

CDC Ebola Response Oral History Project

The Reminiscences of

Emerson J. Rogers

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2017

Emerson J. Rogers

Interviewed by Samuel Robson

March 14th, 2017

Monrovia, Liberia

Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson. It is March 14, 2017, and I am at the Redemption Hospital in Monrovia, Liberia, joined with Mr. Emerson Rogers of the Men's Health Screening Program, here for an interview as part of our CDC Ebola Response Oral History Project. Mr. Rogers, thank you very much for being here with me and talking with me.

Rogers: You're welcome. It's my pleasure.

Q: Could you just state first, "my name is," and then pronounce your full name?

Rogers: My name is Emerson [J.] Rogers. I live at Barnersville Estate in Monrovia. Currently, I'm the program director for the Men's Health Screening Program. I have also vast experience concerning the Ebola outbreak.

Q: I will want to get into that.

Rogers: I know. [laughter]

Q: If you were to tell someone in just one or two sentences what it means to be program director—

Rogers: Program director is the liaison between the Ministry of Health [and Social Welfare] and the Men's Health Screening Program. The Men's Health Screening Program is purely a Ministry of Health program. I represent the Ministry of Health and direct the program in the way it should go in collaboration with WHO and CDC, that are supporting the Ministry of Health.

Q: Perfect, thank you. Would you mind telling me when and where you were born?

Rogers: I was born May 6th, 1971, in Monrovia.

Q: Did you grow up in Monrovia?

Rogers: I grew up in Monrovia.

Q: Where in Monrovia?

Rogers: Precisely, Barnersville Estate, where I currently live.

Q: What is it like there? What was it like there when you were growing up?

Rogers: That was before the war. Things were all okay. We had all of the social services we needed. We had all of the opportunities to go to school, to be better taken care of by our parents. It was fantastic, growing up as a child.

Q: What did your parents do?

Rogers: My father was an educator. He was a master's [degree] holder in mathematics. He got his master's from Illinois State University. My mother is a home wife. But unfortunately, he got killed during the civil war.

Q: Sorry to hear that. What kinds of things were you interested in as a student when you were growing up?

Rogers: Actually, when I was growing up, I wanted to become an accountant. In high school, I did accounting as one of my electives. Then I moved on. My late father encouraged me, "Look, son, when you become an accountant, don't stop there. Try to get your CPA, Certified Public Accountant [license], and then you will be marketable anywhere in the world." I had that ambition, I had that dream. That was before the outbreak of our civil war. When the civil war came, my father got killed. I had to move on to one of my uncles. He was a medical practitioner, and then he started to encourage me in the medical field. From there, I gained an interest to go into the medical field. I went to our medical institution and currently I'm a physician assistant with license. I went to the University of Liberia, and then later, sociologist.

Q: What year was it, about, that you first enrolled in a medical program?

Rogers: That was in 2007.

Q: And then to the University of Liberia?

Rogers: Sorry, that was in 1997. And 2007 is right around the corner. [laughter]

Q: What did you think of that kind of work once you had that degree, that experience?

Rogers: It was interesting. I was very much passionate about the work. Upon my graduation, I worked in a hospital for several years. I worked in a hospital for fourteen years, precisely in the emergency ward, and then in the intensive care unit. My greatest joy during my practice in the hospital was to see my patients' recovery. That was my greatest joy. How critical the patient comes in, you monitor the patient until they recover from their illness, and then being discharged home, yeah.

Q: When you look back, is there a certain patient who stands out in your memory?

Rogers: A certain patient, that was a patient that did not make it. For a patient that was very critical and made it, that was my joy. I had a case which was a child, and they rushed the child to the emergency ward. Very critical, needed oxygen support

immediately. That, we instituted at once. We served all of the medical emergency drugs, stabilized the patient, and then admitted the patient to the ICU [intensive care unit]. I, on a routine basis, had to leave the emergency ward to follow other patients into the ICU, and then I follow up that patient. At times, I used to sleep when I wasn't to be on call. I was praying to God that this patient or this child would recover. The day that the child recovered and started to respond to treatment, and then was transferred to the peace ward, and then later on he started to move around, eat, laugh. I started to say, wow, at least my efforts and that of my colleagues in the hospital is getting some reward. At the end of the day the child was discharged home, saved. On admission, the mother gave up. It was terrible. She was in tears. "Doc [doctor], is this child going to survive? I have no hope. My child is not going to survive." I said, "Just hold on, we are doing our best." And the day she was walking out of the hospital with her child in her arms, smiling, she looked for me. It was good I was on call. She went in the emergency ward and saw me and gave me a hug. She said, "I appreciate you so much." I said "Thank you, that's our job."

