CDC Ebola Response Oral History Project

The Reminiscences of

Michelle Dynes

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Michelle Dynes

Interviewed by Samuel Robson
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Interview 1 of 1

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Q: This is Sam Robson, here today with Dr. Michelle Dynes. Today's date is February 10th, 2017, and we're in the audio recording studio at the CDC [Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. I'm interviewing Dr. Dynes as part of the CDC Ebola Response Oral History Project. Michelle, thanks for being here with me. For the record, could you please state your full name and your current position with CDC?

Dynes: Sure, thanks for having me. I'm Michelle Dynes and I am a nurse epidemiologist here at CDC. At the time of the Ebola epidemic, I was an EIS officer, Epidemic Intelligence Service officer. I'm currently with the Division of Reproductive Health with their global health team.

Q: Thank you. If you were to give someone a capsule description—and this is probably hard, but two to three sentences—of your role during the Ebola response, what would you say?

Dynes: Broadly, my role was on the health promotion team. We had lab [laboratory] team, epidemiologist team and health promotion team and I was on the health promotion

team, focused on community interaction and anything that would help promote awareness and understanding.

Q: Thank you. Backing up, can you tell me when and where you were born?

Dynes: Sure, I was born in La Crosse, Wisconsin. I am from the Midwest. I grew up in a little town in northeast Iowa and actually went to college in the same town that I grew up—I went to Luther College as a nursing major.

Q: You were born in Decorah?

Dynes: You know Decorah?

Q: I am from Iowa.

Dynes: You are?

Q: Yeah. [laughter]

Dynes: That's awesome.

Q: Like all of my cousins went to Luther for college.

Dynes: I went to Luther. I'm so happy. Luther's awesome.

Q: Yeah, they tell me.

Dynes: Where did you grow up?

Q: I grew up in Ames.

Dynes: Okay, that's great. I love Iowa people.

Q: Okay good, me too. Well, can you describe Decorah or that area a little bit?

Dynes: Yeah, sure. Most people think of Iowa as being flat and all crop land and boring, and Decorah is the opposite of that. Decorah is the northeast corner, and if people understand the geography well enough, the eastern border of Iowa is the Mississippi River, and along that is a really beautiful area of hills and bluffs. Decorah is kind of picturesque. In fact, I think it was named the—most recently, something about the nicest small town in Iowa because it's so beautiful. It's probably a population of around ten thousand people. But it was settled by Scandinavians, and so it has a very Scandinavian feel and the King of Norway comes to visit several times in the past couple of decades. It's just an amazing place to grow up because with a small liberal arts college you had access to arts and music and things that you wouldn't otherwise, so it was great.

Q: Thank you for that. What kinds of things interested you when you were growing up?

Dynes: I was a swimmer, so that was my primary physical activity. I really liked swimming. Let's see, in high school, I was really into speech and drama-type activities, so that was my group of friends. In Iowa, in general, speech contest is a really popular thing. You have these large group speech contests and small group speech contests and individual speech contests, and I loved that stuff because I got to spend time with my friends doing it and being creative. It was fun. Those are the types of things I loved to do. I also played tennis, not that well, but it was fun anyway. But I kept really busy growing up.

Q: Do you remember any topics of speeches that you gave?

Dynes: Always kind of a human rights bent to them. I always had that interest in social justice. One that had nothing to do with social justice issues, but kind of in a way, was a choral reading group, and it was the anniversary of the Bill of Rights. We did our whole choral reading thing, I don't know what you would call it, performance on that and that was really interesting and fun now looking back at that.

Q: Cool. Oh, I forgot to ask, were you raised by your parents?

Dynes: Yes. I was raised primarily by a single parent, my mom. My dad died when I was a toddler, suddenly from a heart attack. So it was my mom and my brother and sister.

Q: What did your mom do?

Dynes: She was a secretary. She was a stay-at-home mom at the point that my father died, and then started working as a secretary after that. Eventually, I think I was in maybe third grade, she got a job at Luther as a secretary. That's why we moved to Decorah from Waukon, which is not too far away. And then that's where I grew up. That was my connection with Luther.

Q: Can you tell me about then going to Luther and what happened there?

Dynes: Yeah, sure. I started off as a biology kind of pre-med major, and probably half a semester into it, I realized I didn't want to do that, and that nursing was a better fit because nursing, there's just a much bigger connection with people. Your job is to take care of people and have that connection. For me, that was a much better fit, and I went straight into the nursing program from there. We spent our junior year at Mayo Clinic in Rochester, [Minnesota], doing clinical work. I did an internship at Mayo the summer of my third year in nursing school and then ended up working there on weekends through college. Luther was fantastic. I got involved with things that really mattered to me. Things like sexual assault awareness on campus, anything that had a reproductive health focus—at that point in time, I was already starting to go in that direction. Then, one of my last semesters at Luther, I had my OB [obstetrics] nursing class, and for that class we got matched with a couple who was pregnant. We would go to prenatal care visits, we

would go to their delivery, go see them after, and my couple actually had a midwife that was a nurse midwife who worked at the hospital in Decorah. I felt so lucky at the time because I really didn't know anything about midwifery, and I immediately knew this is what I need to do. I started thinking about applying for graduate school right away.

Q: I'm going to pause this for just a second because a little notice jumped up on the screen behind you.

[break]

Q: Also, one of my good friend's moms is a nurse at Mayo.

Dynes: Oh, really? Are we—

Q: Yeah, we're back now.

Q: I actually worked at Mayo as a midwife for a very long time.

Q: Gotcha. Neat! [laughter] Can you tell me about this person that you met, the midwife. Did you learn a lot from this person?

Dynes: Not really. I didn't learn a lot from her because I didn't have a lot of interaction. It was really the role that I was drawn to. I knew going into nursing that I wanted to do an

advanced practice nursing option because I really saw myself more in an independent role as a clinician. When I realized or recognized that midwifery was an option, I just knew immediately that that was the right option for me. I just feel lucky that our paths crossed, even though I don't really know this midwife and I didn't get to know her, it didn't matter.

Q: That makes sense. So I suppose you graduate?

Dynes: Yep, I graduated from Luther and I worked for a year while my fiancée was finishing Luther and then we got married a year later. Then we moved to New Haven so I could do graduate school at Yale for two years. That was a Master of Science in Nursing with a focus on midwifery.

Q: What was that like?

Dynes: It was awesome. I remember coming home for Christmas that first Christmas, or Thanksgiving, one of those, and realizing I was going back and in my next clinical we would be delivering babies for the first time, and that was amazing. But it wasn't just the delivering babies, it was just all of the interactions with women, with adolescent women, trying to understand their reproductive needs. I was really drawn to more vulnerable populations, minority groups who didn't have health insurance, or refugees. That was always my interest. So from Yale I graduated, I was twenty-five, midwife, and I started working on the Yale [Midwifery] Faculty Practice. Worked on that for two years while

my husband went to graduate school at Yale. When that was finished, we decided to move back closer to home. I got a job as a midwife at Mayo Clinic, and then I was there for seven years.

Q: Okay. What was your husband going to school for?

Dynes: His master's degree is in environmental science. He was at Yale's forestry school [School of Forestry & Environmental Studies].

Q: Can you tell me just a bit about those seven years at Mayo?

Dynes: Sure, it was a busy seven years. About two weeks after I started, my first baby was born, Forest is his name. I like to be productive, so just try to imagine these seven years and how much can be done in seven years. Basically, I would say in these seven years I became an expert in my field as a midwife. I started a Centering Pregnancy program, which is a group prenatal care program. I did not design that—it's something that's very common around the country, but Mayo didn't have a program, so I started that. I recognized at the time that our Somali refugee women really weren't getting their needs met in our prenatal care system, so I developed a completely new system, prenatal care system, specifically for them and I implemented that. After Forest was born, three years later we adopted a child from Ethiopia, Amara is her name and she was two at the time, and then two years later we adopted our third child, Shen, who was two at the time and he's from China. That was, okay, family was set at that point. I had done these two

different—implemented these two different projects, including getting funding for them. I was just doing the work of being a midwife, which was crazy, especially the first few years because there are only four midwives and we were on call every fourth day, basically. Then I decided, I don't know if you want to hear this story, but this is to me, really was a pivotal moment.

Q: I think I do, yeah. [laughs]

Dynes: When Forest was a toddler, or this was when he was almost three, we were just about ready to go to Ethiopia and adopt our daughter. I decided to go to our midwifery conference that year, which was in [Washington], DC. And DC has a big Ethiopian population, just in general, so we went and had our first-ever Ethiopian food meal there, my husband came along on this trip. I went to a global health session, and it was like a round table, you could pick which round table to go and hear about. There was a sign and it said "Ethiopia" and I was like, I'm going to hear about that, whatever work is being done there. It was a project called Home Based Life Saving Skills, which is basically a program that was developed to reach people who don't either have access to facilities for delivery, which is really common across Sub-Saharan Africa, or people who can't get to a facility for some reason. It's a training program, but it's community-based and it's meant to train family and anyone who might be at a delivery. I was immediately touched by that project, specifically, and I felt like hey, we're going to Ethiopia to adopt a child and we're getting so much from this, what can I do personally to give back to, not just Ethiopia, but women everywhere? That really led me down my global path, journey.

I signed up right away to get trained in Home Based Life Saving Skills. I spent a month in Bangladesh, took a month of vacation time from Mayo and went for a month and helped to implement that program. Then I started an MPH [Master of Public Health] program from the University of Minnesota in maternal and child health, and I did that while I was working full time. Finished that, spent another month in Bangladesh, and at that point, I was fully and a hundred percent committed to global maternal health and I felt like I had done everything I could do at Mayo. It was seven years in, all my children were part of our family, did the MPH, implemented projects that I felt were important, and I was ready to move on. I think most clinicians, if they're honest with themselves, would admit that they feel like they reach a point of plateau in their career, and I was there. I had plateaued—I couldn't do anything else at Mayo. I couldn't continue to take a month of vacation every time I wanted to do global health work, so I felt like this was a good transition. That's when we moved to Atlanta so I could do a PhD program.

We moved to Atlanta, I could work with Lynn Sibley, who is an anthropologist and midwife, nurse midwife, at the [Nell Hodgson Woodruff] School of Nursing at Emory [University]. She was doing exactly the type of work I wanted to be doing, and so she was my mentor and my advisor. We were leaving a very comfortable life in Minnesota because my husband was a stay-at-home dad, I was a nurse midwife, and we were very comfortable there. We were leaving my salary and totally jumping into a new life trajectory here. and he was on board. In fact, I remember our anniversary the summer before that I had been saying, "I think I might be interested in a PhD program." He, the

card was little cut-outs of things from Georgia, like it was a peach and I can't remember the other things, but it said—it must have been our ten-year anniversary or something like that because it said, "The last ten years were great, but I know the next will be even better." It was basically saying I'm onboard, let's do it. So we completely moved the whole family and started over. I said I'm going to do this PhD as fast I can because I know this is hard on my family, so I did it in four years and I did research in Ethiopia on maternal newborn health. During that time, I also did a few other types of global health consultancies, so I was just increasing my experience. Once I finished my PhD, I applied for EIS. I was initially put on the waiting list and then found out just a couple of weeks later that I was in. I got matched with the Emergency Response and Recovery Branch, which is within the Division of Global Health Protection.

