CDC Ebola Response Oral History Project

The Reminiscences of

Tamba S. Alpha

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2017

Tamba S. Alpha

Interviewed by Samuel Robson
March 5th, 2017
Monrovia, Liberia
Interview 1 of 1

CDC Ebola Response Oral History Project

Q: My name is Sam Robson and it is March 5th, I think, 2017. We are here in Monrovia at the Cape Hotel, interviewing Mr. Alpha about his experiences fighting Ebola in the 2013 to ’16 West African epidemic. Thank you so much, Alpha, for being here.

Alpha: You're welcome.

Q: Would you mind pronouncing for me your full name and telling me what your current job is?

Alpha: I am called Tamba S. Alpha. The S stands for Saah, S-A-A-H. Presently, I work with the Lofa County Health Team as the county surveillance officer. That is the job I do.

Q: Perfect. If you were to describe to someone in just two or three sentences what your role of fighting Ebola was, what would you say?

Alpha: Well, I was a key element in fighting Ebola in my county and in Liberia at large. That is what I would say. I played a vital role in making sure the disease got out of Liberia. Yes, I was a vital element in fighting Ebola.

Q: Thank you very much for that. Now just to go back in the past, could you tell me when and where you were born?

Alpha: Yes, I was born on April 20th, 1977. I was born in a village called Gbandu, Foya District. That is in Lofa County, where I personally work. I grew up there and I schooled partly there. Then when the war came, we went into exile in Guinea, a French country, so I went to school there. The school was sponsored by the UN [United Nations] through IRC, International Rescue Committee. It's an American organization that was there for refugees. So I am a product of the IRC's school system in Guinea. After a while, then I enrolled in a nursing school in Conakry, Guinea, after which I did some work there. Before then I was a peer educator. "Peer educator" means one who educates colleagues on sexual and reproductive health activities. That is where the whole idea, concept of health started from. The IRC school system was a British system where you are promoted for tenth grade. You are given the option to go either to be an art student or science student, or whatever student. For me, I was good at both, so the school decided I'd be science. I developed ideas in science, and I became a peer educator thereafter. I became a young men's social club head. Also, it's the same sexual and reproductive health activity. Thereafter, I enrolled as a nurse. Upon my graduation, I taught in a reproductive health literacy school that was also run by American Refugee Committee, ARC. I worked there for some time and then after the war, I came home and I enrolled in my country as a physician assistant. While going to school, I was also working with the Department of Defense for Liberia at the Ministry of National Defense for Liberia.

Q: What year was it that you came home?

Alpha: Two thousand six, January 6th. I returned home and I was fortunate to be trained by the Security Sector Reform committee that was here that was also sponsored by the American people, SSR. I worked for the Ministry of Defense as a health administrator for a couple of years while going to school as a physician assistant. I've worked in a couple of areas in nutrition, providing curative services as a clinician. There, we landed 2014, early 2014, January, I took an assignment in Lofa, my home county, and that was at the beginning of Ebola.

Q: Did you take the assignment before or after you heard about Ebola?

Alpha: Before.

Q: Before?

Alpha: Before, yes.

Q: So you were in Lofa when you started hearing about this?

Alpha: Yes. Ebola historically started in Guinea in 2013, December. I started work in Lofa on January 27th, and Ebola that started in Guinea was not known until April. Yes,

March, April, when there was [unclear], it was known to the world. So I was working in Lofa already before Ebola. We heard of Ebola in Guinea. There, I was playing a different role. I was doing nutrition work. I was coordinating nutrition activities in the county. But there was someone doing a surveillance job in the county, so when the first Ebola came, the first phase of Ebola that hit Liberia, that was in March. When it came, six persons were involved. All six of them died. After the completion of that phase subsided, the surveillance officer quit the job, so I was asked to take over the responsibility, and I took it immediately.

Q: I'm sorry to interrupt. Do you know the reason the surveillance officer quit?

Alpha: Well, I can't tell any reason.

Q: Sure. You could only guess.

Alpha: Yeah, I can only guess and my guess might be wrong or right.

Q: I understand.

Alpha: So, when I took the job, I knew before taking the job there was a lot of denial by communities fighting health workers. But at the time, there was no Ebola in Liberia any longer after the first phase. When I took assignment, the first thing I did was to go to my home because people were calling me, saying this and that, and my home is very close to

Guinea, at the border. One of my sisters was already infected in Guinea. She escaped Guinea, but I didn't know. She escaped and came to my village when I arrived there.

When I reached my village, I went with the purpose of educating them, telling them Ebola was true, what are some preventive measures we can put in place to prevent it. I went because they were denying all the health workers. I am their son. I believe that if I am talking to them, they will better listen to me. That alone taught us the lesson that it's good to always use the community, the people themselves to help to fight Ebola. That is a very good experience [unclear]. So, I went there, I talked to them. When I reached there, already my sister, I told you, was infected. She came back from Guinea. She was the only person that died. Because when I arrived there, a few minutes later, she came. Before she could come, I had already sensitized the people about what to do and what not to do with someone that is suspected to have Ebola or someone that has the signs and symptoms of Ebola. That's where my village, the entire village got saved. The entire village—no one else died throughout Ebola. But the nearby villages almost got wiped out. I arrived there on May 29th.

It is very close to Sierra Leone and Guinea. It is at a triangle. Liberia is here [gesturing], Guinea, Sierra Leone, and my village is here. When I reached there, the next day there was a market in Sierra Leone, so I decided to go there as well, and already Ebola was there because we share common boundaries, villages, we do farming together. Those people too, I decided to talk to them. Before I reached there, there was a village called Gbondu in Sierra Leone. There is where Ebola started in Sierra Leone. There were

already nine persons that died of Ebola, and my sister was as well infected from there. I tried to talk to them because there was huge, huge denial. I learned they beat health workers, they threw stones at their vehicles. I went and talked to them, and even for them they accepted, that very day with call for health team, they accepted for the health team to come in and then talk to them when we went there.

Q: What were you able to say to calm them?

Alpha: Firstly, I went to them as their son, as I mentioned earlier. That even though there are rumors that health workers have taken money to kill you people, I am your son. If you know how you brought me up, if you know the person you know me to be as your son, who cannot lie to you, I'm here to tell you that indeed, Ebola is a disease and it can kill people. We need to do whatever, irrespective of how it came into West Africa. The primary thing is for us to take precautions and to keep safe. That was my key message, telling them how to wash their hands, to reduce contact with each other. Giving—I had some chlorine with me. I took it for them and then provided a bathing bucket, provided it to those villages so that at least they can use it to wash their hands in case anyone thinks they touched something unusual. That is what I was telling them, and I found out people listened to me, and we used that same strategy. Immediately, I returned on the 30th of May.

