

CDC Ebola Response Oral History Project

The Reminiscences of

Sarah D. Bennett, John T. Brooks, Oliver W. Morgan,

Mahesh Swaminathan, and Ian T. Williams

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Interviewed by Samuel Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: Hello, this is Sam Robson, recording with the David J. Sencer CDC [Centers for Disease Control and Prevention] Museum for the Ebola Response Oral History Project. It is August 15th, 2016, and today I have a group of people here to talk about a series of exposures that happened in Port Loko, Sierra Leone in 2015 and walk us through that and talk about why that was important. I'm going to ask everybody in this room, maybe we can just go around clockwise and if you could state your name and your current position with CDC, that would be fabulous.

Swaminathan: My name is Mahesh Swaminathan and I'm a team lead for one of the surveillance teams in the Division of Global HIV and TB [human immunodeficiency virus and tuberculosis].

Brooks: I'm John Brooks. I'm the senior medical advisor for the Division of HIV and AIDS Prevention [acquired immune deficiency syndrome].

Williams: Hey, I'm Ian Williams. I am the chief of the Outbreak Response and Prevention Branch within the Division of Foodborne, Waterborne and Environmental Diseases.

Morgan: My name is Oliver Morgan and I'm currently seconded to the World Health Organization in Geneva.

Bennett: Sarah Bennett, I am a technical lead on the Ebola Affected Countries Office team.

Q: Great. Thank you all so much for being here. As I said before we started recording, I think just going about this chronologically will probably be the easiest to keep everything organized. The first question is wherever this story starts, and I think maybe it was with Oliver.

Williams: Do you want us to tell who we are and what our role was during the response?

Q: We can do that too, sure.

Williams: Would that be helpful? Because that would sort out where it starts because Oliver is key to all of this.

Morgan: I think it would be good too.

Q: Sure. How about, when you start talking, say again your name and your role with the response.

Morgan: My name is Oliver Morgan and at the time, I was the acting country director in Sierra Leone. Can someone remind me of the dates?

Brooks: March 10th was probably the date—

Bennett: —he was admitted.

Brooks: The staff member? Which one was it? Our staff member or the Partners In Health staff member?

Bennett: The 10th was the day that our Partners In Health staff member was admitted, but the testing, I think, didn't come back until the 11th, on the next morning.

Morgan: It was the 10th of March. Anyway, I'd been in Sierra Leone since November 2014 and this was the 10th of March, 2015. I recall getting a telephone call from the in-country director of Partners In Health that morning to say that one of their staff members had been admitted to Kerry Town ETU [Ebola treatment unit]. Both Sarah and I had dealt with half a dozen or maybe even as many as ten individuals, American citizens who had exposures or needed an assessment of their exposure risk, from NGO [nongovernmental organization] groups and assorted other people who are in-country. I thought this was just another one of those, that they had a staff member who had potential exposure, was ill with an unknown illness, for precaution had been admitted to Kerry Town ETU, and I

just thought that's the way it would go. Then, the way I recall it was that actually the same day the lab [laboratory] result came back because Kerry Town ETU had their own testing ability, and I think they were using BioFire [FilmArray BioThreat-E] to do the tests for Ebola and a number of other infections. Their turnaround times were usually about eight hours I think, at that time.

Bennett: I think it was about two or three hours once the lab was drawn, actually.

Morgan: Once the lab was drawn. Anyway, we did get the lab result the same day. I remember when the director of Partners In Health called me back, the very first thing I said to him was, "Do not let anybody from Partners In Health leave the country until we understand what's happened." Because at that stage, we didn't know what the exposure was, we didn't know if there were other individuals who were sick. We didn't know anything, any other parts to the story. CDC had a kind of pivotal role supporting the [ministries] of health function within the three affected countries and we were particularly worried about individuals traveling back to the US with Ebola. That was top of my mind. I said to him, "Do not let anybody leave until we can figure out what's going on." Jumping ahead a little bit, later on that night, I found out that their medical director had got on an airplane that very day, just after I had spoken to their director. John [T. Brooks], I think you can pick it up, you've probably tracked the guy down here. Anyway, we'll get on to that. In the end, that turned out to be a bit of a problem. After that we actually set up a kind of mini-incident command center, didn't we, in the hotel.

Bennett: [laughs] Yeah, we took over the business center. On the fifth floor.

Morgan: Yeah, we actually commandeered a room in the hotel to make a little incident command center up on the—yeah, the fifth floor. They had a business executive lounge, a business suite or something, and I asked the hotel manager if he could basically lend us this room, this big suite for a week or so. He said yes, so we set up—outside the Cave we set up this separate room and basically Sarah and myself went up there and basically didn't come out for two or three days. We got Amera [R.] Khan to come up and help. I can't remember who else, but it was a small number of people to start running this as a kind of separate incident.

Q: Just to let listeners know, their hotel is the—I think the full name is, Radisson Blu Mammy Yoko Hotel. Is that right?

Bennett: Yep.

Q: In Freetown, Sierra Leone, which served as CDC's base of operations for the response in Sierra Leone. And the Cave was the nerve center, the real HQ [headquarters] in this kind of basement—windowless, dank room. I haven't been there, I'm just imagining it, where people were huddled around computers and otherwise just taking care of the business of an Emergency Operations Center. The fifth floor would have been what, six floors above the Cave?

Morgan: Right. The Cave was a kind of sub-basement or basement level.

From that point on, I called the ambassador [John Hoover] first thing to let him know that an American citizen was admitted to Kerry Town and that there's likely an exposure. The ambassador also knew people who were working Kerry Town, and actually, a very senior CDC colleague—actually at that time he'd left CDC and his wife was working for Partners In Health. I'm not sure if she still was at that time. Was she?

Bennett: She was in-country, as I think she came out on one of the airplanes.

Morgan: Anyway, there were lots of connections with what was going on. I think maybe I'll hand it over to you, Sarah, to talk about the more tactical part of the response.

Q: If you could start again with your name and what you were doing as part of the response.

Bennett: Sure. Sarah Bennett, and at that time I was serving as the team lead for the infection prevention and control team. This was quite a ways into my deployment, so I had had a lot of experience with health care worker infections. I think what we did was we called Mahesh [Swaminathan]—Mahesh was out in Port Loko on basically one of our satellite epi [epidemiology] teams—to get the ball rolling on the investigation.

Swaminathan: Yeah. So, I guess it was an ordinary day. My name is Mahesh Swaminathan, by the way, I'm a surveillance epi [epidemiologist] in Port Loko, Sierra Leone, at the time. It was an ordinary day in an Ebola outbreak and Sarah called me and basically explained the situation, and I think I may have used some foul language at the time.

Bennett: I might have as well. I don't remember the call. [laughter]

Brooks: I definitely did when I got a call.

Bennett: You just can't help it.

Swaminathan: I don't know if the listeners can imagine, we talk about the Cave and the hotel—we had a much smaller, much darker, much dirtier cave where we were working. There were several of us in a room. The other folks in the room overheard the conversation, my side of the conversation that I was having with Sarah, which involved curse words, “infected,” “sick,” “American,” and “Okay, yes, I will go and take care of it.” [laughter] I think I may have said that actually.

Morgan: Little did you know.

Brooks: Little did you know.

Bennett: You always wanted to work on an outbreak with me. Now you got what you wanted.

Swaminathan: I have to tell you, I was pretty impressed by both my colleagues from CDC who were there, as well as, we work very closely with folks from the World Health Organization. Very quickly, we met with the British military and the medical director for Partners In Health, which was a very interesting meeting. I think he was obviously very nervous and very stressed by what was going on. I think I intellectually knew that this was a big deal, but I don't think I completely emotionally understood that until a few days later when I started seeing things in the newspaper. But I think he was obviously very stressed.

We had a very quick meeting. At the beginning, there was definitely a lot of cooperation from those of us at WHO, the Brits, as well as CDC. Initially, the Partners In Health medical director was a little frightened, a little defensive, which I think is understandable. Then immediately we went to the—I don't know if we can call it a camp.

Bennett: A base camp, the tent city.

Swaminathan: The base camp where—

Brooks: You mean the tent city where they were all living?

Bennett: Yeah.

Swaminathan: Yeah, where this gentleman was staying and—

Morgan: Maybe you can explain what IHP [International Humanitarian Partnership] base camp was.

Swaminathan: Yeah. In that part of Sierra Leone there aren't really that many hotels, if any. Mostly guest houses, and certainly not enough to provide housing for all the responders. So a non-profit from—I believe Denmark—

Bennett: Yes.

Swaminathan: —set up what they call a tent city or base camp. It was actually very nice. It was essentially like if you were with the military: tents, clean water, food, and actually I think the tents had air conditioning too. They were quite nice. A lot of the staff from different non-profits would stay there. In fact, some CDC staff would stay there as well. It was actually a very nice facility, but if you can visualize a city of tents where each tent has maybe six people in a tent, maybe their own little space, but still very close quarters. It was obviously a very tight living space, and also was where maybe about half, give or take, at least a third of the people who responded to the Ebola outbreak in Sierra Leone were living there. Obviously, one of the first things we were concerned about is, this gentleman who was sick, who had he accidentally possibly exposed?

The camp is where we first went because that's where he was staying. I remember it was really hot and it was myself and two other CDC staff who had to interview the hundred people that were there at the time. We set up by the entrance and as people came in, we would corner them and talk to them. Things seemed to be going pretty well, I would say. One staff member got heat exhaustion a few hours into it and no, this wasn't me yet. [laughter] He had to sit down. After several hours of this, we had interviewed like one hundred fifty, some absurd number, very quickly. Then we heard that another young lady who worked for Partners In Health also, right?

Brooks: Yes.