Q: Right. Do you mind if I ask a couple of follow-up questions?

Dynes: Sure.

Q: You mentioned this person, Lynn Sibley, you worked with, and that she was doing exactly the type of work that you had wanted to do. Can you describe a little more specifically what that means and how she might have influenced you, and those years getting that PhD and what you learned?

Dynes: Sure. If you remember back to the moment in DC where I realized there's this program that existed, Home Based Life Saving Skills, Lynn Sibley was one of the authors

of that program. When I was in Bangladesh and helping to implement it, that was Lynn's project. That's when I got familiar with Lynn Sibley. I remember being in a car in Bangladesh with Lynn and she was telling me about her PhD students and the type of work they were doing, and I just remember thinking, for probably the first time in my life, that I really understand why doing a PhD is important. And that I could see myself doing that. Because I really thought when I went to Yale and I was a midwife that that was it, that I had really reached the thing that I wanted to do for the rest of my life. It's just an evolution of life and career path, and so that moment in Bangladesh with Lynn solidified my interest in doing a PhD program. Then, in the program, she taught me how to not only care about the numbers, but care about—we're not just measuring what has happened from a maternal mortality standpoint or newborn mortality, but it's the why and the how that really matter. You can measure the numbers all you want, but it doesn't matter if you can't do anything about it. It's the social science aspect, the behavioral science aspect that really touched me and pulled me in. As an anthropologist, I think that's what I got from her. I had two other people on my committee that were really influential: another anthropologist, Craig Hadley from Emory's [Department] of Anthropology, and then Rob Stephenson, who used to be with Rollins School of Public Health at Emory and now he's with the University of Michigan. Collectively, the three of them were so influential on my research, and so my research was just this amazing amalgamation of their insights and what I could draw from them. It was mixed-method, so I had qualitative work and quantitative work, followed by qualitative work again, and it was amazing. I felt I came out of that with so many skills and such a good foundation for doing good research.

Q: Thank you for describing that. Sorry, back to—you said you were matched with ERRB [Emergency Response and Recovery Branch]?

Dynes: Yes, ERRB. They were looking for someone who would focus fifty percent of their time on reproductive health and fifty percent of the time on just anything that came up. I remember getting the email from EIS with the list of potential positions, and it was one of the first ones on the list, just randomly, and I read it and I remember thinking, that's what I want to do. That's the one I want to do, because it wasn't just the reproductive health, but it was the vulnerable population side of reproductive health. It was refugees or internally displaced persons, people in really dire circumstances that needed reproductive health services. It was a perfect fit for me, coming from Mayo and doing the work with Somali refugees and everything, it was perfect. I tried really hard to get that position, I ranked that position number one because we have to go through a ranking process, and I was luckily matched with that position.

Q: What happens next?

Dynes: I started EIS, and it was unsurprisingly crazy from the beginning. I started in 2013, and we had our month-long course in July, and in August I went to Jordan and spent a month there at Zaatari refugee camp, which is about ten to fifteen kilometers from the Syrian border. I was doing an evaluation of their reproductive health surveillance system. It was during that time when the chemical weapons had been used and there was

all this concern because we were so close to the border that the camp could be impacted. The camp at the time had 120,000 refugees, and it was growing and growing by the moment. It was an interesting time to be there because this was early on in the Syrian crisis when the world hadn't decided what they thought the US's role was in that. Everyone in Jordan, including taxi drivers and everyone, if they found out you were American they would say, Americans should stay out of this issue. This is our region, they shouldn't bother with it. And then you had all the refugees saying, why isn't the US doing more? Why aren't they doing more?

The day that the chemical weapons happened I was interviewing a midwife in one of the small clinics inside the camp and our driver came up and he said, "Come on, we have to go." He was not running, but walking fast to the car. We all got in the car and I turned around and as we were driving away, they were starting to protest within the camp because of the chemical weapons use that had happened and the group was coming up over the hill as we were driving away. I don't think there was anything violent that happened that day, but it was just this idea that it's a mass—it's a large number of people and you never know what can happen. You know you realize when you're doing things like that how many different sides there are to every situation, and what can we say to the refugees who say, why isn't the US doing more? What can you say to that? There's nothing you can say to make it better. Then you have the complete opposite of that outside of the camp, so it was interesting.

That was a month, starting in August. Then I had two trips before Christmas to Haiti, doing a gender-based violence study in Haiti. Then I had three weeks in Tanzania in a refugee camp, Nyarugusu refugee camp in Kigoma Region, and that camp at the time had primarily DRC [Democratic Republic of Congo] refugees and some Burundi refugees. Now, there's a lot more Burundi refugees there because of the more recent issues. But that was a neonatal mortality study that I worked on there. I came back from there, so that was in November, I think I had another trip to Haiti in December, probably three more trips to Haiti in the winter, spring, spent a month there in the spring, and then went to Sierra Leone in August. This was just the start of my second year in EIS when I went to Sierra Leone.

Q: Right, wow. August 2014?

Dynes: Yep.

Q: What had you been hearing about the Ebola epidemic and EIS's involvement potentially?

Dynes: At that particular time, I had a couple of friends who had been involved with the outbreak that had happened in the spring in Guinea, and everyone thought that that was under control for several months. Then obviously in the summer, things started to change. I was, this sounds ridiculous, but I was waiting the birth of my friend's baby because I was going to deliver her baby at one of the hospitals here in Atlanta. As soon as he was

born, I said okay, I'm ready, I can go, I can go, because they were looking for people to go, they were recruiting people. I had absolutely no hesitation. I knew I wanted to go, I wanted to be part of it. Then one of the days, I got an email about the health promotion team specifically, and I thought, after reading the description, that my experience with anthropology and mixed methods would be a really good fit for that and all of the community-based work I had been doing with HBLSS [Home Based Life Saving Skills]. I thought okay, this is a good fit, so I got in touch with them and then we were able to get set up so I could go right away.

Q: What does "right away" mean?

Dynes: Well, it was like a week.

Q: Okay.

Dynes: Yeah, maybe. I was ready. I was really looking forward to it. At the same time, I really had no idea what to expect. I had been doing a lot of work, I probably travelled fifty percent of my first year of EIS, and so I had a lot of experience, but I had no idea what to expect from a true epidemic because I didn't do infectious diseases. That wasn't my thing, it was reproductive health. I really was so happy to have the opportunity to be involved. I actually remember the very moment I told my kids that I was going. This was maybe a few days before I was going to leave, and it was probably around bedtime because all three kids were in my daughter's room. I sat down on the bed and I was

talking to them and I said, “You guys, I have a trip. I just wanted you to know.” The sooner they know that, the better, generally speaking, especially my youngest. He’s always wanting to know the details, exactly when am I leaving, exactly when am I coming back. I said I have a trip to Sierra Leone, and I think my daughter at the time was ten and she said—she was a little bit quiet, and then said, “Ebola?” Question mark, Ebola? And I said “Yeah, it’s for Ebola.” I explained that I was going for the health promotion team and the types of things I would be doing and I wasn’t going to be doing patient care and that the risk was really low, and trying to offer some reassurance. Probably one of my favorite memories of the entire Ebola experience was this next moment. She said, “Mom, if you get sick, just don’t come home.” [laughter] How hilarious is that? I started laughing, and she was like, “I’m just kidding, but really, don’t come home if you get sick.” And I said, “Honey, I promise I will not come home if I get sick.” I felt so much pride, like here’s my little epidemiologist and she’s so pragmatic. If you get sick, that’s really bad, but we don’t want to get sick, so please just stay away. I said, “I promise I will not come home if I get sick.” That was so funny. It was a funny moment. It was a good moment for us as a small little family because we could just laugh and not be too serious.

Q: Right, right, exactly. That’s awesome, thank you for sharing that one. And so you go?

Dynes: Yeah.

Q: What happens?

Dynes: There was a visa mix-up, this happened to my colleague Anne [E. Purfield] and I both. We ended up going maybe two or three days after the group was going to be leaving. We travelled together, and I remember arriving, went through Paris and then into Freetown. In the airport, you can drive to the main part, main land, but it's a really long drive—I think it's like a three hour drive—or you can't take a boat. It was nighttime and it was pouring rain and we took the boat because it was just an easier way. I remember it feeling kind of symbolic. I'm off the plane and am on this boat, it's really windy, really wavy and it's pouring and people are bracing themselves for the waves that are coming and the rain and trying to stay dry. I just felt like, oh my gosh, this is so symbolic, it's almost ridiculous. Everyone getting off that plane was coming to help with Ebola, and no one knew what to expect, and it was like a perfect situation for that.

We arrived in the Radisson Blu [Mammy Yoko Hotel], which is where everyone was staying—kind of what you would expect for a capital city, one of their nicest, probably one of their nicest hotels, very fancy. Not a type of place I would normally stay for the work that I do because usually the work I do is either in really rural areas or—and I don't stay in places like that. It's always strange, you're in a country that health-wise isn't doing well and they have these fancy hotels and automatic doors and I don't know why that always strikes me as wrong. Anyway, stayed overnight, the next morning I found out that the health promotion team were actually in Kenema District and they were just there for a few days and that they were coming back. Anne was assigned to Kenema on the epidemiology team, so she was going to be travelling there and I thought well, I can just

be stationed in Kenema. As a health promotion team member, there was a lot of fluidity in terms of what people were doing. The main team, which was just a couple of people—a "team" is a little bit of an exaggeration—at the time, there was just a couple of people, two people, maybe. They were in Kenema, but they were coming back and they were really stationed in Freetown. I thought well, I can go into Kenema and just be stationed there because we don't have anyone there. Off we went, I think the next day, and drove to Kenema. What should probably be, I don't know, a three to four-hour drive is like a five-hour drive because of all of the checkpoints along the way. You'd stop, get out, take your temperature, get back in, go to the next one, stop, get out, and it was maybe six or seven times along the way. Sierra Leone is a beautiful country, and so that drive from Freetown to Kenema, absolutely beautiful, very green time of year, just what I was expecting from West Africa. I had not been in Sierra Leone before, but I had been to Mali, so I had a sense of what that part of Africa looked like. We got to Kenema, I think I had one conversation with the head of the health promotion team that evening, and then he left the next day. I was the only health promotion person left.

Q: Who was that person?

Dynes: [pauses] Who was it?

Q: It's okay.

Dynes: I can get back to you. I talked to him about some of the ideas I had for health promotion. He gave me an overview of the type of stuff they were doing. They were doing some work with I think the police, and they were doing some trainings. But they were finishing that up and were back to Freetown, so I said goodbye to him and then I started off with the work I was doing. Yeah, that was the beginning.