The cases in Sierra Leone—that is the second phase of Ebola—how it entered Liberia. There was a lady, a pregnant woman, who was infected from the village I mentioned in

Sierra Leone. Gbondu. She was attended to by a midwife and two TBAs, traditional birth attendants. The midwife got sick and was taken to Kenema in Sierra Leone, and she died there. The two TBAs ran away. One of them entered through Lofa and the other came to Monrovia. But at the time, there were sporadic cases now of Ebola in Sierra Leone, very close to Liberia—very close. Those villages, we do everything in common.

There was another death. The second phase of Ebola in Liberia, there were three index cases—three. I've already mentioned two. The third one, a lady attended a funeral in Sierra Leone, and then returned to Foya. Foya is a district, a statutory district in Lofa County. She returned there. These three cases—three index cases—spread Ebola, brought Ebola back in Liberia, that took the entire country. Okay? The one that entered in Foya, that attended a funeral in Sierra Leone, I cannot remember her name now but I can provide it to you later. She came in Foya and got sick, was admitted in Foya-Borma Hospital, and knowing that she was infected, the health workers tried to isolate her. The family came and signed AMA—what is called AMA, against medical advice—they took this lady out of the hospital from Foya. She died in their hands and they buried her. The name of the family she is from is called the Sia Gbembo family. Almost all the Sia Gbembo family, we lost them during Ebola. It is also among them we have the first survivor of Ebola in Liberia. That is how it started in Foya District and it spread. I wish you had the map of Liberia so I can show you where.

Q: Oh, no. I'm sorry. I can imagine.

Alpha: Then the second index case came to Voinjama District. Voinjama is also another district in Lofa County. This case came sick, and because she had a son there who is pastoring the church there, she came sick and they suspected. How did we know they suspected? Because the level of interaction between the family members and the case. This case was admitted to the hospital in Tellewoyan Memorial Hospital in Voinjama. That is the health quarter for Lofa County, the capital city. When she was admitted there, they just used to come, stand at a distance—speak and go—the family. But health workers did not know. At the time, health workers had no idea of Ebola. IPC [infection prevention and control] practices were very zero. I can't say poor. They were at zero. Health workers attended to this lady, the nurse, and the nurse aid that attended to her from that hospital got infected.

Then there was another patient admitted in the same room, a male patient admitted in the same room. The wife was taking care of—the lady was sick—yeah, the lady was sick, excuse me. The lady was sick. Another lady was sick, lying down opposite her, and the husband was there helping that lady. Since this case, the second index case, had no direct caretaker, the husband of that lady became a caretaker supporting her, as well. If she wants to sit, he will help. And he got infected. When he got infected, he infected his wife.

The wife got stable for the sickness she was admitted in the hospital, and was discharged. Just two days later, symptoms of Ebola started on her. Then the husband also got sick, and then they brought him back to the same hospital—the husband. The wife was left home. When that happened, we lost the husband also in the hospital there. But this lady,

the index case, as well died in the hospital. She died and she was buried by the community people. Cleverly, they used IPC methods. Unknown to the county—at that time, no Ebola was declared in the county. But when I saw them going for burial and I asked a colleague, "Who is that?" He told me, "There is a lady that came from Sierra Leone just a few days and died." Knowing that I was right at the border there and I was some of days back in Sierra Leone, I told him, "You have to be careful." He went, he stood, he just observed them. They wore gloves, they used chlorine. At the time, less people had an idea about chlorine. But how? In fact, the immediate family members did not touch the corpse. They took other women age fifty and above from the community to come and bury her. So they buried her. Fortunately, none of them came down with signs and symptoms, but her immediate family, grown children that interacted with her in the house the day she arrived—all of them died. Before they could die—this Mr. Dixon is the one that got infected in the hospital while assisting, Mr. Dixon.

Okay, so Mr. Dixon got sick and also died in the same hospital, and his wife was critically ill behind. We received a call from the clinic that there is a lady here sick, but at the same time, her eight-year-old son was as well sick with fever. This is how we also detected Ebola the second time in Lofa. The clinic called us that we have a woman here sick, the husband died two days ago and her son is as well sick. Before we could arrive there, they have taken the lady and run away to another community with her. When we came, we arranged for an ambulance to go for her. We talk, they agree. When we took her, before reaching Voinjama, she also expired. She died as well. We lost her. It became a tough war. They said the health workers, they're trying to kill people. So we talked with

the community. We asked them to provide people. We trained those people to do the burial themselves. But it was a tough thing. We spent the whole day, yeah, to bury. After we buried the boy, eight-year-old boy was taken away, as well. This boy, they ran with him into the bush. Why into the bush? They also abandoned him because he got critically ill. When they abandoned him, he was walking helplessly. He suffered in a town, another district called Zorsor District. He suffered because already people—everyone knew that that boy was missing, so everyone was looking. When they found him, they alerted us. We told the hospital there, they took him and we took him to the ETU [Ebola treatment unit]. Fortunately for us, he survived. This is how that community built trust in us.

But before I came there, there was a day after the first lady died there, we buried. Another person died. If you have the opportunity to go there, the village is separated by a street—major road from Monrovia to Lofa. Almost half of one side of the village was abandoned because everyone died in that village. So another person died. When we went, we heard of it, we went there to inquire so we can see how we can do safe burial. We went there, we were beaten. I carried one of my district health officers. We were beaten there by the community and we had to escape for our lives.

Q: Oh, no.

Alpha: Yes. So—

Q: What exactly were they doing? They were—

Alpha: They felt we were the ones killing their people. They never wanted us. They had the body, a corpse to bury, they were digging graves themselves. We went there, but they said we have no reason to go in their village and asked us to leave. While we were trying to leave, they came, surrounded our vehicle. I was in the vehicle, held the seatbelt and removed it—beating us. Yeah. Fortunately, we didn't die. We didn't get infected.

Q: Were you badly hurt?

Alpha: I was not injured. I was not injured. But those guys that beat us afterward, all of them came down with Ebola. Because they buried that particular corpse and they died. This is how it started in Lofa. In Monrovia, another lady left and came to Redemption [Hospital]. She suffered. She was sick and suffered at Redemption. I don't have much information about what happened here, but a lot of health workers as well got infected from the hospital there.

Q: I should be spending a day at Redemption in the future.

Alpha: Yeah. So this is how the three cases brought Ebola into Liberia, the second phase. That was as of May 30th, 2014. The first one was in March. Six cases. It also started in Lofa. For the first one, we heard of rumors of Ebola, and then even though we knew nothing, what to do to prevent Ebola, some of us cleverly started going on the net and reading about Ebola. I didn't know about Ebola. Reading immediately and reading about

Ebola and getting some facts of what to do, what not to do. When it came, there was a lady that actually crossed—even though our health surveillance system was weak, but they did what they could do. They captured the case earlier. But there was massive denial. They saw this case—this lady was sick in the hospital there. She was admitted there. But some health workers went to provide care. Two health workers from Foya-Borma. I can as well provide you their details, information. Those two health workers died. The lady in question died in Foya. Then there was a caretaker, a sister, who escaped from Lofa and came to the Grand Bassa [County] area and then moved to Monrovia here and also infected two others. That made it six. All of them died.

Q: Did she infect people in both Monrovia and Grand Bassa?

