however, Liberian communities engaged in localized surveillance, treatment and support of members showing high levels of resilience (Abramowitz et al., 2015; Gizelis et al., 2017).

Initial evidence about post-Ebola perceptions of the government was mixed. According to a study by Mukpo (2015), a total of 81 % of survey respondents reported being “angry” at the government’s response

efforts, mainly due to its perceived slowness. Other studies show more optimism.<sup>19</sup> Armah-Attoh and Okuru (2016) find that most Liberians rated their national government and local governments as effective in controlling the epidemic. The disparity in the findings may be due to the way sampling was conducted. It is possible that in marginalized communities, where the epidemic was particularly devastating, opinions of the government were less optimistic.

In response to the epidemic, the government eventually initiated many actions after declaring a state of emergency on August 15, 2014. From that date, the crisis was securitized. Of notoriety and importance for this paper was the quarantine that was enforced on the *West Point* community by the security forces including the military and the police. On August 20, 2014, the Ebola Task Force, a joint operation led by the Armed Forces of Liberia (AFL), instituted a quarantine around West Point, one of the informal communities in the study. They did so because of reports of Ebola Virus Disease victims leaving sanctioned health facilities and running away, which constituted a health (and therefore security) threat, as West Point is very densely populated.<sup>20</sup> On August 15 a holding center for victims was ransacked and suspected Ebola Virus Disease patients escaped, and looters stole infected materials and mattresses from the center. The quarantine was supposed to last 21 days, but only lasted ten. When the residents protested, the Armed Forces of Liberia, with the Liberian National Police present, responded with beatings and live ammunition, killing at least one person. By August 30, the quarantine was lifted. The use of the Armed Forces of Liberia to enforce the quarantine marked the *first time* that the government used the military for an operation since the war. It constituted military use of force during peacetime due to a national security threat. West Point was not the only place that received a quarantine. Neighborhoods, including Peace Island, experienced check points and increased security force presence by the police, but West Point was the only community to experience enforcement by the military. Participant observation by the authors at different check points in the country, at Police Headquarters, and with the UN Mission in Liberia confirmed that the police units such

<sup>19</sup> See Gizelis et al. (2017) who find that there was a substitution effect with respect to maternal health between public and private facilities, suggesting that maternal health shortages may not have been as severe as initially thought.

<sup>20</sup> Importantly, the underlying conditions of West Point did not trigger securitization, but rather, the escape of the victims triggered the response. One author was present at some of the UN and LNP meetings that led to the decision.

as the riot and SWAT teams were dispatched for enforcement, and that the police started to coordinate with the Armed Forces on enforcement of quarantines. This was the first time that the police and the Armed Forces enforced large-scale check points, quarantines, and lockdowns since the war ended.

While securitization of the health crisis occurred through the increases in security powers of the police and dispatching of the Armed Forces, the security forces also played a role in disaster relief. For example, immediately following the quarantines, members of the Armed Forces, with some help from the police, rebuilt infrastructure. These humanitarian efforts occurred primarily in West Point immediately after the media reports of military abuse internationally. Thus, even though the security forces engaged in “security” activities, they also engaged in humanitarian relief efforts embedded within securitization, which makes securitization of a community as a treatment, a messy, “bundled treatment.” Thus, on one hand, the securitization that occurred in marginalized communities such as West Point and Peace Island could exacerbate perceptions due to community members’ prior experiences. At the same time, it is possible that the increased presence of state agents during the securitization of the Ebola outbreak enhanced perception of the security forces’ ability to handle emergencies. It is not possible to disentangle the security forces securitization roles—abuse versus humanitarian—at the community level, which is why we also rely on data at the individual level.

