CDC Ebola Response Oral History Project

The Reminiscences of

Yolonda Freeman

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2016

Yolonda Freeman

Interviewed by Samuel Robson
August 30th, 2016
Atlanta, Georgia
Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson, and I'm here today with Yolonda Freeman. Today's date is August 30th, 2016, and we're here at the CDC [United States Centers for Disease Control and Prevention] Roybal Campus's audio booth in Atlanta, Georgia. Yolonda is joining me today to record for the CDC Ebola Response Oral History Project. Thank you so much, Yolonda, for being here. I usually start out just asking, can you pronounce for me your full name and tell me what your current position is with CDC?

Freeman: My full name is Yolonda Freeman. I'm a health communications specialist with OPHPR [Office of Public Health Preparedness and Response]. I'm in the Division of Emergency Operations, and I've been at CDC for twenty-five years.

Q: Is it twenty-five this year?

Freeman: Yes, it was twenty-five in July.

Q: Wow, congratulations.

Freeman: Thank you. Never thought that was going to happen.

Q: [laughs] We'll get into that. Can you tell me when and where you were born?

Freeman: I am originally from Cleveland, Ohio. I grew up in Cleveland and went to college at the University of Cincinnati.

Q: Can you tell me about growing up in Cleveland?

Freeman: I grew up in the suburbs of Cleveland, in Garfield Heights, actually. It's no different. I guess I just grew up in an average, middle-class, suburban neighborhood. I never thought I would work in public health. That was just a fluke. I grew up thinking I was going to become an attorney, to be honest, and fell into public health.

[break]

Q: How did you decide at that younger age that you were interested in maybe becoming an attorney at some point?

Freeman: I think probably watching television. I was quiet. I wasn't very outspoken, outgoing as a child. I was active in my church and semi-active in school, but I had a passion—I really liked law. I liked the debating that came with becoming an attorney.

[break]

Q: Were there subjects that you were attracted to in school?

Freeman: Actually, I enjoyed math. I loved to read. I read a lot as a child. Enjoyed reading fiction, mostly, and autobiographies when I was a child. I loved mostly reading.

Q: Any particular autobiographies that you remember?

Freeman: There's a couple—actually, when I was in eleventh grade, and I hate to say it—I went to a school that wasn't very diverse. [laughs] I was the minority in the school. My eleventh-grade English teacher wanted me to read *The Autobiography of Malcolm X*, which at that time I was like, why is she wanting me to read Malcolm X? Nobody else is reading Malcolm X. It stood out, and actually, the other book that always stood out was Richard Wright's *Native Son*. I actually read that book twice. Those are the two that stand out from high school.

Q: You said after high school, you went to Cincinnati for college?

Freeman: Yes, I went to the University of Cincinnati for college and then decided I wanted to become a business major. Actually got my degree in marketing, so everybody always wonders, how did you end up in public health with a marketing degree? But since I'm a lot older than I look, when I graduated, a lot of companies were getting rid of their marketing or downsizing their marketing department, so it wasn't that easy to find. I

really wanted to work in sports marketing. My dream after law went away was to actually work for the NBA [National Basketball Association]. That was my dream job, was to actually work in sports marketing and to work in the NBA. But as we can see, I didn't get there. [laughter]

Q: That's okay. I mean, it was years of turmoil for the [Cleveland] Cavaliers until they won the title this last year.

Freeman: Yes, and I was in American Samoa, looking at my phone as I watched ESPN do the play-by-play, and then it got stuck at ninety-three to eighty-nine with ten seconds left, and I was in a panic, what happened, what happened? Then when I was like, oh my God, we actually won. Being from Cleveland, it meant the world. [laughs] It meant the world to me.

Q: That's great.

Freeman: I've been a Cavs fan. I see them every time they come to Atlanta.

Q: Beautiful. So what kinds of jobs did you hold after college?

Freeman: After college, I became a substitute teacher. One of my favorite aunts was a teacher, and since I didn't have a job, I substitute taught for a while and realized teaching was not for me. I also worked for the Department of Health and Human Services in

Cincinnati—not HHS—it was actually, most people know it as the welfare department. I was a case investigator for them, working with people who were on public assistance. I did that for a while, and then actually looked—because I had a desire to move to Chicago. This is how old I am, because we still looked in the paper for jobs. Saw an advertisement for a disease intervention specialist. You called a one-eight-hundred number and it said something like, "If you don't mind working in low-income areas, the jails, drug-infested areas that you may have to work in," and I decided well, I'm just going to go ahead and apply. I had my father listen to—what did I say, "Daddy, listen to this." When he hung up he was like, "I don't think too many people are going to be applying for that job." [laughs] And it actually was a job with CDC. I interviewed in Detroit. My initial interview—at the time, CDC had four training sites, and one was in Chicago; LA [Los Angeles] area; Atlanta; and Florida, Miami-Fort Lauderdale area. Because I had a desire to go to Chicago, I went to Chicago and started out as a public health associate, at the time, as a disease intervention specialist working in the STD [sexually transmitted disease] clinic for CDC. As I stayed in—I didn't know what a public health department was. [laughs] I hate saying that now. I knew nothing about public health. I just knew I wanted to move to Chicago, and this job was in Chicago. Twenty-five years later, I'm still here. [laughter]

Q: Do you remember some of the early things that you did on that job?

Freeman: Oh yes, plenty. Because what we were responsible for doing was when a person came in with mainly syphilis, at the time—HIV [human immunodeficiency virus]

wasn't really—because this was the early nineties, and HIV was just popping, coming out—we were focused on syphilis. If a person came into the clinic or at the hospital or we received them, we did contact tracing. We interviewed the patient, and we had their contacts, and we would go out to the field, knocking on doors, trying to get those people back into the clinic before it spread. It was really important, especially if the person was pregnant, to get them in the clinic as soon as possible because they could have had a congenital syphilis baby, and that was the one thing you didn't want. I remember the first time I shadowed one of the supervisors. As I stated, I grew up in the suburbs of Cleveland, I had never been in the projects I don't think, at all, or especially projects like in Chicago which are well known. We went into—I think it was the Robert Taylor homes at the time, and I shadowed him as we were looking for contacts. We were walking the stairwells, and there's drug deals going on, and my eyes are getting bigger and bigger as we walked through. He comes back and he tells my supervisor, he says, "I don't think she's going to make it." [laughs] He's like, "I don't know if she's going to make it. She was a little scared and a little skittish out there in the field." Every time I see Aaron [K. Zee], because Aaron is still at CDC, I say, "I'll never forget you telling that story that you didn't think that I would make it." I was a little bit of a naif in a different world at that time, but I learned to adapt. I was put in some very compromising and dangerous positions while working in the field, but people are people. A lot of it is about how you treat them and showing them respect. Their circumstances of where they live is for various reasons, but I think the most important thing is to respect them.

Q: Was there a time, an interaction that you had with someone at some point, that really illustrated that truth to you?

Freeman: After Chicago—with the training sites, you stay in one city for like eighteen months, and then you transferred. I was transferred to Prince George's County, Maryland, which is right outside Washington, DC. I think there, I had several. Most of them were HIV related. One I'll never forget, because it was a young lady—the gentleman named her. He was like, "She's going to know." Because of confidentiality, we never told. He's like, "She's going to know it's me." I said, "How do you know?" He said, "I'm the only person she's ever been with." I was like, "You don't know that for sure," and he's like, "Yeah." So I met her, she was about my age. She was a college graduate just starting her career. We started talking, and I told her she had been exposed to HIV. And she tested positive. I had to tell her that she was positive, and at that time, I said, this could've been me. Our worlds were not that different. Due to circumstances, she didn't—it wasn't like she was out on the street prostituting or anything. She met somebody that she fell in love with, and she was willing to commit to that relationship. That changed a lot. The view—and especially because this was the beginning of the HIV epidemic, and at the time it was focused mostly on white, gay males, and it wasn't even thought of, of Black women, who are now the highest number of infected. That's when it became real to me. I mean, it had always been real, but because that could've been me on the other side of that conversation—I'll never forget. I tried—it wasn't in my best interest to keep in touch with her, because I would've gotten emotionally—and I really don't know to this day what happened to her. That was one instance, and then there were a couple others, and

they were HIV related, where it wasn't like they were sleeping around or doing anything. It was just the wrong person who they did, and you had no idea. The outreach wasn't going towards Black females at that time. There's a couple stories like that.

Q: At that time, were you doing anything communication-related, related to the outreach part of things?

Freeman: We were doing—a lot of it—we worked out of schools, and in Prince George's County, we had an outreach team and we would go out into the community and talk about STDs and HIV and doing STD prevention, talking to people about condoms and things that they could do to prevent themselves from getting infected. We did a lot of community outreach and working within the schools and with community organizations. That's probably where my communications started to be built, is actually in Prince George's County, because we did a lot of outreach activities.

Q: What happens after this?

Freeman: It's interesting. When I first started with CDC as a disease intervention specialist, we would still get the announcements—at that time they were paper, and we would get paper announcements, and I saw a position for a health communication specialist. I was like, this is what I want to eventually do. Which is really kind of unheard of, that a person comes out of a PHA [public health advisor] and goes into another series—especially another health communication specialist. Then later, a friend of mine

who worked with me, she ended up getting a position as a public affairs specialist within the director's office, and that was really unheard of, but her background led to her getting that position. So I said, I know this is possible. I volunteered, I did a lot of volunteer work. I would volunteer with the Washington, DC Rape Crisis Center as a spokesperson, actually going out to do speeches about rape prevention, and actually took some classes. I started doing extra activities so that it could prepare me and make me better qualified to become a health communications specialist. After Maryland, I went into the HIV program and moved back to Chicago. While in Chicago, we did a public access channel where we talked about HIV, TB [tuberculosis], and so I was able to do some communication stuff by actually participating and doing the television show.