Alpha: Yes, she did. All those people died. They were six in number. So, this is how the first phase subsided. But there was no lesson learned from the first phase of Ebola. No lesson. It just happened in Lofa. At the time, we did not have testing capacity. We had to take samples to Conakry for testing.

The second phase now, when it started, we decided to organize ourselves as a team. To organize ourselves, the county health team, we pulled some health workers from the facility to join the response team. Then there were organizations, community-based organizations. Those also came in to volunteer after the people accepted it.

But I can tell you one historic thing that made people accept it in Lofa. There was a case we learned, took a corpse from JFK [John F. Kennedy Medical Center]. This corpse was already, according to information, was already in a body bag—a suspected case, and then they took this case overnight. He was a driver. He drove this case to Lofa in a town called Barkedu. Barkedu is a town that more people died in Lofa. Yeah, Barkedu. So he took this body to Barkedu for burial. En route, they removed the body bag and threw it away. After burial, they returned to Monrovia. He got sick. Everyone in the community in Monrovia abandoned him. They asked them out [unclear]. So he hired a car, a taxi, to go back to Lofa. Because at the time for Ebola, we had better experience. We had an ETU. That was the first ETU, the only ETU in the country. He felt he could be saved, so he ran to Lofa. Unfortunately, when he arrived, we were already overwhelmed with people from Zangota. Zangota is where I was mentioning where Mr. Dixon and his wife—okay. Then Barkedu where they also buried the case. We were overwhelmed with cases there. Then Foya as well. All this is Lofa County. We were overwhelmed. The ETU that was meant for fifteen beds, we carried seventy-six patients. We knew it was not the best, but we did that because it was getting out of hand. People in the community, infected people, were moving from place to place, infecting others. All we did was the moment we found you met the case definition, the standard case definition, we took you to the ETU.

Q: How did you physically fit them all in? Did you have more beds? Were people on the floor? What was—

Alpha: Those beds we had critically ill patients, those confirmed already were on the bed. Those that were suspected, we built or we erected a tent within. But this tent, we just poured cement for the floor. You go there, you lie down there. All of them were lying down there. When this fellow came from Monrovia, infected, the ETU was filled full and they could not accept additional patients. They told us no, you can't bring another patient here. This case was left outside there, nowhere to carry—hospitals were closed, clinics were closed. No one was providing services. He demonstrated all the major signs of Ebola: bleeding from the nose, the eyes, the ears, vomiting, toileting. People were standing at a distance to see him. This is how the majority in Lofa believed that, indeed, there's a disease called Ebola. Immediately after that incident, people started pooling in now, coming to the county health team to help. Volunteers, young people, students—schools were closed, you know—coming to say okay, we are available, train us and send us to go and create awareness. The community accepted it and it greatly helped.

This is how we organized the response team. In the response team, I was coordinating the technical arm. We had the bigger arms, the administrative arm, the county superintendent, Honorable George S. Dunor. George S. Dunor was the one heading the response team in the county. Then the secretary for administrative was the county health officer. The then county health officer was called Dr. Josephus Bolongie. He was serving like the technical—the coordinator. Then I, as the county surveillance officer, was coordinating the response.

In the response, we developed pillars. We had social mobilization, we had case management, ambulance services, we had contact tracing. We divided ourselves in this. The staff from the county health team, we pulled all those reproductive health supervisors and others. We pulled them over and said hey, leave everything we're doing now and focus on Ebola. Because our colleagues were even dying in the office. Sometimes you are sitting like me, you and I are sitting. Before you notice, the person will tell you oh, I came to you—my two children have died, my wife has died, I am having fever, please help me. Ah, it was heartbreaking.

Q: Is that something that would happen to you?

Alpha: Yes, and it went to the extremes. People were taking corpses from the community, throw into our office. Yes, bringing to our office.

Q: What would you do then?

Alpha: We are the health workers, they don't know how to take care of it. So they expected us to come. They were calling us but we were not readily available because we were limited. We had a series of challenges. There were no resources to use. No fuel, no gasoline. And it started—Liberia, we have the fiscal year for government operations, finance. We start in June to May the following year. Ebola started in May. The June budget finished late May, May 30th. So I can say it started in June, which is the last month of the fiscal year when all the resources were depleted. Partners had not signed

contracts with government to continue support, so it was a very challenging time. We never had an ambulance. We were hiring pickups to carry corpses, or there's a common vehicle here called Kia motors. It's a form of truck. I have some photos that I can share with you.

Q: I would appreciate that.

Alpha: Yeah, I have some photos I can share with you. What we were doing, we sent a team in the morning, they went. Our priority was those alive, sick. We pick them up, we put them in the ambulance, we take them to the ETU. We take them, and in the ETU, we had Samaritan's [Purse] supporting at the time. During the first phase, because MSF [Médecins Sans Frontières] was in Guinea, they came across to Liberia. They also built that first ETU—MSF France. They built the ETU. MSF France and Belgium. After the first phase, MSF France and Belgium left. When the second phase came, Samaritan's Purse was the one helping us to manage the cases in the ETU. But the cases got overwhelming and some of their staff got infected in Monrovia, so they had to pull out. When they pulled out, we had no one managing, but the government stepped in temporarily to be managing. That was the time I was telling you, the ETU, we had to carry [unclear] persons in a fifteen-bed capacity area. After a few weeks, MSF France came in. They upgraded the ETU. Very wonderful people. Very, very wonderful, MSF France. They are good in managing Ebola. Had it not been them in Lofa, we would go say another thing to them. But they came in and they were willing now to accept patients at any time. They were constructing the ETU—extending the ETU. At the same time

patients are coming in, recruiting new staff, training new staff. We organize ourselves in such a way, management of the ETU was purely MSF France with oversight from us. Supervision, we get the data, we report the data, but they also had their database the staff brought to have their data they needed.

Then at the county level, every case that we picked up every day at the end of every day are compiled [into] the reports and shared with partners in the county, in Monrovia. So we decided to have coordination meetings every morning at seven. First thing, we meet, we discuss, what did we do yesterday? What was there that was good that we can do today? Okay. Even though we have no experience. It was coming. Okay, then today, what do we have to do? Who do we send where? At the time, corpses have come. We have fifteen dead bodies, we have seven persons sick here, we have to send the ambulance. No ambulance. So when the community accepted, people were begging now. Calls were coming in everywhere. You know what we did? We didn't even have a call center. It was my line, the one you called me on.

Q: Really, your cell phone?

Alpha: Yes, my cell phone. My line was the one that was used. That was the strategy we developed. Because if we didn't have a call center, at night people might go to sleep and this, that. We're not going to risk people's lives at night because people were doing bad things at night. Some people were intentionally infecting people.

Q: Really?