## 5. Research design

### 5.1. Data

To understand the effects of experiences with the securitization on public perceptions of the security sector, we leverage two cross-sectional surveys conducted in 2012 and 2015—before and after the Ebola Virus Disease epidemic. The two surveys were conducted in the two informal communities in Monrovia—West Point and Peace Island. We choose these two communities because they were most likely to have individuals who experienced securitization and because a partner organization conducted surveys in these two communities in 2012. As mentioned earlier, the origins of the settlements have historic ties to the war, which make them unique neighborhoods compared to other communities in Monrovia. Those living in these two communities are more marginalized than members of other communities in Monrovia.<sup>21</sup>

The initial 2012 survey was conducted in conjunction with the Carter Center, which delineated the parameters of the survey. The goal of their survey was to analyze perceptions of justice and security in informal communities among those *who experienced disputes*. Thus, the survey only included a sample of people who had experienced a dispute. In other words, it screened out anyone who did not experience a community dispute (requiring a “palava”) in the past year.<sup>22</sup> The second survey was conducted in September of 2015, in the immediate aftermath of the Ebola epidemic of the same two communities, but of a *representative sample*. In some of the analysis below, we subset this representative sample to only those who experienced a dispute to compare it to the 2012 sample. Given these constraints, causal identification of exposure to securitization is not possible. As such, our analysis relies on correlations and descriptive evidence.

Because of the differences in survey sampling, we use different methods to test our hypothesis. First, to assess post-Ebola effects, we needed to ensure consistency across the two waves. To compare the

2012 and 2015 surveys, we had to drop the respondents who did not experience a dispute from the 2015 sample, leading to a reduced sample. Thus, when there is analysis of the 2012 and 2015 surveys, the sample is only limited to those who experienced a dispute. There are obvious limitations to this design due to a decrease in sample size and the biases this introduces. For example, those who experienced a dispute are more likely to have prior contact with the police, which means that they have likely formed opinions about the police.<sup>23</sup> However, the proportion of those who experienced a dispute in 2012 and 2015 are, on average, the same, which means that the number of people experiencing a dispute does not appear to change over time.

Given that the 2012 and the reduced 2015 surveys lead to a smaller and biased sample, we also analyze the full representative sample of the 2015 survey. If the analysis below uses only the 2015 survey, then *all respondents* including those who did and who did not experience a dispute. That is, we utilize the entire 2015 representative survey of Peace Island and West Point for a different set of analyses. We treat individual level exposure to securitization and exposure to security force abuse as quasi-random given that other studies have suggested that security forces may target communities, but they indiscriminately target individuals within the communities (Rozenas et al., 2017, Bauer et al., 2016). This means that a community (West Point) may be targeted by the security forces, but that specific individuals who live within that community are not necessarily targeted by the security forces.

Both surveys were implemented by the Center for Action, Research, and Training.<sup>24</sup> For the 2012 survey, a cross-sectional random cluster survey of 397 adults, who experienced a dispute, aged 18 years or older was carried out in the two communities (West Point (212 adults) and Peace Island (185 adults)). In this survey, sampling was conducted by dividing up the communities into zones marked by GPS coordinates (in Peace Island, zones of 136,604 square feet and in West Point zones of 25,091 square feet). We then randomly sampled 25 zones from West Point and 34 zones in Peace Island based on the population in each community. Using GPS devices, the enumerators located the zones and counted the number of houses within each randomly selected zone. They then randomly selected houses within those zones, and within the houses, they randomly selected an individual to interview.

For the 2015 survey, enumerators returned to the same zones and used the same techniques to identify households. The entire sample includes 545 adults aged 18 and over who experienced a dispute. While these data are not panel, the same enumeration zones and building structures were sampled allowing the samples to be comparable.

Our survey data do not allow us to compare West Point and Peace Island to other communities in Monrovia. As such, we descriptively compare perceptions of the security forces with surveys conducted in all of Monrovia and Afro-barometer data. Specifically, we conduct descriptive analysis of Afrobarometer data from Round 5 (2011–2013), Round 6 (2014/2015), and Round 7 (2016/2018). Together, the triangulation of methods and data provide a way for us to test our hypothesis.

We use survey data (and self-reporting of exposure to securitization) to test our hypotheses and not actual measures of securitization for several reasons. First, securitization cannot be randomly assigned in our study, which means that we can only provide observational and descriptive analysis of our hypothesis. Furthermore, the Armed Forces of Liberia only enacted a quarantine/checkpoint in one community (West

<sup>21</sup> The Carter Center as well as Liberian enumerators confirmed this in 2012 when the Carter Center sought to survey marginalized communities. Other studies have compared these two communities as a “matched pair” (Karim, 2019).

<sup>22</sup> If someone had not experienced a dispute, they did not go on to take the survey.