Q: Thank you for telling me about that. But then you went back to school for sociology?

Rogers: Yes.

Q: When was that?

Rogers: That was in 2006.

Q: Why did you go back for sociology?

Rogers: By then, I was working. [unclear] We had so many engineers in the country. I was working with MSF [Médecins Sans Frontières] Spain, and the work was stressful. You had to be on call. By then, I had just enrolled in the university in the science college. Honestly speaking, I'm an A student from grade school. I take eighty-five to be a failing mark for me. All my grades were ninety, one hundred, between those. When I got at the university in the science college, I was informed then that I did not have the time to study. It was regrettable because I had to be in between. I was on call and I had to run from the emergency room, go to attend a class, and then when my phone rings, I check, I say wow, I'm being called back at the hospital. Then had to get in my car, run back to the hospital. It was frustrating. Later on, found out that I wasn't actually going to be satisfied with my grades. So I'm better to make the choice early than to remain there and at the end you are not satisfied with what you are doing because you are not [unclear]. I should be making ninety-eight, and then I find out that I'm making fifty, I'm making forty. [laughs] It was frustrating. I had to change from the science and went into Liberia College, into the liberal arts. That's how I did sociology. I really chose sociology because it's human interaction. I've been a medical person, and sociology is the study of human behavior, so I was just flowing in line with what I really love to do.

Q: What happened after you graduated from that program?

Rogers: When I graduated, I was still in the hospital, still working, and things were just moving as normal until we had the Ebola outbreak.

Q: Tell me about the early times of the Ebola outbreak for you.

Rogers: First, I must give God the glory. If it had not been for God's protection, I wouldn't have been here sitting before you, conducting this interview. My family would have been wiped out by the virus. Reason being that I own a clinic. I own a clinic. It's licensed, I'm registered with the Liberia Medical and Dental Council. When the outbreak started, we all were warning our citizens, warning even our staff at the facility. Also, I was at the hospital working. Though I had my private clinic, I was at the hospital working. When this started, really, we didn't know what was Ebola. Nobody had experienced Ebola in Liberia. As head workers, we were like—symptoms that would present like malaria, we were taking it to be malaria. Because Ebola presented with all of the symptoms of malaria—diarrhea—and that of typhoid, with the exception of the red eyes, maybe bleeding from some of the body parts, which were rare. But the common signs and symptoms were all in other diseases that we have been treating in the country. That was one of the reasons that led to most of our colleagues dying from the virus. Actually, we did not know what we were dealing with until things started to improve. Knowledge started to be shared and precautions were also shown as to what to do.

What actually led me into getting interest in the outbreak, I had a case at my facility. You wouldn't believe it, Sam. One evening while home, they brought a patient. I was at the

clinic and they brought a patient. They explained, they gave a different case history. So I assessed the patient. Already we have this outbreak, so we were using the universal protocol, the IPC [infection prevention and control] protocol, everyone in the clinic wore their gloves. Whenever a patient came in, everyone wore gloves to assess the patient. I went and assessed the patient [unclear]. Incredibly, the patient also presented, and when the results came, malaria positive. I admitted the patient on a short stay. Treated the patient with undergoing treatment. Then, after an hour, they brought a kid. A kid was brought in around nine to ten years, a boy, with a history of diarrhea. I said, “Only diarrhea?” They said, “Yes, just diarrhea.” “When it started?” “It just started this afternoon.” It was during the nighttime they brought the child, during the evening hours, around about 8:30 to 9:00 pm local time. The first patient they brought was from the same house that this child came from. They designed a strategy, very wicked strategy that the first group that brought the first patient were not the same group of people that brought the second patient. They made it look like they came from a different location. So I admitted the patient also for a short stay, tried to rehydrate the patient, and the patient spent the night at the clinic. But the first girl that came from the same house was discharged later, overnight. When day broke, they brought a little girl from the same house. You wouldn’t believe it, Sam. We did not know that we were dealing with Ebola definitely. They brought the same girl from the same house, she was about seven, eight years old. While I was in the consultation room, one of the nurses called me. She said, “We’ve got a patient out here, very weak, unable to balance.” I said, “Okay, I’ll soon be out there.” While in the consultation room, I heard one of the—a patient went to take a follow-up injection, and then the patient said that—but this girl is from the same house