Alpha: Sure. Some people. Very few persons, knowing well they are sick, they won't tell you the truth. They will come and tell you a different thing. So we couldn't risk the lives of our staff at night. Besides, Ebola suspected cases, transporting them at night is very risky. Very dangerous. Except if you are in the ambulance already in PPE, personal protective equipment, then we can continue to move with you. But to go in a community at night to look for a sick patient is dangerous. So we were working in the day mostly. Early in the morning we have coordination meetings with the core team. In the evening, everyone reports, submits a report to national. Early in the morning, again we meet. We see what is happening.

There came a time, we said okay. We were doing work, but cases were increasing, so what can we do so by this time next week we have less cases to pick up from the community? We took the decision of increasing ambulance services to pick up cases. This is how we had more cases in the ETU. I went in a community—I was very, very touched. Two instances. One, a lady and her husband got infected with Ebola. The community told them not to go out. They stay in house. They had a two-year-old child, a son. They were in there. The community didn't know how to feed them and to give them food. Two of them died. They left this two-year-old boy alive, and the boy tried to get out and the community told the boy to go back in. He was there. He died of hunger. When I reached there, I shed tears. Each time I think of this, I shed tears. People were not just

dying of Ebola, but they were also dying of hunger and other things, other medical problems.

Q: How were you able to provide—were you able to provide food and resources for people? I know you had very limited resources overall anyway, but were there ways you tried to address that issue?

Alpha: Yes, at a later time, yes, we were able to address that. But at first, when we go in your house and suspect you of Ebola, we're taking you and removing your mattress, your clothing, and we burn everything. We take you to the ETU. Our primary concern was your survival. If you survived, then we can talk of where to find material. When we did that, we were getting into serious trouble. Luckily, the partners—international governments came, the US government, CDC [United States Centers for Disease Control and Prevention] came. When we were first reporting, we didn't have any correct template of reporting. CDC came and they went in Lofa, they installed DHIS2 [District Health Information System 2] for us, a database, and we started entering all our cases in, reclassifying them at the end of every day when we had the results. The lab [laboratory] facilities also, we got help. MSF, instead of doing tests in Conakry, they moved their lab, mobile lab to Guéckédou in Guinea, so we were also carrying our samples there. Even in Monrovia when Ebola started, they were taking their samples to Guinea, so we were getting our samples there. They were sharing results with us through the help of MSF and Belgium.

Then when partners came in, some partners came with different objectives. Some came for psychosocial support. We had people like Liberian Red Cross and other Red Cross societies come in, and we had WFP [World Food Programme] that came in as well because that whole year there was no farming activity taking place there. And Lofa is where agricultural activities are mostly practiced in Liberia. Nothing was done that year, so WFP came in and started supporting us, and Liberia National Red Cross. Survivors that were discharged from the ETU, we were giving them mattresses, mats, and some clothing. WFP would provide food. They started providing.

As the response went, we were getting smarter every day—experience. We decided, to finish the disease, we started the issue of quarantine. If we have a suspected case in this community and a particular portion is exposed, we quarantine them with the help of the community. We can't stop them from doing their normal activities, but we monitor them every day. The community has volunteers. We trained them to monitor their temperature every day—to check them. The moment they report with fever, [unclear] we take them to the ETU for testing. Luckily, at later dates, we had also lab facilities in Lofa. A mobile lab was installed in the ETU in Foya. So we were doing EVD [Ebola virus disease] testing there now.

As I was saying earlier on, another was involving my very self. There was a time I received a call on Sunday to go for a suspected case at about two hundred kilometers away from Voinjama and about almost seventy-five kilometers from Voinjama to the ETU. So let's say roughly 275 kilometers distance. At the time, I had all my staff

deployed to go in the field, and we wanted to finish Ebola. Our target was picking up suspected cases. There was a case called in Zorzor District, a town called Zolowu. This case, there was no one to go. There was a vehicle available, MSF funds hired a vehicle, untrained driver, and they just went to the community and hired a vehicle, two doors, and then pickup. As a pickup. We couldn't find any trained staff to go for this patient, so I had to get onboard. We went, we picked up the case. The case had all the glaring signs. At this time, at about four or five we reached. The distance is far. We picked up the patient, we started coming. The driver told me, "Please, let me ease myself." He went, we had the bedpan in the vehicle that the patient could use to urinate and do other stuff. He just asked me to ease himself and he went and he took that away and threw it away. He threw it in the bush. So we're coming and the patient had nowhere to use, so she urinated in the car and wasted on the car, around the car, everywhere, and it got late. We were traveling at night. Reaching about fifty kilometers away from Voinjama, where I'm basing, we had a problem with the vehicle tire at night. No light. We used my phone's light to change the tire and you could see her vomitus, urine, everything on the car. We exposed ourselves too much. We took her—before reaching Voinjama, she was gone. That was one thing also that killed patients at the beginning of the fight. The actual fight—during the actual fight—the distance of referral. ETUs were not many. It was only when the US Army came in we had a lot of ETUs. But if you have an Ebola patient to travel 275 kilometers, it's more risk, more risk. This patient also, we lost her, and the next morning we took her swab, she was positive.

I was worried—very, very worried. At the time, my family was based in Monrovia, but Monrovia's denial was too high. In Monrovia, here. Too much, so I said okay, since Lofa people have accepted there is Ebola, come here, stay in the house with my daughter. So I took my family there. They were with me. After two days, I had, ay! My stomach—diarrhea. I had diarrhea. I was worried. Because we had a challenge, a serious challenge. Health workers were also those people carrying the infection. We were hiding it. If health workers know they are exposed, they won't tell their family, they won't tell their colleagues. The moment I noticed this, I told my wife. I left the room. I went in and lay in the room. I slept there. Early in the morning, I took my motorbike, I traveled seventy-five kilometers distance and went to the ETU and I reported myself. Because the hero must not die. The hero must not infect other people. I should not be the one to infect my family or other colleagues. I didn't even tell my colleagues. They heard I was in the ETU. Fortunately, I was negative. [sighs] Yes. [laughter] I was negative. After repeated tests, I was negative, so I got discharged. When I got discharged, one of my ambulance drivers that brought me got infected. Yeah, he got infected, he died. Then we also had a contact tracer. He was among the community volunteers that came. He was a former commissioner. He reduced himself to a contact tracer. He was doing contact tracing. He also got infected and he died. So we lost a lot of health workers in Lofa. We lost eighteen health workers, professional health workers in Lofa, and we had one that survived—only one. No, no, we had two health workers that survived.

Q: So you had maybe twenty overall and eighteen died?

Alpha: We had twenty overall, yeah, eighteen died and two survived—two health workers. One of those health workers is personally working with me as district surveillance officer. We had to incorporate these people to keep.

