

CDC Ebola Response Oral History Project

The Reminiscences of

Oliver W. Morgan

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Oliver W. Morgan

Interviewed by Samuel Robson
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Interview 2 of 3

CDC Ebola Response Oral History Project

Q: Hello, this is Sam Robson here today with Dr. Oliver Morgan. Today's date is July 5th, 2016, and we're back in the audio recording studio at CDC's [Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. This is my second interview with Oliver as part of our CDC Ebola [Response] Oral History Project. Oliver, thanks again for being here with me.

Morgan: Sure, it's a pleasure.

Q: Great. When we last spoke, I think we got up to about the summer of 2015, when you were mainly focused on some of the scientific studies that were going on, the STRIVE [Sierra Leone Trial to Introduce a Vaccine against Ebola] trials, the PREVAIL [Partnership for Research on Ebola Virus in Liberia] study.¹ Picking up with about that time period in Sierra Leone. I remember last time you mentioned one of the big aspects for you as country director in Sierra Leone was just presiding over such a huge response. Just the large number of TDYers [staff on temporary duty assignments] and the local contract staff. I'm wondering if you can just talk about that a little bit, what that was like?

¹ PREVAIL was a US-Liberia clinical research collaboration sponsored by the US National Institutes of Health.

Morgan: Yeah, that was certainly a new experience for me. I'd come from running a country office of about eighteen people, or eighteen staff members. And suddenly I was pitched into a situation with, I think we maxed out at one hundred eight TDYers. And we had probably about one hundred, one hundred fifty contract staff, which, although I wasn't directly responsible for [them], we had some duty of care for those individuals, too. It was really tough, especially—

[break]

Q: Okay, hello, and we are back. Sorry about that little brief interruption. There's some sort of recording thing going on in our same audio booth. But yeah. Oliver, Dr. Morgan, was just talking about his experience providing a—presiding, excuse me, over such a large response with this Ebola epidemic.

Morgan: Yeah, it was certainly one of the more challenging aspects of the response in Sierra Leone, at least. Like I just mentioned, we got up to about—we got up to one hundred eight TDYers at our peak. In total, we accounted for half of all the CDC's deployments to West Africa. We had as many TDYers to Sierra Leone as there were to both Guinea and Liberia combined. That gives you an idea of the size of it. It's also complex because a lot of people were rotating out either after a month or every couple of months. That was really quite difficult to keep track of what was going on.

A more subtle issue, which is something that I reflected on quite a bit when I got out there, was that, as an organization, CDC often promotes individual thinking. It promotes people exploring their own ideas. And I think that was very much the situation when I first got into the country, was that we had maybe about fifty, sixty people on the CDC team, but a lot of them kind of going in different directions and doing the best that they could, but without a very clear focus. I saw very early on that we needed to have much more of a command-and-control type structure, like you would have in, let's say a more military type organization, where people would be assigned tasks for their twenty-eight days, if they were there for just twenty-eight days, and have a very clear frame of reference for what they should be doing. And that's a different type of organizational culture than what CDC normally does.

So, I did a couple of things to try and move us in that direction. The first was to essentially come up with a strategy of what we were trying to do. At various times, my predecessors had focused on supporting the Ministry of Health [and Sanitation] in Freetown. Some had then expanded our presence in the districts. And we had the teams more out in the districts, and not in Freetown. There had been different approaches. I really just sat down and wrote all of the teams down—we had about six teams. And then, for each team, I wrote four or five objectives that we needed to focus on. That was our strategic plan. It took me about twenty minutes to do, late one evening. But it was simple, and it was enough for me to be able to communicate with everybody coming in-country, what it is that we were trying to achieve. For example, for the epidemiology team, we were focusing on identifying new cases and contacts of cases. For health promotion, we

were focusing on—at that time, back in November 2014—on promoting early notification of cases, promoting calling 1-1-7 for safe burials and so on. With that very simple approach to having a strategic plan, I also made sure that every time a new group of CDC deployers arrived in-country—and at that time, there were two flights every week. But then we eventually moved to having just one arrival per week, just to try and streamline a little bit the process. I made sure that I would brief everybody in person. Typically, that would be a room of fifteen or so newly arriving people. I would explain what our strategic plan was, explain what it was that we were trying to do in-country, and also give them a chance to see that there was a country director, and to know who that country director was. Because in reality, I did not have the chance to engage with a lot of people, especially if they were out in the districts. I might only have seen them once or twice in their whole deployment. But there were a couple of different things that I tried to get us all pulling in the same direction and focused.