that the little boy in there is from. And they got Ebola in their house. The father had died a week before from Ebola. And nobody knew. And that very morning they have another body in the house but they did not say. When I got the news, I got annoyed, I got frustrated, because we have interacted with these patients not knowing what we were dealing with. The only thing we on were gloves, and we were frequently washing our hands with chlorine by then. I got annoyed and I said, “Where do they live?” I told the nurses to find their chart. The nurses located the child’s—we got the address, they were right on the estate. So I got in my car and I drove straight to the house. When I got at the house, I met one of the relatives in the house making a phone call, calling the Ebola burial team to come because there was a body in the house. I stood by and I overheard the conversation. When he got through, I said, “You guys are wicked. You know that you people got a dead body in the house, and today, the father of this house is being buried. And then you send three patients at my facility, not explaining anything. That’s being wicked. You go right now and get the two kids from my facility.” All along in my medical profession, I have been so passionate. I’m compassionate with my patients, very moderate. But I was annoyed because my family’s life was involved, definitely, and the lives of my staff were involved. I told him, “Either now you’ll remove the kids from my facility, or I will remove them myself.” So they had the mother went and she took the children away. I said, “The best advice I have to give you is take these kids to the Ebola unit. I’m not saying they have Ebola, but it’s better for them to go through the test. If it is, they will be treated.” And they went home. They did not yield to my advice, and the boy died, but the little girl survived.

Right there, I closed the clinic. I said, I don't know what will be the next condition that may come and we may not be so knowledgeable to say right away, gloves, and [unclear] emergency, we want to turn to this patient at once and we will mistakenly touch the patient with our bare hands. So I spoke to the staff. I said, "We have to shut down for now." We had to shut down, only left the pharmacy open. But then I got so afraid, very, very much afraid that I interacted with these cases, and my entire staff were afraid. Then I said, well, if I can sit at my own facility and then receive Ebola cases, I'd better go to the unit to help save the lives of our Liberian people, of my brothers and sisters and my fathers and mothers. So that way I gained the courage to go into the Ebola unit to fight the virus. It was August 17th when I entered the Ebola unit at the JFK [John F Kennedy Medical Center] Ebola treatment unit.

Q: What was the condition there like?

Rogers: At JFK?

Q: Yeah.

Rogers: By then, JFK was very small. We were using the cholera unit, not the entire JFK complex, but they had the cholera unit. That unit was being used as the Ebola treatment unit. It was congested. We had a place, a bed, for forty-five. And then we were admitting up to seventy Ebola cases. They were all on the floor. When I went to the unit, my immediate boss was Dr. Soka Moses, and I was appointed by him as the clinical

coordinator for the Ebola treatment unit. I was monitoring, supervising, evaluating the physicians, the nurses, the hygienists, making sure that the right things are being done. Also, I was closely working with Dr. Moses going on the ward. By then we had a WHO team, one Dr. [Anne Deborah Atai-Omoruto], she's late now. She passed a year ago, a Ugandan. She was brave, very brave, and she encouraged us a whole lot. We went through it at JFK. It was tough. Yes, it was tough. Sometimes you go on the ward to make rounds, you spend more than an hour on the ward. Sometimes you spend up to two to three hours. You have to see Ebola cases, some lying on the floor, you know how uncomfortable it is. You are in your protective gear, you have to bend over to assess a patient that is dying that needs your help. Our lives were really at risk, but we have to take the risk to save the country. Yes, that's the most important thing. We saw a lot of things that were traumatic. One that up to now, that when I think about it, that left a scar on my mind, was a woman and her two kids. They were brought to the treatment unit very ill, and the mother was very, very weak. They were placed, admitted, on the floor on the mattress. I used to go in every now and then to cater to them, whereas other patients that were admitted. They were making rounds. I saw her son; not the son, the daughter. The daughter, she was like lying, and then the two children were next to her. I saw the daughter giving up the ghost. This mother was weak. She only opened her eyes, she looked at her daughter, and her daughter expired. She couldn't cry. So we are seeing she has lost one. We need to exert all of our energy to see whether her son would be safe. We were doing everything, the same as we were doing for the rest of the patients. Interestingly, I went on the ward after like two days to make my regular rounds, and then I saw the son giving up the ghost, Sam. The only thing the mother did was she lifted her

head, she wanted to touch her son, she's trying to stretch out her hand to touch her son but she couldn't. She was very, very weak. When she saw her son gasping, the only words she said, she said, "My son, you are leaving me." I don't like to—each time I think about that—ethically as medical practitioners, we are always in empathy with the patient, not sympathetic. But I got in sympathy with that mother. And that child died. I stood with all of the effort, and tears, yes, tears poured down my eyes. It was traumatic. Yes.