So, we had isolation. At the end, we had food to provide for people. Those communities we isolated—quarantined. Those communities were quarantined for twenty-one days. After twenty-one days. But the first lesson we learned was the use of the community people. Had it not been the community people, we couldn't succeed. Because in a fight, any outbreak, if the community people reject that outbreak and fail to work with the health workers, they will hide patients. Because they are key informants. They are the ones that tell us someone is sick. If I'm sick, I should be the one to tell you I'm sick, I have pain. If the people don't accept, you can't succeed. In public health, we should encourage community engagement, community involvement in our response. Had it not been that—there were a lot of communities we attempted to go into. Each time we go, they drive us with stones. They run after us. But when the community got ready, the leadership worked with us and said hey, gentlemen, we are from the community. We have to go. What we did, we trained their own children to go and work with them. This is how we were able to fight Ebola. Later trainings came to formalize, to finish the Ebola. Trainings came, how to do infection prevention, how to transport, transfer infected patients or suspected patients, how to manage a case in the ETU. All those trainings came later. While we did the physical work, we don’t survive if we were men to survive by God [unclear]. [laughter] Otherwise, I couldn't be here to say this.

So, we have a lot of stories about Ebola. Health workers. No system in place for survivors after some time, now people are coming in. But post-Ebola, there is more yet we need to do. We need to still keep the community involved in what we do. We need to rebuild community trust because it was broken completely. It was broken. Now they were forced to accept because it was overwhelming, they were dying. We need to focus on community engagement so we can build trust and they can trust the health workers again. And that begins with we, the health workers. We need to start doing the best we can for the patient to trust us, to know that we are working for them. Even though we have limited knowledge, but our government is now doing well, prioritizing public health services, surveillance activities, training people. But there is more we need to do with the community.

Q: Thank you so much for this incredible testimony. I'm touched by your strong recommendation of community engagement. What impact did it have—you said that initially when you came, you were able to present yourself as I am a son of Foya, I think you said.

Alpha: Yeah.

Q: Can you talk more about the impact of your originally being from the Foya area on your part in the response?

Alpha: Yes. The impact it had is the trust. I am from there. We grew up together and they brought me up. They know what I'm capable of doing and what I'm not capable—if I can lie or not. They know this. Each time you use the people themselves, their own children to come, you will find out that it will be difficult for anyone of the community to come and harm them. That is one. Because they know he or she is part of the community. And then two, because that person is from the community, they also have a part to say in their community. They have a role to play to protect the community, as well. Then three, this person being from the community has the responsibility to support the community in times of danger, in times of goodness. Besides that, once you are from the community, people tend to accept you. That is one of our own, that is our own. People take ownership of whatever you do. They know it is ours. Yes, high school—I was going to school, they provided one way or the other support for me. Coming to the way there is satisfaction about certain things. If I come to talk to them, yes, they will listen to me because I'm one of their own. Yes, they will listen to me because they know that I can't lie to them. Yes, they will listen to me because they know they sent me to school to protect their lives, to work as a health worker. Yes, they will listen to me because they don't know me to be a cheat. But a stranger, they will not. They will also listen to me because I know the culture. I know the norms, I know what they respect, I know their leadership structure, I know who to tend to for what. They [more] easily listen to me than someone who comes and does not know the culture. They have to read, they have to ask, they have pass through people. Maybe the person they might pass through is not someone people respect, people listen to. You see?

When we were using the community people themselves, apart from me, they knew who to go to who had more influence on the people. They will talk maybe to the town chief, the pastors, the imams—they talk to them and they make these people have control over complications so they can easily motivate them, they can easily convince them on issues. But if you bring people—if you come, sometimes—like you, you come, the way you talk, people don't understand you. Yeah. People don't understand you, then it's difficult for them to take in what you will be saying. But if I speak to them in my home language and tell them hey, this thing can kill people if you don't do this, if you don't do this. I'm your son, I can't lie to you. If I lie to you, what would it benefit me? Where am I going to go? [unclear] I'm from here. I'm here to work for you people. You sent me to school for that, so that was the impact.

Q: But I can imagine that being especially painful for you to see this awful epidemic happening in your own community.

Alpha: Yes, very painful. I can tell you I saw my team members dying. I saw my friends, my schoolmates, my family members dying from Ebola. A lot of people that were very close to me dying, my teachers, and most especially those that were fighting together to save lives. I saw them dying. It came to the point where I would say I was traumatized. I go to bed, I dream of nothing but Ebola. I go to bed, I hardly sleep. If I sleep, I dream I am infected or someone is running after me. An Ebola patient is running after me. Yes, I couldn't—I hardly slept those days. Yes. In my room, everywhere you pass, I have

chlorine there. Everywhere. If I come from work, I don't enter in with my clothing. I take everything out before I enter my room. I go to bed, I had bad dreams, nightmares.

[break]

Alpha: So it was very much painful seeing your community, your people dying of Ebola. The question you had is, today, it's this person; tomorrow, it might be me. Most especially, we are the ones picking people up, and the most dangerous bodies. Your own people looking at you saying, you are the people that are bringing Ebola. We will target you, we will kill you. It was very painful. You were trying to work for them. They're misunderstanding you. It was very, very painful.

Q: How do you explain the initial reluctance to believe that Ebola was real?

Alpha: The initial reluctance for people to believe, I will tell you it was due to several factors. One, where it started from. It started in Guinea. There, it started with denial. People have a myth attached to it, the way it started. People said Ebola came into West Africa through vaccination programs. Because what we learned in December of 2013, there was a vaccination campaign carried on in Guinea, and that was the time right after that time Ebola started in Guinea, but it was not reported. So people think they might have brought Ebola through the vaccination program. That brought this reluctance, this denial. Then also the clinical manifestation of Ebola—very confusing. It made people lose trust in you. You can take the patient here that is talking to you good, with signs of

fever, only fever. You take them to the ETU and you take another one that is critical. The one that was active will die before the one that was critically ill. Internally, you don't know what is happening with the patient. So the way Ebola treats people was also confusing. I can tell you it happened in our case. We took three health workers from one of our hospitals, infected. We carried them to the ETU. Two were there almost bedridden, very weak, very lethargic. Another one was there, active, who told his wife, don't worry, I'm going to come back, I will soon come back, don't worry, this is not Ebola. And when we brought him in the ETU, he died that very night. He appeared strong, but he died. The next morning we were shocked. What to tell the family? The family said, yes, we told you not to go, we told you not to go—you see, they have killed him. He was strong. What about the people that were sick? They didn't die. He that was strong—so that caused a lot of denial. Then also there was some—there is this lack of trust for government. Lack of trust for government. People believe government has done this to raise resources, to raise funding. This is why they encourage people to come to West Africa because government cannot explain to them. Some people believe—it's what you call ritualistic practice. Some people take money to sacrifice other human beings. People believe that brought the denial about Ebola. People attributed it later to so many things, spiritual things. People felt health workers were poisoning their pumps. I can tell you during Ebola, one good thing that I can say Ebola did, it made every village fence their pump. Every village, they fenced their pump. They put a fence around—put a door and lock. They can't allow anyone to enter there without permission. Before, the hand pumps were exposed to cattle in the villages, but during Ebola people believed that they were bringing Ebola through their hand pumps and they were putting Ebola virus in the water, so all of them went on

fencing their pumps themselves. That is a good thing they did. But they had different beliefs about it. That is the reason.