Q: Thank you for that. One other thing that I was hoping we could speak about a bit was, I talked with Kathy Hageman, who was a behavioral scientist in Sierra Leone, and she spoke about how in 2015 that became kind of a new focus in that country, and that you really were the initiator of that. Can you talk a bit about your impetus for wanting to get more into the behavioral science, and look at, for example, why people would not be using resources that you'd think are available to them?

Morgan: Yeah. You know, it was something—a component of the CDC response that certainly predated me was what we called health promotion. Those efforts were largely

around communicating. At the early part of the response, there was a need to communicate to the population that Ebola was a real thing. Because there were doubts about the reality of whether it's a virus, or what was going on. And latterly, those messages became more and more refined. I think we did a really excellent job. But by the time we got into early 2015, the messages had already got out there. People were aware of what Ebola was and how they could get it and what the risks are. But we were still seeing the same behaviors as before. As an organization, CDC has quite a lot of depth in behavior change. We needed to go that next step, from just getting the messages out there, to actually changing people's behaviors. I spent quite a lot of time talking with Kathy, especially because I had just come from working on HIV in a kind of global HIV setting, where we do a lot of behavior change interventions. Also, actually, CDC in their domestic HIV work does a lot of behavior change intervention. We've got quite a strong skill set in that. But we had to then try and take those experiences, and try and adapt them for an Ebola context. It was really trying to encourage Kathy and her team to take us beyond just messaging, to really getting people to change their behaviors.

Q: Wow. That's neat. I didn't realize that that past experience kind of influenced that direction in Sierra Leone.

Morgan: Yeah. I think it was definitely a reflection on the type of work that we do in other settings, and thinking about, what skill sets does CDC have to offer? And trying to think a little bit outside the box, rather than traditional Ebola response.

Q: Right. Well, that's really neat. Thank you for that. Let's see. I have a couple more bullets that I wanted to go over, before we get to incident manager, if that's okay.

Morgan: Sure.

Q: One of them was, what was it like for you, as a British person, working for CDC, an American government institution in Sierra Leone, on a response that was being headed up by the UK?

Morgan: Yeah, at times, it was amusing. At times, it was awkward. Initially, there was a lot of confusion as to who I was, both from the—mostly from the UK side. People were not aware that I actually worked for the US government. They thought I worked for the UK government. So that led to several amusing situations.

Q: Do you remember any in particular?

Morgan: Well, probably the most amusing one, which I probably shouldn't divulge, but I went to a meeting at the British embassy with the British ambassador and their head of their response. The people at their reception showed me through security and escorted me into the embassy, which is normal protocol. Then escorted me to the meeting room, and then opened the door for me to come in. And it appeared that they were having some, I think, classified briefing with London. And the person who escorted me assumed that I was part of the UK Ebola response. So took me in, thinking that I worked for the UK

government, when actually, I was working with the US government. There were a couple of moments like that.

Personally, it was a little bit challenging, because there were times where the UK was not necessarily leading the response either quite in the right direction or quite at the right tempo, or there needed to be adjustments. Sometimes that was possible through diplomacy, and sometimes it needed a bit more of a firm push. And sometimes, even a push from the Washington side, rather than from in-country. So there were some challenging moments personally. I've had feedback subsequently that, for a lot of the people in the UK response, they found it helpful to have a British person heading up the US response in Sierra Leone, because I think they just felt more comfortable being able to express themselves in a way that I would understand.

On the whole, I think we had a very good partnership. It worked very well. But from the US side, I also had, occasionally, situations—especially when I was briefing the National Security Council, when there was confusion in the National Security Council as to why somebody from the UK response would be on a classified call. [laughs] Yeah. But I think, being able to work very closely with their leadership, the UK leadership was definitely a plus. Definitely, I think the benefits outweighed the challenges of it. I thought the person who responded best was actually the British ambassador. Most of the other senior UK staff in the response kind of had an attitude of, well, he's English, but he's gone over to the Americans. So he's a little like a turncoat. [laughter] But the British ambassador would always say at functions and meetings, "He's working for the

Americans, but he's actually one of ours." And that made me feel less of a—I don't know, a turncoat, I guess.