Swaminathan: Wasn't feeling well and had some gastrointestinal symptoms and had also gone to Kerry Town.

Morgan: Maybe just make a point. Looking at it from, at least to their country, the capital and dealing with it and the next step up, the whole issue with the IHP base camp was like a perfect storm. You have one hundred fifty or two hundred frontline responders who are responding to an Ebola outbreak, all living in close—

Bennett: In a high-risk job.

Morgan: Doing high-risk jobs, all living in close quarters. What was running through my mind, at least, was oh no, have we now got an Ebola outbreak in the international community of responders living in this small camp?

Brooks: And weren't there responders from other countries who were regularly departing and going back to New Zealand, going back to Japan?

Bennett: Yes.

Brooks: I remember I was looking at my notes and I kept saying, I need to follow up with New Zealand and Japanese governments.

Q: When you're having these initial reactions and the swear words or whatever are coming out, this is motivating some of that.

Brooks: This is a really like, I could have a—

Bennett: Where you go throw up and then you have to work.

Brooks: —liquefied movement shortly, kind of information. [laughter]

Swaminathan: I think because I was so busy, I didn't quite have the sense of terror that everyone else did until maybe later that day when this young lady was supposedly sick.

That's when I'm saying, okay, that's not good. Then we got a preliminary report that she might have Ebola a couple of hours later, and that's when it really hit home to me. Like oh, this could actually be a total disaster. Actually, it's funny, they told me she wasn't feeling well when I was telling the camp that everything was going to be okay. [laughter] Which is by the way, for future epidemiologists, never tell anybody that they're going to be okay. [laughter]

Brooks: Never, never.

Swaminathan: Never tell them. Then about a minute later I got heated and I passed out. I think people really, when they saw me fall over, I think people really started to panic. I was able to come to after a few minutes, but—there was a lot of panic, they shut the camp down, they kept everybody inside and we had to redo the interviews. It was interesting to see how people respond within the camp to that sort of stress. They had cordoned—they basically asked all the Americans to go into a corner, and so I kind of felt bad for them. Eventually I came and said okay, you guys can—after we talked to them. Most of the people in the camp responded quite well. I think the Americans, I was proud of our people, they said eh, I'll deal, this will be fine. The Brits asked for more beer, which I was very impressed by too. [laughter] But there was a lot of panic, there was a lot of arguing and yelling. People were very upset at this gentleman for getting sick. However, what I will say is by the end of that night, when we then got another call saying that this young lady did not have Ebola, which was a big load off, that initial fear was tamped down a little. But what that left us with was the rest of the response, which was we still

didn't really know that there wasn't an outbreak going on among health care workers, but we really had to confirm that. That's when I realized too that this was probably going to involve a lot of people having to go home and being evacuated, which is an unfortunate thing and also wasn't good for the response. Over the next few days, myself and the rest of the team interviewed maybe almost all of the expats [expatriates] in Port Loko except for a very few. We also interviewed over maybe two hundred Sierra Leone nationals who had come in contact and so forth. It was a pretty big response, and we did it very quickly. This jumps to the end, but what was the whole thing, five days?

Morgan: Yes, four or five days.

Bennett: Yes, not long at all. We got hundreds of emails about it.

Brooks: I was amazed. I was just looking at my notes and it was like, these people were on planes by the 13th.

Williams: Starting to be on the plane.

Brooks: Right, they were getting ready to get on the plane. They were going and then we were scheduling the pickups over the weekend.

Morgan: I think this happened over a weekend if I remember correctly, although the concept of weekends seemed to disappear at that time in my life.

Swaminathan: I think it was like middle of the week, but then a lot of the trips—

Morgan: The reason I remember it was a weekend was that—

Bennett: The flights were scheduled for like Sunday and Monday.

Morgan: Yeah. Once I informed the ambassador, we had an emergency meeting at the embassy, and there's a formal process that the embassy has when you need to medevac somebody. They seek—I can't remember the exact term now, it's some kind of waiver so that they can disclose a person's identity, an American citizen. The deputy chief of mission, Kathleen FitzGibbon, who's a very dynamic and courageous kind of person, said okay, today in the morning I'm going to go down to Port Loko with the senior consular officer. Actually, there's no consul, well, no real consular office in Sierra Leone at the time. She said "Well, I'll go with somebody else." Then they went to identify all the AMCITS, American citizens. In her brilliant way, she made sure that that night she cooked a whole lot of brownies and took some brownies and red wine, I think it was, for the people down there.

Swaminathan: And an excellent pasta salad, actually. She's a very good cook.

Morgan: She got on the road at five or six o'clock in the morning and herself went out there to help you guys deal with it.

Swaminathan: Yeah, and she was wonderful. That next day, I think, wasn't very easy for the Partners In Health team because we had interviewed everybody, we had a list of people and a list of people who are unlucky enough to have been exposed. That was not a very nice conversation to have with them. These are people who—some of them were new to international work, but all of them had come for the right reasons. They wanted to help people. Certainly, there wasn't a ton of encouragement and support in the United States for that. Some of them had not been there very long and now they were faced with reality, that they might have been exposed to Ebola, they might get Ebola, they would have to go home and face some of that stigma. I felt a little bit of that as well because that could very easily be one of us. It's a little different than I think being in the United States, let's say you're with the Department of Health [and Human Services] and you're investigating an outbreak of disease, there's a little more separation I think. This became very personal because one of us could be in that same situation.

Morgan: I don't know if you recall actually that at one point, as the investigation unfolds and more and more information is ascertained, the number of people who are potentially contacts grows. At one point, we had to go through all of the CDC logs of which CDC personnel had stayed at the IHP base camp. I remember us having to track down, I don't think you guys did it. I think we did it.

Bennett: We did not. We actually asked the WHO to track them down and do the interviews with them and then they wrote back saying we don't have any concerns about these individuals other than the risk they would have incurred by being in Sierra Leone.

Swaminathan: Also a lot of people—and this goes to what I think Oliver was saying before—a lot of people had already left and so it was a real big deal to call people. I remember thinking, how am I supposed to call Sweden from—

Bennett: Loko?

Swaminathan: Luckily we had tremendous support from Atlanta for that. But it was—I felt really—it hit a little close to home because I had told thirteen people that day, “I’m sorry, you have to go.”

Brooks: You have to go home on a plane.

Swaminathan: And they’re like, when? Maybe I can go next week. And I’m like no, you have to go now.

Bennett: As soon as we can arrange it.

Brooks: This is John Brooks. I was on the domestic end receiving these people. My job as the Domestic Task Force lead was to organize their repatriation. I had been the task force

lead earlier in the year when the Dallas case occurred under my watch, and the other cases occurred and all that, and I thought, I came back to do this a second time thinking oh, it's all going to be a well-oiled machine, nothing is going to happen the second time. I had gotten to know the Partners In Health folks very well because one of the things I had done on the previous job was develop the training program for people going to work in ETUs and they were the first sets of people we trained. I didn't know any of them individually, but I was very well aware that we had been, as an agency, responsible for training them to exercise proper infection control. I don't know how many in this event were actually part of our—I know some of them were because I found it anecdotally later they had attended it, but not all. That was a little bit unfortunate. They also had to be reminded that you signed something on your contract with Partners In Health that should an exposure occur, you will no longer be able to dictate the circumstances of your return to the United States. I think that was a very hard message because people signed it, at the time they signed it they thought this isn't going to happen. It won't happen to me. Suddenly, it's first thirteen and then maybe fourteen and an increasing number of people, all of whom were like well, I'd like to go back to my family, I live in Boston. I'm like, I'm sorry, you're not going to be able to go back to your family immediately, we need to take you to a place in the United States where in the event you begin to develop disease, you are very close to a center in the US that can treat you. They all had to come back to Atlanta, Oklahoma City, if I'm not mistaken. And what was the other—

Bennett: Omaha.

Brooks: No, sorry, Omaha, Nebraska.

Bennett: Omaha, Nebraska, and [Washington], DC.

Brooks: It was Omaha, Nebraska and DC. When I got this message, I had this very funny thing on the night of March 9th. “Sarah Bennett called—” [laughter]

Bennett: It’s not good when I’m calling you.

Brooks: I think worth the time, and I’m looking back going country code 232. But the message—I quickly appreciated, having done a lot of these repatriations, bringing them to these cities. At that time it had been one-off, and it wasn’t very hard because many of these centers had a bed that they could fill. But now we’re talking lots of people who weren’t really sick, they just needed to be housed—we ended up calling “nested”—until they got through their incubation period and could be told, it’s unlikely you’ve got disease, you’re welcome to be free.

Bennett: Welcome to be free? As if they—

Brooks: Welcome to be free. I mean it’s frustrating because they felt, when I had to work with them later, when they got here, daily, if not twice daily conversations with people who had been part of this group about “we are doing our best to protect you,” and convincing them to stay. We never had to do it, but there were some discussions of, what

if somebody decides to get in a car and start driving, what are we going to do? Didn't have to do that.

Morgan: I mentioned earlier about the medical director, in-country medical director of Partners In Health who jumped in an airplane the day that one of his team was diagnosed positive. I think I—did I speak to you—

Brooks: You did.

Morgan: —and I asked you to get in touch with the CBP [US Customs and Border Protection] and have him detained on arrival.

Q: Customs official?

Morgan: Yes.

Brooks: It was too late, I think he'd already immigrated and he was completely out of contact, nobody could find him. He wouldn't answer his phone, nothing, and nobody home at his address. Folks were trying to locate him because at the time, the greatest fear was he could inadvertently be contacting and possibly infecting other people. Much like the Nigerian story, of another person who got inside information and then quickly departed. Unfortunately, he got sick and died, but this guy didn't. When he was

ultimately found, I can't remember exactly what happened. I don't think his identity was ever revealed. I know Partners In Health staff were livid.