Q: Thank you. You mentioned a couple of people who were vital to the response in Lofa. George Dunor, Dr. Bolongie. Would you mind describing those gentlemen in a little more detail?

Alpha: In terms of what? Their role or their physical appearance?

Q: Actually, just their character. Like who they are as people. And any moments you especially remember of them and their part in the response.

Alpha: Yes. What I do remember for Dr. Bolongie, he is a health worker, that I know him to be. He has this passion of saving lives, making sure people live healthy lives. During the response, those things I remember, he was there advocating. He loved to see his staff on top of information. He loved to see his team do jobs to bring results. He's the kind of person I see him to be. He is one person, I know he believes also in scientific principles. If you tell him something, you should be able to convince him. You tell him why, you should tell him clearly reasons for what you are doing. Once you are able to convince him, he'll give you the go-ahead to do that. Though he had some challenges as well, sometimes maybe the way he argued issues out. People who are not used to him, they take him to be aggressive, okay? Aggressive. All right?

For Honorable George Dunor, well, I'm not too used to him, I'm used to him because of the role both of us played. But what I do know, he is a mobilizer. He is a resource mobilizer because that is the role he played. He is more or less the eye of the president, of the county. He was there making sure, advocating for resources for the response team, and he was there making sure, making contacts to see how we can get help, and then also advocating for most effective communities, how these people, we can pay more attention to them. That's the kind of person I know him to be.

Q: Besides those two, are there other people who will always be in your mind linked with your part in the response who are the most important people when you look back?

Alpha: Sure. I have one I mentioned earlier, we were meeting alone, we were meeting together. The then district health officer of Voinjama District, Dolfesson Jayguwoyein. I remember him. He is a hero—hardworking fellow. He risked his life. Very much he risked his life.

Q: How did he risk his life?

Alpha: He was always in a form to go and pick patients in the community. I will share some photos you might see him in. He had no PPE on. He will go and share PPE to infected patients, and when he is among them standing like this, like ten to fifteen persons, he's standing among them in the community. He contributed greatly in the fight

of Ebola. He was always there. Every time you call him in the morning to go and pick up cases in the community, he was always there.

Then there is also a hero that I remember, I always will remember, by the name of Dr. Clement [Lugala Peter Lasuba]. Dr. Clement, I know him to be the one who drives us to succeed. We were responding with no experience, we had no measurable things to look at and say yeah, this is what we have as an issue. But when he came with his expertise—he is a staff of WHO—when he came with his expertise, he guided all, "Hey gentlemen, yesterday you took five cases in the community, today you have twenty. That means you have done nothing. Yes, there shouldn't be twenty today. If you had taken them all yesterday, or most of the cases yesterday, then today you should be having less." He guided us with simple principles of response. Every day he made sure if he asks you, I want you to go this far. You say okay, I want to go, I don't have these resources. He'd say okay, what do you need? He will make sure he provides and make sure you do the work. If you don't do it, he will go and check. I love him for that. I will always remember him because when he came, we started measuring achievement day by day until we succeeded.

Then, there is this lab technician, Mark Sesay III. I remember he was there collecting samples on dead bodies, on patients, anytime. Anytime you call him, anytime we went in the field. And do you know what happened to us? It's good you have this bottle here. This is what we used sometimes as the spray can.

Q: A big water bottle?

Alpha: Yes. We went in the community of Barkedu. I mentioned one community. The highly hit community. We had over fifty suspected cases to transport. And we had five corpses to bury. That day, we had to go have a meeting with the superintendent, George Dunor, Dr. Bolongie and others, for the community to accept us to take the sick people and bury their bodies. The meeting took a longer time. In the afternoon, they allowed us to do what we were able to do. We had one sprayer and the sprayer blew off. Nothing in account, absolutely nothing in account. And we had a corpse already in our hands to bury. He developed a strategy: this bottle top. He took a needle and put some holes.

Q: Right in the top of the bottle?

Alpha: Yes. Right in the top of the bottle, and put chlorine in, and closed it tightly, and used it this way to spray.

Q: That is a simple and ingenious method.

Alpha: Yes. It was very risky, but we had to do that because we already have the corpses—some were already put in body bags and some were not. We had to bury them that day. That is what fantastic that we developed for the two days we were doing this, no sprayer. We risked our lives. When they took the bodies, the people said that very day, we had to carry the corpse into a mosque for them to purify before we can bury, after

they had taken the corpses to the burial site. I was the respond team head in the field. They came to me and said, hey, if you don't bring our bodies back, you are not going to leave from here. Some of these people were sick. You could see their eyes—very red. Signs of Ebola. Yeah. They come to you, hey, be touching you, knocking you, "If you don't bring our bodies here, our corpses here, you will not go." I have to coordinate. "Gentlemen, please bring the bodies." We talked to them, said okay, for your sake, for your respect, we will allow you to bury these bodies, but next time, if you pick up any corpse here, we must —so we have to leave, you know? Even during the response we had to respect the culture of the people. We had to respect their culture. What we did later, we started training them to do their own burials. We go in a community, we ask them to select their own people. They select them. We train them how to wear the PPE, how to bury infected bodies, suspected bodies, how to collect the soil. They were doing it themselves because some bodies they would tell you, this is a society of bodies you can't touch. You can't touch. So that is what we did. We trained them and they took ownership. They were part of the response team now. Their children were the ones going to create awareness. Their children were the ones burying bodies, and even the ambulances—those that can speak their language were the ones we were sending there to pick up the bodies and the suspected cases and carry to the ETU. This is how we worked with the community. We respected the culture of the community and this is how we succeeded.

Q: So having the community members themselves, a select number of them bury the bodies—when you look back, did that work? Did it increase people spreading the disease at all, or did it really just gain support from the community?

Alpha: Yes, it gained support. I can tell you what my Ebola experience in Liberia and what I do know. None of those people got infected because that was one thing we were very keen on. The moment any of them get infected, we will lose the trust of the community. So we did all we could to give them the best training, and all of them did the burials until the end of Ebola. None of them came down. So—

Q: That's incredible. I had one question, and that was you mentioned that when you came with an ambulance to a community and you had to take people, and there were some sick and there were some dying, you would prioritize the ones who were still alive because maybe you could still save them. But of course, there are people who are more sick than others. Did you ever have to prioritize among people who are sick, which ones you will take and which ones you will leave for now?

Alpha: That is what we did not do. We did not—sick is sick. Because we knew Ebola, the person that might appear stable, might be the most critical one. With that at the back of our minds, we didn't classify patients. We only classify them in the ETU. In the ETU, we have those that were suspected, those that were probable—probable if you had an epi [epidemiologic] link, if you had history of contact with a confirmed case or someone who recently died of Ebola. Then we would classify those people as one category, as probable. Those who just came down with signs and symptoms of Ebola with no history, no information as to they were in contact with another case, or took part in funeral activities, we had allowed a portion for them, and those confirmed, another portion for them.

Q: But were there some instances where an ambulance only has so much space and not everyone could get in?