I eventually got a position with ATSDR [Agency for Toxic Substances and Disease Registry] as a health communication specialist working with communities that had been impacted by toxic substances, and going out and doing health and communication and health education in communities that had been affected by either some toxic substance or possible exposure to a toxic substance. That's how I ended up getting into health communications.

Q: When you say "toxic substance," what kind of—

Freeman: It could have been arsenic. It could've—I dealt with a lot of communities that were near military installations, so it could have been whatever. They could have been exposed to some—could have been lead or anything that—especially if it's near old

industrial sites, because regulations changed and it got into the soil, or it could have gotten into the water. The unfortunate thing about that is that we could see that people in the neighborhood had cancers and different kind of cancers, but we couldn't definitely say, your exposure to this could've led—because there's also other factors. Because we would go and do community meetings. They were ranting and raving about what this plant could have posed, but then they take a break and they're all smoking. And we couldn't say anything, that you're also putting yourself in danger by smoking, because they only see yes, it's this chemical we're exposed to. It was a difficult challenge to work in that environment because I couldn't say yes, you were exposed to arsenic, this is what caused you to get sick. Unlike HIV or STDs, where I can definitely tell you that this is what the cause is, you couldn't do that in environmental health. That made it a little difficult, and it made it challenging because people wanted answers. Unfortunately, the science isn't truly all there, in one instance, when it comes to this, because there's so many other factors that take part in why this person got cancer and this person didn't.

Q: It sounds also bound up with issues of liability, right? And corporate responsibility and government responsibility, if it's by a military base in these things.

Freeman: Yes. It's challenging for ATSDR in a sense because they're funded by superfund funds, which are usually given by the person who caused the problem. I don't know if we need to put that in there, but so it's one thing people—when you go out and they see that, especially where we're EPA [Environmental Protection Agency], that you're funded by who could have caused this. Especially if it's the Department of

Defense or the Department of Energy or something. We are a government agency. Not that that affects any of the science base that's gone on with who funds it. It's just that the perception that the community may have.

Q: That's fascinating. But we should probably move on. Sorry, I have my own little interests in things. So what happens after that?

Freeman: After ATSDR, I took a position with—at the time we had the marketing center, and within the marketing center was the Emergency Risk Communication Branch, which I ended up getting a position within the Emergency Risk Communication Branch within the marketing center, and that focused primarily on emergency response. Working in the Joint Information Center, doing communications during hurricanes or any of the responses. I've been primarily, for the last several years, working mostly on emergency responses—communication for emergency responses. In the beginning, it was strictly within the Joint Information Center. Now I'm in a different team, and so I'm not focused so much with working within the JIC [Joint Information Center] anymore.

Q: What year did you come down to Atlanta?

Freeman: I came to Atlanta in '99. Ninety-eight? Yeah, '99.

Q: Late nineties.

Freeman: Yes. Late nineties. [laughter]

Q: Any situations there with emergency response in communications that really stand out to you when you think back?

Freeman: In the beginning of my emergency risk—yes, I think we had a TB case that was unique in the sense that it was [MDR, multi-drug resistant]—I have to look up and make sure. We had a TB patient who traveled, and tried to avert, and the challenges with communicating that out to the public without fear, and also not making him feel like he was a criminal. I think unfortunately he did feel like he was criminalized, and he was sick. It was interesting because we went to an event in Piedmont Park, and he was there. You see this person on TV, and this person has a name, but to actually see them face to face—not saying anything to him. We weren't there as CDC. Just a group of us went to an event. To actually see the person we had worked with and talked about—

Q: So this was—

Freeman:—for months.

Q: This guy was high profile? This guy was on TV?

Freeman: Yes, he was on TV because it was—this is like one of those cases probably where you look at global security now has come out of, because this person traveled

overseas. He travelled through Canada, and he had an infectious disease, and how quickly that could have turned into something else that we'll get into later. That probably is the beginning of looking at, how secure is our health when you can get on a plane and be somewhere else in four hours in a different country?

Q: Can I ask, during these years—I suppose, a little less than fifteen years before Ebola at CDC—are you mostly communicating with the communities most affected, or are you doing the media outreach, or a mix of the two?

Freeman: When I was working inside the JIC. We were doing a lot of the internet—putting stuff up on the web pages. We were also working with the states in getting messages and getting the information cleared here at CDC that the states could use, out in the states. Or at that time, because I wasn't working deployments or with field staff, so that they could get that—and with our partners to send out, like during the hurricanes, Rita and Katrina, we were sending out materials and messages to get out to the public that way. It was the real beginning of social media and tweeting. We had just started trying to tweet messages out during one of the hurricanes, I think it was Rita, was the first time we actually tried to use—not tweet, but use SMS [Short Message Service] messages out on people's phones to get messaging out, because it was new technology to do that. This was all before—now it's like the norm, and social media's the biggest thing, but at that time we were just testing some of the new technology to able to get out to the public and seeing if they could get text messages about an emergency.

It was two parts. We also had the healthcare community, and getting messages out for the healthcare community, because it was really important for them to know what guidance, especially during [influenza A virus subtype] H1N1. We had to work with different sectors to get messaging with healthcare, with the schools, and everybody else. We did a mixture of communication within the JIC, the Joint Information Center, to get out to the public.

Q: What were you doing right before you got involved in West Africa?

Freeman: I was actually the team lead for the information management team within there, and we were responsible for getting things cleared, the clearance of information. How I got into West Africa is that I did a STOP assignment, which is "Stop Transmission of Polio," in 2010. I volunteered to do a STOP assignment that led me to Nigeria. I had been to Nigeria previously to do some risk communication training—emergency risk communication training—and that had to do around bird flu and H1N1. We did that in Nigeria and Kenya, but this was the first. I had previously done an IETA assignment—an [International Experience and Technical Assistance assignment] with GAP [Global Action Plan]—it was called GAP at the time—in 2006 in Ethiopia. So I had a little bit of international experience before STOP, but STOP was totally different in a sense that it took me back to Nigeria, and I was in the northern part of Nigeria at that time, working with UNICEF [United Nations Children's Fund] and WHO [World Health Organization] for polio eradication. It was a totally different experience than my IETA. One, because I

wasn't there as a CDC employee, so all of the perks of being a CDC employee were out the window, and then—

Q: What do you mean the perks of being a CDC employee?

Freeman: You work with the embassy. You work with the CDC office and staff within the country. This time, I was working with two internationals, and you followed their rules and their security, and you stayed where they placed you more so than with my IETA assignment. Both experiences were great. They were just totally different. That's how I got involved, actually, with working in West Africa.

At the time, Boko Haram and all of the dangers were underlying. There wasn't bombing going on. Bombing had happened the day we flew out for Nigeria, but it was pretty safe and we could go to areas that now are restricted. It gave me a real opportunity to work within the villages. Work within a lot of the villages there, in the sense of meeting the people. I just told Dr. [Thomas R.] Frieden, I had a conversation with Dr. Frieden last week, and I told him it was amazing because I'm a Black American and I go to northern Nigeria, and they look at—I'm stared at. I kept wondering, why are they staring at me? You don't expect to go to a country of color as a person of color and feel like this outsider. It was explained to me that, "Well Yolonda, you look a little different. Your features and everything." I was like, oh. Then I also realized that the majority of people in northern Nigeria had never seen a Black American before in person or experienced that. They thought of me as a darker skinned white person more so than that, so that was

a big adjustment for me also to just, well okay, they're not accepting me as them. Which is understandable, but that is kind of a culture shock to you when you actually go there because you think I'm going home or something, and it's like no, not exactly. [laughter]

Q: Can you tell me more about the substance of the work you were doing?

Freeman: I was working in communications. In polio, they have what are called polio campaigns, and once a month, they would go out—or every six weeks, they would go out and actually give the drops to the children. As a Westerner growing up in America, you just expect that people will take the vaccine. How are you going to allow some strange person to put vaccines in your child's mouth? It was challenging because one of the things is that they didn't trust the vaccine because it was from the West. They thought it was a way of getting rid of their culture and their people because it was predominantly a Muslim part of the world, and the challenges of communicating. Also, because I didn't know the language, so I was a stranger to them in that sense. It was a big learning curve, and for me to be able to get people to even trust me to walk into their homes and into their community, and eventually, with an interpreter. One of the things that I saw when we would go out into the communities and doing the vaccines, at that time, older women would come out and talk to the parent and usually the home care person, the child care person, to convince them to take the vaccine. We have to do a project when we're in STOP, so I created what was called a neighbor-to-neighbor project. What it was is to train neighbors on how to communicate with their neighbors and talk to them about polio and the vaccine, to gain their trust and knowledge that this is a good thing. So that they

could assist someone, people come out, that they're more willing to take the vaccine. I created a project for that and a training for that, and after I left and I sent it back, they eventually used that as a pilot to develop what became the volunteer mobilization. They brought in and started training mostly women, because men are not allowed in the homes if the man is not there. It spread it into something that's a much bigger project that they've used, and it's been very successful in northern Nigeria to get children vaccinated.

Q: It's still about finding people in the community to do educational work, outreach, within their own community?

Freeman: Yes.

Q: Wow.