We really had a great time. It was a great time because we were like on the battlefield, like on the warfront fighting Ebola that you cannot see, fighting a virus that you cannot see. You are working with your colleagues that anyone could have mistakenly gone against the IPC protocol and then could have caused infection among the staff. You should know how vulnerable we were, being that the [unclear] was clustered. Very tight up, we were working. Even then, we lost two of our colleagues. One was a medical doctor and one was one of the security at the JFK unit. Then, when the international community got so involved and came in from the plea of our president, when they came in, they established, they standardized the Ebola treatment units. We call it MOD-1. The site that was used was where the Ministry of Defense prior to the war was being constructed, but the war disrupted the entire construction process. Being that it was the Ministry of Defense, the Ebola treatment unit was named MOD-1. We had two big units. The second was named MOD-2. MOD-2 was for training. We had the Cuban medical team that came, we had a EU [European Union] medical team that came, and we had a Liberian team, so those people would be trained at that unit. We moved onto the MOD standardized treatment unit on October 1st, 2014.

Q: What happened there?

Rogers: At that unit? It was quite different. The experiences there were quite different from that of JFK. It was at that unit that all of us that moved, to move from JFK to that unit, came to realize that our lives were at risk at JFK, because the unit was big. You didn't have to rub against your colleague. The same team moved. I was still the clinical coordinator, and Dr. Soka Moses was still the head of the ETU, and we had all these international staff: WHO staff, the Cuban medical team, the EU medical team. We had close to two hundred plus staff at that unit working on shifts. It was very much incredible and rewarding because we were able to give the maximum care to our patients. At that unit, we did not experience more deaths because all of the patients were on beds and everyone was being cared for appropriately according to protocol, IPC protocol. One of my first—I would term it as a challenge in my leadership, was Dr. Moses had this opportunity to travel to Geneva for an Ebola conference. That was in I think early December of 2014. He said, “Emerson, I don't trust anyone to leave in charge but you, so you have to take up the mantle until I can return.” I said, “Wow, that's a great responsibility.” I had to have coordination meetings like every Monday, coordinate the staff, and you wouldn't believe it, when I go to work in the morning, before I enter the office from my car, people are entering the office. I'm being stopped by like fifteen to twenty of the staff one at a time wanting me to address their issues, wanting me to address their concerns. Administratively, what I could handle, I would handle it. What I couldn't, I would tell them, “Please just wait for Dr. Moses, when he comes back, and

then he will see how we can address this other issue.” It was interesting. And interestingly, let me just go back a little at JFK. When we treated patients at JFK, Ebola patients at the treatment units, and then when you see the patients start to recover, it was an experience of joy. All of the staff working, we start to rejoice. Patient in bed eight is recovering. So when the shift go in, make their rounds and come out, patient in bed eight is recovering. That’s great news. Whenever a shift is changed, when that shift goes in, you go straight to bed eight, you converse with the patient because to survive from the virus that is so deadly was a miracle. So we had several patients that were being discharged from the JFK treatment unit. Several patients were being discharged, though we lost a hundred of them. Many of them were being discharged based on the care that was given. And really also based on their own immune system. You have to fight the virus because the viruses did not have a definite treatment, no definite cure. Even up to now, the investigations they’re undergoing as to what vaccine to be developed to combat the Ebola virus. By then, we were just doing it symptomatically. You come in presenting with diarrhea, losing a lot of fluid, we will rehydrate you just symptomatically and give you the best of care until you recover. It was the same that went on when we moved to MOD-1. Interestingly, with the experience, we became master trainers of the Cuban national team, medical team that came. We became master trainers for the African Union medical team that was sent. We trained them in MOD-2. We used MOD-2 as a training facility. That was done based on our experience with the fight of the Ebola virus.

Q: What was a central message that you knew that you had to get across to the Cubans and to the EU members?