<sup>23</sup> Individuals who have multiple contact with the police have hardened priors and one additional interaction is unlikely to change their priors (Karim, 2020).

<sup>24</sup> Enumerators from CART included trained Liberian enumerators of both sexes, who had previous experience conducting surveys to implement the survey. The enumerators ensured that the questions were culturally appropriate and written colloquially. Pilot test of the questions was conducted to ensure the validity of the questions. Enumerators received permission from the village elders to be able to conduct the surveys in the community, which ensured that people trusted the enumerators.

Point). In this sense, not only was securitization not random, but there was also only one strongly “treated” community. Peace Island was weakly “treated” in comparison because there were police patrols in the neighborhood to enforce quarantines, but no enforcement of quarantines by the military. We leverage this difference in our analysis by including an interaction term for West Point (strongly treated) and the post-Ebola survey. However, while West Point was more strongly treated than Peace Island, the security forces also engaged in reconciliatory, humanitarian actions with the community after international news reports emerged of the military engaging in abuse. This means that the treatment is not clean and is likely bundled. Given the lack of a clean assignment of treatment at the community level, we rely on individual level treatment or exposure to security force abuse across both communities to supplement the pre/post Ebola analysis. Thus, our goal is not to show that marginalized communities are more securitized than non-marginalized communities, but rather that any individual who is exposed to securitization will have changed perceptions of the security sector. Finally, data sources on police patrols, armed forces patrols, quarantines, and crime are not accessible nor reliable. As such, the most reliable data on exposure to securitization is from survey data.

One pressing concern is that events other than Ebola could cause changes in perceptions of the security forces over time. There were no other major events during this period, such as violent uprisings or elections, that would have led to a significant change in public opinion. There was a contentious election in 2011, which could have suppressed demand for the police, but the high baseline in 2012 shows that this was not the case. During the period (2012–2015), one of the authors visited Liberia every 3–6 months, and conducted participant observation of the Liberian National Police, as well as in these two communities. During this time, the Police Commissioner stayed the same, and the police reform programs continued to be implemented in the same way by the United Nations and the U.S. State Dept. The major police and military reforms all occurred prior to this period.

### 5.2. Independent variables

We present different ways to measure exposure to securitization. Specifically, each type of analysis presents different independent variables. We first present pre and post-Ebola results. The independent variable labeled “After Ebola” represents the 2015 survey or the “post” Ebola condition. The model includes an interaction term to account for the conditional effects of West Point (more highly treated) on the 2015 survey. Next, using the entire sample of the 2015 survey, we use the following survey questions to measure exposure to the police and military during securitization and to measure whether they witnessed police/military abuse during the securitization phase: “During the Ebola emergency starting in July 2014, did you have contact with the LNP?” “During the Ebola emergency starting in July 2014, did you have contact with the LNP/AFL?” “During the Ebola emergency starting in July 2014, did you see the LNP/AFL beating people?”.

### 6. Dependent variables and models

We utilize a variety of variables to measure negative perceptions of the security forces. We do so to show whether perceptions changed consistently across different measures, rather than cherry picking questions from the survey. First, we use a question about continued demand for police and military security services. Specifically, the question asked, “who do you think should provide security to the community?”<sup>25</sup> The responses include religious leaders, Liberian NGOs, International NGOs, women’s groups, Council of Elders/Community

<sup>25</sup> We chose to include different options for security responses to cover a wide range of security needs, including responses to crimes that affect women disproportionately.

Watch team, Police, Judges, Township Commissioner, peacekeepers, or the Armed Forces of Liberia.<sup>26</sup> We created a dichotomous variable for choosing the police and for choosing the military.<sup>27</sup> Thus, we use a logit model to estimate the probability that the respondents chose police conditional on taking the survey in 2015 and being from West Point.

We also use questions related to perceptions of police fairness and respect to better understand why demand declined. The questions asked, “are the ways that the police cut the cases usually fair to all the people involved?” and “are the way that the polices cut case usually respectful to the traditions and beliefs of the people who live in your community?” The responses included a “1-Yes, almost always,” “2-No never fair/respectful to either party,” “3- Usually unfair/respectful to at least one party,” “I don’t know” and “Refuse to answer.”<sup>28</sup> We use a linear probability model to assess these outcomes.