Freeman: Yes, which was very key to the success in Nigeria because you can't always send someone who looks a little different, sounds a little different, dresses a little different within their—and the women who are the volunteers for this are known in the community. These are people that they trust and they're known in the community. That was really important, to use trusted sources to get—because if not, it wouldn't have been successful.

Q: Right. You went to Nigeria in 2010? Is that right?

Freeman: Yes.

Q: How long were you there that time?

Freeman: I was there from October to December. Two weeks after I left, they started bombing. I was probably the last CDC person that STOP has ever been able to send to northern Nigeria. It was a couple of us in that class, and we were probably some of the last who were able to go and stay in northern Nigeria, because right at Christmas time—we got back a couple days before Christmas, and that's when the bombings started.

Q: Who was doing the bombing?

Freeman: Boko Haram had bombed a church at Christmas time. It was actually probably a couple of days after I got back. That was the start of a lot of the terror that began in northern Nigeria.

Q: That must've been difficult for you.

Freeman: It was. It was difficult. It was also difficult when they bombed the UN [United Nations] house, because we had spent so much time going—doing and taking care of it because we were there under the UN mission. When I saw the bombing at the UN house, it was very difficult. When I went back with CDC for polio, we rode by the UN house to see it and the destruction that it had caused.

Q: Wow. So what happens after you come back? It's, I guess, early 2011?

Freeman: Yes. Early 2011, I go back to working in the Division of Emergency Operations, and I'm not working in the Joint Information Center anymore. I'm working with a different team, and basically doing communication for getting people as responders. We'll go a little further. Then in 2012, Dr. Frieden initiates the IMS [incident management structure] for polio. Because of my work previously, the global polio program asked me if I would go to Nigeria and assist them with the polio eradication efforts in Nigeria. So I went back and forth for probably two years with GID [Global Immunization Division] to work on polio, working with UNICEF and WHO and the [Federal] Ministry of Health to come up with programs and communication efforts and training for the polio eradication efforts.

Q: Can you tell me more about working on creating the trainings?

Freeman: Yes. By that time, they had started the volunteer social mobilization teams, and so I was assisting UNICEF on some of the training for that. Actually, we had someone come in and do an evaluation. We had also—CDC has started an NSTOP [National Stop Transmission of Polio] program—it was the Nigeria STOP program—and brought in Nigerians to assist, and we had some training to do with them. We also developed a radio program with Voice of America to go out and train journalists on how to report on polio and other health issues. We did a lot of the training in the North with VOA, and VOA ran

it as programming to get some—they would do these community roundtables. We had to be very careful because they could not be totally open to the public because we don't know who could actually come in. We would have them and air them on VOA radio so that people could actually hear and could know, and even though we couldn't do them in the public anymore—because at that time, we couldn't—the CDC, the US government couldn't go outside of a certain area. We could not go actually to where polio—because all of our restrictions, because it was too dangerous for us to go outside, to the areas in northern Nigeria. Eventually, it started to slow up, and we could actually get out and be able to travel to some of the areas where polio was still active. But the two areas—Yobe and Borno—we could never go, because it was just way too dangerous for us to go up there.

Q: What was it like working with UNICEF and WHO?

Freeman: I spent most of my time with UNICEF, and I loved working with UNICEF. I loved working with the staff at UNICEF—they're like family to me, even to this day—and doing the projects with them. What was even more exciting is—and we ought to talk about the Nigeria Ebola—but during that time, I met someone who worked with Nollywood, which is the Nigeria Hollywood, and got a project so that they could actually do some movies and stuff. That was probably the last thing I did before I left. That was exciting to see. The thing I always tell people about my deployments and working on these assignments is that you can actually see the work that you're doing in progress, versus me sitting on the fourth floor, where I can't really see how I'm impacting a

community. Having that opportunity to see the impact of something that you thought of and you talked about and worked with people on creating, to actually see the impact it's having is amazing. That's part of what I enjoy about working in polio, because even though they've had a case recently—to see Nigeria, to make it almost two years without a polio case, is amazing. To be a part of that is an amazing thing.

Q: What happens then?

Freeman: I still was working. In July of 2014, I was in Nigeria, in Abuja, working on polio on a team of CDC staff. We were there doing some work with NSTOP and UNICEF and other partners working on polio. About that late July evening, we get a call from the Ministry of Health. John [F.] Vertefeuille and Dr. Frank [J.] Mahoney were there, and they get a call that a patient had arrived in Lagos—at the time, we didn't know it was Ebola—who was sick and had hemorrhagic fever, is what they thought. They were watching it to see what the patient had. We find out it's Ebola, and Dr. Mahoney goes and takes a team of the NSTOP staff with him to Lagos. About three days later, he's calling, "Yolonda I need you to come. We need you to come down here and help with the communication and the social mobilization." And I was on a plane to Lagos.

At this time, we knew it was Ebola. The patient had died. We knew that we had people out in the community. The thing is, people don't realize that Lagos is the most populated city in Africa. It's not only populated, it's densely populated. It's also probably the airport with the most traffic out of West Africa. It also has very, as we call it,

megachurches. These megachurches are humongous amongst West—people come from all over Africa looking for healings. We had all been watching Liberia and Sierra Leone and Guinea on the news, and now we were faced with it in Lagos. Probably the worst place in the world you wanted to have an Ebola outbreak, because even though it is one of the most populous and has a little more infrastructure, the hospital system is not that strong. He went into a private hospital. At the time, he was sent to a private hospital.

Not thinking I was ever going to have to work on Ebola, because I was working polio and I was going to stay in polio, and I get to Lagos. I always say it was probably one of the scariest moments in my public health career. It wasn't that I was afraid that I was going to get Ebola, it was just, what was going to happen? Because we didn't have a place to put patients who were coming down with symptoms—the government hadn't provided a hospital, a wing—nobody was taken. Because people had seen what Ebola was doing in other parts of West Africa, they were afraid, and panic was starting to come about. People think, why didn't the CDC just go in and do—we can't just go in, renegade, in any country. We have to have the government's assistance. We have to have permission to do a lot of these things, and working with WHO and UNICEF and other partners, to go in and do this. It became frustrating because in the beginning of the response, I think the government just didn't know what to do. They took the hands-off approach, not realizing this is a serious matter.

Q: What does the hands-off approach mean?

Freeman: At one point, because we didn't have a place—they kept saying, we're working on it, we're working on it. In the meantime, there are contacts that are becoming symptomatic. They're in the households with their family. They're out in the community. They couldn't stay in those areas, and we had no place to take them. Because everything is run by the government, the hospital system, the public system. We kept asking, where are we going to take the contacts? Where are we going to take them? And they're like, we're working on it, we're working on it. At the time—the US Embassy has a consul in Lagos, and he wanted to meet with us. I had to go and meet with him and update him on the situation. I told him our main issue right now is we have no place. People are in ambulances for twelve, thirteen, fourteen hours because we have no place to take them. Not knowing, he was like, "I have a meeting with the governor of Lagos. Yolonda, come with me." [laughter] I'm like, okay.

Q: This is the US ambassador?

Freeman: This is the [consul general]. The US ambassador's in Abuja, but they have a little satellite embassy. He's like the second ambassador. So we go to the governor's house, and I'm updating him on the situation. "Governor, we need some place to put patients. This will get out of hand quickly if we don't have a place to take them." He was hemming and hawing. "You all give us a plan. We'll build a tent city out somewhere, we'll find some land, you give us a budget." The medical officer for the embassy was with us, and he's like, "All we need is a wing. We just need some rooms." The [consul general] just went to him [the governor] and said, "What is it that you need? Do you need

money?" He's like, "How much money do you need? We'll get you the money if it's a money issue." He [the governor] talked to the minister of health, and he finally was like, "Okay, I'll give some money, and they can actually get the wing, an area, so that we can take"—because they kept telling us they were constructing a place, and they really weren't doing it.

Q: Sorry—to clarify—it was the governor who went to the minister of health?

Freeman: He called him on the phone.

Q: Oh, he called him on the phone.

Freeman: And said, "What is it that you need?" He [the minister of health] was like, "We need money to get this place." Because what it was—it was two abandoned buildings that hadn't been worked on, nothing had been done, and to set those up. Eventually, the governor gave the money. The president hadn't even called the governor to see what was going on. At the time, the president of Nigeria was in [Washington] DC because there was an African conference going on. The State Department asked Vice President [Joseph R.] Biden [Jr.] to talk to the president of Nigeria because—I think part of it is—I don't want to speak for the government of Nigeria, but I think part of it is you see what's happening and you just don't think this can happen here. And some, paralyzed, thought at the time that this is going to go away. Because from the conversations that we had in the emergency operations center in Lagos, WHO kept saying, what's going on right now is

how all of this started. This is how it started in Liberia. This is how it started in Sierra Leone. It was one case, and it spread so quickly because nothing was done to prevent it in the beginning. I think that was part of the hands-off approach with the Nigerian government. It's just a part of "WHO or CDC or somebody else is going to take care of this. It's not going to happen here." Eventually, they did realize this can't get out of hand, because it was—as I told Dr. Frieden, I think that a lot of it became—everybody became focused on the sensationalism of bush meat. And eating monkey and bat. We had to get them refocused off of that, because we're like, this is not how Ebola came to Nigeria. Ebola came to Nigeria on a plane. A person brought it, and this is human-to-human contact. They were like, people eat that. I said, that's fine, but they've been eating that for years here and you haven't had it. We really need to focus on truly how it's going to be spread in Nigeria. We can talk about that, but the real focus is getting—and I spent a lot of time talking about, you really have to focus on the human contact because that's how this is going to happen.