Rogers: The first thing that we told them was IPC protocol adherence was the key to walking out of the unit alive. That was stressed. While going through the training, we were always stressing on the IPC adherence. IPC adherence. IPC adherence. Even during the training, we were doing the dummy where you have to doff and don the PPE, and after you are gone from the ward, when you come out to doff—there's two terminologies. You "don" to put on and you "doff" to take off or remove. When you come out to doff, you are being observed and guided. You are not left alone. The hygienist, the sprayer, will be there. I was always there as clinical coordinator to monitor every step as you doff. During the training, if you miss a step, I'll tell you, you have to redo. You have to redo because if you go in the alive ETU and you miss a step, doffing will be at your own risk. At the end of those sessions, when they were ready to go into the ETU now to work, they appreciated me, they appreciated the entire training team because it was like when they come out, every day, "Emerson, you guys did well with the training." Because what we see on the ward, even when we come to doff, we are afraid to doff before we make mistakes. But then we keep calculating what you guys were training us to do while doffing. That was a key message. You have to save yourself, keep yourself safe, before you can save the next man. So that was it. Another key word was when you are experiencing any strange feelings like illness, please don't hide it, don't keep it as a secret because we work as a team, we work as one family. The moment you keep it as a secret, and then it gets worse. And then it happens to be Ebola. You put the rest of the team at risk. We were like security on security. [laughs] Before you enter the unit, your temperature is being checked. The moment you come to me, oh, I'm not feeling well, I

have a headache. Are you sure you have a headache? Say yes. We check the temperature. Another thing, if you get any other associated signs, the first thing we draw your blood, we send it for testing alone to do the malaria test. and they will ask you to stay home until your results can come.

Sam, one of the things that was so emotional for me, at that time, my little daughter, whenever I get home, we were so close that before they outbreak and before I could go into the ETU to work, as soon as I get home, she would run to me, “Daddy, Daddy!” I would hug her, take her in my arms, kiss her and give her a soft word always, “Daddy loves you.” She said, “Yes, I know.” And then during the outbreak, I wasn’t able to be touching my daughter again. Whenever I get home, she would come running and I would go running away from her. Yes, it was emotional. At first, she did not understand. She was wondering, why are you running? [laughs]

Q: How old was she?

Rogers: Then, she was like four years. Three, four. “Why are you running?” Then I said, “We are fighting a war.” But then when I had gone through the cleaning process and everything and I feel safe, I would go around her and would tell her, “Look, Daddy doesn’t hate you, Daddy is not running away from you. But Daddy wants to keep you safe, Daddy wants to keep mommy safe, Daddy wants to keep the home safe. So please, when I come from work, don’t just run to me again; I will run to you.” And she understood. When I get home from work and park the car, she would see the car. The first

few days, she would make an attempt to run out, just look out, then she would stay in.

[laughs] I was going in the clinic to take my shower, do everything before I enter my girl's home. And that was what I was doing.

Q: What did you do after the trainings? What happened with you then as part of the response?

Rogers: After the response?

Q: No, as part of the response after the trainings.

Rogers: After the training, right? Alright. After the training, those would be monitored as I said. Those that we trained worked in the Ebola treatment units, and I coordinated them along with my immediate boss, Dr. Soka Moses. Then, after the outbreak subsided, when the ETU, the treatment unit, was being decommissioned, I became trainer. I'm a master trainer of trainers. We launched the KSKS training that was "keep safe to keep serving," so we called it KSKS. This was developed with the collaboration with WHO and the Ministry of Health.

[interruption]

Q: So the KSKS.

Rogers: The KSKS, keep safe to keep serving. We launched it in Lofa County, and that was training health workers how to remain safe in order to keep serving the community, in order to keep serving the public. We had three teams in that county, that part of the country, and then I was supervisor for one of the teams that was assigned in Kolahun in Lofa. It's one of the districts in Lofa County. I was there for six weeks, launching the KSKS, and it was successful. It was rewarding. Staff were being taught how to first save themselves, prevent themselves from infection, in order to be ready at all times to save others that will come to them for help. Most of the things that were being taught was the universal IPC protocol. That's what was being taught. How to don the PPE, how to doff the PPE. When you are on the ward, or when you are treating a suspected case, how to handle it, the process of handwashing, all of those things. Those were cardinal things that were being stressed during the training. So actually I have had a lot of experiences.

Q: Where else did you do the trainings?

Rogers: Really, we did it only in Lofa, and then after that other NGOs [nongovernmental organizations] came in, like ACCEL [Academic Consortium Combating Ebola in Liberia] and several other NGOs came in, and then the training was diversified into different parts of the country because we wanted to cover the entire country because with the support WHO had given to the Ministry of Health conducting the KSKS, if we had just left with that team going from county to county, it would have been a long process. So we decided to merge with the other NGOs that were willing to come in and give support. They came in and then the whole thing was decentralized and then they spread

throughout the country. As I talk to you, all of the counties have been covered with the KSKS training.

Q: Did you do some of that coordination with the other NGOs? Like you mentioned ACCEL. Did you do some of that coordination?

