

CDC Ebola Response Oral History Project

The Reminiscences of

Amara Jambai

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2017

Amara Jambai

Interviewed by Samuel Robson

March 21st, 2017

Makeni, Sierra Leone

Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson. It is March 21st, 2017, and I have the privilege of sitting here with Dr. Amara Jambai as part of our CDC [United States Centers for Disease Control and Prevention] Ebola Response Oral History Project. I'm talking with Dr. Jambai about his part in the Ebola response here in Sierra Leone. I should mention that we are in the Wusum Hotel in Makeni, Bombali District, Sierra Leone. Thank you so much Dr. Jambai, for joining me.

Jambai: Thank you for having me.

Q: Of course. Could we start out, would you mind saying "my name is," and then just saying your name?

Jambai: My name is Dr. Amara Jambai, and I'm currently the deputy chief medical officer within the Ministry of Health and Sanitation in Sierra Leone. At one time, I was the director of [the Directorate of] Disease Prevention and Control, and that was during the outbreak and towards the end of the outbreak.

Q: What does it mean to be deputy chief medical officer?

Jambai: It means you need to have some sort of bird's-eye view of almost every technical area that is in your area of expertise. Myself, I'm sort of the surveillance and epidemiology technical expert within the Ministry, so I need to be looking at issues pertaining to the International Health Regulations and the Global Health Security Agenda issues. Those areas fall within my area of supervision and coordination. At the same time, I'm not a doer, but I make sure that people do things that they are supposed to do.

Q: That's a brilliant summary. Thank you so much. Could you describe—actually, you've already described this. Would you mind telling me when and where you were born?

Jambai: Born in Freetown, Sierra Leone, somewhere along Campbell Street right in the middle of Freetown. But actually, my father comes from far away, the eastern part of Sierra Leone, Kailahun District. Went to school in the middle of Sierra Leone, Bo. And from there, went out and was fortunate to have had a scholarship, did my medical training in Romania. In Romanian, for that matter. So I'm from Romania. [laughter] Somehow I have that attachment. I came back in 1986. Ever since, I've been working in the Ministry of Health, and been all over the country: Pujehun [District], Bo [District], Western Area, and finally to the Ministry of Health.

Q: Back to the beginning a little bit, what did your father do to make a living?

Jambai: My father was an administrator. He was very much educated. He was an administrator, and he went all over, all over the country. In other words, I've been everywhere in Sierra Leone as a child, then also in my working life, I've been almost everywhere. So that is it. He did provide for us a good starting point.

Q: Did you say you went to high school in Freetown or in Bo?

Jambai: I started my primary school in Kenema. Then because of his movement, we were all over the country. Kenema; somewhere in Lunsar; Kambia [District]. Then after that I went off to the [United] States and did some of my primary and part of—it was the fifth, sixth, and seventh grade. I was there for some time in Lancaster, Pennsylvania, and afterwards, came back. I think it was during a period when my dad said, I'm losing my child if he stays there. And maybe if I would have stayed there, [laughs] I wouldn't have been [living] in Sierra Leone today. But he brought me back.

Q: When you went to university, were you studying medicine there?

Jambai: Well, I came back and completed my secondary school here. I did Bo school, then afterwards, went on to the University in Craiova, that is in Romania, Craiova. University of Craiova. I was there for seven years.

Q: How did you end up in Romania?

Jambai: Those days it was like, chance, and I was given the chance to study there. It was a government sponsorship. Those days, if you can remember what it is: extending the East-West relationship. We happened to have sort of benefited from that, and I was educated because it was free. Went and stayed there for seven years, and did not come back for seven years. You can imagine, I was longing to come back to the country.