That night, after we met the governor, we were able to put some of the contacts—because the contacts were healthcare workers. These were doctors and nurses who risked their lives because this person wasn't honest enough to tell them. They lost their lives because this person—and I'm not blaming the victim. I don't want to say I'm blaming the victim, but he knew he had been exposed. His staff that was with him knew that he had been exposed. I think you know some of that, with the fear also for him, because he was a higher-level individual. But they lost their lives doing their job. You had asked me earlier, what was one of those moments? One of those moments for this came when the

lead doctor's test results came into the EOC. We were told they were inconclusive. Dr. Frank Mahoney, who was with CDC, pulled us to the side and told us, "She's positive." We were all devastated because she doesn't remember, she thinks she had a cut on her hand, and she said I don't even—she never wore gloves and she didn't even remember washing her hands the whole day. She went in there to change his IV [intravenous line], and that's pretty much the contact she had. When her test results came back positive, it was a blow to all of us and especially the contact tracer because he had been in contact with her. One of our NSTOP staff took it really hard. It was also the day that Kent Brantly walked into Emory [University Hospital]. We were watching that, and I kept saying, "Look, not everybody's dying immediately. We have to have some hope here because he's walking." He had on the suit and everything, and he still had a ways to go. He made a plane ride. It was one way of just trying to keep that momentum going.

Even though I was only there for a little over a week because I had to get back home, and so did Dr. Frank Mahoney. He had to get back home. But I always say that I admire him, Dr. Mahoney, so much because he stayed and cleaned out those rooms and set those rooms up so that those patients had somewhere to sleep that night. It wasn't in the best condition, it really wasn't anything anybody would really want to—this is not how you would want to treat a healthcare provider. But it was better than them staying in the ambulance, because they were in the ambulances for twelve hours. He stayed there until ten o'clock at night. I get a little emotional talking about it because he did this because he was so dedicated. We all were dedicated to seeing—because we had invested so much in Nigeria, working in polio. We had been working there for two years on it, going back and

forth, and so Nigeria was part of our country, too. And to see that it could be devastated this quickly because somebody got on a plane and flew into Lagos. Also, there was a Dr. David [Brett-Major]—I can't remember his last name—with WHO. At the time, all of the doctors were on strike in Nigeria. There were no doctors who could come in and take care of the patients because they all worked for the government and they weren't getting paid. He was the only doctor who could actually go. He couldn't give our kind of care, he could only go in there and assist with some basic things because he wasn't licensed to work. He was the only doctor seeing them. Standing out there at eight o'clock at night, and you're standing out there, and he's giving instructions to the person who's assisting him so that they don't become infected as he's taking off his gear, and how hard—because he was there practically twenty-four hours. The exhaustion level, because there was nobody else there to take care of them.

People were scared. Even if they wanted to volunteer, it was hard to get them because for months, you had seen all of these people just dropping dead on the street in other parts of West Africa. We had a lot of people who were afraid. Eventually, some nurses did volunteer to come and help, but in the beginning, we didn't even have that. We had people who were running away. One of the nurses who got sick—thank God for the contact tracers because they were the ones who had to talk to these people and go to their house and knock on their doors to do temperature checks every day and track people and convince—especially those who had symptoms—to come in and keep in contact with the families. Because that was a big issue too, is that you're taking a family member away. I don't know where you're taking them, or—and the other thing about Nigeria is that,

because most of them were doctors or nurses, they lived in really nice neighborhoods. They didn't want ambulances coming—the sirens—because they didn't want to bring attention to their neighbors that something was happening. So we also had to deal with the stigma of just having the ambulance, because they know on the news that something's happening because now it's on the news. It's a story that Ebola has hit. Everybody knows where everybody works or what they do. So we also had that issue. Then we had the issue of the ambulance drivers. They were scared because people were getting sick in the ambulance, and they're in the ambulance with them twelve hours, and they're afraid. We had to figure out how to feed people and get them water.

So there were a lot of major challenges in the beginning in Lagos. When I left, I was scared for Nigeria. It's something I don't talk a lot about, that experience, because I don't think anybody could really understand unless you were there that in the beginning, we really didn't know what was going to happen. We thought the worst was going to happen. Thankfully, it didn't turn out that way, because we had some dedicated people, with the contact tracers and the workers that came down there who volunteered to help, and the partners that came in, and eventually, the Nigerian government, so that it could become controlled. Versus, it would've probably been one of the worst things we've ever witnessed because we did have—we did have one of the men who was with the initial patient—he ran and went to another state. He got sick in the hospital room and called in a doctor. The doctor took care of him. He never really told him what he had, and that doctor ended up dying and that man survived, because he didn't really tell him. At this time, because it was the beginning of Ebola, there were a lot of things we didn't even

think about. We weren't even prepared for somebody getting on a plane sick at that time, and so we had to do a lot of work at the airports. That's when all the airport screenings started, because of this case in Nigeria. As they say—we talked a little about global security, and this is how the whole issue of global security—that one person could have a deadly disease and go through several places and pretty much put a nation on alert.

Q: Can I ask, did you ever have contact with any of the people who were exposed in Nigeria?

Freeman: I did not have actual contact because CDC—that was one of the things you did—even though at time—because this wasn't even thought of. You're not to have personal contact, not to put yourself at risk. So we kept a distance. We talked to some of them, like they were in the ambulance. I didn't, but Dr. Frank and a few other people would talk to them while they're in the ambulance and kept a good distance. I could see the patients, but I didn't actually talk to them. The thing is that I can see the doctor who died—the head doctor who died—I still have visions of her walking around in the treatment center because we could see her when she was in the treatment center because we could see in there. I still see her in that treatment center to this day. When we were back in Atlanta, when we got the news that she died, it hit hard because she was just doing her job. She was taking care of a patient, and you don't expect that. You go to do your job and a couple weeks later, she died.

Q: Are the people who are the contact tracers in Nigeria—are most of them, like, who are they? Are they mostly people who had worked on polio?

Freeman: Yes, most of them we had were—the Field Epidemiology Training Program.

Q: Okay, FETP people.

Freeman: Yes, they were out there. Because Frank had gotten them from Abuja, and they were the unsung heroes.

Q: Are there some of them who you remember specifically?

Freeman: Yes. Actually, when I went to Liberia, they had been trying to get them in Liberia. They finally got them towards the end of the epidemic in Liberia, but they came and we were having a polio campaign. The first polio campaign since the outbreak, and they were able to come. One of them specifically, Peter, he was the one who actually was in contact with the doctor the most. When they came, and they found me, and we were all excited in Liberia, he didn't want to talk about Nigeria, that experience. Because I think it still, to this day, is traumatic for some people and for the contact tracers especially if the person died. Because they talked to them constantly all day long. They went to their houses. They had very close contact. I was trying to say he's one of those heroes, and he was like, "I don't want to talk about—I can't talk about that."

Q: While you're setting up this new incident management structure, is it the incident manager of polio who becomes the incident manager of Ebola?

Freeman: In the beginning, it was not. It was people who were assigned by the government who took over. The incident management system, which eventually—because polio had an EOC and an incident management system, they realized that they could just bring that to Lagos, and they brought some of those—and it actually changed everything. In the beginning it was very rough, but then they brought in the people who were at polio and the incident management, and that also changed direction for the response completely. It made a tremendous change.

Q: I heard about endless meetings beforehand and that kind of thing. How did the direction change in a positive way?

Freeman: I'm trying to say this in a—the previous incident manager focused, yes, on a lot of endless meetings, didn't have a real structure, and then we'd have people sitting there instead of out working in the field or taking care of things. We were meeting for five hours or watching a video. We watched the burial team video WHO had, which could have been beneficial for a burial team, but we weren't there yet. I left before the new—I think he came—the incident manager for polio, he ended up coming the day after I left. And from my understanding—because I still kept in touch with people because I had some other things that I was assisting with from Atlanta with the team—he put in a structure. And also, the Gates Foundation and some of the other corporate came in and

actually helped build and redo the room. My first day in the EOC, there's a ton of people in there and some of them were reporters and nobody knew. There was nobody monitoring who was coming in and out, so things that were discussed in these endless meetings would show up in the paper the next day, or it would show up on a radio program a couple hours later. I'm like, that's because you're allowing reporters in here and you're not saying anything, so it's a free room to come in. A lot of confidential information was leaking out to the press.

Q: Like what kind of confidential information?

Freeman: More information about the contacts, the patients. We didn't want people to know where we were taking them. Fear of protest. Fear of, "we can't have this in my community," because that was another big issue. Where are you going to put people? Because nobody wants an Ebola treatment unit in their neighborhood. They had that same issue in other parts of West Africa. We had to make sure that the patients were secure, and their privacy. But you're talking about this in an EOC meeting and the press is there. Once the new system, the polio system that was used, was in place and the people that worked in incident management on polio came, that stopped a lot of that. It stopped a lot of leaks to the press. They put up a system where we had press—in the beginning we had—I don't know if I want to talk about it. Press briefings—myself and another colleague, we were writing them. There was nobody from the government helping us write the press briefings. We kept saying, "We should not be writing these." We would be up at three o'clock in the morning writing press briefings, press announcements, and

getting them so that they could do them first thing in the morning. The other thing that also happened a lot is that people were like, "I heard if you take this nut, it will stop." All of the rumors that were out there and the misconceptions and things that people—we had to address a lot of that also. We had Red Cross volunteers coming in, and they had a lot of misconceptions about Ebola. We had volunteers going out into the public, and they had misconceptions about Ebola. So we had to address a lot of that. With the new incident management system, that actually helped because it put in a better structure, system, than we had in the very beginning.