Q: What happens then?

Dynes: We started at the Luawa Resort. Have you heard this in other transcripts?

Q: I don't think so.

Dynes: It's a fantastic little place, actually. I don't know how we ended up there, but it was this little hotel, and all of the rooms opened to the outside, so it's what we would think of as a motel maybe in the United States. It had a little, tiny swimming pool, and it even had a little bar area. We filled the place, and they made our food in the morning and they made our food at night and it became our home, for sure. Just the place that we felt was our home.

Q: Right. When you say "we" and "our," who is that?

Dynes: The whole CDC team was there. There were usually two or three epidemiologists, and then maybe three lab people. We became a little kind of a core team. We had our

little health promotion person, who was me; we had our epis [epidemiologists]—even though I'm an epidemiologist at CDC, that wasn't my role there. And then we had our lab. That became our core group of people. We'd get up in the morning, eat breakfast pretty early, six thirty, seven, drive to the hospital, be there for the day. The end of the day was always the emergency operations center meeting, which happened at Kenema Hospital, which is where we were stationed. After that meeting we would drive back, eat dinner, and go to bed. Oftentimes, we didn't get back until 9:00 pm, and that's because of that EOC meeting taking a couple of hours usually, every night.

Q: Oh my gosh.

Dynes: Yeah. I remember the drive, it was always dark at this point, after the EOC meeting to the Luawa Resort. Everyone was on their BlackBerry sending messages to their team in Freetown and the EOC here in Atlanta. We were supposed to send bullets about what we did every day, and so that's what we did. We did our bullets. And we kept getting these messages back from Atlanta, could you give more detail? We just thought, no, I can't give more detail. We're doing this with our thumbs, we didn't have internet otherwise and we're giving as much as we can, just as much as we can, and they wanted more and more and more, but I just thought that was so ironic. Could you send more detail? [laughter] Like, what are you talking about? You don't know what you're talking about.

The bullets thing, the summary bullets that they wanted every day, I totally get it, it makes sense. They really wanted a connection with the field and what was happening. But what it felt like to us, or at least to me—and I know that other people felt this way: here we were, this tiny contingent of CDCers in Kenema, which was one of the central points of the epidemic in Sierra Leone. This tiny group surrounded by chaos, which we can talk about more later, and trying to send information to what we perceived as this much larger contingency of CDC people in Freetown, at the Radisson Blu, like they are spending all of their time there. It was crazy and weird because that's—the epidemic shifted to Freetown, absolutely no question, but at that time in August, it wasn't, and yet that's where everyone was. And then you had the [Atlanta] EOC and then you have an even larger contingency of people running around the EOC, and we were just like, what is going on? Things are happening here in Kenema. Why is it such a small group of people? I think that was an overwhelming, overriding feeling the entire time. We're such a small group of people and this is where everything is happening, and why aren't there more people? I know the EOC struggled with getting enough people [to] places, but it was overwhelming to think about these hundreds of people they talked about in the EOC here and we were six people.

Q: Can you tell me, so you're sending off these bullets?

Dynes: Yeah.

Q: Are you getting anything back from them that is useful to you?

Dynes: No. Well, lots and lots of emails with attachments, which by the way, were completely useless. We couldn't open any attachments.

Q: Oh, because of the internet situation.

Dynes: Because of the internet. You have what we would consider high-level things happening in Atlanta and even in Freetown that wasn't funneling its way back to us at all. All we were getting were continuous requests for more information. It was so strange to be in that situation. We did have phone calls, I remember at least one phone call with the health promotion team and it was with people in Atlanta. Otherwise, it just felt like we were on our own pretty much.

Q: Sure. And when you're sending—I know we'll probably get into the details of this later, but those bullets, what kind of information are you sending and what kind of more details are they asking for?

Dynes: I'm trying to think of some examples, sorry, it's been a couple of years now. Things like, "Here are my activities for today: number one, attended the Kenema District Health Management Team Ebola meeting," which I was doing every day by the way because I was the only CDC person attending that and we needed a CDC person there. "Went with the Kenema psychosocial team to visit three houses with Ebola cases to provide food." It was literally a bullet list of this is what I did today. "Worked with

Solomon on developing drawings," met with blah-blah-blah, whatever, it's just literally a list of what we were doing. And they would say, "Can you tell us more about—" [laughter] I can, but only as fast as my thumbs will write it.

Q: Right, exactly. Well, I'm glad here today we can look back and actually talk into the mics [microphones] and do it a little faster.

Dynes: Yeah. What is nice now is having a little perspective because at that time, it was just so annoying that they were requesting more information and sending mass amounts of information by email that was not accessible. I think at the time, we got to the point we would just laugh, like well, that's funny that they'd like that, but that's not going to happen.

Q: When they would want more information, what is it exactly—do you know exactly what kind of information they're looking for? Just more specifically what you're doing, your activities? What your plans are?

Dynes: Yeah, I think they just craved more detail on everything, just everything.

Q: Just more of everything?

Dynes: More of everything, yeah, and maybe even more so for the epi [epidemiology] team. Although their activities were so focused on that one office at the hospital where

we were all based, that because they had such a backlog of cases to enter, that that's what they spent all of their time doing. I actually felt bad for them because they were not able to get out and go to communities and have real boots-on-the-ground kind of interactions. As a health promotion team member, that's all I did. I was fortunate to have that aspect. But they were getting an influx of requests, and they had stacks of case report forms that needed to be entered for our numbers to be updated. I think the requests were, for them, "we need the numbers, we need to know, we need the numbers," and they were the only ones who had it, but they were the only ones there to put it in. It was overwhelming. It was overwhelming for them. They should have been able to be out doing contact tracing, and I don't think they ever did because they were literally trying to get through the stack of case report forms so that Freetown, so that Atlanta would have the numbers. I love numbers as much as the next person, I love analysis, I love data, but that, to me, wasn't why we were there. Or it certainly wasn't why I was there, and so I was really fortunate to be able to get beyond just data entry basically and do the other work.

Q: Absolutely. Do you remember your first visit to the hospital?

Dynes: I remember—not in general, but I remember a specific conversation. The office that we were working in was this building—so just to explain, in Sub-Saharan Africa and in a lot of other places outside of the Western world, the US or Europe, hospitals aren't a traditional single, large building. It's small buildings, usually just a single story open to the outside, and you have paths that connect the buildings. Kenema was exactly like that. I know the very first thing that I saw when we got there was this wall of pictures of the

nurses and health care workers who had died. It was kind of a grieving wall, I guess. Then we walked down to the building that our office was in, and it was facing the Ebola treatment unit, one of the doors to the Ebola treatment unit. There was a very small building in between, but from the steps going into our office building, we were maybe thirty yards from the steps going into the Ebola treatment unit. All the little kids inside there would come out to the doorway and wave and wave and we would play little games from steps to steps and do little things and then they would repeat it. You know, just little games you would play with kids.

Q: These kids are in the ETU [Ebola treatment unit]?

Dynes: In the ETU. Anyway, that very first day going in there, it was a very small, little office, cramped, the ceiling was caving in in places, and a tiny little bathroom in there. I remember walking in and two doctors, WHO [World Health Organization] volunteers, came in and because of our little bathroom, we had a lot of people who would come in to use the bathroom. They had come in and they were talking and one of them was—well, they were both new, I'm not sure in terms of coming to Kenema because we were on the same boat ride as one of the doctors. These details come back now. Anyway, they were talking to me because they had a pregnant woman in the ETU and she was—I think she had miscarried or had a stillbirth, and then they said she's bleeding, what should we do? They weren't obstetricians, and so I was like, these are the things you can do. But there wasn't anything they could do. There wasn't anything for sure. As you know, I'm sure, pregnant women had an extreme risk for death if they got Ebola. Because what would

happen is they would lose their pregnancy, whatever stage the pregnancy was at, and then they would just keep bleeding. That's what happened to that particular woman. There really wasn't anything they could do. That is the conversation, that was my first real memory of being there, was having that conversation with them and trying to problem-solve ideas for treatment, but there really wasn't anything they could do. Ian Crozier was one of those two doctors, and he had just gotten there also. He was just learning, starting to learn the process of the ETU. So that was my first meeting of Ian, too.

Q: Interesting.

Dynes: Yeah. Ian, as we all know, went on to get sick himself, but that was the very first moment that I remember meeting him, was this discussion about this pregnant woman.

Q: Can you tell me about initially meeting people who you would work with on a more daily basis and getting to know the situation in the field those first few days or weeks?

Dynes: Sure. My task was to try to identify any psychosocial activities that were going on around Ebola. I went to my first Kenema District management team meeting, which was this gathering that happened every morning, around thirty to forty people from leaders in Kenema, hospital management and then NGO [nongovernmental organization] representatives. That's where I met the Kenema District psychosocial team, and that was really my people while I was there. I met them and I said I'm here to do health promotion, so we immediately—I started working with them. The very first thing I

remember doing with them was, one of the tasks that they did was to take food to families who had been quarantined. Some villages' families were being quarantined for a reason, some villages' families were being quarantined unofficially, like the village members were doing it on purpose and quarantining them. We were bringing food to this family who had had Ebola cases. I remember walking up to this series of homes and there was a woman sitting, I think she was sitting next to a tree, leaning on a tree, and she stood up and we went to talk to her. She had just had a phone call from the ETU, and her last two family members had died that morning. They made the ninth and tenth people in her family who had died. She had just found out, she was sitting there in the tree crying and she just told me the story about all of them and how she was a nursing student and she would try to take care of them, trying to protect herself, and those were the last two people and they had just died. That was my first community engagement, was bringing that family food. The psychosocial team also brought clothing that was donated, but specifically food because villagers were not letting these people leave their homes. For a week, they didn't have access to food.

Another early interaction I had with the psychosocial team was we went—I'm trying to remember the details. A young woman, very young, I don't know how young, but she didn't look like she was twenty, had two small children and her husband had contracted Ebola. They had all gone to the ETU, and he was positive, and he died, and the village wouldn't let her back home with her children. I don't know where she stayed, I have no idea where she had stayed for the month, but the month was coming to an end and the psychosocial team was trying to help her to go back to the village. We went to the village

ahead of time, we had these village meetings, trying to explain that it was safe for them to be around this family, this young woman and her two young children. We had gone out to do that and then we took the young woman and her two children to her mother's home. She had—you can imagine, being probably a teenager, two young children—just lost your husband a month ago, being kind of shunned from your village. We were there, we took her to her mother's house, and she hadn't seen her family, hadn't seen her mother, had gone through the loss of a spouse and all of it alone. I have these pictures of her reuniting with her mother and her family and it was so emotional and overwhelming because it wasn't just I haven't seen you for a month, it was them recognizing the loss that she had gone through and it was, yeah, pretty crazy. We brought lots of food to the family and did some education. We did things like that on a regular basis, like a daily basis, going out to check on people who had family members who were sick or going and bringing food and clothes to families. Some of the villagers, they burned things when someone got sick, and so people literally had nothing. They didn't have a home, they didn't have clothes, they didn't have a bed. We were taking things to people, just daily needs.