Came back and was thrust into the work of medicine, clinical medicine for some time. Then I ended up in the public health wing, which to me has always been my calling. Initially, I was in charge of the Pujehun Government Hospital. I was doing the public health aspect, and at the same time, the clinical aspect, because as you know, our numbers in terms of doctor ratio to the population is very, very [low]. Maybe [fewer than] one to five thousand, so you can imagine I was doing the two. But nowadays, it is better because you have almost in every district two doctors, one in charge of the public health and one in charge of the clinical aspect. But in those days, that was 1989, I was the only person at the government hospital, Pujehun, and somehow I managed to survive the challenges and was doing both clinical and public health.

About 1993, I was given an opportunity to do some sort of—I remember it was leadership and management training in Atlanta. Global Health Action was a program with Emory [University], and I did some sort of leadership and management training. At the same time, I was lucky to have gotten some sort of support to do my post-graduate studies in public health. Immediately after completing the leadership training, I went to London School of Hygiene & Tropical Medicine and did a year in public health. It sort of

prepared me to master the art of public health. I did that, followed, came back home, and was sent back to the district. I've always enjoyed working at the district level, with its challenges and with its problems. I was sent to Bo, worked in Bo for about six years, then came to Freetown, worked at the Western Area, District Health Management Team for another six years. Then went to the Directorate of Disease Prevention and Control for another six years, again. It's always six-six-six somehow. [laughter] I was there for a period until nearly after the outbreak, and moved on to my current position.

Q: Can you tell me a bit about when Ebola first started circulating in the region and what you were thinking about it, and your early engagement?

Jambai: I remember it was somewhere in January when we started hearing about Ebola events in Guinea. The early part of January, some strange disease was happening. It was in Guinea, and somehow the magnitude of the problem was unknown to us. We went into preparedness mode because when something is happening as close as Guinea, you in Sierra Leone need to be prepared for any eventuality, knowing our relationship, our interaction. We were hearing about that, but we did not go into a full-blown mode of preparedness because there's always the tendency within our rank and file that you wait until it comes. I think that is where we made some mistakes. Because I remember the post-cholera, 2012 cholera, I asked specifically that we should have resources for an eventuality. Because at that time, I was in charge of the cholera outbreak, 2012. The lesson learned from that was to have resources for preparedness, should at any time any other event come up that is threatening and can be easily addressed. I made that plea

several times, but as you know, it fell on deaf ears. When we needed to be prepared for Ebola, we did not have access to resources. We were sort of told, when it comes, we will address it. I think that was one of the biggest mistakes we made—because it made us not to be one hundred percent prepared. It made us not to—even though now, post-Ebola, the magnitude—but again, if we'd have been better prepared, maybe we would've been able to save the lives of health workers. Because health workers would have known what to do earlier, and saving lives would've mattered a lot.

When it finally did hit us, there was—I remember in May, we held an emergency meeting. Fortunately, at that time the minister of health and myself were staying in close proximity. Sort of all of us mobilizers and came to my house. The first meeting in terms of addressing the epidemic sort of took place in my house, because I have one of these extensive outdoor verandas which was very appropriate. We were there, about twenty of us from the Ministry, to think through what is happening and how do we address the situation. When the result did come out, I had to go over the radio the next day and announce to the general public that we have been able to confirm a case of Ebola within the Kailahun District and the situation is we've taken more samples, we're testing to see if we have other cases. Following that, a lot of questions were asked. We went into a mode of—activated all that was necessary for us to start the response. But as you know, when systems are not in place and the right people are not available, you do a lot of wishful thinking of saying we will do this or we will do that, but you need the required level of training, you need the right people, and we did not have the right people, we did not have the right system for us to approach the epidemic from a technical level. It was

one of those whirlwinds of craziness where people all of a sudden see this as an opportunity to look wonderful and great and thinking that they'll be the one to have the solutions. It did not work like that.