Q: Right. Kind of turning it in the other direction.

Morgan: Right, right.

Q: That's great. Now, I know we've gone over this to some degree, but do you want to talk a little bit about some of the areas where you thought that the British were taking the response in a difficult direction, and Washington maybe had to step in?

Morgan: I think the biggest challenge for the UK response was that they did not have good technical public health advice on the ground. For some reason—and it's an internal issue in the UK response, is that they had people from Public Health England, which is the equivalent of CDC for the UK. They had people from Public Health England, but only working on the laboratory response. They had a couple of epidemiologists, but probably not enough. It was my impression that people who had public health skills were not at the senior enough levels of the UK response. The UK response was a very hierarchical structure, and my impression was the little bit of public health analysis and information wasn't really percolating up to the top for the leadership.

We gave weekly or twice weekly briefings to the UK response—"we" being CDC. And we also had meetings at least once a week between the British ambassador, the US

ambassador, and their technical teams. So there was quite a lot of behind-the-scenes coordination. But that, to me, was probably the area that they struggled with most. Simple issues, such as where to allocate resources; where the biggest problems were; what the major challenges, in terms of public health challenges, were that needed to be prioritized. I think they found that quite difficult to get on top of.

Q: Do you remember one instance where you thought that, this is something they really got wrong, because of that lack of the scientists and epidemiologists?

Morgan: Well, yeah. It was my impression, when I got to country—and when I first arrived in-country, I spent two weeks traveling around all the affected districts, seeing our teams, and seeing the situation on the ground—that really, there wasn't quite an understanding about not just the magnitude, but the speed at which the outbreak was moving. I actually had quite a fundamental disagreement with the UK leadership about the speed at which isolation beds were becoming available. The build plan that the UK had, and others—I mean, it's certainly not their responsibility alone. But the build plan was over several weeks. And really, the number of cases was rising daily, and there was, in my view, a need to really speed things up. But from their side, there were concerns about safety, about not opening too quickly, and all sorts of operational issues that they were trying to deal with. So it was—there was a little bit of sharp elbows, occasionally, with that.

Q: Gotcha. Well, thank you for describing that. And the last thing was, so what was it like working with the US embassy in Sierra Leone?

Morgan: It was really a perfect team. It was a very, very enjoyable experience, actually, despite the difficult circumstances. We had—I mean, it wasn't just with the US embassy, it was also with USAID [United States Agency for International Development]. I think, for me and others, it was probably an example of where US assets from different agencies were brought together, underneath the leadership of the ambassador, and it just worked very smoothly. There were two—there were several key figures who'd been in the embassy, but obviously, the ambassador who arrived, I think in October—September, October, to Sierra Leone—so he was new in-country. And then the deputy chief of mission, Kathleen [A.] FitzGibbon, who had been there for quite a long time, was really just an outstanding diplomat. She knew all of the detailed politics of inside the Sierra Leone government, and she was really just quite outstanding.

It was a real challenge for the embassy, because for a start, they—it was a very small embassy to begin with, in normal circumstances. Then, with the outbreak, they went to what's called “ordered departure,” which means that all non-essential staff had to leave the country. That included spouses, and children, and so on. A lot of the US staff had to be there for a while without their families. And then, when they had the opportunity to go to another post and be with their families, then they took that. It became very difficult for the embassy to replace them. So they were pretty short-staffed in an already small embassy. They had maybe a dozen US staff. We were close to one hundred people

coming in and out, doing things that, operationally, that the embassy doesn't normally support. They really bent over backwards to help us. It was a stressful time for them, too.

Q: Thank you. Well, let's see. In August, maybe, is it? You leave your post in Sierra Leone, and make the transition to become incident manager here in Atlanta, starting in September of 2015. What do you do in that little break between?

Morgan: I took about ten days off. I went and spent it with my family, who were on holiday in Italy. I slept a lot. [laughs] I really didn't do very much. I probably slept for about sixteen hours a day, I think, just to try to recover my energy and spend some time thinking about something else.