Q: Where did the food and the clothing come from?

Dynes: I don't know. They were all donations and they were storing them in this big warehouse, but I have absolutely no idea where they were coming from, absolutely no idea. I feel like they could have given out even more than they did, they just didn't know how long those could last. It was this idea of rationing what they had. But I know they

helped a lot of people with that. When Ebola survivors made it through, which wasn't common—in Kenema, I think they had a seventy percent mortality rate—for that thirty percent who lived, they really helped pave the way for those folks to go back to their villages. Going out ahead of time, having community meetings, trying to step up basic supplies for them, making sure they were accepted back in their community. Those are really the types of activities that we were doing on a regular basis.

Q: Can you describe a little bit more about those community education meetings where you would talk to people, you would go out to groups before someone would return and try and make it so that they would be integrated more smoothly?

Dynes: Yeah, so it was like a—what would we call it here? During the presidential elections we have these like town—

Q: Town hall meetings?

Dynes: Town hall meetings. It was like that, except in a different context. People would gather with the leadership of the village, and it was really just hearing the psychosocial team saying to the leaders, in front of all the people, this family is safe to be around, giving the education so that they would see that exchange and understand and be accepting. It really was opportunities for even people from the press, very locally, to take pictures and see that this was happening and people are returning. Because one of the

biggest fears was people—if they went to the ETU, they would never come back. It was also an opportunity to say, we have survivors who are going to be returning.

Q: This isn't necessarily a death sentence when someone goes away.

Dynes: It's not necessarily a death sentence.

Q: Right, right. Are there questions, is there a Q&A [question-and-answer session] at all? Are you able to learn from these sessions what thoughts and worries people have?

Dynes: Not, I would say, there were not a lot of question/answer sessions during those meetings because it felt kind of formal, you were going to watch this happen and hear and listen, but not interact. We did other work, focus groups with people to try to really understand fears and misconceptions, so that was a separate set of activities.

Q: Sorry, I get us off track with my questions.

Dynes: No, no, not at all.

Q: Can you describe more about the psychosocial team and who is a member?

Dynes: It was about four or five people. My best understanding is that they were the HIV [human immunodeficiency virus] counselors before Ebola. When Ebola hit, everyone

shifted, and they shifted to psychosocial needs around Ebola. It was an amazing group of people and one thing that we talked about right away was the health care workers and how they had been so badly affected. At Kenema Hospital I think they had over sixty people become infected. I think they had twenty-some nurses, just nurses, die. I think all of the lab techs [technicians] got Ebola and all of them died but one. I think I recognized, along with the psychosocial team, that there were some needs among the health care personnel. It was such an emergency situation that mental health and well-being were not the most important thing, but clearly they were traumatized. They were taking care of Ebola patients, seeing their colleagues get sick, taking care of their colleagues, watching their colleagues die over and over and over again, twenty-some times, and they were just working nonstop. We decided as a group with the psychosocial team to try to build a counseling center, both for Ebola survivors, but the primary reason first off was a place for the health care workers to go where they really could just relax, they could receive counseling or they could just relax. This took several weeks, but we found a room in the hospital that was filled, it was just a storage room, it was filled from the bottom to the top and it was probably a room maybe twenty feet by ten feet. We finally got some approval to clear it out, so we all cleared it out, we cleaned it up, and then we went shopping and we furnished it and it was like our counseling center. I was so happy we got that put together before I left because we had a whole group of Ebola survivors that got counseling before they went home, when they were discharged from the Ebola unit. I have these great pictures of them cheering. It was an opportunity for the psychosocial team to give them group education on this is what you should expect, this is what we're trying to do ahead of time to make this smoother for you, here is the number you should

call if you're having any problems. It was a joyous moment, but for them, as survivors, they didn't have a lot to go home to in most cases. Letting them know that they had support was really critical.

Q: What are some names of the team members you worked with?

Dynes: I don't know why, but I really connected with Gladys. We spent a lot of time together, and she was one of the psychosocial members. She had such a big heart and worked so hard. They were putting themselves at risk every day by going out to communities and talking with families. Just to see how dedicated they were, it was really amazing.

Q: You mentioned also someone named Solomon earlier, was he on the team?

Dynes: Oh, Solomon—so Solomon was not on the psychosocial team, but he's an artist. One of the ideas I had, which I really got this idea from all of the work I've done with Home Based Life Saving Skills, so we're closing the circle here a little bit. Home Based Life Saving Skills is based on a pictorial system for educating people who may have low literacy. The pictures, it's a way of teaching people using pictures, telling stories, as a way of learning about something. In my previous work that learning was about maternal health and newborn health, and now I wanted to use that same kind of tradition, but for Ebola. I had two ideas. I saw that stigma was an issue for the survivors and for the family members, even who didn't have Ebola. Then also transmission, just in general, key

concepts around preventing transmission. When we arrived in August, the big messaging was around “Ebola is real.” It was really the very early messaging, people didn’t believe it existed. That was the key messaging, and then it was starting to shift towards “these are the signs and symptoms of Ebola” and “what do you do if you have them or you know someone who does.” This idea of transmission became really critical, for people to understand chain of transmission. I decided I could create these two educational modules, one on stopping the chain of transmission and one on ending stigma and discrimination for Ebola survivors and family members. I wrote two different proposals, we thought we might have a little bit of money coming from CDC to do some activities. One I wrote up for the development of these materials and basically I designed it, I wrote the script for each of the educational modules. Then I needed an artist and so Gladys and the other members of the psychosocial team said hey, we have someone who does a lot of the health care artwork for the district. They got me in touch with Solomon. Solomon is this amazing man who he’s obviously a great artist, but he has such a big heart and he’s an interesting man. I didn’t ever push him on details, but Solomon was missing one of his arms and I believe it was from the war in Sierra Leone. He didn’t let it stop him and did this amazing work for me. We spent many hours together, me explaining how these educational modules worked. I showed him examples of pictures, we talked through what each scene should look like, and we worked for several weeks on this. In the end, we were able to take these two modules and get them printed and laminated so we could start doing the education at the community level. He was such a big part of that work.

While I was there, we did two trainings, kind of training-of-trainers kind of thing, one with Red Cross volunteers from all across the district and then one with community health care workers in—a chiefdom is a smaller part of the district, so within Kenema District, one of the chiefdoms that was on the border with Liberia, which was thought to be a higher risk area. We did a big training of community health workers there. In both of these cases, we sent the materials with the people we trained so that they could use them within their own villages and do house-to-house education or even community meetings using the educational materials. It was so cool because I realize if I had gone in an epi role, I would not have had all of those experiences and opportunities to be creative and to really use my past experiences and knowledge. The idea behind these modules, people call them storyboards or it's kind of using storytelling, but the idea is you tell two stories. One story has an outcome that's not positive, and you always tell that story first with the pictures. You lay the pictures down as you're telling that part of the story, in a line or in a circle. Then you say, "I have another story to tell you. Please listen carefully to this story." It starts off exactly the same, same pictures, same words, same story, and at some point in the story, something different happens. In the case of the transmission module, the difference was they went to a health care worker right away when someone was sick and so the wife doesn't become sick herself and lives. You tell a much happier story the second time, and the real point is the discussion that follows: tell me what's different about the two stories. They usually can say oh, it had a different outcome, but what else is different? What was the change that led to the different outcome? That's what the discussion is about. What do you see in the picture that tells you something different happened from this story to that story? It's all this understanding of action and

consequences. If you take this action, you could have a different outcome, right? What people don't understand, I think, who don't do a lot of education or community-based education, you can't just give people a series of pictures and expect that they understand. Just like in the United States we teach our kids to read, read words, we don't give them words and then expect that they understand it. In fact, it's the same with pictures. You can't give someone a series of pictures and expect they're going to understand the story. This HBLSS educational approach is that you help them learn to understand what the pictures mean and what it's symbolizing. So it's not just telling the story and for them seeing the pictures, it's what do you see in the picture? How do you know they did something different? Oh, he's doing that or he's calling the health care worker. You teach them to see the details in the picture that matter. It was that approach that I took with training of the community health workers and the Red Cross volunteers. Unfortunately, by the time the process of developing them, laminating, doing the trainings, that was right at the end of my six weeks and so I wasn't able to go with them and really see how effectively they were able to implement it, but it's something I wish I had a little more time to see. The psychosocial team kept all of the laminated stories so they could continue doing education and so it was a really good opportunity for us to collaborate with each other and Solomon was a big part of that. Yeah, it's amazing. It's not just that he's a good artist, but he got it. He got the meaning behind the pictures and why it mattered that, for example in the stigma and discrimination module, the first story or the story that doesn't have a happy ending is an Ebola survivor going home to her village and being rejected. It touched him to be drawing that because he felt how sad it was that that was really happening. It wasn't just that he was drawing it, but he felt it in a way that

made him such a great artist. Yeah, it would be so nice to go back and to be able to see Gladys and the team and Solomon, it really would.

Q: Yeah. Did you have other deployments after this?

Dynes: Not back—not for Ebola. I wanted to. In the end, I finished EIS early and started my new position right away, so it just didn't work out. But I really would've wanted to go back. When I was in Kenema it really was the height of the epidemic in the eastern part of the country, and it started to really shift westward in October. By the time I left, which was at the end of September, things changed drastically for them, thank goodness, because it was too much. The level of chaos was overwhelming and people were just having to deal with that day after day.

Q: Do you have any more like memories of Gladys that kind of stand out to you?

Dynes: Nothing specific other than her genuine kindness to people. What a perfect group, to—HIV counselors. They were counselors of people who were stigmatized in the community, and to be suddenly doing this Ebola work—when you talk about emergencies and how things have to change and shift, it was the perfect use of that team. Gladys is the only person I gave a hug to before I left and we really weren't supposed to, like there was no touching for six weeks. You just didn't come into actual contact with people. She was definitely the only person that I hugged because we just had a connection. In fact, I had a phone call with her in the month afterwards, there was another

person—actually a fellow EIS officer who was in Kenema after I was, Kimmie [Kimberly] Pringle, I don't know if you've interviewed Kimmie, but she had arranged a phone call so we could get in touch and it was really nice. Super nice.

Q: Did anything change with the District Health Management Team meetings over the course of your time there? Did you notice any shifts?

Dynes: Oh gosh. No shifts, it was really interesting. It was the leadership in the district trying to maintain control over an uncontrollable situation. You know you could see that they were doing everything that they could do. They were at their capacity and beyond. I don't know if it was the best use of two hours every day, but it was important that CDC be at the table because there was this sense in the news, in the media, that CDC is helping in the epidemic. In Freetown there was a sense, CDC has this huge impact, and we were six people. At the district level, CDC was one very small piece of the puzzle to them. I think they really appreciated the lab because that was a clear gap that they had and a clear gap that CDC was filling. But otherwise, to them, they didn't see a huge contingency of people doing work—they just saw a couple of people. I think that was a really interesting perspective because the way the EOC talked, it was like CDC was running things. I don't know if anyone has said this, but it was such a drastic change from what the expectation was leaving Atlanta to the reality on the ground.