Q: Do you have an example of one of those times when somebody—

Jambai: People weren't coming up with—thinking of so many strategies that were non—how can I say, non-health approach. It was trying all sorts of things which did not work. At the beginning, the controls were not really in the hands of the—we were not given a free hand to practice what all the years we'd gone through. It was late. As we see, this was a big outbreak that had all the dimensions of public health in it: the epidemiology, the social mobilization, the community engagement aspect, the policy looking at the political implications. It had all the five elements of public health into it, which—the socio-behavioral science of it. The dimensions were so vast that almost everyone thought that they should play the leading role, which slowed us down. At one time even during the outbreak, the Ministry of Health was pushed aside and other actors were brought on board to lead. But again, they saw that this was a health issue, and later on—but that delay, do you know how many lives we could have saved or how many lives were lost? It's going to Hell and coming back and knowing that you took a wrong turn. [laughs] But you reached Hell and came back and realized that wow, I took the wrong turn, I should have taken the left instead of going to the right. We did that, and afterwards, somehow we stabilized. I look at it from a health perspective and medical point of view.

Q: I'm interested especially in the decisions that you were part of making, the discussions that you contributed to. You go on the radio that first day and you announce that Ebola is in Kailahun. What happens with you and your role in the response from there?

Jambai: Our role—at that time, as you may know, we did not have epidemiologists on the ground. We did not have the structures looking at, you need to put up an EOC [emergency operations center] to have the command and control aspect of things. We did not have that in place. What we did initially was to train health workers, basically the disease surveillance officers, on the ability to track down the disease and be able to identify it and protect themselves. The rudimentary IPC [infection prevention and control] work started at that time, knowing that IPC was key. The surveillance aspect went into gear, and we started case definitions, and all those case investigation forms were developed, and we did that. We trained the initial health workers. Knowing that we had the center at Kenema, we concentrated our response from the point of view of the viral hemorrhagic fever ward in Kenema. Whatever we needed to do was to help strengthen the Kenema team to adequately respond to the outbreak. Initially, maybe we thought that the magnitude would—Kenema would be able to contain it. But we had help from other actors. The MSF [Médecins Sans Frontières] team I remember came in well and advised us to build ETUs [Ebola treatment units] or holding centers, holding centers at three points, was it Buedu, Koindu, and Daru. And this was done. We started the construction of an ETU at Kailahun Town, a big one, so that the pressure would be taken away from Kenema.

It was difficult initially to have or build the confidence of the health workers to work within these institutions because it was new and people did not know—did not have the requisite training, and all of a sudden, they were seeing their colleagues dying. At one time, the morale within the health workforce was down, and help came from afar, from other countries bringing in health workers who had had experience of working within the ETUs. That helped us. The morale of the Kenema team went up, and the ETUs became part of the vogue in terms of healthcare delivery, especially during the trying times of the outbreak then. But initially, it was a difficult period to get the health workers to be in charge. That happened because the only person who really can take the person, infected person, from the household is Sierra Leonean. And that's exactly what happened.

Somebody needed to be trained, they needed to be motivated, and it took a while because we came up with this scheme of incentives, motivation, and people were ready to go the extra mile to do the work. At one time, “risk allowance,” was it? Or something like that, we called it. Those who were at the forefront or in the ETUs were given X. Those who were in the holding [centers] were given another. It was like that.

Q: I know you were working at a very high level during this time, so I'm guessing it wasn't you in the field doing these trainings with all of these health workers, but your role—what are you doing day-to-day? Are you coming up with these schemes of the incentives and motivations? What is your day-to-day like?

Jambai: The day-to-day life was meetings, meetings, trying to plan. Long days, difficult days, arguing a lot on strategies to use, what strategies not to use. The issue of where to

build an ETU, who to run an ETU, and if it is the community care centers, or CCCs. All those strategies came. We at that level decided on where to put those ones and who to engage the communities and how to do that. We're at that level. Coordination can be a Herculean task. At times, you don't know the weight. It's very difficult, and more especially in a charged atmosphere.

Q: Who are some of those people you were spending the most time with in those meetings?