Q: I'm sure you had quite the sleep debt to work off.

Morgan: Yes. I did, certainly, yeah.

Q: Tell me about coming back, and transitioning to becoming incident manager.

Morgan: Well, it's not something I really had planned, or even thought it would be—I would be asked to do it. I think it was in May, 2015. Dan [Daniel B.] Jernigan, who was the incident manager at that time, called me up and asked if I would do it. I thought carefully about it, and I felt that I would be morally bankrupt to say no. Because having worked on the in-country part of the response for so long, and having been engaged in

discussions with the EOC [Emergency Operations Center] about some of the challenges and sometimes shortcomings of the response, I felt that if I was asked to take on the role, then I should do that to fix things that weren't working or make things run as best as they could. I also had to think about it, because it's quite a responsibility. And it's something I hadn't done before. The incident manager engages daily—sometimes more—multiple times a day with the CDC director, with the National Security Council, with the most senior people across CDC and senior people within HHS [US Department of Health and Human Services], and the US government. It was certainly even a step up from running the operations in-country—a very large operation in-country. So, it was quite daunting, I've got to say. And I hadn't had prior experience of working in the EOC. I think if I'd thought about it for too long, I would have said no. [laughs] But my instinct was that I should do it. And I'm very, very happy I did do it. It was a great experience.

Q: Can you describe your first week or so?

Morgan: I did manage to come in for a couple of days to shadow Cyndy [Cynthia G.] Whitney, who was the—Cyndy Whitney and Dan Jernigan had been doing that role, kind of together, for a few weeks. So I had a couple of days where I wasn't in the chair, but I was able just to observe, which was quite helpful. Then, there were obviously quite a lot of other people there who really did know what they were doing. By that stage, 95% of our response was really overseas. We're talking about the end of 2015. Domestically, from a response point of view, there was really not a huge amount going on. I do remember very clearly, the first incident manager update, which is the meeting—the

weekly meeting, or sometimes we held it more frequently—where you have all of the people from the different sections across the EOC, and it's quite bewildering. You have probably twenty different people reporting to you on different issues. It's quite a big lift. I also remember, one of the first things that happened was that I participated in what's called a deputy's meeting, which is run by the NSC, and it's usually attended by the heads of the key agencies. For HHS, there was Dr. [Thomas R.] Frieden, and then there was Tony [Anthony S.] Fauci for NIH [National Institutes of Health], and then you have people from the State Department, from the Department of Defense, but also at that level. That was my first day, I think it was? Where, although I didn't have to be the principal brief for Dr. Frieden, I participated in that. So I quite quickly got thrown into activities at that level.

Q: Wow. How were you able to synthesize information when twenty people were reporting to you?

Morgan: Well, I had a fairly good handle on the overseas piece. Knowing that I was going to be the incident manager, I spent quite a lot of time traveling to Guinea, and sometimes traveling to Liberia, to get to know those countries and know the key people in the ministries in those countries. So I had a fairly good understanding of what was going on, on the international part of the response. The other parts of the response were a bit of a mystery to me. But luckily, I had worked with most of the people in one way or the other, even on this response, or previously. That helps a lot if you know the people who you're working with.

We had four task forces, which was Domestic Task Force, International Task Force, the Vaccine Task Force, and the Migration Task Force—or Quarantine Task Force. I knew all of the people running those task forces, so that was quite helpful.

Q: Yeah. Those people must have been Barb [Barbara J.] Marston for international, is that right?

Morgan: There's Barb Marston for international. I don't recall who was heading up the domestic, when I got there. It might have been Henry Walke. And then there was—I want to say Jane Seward was the Vaccine Task Force, and Clive [M.] Brown was the DGMQ [Division of Global Migration and Quarantine], which was the Global Migration Task Force.

Q: Right. What was there to do regarding global migration at that point, for you?