Morgan: I was more than livid. Then very early on in the investigation, I don't know if you recall, we learned about one of their staff got in a needle-stick injury six or seven days previously—

Brooks: And had not reported it.

Morgan: She had reported to him, and his recommendation was to essentially do nothing.

Q: How did you find this out?

Bennett: Just through interviews.

Swaminathan: She told me, when I was—she said, “I was exposed to this man, but I also had a needle stick a few weeks ago,” and I was like, “Oh.” She said, “Is that a problem?” And I'm like—in my head I was thinking, it's not a problem for me because I wasn't stuck with a needle. [laughter]

Brooks: I know. That's one of those things that somebody says and you kind of go, um, a sterile needle maybe?

Bennett: Somehow she had gotten my email address and emailed me and had this—I just reread the email. There's this long email about I spoke to your colleagues, I had this needle-stick injury, and then the very bottom was like, and I just wanted to let you know, I'm having nausea and some diarrhea. I think I called you or Regan [Rickert-Hartman] and I was like, somebody has to go find this woman wherever she is. I think you guys were heading back out to the base camp. But ultimately, she was tested and tested negative.

Morgan: It's interesting, John, that you mentioned about the timeline because a number of things happened in such record speed that—like at the same time as the investigation was ongoing in Port Loko, we had started a whole series of conversations with the State Department and the US ambassador in-country and the National Security Council, which got involved very quickly. We had a number of calls with them and they were really, really worried. We would report what we knew, and it was actually quite amusing even at the time that every time we seemed to get on the call, we had a worse and worse story to tell them because you guys investigating on the ground, as you found out about people's movements and exposures and other people who were queried that became contacts, the number of contacts started to grow. Every time we got on the phone, we had this evolving picture—

Bennett: Twenty-five new contacts a day.

Morgan: The people at the NSC [National Security Council], I think, found it difficult to understand that this was one of these iterative processes. They said, can't you find out what the situation is?

Brooks: And then finally—I can't recall the names of the CDC staff who, within a few days, went to inspect the Partners In Health facility. That organization was trying to do a good job and was dealt a very difficult hand in terms of the facility they were given to work in.

Bennett: There were a couple of facilities involved in the investigation. It was the IHP base camp where people were staying, there was Port Loko Government Hospital where through investigation we realized that that first individual had been ill at that hospital. Then he had also spent some time at the Maforki ETU. I think the second case that then became positive was a Maforki ETU worker, and so there was a lot of focus on Maforki as a potential common exposure for the two individuals. But Maforki has a very complex and storied history in Sierra Leone, and I think Partners In Health was the only organization that was willing to take it on in cooperation with the Ministry of Health [and Sanitation]. Almost every other organization, if they were going to do ETU-level care, were going to build an ETU from scratch, whereas Maforki was this old training facility—

Brooks: I think it was a school.

Bennett: Like a school, but a vocational training school, and it was essentially retrofitted. I saw the school when they had picked out the site, and we were all a little bit concerned about how it was going to work, but there were a lot of people assuring everyone that it would happen. But without a partner organization to really support the facility, you get into trouble with management. I think one of Maforki's bigger problems was that it was co-managed by two different organizations. I think co-management lends itself to some problems when you have issues that do arise, like who is responsible for fixing the problem? You don't have gloves, you have a needle-stick injury—

Brooks: Who's responsible for maintaining the quality assurance and setting forth what are our standard operating procedures going to be and enforcing them?

Morgan: I've got to say, it is quite commendable that Partners In Health actually took this on. At the time—

Bennett: Yeah.

Morgan: —it was November/December, I think December is when they accepted their first patient. There were no ETUs in Port Loko at that time, and they really, I think, did a hugely brave thing by stepping in and opening that facility, but I think were unable to maintain the quality standards that they had back in December. I think those probably had deteriorated somewhat.

Q: When you talk about the co-management of Maforki, are we talking about the government and Partners In Health? Or who are we talking about?

Bennett: Yeah, it was co-managed by the Ministry of Health and Partners In Health. Ministry of Health provided a lot of the staff, and then Partners In Health brought in a lot of the expats to help provide mentorship and do some of the management. But in the end, it was never clear exactly who was responsible for the facility. I think this is probably true for all of the facilities, that it was never very clear that people who were put into leadership positions at the facilities had any experience doing ETU care or managing an ETU facility. It's a completely foreign concept to physicians from the United States. You have to give credit, I think. A lot of partner organizations, not just at Maforki, were struggling with these same problems. Identifying management and safety issues was not an uncommon thing in Sierra Leone and probably true for the other two countries as well. It wasn't so much a surprise that we had problems or identified problems, I think it was a surprise how bad the problems were at that point in the outbreak because we're talking like March. We had been doing ETU-level care since July or August in Sierra Leone, of the year before, so to be March and having these problems—and I think it made it easy to close the facility after this outbreak because at that time then, we had two new ETUs run by different partner organizations that were either coming online or already online.

Williams: I was going to say—this is Ian Williams, one of the deputy incident managers—but it really raised the issue, was this a much bigger problem? Were you actually sitting on something that was going to be much, much worse? There was a lot of

discussion about how you manage that because the logistics of how you get people from Sierra Leone back to the United States, who might have Ebola, is not easy because there are a limited number of planes, there were three planes—

Brooks: Phoenix Air had three planes.

Williams: And you could only have one person at a time in the plane, and it takes seventy-two hours or something to evolve the flight and—

Brooks: Yeah, they ended up—for people who were not ill yet, they could take up to three, in one case, four. But then they had to be able to, should the person in transit develop symptoms, they could be isolated, which basically meant they would put them in a one meter by one meter—

Bennett: Bubble wrap.

Brooks: A plastic box, a bubble, until they landed. Yeah.

Williams: There was a lot of this discussion back at the Atlanta site about what do you guys need to do, to support what you might need and to try to think down the road. There was even discussion with the military because they had a special C-140 [transport aircraft] or something where they could put eight people on it.

Brooks: We had visions of, what if we have to take fifty people today and bring them back to the United States? One, not enough treatment beds. We'll deal with that later, but first, how will we get them in the air so they're on their way home? We were reaching out to hospitals because we had just begun that program to certify hospitals, US based hospitals, able to care for people with exposure or experiencing Ebola virus disease. None were the first to raise their hand. Once money was on the table, a little bit later, a lot raised their hand, which is reasonable, it's understandable. But I think Seattle, King County might have been one of the first ones that said, we can do it. I was on the phone with them, and I said, "How close are you to being ready to really accept somebody, just in case?" I got this long pause. I'm like, okay, think about it and I'll get back to you. Then I also called the Rocky Mountain folks because they have the lab there at the Rocky Mountain Labs with one or two beds at a local hospital for managing people who may have been exposed to these kinds of pathogens in that laboratory. The guy said, "We can't accept anybody, we may have two beds but we have no staff." You know, it's a rural place with no support. Unfortunately, we had to take them off the grid as a place we could house people.

Morgan: It seemed to me that, as we went on identifying more and more potentially exposed individuals—really, at the beginning, the criteria that we had for the controlled movement of people back to the United States were fairly clear-cut. Applying it is not always a clear cut, but it was fairly clear cut. But as you went on, did you say we got up to twenty-five contacts? My impression was it exceeded your capabilities of looking after them back here.

Brooks: Oh yeah.

Morgan: We had to review what those criteria were, and there were a number of individuals who were like, Day Seventeen—

Brooks: That would have been very chaotic, had there been twenty-five people who had Ebola virus disease that needed care in the United States. NIH [National Institutes of Health] could manage one of their beds at a time, maybe two. Emory [University Hospital] could probably do two or three at a time. Omaha was very well staffed, they were amazing, I think they had maybe ten, eight or ten beds and had adequate staff to manage them. But okay, that gives you ten to fifteen beds, what happens to the next ten that are ill? It was really a little scary thinking that we're not going to have a domestic outbreak spreading here, but rather a situation where US citizens who we have to repatriate need to be cared for in the United States and how are we going to manage.

Morgan: We also discussed, and I'm not sure who I discussed it with, but the option of sending people to the MMU [Monrovia Medical Unit] in Liberia.

Brooks: We talked about that, that's right.

Morgan: And how did that conversation unfold, do you recall?

Williams: The issue was, it was decided it wasn't a good option. This is Ian Williams. It wasn't a good option because I think they really couldn't provide the level of care that was going to be required.

Brooks: And they wanted to leave that facility available should Americans in Liberia begin to get ill, so that they could be—

Morgan: There's also the issue that transmission had stopped in Liberia and there was that question, should we be taking people with Ebola virus into a country that had just declared or just had stopped a transmission? Luckily, we never had to.

Brooks: It was challenging. You guys had this awful challenge, and I sometimes think that I had all the First World troubles. I had to find housing for these people. Omaha was easy because their containment unit was conveniently located right close to the bone marrow transplant unit where they had a little hotel. [laughter] So all these people who had been exposed could be housed in individual hotel rooms directly adjacent to the containment unit, which happened to be by the bone marrow transplant unit. It was a good thing that some of these people ended up back there. One of the Partners In Health folks was out running on a track one day, do you remember this? He just suddenly was found down and out. There was a nurse who was out running on the track at the same time and witnessed his falling down, he had cardiac arrest, she revived him and he might have died if he'd stayed in Sierra Leone.

Morgan: I didn't know that.

Bennett: So thankful that did not happen in Sierra Leone!