Finally, when analyzing the 2015 representative survey, we look at questions related to personal safety (“I feel safer when the LNP are in my community” and “I feel safer when the AFL are in my community”), as well as whether people believed the police or armed forces would beat people (If the LNP comes to your village, do you think that they would beat community members? If the AFL comes to your village, do you think that they would beat community members?). These responses are dichotomized into “agree” or “disagree. As such, we use a logit model to estimate the probability of believing the security forces will engage in abuse/likelihood of feeling safe conditional on interactions with the police or armed forces.

The models include several control variables such as age, sex, ability to read, the number of children, prior contact with police, and prior contact with peacekeepers. These were questions that were worded the same between the two surveys. These variables and summary statistics of the control variables for the 2015 representative survey are included in the Appendix.

## 7. Results

Among residents who experienced a dispute, we first look at whether perceptions of police demand for security provision changed pre- and post-Ebola, as well as whether residents in the community with more securitization experience (West Point) changed opinions after Ebola (the

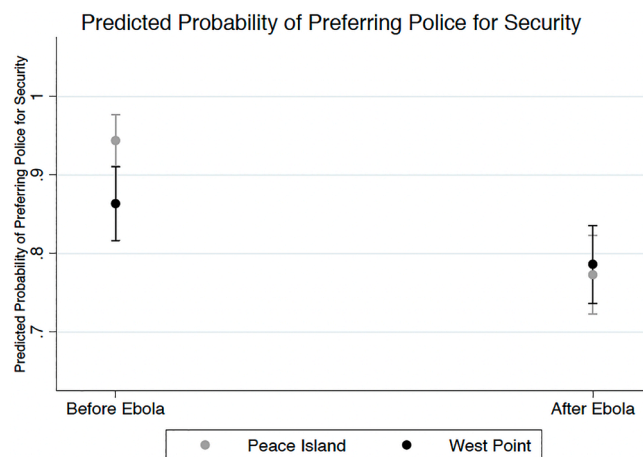


Fig. 2. Demand for Police by Community.

<sup>26</sup> Prior focus groups done with Carter Center in 2012 indicated that these were all potential responses to the questions.

<sup>27</sup> There were too few responses for the Armed Forces for analysis.

<sup>28</sup> “Cut cases” means how disputes are handled. The survey did not include a military version of these questions.

interaction term). Fig. 2 and Fig. 3 show that there was a decrease in demand for the police, but no change for the military. However, this decline in demand for the police occurred in both communities—West Point and Peace Island.<sup>29</sup> We find that police demand for security decreased by 12 %. Interestingly, the coefficient Tables in the Appendix demonstrate that there is a positive interaction term. This means that while those in West Point had less demand for police prior to Ebola, the experience of securitization did not decrease demand in the aftermath of securitization compared to residents of Peace Island. This means that those who experienced less severe forms of securitization, but not restorative actions by the security forces (e.g. residents of Peace Island), had a sharper decline in demand for the police. Nevertheless, the post-Ebola coefficient remains significant and negative while controlling for community, which means there was a decline in demand for the police regardless of community.

These findings differ from aggregate county data from the Afrobarometer survey for Montserrat County.<sup>30</sup> That descriptive data shows that the percentage of people who do not trust the police at all stayed the same during this time period: it was 34 % in 2011/2012, 34 % in 2014/2015, and 32 % in 2016/2018.<sup>31</sup> While a direct comparison across surveys is not possible, there is suggestive evidence that those living in more marginalized parts of the capital viewed the police more negatively after experiencing securitization, whereas the perceptions did not change when looking at the county as a whole.

Figure 3 shows that there is no change in demand for the armed forces to respond to a security incident between 2012 and 2015. The tables in the appendix further show that the interaction terms are not significant. This is despite the Armed Forces’ deployment into West Point for the first time since the civil war ended in 2003. One reason for the null results might be that there was already low demand for the armed forces (in 2012) and experiences with securitization did not affect that demand due to floor effects. In contrast, the relatively high demand for the police meant that demand could only decrease. Demand for the Armed Forces mirrors levels of trust in the Armed Forces throughout Montserrat County. Using the Afrobarometer, trust in the armed forces increases slightly over time. In 2011/2012, 36% of those in Montserrat County trusted the Armed Forces a lot. In 2014/2015, the percentages