Q: That makes sense. Can I ask, was the other person that was helping you write the press briefings, were they CDC?

Freeman: Yes.

Q: CDC also.

Freeman: Yes, Andrea Carcelen. We were up. To be honest, I had never written press briefings and statements. Just because you're a health communication specialist, that doesn't mean you're a media person. I wanted people to understand that. That's not the same thing. I've learned a lot. Ebola has put me in a position to have learned quite a bit and have a lot of experiences. But Andrea was a public health advisor. We are the ones writing press briefings and statements and getting messages out to the media in the beginning. And we were begging, we need somebody from the government to help us.

Q: Can I also ask about the work with partners like UNICEF in those days in Nigeria, what role they were filling?

Freeman: WHO was leading the response and UNICEF was assisting with the social mobilization and the communication, but part of it is that the government has to actually be the lead. When they weren't really taking on the leadership role, it was difficult for all WHO and UNICEF and CDC. Because like I said in the beginning, you can't just go in there and just control everything. But if the government isn't taking that stance, it ties your hands. It was difficult for all of us, and I have to say, WHO really tried hard to get them to understand that what's happening right now is how all of these began. In the other three countries, this is how it began, and if you don't take control of it now, it can blow up really quickly. This is not the place you want this to happen. WHO was bringing in the supplies, and they were bringing in—trying to—because their doctor was the one who was seeing everybody. They played a major role, especially WHO in this, but in the very beginning it was really hard because the government wasn't leading.

Q: You brought it up with polio, but I thought maybe you were saying it came up again for Ebola—Nollywood? Did you guys reach out somehow to—

Freeman: Actually, Nollywood reached out to us.

Q: Oh, how did that happen?

Freeman: Actually it was a person who was with Boston University, and she was working with Nollywood, and she wanted to do PSAs, public service announcements. They contacted me because they had contacted CDC here and CDC was like, we have a communications person. They actually developed, and we assisted them in developing, scripts. They developed PSAs for us for the radio and television for Ebola because they wanted to really become involved with being a part of it. They developed quite—unfortunately, they couldn't do them for the other West African countries because they were funded just for Nigeria. They had the funds to be able to develop, and they developed quite a few scripts, and didn't charge, and actually got them on the air for us. They actually put them on Facebook, and they did some Facebook—because in Nigeria, social media at the time was big in Nigeria. They had a couple Facebook conversations about Ebola with Nollywood and Boston—I think it's Boston University. To do that for us.

Q: What was it like working with them?

Freeman: It was actually exciting, great. There were a few challenges after I left, but I stayed in touch with the person because somebody else had taken over and she didn't understand the project too much and couldn't really communicate it. I think that's part of the whole deployment process—at that time, we could only stay thirty days, and I had to leave early anyway. That transferring of information and that connection that you have, by the time you actually get up-to-speed—which became a bigger problem when I was in

Liberia and West Africa because it was going on so long. A lot of the partners in the Ministry of Health complained, and it's because by the time I get used to this person on board—but at the time it was a State Department rule that we could only stay thirty days. So they reached back to me because I had started the process, and then I would have to call the other person, and "This is what's going on," and explain to them. But I enjoyed—and that was one of the reasons that I connected them with—because they wanted to do some polio work and they just didn't know how to get into it. So I connected them with UNICEF and helped UNICEF in developing a proposal, and they actually did quite a few movies, short movies, that they're doing on polio and other health issues that they actually are showing in northern Nigeria now.

Q: That's really cool to me. Sorry. [laughs]

Freeman: Like I said, those are some of those things that even though this is such a horrible thing to have happened, there are some good things that come out of it.

Q: Right. Some human connections and everything. Okay, and so you had to go back to the United States?

Freeman: Yes, and my ride back to the United States was interesting. I just left, and I'm on the plane back, and it's a straight flight from Lagos to Atlanta. About an hour into the flight, one of the flight attendants said, "Can I talk to you?" I'm looking like, okay. Now mind you, I don't wear anything that says I work for CDC. I don't carry anything. I'm

just an average-looking person on the plane. She was like, "I understand you work for CDC." I went, "How do you know that?" She's like, "We found out that you were." I'm like, "How did you find that out? It's not on my ticket." She begins a conversation about how her daughter wants to work at CDC in the lab. She's like, "Is it safe?" Because at the time we were having a little lab issue here. I told her, "Yes, it's fine, and she should be." Then the discussion came on to Ebola, because mind you the patient had come on a plane, and so a lot of questions came up about, do you think they're going to cancel this flight? Will it be safe for us to fly here anymore? What should we do? I addressed some of her concerns with the information that we had at that time—what precautions they should take if a person got sick on the plane. I said, "If somebody else wants to talk to me after this, after we land, I'll stay back." But I still kept wondering, how did this person know? And then I realized, when you're going to the airport, the embassy provides you with an expeditor. And there's usually probably somebody else from the embassy or another US government agency. There were four contractors with me when I—and they were on the flight, and I believe they told the flight attendants about me. So I stayed back and I talked to—answered any questions, and most of them didn't really have fear. They were like, okay, but they proceeded as I'm walking off the plane to spray Lysol behind me. I'm like, what is that about? We're in Atlanta and we're going through—this is before they even did the whole checking you when you get off the plane in Atlanta, and one of the flight attendants proceeded—"You need to stay away from her." And I'm like, "Whoa, what are you doing?" I'm like, "What are you doing? This is not cool to say." It just was uncomfortable because I didn't realize the stigma. I had worked in HIV, I've worked in STD, I've worked in polio, I have worked in infectious diseases, and I just

never had experienced anything like that before. I mean, I have drawn people's blood. And to have that happen—it was the first time, but I had another incident with it coming back from Liberia. After one of my trips to Liberia, I went on vacation with a tour company that I've traveled with before, and I was rooming with somebody. She found out who I work for. I don't usually tell it, because some people are like, yeah that's great, that's wonderful, and then some people have a different view. I told her I had just come back from West Africa, and she found out where I work. She got nervous because I just came back from West Africa. At the time, Liberia had no transmission. And she didn't want to be my roommate. She thought I had Ebola and made it very uncomfortable for me. Proceeded to tell me I needed to get a room by myself. I had to explain to her—it got to a point where it was bad, and I explained to her, I said, "Let me say this. There are several people who put themselves at risk to go over to West Africa to prevent this from ever happening here. For you to make these judgments and this stigmatizing of me is unfair because what I've done and so many other people like me is to prevent this from ever happening to you." I said, "And second of all, if anything happened to me and I was sick, the last place I'm going to be is in Australia. I'm going to be at Emory hospital." I always tell people, if something happens to me, I want to go to Emory. I'm like, "My office is next door to the best hospital for this. Why would I even put myself at risk like that if I got this?" It really impacted me a lot. I had to call some of my friends and other people and talk to them because I was like, I'm on this trip by myself, pretty much. I am with a group of people, and then you have to wonder well, is everybody else feeling the same way? That if they find out that I work for CDC, and I was in West Africa, that—there would be no way I would put myself at risk for this, nor would I ever try to hurt

anybody else, if I thought in any way, shape, or form I had come in contact with Ebola. So the stigma was very, very real for people who worked on Ebola. I know some people have told their stories in CDC Connects about it, but you don't really realize it until it happens to you. Because on the airplane, that was just like—spraying the Lysol. This was just in the beginning. I was just amazed at—and I could understand it in one way because you're afraid. You're seeing people dying on the street, and we didn't know enough about how this could, at that time, how it could be spread, but it didn't feel good.

Q: No doubt, because there's also—as you're saying, there's also this judgment that perhaps you're being irresponsible and putting people at risk.

Freeman: And did I do the right thing by going over there? I never regret working on it, even though it was probably, like I said, the scariest moment of my public health career—not so much from my—but what could happen. Then to go to Liberia and see it full circle. I had the opportunity to see the beginning of a response and I got to see the end of a response, to see a country that was devastated, to overcome this and be able to celebrate at that time that they had stopped the transmission was an amazing experience for me because I saw how easily it could've devastated, and then to see how you can succeed from it.

Q: I know I've kept you talking for a long time. Would you like a break?

Freeman: No, we can keep going.

Q: We're good? Okay. Cool. So you're in Australia, you come back, how does your Ebola experience continue?

Freeman: My Ebola experience—

Q: Oh, I guess Australia was after—

Freeman: Actually, I have been back to Liberia four times, I think.

Q: Wow.

Freeman: I was there in April to July of '15.

Q: Was that your first time?

Freeman: That was the first time. Then I was asked to come back in September to work on a few things. At this time, Ebola—they didn't have any cases, and the transmission had stopped. The country director asked me to come and work on—at the time, they were getting ready to do some other kind of new testing and things, and asked me to come back. I thought that was my last time there. After I went on vacation, that November he asked me to come back to work on some special projects again. My first day in the office, right after getting off the plane that morning—there was a little scurrying around in the

office, and the team lead for the lab was requesting some equipment. I went, we have another case on my first day in the office. Dr. Desmond [E.] Williams comes in and he tells us, "We have a positive Ebola case." I was there for the first reoccurrence we had had in June, right after going free. Then I was there for this one. I'm like, this is my first day back in Liberia. It was different in the sense that a lot of the staff, TDY staff, had never worked during the outbreak. Quite a few of them were quite nervous because they were like, I didn't come expecting this. I'm like, nobody expects that this was going to happen, there's nothing we could do. It was full steam ahead to address that case. The second reoccurrence of Ebola in Liberia. Needless to say, I didn't sleep. Up until like three o'clock in the morning, had to get up at six and make sure the minister of health had the press statement and everything going and working with the community. It was a little different this time because the government had agreed to use the Ebola prevention vaccine on the contacts and the contacts of contacts. I worked with that, and there was real resistance, which is expected, of the contacts and the healthcare workers to taking the vaccine.