Brooks: Thankfully, she was a nurse, because she understood that if he didn't have symptoms, then I'm not at risk of getting disease. He was also—I don't exactly recall how long, but with every day that you were away from your exposure your numbers are looking better and better, and he was pretty far out. But he was isolated in the ICU [intensive care unit] for a time, in the cardiac unit for a time because they were still concerned. The hardest ones were Maryland because they put them up at a Holiday Inn, which really, I think it was the Gaithersburg.

Bennett: I'm familiar with that Holiday Inn.

Williams: The HIG!

Brooks: It was the HIG!

Williams: The Holiday Inn Gaithersburg.

Swaminathan: I've stayed at that.

Bennett: Yeah, we all did our officer basic course there.

Swaminathan: That one?

Bennett: Yes.

Brooks: And the guy knew, they got the place because he did all this stuff for basic training for Public Health Service Office, he was really gung-ho about the Public Health Service. He didn't anticipate all the news trucks, which never showed up until—what's her name?

Williams: Nicki [Nicole] Lurie?

Brooks: Not Nicki, but somebody went to visit them. There was some interest and they kept downplaying it, downplaying it, downplaying it and you know—

Williams: I think Nicki Lurie went to visit.

Brooks: I think Nicki did. Yeah. But it was, we did everything we could to keep it quiet. Every night on the news, people would be around and they'd disappear. Atlanta was the hardest one because the health department couldn't—and this was, by the way, after we had told people since November when we'd had a couple of these already occur—an exposed, not ill person needs to be housed—in Maryland, Georgia and Nebraska to be ready if more come. But Georgia had no luck at securing a place, and I think the public

health department people here must have made three hundred calls to people with ads [advertisements] for—all hotels said no, universities and dorms said no. They began trying to rent a place, and they'd get very close to the end of the conversation and then said oh, and by the way, the reason we need the place is X, and that was it. They ultimately found—one of the places was, I believe, owned by somebody who was in part of the health department. At my house, we have a finished basement; we would have gladly let somebody stay there, but I think the optics would have been pretty poor if anything happened. But I was asking neighbors, and I called a number of churches and synagogues which had previously worked with us on one case and had helped come up with a place for somebody.

Morgan: But it was enormously problematic for you guys on the ground in Port Loko because nobody knew where the individuals would go to in the United States. Essentially, they were instructed to get on an airplane sent by the State Department and even when they got on the airplane, they had no idea where they were going to and couldn't tell their family members where they were going to. I can only imagine that there was a sense of conspiracy going around the talk within the Partners In Health team.

Swaminathan: Yeah, there was. It was difficult for them. I had no answers, and this is where I think it comes into, you can call it the fog of—

Williams: War.

Swaminathan: War or fog of an outbreak. Things were changing so quickly, there was a whole world of things that actually were happening back in Atlanta that we weren't aware of and it was very difficult for them, I think. They were like, where am I going to go? And I'd say—

Bennett: What am I going to be living in when I get there?

Swaminathan: Right. I'm like, I don't know.

Brooks: And what will I be allowed to do? Do I just stay in my room or do I—and we worked with the health department folks to arrange for them to have a place to walk, to exercise, to see their families. Maybe they couldn't really get touchy, touchy, touchy feely, but they could be with their families.

Morgan: The State Department was really quite amazing because just as this whole thing started and we realized that there were going to be quite a large number of people who needed controlled movements. As you said, we were discussing whether the DoD [US Department of Defense] should send this airplane, and they really wanted to, right?

Bennett: Yes.

Brooks: Yes, they really wanted to.

Williams: But it was going to take too long to get there at the end of the day.

Morgan: The State Department did this great set-up where they had the three flights from Phoenix Air going in rotating patterns. There was a discussion, is it better to take a large number of people out on one flight or smaller numbers of people out on multiple flights? And then, who do you take out and who goes first and who goes second?

Brooks: In an expanding situation.

Bennett: Trying to prioritize the people going.

Brooks: And we prioritized them, I think.

Bennett: Yeah. You were like, I've got this string of emails where I was like, Sarah's working on a list, everybody chill out. [laughter]

Brooks: You were trying to figure out by the extended exposure, who's top and bottom.

Bennett: Who and when. We didn't know where they were going, so that was hard, you couldn't figure out based on where people lived.

Q: Sarah, could you talk more about that process of how you, ultimately, did prioritize people?

Bennett: Well, I think in the end—some of it was that people were in the ETU in Sierra Leone, waiting on their second negative test because they had had symptoms and they were part of that group of people exposed. They ended up on later flights just because you have to—your second test is seventy-two hours after the first one to be definitively negative, or more than seventy-two hours. That made those individuals easy. As soon as they got released, they got on the next flight just to get them out because being placed into an ETU in Sierra Leone isn't a comfortable, easy experience.

Brooks: We had criteria, we developed criteria on the US side, by this point, as to how to define high risk, intermediate risk or some at risk.

Bennett: Which was a little bit of a struggle for us in the field because we were dealing with the WHO, who had a separate—

Brooks: Definition.

Bennett: Not entirely different, but you know there were just enough things that made it a little bit of a struggle to assign risk. In Sierra Leone, you also had the issue where if you've been considered a contact, often you were excluded from working. But they still had patients in the Maforki ETU, so we ended up coming up with some sort of modified structure that we all agreed on with the WHO and the country offices that allowed us to categorize everybody who is high risk, no working, those individuals definitely had to

come back more quickly. Then we had the low risk individuals that we ended up I think evacuating as well, but we allowed them to continue working as long as they were in-country and being monitored.

Morgan: It's important to note that actually, even today, we have no idea how these individuals got infected. There was a lot of uncertainty as to what was going on. The Partners In Health individual who did get infected really was just so—it was such an unlikely scenario for his infection. Having that level of doubt about why did he get infected and how did the local staff member get infected, and what about—

Bennett: We were unable to interview him initially because he was critically ill and so we were missing, we had pieces put together from like Mahesh and Regan in the field, like interviewing as many people as possible, but we never could actually talk to him until several days later.

Brooks: It was actually, it must have been longer because I have notes that when he was at the NIH—he went to NIH, he was critically ill for a long time and repeated attempts to try and interview him had passed. So by the time, I think he finally was extubated long after everybody was back. He incidentally recovered, I believe, and did fine.

Williams: I was going to say, a lot of this was keeping track of making a line list of who, where, when, where were they in time and there was sort of this daily—at least back in Atlanta, it was kind of like, of the how many people we were tracking, where they are,

where they're headed to, what their risk was and there was a lot of back and forth with you guys.

Brooks: Yeah, we had—it was right around Easter. We had taken Peeps, those little chicks, and we had built little nests and then this was the Maryland nest, this was the Nebraska nest.

Bennett: Did you submit that to the Washington Post peep contest?

Brooks: No, we should have.

Bennett: You should have.

Brooks: But as they left, we put them on the map, where they were supposed to go. Towards the end, as they were finally getting close to leaving, there was a sense of relief that nobody was sick and they had seven days of sitting around twiddling their thumbs. As you pointed out, these are very dedicated people who are doing something they feel very personal about and most of them were clinically quite competent. We began, we had daily conversations, first to try and reduce panic. Once that sort of began to pass, the conversations turned towards well, how good are your data that twenty-one days is really needed? Couldn't eighteen be enough? How do you know that that exposure is riskier than that exposure? I've read all the papers myself and here's my interpretation. I remember having these calls and it was very frustrating because I said look, if I were in

your shoes, I would be doing the same thing. Trust me, I have the same passion about what you are doing and I work in the same—I'm doing what I'm doing for the same reason you're doing what you're doing. If you were talking to me, would you talk me down? Would you want me out there? I think when you were able to turn it a little bit that way, it helped. It also helped that where I had done all my medical training was at a hospital where Partners In Health was started, and I knew many of the Partners In Health staff. I was getting messages kind of through the alleyway of how they were having to deal with their staff, because a lot of these staff were very critical of Partners In Health unfortunately. At least at some point, not all, but there were times. There was a very antagonistic relationship.

Morgan: In the end, how many people were admitted to Kerry Town? Because it was more than one.

Bennett: I think it was three or four individuals after the initial one.

Swaminathan: But several of them had—

Brooks: Three.

Swaminathan: —three, but none of them had—some of them had a gastrointestinal illness, and there was another woman—

Bennett: Right, we had two with a gastrointestinal illness and then one who had evaded, basically, contact tracing and had gone—

Swaminathan: She kind of had substance abuse. Then the other, I think—there was another one who I think was almost somaticizing. I think she was under so much stress that, you know.

Morgan: Yeah. In the end, I remember we were discussing what should we do with these individuals, and in the end we were just saying yes, send them to Kerry Town because in Kerry Town they can rule out—

Bennett: Properly assess them.

Morgan: And then it's kind of, within a few hours they can test them, rule them out and then we can move on.

Bennett: There was a problem though it created because there was a staff member at that Kerry Town facility that had gotten sick with Ebola and had to be evacuated, coincidentally at the same time this was all going on. Several of their staff were then involved in that investigation and caught up in that investigation. Then we had this, I mean, three patients doesn't sound like a lot, but it's pretty high volume to go through an ETU that's not very large. You had that volume coming through. Then when the second individual associated with the Partners In Health facility got infected, there was no space

for him at the Kerry Town ETU initially and he had to go to a different ETU in Port Loko. There had been this understanding that health care workers would be treated at the Kerry Town facility because it was believed to have a level of care that was higher than what could be provided at any of the other facilities. And that actually—I just reread the *New York Times* article about, you know, white American gets better care than black Sierra Leonean staff and some comments by other partners who were staying at the base camp, seeing the investigation happening.

Morgan: Because the Sierra Leonean Partners In Health individual was admitted to GOAL ETU, if I remember correctly.

Bennett: IMC [International Medical Corps].

Morgan: Was it IMC?

Bennett: Yeah.