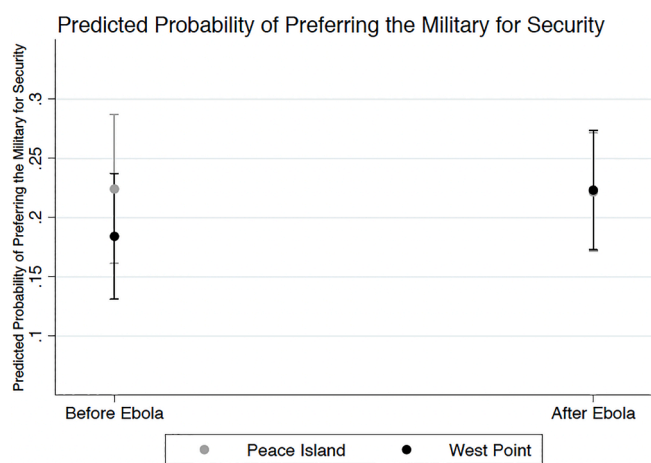


Fig. 3. Demand for Military by Community.

<sup>29</sup> In the appendix, we look at demand for various types of security concerns and find consistent evidence.

<sup>30</sup> Montserrat County is the country that includes the capitol of Monrovia.

<sup>31</sup> Note that the percentage of people who trust a little, trust, and trust the police a lot (81% in 2011/2012 and 88% in 2014/2015) is lower than our levels of “demand for the police,” but still largely positive.

increased to 39 % and in 2016/2018, it increased again to 41 %. Thus, the percentages are slightly higher for the county than in the two communities.

Figure 2 and 3 NOTES: The dependent variable is the survey question “who do you think should provide security to the community?” We code a dichotomous variable for whether the respondent chose the police (Figure 2) and if they chose the military (Figure 3). The independent variable is whether the survey was taken before Ebola (2012 Round) or whether the survey was taken after the epidemic (2015 Round). The

Table 1

NOTES: The model is a linear probability model. For columns 1 and 2, the dependent variable is the survey question “Are the ways the LNP cut cases usually fair to all people involved?” Higher values indicate perceived unfairness by the police (or the response: “treated unfairly”). The interaction term in Column 2 is insignificant. For columns 3 and 4, the dependent variable is the survey question “Are the ways the LNP cut cases respectful to the traditions and beliefs of the people who live in your community?” Higher values indicate perceived disrespect by the police (or the response “treated not respectfully”). The results show that people were more likely to view the police as less respectful after Ebola. However, the interaction term is insignificant, suggesting that perceptions of respect after Ebola do not vary by community. The sample includes those who experienced a dispute only.

	(1) Police Unfair	(2) Police Unfair	(3) Police Disrespectful	(4) Police Disrespectful
After Ebola	0.0621 (0.0622)	0.0966* (0.0433)	0.248*** (0.0712)	0.221*** (0.0494)
West Point	-0.103 (0.0641)	-0.0663 (0.0424)	-0.0234 (0.0744)	-0.0530 (0.0484)
After Ebola X West Point	0.0660 (0.0855)		-0.0513 (0.0979)	
Age	-0.00350 (0.00221)	-0.00355 (0.00221)	-0.00210 (0.00252)	-0.00205 (0.00251)
Female	0.0473 (0.0451)	0.0476 (0.0451)	0.0489 (0.0520)	0.0484 (0.0520)
Can Read	0.0673 (0.0494)	0.0688 (0.0493)	0.0957 <sup>+</sup> (0.0568)	0.0947 <sup>+</sup> (0.0568)
Number of Children	0.0499** (0.0152)	0.0501** (0.0152)	0.0362* (0.0173)	0.0362* (0.0172)
Contact with UNMIL t	0.0398 (0.0507)	0.0382 (0.0506)	0.0798 (0.0586)	0.0812 (0.0585)
Contact with Police	0.0525 (0.0517)	0.0500 (0.0516)	-0.0472 (0.0583)	-0.0455 (0.0582)
Constant	1.955*** (0.109)	1.937*** (0.107)	1.924*** (0.125)	1.938*** (0.122)
N	823	823	798	798
R <sup>2</sup>	0.029	0.029	0.038	0.038
BIC	1562.2	1556.1	1700.1	1693.7

Standard errors in parentheses.