Rogers: Oh, yes. ACCEL, there were a lot of meetings that were held, a lot of meetings were held and all of the NGOs were on the same page. Things were well coordinated and everyone was following the same training pattern. Not one group doing one thing or practicing one thing and in another area, another group is practicing one thing. It was a universal training protocol, standardized, that was being rolled out throughout the country.

Q: Were there challenges in working with the other groups?

Rogers: There were not much challenges. Some came with other ideas, and those ideas were placed on the table for discussion. WHO had to give the go-ahead. WHO is the World Health Organization, so they guide everyone as to what to do, how to do it.

Q: Can you tell me what happened after that?

Rogers: Right after that training, as I said, I'm a medical practitioner. I went back in the hospital as usual to take care of patients.

Q: Is this the facility that you had?

Rogers: No, one of the government facilities.

Q: Your facility remained closed?

Rogers: No, no, it's open. Right after the cessation of the outbreak, it was reopened. I went back to the hospital, but then while at the hospital, a colleague of mine from the Ministry said, "Emerson, I don't think you belong in a hospital. With your expertise, with your leadership ability, with your wealth of experience, you need to come give some assistance." So I was called to the Ministry just to do some voluntary work, and then I was sent in the field to do some supervision work for that particular department.

While in the field, the Men's Health Screening Program was being given birth to by Dr. Soka Moses, by Dr. April [Baller], by Dr. Nuha [Mahmoud], and Mary from CDC, Dr. Mary Choi. Things were being discussed regarding the formation of the Men's Health Screening Program, the importance of the Men's Health Screening Program, and it was given birth on July 7, 2015. It was launched on July 7, 2015. Immediately, they began work, and in September, Dr. Soka had a scholarship to go and get a master's in the UK, United Kingdom. He was directing the program by then, and he was asked, now you are leaving, you can't leave the post, the position vacant. We need someone from the Ministry to direct the program, but this is a Ministry of Health program. He said, the only

person I have confidence in to direct or to do what I'm doing is Emerson. I was in the field when he called me, said, "You are needed at once because I recommended you." And I worked with Dr. April. She is with WHO. She is the case management lead. I worked with her throughout the—when she came from the treatment unit, and on the KSKS team I worked with her. Even Dr. [Moses] Massaquoi saw me when we were at the treatment unit. When my name was submitted, they said, we don't have a problem with Emerson, we know what we can do. That's how I took on the responsibility of the Men's Health Screening Program.

Q: Tell me about those early days of taking on that responsibility, of learning the full extent of your duties, of your roles, of getting comfortable in that role.

Rogers: Wow. Initially, it was challenging. Challenging because since Dr. Soka Moses, as I said, had a scholarship to go, and he couldn't turn over officially. You know what I mean? Everything was in a rush for him. Time was against him. He didn't have time in his favor. He had to prepare, he had to get ready to leave, so he said, Emerson, I need to do a formal turnover to you, I need to tell you X, Y, Z, but I'm not in a position to do it. I'm very sorry, but I trust you can move on. [laughs] Oh, yes. So I was given my term of reference. I read it carefully, and then I started coming at Redemption because back then Redemption was the only office for the Men's Health Screening Program. Right now we've got two other offices, or two other sites, but Redemption gave birth to those sites. I was like, wow. I have to understand the Men's Health Screening Program because I wasn't there for the formation, you know what it means. They just brought you in and put

you. [laughs] What I did, from my experience, from God-given wisdom, I proposed to myself that I would use two to three weeks as adjustment, as a learning period, what the Men's Health Program is all about, what my roles and responsibilities are, what coordination role I will be playing between CDC, WHO, with respect to the Ministry of Health. I was like, when I come at Redemption, I will just sit in the office quietly and when I see a staff doing something I will go to him, "Hello, your name? Why are you doing this?" The person will explain. Because I was learning. "Why are you doing this?" Explain. "Oh, okay. So that's the right way to do it?" He say yes. Alright. That is already documented. Then I move on to the next staff. I wasn't talking. Like two weeks I did it. When I come to work, I would just sit quietly and observe everyone's role, and I got fitted in. It didn't take long. I got fitted in and things started moving. Really, really, I must give a lot of appreciation to the CDC staff that have been coming. Every one of them, most importantly Mary. And also the WHO staff, they have been very, very much supportive; very, very much. Sometimes, when I meet Dr. Desmond Williams, he, "Oh, Emerson, how is it? Any problem?" I say, "No, it's okay." They say I trust, I know you can make it. When I meet Dr. [Alex] Gasasira from WHO, "Hey, Emerson." Sometimes we meet at the Ministry of Health. "How are you doing, how is the program?" I say it's okay, things are moving on. Usually we have technical meetings every two weeks and that meeting is chaired by me as the program director. There, we have Dr. Gasasira from WHO, Dr. April, Dr. Nuha, Jomah Kollie. Those are representatives from WHO. And for CDC, Desmond is always present at the meeting along with the CDC representative to the program that will be in country. If Mary is here, Mary is always there. If Rodel [Desamu-Thorpe] is here, if Lawrence [J. Purpura] is here, just like that. Because they