Jambai: Within the Ministry of Health, what we did was to re-allocate functions. Because of the magnitude of the problem, we called upon some of our colleagues who were in other programs to leave their day jobs and come into another job. This happened. We repositioned colleagues to either be in charge of a district or be part of a technical working group. We brought colleagues to the case management group, we brought colleagues to the social mobilization. Initially, we had only the surveillance group, which was taking care of the labs and contact tracing. I was leading that particular aspect, the surveillance, contact tracing and laboratory, it was the big three. Then we saw that it would not work, so when we had the capacity like in labs [laboratories], we devolved the labs. We allowed them to stand on their own because the experts had come. We saw a tremendous improvement in terms of turnaround times and locating the various labs, the help. So, the lab was able to stand on its own, but initially, we were doing it in one place because we did not have the expertise and we did not have the resources to bring many labs. But when—at one time, the Canadian lab, the CDC lab, and other labs came in-

country, and all of them came with technical experts who were able to divide up the group.

Then we also saw that the contact tracing group needed to stand alone because it was the group that needed to chase the virus, and that contact tracing was on its own. Even though I was still sort of heading that, but it was with—UNFPA [United Nations Population Fund] came in and they were doing contact tracing, and WHO [World Health Organization] played a back role on that. But strategically, we tried to make sure that it was in the hands of the WHO. So we brought it back, and we somehow did a manifest, made sure the technical expertise of the organization remained. That was challenging because of the issue of contact tracing being taken away from—which was a core, key strategy overcoming the epidemic. But we made sure that we did not have many problems. It came back, and all of a sudden, the epidemiologists now were following up contacts, we were following up where the cases are going, how the chain, the links, became evidently clear. Then we saw the cases going down. Because if you have multiple transmission chains all over, it's impossible to follow. But all of a sudden, because we had the right organizations delivering their key and core values, we were able to overcome many of the problems. Where those technical meetings—the surveillance, contact tracing, the labs, meetings—then even at times, we needed to be part of the social mobilization because the message—you need surveillance or epidemiological views to articulate the message going out. I was almost always called upon in those meetings to advise, and somehow, strategies changed.

In some cases, these were always strategies that always existed, but we at times found them late. [laughter] You talk about community engagement. It's always been community engagement. We always say, and I always—why did primary healthcare come about? It's because when people perceive problems bigger than the health system, they take it down to the communities to sit with them and solve it as one. Basically, that was a jury. But it took us a while to realize that that is it. That the community, they have the answers, it is not us. Some of us who have been in this, we were telling this, let's take it to the community, they will have the solution, and they will have no problem. It took a while. Finally, when that happened, the messages changed. This sort of respect—because in our own setting here is if you go into a community and you engage the leaders through the traditional way, they will give their support and they will give you their preferred solutions. But many a time, if you think that you know it all and you go in thinking that what you're going in with is the ultimate solution, they will sit with their hands folded, allow you to fail, just for you to come back and for you to realize that they are important. Those at times I call them the ego wars. It happens between the Ministry, it happens between the Ministry and partners and community, and ourselves and the communities. We go through those cycles until it comes back, and then we realize we should not have. So that was it.

At the high level, we were really trying to find strategies. We were really trying to create partnership to make sure that each and every partner felt relevant, each and every partner had a window to sort of operate, not in isolation, but tried to make sure that we were working as a team.

But again, when you look at it, we were doing this, then we sort of—at one point, I had this feeling. I call it the broken arrow phenomenon because we at the Ministry of Health, we were taking leadership, we were working, but we had no control over our DHMTs [District Health Management Teams]. When that control does not exist, it's like it's broken. At each and every level, you had other institutions that had been created to manage the epidemic at that level. Then, if the sort of coordination at that level has no link to the national level, that is what I would say is a broken phenomenon, it's a broken arrow. You do not go in a straight line. We had that until we were able to straighten that and make sure that what we're doing at the national level, the actions we're taking at the district level based on—but we went through that, we went through a lot. Because for a long period, it was this phenomenon of broken arrow, so that is why I always say maybe at times, the outbreaks take longer than they should have because there was no command center relating it to the district level. It was difficult, and it took a while for us to—even in some districts, the DHMT was sidelined, and other institutions came up and wanted to do the job for the DHMT. It also took a while for them to realize, health is health, and you cannot do it without the health guys. But it was as if oh no, this is an Ebola war, we are specialists in this. You have no right to do—and they were sidelined. The same thing happened to the national level. I'm of the opinion that these sort of delays, this sort of—to me, it was interference of the highest order in healthcare delivery. Why do you have an army to defend yourself, and when the time comes for you to send out the army, you send out others? It was challenging, but this is the sort of atmosphere we were in and we took