Q: This is in the November reoccurrence?

Freeman: November reoccurrence. That's when they decided to try the Ebola—they were doing tests. Trials. They wanted to see, and the government had agreed to have it done then, but there were a lot of challenges. There were a lot of communication challenges. There were also some challenges within the Ministry of Health [and Social Welfare]. Should we do this or should we not do this? We saw some of the results in Guinea and

Sierra Leone where they still had active transmission and they were using the vaccine. They saw a decrease in the number of people who were getting Ebola, but in Liberia, this was the first time we could use it in active transmission, but it was quite challenging, especially with healthcare workers.

Q: Do you mind if we actually back up for a bit and just make sure I get your first couple times in Liberia?

Freeman: Okay.

Q: Okay, thanks. So were you working in the EOC or the IMS structure back in Atlanta when you came back from Nigeria?

Freeman: When I came back from Nigeria—I actually went back to Nigeria, but for polio.

Q: Oh!

Freeman: Because I was assigned to polio at that time. I was detailed to the Global Immunization Division, and so I was still detailed to GID. I came back for vacation from Nigeria, then I went back like a month later to work on polio. I stayed working on polio until late December.

Q: And that's when the bombing was starting to happen?

Freeman: Well they stopped—

Q: Oh no, that was way back.

Freeman: That was way back. They were still bombing. Boko Haram was at its height at this point.

Q: Oh my gosh.

Freeman: But in 2014, I was still working in polio. So when I came back—I just came back for my vacation—and then I went back to Nigeria—

Q: Then you went back to Nigeria.

Freeman:—to work on polio.

Q: And so do you hop over from Nigeria straight to Liberia? Is that what happens?

Freeman: No. I came back—because I came back in December and my detail had ended with GID. So in January, I come back to the Division of Emergency Operations, to my permanent locale, and then I was requested for—because I have a good working

relationship with Frank Mahoney and Frank was the lead for the Ebola response in Liberia at the time. He requested for me to come back. At the time, my division didn't want me to go for a whole lot of different reasons, and so I didn't go to Liberia at that time. Then a second request came for me to go in April, and my division was willing to let me go then in April. So I had like a three-month reprieve from either polio or Ebola.

Q: Do you mind getting into just like the superficial level of why the division didn't want to let you go immediately?

Freeman: Because I had just been in polio for like a year, and so I was just coming back to the division, so they felt that I should have a responsibility within the division.

Q: Sure. Okay.

Freeman: As diplomatic as I can say it.

Q: Got it. Thank you. So tell me about what happens in April when you get over to Liberia.

Freeman: In April, at that time, there was very little transmission of—I think they had just come out of—the sexual transmission case had just happened a couple weeks before I got there. That's when we realized that sexual transmission can be a cause. I was really working with—I had taken over as team lead for the per—and so our work was different

because it wasn't this mayhem of cases and things. We were going more into a recovery phase at that time because the countdown had started, and so working with a lot of the partners who were still there and looking at how do we move forward without losing the messages, especially the prevention messages. Because it was still in the—the borders are open. Sierra Leone and Guinea were still having cases. And people were tired. The community was tired of Ebola. They're having a hard fight, and the thing about the bucket, washing their hands. They still weren't able to hug or shake hands at this time—and how do you recover from the worst—your country has been through two civil wars, then Ebola. How do you recover from that? A lot of our focus was on the recovery and maintaining our messages when I got there. And also capacity building, because CDC was opening up an office there—a new office. We hadn't had an office there before this. A lot of my focus when I got there was more on that, and then in May we could celebrate that we're Ebola free. Then June.

Q: Then June. [laughs]

Freeman: So then June came, and we had a case. It was found post-mortem. It was a young man who died, and his neighbor was on the burial team, and the father had—and so he took—at the time we were doing body swabbing. He took a swab before they buried him and it came back positive. So the clock starts over. John [M.] Saindon, who is the team lead for the lab—we always joke that we can't be in Liberia at the same time, because this happened to us a couple of times when we were there and this was the first one. The race was on to control it. To make sure that we didn't have a spread from this

case. The contact tracers went out, and that means everybody went out to try to make sure we controlled it. And it was controlled. There were a few cases that came out of it, but it didn't spread. And then I left in July.

Q: Can you tell me a little more about the messages that you're continuing to put forward? Because it sounds like Liberia is having some fatigue at this point with Ebola probably. I can imagine people hearing the same messages over and over again. How do you deal with that?

Freeman: One of the things is one, we wanted to keep the hand washing messages. What we were finding out is that they were given buckets. Everybody had a bucket. There was a bucket in front of every business to wash your hands before you go in, and people only perceived that for Ebola. Hand washing was only associated with Ebola, not anything else. Cholera or anything else. When they became Ebola free, the first thing to go was the Ebola bucket. Because it represented so much of the pain to the community, is what these buckets stood for. Working with partners, because we were doing polio and measles, and because it was a real scare that during this time period of the outbreak, children weren't vaccinated because the healthcare system was broken. It wasn't in the best condition before Ebola, but after Ebola it was devastated because people were afraid to go back to those clinics because you saw mounds of people there and people dying and the sickness and everything else is what those clinics stood for. Part of our messaging also had to do with letting people know it was safe to go back into the clinics and go back into the hospital. One of the hospitals, Redemption Hospital, was like the scene of the worst of

the Ebola outbreak. We did a press briefing and a tour so people could see it's working. It's not perfect and it never will—but it's safe to go back, and showing the precautions that were put into place so that people would know that. Because at the time, there were still rumors that there was a case here and a case here. There's a rumor that there's a case here. You know, somebody died at Redemption. So we had to address a lot of the rumors and misconceptions that were still out in the public. This was before June. Before the outbreak. A lot of our focus of our messaging and working with the partners was just letting people know that the healthcare system—to let them know they could go back into the healthcare system. We had to deal with the fact that—I remember I went out on the measles campaign, and at the time the Ebola vaccine trials were going on, so people were thinking that we were trying to give their kids Ebola. We had to really talk and go out into the community to convince people that this is the same vaccine that they got as a child and that they were getting prior to Ebola. But it was difficult. It was really difficult and challenging for that first measles campaign and polio campaign to get people. Working in Nigeria where polio campaigns are big things, we have a lot of social mobilization going on, people around the community talking about it. There's banners and everything. In Liberia, they didn't have all that. For me, it was a bit of a challenge in that, why haven't they started talking about this ahead of time? Because they hadn't had polio, but the risk was higher now because you've had—there's still transmission in Nigeria, and people move around. Getting messages of the importance of vaccination and—it was challenging. It was really—the vaccine program struggled the first couple months after Ebola, because people were scared. That was a lot of what our focus was at the time, is just getting people to trust the healthcare system and also to trust the

government. There was a lot of issues of trust in the government, and so preparing the government to get messaging out, and they did that. But to be more transparent in the messaging that they got out to the public. Before June, between April and the end of May, that's a lot of what our communication focus was on.

Q: I actually don't really know much about the measles campaigns. Can you tell me about them?

Freeman: Measles campaigns are different in the sense that because it's a shot—with polio, we could use non-official healthcare workers to give drops, but you have to have an actual healthcare professional to give because it is—and they usually don't do it in the field. We had thick stations, meaning that there was an area within, like, by the church we would set up a station where polio, we can go door to door. Here, we actually set up a place because they're given a shot and bring the kids to that area and give them a shot. They usually prefer that they go into the clinic to get the shot, and you can go into the clinic, but because so many kids hadn't been vaccinated, there was a fear of a measles outbreak. They've had some measles outbreaks since the Ebola outbreak. We'll go house to house to encourage people to come, either to the clinic or to this fixed area that we're giving the vaccine, and give the vaccine that way.

Q: Got it. Who had the initiative to start this?

Freeman: The Ministry of Health and UNICEF and CDC have done this, so it's unusual to hear about it—in the United States, we don't hear about it because everybody goes to the clinic, but in remote areas where people have to travel miles and miles and miles and miles to get to a clinic and the clinic is inaccessible, you have to go to them. So that's what we did in Liberia. They did it all over Liberia at that time for that, and we would go out and try to encourage people in the market and stuff to come and get your child vaccinated.

Q: Right, got you. Thanks for that. Can you tell me about some of the Liberians that you worked with mostly closely from the April to July deployment?

Freeman: I'm not going to pronounce his name—I actually worked very closely with the incident manager, Tolbert [G. Nyenswah]. I actually wrote a lot for him. A lot of his press statements and stuff, which is interesting, and I worked with Dr. [Bernice] Dahn, who is the minister of health, and I wrote mostly all of her speeches. She's not one really for doing press. I worked with a lot of the higher level in writing a lot of their press statements and press briefings. Then I worked—actually, with everybody within the Ministry of Health that was working on the incident—on Ebola, or with their IDSR, integrated disease [surveillance and response], because we were working on that also—surveillance and response program. There were several people, and I hate to give out names because I feel like I might miss somebody, and then they are like, oh, you forgot me. She forgot me. She forgot to mention me. [laughter]

Q: Everyone listening, understand, there are many people.