I've mentioned this before, but Dr. [Thomas R.] Frieden came to visit Kenema. He was in all three of the highly-affected countries and had a short visit through Kenema. We called

these kind of things Ebola tourism or something. I actually don't feel it was that way for Dr. Frieden, but for other members of CDC who were in Freetown, they thought oh yeah, let's go see, we want to see where things are really happening. Then they'd come for an hour and then they'd leave and that was it. But for Dr. Frieden, it really was important for him to be in Kenema because that was going to bring more attention to the area not just in Freetown, but in the US. Kenema needed more help, and I think his presence in Kenema was really, really important. It caused a lot of chaos on our end in terms of preparing for that, but well worth it because he was a figure, kind of a national figure, international figure, it was really important that he was there and I really appreciate the effort that that took. Now, the difficulties that it created at the ground level were not minimal. For example, this management team meeting that I was going to as CDC's representative, I told them that the director of CDC was coming and they were absolutely certain that he needed to go and see the head kind of government official, the lead government official for the district. Not Dr. Frieden, but his contingency, his folks around him, said no, we don't have time to do that. I was literally begging for days before this for them to go. Quick meeting, it's not a big deal, this has to happen for political reasons. The day of, I'm in this meeting, the daily management meeting, and they said well, he has to come see, and I had thirty to forty people saying to me, he has to stop and see our leadership, he has to. I am on the phone with the CDC folks and they're telling me there's no way he can do it. There's no way, he doesn't have time. It's not an important enough thing. And I did something that I don't know now if it was appropriate or not to be honest, but I emailed the one person I thought could make a difference and that was my friend, who happens to be Frieden's chief of staff. I said, "Listen Carmen, this is going to be, maybe

not an international incident, but at least a district/regional political incident, if he does not go to see"—and I don't know if that email made its way to Dr. Frieden or to the people planning his schedule, all I know is they said fine, we'll do it. Literally, in that tone of voice. [laughs] I'm on the phone with them trying to say, please confirm you're going to stop, please confirm. All the people in the room are looking at me like you have to make this happen. Finally they pulled up and we went to the—I'm not even sure exactly what the building was, but it was like their government building for their leader. Went in, had a very quick, five-minute conversation, it was extremely appropriate, very fast, there's no way it interfered with his schedule, and it was done and that's all that was needed. It was so ridiculous to me that there was ever any doubt that that should happen. I don't think the doubt was from Dr. Frieden at all. I don't even think he was part of those conversations, I think it was this group that had in mind what he was going to do and they didn't care about anything else. Maybe they don't have local experience to understand why those types of things matter so much. From there we went to Kenema Hospital and then he was able to tour, talk to the epi team, talk to the lab team, he talked to the WHO volunteers, the staff at the hospital. Then he did a quick tour of the Ebola treatment unit, which I think was—it was good because CDC got pictures and the publicity part of it. Yeah, I think it was good. I think he needed to be there to see it in person.

Q: Can you kind of explain why it was so important that Dr. Frieden meet with the local leadership?

Dynes: First of all, it's just etiquette, social etiquette. That's so important there that to go against it could mean we're not inviting CDC back to the table at these meetings anymore. It really could've been that. CDC only goes to places that we're invited to. We can be uninvited just as quickly, and it really was that level in my mind—that's how much it mattered. As I said, that district level didn't see CDC as being this big force because we weren't a big force to them. Maybe if they were in Freetown and they would've seen a bigger group of people it would have been different, but they saw a small group of people and we didn't have the influence at that level that we would've wanted to have. A faux pas, a social faux pas like Dr. Frieden not going to meet could have reduced that level of influence even more.

Q: So who was in the driver's seat in Kenema?

Dynes: Well that team, the District Health Management Team meeting were kind of the people making decisions—

Q: Right, and that's made up of—

Dynes: Administrative, high-level Ministry of Health [and Sanitation], District Ministry of Health, and then folks from the NGOs were there, invited to the meeting, but I don't think they were making decisions.

Q: Sure, sure. So it was like regional Ministry of Health officials, is that right?

Dynes: Not even regional, I think district. Although I'd have to look, the regional might have been based in Kenema too. Kenema is one district in the eastern region, but it may have also been the—yeah, it may have been regional level, not just district level. But they were really making decisions. The frustration on their end and on our end was that we knew funds and equipment was funneling into Sierra Leone, at least into Freetown, but it was not getting to where it needed to be. It was so clear. I mean they were literally—they would have little mini ceremonies of appreciation for people when they made donations, locally made donations, one hundred dollars, two hundred dollars. Because their budget was blown apart, they had nothing. They did not have the funds that they needed to do the work that was there. They couldn't pay the health care workers.

In fact, this one day—I told you I came with Anne Purfield. She and that team, including the lab, were ready to go to depart for home. I had extended for two weeks, so I wasn't leaving for another two weeks. The new team was coming, had just come. The old team, they basically had half a day or a day to get them up to speed and then they were leaving. It was that day where we had both teams there in the office. I was there, and someone came into the office, and I looked at his face and he looked scared, that's the only way to describe it. He was one of the IT [information technology] people at the hospital and he said, "I have a problem. I have a problem, you have to help me." We all said, what's happening? He said it was like a week and a half before, he and his friend were sick, and so they went to the Ebola treatment unit. They were tested and admitted into the area where you wait before you find out the answer, and he said they were there overnight and

that, I believe, they were both found to be negative the next day. But it was such a traumatizing experience for him in the Ebola treatment unit that he came—so now we're talking a week and a half later—he comes in and he says, "I'm sick now. I'm sick. I was negative then, but I am sick now." He's like, "I don't feel good, I have a fever," and he said, "but I can't go back. You can't make me go back."

Here I had these two small epi teams, these two lab teams standing there, I was the only one who wasn't either new or leaving—and they were literally leaving that afternoon. I said, "Okay, I'll handle it, you guys just keep doing what you're doing." They needed to do more handoff of information. I said, "You just have to come with me to the ETU. Please just come with me to get tested." It really took a lot of talking him into coming with me. I said, "Just come." So he turned around and he walked out, and I turned around and I just said, "Wipe everything down that he was touching. It will be fine." I walked him up to the triage area, and the triage tent is filled with people. I had never seen it so filled. I'm guessing maybe forty or more people were sitting on benches in the triage tent, waiting to get triaged, waiting to have it decided if they needed to be tested or not. I walk up, and the reason all of these people were there was because the nurses had gone on strike that morning, they had just gone on strike. And this is why the story comes up is because of the financial situation of the region. It was not good, they didn't have money to pay their health care workers. The nurses went on strike. No one can blame them for that, it was not safe circumstances for them. The triage tent was full, nurses just went on strike, and I talked to—I said, "We have to test him, he's a hospital employee, is there any way we can get him tested?" They said okay, so they got him in line first. They did

draw his blood, and then when I went back to check on him later, he still refused to go into the Ebola treatment unit. He was kind of standing in the triage area. I went back and that entire triage tent was gone, everyone had left because there weren't any nurses. They just went back, back home, back to their communities with Ebola maybe. That was happening on a regular basis, and you just think forty people—let's say half of them had Ebola, how many more people are going to have Ebola now? So this poor guy, this poor IT guy, the good news is that he tested negative, but the fear he had, it wasn't because of any unknown, it was because he knew what it was like inside the ETU. He was so traumatized by that experience. In fact, at one point, they were having a hard time keeping track of who was inside the ETU. As ridiculous as that sounds, they couldn't keep track. It was so overburdened. It was meant for thirty beds, fifty beds, maybe sixty, and they would have ninety or more people in there. They were having a hard time keeping track. At one point, the lab team, the epi team were really working on trying to get a list and they found fifteen people, ten or fifteen people who had been in there for a couple of weeks, who had never gotten their results. If they didn't have Ebola [before], they probably do now because it was such chaos. There weren't enough health care workers to do the work. They couldn't keep patients in beds, they were wandering around because they would kind of lose their mind in ways, just as a result of the disease. People were just wandering around. The fact that this district, this region, did not have the financial support they needed just had a huge impact on people's lives. How many people would have been saved had those forty people not been sent home?

You had asked earlier about people we worked with on a regular basis.

Q: Yeah.

Dynes: One of the people that we worked with was a nurse named Nancy. Nancy, I met on one of the very first days I was there, because we—the epi team would typically go up to the low-risk part of the ETU to get information from the nurses—it was like the nurses' station—and then take the information back down and start entering more information into the database. I was with the epi team, and we were talking to Nancy, and she handed something to one of my colleagues, like a folder with a papers, and it looked dirty. It looked smudged, like it had been stepped on or was on the ground. I made a quick comment to Melissa [Rolfes], one of the epis. I said, "Melissa, I just want you to know that's something you should be careful about. The things that you're touching, you have to consider who's been touching those things." She said "Okay, yeah, I'll be careful." Nancy overheard the conversation, and she said, "What did you say?" I didn't want to make Nancy feel bad, and I said, "It's fine, Nancy, don't worry." She's like "No, no, please tell me." So I said, "I just was telling her that those folders, papers, looked dirty, it looked smudged." And some people might have guessed it was old blood, but I think it was from the ground because the soil is red. It looks really a lot like dried blood, to be honest. I said, "Nancy, I was just telling her she in general needs to be cautious of what she's touching." Nancy said, "Oh, don't worry. We appreciate any recommendations you have." She was really kind about it. We had ongoing contact with Nancy, and a few weeks later, Nancy got sick with Ebola. We found out, and some of this information is secondhand, I'm not sure, but some people told me that she had been

coming to work for five days with symptoms. She was either afraid to tell people, to admit it to herself, or wanted to continue doing the work she was doing. Probably both. I was in a grocery store with the psychosocial team getting snacks for the counseling center when I heard this screaming, and we went to a different part of the store to see what was happening, and it was Nancy's sister. She had just found out that Nancy died. You know, even when Nancy got sick I thought she wasn't going to die. I don't know why I thought that. It doesn't make any sense because the mortality rate for the health care workers was very high. What's so sad is she got sick, she went into the ETU, the very ETU she had been working in. Then we have all of our WHO volunteers, they get sick and they get flown out for the best health care possible. I don't know, it's hard.

Q: Is that something that anyone ever told you, any Sierra Leoneans ever mentioned to you, this seems unfair to me?