it. That is why maybe changes have come to make sure that any time it comes, it's still health and it will always be health.

Q: Who, can I ask, was sidelining the DHMTs? Are these international organizations, partners?

Jambai: Partners, but again, it was—if you can remember, the management of the outbreak was given to an institution, the NERC. The [National] Ebola Response [Center]. And their own mode of working was, we work with those institutions already on the ground. It depends, again, on who is playing the leadership role at ground zero. If you have a DHMT that is carrying this and wants results, you will see—and it's results-oriented—like in the early days, Kailahun early in the outbreak was quelled using the DHMT. Kenema, likewise. Bo, the same, more or less. It was the Ministry of Health at work. Then, all of a sudden, when others came on board thinking that they can do it, Port Loko went overboard. Kambia. These ones did not have the DHMT in the lead. I will say this. We are bound to differ, people differ in so many ways. But Kambia, Port Loko did not—and part of here also, Bombali, did not have—the leadership was not health, per se. It was in the hands of other entities. So maybe the delay could have been attributed to that, or maybe just because of the social issues that contributed to so many things.

Q: You have described a couple times that moment when the Ministry of Health was kind of pushed aside and then the NERC comes in and the DERC comes in. What changes in your life and in your part in the response with that transition?

Jambai: Well, when the NERC—at one time, we went to the NERC and we asked, they said no, the Ministry of Health has nothing to do with the Ebola. So we went back, all of us, it was like that. There was a period of about two weeks, three weeks, we were not going to the NERC. That was the period we realized that this is a health issue. That three weeks, to me, brought about misery.

Q: Interesting.

Jambai: We went there and they said, no, the Ministry of Health, go about and do other the work. This is what exactly was said, that we should not be part of the response, we should be doing other things. [unclear] I remember it was at that time when we were asked to—because we are Disease Prevention and Control, we had the data, I had data, most, all. And we were asked to move into the NERC. I said no. If I move into the NERC, you will never see the constraints we as a ministry are going through. You will not see my needs, and it will end with us not having the requisite armed force to control any other outbreak. I said, I will stay here. You will see if you need to help me, if I'm not doing anything good, or if I'm doing it, help me do it better. And that happened. The EOC came about with that because we were sitting and they saw that hey, this is not an appropriate seating arrangement. The data collection is good, it's happening, but we can do it better. And out of that came—I believe out of that came so many things. Because we sat, you came and saw our environment. I remember we were sitting in this small room. How many of us, maybe twenty, thirty, in a cramped room. But that was what we

had. Now, it's the EOC, the EOC. But if you hadn't met us in the makeshift environment, you would never know that we need such an effort. Then, we would not have had it.

Q: Who are some of the big movers and shakers who created the EOC?

Jambai: That was beyond us, the Ministry of Health. That was a presidential delivery.

Q: President Koroma came out and said—

Jambai: Yeah, yeah.

Q: Gotcha. Sorry, I'm kind of reviewing some of these things for a second. Back to the connection between the head offices and Freetown and the DHMTs out in the districts, right, and you talked about the broken arrow. How did it develop that the arrow was broken?