Freeman: Yes, and that we worked with. Actually, I worked really closely with the health promotion staff in Liberia, with Mr. [Richard] Zeon and—I'm drawing a blank on his name—I'll give it to you in the edit. I worked really closely with a lot of the health promotion staff, because they didn't really have a public affairs staff there. And—Reverend [John] Sumo. Reverend Sumo, who leads the health promotion department. Reverend Sumo and I had a really interesting working relationship. He trusted me and everything, because there were some challenges. Reverend Sumo had some challenges—some, that you know—you have so many people who came, and partners who came, and unfortunately, sometimes there's a lack of respect for local staff. Most of the people in Nigeria who are educated were educated in the [United] States, and they went to college in the States, and had the same degrees and education, and sometimes he felt people disrespected him. I made sure to show him the respect. We battled, but I think he respected me in that sense that I know he had knowledge, because he had been working in Liberia—this is his people. He understands the structure, and showing him that. Sometimes I had to serve as a mediator for him, and I would always get the, "Yolonda, go talk to Reverend Sumo," because he had some legitimate concerns when it came to messaging about body swabbing or the vaccine. He had some concerns working with one of our partners with the Ebola vaccine. I think that was part of my job. The main part of my job was to mediate for him, in between him and others, to address his concerns. Because he had concerns and they deserved to be addressed. Probably one of my favorite people, and a special relationship with Reverend Sumo. And his whole staff.

Q: Any other memories that come to mind from the first deployment to Liberia?

Freeman: To Liberia? Having the opportunity to write talking point for the president of Liberia—for her speech for when Ebola was free, and actually getting to meet her. The first time they had—they had a big celebration, but on the actual day, we had a special meeting in the EOC, and only select people could come, and I was able to come. The ambassador and the president spoke and discussed, and being able—some of the words that I wrote, she spoke during that time. That was a pretty cool experience. Like I said, I hadn't really done media work prior to Liberia, and so even writing stuff for the ambassador, seeing the speeches that I wrote for the department of health and Dr. Dahn and seeing it on CNN and I'm like, those are the words I wrote. I remember Tolbert had to do a congressional briefing in Liberia, and so I had to write what he said, because at that time the government was considering closing the borders between Guinea—because Guinea kept having cases, and Liberia was scared and nervous. The stance was that we didn't want to close the borders because it impacted—because on those areas, people, families live right over the border, or trade goes on at the borders, and it would have had an impact economically on Liberia. So writing his congressional statement, and Satish—I forget Satish's last name—

Q: Satish [K.] Pillai?

Freeman: Yes. He, at that time, was the team lead and he went with him before congress, and Satish writes me a note back and said, "He read everything you wrote. You did a great job," and that felt good. I always say that the experience and the opportunity I had in going to Liberia—I had never done a lot of this stuff, and it built my confidence. To say that you write for the president and you write for the ambassador and congressional briefings—some people get to do that all the time, but from a person who went knocking on doors and asking people about their sex lives and partners to this has been an amazing experience through it all.

Q: No doubt. And you're bringing to mind also—sorry, and this is a completely different track, but the sexual transmission of Ebola almost brings you full circle back to something you had been doing before, and different communication issues—that brings up a whole new range of communication and complications with culture.

Freeman: Yes. I thought I was finished talking to people about sex. [laughter] And then here I go. We find out Ebola, and then I got to work on Zika, so it's all full circle.

Q: It's all full circle.

Freeman: I've come full circle again.

Q: You mentioned in September of 2015 when you went, there were some new initiatives that you were involved in?

Freeman: Yes. At that time, that's when the rapid testing—but we had to do it because there wasn't transmission in Liberia at the time. We had to develop a protocol for doing it on dead bodies. I hate to say "dead body swabbing," but that's how it's called in-country. A corpse at the time [unclear] people. We were piloting it at the time, and we had to write up a communication—I had to develop a communication plan on how we're going to do this for the—because it's difficult to see how a loved one died, and they didn't have symptoms of Ebola, and all the stigma that came with Ebola, and somebody shows up to your house and they have put on PPE. Everybody in the neighborhood is going to know, because they're going to know PPE was used for Ebola. The challenges of getting people to allow the Ministry of Health to do testing. We had to come up with messaging around when a person was tested and protocols on who should get tested, and so at that time in September—September, October—is when we were working on how are we going to do this and the challenges of—and because there was a lot of challenges, because nobody wanted the Ministry of Health to show up to their house if someone died because of all the stigma with Ebola. "How do you do this when my family member didn't have any symptoms? I know this person died of a heart attack." But because there was still transmission in other countries, and we weren't really sure because dead bodies—people who died, not everybody was getting tested. We didn't really know if the transmission had stopped, we didn't really know, because Liberia had one of the lowest rates of testing of dead bodies than Sierra Leone or Guinea. Their rates were so low because they weren't testing them prior to burial. That was the focus when I was there in the fall of last year.

Q: How did you meet some of those challenges regarding the government testing people?

Freeman: Part of it is we actually tested some of the messages. We wrote some PSAs and we had them test—because in—I didn't work in a bubble. There was a group of partners in the Ministry of Health, where we actually took the messages, and they would test the messages, and they'll test the PSAs. We developed PSAs to let people know, when your loved one passed away, call this number so that they can ensure that the person didn't die of Ebola and to keep Liberia safe, was pretty much our messaging around that. We tested the messages before we put them out so that people were prepared that this was what was going to happen if your loved one died—someone died in your home, because most people died at home. To meet some of those challenges—and we had focus groups and asked those questions, what were some of their concerns, and a lot of it had to do with the stigma of, is this person going to show up in all PPE? So we had to have a protocol—should the person put the PPE on in the house before they go into the room, and not to show up dressed in PPE walking into the house? But then the question is where do they take it off. The whole CDC team, we were working together on how. Even though we were working on the communication, but we also were working on the protocol of how do we do each step of this because it could lead to a whole lot of other issues if it wasn't done correctly.

Q: Right. Do you remember what you came up with in the end for the procedure?

Freeman: Actually, in the procedure, the person does get dressed in another room that the person—the body—isn't in. They keep changing some of the things that they're doing. Even today I'm pretty sure there's some other stuff that's done. Now with the rapid testing, if the person tests negative—because the family usually buries the body. If the person tests negative, the body is released for the family to do their traditional [burial]. If the person tests positive, they took a second test and then also some other samples and the burial team would have to actually—and that's the hardest one for people to do because then there's a team of people coming up and taking the body away and the house is cleaned and all of that. But I think that we've had a few false positives, which has caused a little concern, but it's expected and—because those are the ones that are harder, because you have a burial, and so everybody's seeing because they know what the burial team is about. That was another—I know I'm kind of jumping around—because that was also another issue in Liberia. Before the burial teams, they had hired some people who took care of—and they burned the bodies at that time, and that became a big issue because of what happened to those men who did that. So that was another communication challenge that had to be addressed, because it was a big news article in the *New York Times* from a Liberian who interviewed him. There was a lot put on the government of the mistreatment, they felt, of these men because they weren't allowed back in their communities because burning of bodies, cremation, is not part of their culture. That these men did this, they weren't welcomed back into the community, so they were ostracized, and a lot of them ended up having a lot of drug addiction problems or alcohol addiction problems. They can't get jobs because everybody knows who, and they don't want—and so it was a big article about that. And then a story. We had to write a statement for

Tolbert to say, this is what happened, this is what we did. The bad thing about all of these countries—and I know specifically for Liberia—that there's not really a mental health structure in place for anybody. You're dealing with a system that's already weak, and then they didn't have a mental health structure, so how do you address everybody, even the burial teams, and everybody else that's going to have the aftermath of Ebola afterwards, when there's not any social services in place for that?

Q: Were you part of trying to figure out how to work with the men who had done the cremation?

Freeman: I wrote the statement that Tolbert gave. Dr. Frieden was concerned about it, but it was really—what could we do. We came to the conclusion that there's not much we can do. Unfortunately, it's not CDC's role that we could do—the government doesn't have the resources. They paid them like a three-month salary after they let them go, but unfortunately, there's no mental health or social services available for them. It's the same we could say about the orphans, about the healthcare workers who were traumatized by it all. You just have a whole country that, unfortunately, the aftermath of this will last—and it's not just Ebola, but you're also talking about a country that has been through two civil wars and traumatized in so many different ways. How do you address all of that? Because, as they say, this is the camel. This is the straw that broke the camel's back in one instance for Liberia because they were just rebuilding from the civil war in the early 2000s, and even today you can walk through and you can still see where the bombs have

blown up and the buildings and the stuff that's gone on. Those people are still alive, and then you go through seeing your nation devastated.

Q: I want to make sure that we go back to where I cut you off, sorry, earlier, where you were talking about the vaccines in November and how there was some community resistance against that Ebola preventative vaccine.