<sup>+</sup>  $p < 0.10$ , \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ .

sample is reduced to those who experienced a dispute only.

We next assess whether perceptions of fairness and respect changed before and after the Ebola Virus Disease among those who experienced a dispute to better understand why demand may have decreased.<sup>32</sup> Tables 1 shows a linear probability model for the questions that asked

<sup>32</sup> The survey did not ask these questions for the military because the military does not handle dispute resolution.



**Table 2**

The models are logit models. For Models 1 and 2, the dependent variable is the survey question asking whether they agree or disagree with the following statement: "I feel safer when the LNP/AFL are in my community." For Models 3 and 4, the dependent variable is the survey question asking whether they agree or disagree with the following statement: "If the LNP/AFL come to your village, do you think they would beat community members?" The independent variable is whether they had contact with the LNP/AFL and whether they saw the LNP/AFL beat people during the epidemic. These questions were only asked in the 2015 survey. The sample includes all respondents.

	(1)	(2)	(3)	(4)
	Feel Safe with LNP	Feel Safe with AFL	Police Abuse	Military Abuse
Contact with LNP (during Ebola)	-0.338* (0.133)		0.435** (0.141)	
Saw LNP Beat People (during Ebola)	-0.585*** (0.132)	-0.423** (0.132)	0.765*** (0.141)	0.212 (0.138)
Contact with AFL (during Ebola)	0.270+ (0.136)		-0.118 (0.147)	
Saw AFL Beat People (during Ebola)	-0.177 (0.136)	0.166 (0.137)	0.426** (0.147)	0.144 (0.147)
West Point	0.414** (0.127)	0.196 (0.125)	-0.466*** (0.136)	0.169 (0.132)
Age	-0.0131* (0.00570)	-0.0187*** (0.00562)	-0.00427 (0.00593)	0.0185** (0.00567)
Female	-0.166 (0.136)	0.0791 (0.133)	-0.651*** (0.143)	-0.208 (0.140)
Can Read	0.156 (0.143)	-0.258+ (0.145)	-0.0516 (0.155)	0.557*** (0.157)
Muslim	0.0223 (0.205)	0.446* (0.217)	0.260 (0.208)	0.455* (0.204)
Born in Montserrat	-0.249+ (0.134)	-0.120 (0.133)	0.0357 (0.144)	-0.0452 (0.141)
Income	-0.0592 (0.0386)	0.0263 (0.0380)	0.0707+ (0.0414)	-0.0152 (0.0406)
Experienced Dispute	-0.0110 (0.0146)	0.0254 (0.0318)	0.00392 (0.0208)	0.0141 (0.0146)
Experienced Wartime Violence	0.332* (0.133)	0.307* (0.132)	0.0474 (0.0544)	0.0414 (0.0467)
Knew Someone Infected with Ebola	0.227 (0.140)	0.103 (0.137)	0.130 (0.147)	0.465*** (0.140)
Constant	1.593*** (0.357)	1.370*** (0.354)	-1.347*** (0.375)	-2.364*** (0.380)
N	1211	1212	1217	1214
R <sup>2</sup>				
BIC	1582.9	1607.7	1437.8	1484.9

Standard errors in parentheses.

+  $p < 0.10$ , \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ .

respondents about police fairness and respect.<sup>33</sup> After Ebola, respondents were more likely to have negative beliefs about police respect.<sup>34</sup> There is no consistent difference in perceptions of police fairness after Ebola, and the interaction terms are not significant. The latter suggests that perceptions of police disrespect are not conditional on community. Yet, the results point to a possible reason for why demand for police may have declined after Ebola. Respondents in both communities may have perceived the police as more disrespectful after Ebola, and thus preferred that other actors respond to security situations.

Finally, we use the full sample of the survey conducted in 2015 to assess whether individual-level exposure to securitization affected respondents' likelihood of perceiving the police and soldiers as providers of security and/or as abusers. During the securitization phase, 34% of the sample had direct contact with the police. Those who had contact with the police during the securitization phase were 8% less likely to feel safe with the police in their community, and they were 9% more likely to think that the police would beat them. About 47% of the respondents saw the police abuse people. Tables 3 and 4 show the consequences of what happens when people saw the police engage in abuse. If the respondents witnessed the police engaging in abuse during the securitization, they were 13% less likely to believe that the police will keep them safe, and 16% more likely to believe that the police would beat community members. This means that both contact with the police and witnessing the police abuse led participants to form negative perceptions of the police.