Brooks: You're saying he stayed in Sierra Leone.

Bennett: He stayed. Well yes, he stayed in Sierra Leone, but he didn't even get—he initially did not get transferred to the—

Morgan: Kerry Town.

Bennett: —Kerry Town facility. He had to go to the IMC facility, which is also a good facility, but it's not the same as the level of care that could maybe be provided at Kerry Town. Although at that time, with the volume going through Kerry Town, their UK [United Kingdom] staff nurse who had been infected and we never found out how she got infected—maybe in the end it might have been ideal.

Morgan: I think they eventually closed it down because we had one of our staff members in the ETU when we had—there's a Partners In Health staff member in the ETU, and then one of the UK military nurses got sick and was in the ETU and I think that they effectively were overwhelmed and stopped accepting any more patients. Because they had gone for weeks without any patients.

Bennett: Then it kind of—we transferred out the Partners In Health guy, our staff person came out as negative, and so then they started taking patients again from this cluster for evaluation, but it didn't leave room for that second health care worker. He did eventually get transferred to Kerry Town, but the optics were not great. It was a difficult thing to manage.

Swaminathan: I think, actually—and this goes into the fog of war—but also how the press reacts. I remember, to me, that's when I felt—that story, I think, made me feel things were a little out of control because a lot of things that were in that story were not true.

Q: Can we talk about this story, what is the story?

Swaminathan: The story was a *New York Times* reporter reported essentially that these two staff members from Partners In Health, one was a Sierra Leone national and the other was an American, had both been infected with Ebola, were both sick, and that the American was instantly whisked away to the United States—

Bennett: To a great facility in the United States where everything is available.

Swaminathan: And the other went to an ETU that provides care to—

Bennett: Everybody.

Swaminathan: —everybody. The implication being that there was favoritism there and more of a racial or colonial sort. It was really, it was bad, because I think as Sarah was saying, there was not space in that ETU. The other thing was that the ETU this gentleman went to was actually very good. It was also very disappointing because they interviewed some expat staff who were a little loose, I think, with their language. The thing in a situation like this is that everybody essentially works very closely together. We all stay at the same place, we're in the same office, and when someone from one nonprofit says something that's about another nonprofit and they're working very closely together, you could tell that the stress in the area became very high. That's when it became very

worrisome because now, are we going to start turning on each other? Are we going to start panicking? It was very difficult and I was very disappointed to see that story because I think as Oliver was saying, I think people who do this kind of work are not perfect, they make mistakes, but they also are doing things that nobody else is willing to do. It's very easy, I think, to be brave in New York City.

Williams: I was going to say, but I think it was a legitimate discussion because going back to sending people to Liberia, to the MMU there, it was decided the care wasn't good enough in our—the one MMU we built, to treat for people in Liberia. No, that wasn't good enough, you had to come back to the United States. It did raise some issues of was there a dual standard of care going on and a discussion. I don't know what the right answer was, but it certainly did raise some interesting discussion points.

Morgan: In the middle of all of this was the question about whether this individual should be enrolled in the ZMapp trial, which is something I discussed in a separate session with Cliff [Clifford H.] Lane and Kevin [M.] De Cock and a number of others. But in the middle of it, there's this big debate going all the way up to the Secretary of HHS [Health and Human Services] about whether this individual should get the ZMapp, and we have it in-country. He never got it in-country, in the end.

Brooks: How did he do?

Morgan: In terms of—how is he—

Brooks: I think he survived, yeah?

Morgan: He did survive. And the local—

Williams: He got randomized, as I recall.

Brooks: I think he might have been randomized.

Morgan: He did get randomized when he got back to the United States because the UK refused to randomize him.

Williams: That's right.

Morgan: The other few things that I remember was that the UK perspective was, at least issues coming across my desk in the middle of all of this—the Partners In Health ETU at Maforki was funded by the UK government. And Partners In Health was funded mostly by the UK government, and that raised a lot of concerns for them, not only in-country, but also back in the UK at the political level because people were asking the question, you're funding this unit, but you're not doing proper quality control. How are you managing this multi, I don't know, million-dollar investment to an organization in Sierra Leone? That caused them an awful lot of problems and they really didn't have anybody who was capable of making the assessment. The work that you, Mahesh and your team,

did was really important for them. One of the after-action things that we did, possibly after you left, was kind of debrief the UK and go through, what are some of the corrective steps. Because they had really big questions like, should they continue to fund Partners In Health at all? We really had to—I mean, we were obviously not the deciders of that decision, but they wanted CDC's technical opinion and WHO's technical opinion about what had happened to inform them. So there were some pretty serious ramifications after that. I think really, that event in Maforki led to the end of Partners In Health doing Ebola care. I think they very quickly transitioned into other projects, which they are very, very well-suited to do, which is supporting primary care and hospital care, working with the Ministry of Health. But really, I think after that, they never—

Bennett: Well, they continued to support the holding unit at Port Loko Government Hospital.

Morgan: That's right.

Bennett: So they would have been handling suspected cases until confirmation, although fewer and fewer patients were going through that system and instead were self-referring to ETUs if they felt they had Ebola.

Morgan: But it also led to the closing of Kambia ETU. Because Kambia ETU also had some quality issues, and after this event, Partners In Health was essentially defunded by the UK government to run Kambia ETU. Which led to a bit of a scramble on our side. I

remember pushing OFDA [Office of US Foreign Disaster Assistance] to push, in their turn, push IMC to reopen Kambia ETU because there were no ETUs in Kambia and that's where the remaining transmission was going on. It sparked another whole chain of actions where we had to essentially push IMC to open the Kambia ETU in rapid speed. So there were some quite big implications from all of this.

Bennett: And interestingly, they ran into problems where they—because it was another facility that was a retrofitted, it was an old leprosy TB hospital, I think, and they had to retrofit it to do Ebola care within the facility. They did a pretty good job, but assessing these kinds of facilities, you can tell how difficult it is to try to do Ebola care in something that's not purpose built for that.

Q: Can I ask, just like in concrete terms, what were the problems that were found in Maforki and that were later found in Kambia?

Bennett: We could start one at a time. The IHP base camp, which was where everybody was staying, was a community of Ebola responders, but didn't really have enforcement of the usual IPC [infection prevention and control] precautions that you saw at every hotel in the country. Which was handwashing at entrance, sometimes temperature checks at the entrance of the facility. They had a medical clinic onsite that was staffed by some Danish physicians or physician assistants, nursing staff, and they didn't really do any screening of people who came in to seek care there. You have these Ebola responders doing ETU-

level care, may or may not have reported an exposure in the facility, but then seeking care at the specialty clinic.

Brooks: With a fever, as you put your hands on them.

Bennett: Right. There were some problems with the screening and how they triaged, particularly the first case that brought this cluster up. A lot of mitigation had to happen at the IHP base camp in order to continue to make it a safer place for people to stay. And then Port Loko Government Hospital, which was where the first patient was working when he became ill, this was not the first time we had been dealing with problems at Port Loko Government Hospital. That was just a continuous problem.

Williams: But he was not doing Ebola care there.

Bennett: He was not doing—he was on a general male ward.

Brooks: Right. He was just working in a general hospital setting.

Bennett: Right, and collapsed on rounds where, of course, everybody then swooped in to help him.

Brooks: That's where all the exposures occurred.

Bennett: All the exposures occurred. You've got a government hospital, and all government hospitals at the time were struggling with infection control, good infection control practices. Then Maforki ETU, I think the most concerning things were the management problems where you did not have enforcement of the policies and protocols that should be in place in an ETU. The way you tell that is when you're going around doing an inspection, you don't see the job aids on the wall that help you with doffing. You don't see the good documentation of the shifts and who's on each shift and when they start the shift and when they end the shift, were they monitored coming in and going out. There were practical problems. Because of the rains, everything floods, so the buildings were up a couple of steps. In PPE [personal protective equipment], where you have limited visibility, people had to go up and down steps on concrete, and then there are gravel pathways everywhere. So there were a lot of potentially harmful problems there.

Through discussions, we did find out that there were two concerning breaches, one in the first patient who had doffed his gloves and instead of doffing the first pair and then continuing with the rest of his doffing procedure, and that last pair comes off almost last, both of his gloves came off. He was trying to doff the rest of his PPE with one bare hand and one gloved hand. That was never reported to any administration-level staff member, but it was through interviews with his colleagues that this was reported. Then the second one was the needle-stick injury that had been reported, but was not handled in the way that would have been recommended for handling a needle-stick injury in a red zone.

Williams: That nurse never got sick, was my recollection.

Bennett: She had some like GI [gastrointestinal] upset, but yeah, never had Ebola.

Brooks: She was never diagnosed with Ebola.

Bennett: Right, and very fortunate. But there was a lot of lack of clarity on whether she actually pierced her skin with a needle or there was a tear in the glove. But these things are very hard when you're covered in PPE to—

Brooks: And it's a very—I mean, it must be an incredibly challenging place to work. But places like MSF [Médecins Sans Frontières], which wrote the book on how to do these and have had years and years—they had the privilege of many, almost decades of experience before these. They were the super strictest people. You come out of the ETU and you stop and there's somebody, it doesn't matter how tired you are, somebody is yelling instructions at you that you must follow and demonstrate things and it's done in a very mechanical way and it's a whole mentality. When a place gets busy, it's an environment that's not easily controlled, not necessarily by your own fault, but just the facility they were given—

Bennett: And MSF had had problems in Sierra Leone in some of their facilities, quite a few infections. I think it just goes back to the, we can do a lot of things to reduce the risk of you being exposed to Ebola while doing ETU care, but it is an incredibly risky job. We

have many examples of health care worker infections where, for the most part, it seems like they were doing everything right or just about everything right and they still got infected.