Freeman: Yes, a lot of the resis—it was surprising to all of us that the main resistance came from healthcare workers. This was November, and then I went back in April because we had another case in April and we were doing the same thing with the vaccine. That's why I'm bringing it up, is because the challenge—the biggest challenge we had is the people who were at the highest risk in Liberia refused to take the vaccine. In November, I actually went with the CDC anthropologist [Denise Allen] that's stationed in Liberia. We went out and talked to the health workers who work under volunteer observation. We don't say quarantine anymore. Voluntary precautionary observation. We went out to talk to them the first time to get a better sense of why they didn't want to take the vaccine, and they didn't even want to talk to us. Only one of the residents at the time took it. He understood. They really were—they were like, "I don't want to talk about it, I don't want to discuss it, I don't want it." We were like okay, let's go out there one more time. We took a trusted colleague of theirs, and said, maybe you can figure out what it is—why they are choosing not to take it. Then they felt a little comfortable with talking to us this time. We never came and pushed. We were like, we're not here to push you to take it, we just want a better understanding for the future of what we can do, because

"people are saying this could save your life" wasn't resonating to them. Once we got down and talked to them individually in private settings, there was a lot of different reasons. A lot of their families were calling them not to take it. Hearing the word Ebola in anything is frightening. A lot of them were afraid of the symptoms, the side effects from it, because those side effects sound like Ebola. You might get a temperature, and one of the biggest fears they had is that they would be taken out of there in an ambulance and taken to the ETU, the Ebola treatment unit, and they did not—because they remember during the height of the outbreak, their colleagues never came back. Some of them—it was a lot about their family. And then the other issue that came up was the people who got sick got sick within fourteen days. Because we kept saying we want to wait fourteen days—like, what is this fourteen days threshold? We're like, it's twenty-one days, and they were like, because they noticed if anybody got Ebola, they got it within fourteen days after exposure. They wanted to wait the fourteen days, and they figure if they got past the fourteen days, they were okay. Eventually, those healthcare workers—the majority of them—did end up taking the vaccine because part of the messaging there is that this gives you peace of mind, because it's going to happen again. The reality is Ebola is going to always be in that region at some point. There will be another patient to walk into—because this young man walked into the hospital, and they didn't know—after everything that went on with Ebola, they didn't really even take the precautions with him, even though he had all the symptoms. This may happen again, and it did at a different hospital, but in April of this year, another patient walked in with Ebola into a hospital setting. The difference is, we could actually talk to the first group. The second group, we never could get them to take the vaccine. They were quite resistant and refused. None of

the healthcare workers at that particular hospital chose to take it. We really could never really get to the main issues. I think it was some part of the treatment that they were forced to go into—some of them felt they didn't even have interaction. We were challenged with a whole lot of other issues, so we couldn't even get those healthcare workers to take it. When we look at both instances of the vaccine, the challenge is still with healthcare workers. In our mind we're like, I would be the first one in line if I worked at a hospital in an area that I would take this vaccine. But it's not that easy. It's not that easy to see. In Sierra Leone and Guinea, healthcare workers are more—and we're looking at why are the healthcare workers in Sierra Leone more accepting of the vaccine versus the healthcare workers in Liberia. That was one of the things that we were trying to figure out before I left for Zika. How can we look to see what's going on, and the differences here, because there's obviously some other barriers and concerns going on in Liberia with healthcare workers.

Q: You're involved in so many fascinating things. [laughs]

Freeman: The Ebola experience—I think when you talk to some other people—I think for all of us who have worked—most of the people who I know who have worked on Ebola and worked on this end of Ebola, of actually working at a community level or with patients and stuff, it was just so different than anything else that you had really truly experienced in a sense that—even though I never was at the part of where the height was of people dying on the streets, I never—either instance, I was never in. But the fear and the stigma will last a lifetime, and you see that. How do you get past that? How does a

nation—how do any of these countries try to rebuild after something so devastating? In my lifetime, I had never seen anything like that, and I hope I never do see anything like that again, even though my experience with Ebola has been grand. One thing, I wouldn't take back any of my deployments to Liberia or Nigeria, and I'm grateful that I had the opportunity. I always say that one of the things—it's great to see the recovery. One of the things, like in Liberia—they didn't have a cholera outbreak after Ebola, because some of the precautions that people were taking helped them not to have a cholera outbreak. Hopefully, some of the lessons—a lot of the lessons taken from Ebola will continue to strengthen that country. And I talk about Liberia because that's the one I worked in and the one I know the most, and I'm sure Sierra Leone and Guinea would be the same, and taking those that they can build on.

I always say in every deployment that I've had that if I don't leave something positive in some way that was a capacity building moment, then I did a disservice in my deployment. I hope that they can say that—that when Yolonda came, she gave us this. And it's not about me. I'm not looking for accolades or anything, because I think that's the key that CDC offers is that we build that capacity within the countries that we go to and that this isn't a self-serving mission. And it's not a self-serving mission for me. It's more of, I want to see that it gets better and that I left something behind to make somebody else [unclear] this instance, that if it happened again, that they are able to take something I left behind.

Q: Did you have one more deployment after November?

Freeman: I did, in April.

Q: In April of this year? Oh, you went back for that one.

Freeman: Yeah, I went back in April.

Q: Is that another sexual transmission one?

Freeman: It was, but it was in Guinea.

Q: Oh, that's right.

Freeman: Her husband died in Guinea. Her family was in Liberia, and she came over from Guinea. That case is sad in one instance because there were two children that were orphaned from this. I'm sure there's a lot of them, but we think about these children, come to another country, and now they're with family that they really didn't know and both their parents are gone and both of the children were infected, but they both survived. Yeah. So I went out there. I was asked to come in April because we were doing the Ebola prevention vaccine again, and to address—there were some issues with communication and some issues going on with actually doing social mobilization within the community at the time. With this one, there was some other, outside factors where the workers hadn't been paid, so that also had an impact. Things that were out of our control. We had to

figure out—we couldn't have these big town meetings. Then we would have these big town meetings and things would erupt. We realized that that was not the way to do this, and we had to have little, small comm—you know, go into the communities and have small little group meetings instead of having these big town meetings because they weren't very effective. People are still scared. Because you're only giving the vaccine to select people at this time. It's not a vaccine that can be given to everybody, and people don't understand that either.

Q: There's just a limited supply?

Freeman: Yes, it's because it's still a trial.

Q: Oh, sure.

Freeman: It's a trial vaccine. It has to be in a trial setting, and the way the protocol to use it was laid out. There's a stigma associated with people who get the vaccine, and so you have to address that within the community. Not to stigmatize people, because it doesn't mean that they have Ebola. This is just preventing it. This time around, a lot of messaging had to go around on why people are getting the vaccine, and not to stigmatize, because we had a lot of issues with stigma during the first one and the second time we used the vaccine.

Q: How are you able to evaluate the progress that you make in anti-stigmatization stuff?

Freeman: That's a good question. It's hard to do that with communication, period. Because my deployment—this last one—was a two-week deployment, I can't say—we can look at how people are treated in the community afterwards. Are they accepted back into the community? Because the case in November—that family was really stigmatized, and they had to move out of the community. They weren't accepted back. Then there were some inner issues within the family that caused—so we can look at that one and see that they were—because we put out a lot of messaging of, "welcome them back." We went into the community. "They don't have it, welcome them back home." But it's hard to say because nobody else around them was infected. People thinking a lot of different things because well, why is that the only house that got it? And last time everybody else around and why—and there's things we can't answer because we don't know scientifically why this person could have been laying in the bed with this person and they didn't become—their immune system is totally different, and why they were infected. It's a huge challenge. To evaluate the stigma behind it is hard because these are mini, little outbreaks that come out. It's hard to see that right now. Maybe once the vaccine is out of trials, we can actually really look at the stigma behind it a little closer. Because then we'll have a larger sample to look at, but right now—and that's somebody else's job because I'm not on that anymore. [laughter]

Q: So for the last year have you mostly been focused on Zika then?

Freeman: I became focused on Zika in June.

Q: In June of this year?

Freeman: That's when I went to American Samoa, because this year has been—when I went to Liberia in April, then in May I went to Geneva for a polio assignment, and then Zika.

Q: A bit of a whirlwind.

Freeman: Tired. But I enjoy it, and I am honored that people ask for me to come and work with them.

Q: As you look back at your Ebola experiences, or any experiences, are there any memories that you would like to share that we didn't get to?

Freeman: The good memories of it all—I'd have to say that the people I worked with, especially—because I had worked with them with polio—are like family to me. Actually, I worked with Frank Mahoney in May in Geneva. He asked me to come and help him with a special project, and we talked about the Nigeria Ebola experience a little bit, and I would have to say, those of us who worked it in the beginning, we have a special bond because we saw so much. Not to say that people who came after us are not, but it was different. We could communicate about how we felt about it and that experience because we don't really talk a lot about it, but we have a special bond that I don't have with any

other group of people I've ever worked with. Even that had grown out of working on polio, but even more so because we were up until three o'clock in the morning working in a hotel room. I would have to say that—and I've said this before—that I have been honored to work with Dr. Frank Mahoney. I had never worked with somebody who is so dedicated to public health and to the public as I've seen working with him. It's been an honor to—he's a very low-key, modest man, but when he's in the field, his dedication is amazing. It makes you want to work harder. It made me want to work harder because you see how hard he's working. For Liberia, working with the country director, Desmond Williams, has been an honor for me in a sense that he trusts me enough to let me do these assignments and keeps calling me back. When you see somebody trust you enough and have enough belief in the work that you do, I have to say, it's really hard to have that experience in my career. That helped me a lot to know, because some of these things was the first time I ever got to do them. I never wrote for a president before. So to be able to have those experiences, and that I have the ability and believe in the work that I do, and to teach also. Those two were like, you can do this. For both of my experiences, to have a group of people, a leadership, that's like, you can do this, I believe you can do this, has been one of the greatest experiences I've had. And working with the people, especially in Liberia because I worked closely with the Liberian staff, and being able to accept me into your culture, and being a part of that, has been an amazing experience.

Q: Well Yolonda, I want to say to you before we go off the air that it has been a privilege to listen to your story. It's always a privilege to listen to stories, but this one and listening to you has been special. Thank you.

Freeman: Thank you for the opportunity. I appreciate it.

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