always—the CDC staff always change. When you think you are getting used to one, just forget it. [laughter] After three weeks, you see another face from CDC.

Q: Is that difficult?

Rogers: Initially, it was a bit confusing, but we have gotten used to it. What we tell ourselves, our staff, is that okay, this time the CDC staff is going, another one is coming. Initially, it was like when one leaves, when the next person replaced the one that left, is that he or she comes with different style. You have to get adjusted with his flow. After one, two, three, four months, like five months, we said, well, as one CDC staff leaves, when any more come, they are being briefed. What really synchronized the flow is that when a staff is leaving, when the replacement comes, that replacement is being briefed thoroughly so that he or she does not bring in a different style. So now it's a continuous flow.

Q: And that's something that has developed over time?

Rogers: Yes, that developed over time. It's a continuous flow.

Q: But originally people had a different style. Could you describe people's different styles a little bit?

Rogers: When you talk about different styles, like a representative will come and say, well, let us do it this way, which is really not against the program, I think we should do it this way. It's not demanding. Suggestion, discussion. It was something like, oh, this time we're confused. No. But it happens everywhere. Even when you have a transition, when you have a change of leadership, change of government, definitely, you don't expect the person to flow the same way. But for the past seven to eight months we've been having the same people coming out, like Rodel, like Mary, like Lawrence. Who else? Another guy. It's the same people coming back, and we're just moving on. But really, CDC—I mean, CDC is the backbone. To admit, CDC is the backbone of the Men's Health Screening Program and supported one hundred percent from WHO.

Q: How do you evaluate CDC's work as the backbone of the program?

Rogers: Technically, technically. When we come to data issues, CDC is on top. Data analysts analyzing the data, scrutinizing the data, making sure that the right information is placed in the database. CDC makes sure that is done without error. The moment there is error, CDC is notified that there is error. It does not go error-free. I give CDC, I rate CDC a whole lot because at a certain point of time, CDC recommends, you have to do this data cleaning and it has to be done. And it was done. From such a work—CDC has published many journals from the Men's Health Screening Program, has gotten so many awards, accreditations. All of that is because of the good work, the teamwork. We have always worked as a team. It's the most important thing. We have always worked as a team. Usually, on a periodic basis, I make presentations at the IMS [incident management

system] with assistant minister of health, Mr. Tolbert [G.] Nyenswah. A lot of NGOs are present at that meeting. I make presentations for the Men's Health Screening Program. The progress, the stage at which the program is. It's opened the minds of those in government and those in the health area as to what is unfolding within the Ministry of Health's own semen testing program. CDC is—I don't know, but they are very—[laughs] they have really, really kept the Men's Health Screening Program as number one, along with WHO. What I enjoy most, what I admire most is the coordination. The coordination between CDC and WHO, with that of the Ministry of Health. Perfect coordination. There has never been any collision.

Q: Who are some of those members of WHO who are involved?

Rogers: With WHO? Dr. Gasasira, the country representative. We have Dr. Nuha, we have Dr. April.

Q: Does WHO have a distinct role in the whole process?

Rogers: WHO has a distinct role, yes. They have a distinct role in the sense that WHO is responsible for incentive payments. They provide for logistics, for movement, for vehicles. Even for CDC staff representatives that have been coming, WHO are responsible to provide logistics for them.

Q: So WHO does a lot of the logistics and the financial stuff. CDC does a lot of the coordination. Is that right?

Rogers: Technical.

Q: A lot of the technical advising.

Rogers: Yeah.

Q: And then the Ministry of Health itself?

Rogers: The Ministry of Health itself is like the warehouse, because the Ministry of Health is the owner of the program. The program is a Ministry of Health program. CDC and WHO are supporting the Ministry of Health with the Men's Health Screening Program. If you would just look at the organogram, it's like WHO gives financial and technical support, CDC, one hundred percent technical support.