Alpha: Lots of instances where we had limited space to carry the cases. People were begging, "I beg you, don't leave me here." Because people knew that the more the delay, the more dangerous it is. So people had wanted now to go earlier. The moment they noticed they had the signs—also, resources were limited. When we got ambulances in Lofa, there was no longer confirmed cases there. When all the ETUs were built, we no longer had confirmed cases.

Q: They were too late.

Alpha: Yeah, they were too late. They were too late. But when we had confirmed cases, we were using community vehicles or hired vehicles. These people are not trained as well, so you take their vehicle—after we finish, we disinfect and tell them go. They go and take other passengers and go where they want to go. So we had a lot of instances where there was no space. The day we went to Barkedu where we invented this use of a mineral bottle to use as a sprayer, that day I told you we had over fifty suspected cases in one town. Five dead bodies to bury. We had three vehicles to carry patients. We put patients in three vehicles—ambulances, to go. The first vehicle got stuck in the mud, so others could not pass. We were there detained. When we managed to remove that ambulance, the other pickups were able to pass. We reached Voinjama, and it was late for

us to carry patients to the ETU. The ETU was not accepting patients at night. So they said okay, the patients can sleep—tomorrow we will bring them. So they had to sleep in the ambulance. In the morning, we find three dead. We removed those three dead, and we've got no hospital to put them. Nobody was working in the lab. We did too many bad things, but we did it in good faith. We did it in an attempt to save lives. So there were a lot of instances we never had space to carry people.

Q: In those instances, though do you take first the people who are sickest or the people who show symptoms? If you have to leave some behind, do you leave behind the sickest or the least sick?

Alpha: When we carry an ambulance to an area, before we dispatch an ambulance, we had our teams in the field from the community members themselves. They would call and say okay, we have X, Y number of people. We decide which type of vehicle should go there. As time went by, that did not stay long. As time went by, we introduced these bigger vehicles, those pickups, something like a trailer to carry everyone that can take so many persons in. Yes, that was why we introduced more. At the beginning, if we went in a town, we find fifty cases and only ten can go, those that are prepared to go, those that are willing to go, those that are set—some people will say, wait for me a little. Those people, we pick them first. Even though those who were critically ill, not able to stand, we would pick them first. We will lay them in the car. But among those that were able to walk, we were not even classifying them, we were not categorizing. You who is ready, you get in the car. We move. The ambulance goes and drops and comes back. You wait.

If we have another vehicle, get in. If no other vehicle, you wait the next day. Some people were waiting, they died.

Q: Thank you. I was touched by your description of MSF. I think maybe it was MSF Belgium? Were they the ones who expanded the ETU?

Alpha: France. MSF France.

Q: MSF France. Are there individuals from that organization who you remember specifically?

Alpha: I can't remember their names now. I can remember some people but the name is the problem.

Q: It's okay.

Alpha: Yes, I remember the first lady that was sent by MSF France to Foya, to Lofa. That lady is a genius. She is a mother. She is someone to remember. She's the one that helped us collect most of the cases in the communities and carry them to the ETU. Some people came later after her, they brought a lot of protocol. You know MSF France, we had this challenge working with them. They don't believe too much in government policy. They don't believe in that. But for her, yes, I give her that credit. She worked with government and she was hardworking. At night, you call her, she will tell you, “Alpha, you need a

vehicle, tell me. I have a little money, my per diem, I can provide—you find two vehicles and go for those people." She was very, very helpful. Very, very instrumental. It's unfortunate I can't remember her name now, but I'm sure I will share her name with you.

Q: Oh, for sure, and we can add that to the written transcript so we get that recorded. Can you give me an example of an instance where MSF's distaste for working together with the government affected the response?

Alpha: Yes, there are a lot of instances. MSF had their policies, whether it is in the interest of government or not. In the first area, the issue of data. The patients are Liberian patients. The data is Liberian data. When other people were managing the ETU, we go with collect the data as government representatives. No problem. But when they came, it became a tough issue. We had to inform Monrovia. They said we can't have data in the ETU. So that was one instance. We had to inform Monrovia, and Monrovia told them you have to let one of your communicators go to their office before they allow us to get the data.

Q: Oh, they did not want to let the data managers into the ETU?

Alpha: No, they did not. They brought someone to manage the data for themselves.

Q: Did they share data?

Alpha: Yeah, later they shared, yes. They shared. Yeah, we made publications together, sure, later.

Q: Eventually, did they let the data managers in?

Alpha: Yeah, they let the data managers in. Yeah. What we were doing first, if the patient is managed and discharged or died, the charts are no longer useful in the ETU. We need them at a county level where decisions are made, where data is analyzed. We wanted those forms. They said no. In later days, we ended up going there to photocopy. We carried a photocopy machine and photocopied. That was what they could do. But later, they had to turn them over. I have them now in my office. They had to turn everything over. So that is one instance.

Another instance, they were more involved with managing the cases. Later, they decided to help in the transfer of patients because they had field ambulances they could help us with, so they started going in the community without us, without informing us. They went in communities. They drove there. They went in the communities and people rejected them. Now, they had issues. A lot of issues. Took the wrong patient, gave them a different, wrong name, you know? We had these irregularities. But this, we're not perfect. They were in good faith as far as helping the Liberians. We had an instance where a suspect was tested negative. This person tested negative for Ebola. First test showed us in the ETU, and then later her grandson tested positive, and the son was transferred to the positive unit. She moved there. The lady that tested negative

unknowingly went in the ETU where they have confirmed cases to get out to the son. The son died and she was there. In order for her to be discharged—they felt she was confirmed because she was among the confirmed unit. So they repeated her test—negative. They gave her a certificate of survival. She came in the community and came down with Ebola, infected a lot of other people. We summoned them. We discussed this and then we [unclear]. A lot of people were dead. It happened like two times, three times. We had a little girl, eight years. She was in the ETU very normal. Tested three plus. We don't know how. Then the next day she was jubilating, moving around the ETU, okay, stable. Then after a few days, they discharged her as a survivor. When she came to Voinjama, she came down with Ebola again. Yes. Her specimen was taken outside Liberia even to the US for testing, yes. I think you can ask Dr. [Mosoka P.] Fallah. He will tell you more about this.

Q: Interesting.

Alpha: Yeah. So there were some irregularities, some areas where we felt you needed to work more with government to help prevent such things from happening, but—

Q: Of course, of course.

Alpha: We were getting drowned in the river. Someone who came with a stick to help us out, we appreciate them highly.

Q: You know what would be really helpful—part of what I want this project to do is to highlight not only areas where CDC did well, but areas that CDC could improve, to be a document for history for that. Are there any experiences you had with CDC that you think, maybe this points to an area where they could have improved?

Alpha: CDC, as I mentioned earlier, they came in the county to where I work and they came in and supported the surveillance system, identifying cases in the community. Then they were more involved in data management, data issues. When they came, they installed a database. That helped us a lot. Besides that, we recruited some staff that they helped us to pay for some time. Then apart from that, they joined the European Union lab that was testing the Ebola samples in Foya. They were also involved in that. Besides that, they provided trainings on contact tracing, Ebola survivor management. They provided a lot of good trainings.