Morgan: Really, that became one of the major work streams that I had to deal with, obviously with lots of other people. That was all around turning off the screening for people traveling back from West Africa. As we got to a point where there were no longer chains of transmission occurring in the three countries, we then had to essentially establish a process by which we could assess the situation, share that assessment with the National Security Council, and enable them to make an informed decision about turning off the screening. That was quite a lot of back-and-forth with the National Security

Council. I think there was concern from their side about the possibility of cases still coming out of a country that had only recently stopped having widespread transmission. The process lasted a long time. Liberia was first, so we had a process for that. Then there was Sierra Leone, and then Guinea. For each country, the situation was a little bit different. It did take quite a lot of time.

Q: Was there concern among migration people? How was that concern affected by revelations of how long people could have the virus, and still transmit it sexually?

Morgan: Well, that was one of the issues that we had to consider was, in a situation of no ongoing transmission, and then we turn the screening off, what would happen if there was a flare-up, or a new outbreak? Would we have to turn the screening on? Under what conditions would that be a requirement? We found a kind of an accommodation, so that we could increase our confidence that we were not going to see cases coming out of West Africa and flying on commercial flights to other countries. But at the same time, keeping the borders as open as possible. It took a bit of negotiating. But I think we got there in the end.

Q: Gotcha. What were your other big concerns early on, as an incident manager?

Morgan: The perception I had from being in-country, and the one that I found out to be pretty much correct when I got back here, was that there was no real strategy going on. A lot of the activities in the response were reaction to requests by Dr. Frieden himself, most

often. That resulted in a lot of short tasks, and a lot of activity based on the things that Dr. Frieden was interested in. Which most of the time, were the right things, but because they were often short-term things, the longer-term goals seemed to be a bit missing. That was probably my major challenge, which was to somehow put a little bit more structure to what was going on in the EOC, while at the same time, responding to Dr. Frieden's interests to be constantly looking for new things or trying new things. I would say that's probably the theme that ran through most of my time as incident manager there.

Q: What is the strategy that you were able to put together?

Morgan: Well, I worked very closely with Carmen [S.] Villar, the chief of staff, and Stefanie Bumpus, who's Dr. Frieden's special assistant for—really, for the Ebola response—to come up with a proposal that Dr. Frieden felt comfortable with, and that others felt comfortable with. And that would help me also communicate to our country offices. If you can imagine that they had Dr. Frieden, who's essentially leading the response, and then they had the country offices, and the communication between the country offices and Dr. Frieden would happen every Saturday on these country calls. But there was a kind of gap in the middle. And the EOC was—I don't think was making that link—communication link.

We focused on a number of key areas, key strategic areas, and we got buy-in from Dr. Frieden and from the country offices at the same time. Slowly, we managed to pull

everybody onto the same page, so that we knew what our top priorities were, and then, from that point, we could go into planning specific activities around those priority areas.

Q: And how did things evolve from there?

Morgan: I think it was a partial success. It certainly didn't stop the tendency for us to move in response to Dr. Frieden's interests. But it did allow us to communicate better, both up the chain to Dr. Frieden and then down the chain to the country offices. I think it helped a little bit by reducing some of the extraneous activities. It enabled me to start switching things off, which is another objective that I had, was to reduce the size of the response. Even by the end, by December 2015, we had about two hundred eighty people in Atlanta working on the response. It was still a big operation, probably bigger than it needed to be. And there were all sorts of other quite complex financial issues, budgetary issues, as well, for maintaining a response that big.

Probably the area in which it helped most was around providing laboratory support to the three countries, which CDC had been working with a couple of companies to develop rapid tests. But we had failed dismally to roll those out into the field. So, VSPB [Viral Special Pathogens Branch] here in Atlanta worked on the development of those kits, but we really didn't have anybody who was able to take the kit that came out of the manufacturer, and then start implementing it in-country. Even though that's a skill set that we have in the agency, which we used for HIV, for malaria, for STIs [sexually transmitted infections], and other things, we were just not getting the right traction, and

that project had been going round and round and round for months, literally months. It was a major failure for CDC, is that rapid test. The failure to roll out those rapid tests more smoothly. That was an area that, coming into this, into the IM [incident manager] position, I knew that I was going to have to really tackle head-on.

Q: How did you do that?