Dynes: Not at all. Not at all. I didn't ever get the sense that they felt how unfair it was. I think they just didn't verbalize it. Every Sierra Leonean I ever met was appreciative that we were there to help, but the inequity from my side was so drastic. The first week I was there, one of the nurses—he was a WHO volunteer from the UK [United Kingdom]—he got Ebola and was medevacked out. Then another one of the doctors got a needle stick and was medevacked out and she ended up not getting Ebola, which is great. Then, one of my nurse colleagues from the International Federation of Red Cross and Red Crescent Societies, he was working at the new Ebola treatment unit that had just been built and was helping people out of the back of a truck who were coming because they were Ebola

positive. They had been tested and were positive and people had died along the way, and they had spent hours in the back of this van with corpses. This child, as he went to help the child out, bit him really hard because he was freaked out, as anyone would be under those circumstances, and he got medevacked out. He was okay, he was negative in the end, which is really good. I knew CDC people who had contact with drivers who ended up getting Ebola and they were medevacked out. None of these local people ever received any level of support like that, nothing. In fact, when Ian got sick, there wasn't anyone left around to help.

The circumstances around that were really dramatic because it was Ian and two other doctors and one nurse—that were the WHO volunteers for the time I was there primarily—those four people, and they were doing their shifts inside the ETU and doing amazing work. The three were getting ready to go home, and Ian extended, and so we all went out to dinner as a farewell to them. The next day, the three left, and Ian was the only WHO volunteer left. There were, I think, a couple coming early the next week. I think we had dinner on a Wednesday or a Thursday and they left the next day. It was Saturday when Ian got sick, and he was positive on Sunday and then got medevacked out. I remember—sometimes you're not sure if a memory is real or if—because of details you find out about later, if you made it up in your mind. But Ian had been trying to help another—I don't know if he was a lab person at the hospital—who had gotten Ebola while we there, and he was really sick. He knew a couple other people that had been survivors, so they were looking into blood transfusion options to try to get antibodies from the survivors to the currently ill. One of our lab people said, "Can you go get

some—" I can't remember, it was me needing to get some information from Ian for our lab person. I had this little paper from the lab person, I went up to Ian, this was I think Friday, the day before he got sick. I remember walking into the WHO room at the hospital and Ian was sitting there and he just looked tired, worn out. But it wasn't like oh, I think he's sick, it was just like oh, he looks really worn out. I should have thought—like Ian, I'm concerned because you don't look very good. I didn't even say that. I look back and I'm like, why didn't I think of that? I handed him the piece of paper, he wrote down what the lab needed for blood type information, and then he handed it back. I think I just said, "Are you okay?" He was like, "Yeah, I'm just tired." The next morning we go in to the hospital, the old epi team/lab team is gone, the new epi team/lab team is there, and so it was me getting to know the new group. It was right at the end, it was right at the transition. I went in and our lab person, Ute [Stroeher], was there, and I think she got a phone call. But anyway, I was the only one there with her and it was from Ian. It was like the phone call of "I'm sick and I need to be tested." I was like, "Ute, let me go with you because I can draw his blood." I am obviously a nurse, and she's not, and I was the only CDC person there who was clinical. She was like, "No, you can't, I can't let you do that." In the end, Ian drew his own blood, that was the story. I'm not sure if that's really what happened or not. I had this information, Ian's sick, and none of the other team was there. I don't know what they were doing, to be honest, and at some point they came back, but I couldn't tell anyone because first of all, we didn't know the result. So Ute went, drew the blood, did the test, he was positive, and if you know anything about Ebola testing he was really positive. I went up to the WHO office, basically the WHO head guy refused to go back in the office until it was cleaned and decontaminated. Ute and me and one of—it

was a different WHO person that was specifically focused on infection prevention, we had to clean and decontaminate everything in the office. We're doing that, throwing almost everything away that wasn't necessary to keep, chlorinating everything. I was taking anything that was clothing that could be immersed in chlorinated water and doing that. I remember one point I was in the room where they had the scrubs, so I was throwing the scrubs in the bucket. There was a garbage bag with a couple of things in it, so I ripped it open and it was a pair of clogs and scrubs. I was like, "Ute, do you know whose these are?" Because clearly it was someone's. She was like "Oh, that was Ian's." They had put Ian's stuff in there. So I decontaminated that stuff. We decontaminated everything so at least WHO would come back in. I feel like that was really cathartic to be part of that process because you have this terrible thing you just found out has happened and you just want to do something about it. That was helpful in my mind.

At the same time, recognizing that he was the last volunteer, there wasn't anyone else, and we had this whole weekend before anyone new was coming, I contacted my friend again. Again, I look back and I don't know if that was appropriate or not, but in the moment it felt appropriate. I said, "Carmen, please ask Dr. Frieden if I can just do this. I am a nurse, I've been training nurses for the IFRC training, the local nurses to do Ebola work. I have been training them on PPE [personal protective equipment], training them on care. If anyone can do this, I can do this. Let me do this." It was a plea, it was a beg, it was please let me do something that would be helpful at this moment. Let me do something with myself that I can say at least this was really helpful. She had some conversation with Dr. Frieden and they responded that it wasn't really his decision

because it was the decision of our head guy in Freetown, and so it got passed to him and he responded that if it was up to him he would say yes, but that ultimately we weren't there for that reason, to give clinical care. Ultimately, it was a no, and I was devastated. I didn't think they were going to say yes, but it was like one percent of me thought maybe. So, there were the nurses that had been there doing the work, the local nurses, and they had no support. People were in the ETU, dying because they weren't getting water to drink, they were dying from being dehydrated because there wasn't anyone to give them water. And we just flew how many people home, some just because of—I don't mean "just" because—but of some exposure or some problem, and others because they were actually positive. But the resources that we were using in that process and the resources that existed there for the people who were sick, you can't rationalize that.

Q: How long was the ETU without a doctor or nurses who could help?

Dynes: I think maybe three days, and that's all I was asking, was to be able to fill the gap between when Ian left and when the new group came. And they just couldn't do it. It was a very defining moment for me. What's more important, my professional ethical obligation as a clinician or keeping my job? I felt like those were the two options because I felt like if I went in and I did that and they knew that, I would lose my job. It's not that anyone said that to me, it's not that it was used as a "this is what's going to happen if you do this," it wasn't like that. I don't want to give that sense. But it felt like those were the two options, and so I didn't do it. I don't think it was the right thing, at this point.

Q: Looking back now?

Dynes: It was the right thing for me professionally, from a CDC professional standpoint, but was it the right thing for me personally? No. That was the hardest thing about the entire six weeks was not being able to go in and help when I felt like I was the only one who could do it. We had epis, we had lab people, but it would not have been appropriate skill-wise for them to offer that type of help. It was appropriate for me. I understand from a perspective of if I had gone in and done that and if I had gotten sick, what if they would have pulled all CDC personnel? That would have had a terrible outcome on the whole trajectory of the epidemic in general, and I wouldn't have wanted to have that responsibility for sure. But in the moment, I wasn't thinking that way. I was thinking that I'm not fulfilling my own professional obligation as a nurse, really as a human being with skills to help and not doing that. It was really terrible, emotionally the most difficult part of the whole thing, by far.

Q: Is it something that you still think about?

Dynes: Yeah, a lot. Yeah. Yeah, I mean, it's not like we needed to go into the ETU to do all of these interventions. It was simple fluid hydration, support, emotional support so that the nurses, the Sierra Leonean nurses didn't feel like they were in it alone. And the more they worked the more they were at risk because the more tired they were, the more likely to make mistakes, the more risk, in terms of actually getting Ebola. I just felt so

much obligation to step in. And then to just be told no—it wasn't a surprise, but it was such a disappointment.

Q: I'm a little unclear still. So there were still some Sierra Leonean nurses who were going through the ETUs, and could they hydrate people?

Dynes: Yeah, but it was really the WHO volunteers who were running the whole process. They were taking charge and formulating the plan as the process was happening. The Sierra Leoneans certainly had leadership among their nurses and had developed the expertise, no doubt, but they were just a small number of people. I just felt like they needed to feel supported by us. Yeah. It was terrible. It was just terrible, and Ian was so sick that we were getting these reports that were—one was worse than the one before. He was, at one point, intubated and on dialysis, and I thought he was going to die for sure. I didn't think Nancy was going to die, I don't know why. It was terrible. Then you have these groups of people at the EOC, "send more details." Tell me I can do the work I want to do, that's what I want to know. Of course, I never engaged at that level. I only engaged the very highest level, and then the highest level in Freetown because that was—I wasn't trying to make this about me. It wasn't like please, anyone who can get behind me doing this, please step up. It was just, this stuff was happening and the EOC was filled with people.

But the reality on the ground was it's a one-on-one situation, it's not a population anymore. It was odd. I was on a phone call after Ian got sick, and I said—I think I

mentioned that I had gone in and helped decontaminate the WHO room so that they would go back in there, literally. I think I completely got into trouble for that. Basically, all I know is, they were like oh Michelle, you should come back to Freetown. I was like, I don't really want to, I only have a week or two weeks left—I guess two weeks left at that point. They were like no, you should come back. I said okay, I'll come back for a day. So I came back and the good news was that the head of CDC's communications, what's her name, Lyon—

Q: Oh, Katherine Lyon-Daniel?

Dynes: Yeah, Lyon-Daniel, she was there. I got to have a meeting with her and I said, "I really want to implement these educational modules." I brought them, and she basically gave me clearance in that meeting, which was fantastic. Otherwise, CDC's processes, it would have just taken forever and I wouldn't have been able to do anything with them before I left, so I was really appreciative of that. What I think really that was all about was getting your hand slapped for doing something you weren't supposed to, which was decontaminate the office. I don't know what to say about that. I had a little meeting with two people in Freetown in the Radisson Blu and they were like, that's not your position, and they made it clear that it wasn't the right thing to do. So I made it clear that I was sorry, but I really wanted to go back and I needed to be back there. It was fine, and they kind of gave in, I think, and I was able to go back the next day.

But while I was there, this is the type of incongruity between Kenema and Freetown. People, I think it was health promotion people actually. I don't know if we were having a meal or something in the Radisson Blu, and someone said, "Oh no, how tragic." I said, "What?" And she said, "I just chipped my nail." They had gone that day and gotten manicures, and they said they had done it with some Ministry of Health staff, so it was meant to be a bonding thing. I just remember thinking, oh my gosh, let me leave this hotel right now because I can't handle it. She was joking, it wasn't meant—it wasn't meant badly on her part at all. It really was a joke, but it hit me at the wrong time and the wrong way and I was like oh my gosh, I can't handle this. Please let me go be surrounded by the people who day in and day out are dealing with really tragic things. So I don't have positive experiences of the things that were happening at the country level. Every time I would say what I was doing, it was like their need to say that they were doing the high-level work. I thought, that's fine, that is incredibly important and probably has a bigger impact in the long run, but it doesn't minimize what's happening at the local level. But yeah, that whole series of events was by far my most difficult time.

Q: When you go back to the field, do you have that next—is it another week or two weeks that you have?

Dynes: I'm trying to think—it must have been about two weeks.

Q: Must have been about two weeks?