Q: Were those trainings useful?

Alpha: Very, very useful. Very, very useful. CDC, normally when we are talking, you don't hear much CDC's name because CDC does not implement directly. They hire people. Except these people keep linking, this money is from the American people, it's from CDC. So that is one area I think they need to look at when they send their money through partners, through implementing partners. Implementing partners need to make it more clear that this money, this support is coming from CDC, from the American people, from USAID [United States Agency for International Development]. Normally, partners

don't sell the donor much except if it comes directly—like the database, what I'm telling you, the payment of staff, they came directly. They did that because it was an emergency. Those things we know CDC did. But there are a lot of good things CDC did that we do not know directly. But we, because we are not at the managerial level—maybe Dr. Fallah can tell you more, but CDC—one thing I know—CDC is still doing and providing surveillance training, field epidemiology training, and I'm one of the beneficiaries. Yes.

Q: You're an FETP grad [Field Epidemiology Training Program graduate]?
Alpha: Yes, and I was the best student for Cohort One.

Q: I don't doubt it.

Alpha: Because of that, I attended a conference in the US on the Global Health Security Agenda and I visited CDC headquarters.

Q: You did? In Atlanta?

Alpha: Yes.

Q: I wish I'd known you then.

Alpha: We had lunch there at your hall. Yeah, CDC—we went into the EOC. They are doing greater things in Liberia. It's not just what they have done, but they are still doing.

Surveillance now in Liberia is in the hands of CDC. Technical. They are giving us the knowledge, because after Ebola, that is what we need. We don't need any longer to wait for international bodies to come to help us fight Lassa fever, fight Ebola. No, we can do it ourselves and that is what CDC is doing. They are giving us the knowledge. They are training us. Soon we will be starting intermediate level. So they have provided our training. They have provided other field epidemiology training or training in public health for Liberians that are in other countries. They are providing such training. And they are supporting our local organization. That is one thing. They got us trained and also they are supporting Liberian organizations to implement programs themselves. They are giving them support to implement. So that is a good thing. Even though we do not see them often in the front, they are behind the scenes, doing mighty things through these people.

For the data that we had in Lofa, we would have loved for that database to stay, even though we sent it to national—we shared with national, but we would have loved for such services to stay in our county knowing that that county always report outbreaks, for such opportunities to be there. So we have a therapist there that can track some of these things.

Q: Is that something CDC could help with, establishing a database in the county level?

Alpha: That is what we want CDC, if they can help—to help us establish a database, first at national, now that they are training us. At national, we have the general database there. Then at the county level, we can have where we can store our county information, and

then we share with national so that the county level would be able to have complete management of our data, we'll be able to analyze the day and time and then take action instead of waiting for national. That is what CDC—they are giving us the knowledge, so we also want them to have the tools, a database so that we'll be able to—

Q: I understand how if CDC announced its presence more and said, CDC does this and CDC does that, that it would help CDC's reputation of course because people would know about it. But would having the CDC name out there more actually help people in Liberia in any way? Would it help the programs themselves in any way?

Alpha: Come again?

Q: So you said that of course, and I know this to be true, that CDC does a lot of behind-the-scenes work. People don't necessarily know that CDC was the one that did it.

Alpha: No.

Q: If CDC made more of an effort to let people know, what good effect would that have on the programs? Or would it have no good effect?

Alpha: Well, I think it won't have any good effect, but it's also good for the sake of appreciation. For people to know, yes, I received this assistance from this person. That's good. And like what I see USAID doing. If they have a donor, if they have a partner

implementing their programs, they carry their seal on their material in the vehicle. Things like that is what we see, so we know it is these people, they have been supported by CDC.

Q: That makes sense. Thank you. I'm just running through my notes again, I know I've kept you here a very long time. I wrote this note down. You had mentioned that there were two moments that really touched you. And I think we got to both of them, didn't we? There was the child who starved to death and then the second time—what was that moment?

Alpha: The second time was the woman that touched my very self when I went in the ETU.

Q: When you had the experience of actually knowing, this is the fear that people have.

Alpha: Yeah, when they get Ebola. And do you know what happened to me? When I suspected—the day I suspected myself I had Ebola, I suspected having some signs. I worried until I started having pains in my heart. Not only that, I lost a phone that I had used for three years. I lost it the same day and I drove a motorbike to go and retrieve a SIM [subscriber identity module] card to the communications center. When I reached, I parked my bike. I went to retrieve the SIM. After retrieving the SIM, I forgot that I had the motorbike. I had to walk half of the distance home. I was completely out. It's bad to

know that you would be dying the next two days. It's bad. Very bad. It's heartbreaking. Yeah.

Q: I can't imagine.

Alpha: I forgot my motorbike there. First time. I walked. When I reached to the motorcyclist area where people pick motorcycles as taxis, I saw people getting on motorbikes. This is how I noticed that I need to get on a bike—then, where is my bike? I knew that, yes, I left my bike somewhere. Yeah. And I went to bed, I couldn't sleep. The moment I have sleep, I find myself dead, they were burying me. I could see my family crying, but I was unable to do anything because I was a dead body. Something like that. It was very stressful.

Q: Yeah. I think that we've covered a lot of really important material here. Alpha, is there anything that I have not asked about, any memories that you have that you would like to share before we finish the interview?

Alpha: Well, the issue of Ebola, we need to document some of the things we did. But we as Liberians for now, we do not have good people, historians like you. We don't have good writers, to help us write what we've learned, what we've experienced. But it's good that when you say things I've done when we recognize them, we share copies so that at least we know we can have some of these documents for our people to learn in the future.

What I want to tell you lastly is Liberia—now, I can tell you if even an outbreak happens here, it is not going to affect Liberians like it did, like Ebola did in 2014-15 because most of the Liberians have knowledge in responding to outbreaks. With that knowledge, we want to tell you we can do some work to avoid the outbreaks from spreading. But what is important that we all need to take note of—the information sharing is key in placing importance with our counterparts, with our neighbors. When a new disease starts somewhere, it is important for countries to take responsibility and begin to know about a disease. Because no one knows when it will surface there. That was the mistake that we did in West Africa. It was in other countries, Central Africa, East Africa. We didn't bother to know about Ebola until it came here and it killed a lot of people, a lot of [unclear]. So if we can take into account such things, those good documentaries we're making, and will both follow those recommendations, any new emerging disease, let International Health Regulations make it a priority for its members to know it and know facts about it so that in case it surfaces—because today the whole world is a global operation. Because of technology, things can move faster. Diseases move faster. It's good that we all are prepared and we share the information in time so that we help to achieve the goal of global health security.

Q: Thank you. And there's one thing I just wanted to acknowledge before I turn the recorders off, and that's that you mentioned that your sister had passed away, and I'm sure people you knew and friends, and I am sorry. I'm sorry. Thank you very much, Alpha. This is great.

Alpha: Thank you.

END