Morgan: Well, I think that, again, it was more of an organizational challenge than anything else. It was really getting the right people in place. I was fortunate that Barry [S.] Fields, who has a huge amount of experience in the lab doing lab work at CDC, came into the response, and he was able to stay, actually, for all the time that I was there. We had great leadership by Barry. We also prioritized getting the right people out to countries and making sure that they had also people there long-term. Then, the third piece was to, again, clearly articulate what it is that we are trying to do and have a common understanding. Because one of the problems was that people were, again, pulling in different directions. It was still a heavy lift, but we did get there. We did get there.

Q: Great. You mentioned some budgetary concerns, also. What was going on there?

Morgan: The budget had really been addressed before I came back.

Q: With Dr. Jernigan?

Morgan: Right. But as we got towards the tail end of the response, there were a number of different opinions and forces pushing at the same time. Dr. Frieden was quite cautious about turning things off too quickly and reducing the size of the response too quickly. Us having seen outbreaks popping up, associated with survivors, and there was a lot of science that we didn't understand at that time and still don't fully understand. I think quite rightly, he was concerned that, given that we didn't understand everything that was going on from the epidemiology, then we shouldn't switch things off and leave ourselves short, if there was need to ramp up again. But at the same time, as I just mentioned, we had two hundred eighty people working on the response, and every single work day gets charged out of the Ebola budget. The country offices, and people—DGHP [Division of Global Health Protection], and CGH [Center for Global Health]—were interested in not squandering the budget that they had by employing people sitting in Atlanta. They wanted the money for programmatic work in West Africa. So they were keen to shut down, as quickly as possible, so that we would not unnecessarily burn through their budget with things that they didn't perceive as necessary. So there were those kinds of forces at play, which needed a bit of negotiating. And then certain groups and centers who had different projects that also needed quite a lot of negotiating around.

Q: Right. So what happens to the size of the EOC after, say, December of 2015?

Morgan: From the day I started, we put in place a transition plan. That piece of work was started by Henry Walke, who was the deputy incident manager when I got there. That was followed up by several other deputy incident managers. The transition plan was to

really take us from full activation down to turning off the activation. I mean, it really did take the entire six months for us to do that. I started in a fairly simple way, by making sure that there were not—you know, there were a lot of meetings and a lot of process things that took up a lot of time. Where possible, I shut those down. I said, okay, we don't need to meet this frequently, or we can maybe just do an email update, rather than a phone update, or something like that. Trying to just reduce the kind of frenetic activity that happens inside the EOC, which is somewhat self-perpetuating.

Then we had a written plan for each team, and how they would slowly shut down, at what point. That was agreed—you know, we had kind of like a working group, so that everybody would go through that. Then, by the time we got to the end of 2015, we'd had a staffing plan. It was a bit challenging because there were a lot of people who had been contracted especially to work on the Ebola response. So we were essentially ending people's contracts. And some of those people got contracts with other parts of the agency, and moved on. So we had quite a few of those types of things to take into account. But really, by the end of 2015, we had a kind of a clear plan for slowly turning things off. It didn't quite go entirely as planned, because we'd hoped to switch off by beginning of March. Dr. Frieden thought that was too—I think, following the outbreak in Sierra Leone in January, I think he thought that was too soon. So we ended up switching off at the end of March.

Q: Gotcha. What was it like, watching further outbreaks, although small, in Sierra Leone, from Atlanta?

Morgan: Yeah, very different. When you are in-country, it's not clear why Atlanta is requesting so much information, really detailed information about every single case and contact. And when you're back here, you realize that there are a number of imperatives. Having the information here doesn't mean you can intervene. But you certainly want your agency director to be better briefed, and briefed sooner than other agency directors. What you don't want is, you don't want to have somebody from the Department of Defense or another HHS agency knowing more than your agency director. So you want to make sure you brief your leadership very well and very quickly. That's one imperative.

Also, I thought that—and again, this is really just my impression—I thought that by having that information, it instilled a level of confidence at the NSC, that CDC was on top of the situation. There are lots of inputs coming into the NSC. They would hear information from other sources. It could be from the World Health Organization or somebody in the UK response, or it could be something leaked into the media or something published in the local media in Sierra Leone. That happens quite a lot. There's a lot of noise, a lot of buzzing around new outbreaks. You really want to get the best information on the ground. It's hard from the ground, and it's also a sense of, well, we've got a whole team down there. We should really know what's going on. So there are a number of reasons why it's important to communicate that stuff. But it doesn't have direct impact on the actual outbreak control.