Brooks: The two nurses in Dallas, in an American ICU, highest level of care—somehow they got infected, and I don't think anybody will ever know.

Bennett: There are just things that we don't understand about all these procedures.

Williams: But also in Dallas, the girlfriend and the kids didn't get infected who lived in the apartment with him for a week.

Brooks: That's right. It was amazing. A radiology tech [technician], while this guy was covered in various body fluids, goes to the bedside. You have to lift him off the cot, put the plate behind him, put him back down, in scrubs. Took a picture, walked away, he never got ill. Never. Family members never got ill. People who touched this guy in the emergency room never got ill, it was only the two nurses.

Morgan: I think there are many, many examples like that where you can't quite—people who had gross exposures are fine and people that had no known exposure, you got ill and died. A really difficult piece at the end, wrapping up with this event, was actually closing down the Maforki ETU. It stayed—well, they had patients in there for weeks afterwards.

Bennett: Until the 17th of March, and then the last three patients were discharged on the 17th of March, so about a week—

Morgan: Maybe about a week.

Bennett: —and a half, but it was a week and a half of no staff. They had no Partners In Health staff because they stopped sending their staff there, so it was just being run with a skeletal Ministry of Health staff.

Morgan: It became an internal political issue in the government because it was a government facility and there was reluctance to close that down, both by the local government and also the national government for various reasons. Actually, if I remember correctly, largely because people were still getting hazard pay. The local staff members were receiving an extra supplemented salary.

Brooks: A salary supplement, yeah.

Morgan: They didn't want to close down the ETU because they would lose their supplementary pay, which is one of the factors of many that—

Bennett: Well that, and there was this—the local community, I think, preferred Maforki because they saw it as “I'm being taken care of by people who understand me and know me.” I remember the second case, he worked there. He had had various medical

encounters, but it was a later encounter where he was told like, you should probably go and be tested, and he didn't because I don't think they were accepting patients at Maforki during that time because of the investigation that was going on. I think he ended up getting home care and then he was really sick and then came to work and then they realized, uh, we have a problem.

Swaminathan: I think this is true for health care workers in general, as a physician I have to guard this for myself, is that you don't have professional distance when you're dealing with yourself or with your colleagues. I think we saw that in this case where this gentleman was sick for days, actually saw some of his colleagues who said you have reflux, you're just not feeling well. They also provided him infusions and so forth outside of the medical system. This also goes to the base camp. You say, these are doctors and nurses, how come they don't have the strictest procedures? I think there could be a little bit of overconfidence, it's easy to be sloppy.

Bennett: Well, and most of us would write off a headache or fatigue easily because you're doing a job in Sierra Leone that promotes the conditions of headache and fatigue. That, unfortunately, is one of the earlier symptoms of Ebola. You're like, I'll feel better tomorrow.

Swaminathan: And doctors and nurses around the world, all of them, are trained to work and continue working even if they are not feeling well. Headache doesn't matter. So you have to overcome that culture. To me, his story was not surprising.

Bennett: Unique.

Morgan: I do look back on the event and wonder whether all the majority of individuals exposed were actually from the UK, whether it would've been handled differently because the CDC's, was a movement—wasn't it monitoring and movement?

Brooks: Monitoring and movement.

Morgan: The M and M, I can remember.

Brooks: Our monitoring and movement rules.

Morgan: The monitoring and movement rules were really much stricter and more detailed than any other country had, so a lot of people were doing this shopping around, looking at different recommendations from different countries and saying, well—

Bennett: Oh, I have terrible emails about that.

Morgan: Right, you know, the UK recommends this or New Zealand recommends that.

Bennett: WHO does that or—

Brooks: Can you send me to France? Why do I have to go back to the United States?

Morgan: That's one of the things that I had left in the back of my mind was, were our rules so complex and difficult that it also generated some of that difficulty for them?

Bennett: I did a lot of assessments of exposed or sick people that were American citizens in-country, and I think it did seem to help to have those guidelines in writing. It was something that was published online and so you can point people to it. Like, I've assessed you at this risk level and this is what we're recommending and here's where you can go to read the guidelines about it and here's more information on Ebola. So that, I thought, was much more helpful than dealing with—we often would be asked by organizations that were American but had employed staff from other countries and those staff, we could provide an assessment but it was sort of up to them, the WHO and that host country. So it actually created, I think, a little bit more nebulosity for the person involved.

Williams: But I would say this occurred after Dallas and the world of what risks were tolerable after Dallas changed. I think that a lot of the guidelines were such that the risk of somebody getting ill, getting infected, transmitting in the United States overwhelmed—the risk-to-infection ratio changed in the favor of no, it can't happen, we need to control it, extremely. That was coming from the highest levels of government.

Brooks: You're right, there was an awful lot of pressure to have an almost zero-tolerance stance here instead of a harm reduction approach. But what you said, Oliver, made me think, there were people who popped up in Spain, Britain, I'm trying to remember—

Morgan: Denmark.

Brooks: Denmark, thank you. Italy? I think there was an Italian case.

Bennett: There was an Australian.

Brooks: Regardless, there were people popping up with Ebola who had come home through routine means, whatever that—you know, commercial travel.

Bennett: Italy.

Brooks: Those countries didn't adopt the same strategy that we chose to try and ensure that persons who may have been exposed were optimally monitored and cared for if they were found to have illness. Was there any other country where a person came home, became ill and then locally transmitted?

Morgan: Well, Spain.

Brooks: Spain, that's right. The nurse with the priest or something?

Morgan: There were two missionaries and they infected one nurse, I think, at least one nurse who then subsequently died. I think that's the only one.

Williams: But I think the reality is if a Partners In Health person got on a plane, got sick and made somebody else ill with Ebola, that was unacceptable. Even though the risk was vanishingly small from all the other experience, there was a zero-tolerance political viewpoint.

Brooks: We spent a lot of time managing this, both from the very beginning and late into the event, trying to help people understand what the appropriate level of concern should be. Would you try to put into perspective the likelihood that a person with Ebola would begin to start a chain of transmission that would be sustained and threaten hundreds of people? It's very hard to imagine in this country, whereas we're all going to drive home in a car tonight, we each have a pretty good risk of being in some sort of car trouble in the next year. It was very difficult.

Williams: I think one of the challenges, at least on the Atlanta side, is trying to balance the political side with you guys actually doing the investigation in the field because there's a lot of need for situation awareness, know what's going on, and you're trying to investigate it and figure out what the heck's going on and there's an awful lot of people who want to know what's going on and want basically no risk to happen.

Bennett: I just saw this email that you had sent me where it had a couple of forms attached to it and you were like, we need all these forms filled out on all of these individuals. I think I wrote something very nicely back to you like, sorry, but it's never going to happen and you were like, well, can you just give them the forms?

Brooks: I know, like let them fill them out because this was the kind of pressure we were getting because you know—

Bennett: Yeah, it was the endless—and now, actually, the strings of emails, I can't even follow them anymore because so many of the strings are about one particular contact and changing their status or one contact fell off the list, we don't know why they fell off the list. There's hundreds of those emails.

Morgan: Looking back on it, my perception of it is dissonant with your experience of it from here because like you were saying, there are a number of other things going on in Sierra Leone. This was not the only game in town.

Bennett: It was a really terrible week, now that we think about it.

Morgan: Like you said, there was an enormous outbreak or we were doing a really large investigation in Makeni, a different district, in which we had to—I was kind of working two phones and the other phone I was speaking to the Public Health Service in Liberia, begging them to send people from their MMU over to Sierra Leone to help on this

investigation, which ended up revealing this huge outbreak, that sustained outbreak in a hospital, in the government hospital in Makeni. There was that going on, was it about five or six CDC staff up there, at least?

Bennett: Yeah.

Morgan: And we had to override the WHO. I basically said, we get in there and we take over this investigation. It was politically quite a challenging thing to do because they were not really making the progress they need to. Then we had, as you said, very shortly after that, our staff member who got sick. No, that was in the middle of it.

Bennett: She came out at the beginning of it, but she was already in the ETU for a couple of days before the Partners In Health person.

Morgan: And then she remained in-country for over a week because they—

Bennett: We had to figure out how to get her out.

Morgan: Right, because they couldn't get a Phoenix Air flight to get her out because they were all being used for Partners In Health people.

Brooks: Didn't we use another service?

Morgan: This is another whole saga of getting a different air ambulance service to medevac her out. In the end, we got her on a commercial flight and she had gotten better, well enough to—she said, I just want to get home the fastest route and that was going to be a commercial flight rather than a private flight.

Bennett: I think in her case too we actually had a diagnosis for what was causing her symptoms.

Brooks: That's right.

Bennett: If maybe we hadn't had a diagnosis and she had still continued to feel a little bit poorly, we probably would have been a little bit—

Morgan: We would not have sent—

Bennett: —we might have made a different decision.

Brooks: But I recall, there were two negative PCRs [polymerase chain reaction tests] and she had some GI syndrome.

Morgan: *Campylobacter*—

Bennett: *Campylobacter* gastroenteritis, yeah.

Morgan: Anyways, that's a major event happening right at the same time. Then we also had the ZMapp saga that was also ongoing.

Bennett: It was the Koinadugu cluster that was newish and nobody could figure out where the heck that came from, and that was in a really remote—

Morgan: We think it was importation from Guinea. Then there was the whole STRIVE [Sierra Leone Trial to Introduce a Vaccine against Ebola] trial thing, is another story, and that was really starting to—

Bennett: And then the Virus Persistence Study team was in-country trying to put together protocols.

SPEAKER: Oh yes, the semen studies.