Jambai: As you can see, initially, those who came and thought that it was a non-health problem, right, wanted to sort of do it on their own. That was when the head, the central level said no, do what you do, other health activities, and we will take care of the Ebola. This was done, and remember they were doing Ebola, then who say okay, the ramifications of Ebola will have non-Ebola issues, but other health issues, which only the health worker will know the difference between Ebola and non-Ebola. So in the end, you had people dying of maybe malaria, people who had a stroke would not be attended to

because those who to [had] fear. Non-Ebola issues took away more lives than even Ebola, because practically, the health system failed. Because those who were doing Ebola were not at the same level with those doing health work because we've been divided. So that contributed a lot into the loss of lives.

Q: But if you were not a health worker and you were working on Ebola, what were you? Were you with defense, were you with—like who?

Jambai: The defense people came in. Because the NERC had a defense orientation.

Q: Sure.

[break]

Q: I enjoyed how you were talking about creating those partnerships where everyone is included, where everyone has kind of complementary roles and feels important and that kind of relationship management aspect of things. Could you talk for a minute about working with CDC as a partner and how your relationship with CDC developed, what you did with CDC?

Jambai: Yeah. I remember when CDC came. At that time, we were in the early days of the outbreak. The strength was in the surveillance aspect, and most of the teams would come and work at the Directorate of Disease Prevention. I was opportune to have met a

lot of—[laughs]—dozens and dozens, I don't even know the number—of good people. It was done out of mutual respect. Basically, it was a professional courtesy that was extended to all of us. We were like the eyes of the Ministry that received that competency. We worked very well because when CDC came as a small team initially, they went to about six districts and divided themselves into teams at each district. At Kailahun, Kenema, Bo, Bombali here—about six districts initially. All the planning was done with us, and was very, very respectful of how we were going to manage the outbreak, work with the DHMT. It was one hundred percent work with the DHMT. That's why any CDC person that comes or that has been here will know the relevance of the surveillance officers on the ground, because they were the hands-on people. They did work with them, and many of these guys who were at ground zero were the ones who were head of the response. That respect for them is still manifested up to this time, and that is why we see their training, to now, is key in bringing the workforce to where it should be. That exactly, because you saw them at work, and these were the structures which we had in place.

Q: Who were some key individuals from CDC with whom you spent the most time?

Jambai: Wow, wow. It would be unfair of me to name them. [laughter] I will not do that. You will not get me to do that. [laughter] But they were wonderful, almost all of them, yeah.

Q: Okay. Well how about, I do like just hearing about the people worked with the most. How about just anyone at random who is not CDC, or who is? Just somebody who you spent a lot of time with during Ebola and maybe got to know in a new way. Can you describe someone?

Jambai: Wow. Well, I've had a lot of people who've somehow influenced me. But again, I sort of matured and grew out of this contact. Everyone that comes has different capacity and competency, and it's left with you on the ground to sort of absorb those qualities. I see myself as a sponge. If you come near me and you're good, I absorb the goodness in you. And this is exactly what some of us have been doing over the years. Where we are today is not because of ourselves, but it's because of those opportunities to have had the chance to work with good people. When you work with good people, good people, it is for you to realize they are good and take out that quality. I've been the luckiest person to have had epidemiologists of the highest quality. When we look at what is field epidemiology in an Ebola setting, you will see that you need to go with the person that looks at data, but has the capacity to take the medical actions required for you to quell those numbers. At times, we differ. When you have a medical disease on the ground—like Ebola has medical components. The case management, the this, the that, IPC. You need someone who appreciates and someone who will take the action required. But at the same time, they need to have the data aspect in them to see that, as a medical person, I need to do X, Y, Z to quell the situation. That's why I say medical epidemiologists, medical field epidemiologists. Because somehow, at times, it's not most often, but you need to have that medical aspect. I remember a very good guy came, he was only in data,

the CDC guy. I remember him, I will not call his name. [laughter] I said, “Now. You have given me this data. What next?” Beyond that, he could not. But he was good in creating the data. As of now, I need the action required for us to bring those numbers down. It’s difficult to have that capacity in one person, but indeed, there were a few people who had that capacity and I will not call names. [laughter] Some of them are big paramount chiefs, but they had that capacity and were able to make things happen in the field.