Q: Right. I know I'm cycling back to something, and I apologize for going out of order a little bit.

Morgan: That's okay.

Q: But can you give me an example of a request that Dr. Frieden had that took up a lot of energy in the response? And an example of something that perhaps was left behind, that you were able to re-integrate once you were able to come up with a wider strategy?

Morgan: I think the whole issue around the dog remains from Margibi County in Liberia was one of the more challenging issues to deal with. There was real disagreement among people here at CDC about even the possibility that a dog could have been involved, or even initiated this outbreak in Margibi. Some people passionately believed yes, some people passionately believed no. Dr. Frieden really wanted to try and really go as far as he possibly could, to try and understand this. It took up a lot of time to get the remains because it was a complicated process from a bureaucratic stance, to get these samples back from Liberia. And the testing here was also not going to be straightforward. I think there was a lot of effort that went into that for a very small return on that investment of effort. I think Dr. Frieden's rationale was that we should do everything in our power to try and get answers to some of these things. But at the same time, from a very pragmatic point of view, we don't have unlimited resources. Even though we had many resources for the Ebola response. So for me, that was a challenging situation of having an

imperative from Dr. Frieden, but at the same time, that imperative really sucking up a lot of resources that we could have been spending elsewhere.

Q: Right. What's an example of something that you were able to reintegrate?

Morgan: I spoke already about the rapid tests, which is really, I think, the main issue that we were able to address that was a loose thread or unfinished business. Another plank of the strategy was to provide support to survivors. Again, that was an ongoing challenge which I don't think we got right. At CDC, we believed quite strongly that we should be trying to support survivors, if at all possible. There wasn't a similar view from other USG [United States government] agencies, or even within HHS. I think a lot of other agencies saw this as either outside their scope of work, or their ability of their agency to do it. It was not very clear to some people, in their minds, how this was beneficial in terms of outbreak control and prevention. That took really quite a significant amount of effort from myself and a lot of other people, trying to get a better strategy about how to support survivors. I don't think we ever quite got there, or not to my satisfaction anyway. We were able to push the agenda in the right direction, a little bit, but not quite far enough. So I felt that was a half victory.

Towards the end, pulling together some of the outstanding bits of science work that needed to be done, and getting a dedicated budget was a big success. Although we still have quite a lot of work yet to do to finish up, because there were a lot of projects that

were started and never quite finished. Really focusing on those, I think it was also something that was quite helpful from a strategic point of view.

Q: Right, absolutely. Can you talk about, kind of the endgame?

Morgan: In terms of the outbreak response, or in terms of turning off the activation?

Q: In terms of—oh. The fact that those two are different, actually, is interesting.

Morgan: Right, so the endgame, obviously, is to stop widespread transmission, in terms of outbreak control. But I guess a deeper view on that endgame is that you don't just want to stop widespread transmission, but you also want to have enough capacity in-country to respond if there were new outbreaks.

Q: Right.

Morgan: So there's a kind of capacity issue—

Q: Indeed.

Morgan: —right, building up capacity in the Ministry of Health, making sure that that capacity is sustained, making sure the other international partners remain on board, which was also an issue, both from US—with your USG partners, and—so, for example. CDC

throughout was totally committed to staying there for as long as it takes, and we're still there because we understand the nature—or we have a reasonable understanding of the nature of this disease. But other agencies who don't normally work in infectious diseases, were fatigued and wanted to move back to their core work. The Department of Defense, for example, was very keen to move on, and they have withdrawn all their troops. But they were still providing support, especially in Liberia. We were constantly—"we" as in the agency—were constantly in danger of having a lot of these issues dumped on us and our other partners. You know, essentially getting on and doing different things. But we don't have capacity to do everything. There was a lot of work trying to keep people around the table and keep people on board and focused, from other agencies. And also from other countries. Make sure that they continue to invest in the response.