Morgan: Right, so this was just one. And we've discussed this subsequently, it was almost just another day for us, and we just kind of worked the problem as it were along with you guys in the field and you guys here in headquarters, and we just went through it and just did it. I had no real appreciation at the end of all of that how big a deal it had been here in the US.

Brooks: I think our panic meter started approaching eight, nine.

Williams: I think part of our job was to insulate you from as much of that stuff as possible—

Morgan: You did a good job.

Williams: —because this is also in the context of stuff going on in Guinea. It's sort of the larger context as well, but I think John did most of the work. But I mean, part of it is to insulate you guys so you could actually do the investigation and keep from having people from Atlanta call you too much because—

Morgan: The first time I got an inkling that it was such a big deal was a couple of weeks later. I was in Guinea, maybe three or four weeks later, I was in Guinea and I was in the CDC team meeting in the hotel, the Palm Camayenne in Conakry. I got a phone call on my BlackBerry and there was a US number and I was like, that's unusual, who's calling me? I step out of this meeting and it's actually Secretary [Sylvia M.] Burwell on the phone. I'm like, uh, and she said, "I'm just calling to say thanks for all the work on Partners In Health." I'm like, what? [laughter] That was the first time I had the inkling that it was such a big deal.

Brooks: Yeah, for them it was big. I hope you guys felt supported by what we were doing to help get the people out of there.

Morgan: I guess we were. Mahesh is the guy who was at the sharp end of the stick.

[laughter]

Williams: I know we annoyed you a little bit, but you guys were feeding information so we could feed the beast back here in Atlanta.

Swaminathan: There were times I was worried, but I was kind of like, tell them to be cool, things are fine. When they said they were going to send a C-140, I was disappointed they didn't send one because I had never seen one. But I said, why are you doing this? What if we have to evacuate fifty people and like—

Morgan: You don't have to evacuate.

Swaminathan: You don't have to evacuate fifty people. But they're saying that that could happen. I'm like, it could, but—and as Oliver was saying, there were still people dying from Ebola. People were fixated on this, but we still had to respond and our district was very busy still.

Bennett: It brings that up because there were some community cases that there was a suspicion that they had also been exposed at Maforki ETU because they had dates—they had come in as a suspected case and were discharged from the ETU as a not-EVD [Ebola virus disease], but then later developed EVD in the incubation period and the records put them at the ETU at the same time as the two individuals from Partners In Health. That

part of the investigation continued to happen after that, it was a woman and her mother, I think the mother died.

Morgan: One day we'll get the sequencing data to actually know who infected who and where the exposures came from.

Brooks: Or at least what the pairs were. Maybe directionality may not be easy, but you know the pairs.

Williams: But I'd say a lot of this was the logistics of trying to think three days down the road where you needed to be, given the information you had, while it's sort of all unspooling in front of you. You're doing the investigation and trying to figure out what's the worst scenario, what's the best scenario, what do you need to be so you're not caught in that political reality where something really bad happens and you look like you're not prepared. You were prepared to answer the question. How to strike that balance is a hard one. You guys did a great job of feeding the beast, collecting the information and striking that balance to push the investigation forward.

Morgan: Yeah, I'm really glad I was there and not here during that. [laughs] That's tough.

Bennett: Some things did kind of come through. There was this whole discussion about well, don't you guys have IPC guidelines? And I was like—

Morgan: Oh, yes.

Bennett: —yes, of course we do, but I don't know how to convey to you how incredibly difficult it is to do this in a tent in the middle of a hundred degrees. Maybe you should write guidelines, is what was said.

Morgan: It sparked a line of thinking at the NSC that, why is CDC not applying infection control standards to all of the ETUs in West Africa?

Bennett: Like, why aren't we mandating it and enforcing them.

Morgan: And by implication that we are somehow dropping the ball. The fact that it's not our job anyway, and it really—I'm not pointing any fingers, but the way that we divided the workload was that because CDC wasn't allowed to go into the red zone, we were not doing any IPC in ETUs, but they were in non-Ebola treatment facilities. Another organization with a three-letter acronym was doing IPC in the Ebola treatment units. I had forgotten all about that, there's that really high stress—

Brooks: I remember this too.

Morgan: “Why are you not ensuring that they are using the right guidelines?”

Brooks: But I think we spent a lot of time reminding folks that the reason that no CDC staff have gotten ill, knock on wood, has been that we don't go in the red zone and we can't take responsibility for something that we're not—but we certainly gave people the best available information we possibly could.

Bennett: Well, we were writing, we were participating in writing the guidelines that were being used.

Brooks: Yeah, yeah.

Bennett: It was a particularly difficult—I mean, just to try to explain to people the difficulty of doing that kind of thing in the field. Every ETU is different in-country and they all are doing the best they could.

Morgan: I got a call from—was Dan [Daniel B.] Jernigan the incident manager at the time?

Brooks: Yes, he sure was.

Bennett: Yeah.

Williams: He came sort of at the end.

Morgan: I got a—was it a call or an email? I'm going to say it was a call because it sounds more fun, but Dan reached out to me to say that when we're on these teleconferences with the NSC that we used to do with the ambassador from the embassy, that every time I spoke I needed to start by saying, this is Oliver Morgan, the CDC country director. Because the people at the NSC were questioning why somebody from the UK government was on the call. [laughter] I kept having to say, I'm the CDC country director.

Brooks: Oh, because—I'm so slow, the accent.

Morgan: Because the accent. They got confused as to who I was and why I was on this teleconference with the NSC.

Bennett: I think the other thing that came out of this, and I think it was probably this outbreak more than some of the others that we dealt with, with other partner organizations, was that we made a point to have our staff that might have had exposures interviewed by another organization. I presented this to the foreign medical teams cluster that's run by the WHO, about this need to be transparent about who might be involved and what their exposures are and actually to have an independent review. Because you brought up the statement that you just can't be objective when you're dealing with—you're much more likely to write something off as a non-thing than somebody who has no—

Brooks: You need a third party.

Bennett: You need a third party. And that mentality did not exist, really. I think partly because the funding was tied to performance and if you had a bad experience then your funding was taken away. I don't think this outbreak made people feel any better about that because things were very difficult for Partners In Health afterwards.

Morgan: That remained. In my view, the UK response had a very punitive view towards any kind of mistake that happened in ETUs, and that lasted all the way until the very end of the response.

Bennett: Yeah, and you get partner organizations then not cooperating with an independent investigation.

Morgan: And hiding things.

Bennett: There's some good examples of some scary things that happened because of that mentality.

Brooks: Sort of like the people who choose to do the most difficult job are going to face the worst outcomes and they are punished as a result of it.

Morgan: Right. The thinking was a little bit upside down.

Bennett: Although, I do think that the individuals who were doing the actual high-risk jobs would have preferred probably independent review. It was really the management level at these facilities that were afraid of things like funding or bad reputation or poor media control. It really was very difficult to get partners to open their doors when they had a problem, and trying to explain to people that, if you can do that and we can work together as a foreign medical teams group, then we might be able to solve some of the problems or share ideas. When you've had a problem, we should maybe go back and look and see whether we have the same issue and we just never uncovered it.

Brooks: That's a good lesson for the future, I think, recognizing that in similar circumstances there are going to be partners who are just given more difficult situations to deal with. That being prepared to say if there are bad outcomes, it's not going to be unexpected. Thank goodness they're there and someone is taking care of them. They should be lauded for running towards the fire rather than running away.

Morgan: I think in the end, I think the experience left a very positive dynamic between CDC and Partners In Health. Certainly, you guys in Pork Loko and I think you guys sitting here at headquarters got the right balance working with Partners In Health. They felt a level of trust that we were not going to judge them or be whistleblowers and expose them or anything like that. Very soon after the individuals left the country, some of their senior leadership came to Sierra Leone to take responsibility for the organization going

forward in the country, and they were very respectful and very positive and cooperative. I think here, you guys had a very good relationship.

Brooks: Their medical director came to our EOC [Emergency Operations Center] for a day and a half.

Morgan: Oh, is that right?

Williams: Because, I think, John knew a lot of them and there was a lot of personal relationship phone calls that helped manage and smooth over some of the rough—

Brooks: I was calling a lot of friends on the backside saying, listen, I need to know what you're worried about, here's what we're worried about, we're in this game together.

We're not going to stab you in the back. That doesn't make any of us look right. What can we do to build transparency so that you feel like you can talk to us directly and we can talk to you directly? Their medical director, who I had not met before, lovely man, who actually was from here—he's from Echo Lake and went to the high school over there. He'd always wanted to visit CDC. It was very good for him to see how we operate and he began to understand, he didn't ever doubt our logic before but you really understand when you see what's happening, oh, it is just people like me. It isn't a bunch of secret agents hiding out, tracking people.

Williams: But I think if you get on a conference call with seventy people, which includes the NSC and all these other people, that can freak out the Partners In Health people. They just need a personal relationship and a lot of this smoothing over the edges.

Brooks: Right. I think we would try to do the same with any other organization. If it had been IMC, we would have been looking for people who knew the leadership there.

Bennett: Because we had a good reputation amongst some of the partner organizations in Sierra Leone, not just the American ones, as people who could do assessments of staff—

Morgan: On a Saturday night. [laughter] For some reason, they were always on Saturday night.

Bennett: Always on Saturday nights.

Brooks: Assessments were Saturday night?

Bennett: Yes, at late on a Saturday night.

Morgan: We went through like six weeks of having exposure events every Friday or Saturday night, and they went until two or three o'clock in the morning.