Interestingly, the effects are somewhat different when it comes to perceptions of military soldiers. About 35% of the sample reported interacting with AFL soldiers. Table 3 shows a very modest positive relationship between contact and perceptions of safety. If community members had interactions with soldiers, they were 6% more likely to feel safe. Contact with soldiers did not have a significant effect on perceptions of abuse. Our data suggest that 59% of the respondents said they had seen the armed forces engage in abuse. Substantively, if respondents saw soldiers engage in abuse, they were 10% less likely to feel safe and 8% more likely to think that the soldiers will beat people in the community. This means that unlike the police, the presence of the military might have bolstered views of state capacity (or had no effect), but these views were tainted if community members saw the soldiers engage in abusive behavior.

In the appendix, we look at the interaction of West Point with exposure to the police/military and witnessing abuse by the actors. The interaction terms are insignificant for the police and sometimes positive for the military. This suggests that while securitization matters at the individual level, the severity of securitization at the community level may not matter for perceptions about the security sector (e.g. more securitization in West Point than Peace Island). An alternative interpretation is also possible. The null effects could mean that the military's presence in West Point signaled state capacity to deal with the epidemic.

<sup>33</sup> The choice of the model for the main paper was based on reviewer comments. The questions asked: "Are the ways the LNP cut cases usually fair to all people involved?" and "Are the ways the LNP cut cases respectful to the traditions and beliefs of the people who live in your community?" Higher values indicate perceived disrespect by the police (or the response "treated not respectfully." The possible responses included "yes, almost always," "no, never respectful," "usually fair to at least one party," and I "don't know," which was dropped). We re-coded the responses so that a "1" represents "yes almost always," and "3" represents "no never respectful." This means that a positive coefficient suggests that they are more likely to have negative views about the police.

<sup>34</sup> These results are the same when using an ordinal logit model and a multinomial logit model. We note that baseline levels were already low for both questions. In 2012, only 19% thought the police were fair and 7% said they did not know whether the police were fair. About 22% said they thought that the police were respectful and 22% thought that the police were never respectful.

There are several other reasons for why living in the more heavily treated neighborhood (West Point) did not consistently affect public opinion. First, as mentioned, securitization in West Point was accompanied by a humanitarian reconciliation phase whereby the military and police helped rebuild parts of the community after the media reported the abuse. This means that people's faith in the security forces (especially military) may have been restored in West Point, but not Peace Island. The humanitarian actions by the military may have even helped restore the image of the military among those who witnessed abuse. Additionally, it is also possible that baseline opinions in West Point were lower to begin with, which means that securitization did not alter residents' priors. Despite the difference in "treatment" between Peace Island and West Point, however, the results still paint a clear picture: exposure to securitization at the individual level, regardless of community, especially in the form of abuse, is what affects public opinion about the security forces.

In sum, we find some support for our hypothesis when we consider the police as the security actor, and more qualified support when the security actor is the military.<sup>35</sup> We find that individuals in marginalized communities developed negative perceptions of the police. However, perceptions about the military remained unchanged or even improved. The literature posits that securitization of an issue can signal strength and capacity of the state. In our case, the dispatching of the military (not police) may have signaled state strength. Yet, this finding changes if soldiers abuse the population. If individuals witness abuse by soldiers, perceptions of the military decline.

## 8. Discussion and conclusion

The COVID-19 virus led to an unprecedented response from governments around the world. Despite very diverse social and economic contexts, many states imposed very restrictive measures, requiring enforcement by security forces. The social and political implications of such policies remain unclear (Stott et al., 2020). We focus on how two marginalized communities in Liberia responded to the securitization of the Ebola epidemic. We find that exposure to securitization of the epidemic led to negative perceptions of the police, but more positive perceptions of the armed forces. Specifically, the results suggest that experiences with securitization among those who experienced a dispute decreased demand for police services, and that perceptions of police respectfulness declined between 2012 and 2015. Furthermore, using the entire sample from 2015, interactions with police, as well as witnessing police abuse, led to increased fear for safety and increased the likelihood of believing the police would be abusive in the future. In contrast, perceptions about the Armed Forces remain unchanged between 2012 and 2015. Moreover, individual interactions with the AFL led to people feeling safer. However, witnessing the armed forces engage in abuse had negative perceptions of the AFL.