Dynes: A week and a half, it wasn't—yeah, it must have been a week and a half or two because Ian got sick, Anne was still there the day he got sick, and Anne was leaving shortly thereafter. It was probably a week and a half that I had left. At kind of mid-deployment, Freetown started saying people should come back for the weekends to Freetown. I thought, we're just taking the weekend off? I think it was meant as a positive thing from their perspective, but to think of leaving the people who are still there doing that work and being like, I'm going to take the weekend off; I know you're going to be here forever, but I'm going to take the weekend off. I just thought they're not getting it, they're not understanding.

Q: Where did you find room for self-care though?

Dynes: I don't know. I think writing updates was helpful, to a couple friends. At one point, I had maybe—I'm not sure, five, six people I was writing to. Somehow, I don't know if someone shared it, other people became interested. So then I started editing what I was sending because it was going to a larger number of people and I just didn't think it was appropriate. But I think that was helpful because it was something I would just write in a [Microsoft] Word document at night and then hope that I would have internet sometime the next day to send. I think the camaraderie among the small, little CDC contingency that was in Kenema was really strong, and it was strong afterwards, too. We had gatherings and that was really helpful. There was someone I worked with with the International Rescue Committee when I was in Kenema doing focus groups with pregnant women and health care providers. She was stationed in Kenema for IRC before

Ebola hit, and then was there for many months, several months I guess, several months after I left. Then I saw her at a conference in Jordan the next year, and we started talking, and she was still really working through her feelings about it. She was like, "It was really bad," and I recognize in her how I had felt in the first months when I came back because it was as bad as—like I read through some of my emails or think through some of my memories, was it really that bad? Was it really that bad? We had this moment at this conference in Jordan, it was really bad. It was like the lab guy's throwing up in the bathroom and he can't stop and he died. It was daily seeing bodies stacked up in the back of trucks to be driven away, seeing families and communities that were completely devastated. It was a daily influx of terrible things that until you're away for a certain amount of time you can't get perspective on. I saw Laura, Laura Miller is her name, from IRC, and we had this moment of "it really was that bad there," like no doubt. She looked almost in shock, even then, and I felt that way when I first came back too. You know it took a long time to wrap your head around how you feel about it. Did we really do any good or not? I don't know. I still don't really know.

Q: Really?

Dynes: You hope so. It's such a short—six weeks is such a short period of time. It's hard to know. But I don't think CDC did as much at that level as what they thought. Or they needed to be more engaged at that level than they were, at least in the beginning. I think things improved and some of the approach changed and evolved, but early on, it was so heavy in the EOC, so heavy in the capital that that work wasn't necessarily trickling

down. You can do as much as you can do for six people, but in the middle of it, that wasn't enough. It just wasn't.

Q: Can you talk about wrapping up the deployment and to what degree you were able to say goodbye to people in Kenema?

Dynes: I literally did those two trainings with the educational models like the day before I left because I hadn't had the clearance until then, and it took that much time actually to get the materials together. I spent the last couple of days with the psychosocial team, driving to where we were doing the—and being a part of that training was the best way to end the deployment because the team was getting the training at the same time and they were going to be able to keep it going when I left. They really got it, they really connected with it, and there was a lot of positive energy and this amazing spirit of we can do it, this will help us and we can move forward. That was the best way to spend like literally the last day. In fact, one of the trainings may have been the day I went to Freetown. I did it and then we left. It was really at the last minute, so it was the best way for sure. Then I had to leave my second group of epi and lab teams. It was like first team, second teams, my phase one and phase two teams and they were, both groups were so amazing and that was hard to say goodbye. It's like you have shared experiences and you realize the moment I walk away, I'm not going to be around people who have those experiences.

I went back to Freetown, probably stayed the night, I don't even remember. But there wasn't the type of exit process I think they should have had. Maybe that's something they were able to implement further into the epidemic, honestly, I have no idea. But I felt like there were lessons learned and things to share. One really positive thing is one of the EIS officers who was in Freetown really wanted to work with the educational materials that we had developed in Kenema, and she had done that, I believe. That was really positive. I had met with her and reviewed things. Otherwise, there wasn't much discussion and I just left.

Then, this is crazy, but I got on the flight, on the plane, and the person sitting next to me—you know, it takes sometimes up to an hour, you're sitting on the flight waiting for people to board. The gentlemen sitting next to me had his hands on his stomach and he was leaning against the side of the airplane and he was like moaning, "Augh," like that. It happened a couple of times and I was like, am I just hearing things? Then he did it again, "Oogh." I said, "Are you sick?" He nodded yes, and then he pointed to his stomach, and I was like, of all the things. [laughter] For me to sit—so I told, it was KLM, I think, because—I think it was Air France we came on, Air France had pulled out. No, it wasn't KLM, was it? I don't remember. Anyway, whatever we had come on flight-wise, those flights had pulled out and we only had one option and it was through Brussels. I told the stewardess or the flight attendant, I said, "He's sick, he's not feeling good." She's like "Okay," and she just didn't take it seriously. The entire flight to Brussels, he was sick. He didn't eat, he was grabbing his stomach, and I was counting the symptoms up. We got to Brussels, and this was early on in the epidemic, and we just walked off the plane. I'm

trying to even remember if they did a single temperature check in Brussels, maybe, and that was it. That was it, and I thought wow, I hope that he's okay. I also got into Atlanta before all of the crazy screening and stuff happened. That wasn't an issue either, just come home. But it was, I don't know, it was interesting. Things got pretty crazy after that with the media.

Q: Right, that would have been around October, like when the patient in Dallas—

Dynes: The craziness started a little bit before that. I came home right at the end of September and Anne had contacted me about doing StoryCorps, which I actually didn't know much about. She was like, "I just wanted to do it so we seal our memories." I was like yeah, I think that's a good idea. I think I came home on a Wednesday, I'm trying to remember the details of this, and the StoryCorps thing was Saturday, so it was just a couple of days after I got back. We did that, it was good—it was kind of helpful, I think, just to say things out loud, it was just like a conversation with each other. Then things went crazy from there because it was maybe Tuesday, Wednesday, when I got a phone call from NPR [National Public Radio] and they said we want to play your StoryCorps. I said, "Okay, let me get back to you." This is probably one of the funnier moments of this whole experience, I called the EOC and I was like, "I have a media emergency, can you connect me with the right person?" They connected me with the communications folks, and I said okay, I'm freaking out because they want to play this, I don't know what they want to play. I mean it was eighty minutes of discussion that they could have picked from and I don't know what to do. They said okay, well, we need to get in contact with NPR.

There was lots of contact, and they ended up sharing with CDC the couple minute segment that they wanted to play, and CDC approved—cleared it by Friday, and it played Friday. Now I've been home a week, and it goes on NPR, and from that moment, literally from the moment it played, we were inundated with media requests for about a month. It was national news, local news, international, journalists, in-person interviews, live TV interviews, everything that—now, the one thing that helped curtail that craziness was the case in Texas because that happened and that took over some of the media focus. I felt like I could breathe a little bit in November, I would say. I felt like I could breathe a little bit now.

Q: What organizations were contacting you?

Dynes: CBS, NBC, The Daily News in the UK, Democracy Now, I don't know what else. The one interview that didn't play because that next day was when the nurse got sick from—in Texas, was a CBS interview, Nightly News interview, and he said to me in the interview, "If you were President Obama, what would you do?" I was like, "I can't answer that question." First of all, how stressful is it to have to be speaking on behalf of CDC? And the interest in Anne and I wasn't really around our role, it was around the interpersonal stories of what had happened and what we saw there. We kept getting this, oh yeah, it's fine, you can do that interview; oh yeah, it's fine, you can do that interview; from CDC, which was nice of them. However, it was stressful because I felt like, what if I say something wrong? One of the interviews with Democracy Now, which is an online news organization, but it was a live interview, I had the little earpiece and I was seeing

the monitor of the people in New York interviewing me. There's news scrolling and it says, "Dr. Frieden from CDC speaking to Congress," and so they're like, "As we speak, Dr. Frieden is talking to Congress. What do you think Congress should do?" They are making these recommendations for banning flights to West Africa. I was thinking in my brain, I have absolutely no idea what Dr. Frieden thinks about that. I just said, "Well, I am not speaking for CDC, but for myself, I would say—" and I gave all the reasons why I thought that was a bad idea and how that would really ultimately hurt controlling the epidemic. But it was moments like that where I just thought, oh my gosh, I could really mess this up. Everything was fine, and I don't think I said anything that was challenging or counter to what CDC's position was, but it was just being in the role of needing to speak for CDC that was tough. I actually appreciated when that died down a little bit.

Q: Were they asking you to recall a lot of the same experiences?

Dynes: It was always about the baby in the box story, which wasn't even—I didn't feel like that was my story to tell, first of all, because I didn't know the baby. When we got there, the baby was in the nurse's station being cared for by the nurses, and I knew that the baby existed and that was happening, but I didn't know the baby—we knew what happened after that, which is the UK nurse got sick and then like ten other nurses got sick and I think they all died except for the UK nurse, and that was what the media was clinging onto, was that story. I felt, I don't know, I didn't feel like it was my story, even though I was in Kenema when it happened and I knew the nurses and I knew the UK nurse, that was such a personal experience. I feel like the positive thing that came out of

the media attention was being able to share with people in the US and globally how bad the epidemic was in West Africa. I said on interviews, “I understand people’s fear in this country having had that case, having had the nurse case, but the epidemic is happening in West Africa and we can’t forget that.” We have to keep bringing attention back to that and the fact that they’re continuously working, day in and day out, without support, without the resources they need to keep themselves safe. I think it was also a good opportunity to bring attention to the plight of nurses as care providers in a situation like an Ebola epidemic because if you consider, why do nurses become nurses and not doctors? Some people might say because they couldn’t become doctors. Okay, fine, that’s one argument. I think the bigger, more intelligent argument is that it’s because nurses want to do the caring. You have an epidemic like Ebola and you can’t touch people. You can’t reach out and comfort a mother whose child is dying next to them or comfort the baby who’s sick. They were faced with these decisions on a daily basis that were ethical conundrums, there was no right answer. You have the baby in the box example, the mother is sick, the baby is not. What do you do? Do you want to send that baby into the ETU where assuredly the baby would get sick? They didn’t want to do that, and they keep the baby with them, and ultimately it led to a dozen deaths of nurses because they couldn’t just say I can’t do it, I can’t take care of the baby, because it’s who they are professionally. Which is why it was so difficult for me to not do what I could do professionally. It’s like, you have an obligation, you are who you are, which is what brought you to that profession, and now you’re in a situation when you cannot touch people. Doctors are not known for their bedside manner, nurses are. When you ask people about hospitalizations, what do they remember? They remember the nurses who

were there with them. If you are a nurse and you cannot provide the comfort that you're trained to provide, you're not even trained to provide, it's just who you are. I feel like if I were to do things over, I might do some more work on the impact this was having on the nurses. I did those focus groups with health care staff and with pregnant women to understand how Ebola was impacting their work and their ability to do their job for routine services, because that matters for pregnant women. They need care, they need to deliver in a facility, yet when you have an epidemic going on, people don't want to go to the facility. It was important to understand that. But I also wish I had been able to have the time to understand the impact it was having on the nurses. Almost every single pregnant woman who got Ebola died. Almost every single one. I heard of one person that didn't. Especially when you have pregnancy, which is by and far a very healthy, normal part of life—and you're not even just talking about one life, you're talking about two lives. To see how Ebola just wiped out every pregnant woman who got it in such a traumatic way, I can't imagine how that impacted the nurses to see that, over and over.