Bennett: It was terrible. I had been there for so long working with a lot of these organizations on other things that you start to develop this relationship with them to garner some trust. WHO was very busy during this same outbreak because they were handling the conveyance of all the non-American citizens out of country, but I guess the response I got from Partners—it just wasn't as transparent or easy for them because their staff were turning over all the time and didn't have personal relationships with a lot of these organizations. They struggled with that a little more than we did. It wasn't easy for us, but it was—

Swaminathan: I think what helps is that they are people in the field, they're sharing the same experiences. We're not out to get them. For things like this, we're teetering on the edge of what is possible and what is impossible. We think about it, no one had ever seen an outbreak like this before. You're doing things that you've never done before in conditions that—you know, I feel like I'm a pretty hardened guy, I work in pretty tough places. But Sierra Leone is not an easy place. I lived off of Clif Bars for weeks at a time. A lot of people don't understand, why aren't you doing X, Y, and Z? It's not that easy. [laughter] Is it even possible? Is it even legal? Yes, we are the CDC of the United States, the US Centers for Disease Control and Prevention. We are not the Sierra Leone Centers for—we can't just tell people what to do.

Brooks: Make them do it right!

Swaminathan: Yeah, and make them do it right. Even in the United States, we can't just walk in and say—I mean, it's funny how people have both—they often have a low opinion of government, but also have an unrealistically high expectation of what government can do. It's a strange sort of—

Morgan: I have not come across any of those individuals from Partners In Health who were in Sierra Leone and who had to return to the US. I personally haven't met them again. I don't know what they're—John, do you know what their view is—

Brooks: Oh, the view of the organization?

Morgan: No, of the individuals.

Bennett: What do they think now that they—

Brooks: You know what, let me find out. That's a great question. I know two people who I've heard about and both were in the end okay with what happened. One was a person who we had already repatriated once for a needle stick back in November or December, had gone back to work for Partners In Health, and had the misfortune of responding when his colleague fell down. He got to go through the whole thing twice. He, interestingly, tried to explain that no, he had been exposed already and was immune. Didn't fully understand—don't fully understand what had happened. Nonetheless, in the end, that's the person I heard from later and was doing well and okay. I didn't hear people later

blasting us for what we did. I think once you have the tincture of time and some room to heal, you look back with more forgiving and better perspective. You know what? It was the right thing to do and if I had gotten sick, I'm glad I would have been in Omaha.

Morgan: My final memory of the event was, remember after those few days, meeting the ambassador? Because we had been in that room pretty much nonstop for that seventy-two hours, in this little incident command center we set up, and literally had been there for pretty much seventy-two hours straight. Then we went out, the ambassador came around, and we went out for a walk on the beach with him on a Sunday afternoon and it was just a beautiful sun setting and there's a gorgeous, huge beach in Freetown. He had also gone through the wringer on this and had also been up like seventy-two hours doing exactly the same for the State Department. I remember, I think it's probably for all of us that it kind of sticks in our minds as a milestone event.

Swaminathan: You know what's funny, I'm going to paraphrase, but Winston Churchill once said, because he was a reporter during the—I think when the Brits were—

Morgan: The Boer War.

Swaminathan: The Boer War. And he said, there's nothing like being shot at and knowing that they missed. You get this sudden joy of being alive. I told this to—actually, during that first meeting in Partners In Health, I said, you're scared now, but when you go back home and you don't have Ebola, you're going to be so happy. I felt like at the

end of this experience, the fact that it wasn't worse, the program wasn't shut down, we didn't have to evacuate everybody—to do this day, I look back and I'm like wow, that wasn't so bad.

Bennett: When you think about it, the response was very, very swift. All these things that happened, I was surprised it was only four or five days. The heart of it was really just four or five days.

Brooks: I know! My memory is like it was a week of time when I was obsessed with this.

Bennett: But when you go back and you look at other clusters that we managed in-country, the ones that dragged on with multiple generations were because we were very slow or did not respond. I think it really does show you that it's really important that you can limit transmission if you get on top of that. I mean, there were definitely a few days where both of those cases were missed by the health care system or the health care system failed them, but in the end, within like three days, you guys had interviewed like two hundred fifty people. We had gotten contacts, and people were going to the ETU when they had symptoms. I think that says a lot about limiting the transmission. I think we're lucky that there wasn't that one subsequent generation because there very easily could have been, based on some of the exposures, or from the needle-stick injury, that would have been completely separate.

Brooks: Or that nobody nesting here became ill. That would have been another real problem.

Bennett: I think that shows the value of really rapid response to try to get people separated from the population. The only other thing I can remember, I was looking through emails, my boss in Atlanta was asking for me to come out of Sierra Leone and I had gotten an email at like midnight on I don't know, some day. I sent it to Oliver and he wrote to you and then you wrote to her, but you couldn't tell her anything. Then there was this string of emails after that.

Morgan: There was botulism in Ethiopia.

Bennett: There was a botulism outbreak in two places in Ethiopia and she wanted me to come out to do that. We had all agreed it was not a good idea.

Brooks: Bad timing.

Bennett: Bad timing, but you couldn't tell her why.

Williams: I think I had to write a very—no.

Bennett: You did, I have that, I have that email still. It makes me chuckle.

Williams: I'm happy to run interference where needed.

Swaminathan: I brought a bottle of eighteen-year Macallan with me to Sierra Leone and I remember when that outbreak was done, six people finished that entire bottle.

Brooks: I think the thing that was most fun for me is I live very close to Peachtree DeKalb Airport, and I had the flight—you get the flight code for each of these planes coming out and you can follow it on FlightAware. It's just that they're not marked, it's an unmarked plane. I remember during all of this, listening, watching the plane come in, they'd first stop at their place in Phoenix [Air] and they'd come into Peachtree DeKalb to do something and then they'd take off and drop off the people for Emory and go on up to Maryland. I was really following this closely because I was like, we've got to get this done. I want to see these people—

Bennett: How many flights? I have in my notes five.

Brooks: There were five flights. There were five flights.

Bennett: But at some point we were planning for seven I think.

Brooks: Right. We were ready for seven, we started with three, moved to four, oh, now we have five.

Bennett: And then in there was that discussion about sending the larger plane. But I think the issue with the larger plane too was that we had all these people waiting on results from their ETU admission and in the end, it was going to end up being small planes anyway.

Brooks: I had this sort of spiritual connection waiting to hear the plane, because it's a very, very loud jet, it's one of the loudest jets that lands at Peachtree when they bring it in. You can definitely hear it, and I knew that was the one. I'd just think oh, now I've heard them leave the country and now they're here, good, next, move them on.

Q: Is there anything else that hasn't been said yet that anyone's holding on to, like I want to make sure that this gets on tape?

Bennett: What do you have uncrossed off on your—

Morgan: I can't read my own handwriting, which is why I didn't cross it off. I remember when we went up to Kerry Town to interview one of the Partners In Health people, it just kind of—do you remember you and I drove out to Kerry Town—

Bennett: Yeah.

Morgan: —to interview, I can't remember her name.

Bennett: Tasha.

Morgan: I was just thinking that because we hadn't really met and we went through—I mean, there's a good example of the three parts of CDC working: headquarters and then the country office and then the field team. I thought that worked really smoothly. And the work with the State Department, I thought, went really, really well.

Williams: It could have gone much worse.

Q: It's an interesting thing, as we were walking in here, some of you were realizing you hadn't ever actually met.

Brooks: Nope.

Bennett: Right. I knew Ian before because we worked together. And I knew Mahesh because we're really good friends and obviously we knew each other. But this is the first time—we've spoken on the phone a million, billion times.

Brooks: Sarah and I had never met. We were on the phone all the time for a couple of days.

Bennett: Yeah. And then during other parts of the outbreak response.

Brooks: Oh yeah, I started to get gun shy when I'd see your number. [laughter]

Bennett: You're like, I don't want to talk to her. It's not good when I'm calling.

Brooks: No, but it was usually good. It was often good news.

Morgan: It's an extraordinary thing for an organization this size that we train and work together so closely, that we're all fairly interchangeable.

Brooks: I wouldn't say we're all experts by any stretch, but we were able to use our relative experience to make it work and that was good.

Swaminathan: I think also, just the expectations of you can say, you're going to do this, and people are like, okay.

Morgan: Mahesh, please go and interview two hundred fifty people by tomorrow afternoon.

Swaminathan: You turn to the office and you say, we need to do this, and people are like, okay.

Bennett: I remember, because when we had to get those two hundred fifty people interviewed, we were like, how the heck are we going to do this? I basically had told you

we need it overnight because Atlanta wants to know now, yesterday. I think you ended up getting interviewers from like Marie Stopes [International] and some of these other partner organizations in-country that were peripherally associated with the response, just to try to knock it out. And then the lockdown at the—

Swaminathan: The lockdown, we did a hundred—that's the thing is that there's a certain, obviously there's a personal capacity in this agency, but also just a strong work ethic and the idea that—

Bennett: Yeah, I had Sophie on our team, Sophia [Greer], she was doing all the IPC stuff and she was just running ragged between three facilities, trying to sort—

Swaminathan: The expectation is you make it happen, and so that felt good that you can just say okay, we have to do this now and that's it. I don't know of many workplaces you can say that, where you can just say, this is going to happen, they are freaking out, but we're going to take care of it.

Williams: I'd say it's a very centralized, decentralized response. The pieces work very well independently, but there's a cohesive sort of response, even though it seems chaotic at the time because everybody is doing their part and there's a lot of communication that happens. People are doing, playing their role, and the right outcome happens. You guys did a lot of hard work.

Morgan: Good team effort.

Brooks: It was really amazing, I was like, wow.

Q: Well, good team effort on this interview. Thank you everybody for being here. I hope this was a great experience. It was great sitting here and listening to you all talk about it.

Brooks: Well, thank you.

Swaminathan: And not a single four-letter word the entire time.

Bennett: I said “heck.” [laughter] It’s better than my interview with John Redd. There weren’t too many curse words in that one, but there were a few.

END