So I think that endgame is kind of a different kind of endgame strategy to, let's say, now, shutting down the EOC, which is kind of a functional endgame. I mean, it's largely functional, but there's also a component of the perception within the NSC and other groups that when CDC turns off its EOC, that means it's over. So, it's a kind of a mixed message of, like, it's half over. It's kind of over, but it's not so over that we can turn out the lights and not worry about this anymore. That's the kind of a nuanced message.

Q: Right. It seems like we had several WHO announcements of the end of the epidemic, which always were accompanied with, you know, this isn't necessarily the end. But when there's one, and then another, and another, it got a little bit confusing, I'm sure, for a lot of people. Can you speak to that?

Morgan: I think the WHO was the most unlucky. [laughs] I think every time they announced an Ebola free announcement, there was a new case on that very day. [laughter] We started dreading these announcements because we knew they were going to be accompanied by new cases.

I think it was confusing. I think the messaging was, on the one hand the country is now Ebola-free, but we're still expecting new cases, is a kind of message that is hard to reconcile, right? But there are other needs of—you know, for those countries to have confidence with trading partners, with tourism, with all sorts of other reasons why being able to say the country is Ebola-free is important. The issue of no longer having widespread, uncontrolled transmission is—I think it could have been messaged slightly differently. For something like that. But we were always expecting there to be these pop-up cases, or these flares. CDC and the USG team, we were very careful not to make any of those kind of announcements.

Q: Can you talk about transitioning away from being the incident manager, into your next thing?

Morgan: I left just before the actual end of the activation. When we went from a Level 1 activation, which is the highest level of activation, we go to Level 2, and then Level 3, and then deactivation. When we got to Level 2, I actually accepted a detail to go to WHO Geneva to help them start up their emergency response or build their emergency response

capacity. I went just before the end, and Satish [K.] Pillai took the chair for the last few weeks.

It has been a bit of a challenging transition. I think partly because I was stuck in response mode for a year and a half. It's very, very difficult to slow down. There's also a slightly awkward—well, awkward. It's an interesting kind of situation, in that certain—so, I think I did six months as the incident manager. I think Inger [K.] Damon did seven months. But it really had become, obviously, like a part of me, having done it for so long, and so intensively. But also, having been used to working at the highest levels of the agency, and then moving on from that, it's kind of difficult to know how to relate to center directors and even the CDC director, and then how to relate with your direct supervisor. You've got these direct relationships with people who are higher up in the hierarchy, and you're used to working in that level. And then suddenly, you're not. So it takes a bit of getting used to, and kind of re-calibrating a little bit, and saying, actually, now I'm back as a cog in this big machine, and I'm no longer at the steering wheel. So there is some adaptation that's needed, I think. But I mean, it was a great experience. So, I wouldn't change that for the world.

Q: Yeah? You said it became kind of a big part of you. Can you talk just a little bit more about what the Ebola response has meant to you, and for you?

Morgan: I don't know yet. I think I'm still figuring that out. I think once I did finish, then I've really wanted to try and get back to life as normal, whatever that means. And so I've

in some senses actively tried to forget about it. Or not dwell on it, maybe, is the thing. I think I'll only really understand the significance of the experience in a few years' time. I think there are some immediate things. You know, there's a personal sense of accomplishment, to have been so closely involved in something that was so big and difficult and risky. And what I think everybody thinks is probably the biggest public health emergency that we'll ever face, or maybe that the world has faced. Being right in the middle of that is quite something.

I also had fairly negative feelings about it. I had a year and a half of my life disappear, essentially. You're just working on this one thing for a year and a half, at the exclusion of everything else. So, I had some kind of bitterness about it, about that decision to have made such a commitment, and the things that I had foregone. Family life and personal goals and anything that's not working eighteen hours a day. So, it is mixed. It's definitely changed me, in a way. But what it really means, I think I'll have to wait and see.

Q: Yup. Okay. I think that's actually a really great place to end.

Morgan: Perfect.

Q: So, thank you, Oliver.

Morgan: The end.

Q: Yeah, yeah, unless there's—is there anything else you'd like to say? Anything for the record, that we don't have yet?

Morgan: I don't think so. I think, actually, it was quite—I hadn't really spent a lot of time thinking about the IM—that IM period. I think—yeah, it was quite interesting for me to think about it. [laughs]

Q: Interesting to listen to it.

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