Q: Thank you for that description. [laughter] Could you tell me a little bit about what happens, about the end of Ebola and what happens with you over the last couple years?

Jambai: I was working with a colleague, and fortunately, we are very close, so he is now the director of DPC [the Directorate of Disease Prevention and Control], and he’s been able to step into my shoes, and I think we are moving forward. To me, it’s been one—we’ve had an opportunity to do things better, to sort of restructure, to think that it goes beyond the—the DPC was originally two arms. You had the response arm and you had the directorate arm. The EOC has come, has emerged out of that to stand as the response arm, and we need to maintain that, and we need to have experts in public health management. We need to have those experts, emergency management. We need to have those people who are like responders. You can be a responder, right, but it doesn’t necessarily mean you need to have the full complement of the epidemiology, the data aspect. You need to know it, but being a responder, you need to appreciate that quality. But there should be also those who are experts in the data, but necessarily they don’t need

to be responders. There are only very few people, as I'm saying, who can be the two. It's two arms. We have seen that you need to have expertise, too. So that is happening, and we have the EOC now, and we have other events that have come and we need to keep our eyes on all.

The Global Health Security Agenda, to me, is a very, very innovative idea of training health and security. I think that when you bring health and security, no one is going to diminish your importance. No one. Because when health becomes a security matter, even if you're reducing the budget anywhere, you will not reduce it. [laughs] That is so innovative, and I think it gives us a futuristic view of looking at things, that things can only get better. That was sort of the GHSA [Global Health Security Agenda]. That is where I am now. I see that as an opportunity for us to take the International Health Regulations to a level which has never happened, and to now have the opportunity and to now have the might, the resources, some more. Working through those two arms, I believe the world will be a safer place. But to me, it's so innovative when you look at health and security, keeping it like that. It gives us leverage and access. Access, because at the end of the day it's resources. At the end of the day, it's resources. If you don't [have them], you can only be wishful thinking. It gives us access to resources, and our importance is [unclear] somehow, and it has helped. That area, I'm still looking at from the big picture, the International Health Regulations and the Global Health Security [Agenda]. And trying to also create platforms of coordination. Because you've seen, when the Ebola came, we were asked to operate and work with people who we'd never worked with. Initially, it was very, very strange and tasking because everyone was

looking at issues from their own, siloed mentalities. We were not looking at it in this global picture and saying, if we work as team, we can overcome it. But now, we see the opportunity of us working in a One Health platform, which we need to push, and it's difficult. The One Health platform whereby people come together and work.

Coordination is key. At times, when you have all the objectives being put out by partners, people forget coordination. Coordination, as we have seen, can stall, can make, or can [unclear] a lot of issues. The One Health platform and many other platforms that we need to create for us to look at holistically, the Global Health Security Agenda, is to me, that is the future of public health.

Q: Thank you so much for describing that. Is there anything else, Dr. Jambai, that you wanted to say for the historical record about your part in the Ebola response or really anything before we end the interview?

Jambai: Well, I value partnership. I value, I've always, and I think we all come to the table with different attributes. There are those who may not have the resources, but they have abilities to do other things, and we should leave that room open for us to be able to engage each other. It's always a difficult, difficult thing to do, but in our setting, as you may have seen, we find it necessary for us to function as partners. Because we are—what can I say? You know the challenges we are in, in terms of economic development and all of that. For us to overcome some of those challenges, it's to us to partner well. That is why, when colleagues—if it means going the extra mile to bring on partners, and for us to work, maybe that is my own quality. [laughter] And I'm ready to give that, because I

haven't got resources to give. At the end of the day, if that makes my country a better country, then I'm happy with that.

Q: Well said. [laughs] Thank you so much, Dr. Jambai. I very much appreciate your time and sharing your experiences with me.

Jambai: Thank you.

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