Q: When you look back, are there certain turning points or developments in your work with the Men's Health Screening Program that you would point to that we haven't discussed yet?

Rogers: I think we have touched all—as I said, with the Men's Health Screening Program, we are merely dealing with the testing of Ebola survivors' semen. The program

is really a public health program. It is there to notify the—handle the public, notify the Ministry of Health that we still have some survivors whose semen is still positive with the virus. With that information, the Ministry of Health continues to give the support that the program has to continue until these people all turn negative. That's the most important thing about the program. The other interesting thing is that the staff are all trained, especially our counselors at the three sites. We have counselors at the three sites, and they all went through the same training with respect to the program protocol. We have semen technicians, those that are responsible to collect the semen when they are produced by the participants at the three sites. We also have receptionists at the three sites, and we have an office manager, and we have hygienists to keep the place tidy and clean. I usually made periodic visits at the three sites because they are in-country. One is in Lofa and one is in Bong County. So I made periodic visits a month to these two sites, and then spent most of my time at the Redemption Hospital, and then at the Ministry of Health because I always have to be coordinating between the program and the Ministry of Health. That's my role and responsibility, updating the Ministry of Health of developments within the program.

Q: Is there any aspect of your part in the Men's Health Screening Program, or really your entire history of responding to the Ebola epidemic, that we haven't touched on that you'd like to describe before we wrap up the interview?

Rogers: Come again?

Q: Is there anything else that you'd like to share regarding your part in the Men's Health Screening Program or the Ebola response more generally? That you'd like to share? Any memory that you'd like to share, any reflection that you want to make sure we have recorded for the project.

Rogers: Really, for the Men's Health Screening Program, presently, we have gone one year plus since the launching of this program. This July will make the program two years. Right now, our focus out of the eight hundred plus participants we have enrolled into the program, we currently have four that are persistent shedders. What I mean is that they still have the virus in their semen, and these are our focal points right now. They are our concern. They are our priority for now. Though we are still enrolling participants, because we included also those participants that survive at home. Initially the program was only open to those that survived at the ETU, with ETU-discharged certificates. But then we sat and talked technically that there were survivors at home. Initially, there were people that were afraid to go to the ETU and took care of relatives that were sick, and they themselves got sick at home and survived at home. We cannot leave them out only because they did not go to the ETU. They could be a potential public threat. What if they still have fragments of the virus in them that are alive, that can cause transmission, or that can be transmitted and cause a cluster outbreak. So that's how we thought technically and then we included these people. Out of the eight hundred plus that we have enrolled, we still have four persistent shedders in the program. Out of the four hundred that we have enrolled, the total that were positive on the first test, forty-one in total. And out of the

forty-one being positive, now we have four that are shedding the virus, with respect to laboratory results, persistently.

Q: Are those four discharged from ETUs or did they survive at home?

Rogers: All four are discharged from the ETU. Interestingly, one of them was positive almost two years after the outbreak. The only signal to us as a program, a signal to the Ministry of Health, they gave a signal to WHO, to CDC, that much is yet to be known of the Ebola virus. Because initially WHO, from experience from the Zaire outbreak, the Ugandan outbreak, has a public health warning that once a survivor is discharged from the ETU, you abstain from sex after three months. The same was done to Liberia when we had the outbreak. But then, after the three months, the person that caused the first outbreak after we were declared free, was discharged ninety-nine days from the ETU, and then he had intercourse and then there was this cluster outbreak. WHO had to revise the three months to six months, and now I think it's nine months. So you see, much is not yet still known of the Ebola virus. We still have to remain alert. That's the most important thing. I really appreciate WHO and CDC and the Liberian government for giving birth to this program because it has educated the survivors themselves a whole lot, how to protect themselves, how to protect their families, and they themselves have appreciated the program. Seriously. Because CDC conducted a program evaluation with participants that were enrolled and discharged from the program. One Dr. Denise Cooper—not Denise, Ruth—

Q: Denise Allen?

Rogers: Yeah, Denise Allen. She and her team conducted a program evaluation, and I made that presentation at the IMS. And the participants appreciated the program, yes. They appreciated the quality of staff that the program has, and that really can give anyone the courage that, yes, this program is standardized, it has the quality of staff needed to run such a program. I really appreciate the staff of the Men's Health Screening Program. We all work as a team, as one unit.

Q: Thank you so much for giving me your time. I very much appreciate hearing about your experience not only with the Men's Health Screening Program but at JFK and at the MOD. Thank you, Mr. Rogers, I appreciate you.

Rogers: It's a pleasure talking to you.

END