The differential perceptual findings about the police and military suggest that it is important to understand how experiences with securitization by different security actors affects perceptions. On one hand, securitization by the police may not improve perceptions because the police already patrol in marginalized communities, and priors, often negative, about them are well-established. In contrast, the military is only dispatched when there is a national crisis, which could send a stronger signal that the state is addressing the problem. Thus, governments should be aware that when they use different agencies to securitize health crisis, their choices might have consequences on how people perceive state institutions in the future.

Not all our findings are easily generalizable. For the pre/post Ebola comparison, we only assessed the opinions of those who had prior disputes, and were thus more likely to have contact with state institutions.

<sup>35</sup> We did not theorize about the military and police separately because securitization occurred by both the police and military.

The 2012 survey demonstrates that the perceptions of the police among this group were positive, as demand for the police services was upwards of 80%. Thus, our study sheds light on whether experiences with securitization reverse trends among the group that might already have positive perceptions of the state. Moreover, the study was only conducted in two marginalized communities in Monrovia, and thus cannot be extended to non-marginalized communities. However, we focus on marginalized communities because they are most likely to experience securitization. Our goal was not to assess the effect on securitization on marginalized versus non-marginalized communities, but rather to assess how individual exposure to securitization affected their perceptions. Though we cannot show this using our data, it is possible that non-marginalized communities experience different trends than marginalized ones. The Afrobarometer descriptive data show that trends do differ when looking at the county versus the two marginalized communities in our study.

Another limitation of our study is that we could not randomize securitization, which means that our analysis uses only observational data. Yet, we triangulate different data to show that that predicted probabilities of perceptions change 1) before and after Ebola, 2) before and after Ebola, based on living in West Point or Peace Island, and 3) based on interactions with the security forces in both communities. Triangulation these data, the results provide proof of concept of our hypothesis.

While our study did not look at how experiences of securitization affect other government institutions, this is an important consideration. For example, scholars have found similar effects of public opinion about the police during the Covid-19 pandemic (Wan et al., 2020). It is also conceivable that securitization might lead marginalized communities to mistrust information by formal institutions more broadly, reducing their compliance with health regulations and increasing civil disobedience (Sedik and Xu, 2020).

Our findings suggest that disease outbreaks could harm some parts of the state building process in fragile and post-conflict settings. If police and militaries are used to enforce health restrictions, the increased presence could degrade the public perceptions of the security forces. Indeed, weak states, post-conflict face a dilemma. On one hand, the security forces have the capacity to enforce; governments may not have other non-militaristic agencies that have the same capacity as the security forces. At the same time, this study shows that securitizing the process could sometimes decrease support for such institutions. As such, it become important for governments to look at levels of trust in their security institutions before dispatching them to intervene in medical crisis. Additionally, while we show that the military may be more effective than the police, there are dangers with military involvement in domestic affairs.

One recommendation is thus to develop alternative state agencies that are non-militaristic to enforce health guidelines. This could take the form of special arm of the security forces specifically for disasters such as the National Guard or Federal Emergency Management Agency (FEMA) in the United States. Regardless, at minimum, if states choose to use the security forces, they should ensure that their security force personnel do not abuse the population.

## CRedit authorship contribution statement

**Theodora-Ismene Gizelis:** Conceptualization, Funding acquisition, Writing – original draft, Writing – review & editing. **Sabrina M. Karim:** Conceptualization, Investigation, Methodology, Writing – original draft, Writing – review & editing.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Data availability

Data will be made available on request.

## Acknowledgment

We are very grateful for the work and insightful suggestions of our research collaborators in Liberia especially Kou M. Gbaintor-Johnson, Director for the Center for Action Research and Training (CART).

Funding for this work has been provided by the Research Council of Norway (Grant # 193754), the British Academy (Grant# SG142574) and the Faculty of Social Sciences, University of Essex.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.worlddev.2024.106587>.

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