Q: How do you feel like your experiences as part of this Ebola response affected you and your career and you personally?

Dynes: I don't know, it's hard to say. I think that it reinforced my own desire to do work like that. I had already been with the emergency response branch doing disaster-related work, emergency-related work. Definitely it reinforced what I already knew about wanting to do that work for as long as possible. I think I'm good in situations like that. People have different personalities and can be successful in different types of

environments, and I feel that that's the one that I'm successful in primarily because I'm very action-oriented and productive. I can be really productive in short amounts of time. But [as for] long-term [effects], I don't know. I think I've developed special friendships with people that I was there with that certainly will probably have some impact on my long-term career. At the same time, there's this giant number of people who are involved with the Ebola response who didn't have that day-to-day interaction with the real epidemic, and it was planning and meetings. That is so important, but they didn't have the same experience. In some ways, it's difficult to connect with them, for me. I don't know. I hope that it was just one among many experiences that just makes me better at the job that I do. Lessons learned. I feel like I would be better in terms of being productive the next time it happens, in responding again. But I don't think it's changed my career trajectory because it's what I always wanted to be doing anyway.

Q: That makes sense. Are there any memories that you have that I haven't asked about that we haven't gone over, any aspects of your experience?

Dynes: One thing I wanted to talk about was the experience of these local EOC meetings that I think I mentioned earlier.

Q: Are those different, I wanted to ask, from the District Health Management Team?

Dynes: Yes. The District Health Management Team meetings were in the mornings and then the EOC meeting was in the evening, at the end of the day. And that meeting was, I

don't know how to explain—my experiences in general with people in West African countries is extremely positive and people are very honest and can talk freely, whereas sometimes in East African countries—this is such a generalization—people tend to not speak as loudly. They want to make sure they don't hurt your feelings. They are very respectful in that way, but you don't always get the full information. West Africa, it's not that way, people say what they think, at least that was my experience. These EOC meetings were a lot of times just people yelling back and forth, arguing. They were under so much pressure and stress that it would boil over in these meetings. These were the meetings. Like, it doesn't even seem real anymore. There was one meeting in particular, where the things that were being discussed just sounded unreal, like they were arguing and to the point of yelling because no one could decide how many people had died that day and how many people had been buried. The numbers were big enough that that was an issue. There was a lab technician who was giving people—telling people that he was giving them Ebola tests, a rapid Ebola test, which doesn't exist, and charging money for them and then telling them they were negative. This same individual was arrested eventually and then got sick himself. I was listening to this story, thinking how much I didn't believe what I was hearing. Then they said he got out and ran through the town, had like three hundred contacts before they finally found him again and caught him, and he died. But that happened, and then they were screaming about the fact that there were four bodies in the pediatric ward that no one wanted to deal with. I don't know why. I can't even remember the circumstances. And I was like, there were four babies in the pediatric ward that have died, and no one wants to do anything? It was like that, it was people getting buried without knowing who they were because ambulances would come

with multiple people. One ambulance, in particular, came in the middle of the night with three people, I think from Freetown or another area. One of them died along the way and the other two became unconscious. They had information for three people, but they had no idea who was who. So they were just buried. They were all just buried. Families will never hear back. It was such chaos that you couldn't get to the point of matching names with people. To imagine that these villagers were sending off their loved ones and would never hear from them again and never have an outcome is pretty overwhelming. When I did those focus groups, people were saying that. They said, if they leave, they won't come back, and it was almost true. WHO was doing the best that they could in managing that ETU, but it wasn't enough. They didn't have enough people with the right skills and it was chaotic. At one of these meetings, the guy who was logistics, he did his little review of what they had and what they needed and he said, "We have four body bags left. It won't last through tomorrow." And they had no idea how they were going to get more. I think at one point there were twenty-four body bags left in the country. Kenema alone would have needed those for the next two days. What do you do? We're six CDC people sitting there, hearing this. I don't know what we should have done. But those are the types of things I would send back in those bullets, four body bags left. How are the burial teams going to deal with bodies when they don't have any protection at all? It was those moments when you started to feel like it's never going to end. How could it end when we have so much chaos right here? It wasn't their fault that these meetings were so contentious, it was the situation. They were working sixteen hours a day from the very beginning and we just came for six weeks and left. I feel angry at myself now when I think back. I remember one Sunday, the psychosocial team told me they weren't going to

come to the EOC meeting that night. I remember at the time feeling frustrated, like this is really important, this is an emergency, we all need to—and I think now how ridiculous I was. They were there for the months before I came and they were there for the months after I left. No one was doing self-care, you know, your question about self-care. We weren't eating lunch, we were eating a tiny little bit in the morning and then we were having chicken and rice at night, every night. There was nothing in between. There wasn't time for self-care at all.

Q: Can I ask a question?

Dynes: Yeah.

Q: This is a little different tack, but I don't really understand the difference between why there was the District Health Management Team and why there was the EOC and the composition of those. Was the EOC something that CDC put together?

Dynes: I'm not sure if CDC put it together or not, but it was happening at the hospital. It was more, I think, the groups based at the hospital.

Q: Okay, sure.

Dynes: And the other meeting was other district, regional kind of administrators.

Q: And those took place, those meetings took place—

Dynes: At UNICEF, I think, at the UNICEF office.

Q: Okay, gotcha. Okay. I just ask because I—

Dynes: No, there was overlap in people who went to that. But the EOC, I think, meetings were more about contact tracing and how many people have died and let's get the update from lab, how many people are positive today? It was kind of running through where we were at with the epidemic.

Q: Sure, sure, sure. I have this conception of the EOC as, you know, this is the organized command structure of how CDC likes to manage emergencies, like other agencies like FEMA [Federal Emergency Management Agency], and that very organized and efficient structure gets mirrored at the national level of different countries that CDC works with and then at the local level.

Dynes: It was, I think, a version of that. But it was probably the most stressful part of every day. It was everyone—it would start at 6:00 pm and sometimes we would leave at nine.

Q: Sure. And it sounds like it was more chaotic than I'm imagining.

Dynes: Oh, it was stressful, I think. Everyone was stressed. There were many EOC meetings filled with—they were trying to figure out how to enumerate the corpses so that they could keep track of who they were and what was the process, and it was talking about processes. Who are we calling in to do that? What do we need? How many PPE do we have, how many more do we need? It was really those details. But everyone in that room was under a lot of stress and it was stressful just to sit and listen to it. It's really hard to describe. It wasn't their fault. No one was inappropriate, it was everyone was under so much pressure that it came out—everything people said in a question came out as more of a, why aren't you doing that? Or, why didn't that happen? Whose job was it to do that and why didn't it happen? That's how it came out. They were dealing with a crazy situation. They would find out a nurse was in one of the wards being cared for by other nurses because she didn't want anyone to know. It was things like that, terrible, sad stories. Yeah, it was, it was very different from the District Health Management Team meeting because that was a little higher level. The EOC meeting was details.

Q: Right. This center, like this hospital, this—

Dynes: Yeah, where everyone is getting sent from across the country, everyone is coming here. And we don't have the capacity. I was walking in between our office and the WHO office, and there was a woman, and she started talking to me and asking me about something related to Ebola. I realized from that conversation and then going, talking to the ETU that she was one of the people that they were just having walk around because they really didn't think she was going to be positive. They just had a feeling, so she was

walking around. That was happening every day to us, not to us, but just in general. A family, I remember—oh, I don't remember the details, but a family was there for weeks and I don't remember if it's because they all came to get tested. They were just waiting. Maybe their village wouldn't let them back in. Honestly, I don't remember, but I would pass them every day, they were just in the hospital grounds wandering around, just waiting, waiting, waiting. I don't know, it was just chaos. Hospital waste getting washed down the paths when it rained hard. When I mean waste, I mean blood. It just did not have what they needed to be safe. That's why so many of their health care workers got sick. They did not have the capacity. And the world did not respond enough, really. It's kind of devastating to realize how little support they were getting. Yet, we had these hotels filled with people in the capital, filled. It's a political game CDC has to play and I totally get that, but the distribution of resources, of even the human resources, was questionable at times. Probably just because we were in the moment and we just thought, why aren't there more people here, but there were other places that were having that moment. Not in Sierra Leone, at the time—Kenema was the center of it, but certainly in Guinea and Liberia. We needed more people, but I'm sure other places needed more people too. But it was frustrating.

Q: And other places then would share that dynamic of maybe there were fewer people in the field and more people at headquarters?

Dynes: It was always like that. It was exponentially different. We would get these emails from the EOC, you know, four hundred and some people engaged in Ebola activities, and

we're looking around like, where are they? Because they're not here and this is where we need them. If the epi team had actually been able to engage in contact tracing in supporting those teams, that would have been amazing. They really couldn't, they couldn't do what they needed to do because they were so backlogged. The EOC meetings were a point of time when everyone got together and frustrations boiled over. We would all leave that meeting feeling like oh gosh, when is it going to come to an end? And then write our bullets on the way home and hopefully get something to eat before ten o'clock and go to sleep and start again.

Q: Was there an incident manager?

Dynes: In Freetown.

Q: Okay, but not for the local EOC?

Dynes: Oh, well, the—gosh, who would that have been? It was not being run like an EOC. It was being run like a meeting.

Q: Right, it was a meeting.

Dynes: Yeah, it really was just a meeting, like no one used that space outside of the meeting itself.

Q: Okay, okay. That makes sense.

Dynes: They called it the EOC meeting. Towards the end of my deployment, even the lab moved. The new lab team that came in pretty quickly was like, it's not safe for us to be here and just felt like they needed to leave. They did, they moved shortly. As my deployment was coming to an end, they were literally leaving.

Q: Left to Bo, is that right?

Dynes: I think so, yeah. Oh, the memories are so strange. I was walking to the EOC meeting with one of the epi team and we were walking and just talking about, how are you doing? How are you doing? Checking in with each other, and just as it always happened, a little truck came by and someone was—a corpse was just lying in the back with legs out the end of the back of the truck. It just went by and we kept talking and walking and then she said something like, "It's not normal." This isn't normal. It's good to be reminded that that's not normal.

Q: Yeah, no doubt.

Dynes: I don't think there's anything else, I was going to check, yeah I don't think so.

Q: Okay, well if you do have some thoughts that come up later, I would always love to have you back and do another session of these. So thank you.

Dynes: Thank you.

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